MEM-Fee-for-Service (FFS) Member Calls Regarding Bills or Refusals of Service

Purpose:

This procedure explains the process of how to handle a Fee-for-Service member's call regarding any bills they may have received or refusals of service.

Identification of Roles:

Customer Service Representatives (CSR)

Performance Standards:

The Member Services and Contact Center Customer Service Representatives are responsible for responding to 80% of calls within 30 seconds of the call entering the appropriate queue. Quality Assurance for all Member Service's calls must be at least 90%. However, enrollments should be completed correctly 100% of the time.

Path of Business Procedure:

Step 1: Calls are routed by an Automatic Call Distributor (ACD) into a billing queue and answered by the next available CSR.

Step 2: CSR accesses the member's file and they will verify that the caller is Health Insurance Portability and Accountability Act of 1996 (HIPAA) authorized to obtain information and make changes to the member's file.

a. Verify the person calling is listed as the member, the case name or the name in Social Services Number Information (SSNI).
b. Verify the mailing address on file.
c. Request the caller's current phone number.

Step 3: CSR will determine what type of service the member is being billed.

a. If the member is getting a bill for a prescription drug, go to Step 15.
b. If the member is receiving a bill from a provider, go on to Step 4.

Step 4: Create Contact Log (See Contact Log Procedures)

a. For billing inquiries, your Contact Reason should be Billing/Claims Inquiries.
    - Keep in mind we can take information from anyone and begin a bill inquiry regardless of whether the caller is authorized or not.
b. For refusals of service not due to a billing issue, please assist the caller to find another provider in their area using the Fee-for-Service 'Find a Provider' tool (https://dhs.iowa.gov/ime/members/find-a-provider)

Step 5: Click the Create MEM Billing Inquiry button on the Contact Log.

Step 6: Clicking the Create MEM Billing Inquiry is only valid for the primary State ID (SID) entered on the Contact Log.

a. You may enter multiple bill inquiries off of one contact log for one member.
b. If your caller has multiple members with bills you will need to make separate Contact Logs.

Step 7: The bill inquiry form will open. Check the top of the form where it is grayed out. This part of the form auto populates from your Bill Inquiry Contact Log. Review the following information:

a. The date of call.
b. The Contact Log #.
c. The member's name is listed and spelled correctly.
d. The member's case number.
e. The member's address.
f. The member's SID.
g. The member's phone number.

Step 8: Enter the SSNI verified name in the HIPAA Auth Rep field (See SSNI procedures).

Step 9: Obtain the following necessary information from the caller:

a. The name of the provider that is billing the member. (If you are not sure how it is spelled, ask the member or refer to the commonly misspelled words list provided to you.)
b. The provider's phone number.
c. The city and state where the provider is located.
d. The specific dates of service.
e. The specific amount the member is being billed for each date of service. (A date range is only allowed for hospital stays; otherwise each date of service must have its billed amount next to it).
f. Whether or not the member was eligible for the date of service.
g. The Provider Number is not required and the Patient Account # is optional but helpful.
h. If the member provides all necessary information, go to Step 10.
i. If the member cannot provide all necessary information, go to Step 12.

Step 10: Once the inquiry has been filled out, verify with the member that the information you have taken is correct. Then explain the inquiry process can take <u>up to</u> 30 days, and they will receive a response in writing.

Step 11: Click the 'submit' button on the Billing Inquiry Form. You have now completed this billing inquiry. Now you may do the following:

a. If the caller has no further billing inquiries, go to Step 14a.
b. If the caller has more bill inquiries for this member, go back to Step 5.
c. If the caller has billing inquiries for another member, go back to Step 1.

Step 12: If the caller was unable to provide all necessary information, advise them of the following:

a. In order to properly research your billing issue we do need all of the information requested. Please contact our office when you have the information from Step 6 (a – e).
b. Go on to Step 14b.

Step 13: If you have advised the member to fax or mail in their bills provide them with the following:

a. The fax number 515-725-1351. Attention Member Services Billing Dept.
b. The address for mailing is:
   Iowa Medicaid Member Services
   Billing Dept.
   PO Box 36510
   Des Moines, IA 50315
c. Do not instruct the caller to put the bills to any one person's attention.
d. Go to Step 11b.

Step 14: Complete your Contact Log with the following notes:

a. If you complete a Billing Inquiry Form, your 'Contact Description' should state the following:
   1. CN/MBR called b/c they were receiving a bill. Requested a bill inquiry and informed CN/MBR they would receive a letter within 30 days advising the outcome.
b. If you do not complete a Billing Inquiry Form, your 'Contact Description' should state the following:
   1. CN/MBR did not have all the information needed to complete bill inquiry. CN/MBR will callback.
   2. CN/MBR had several bills so I have instructed them to fax/mail the bills in. Advised once we receive the bills we will begin research and CN/MBR will receive a letter back within 30 days advising of the outcome.

Billing Inquiry for bills from providers complete.

Step 15: If the member is receiving a bill for an RX issue, CSR will complete an RX Issue.

Step 16: Ask the caller if the pharmacy or physician explained to them why they could not pick up the prescription.

a. If they cannot pick up the prescription due to Third Party Liability (TPL) being listed incorrectly on their file, see the TPL procedures.
b. If they cannot pick up the prescription due to Medicare Part D, refer them to their Medicare Part D plan.

c. If the member states they need a prior authorization, refer the member to the provider that wrote the prescription.
d. If the answer to a, b, & c is “NO”, proceed to Step 17.

Step 17: Collect the following information from the caller:
a. Member name(s)
b. Member ID#(s)
c. Member’s date of birth
d. Phone number where caller can be reached and a good time to reach them
e. Pharmacy’s name
f. Pharmacy’s phone number
g. Name of the prescription(s)
h. Date tried to fill prescription(s)

Step 18: Click the RX Research tab on the Contact Log.

Step 19: The following boxes will be automatically filled out based on the primary ID number on the contact log.
a. Member Name
b. Member Date of Birth
c. Member ID
d. Member Phone Number

Step 20: Enter in the following information onto the RX Research tab:
a. Pharmacy Name
b. Name of Prescription (s)
c. Best Time to Call
d. Pharmacy Phone
e. Date of Fill Attempt

Step 21: Click the Mem Contact Log tab to go back to your main Contact Log.

Step 22: Click the Type of Request drop down and choose Prescription Research.

Step 23: When you have completed the call, hit the ‘save’ and ‘new’ button. Your RX issue will automatically be sent to the Member Services Specialist (MSS).

Step 24: Member Services Specialist will send the RX issue to Pharmacy who will research and respond.

Step 25: Member Services Specialist will call member back with the outcome of the research.

Forms/Reports:

N/A

RFP References:

N/A

Interfaces:

MMIS Claims Inquiry SUBSYSTEM
OnBase Workview
OnBase Workflow

Attachments:

None