San Diego County

Behavioral Health Services

Financial Eligibility and Billing Procedures - Organizational Providers Manual

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Introduction

The County of San Diego Health and Human Services Agency (HHSA) Behavioral Health Services Division is responsible for management of the public behavioral health system. The HHSA Financial Support Services Division is responsible for management of mental health financial eligibility, billing and reimbursement. The public behavioral health system provider network includes County operated programs and contract providers, which are known as organizational providers; private practitioners such as psychiatrists and psychologists, which are known as individual fee for service (FFS) providers; and private hospitals, which are known as FFS hospitals. Each of these provider groups is responsible for specific functions related to determining client financial eligibility, billing and collections.

This manual provides standardized procedures for organizational providers, who may be County or contract providers. Separate manuals outline procedures for individual FFS and FFS hospital providers.

The Organizational Providers Operations Handbook Volume II, MIS User Manual provides detailed instructions for completion of MIS related non-financial administrative processes including entry of new clients, entry of demographic information and diagnoses, assignments and services. This Financial Eligibility and Billing Procedures – Organizational Providers Manual provides detailed instructions for completion of financial eligibility and billing processes including entry of third party coverage and financial reviews (UMDAP), billing and recording of payments.

General Workflow

The following is a summary of a typical workflow for new clients, existing clients who are new to the program and ongoing clients. Please refer to this manual for further detail regarding financial eligibility billing and payment functions and to the Organizational Providers Operations Handbook Volume II, MIS User's Manual for other tasks.

New Clients (not found in client look-up)

- Add the client
- Enter a Demographic review
- Enter a Diagnostic review
- Assign client to program and staff
- Conduct a financial interview
    - Enter 3rd party coverage (Insurance/Medicare Risk/Cal MediConnect/Medicare/Medi-Cal)
    - File signed Authorization of Benefits (AOB) and authorization to Release of Information (ROI), if applicable
    - Enter California Client Financial review (UMDAP)
    - File signed California Client Financial Review Maintenance form (financial responsibility form)
- Enter services
- Contract Providers only – if client has Insurance/ Medicare/Medicare Risk/Cal MediConnect
    - Submit billing to insurance company or Medicare carrier
    - Submit Explanation of Benefits (EOB) to BHS Billing Unit to record payments or denials.

Existing clients who are new to the program

- Confirm/update the Demographic review
- Confirm/update the Diagnostic review
- Assign client to program and staff
- Conduct a financial interview
    - Confirm/update 3rd party coverage (Insurance/Medicare Risk/Cal MediConnect Medicare/ Medi-Cal)
    - File signed AOB and ROI, if applicable
    - Confirm/update Financial review (UMDAP)
    - File signed Financial responsibility form
- Enter services
- Contract Providers only – if client has Insurance/Medicare Risk/Cal MediConnect/ Medicare
    - Submit billing to Insurance/Medicare Risk/Cal MediConnect/Medicare
    - Submit Explanation of Benefits (EOB) to BHS Billing Unit to record payments or denials.

Ongoing Clients

- Confirm/update applicable fields on Demographic review at the time of the Annual Review, as changes occur or become known- the address, telephone, emergency contact and living arrangements fields should be confirmed or updated at each visit.
- Update the Diagnostic review each time diagnosis is changed by a server
- Update assigned staff if applicable
- Conduct a financial interview annually and whenever clients financial situation changes
    - Confirm/update 3rd party coverage (Insurance/Medicare Risk/Cal MediConnect/ Medicare/Medi-Cal)
    - Confirm/update and file signed AOB and ROI, if applicable
    - Confirm/update Financial review (UMDAP)
- Enter services
- Contract Providers only – if client has Insurance/Medicare Risk/Cal MediConnect/ Medicare
    - Submit billing to insurance company or Medicare carrier
    - Submit Explanation of Benefits (EOB) to BHS Billing Unit to record payments or denials.

Weekly and Monthly Self-Monitoring

All programs are responsible for monitoring, correcting and updating the financial reviews; 3rd party insurance entry, Medi-Cal eligibility determination, etc. that are documented in the BHS MIS in accordance with the instructions in this manual. The Provider Self-Monitoring Reports section includes summary information about reports available to facilitate the monitoring and correcting process.

Client Financial Responsibility for Public Behavioral Health Services

In accordance with the State of California Welfare and Institutions Code 5709:

> **Regardless of the funding source involved, fees shall be charged in accordance with the ability to pay for specialty mental health services rendered but not in excess of actual costs in accordance with Section 5720.**

Clients who are residents of the State and who are receiving community behavioral health services, including involuntary admissions, are to be charged a fee according to their ability to pay, utilizing the Universal Method to Determine Ability to Pay (UMDAP) Fee Schedule. Organizational providers must enter the financial eligibility information into the BHS MIS to ensure accurate billing of services. If unable to enter the financial billing information providers shall submit CA financial review form to the County's billing office fax number (858) 467-9682. Note- Programs are not required to UMDAP full scope Medi-Cal clients with no Share of Cost. This is optional incase the client fall out of Medi-Cal, programs should verify if the client has Insurance and collect an AOB and forward to Billing to update in the system if the program is not able.

> **Note:** Clients residing in residential and long term care (LTC) programs may be responsible for room and board costs, which are not billed via the BHS MIS.

