DAUPHIN COUNTY MH/MR PROGRAM
POLICY AND PROCEDURE

<table>
<thead>
<tr>
<th>Department</th>
<th>Policy No.</th>
<th>Effective Date</th>
<th>Revision Date</th>
<th>Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH</td>
<td></td>
<td>April 1, 2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Policy:** All MH/MR network providers who administer medically oriented treatment must verify insurance availability with all consumers on a regular basis.

**Procedure:** MH Providers under contract with MH/MR will assume primary responsibility to monitor the healthcare coverage of persons while receiving treatment under their care. There are three critical reasons for this charge:

1. Providers are responsible for exhausting all available healthcare coverage before the county will pay for treatment.

2. Providers actively involved in the treatment of a consumer have frequent contact with the person, thus affording the opportunity to verify coverage.

3. HealthChoices requires that all available third party healthcare coverage be billed first and that this information be maintained in the MCO’s financial database as an integrated billing resource.

The following steps must be implemented by all providers who render inpatient, outpatient, partial hospitalization, or EPSDT wrap around services to assure that the accuracy of all healthcare coverage is maintained and documented:

1. Initial authorizations from the county will indicate all third party insurance that must be billed.

2. The provider must implement an internal policy that requires regular healthcare coverage verification with the consumer prior to rendering service. This is preferably done at the time of each treatment session, but must be completed at least monthly during active treatment.
3. If the person’s healthcare coverage changes from that which was originally indicated on the authorization, the provider must notify the case manager of the change and provide all pertinent information.

4. If the case manager identifies a change in a person’s healthcare coverage, providers and the administrative office will be notified of this change and given all pertinent information.

5. Consumers who are also receiving transportation to their Partial Hospitalization and/or Outpatient Clinic appointments and are found eligible for Medical Assistance must immediately complete the Medical Assistance Transportation Program application form. It is the case manager’s responsibility to assist in assuring that the MATP application form is completed by the consumer. This form is available through the case manager or can be secured at the Capital Area Transit office.

6. Van service should be discontinued if the MATP application form is not completed.

7. When the County determines that a person has Medicaid, Medicare or any other third party insurance while processing bills, the Fiscal Department will notify the provider of all pertinent information so proper billing can be completed. If the person is receiving transportation services and the County determines that they have Medicaid, the Fiscal Department will notify CAT and the case manager within the next business day of the person’s Medicaid eligibility and the need to apply for the MATP program. Since MATP will not allow retroactive billing for this service, the County will fund all treatment related transportation for a period of 30 days beyond the date of determination that the person was eligible for Medicaid.