

FILING A PAPER OR ELECTRONIC CLAIM IN PRIVATE PRACTICE

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Clinical social workers in private practice are licensed, independent, clinical practitioners who bill third party payers for clinical services provided when diagnosing and treating mental illness and other behavioral disturbances. The largest providers of mental health services in the nation, clinical social workers file health claims through Medicare, managed care companies, and other insurance carriers. For example, in 2002 alone, more than 3,529,000 claims were filed by clinical social workers through Medicare.

Clinical social workers in solo or group practice may submit their own claims for reimbursement, which requires them to keep abreast of the changes in claims processing requirements. Some may use the assistance of computer billing software programs, while others outsource their claims to billing services for completion.

PAPER CLAIMS

Clinical social workers submit paper claims for payment on a claim form called the CMS-1500, formerly known as the HCFA-1500. It is a universal claim form used by outpatient providers to bill for Medicare services covered under Part B. CMS-1500 is a standard form used by most health plans and some state Medicaid programs. Some health plans have their own versions of claim forms, which may or may not resemble the CMS-1500. Paper claims involve a very lengthy process, sometimes resulting in delayed payment and provider frustration.

ELECTRONIC CLAIMS

An electronic claim is an efficient way of filing by computer. Electronic claims are usually processed in shorter periods of time than paper claims, due to standardized information that results in speedier payments. One of the major benefits of an electronic claim is that it often allows a clinical social worker or other provider to be promptly informed if a claim is denied.

Of the six billion health claims filed by health care providers annually, only 40 percent are filed electronically (American Billing Association, 1998–2002). Many health plans have implemented processes to receive electronic claims, and are encouraging providers to submit them electronically. The implementation of HIPAA Electronic Standard Transactions in 2003 is expected to increase the number of electronic claims filed.

PROCESSING A CLAIM

Once a paper or electronic claim is received by a health plan, the patient's and provider's information, the diagnosis, and services rendered by the provider are analyzed and verified. Health care benefits are also verified to ensure that the service provided is a covered benefit, and that the claim is consistent with health plan rules and procedures. These are all labor-intensive tasks, which may extend the processing time and delay payments. It is not unusual for reimbursement policies and procedures to vary among payers, to arbitrarily change, or to be applied inconsistently. Now, forty-seven states and the District of Columbia have state statutes requiring timely payment of claims submitted to third-party payers for health and mental health services.

DENIED CLAIMS

According to the American Billing Association, 30 percent of all paper claims filed may be rejected. The clinical social worker should resubmit any denied claim as soon as possible, following his or her contract provisions, payer filing requirements, and applicable state and federal laws. When a denied claim is not resubmitted in a timely manner, with the corrected or requested information, a loss of payment may occur.

Behavioral health plans may deny claims submitted by clinical social workers for various reasons, based on their individual policies and procedures. Some common reasons for payment denials include:

- Lack of, or improper use of, CPT (Current Procedural Terminology) codes
- Lack of, or improper use of, ICD-9-CM (International Classification of Diseases-9th Edition-Clinical Modification) codes
- Lack of, or improper use of, place of service codes
- Missing provider number
- Incorrect or missing health plan information
- Lack of referral or authorization
- Lack of health plan enrollment
- Lack of supporting documentation

Contact the claims representative and/or provider relations to determine the best method to resubmit a denied claim. All denied claims resubmitted for payment should be properly identified as a "Resubmitted Claim." Attach supporting documentation to correct the denial, and send by guaranteed mail, such as express or certified.

APPEALING A CLAIM

There is a common belief among clinical social workers that appealing a claim may create a burden on a private practice. Not doing so may be costly, however, and may result in decreased revenue. Clinical social workers are encouraged to appeal denied claims that have been appropriately filed, and to bring them to the attention of the health plan through the appeal process. Follow the procedures for the appeal process. Sometimes several appeals are necessary to correct the payment denial. Be persistent and, should you encounter problems along the way, contact NASW for assistance.

IMPLEMENT AN INTERNAL CLAIM AUDIT

It is important for clinical social workers to audit each reimbursement received from various health plans to determine its accuracy. Doing so can help prevent lost of revenue from partially paid, delayed, or denied claims that go unnoticed or unchallenged.

Develop audit procedures in your practice that help track payment for services performed. Conducting monthly collection reports and reviewing the explanation of medical benefits (EOB) can help you determine if the health plan has made a payment error.

SUMMARY

Filing a paper or electronic claim in private practice can be time consuming and very challenging. Processing a claim is a lengthy activity, involving sorting, extracting, and verifying patient and clinical social work information. Denied claims should be resubmitted for payment promptly with supporting documentation. If the claim continues to be denied with proper documentation, it is best to appeal it. Implementing internal practice audits can help ensure proper payment for services provided.

"Dirty claims" are denials resulting from improper, incomplete, or inaccurate information on claim forms. It is the private practitioner's responsibility to ensure that claims submitted have complete, correct, and current information.

RESOURCES

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