Behavioral Health services provided by the following areas are not chargeable to the client and are therefore exempt from the entry of UMDAP in the BHS MIS system:

- Adult Forensic Services
- Cal-Works
- Clubhouses
- Residential Programs (Does not include Day Treatment Services or Adult Crisis and Residential)
- Long Term Care Institutions
- Outreach and Community Services

In order to be eligible for UMDAP, residency in California is required. Residency is defined as intent to reside based on the client's verbal declaration. This applies to foreign nationals, immigrants and nonimmigrants, regardless of immigration status. Without intent to reside in the state, the client is not eligible for UMDAP and must be billed at full cost.

> **Note:** In accordance with Federal, State and County policy, person who are known to be undocumented immigrants and are 26 and over, Medi-Cal eligibility is restricted to Pregnancy related (client must be pregnant or within the postpartum requirements) or emergency services provided at an acute hospital or if the service was an emergency at the crisis stabilization programs and documented as an emergency. Check the aid code listing for eligibility status. As of May 1, 2016, a new law was passed Senate Bill 75 (SB75), this provides for children under the age of 19 that do not have satisfactory immigration status (undocumented immigrants) to be eligible to full scope Medi-Cal Sate General Funds (SGF)only. As of January 1, 2020, the State of CA has implemented a new program called the Young Adult Expansion (SB 104) to include undocumented immigrants from 19 to 25 years of age. Medi-Cal Counties are reimbursed SGF, no FFP for clients who fall under the SB75 and SB 104 the young adult expansion program. Any service that is not reimbursable by Short-Doyle/Medi-Cal maybe chargeable to the client. Effective May 1, 2022 (AB 133) will include beneficiaries 50 yrs of age or olde that will be eligible to SGF. The DHCS has issued a directive that clients that fall into category one are qualified non-citizens who have been in the United States for less than five years (qualified Non-Citizens) and category 2 individuals who are (PRUCOL) who show eligible to full scope Medi-Cal are the Counties responsibility to pay the cost of non-emergency and non-pregnancy related services.

Cost Sharing – Any cost sharing imposed on Medicaid Enrollees must be in accordance with FFS requirements. Any Indian who is eligible to receive or has received an item or service furnished by an IHCP through referral under contract health services is exempt from premiums and any Indian who is currently receiving or has ever received an item or service by an IHCP is exempt from all cost sharing. 42 CRF 447.50 thru 42 CRF 447.82,

Third Party Liability - If the State enters into a Coordination of benefits (CBA) with Medicare for FFS, and the MCP contact includes responsibility for coordination of benefits for individual dually eligible for Medi/Medi, the contract requires the MCP to enter into a CBA with Medicare and participate in the automated claims cross over process.42 CFR 438.3(t)

Determining Financial Eligibility

Organizational Providers are responsible for conducting a client screening/ financial interview with new clients and existing clients who are new to the program prior to providing non-emergency or crisis services. If a financial review was completed at another program prior to the client receiving services at your program and nothing has changed, no need to do complete another financial review. If clients are provided emergency or crisis services in advance, the client screening/ financial interview shall be completed before the client leaves the facility or as soon as possible thereafter. Ongoing clients should receive a financial interview at least once per year and whenever there is a change in the client's financial situation, e.g. change in income or Insurance coverage**.**

In order to take full advantage of the software functionality, program staff should gather the information from the client and enter it directly into BHS MIS as an interactive process. This manual includes forms designed for use if the financial information must be gathered from clients by direct service staff in situations when it is not possible to enter information directly into the BHS MIS.

Client Screening/Financial Interview

The purpose of a client screening/financial interview is to identify and document any third party coverage that the client may have and to determine the client's responsibility for payment for services. In addition, as part of this process, clients who appear to be eligible for Medi-Cal should be referred for assistance with applications for Medi-Cal.

The screening process consists of a Client 3rd Party Coverage review which includes Insurance/Medicare Risk/Cal MediConnect and Medicare, Medi-Cal Eligibility Review, and Client Financial Review or UMDAP. It is recommended entry is made directly into the BHS MIS. In situations when that is not possible, the following BHS MIS forms should be completed for later entry into the BHS MIS:

- Client 3rd Party Coverage Screen
- California Client Financial Review Screen
- Assignment of Benefits and Release of Information Form

Client 3rd Party Coverage (Insurance/Medicare Risk/Cal MediConnect/ Medicare and Medi-Cal)

When a client visits a program and has been determined to have Insurance, Medicare Risk/Cal MediConnect/Medicare, or Medi-Cal, the coverage shall be entered in BHS MIS in the Client 3rd Party Coverages view.

Insurance/Medicare Risk/Cal MediConnect/Medicare Coverage Entry

Ask the client for his/her Insurance card. Make a copy of the card (front and back) and file in the client's chart. In the Client 3rd Party Coverages screen:

Step 1 – To select Client

- Search for client using magnifying glass
  - Click on "ALL" button
  - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
  - Highlight appropriate client and click OK or double click

Step 2 – To complete 3rd Party Coverage

- Main (1)
  - Search for Pay Source using magnifying glass
    - Look for Insurance name and billing address provided by Insurance Company
  - Enter Benefit Plan:
    - Benefit Plan 1 – Standard
      - This is used for standard insurance policies.
    - Benefit Plan 16 – HMO Medicare Risk
      - This is used when insurance has been identified as a Medicare Risk/Advantage or Cal MediConnect policies, when verified with insurance company.
    - Benefit Plan 9020 – Inpatient Only
      - This benefit plan is considered a 9000 series benefit plan. Therefore, this does not require selection; all clients are automatically set up with a 9000 benefit plan – so based on the Pay Source selection (insurance company selection – inpatient services can be billed if appropriate)

Caution: Many insurance companies have similar names. Carefully choose the insurance company that was verified when insurance company was called. Please consult a copy of the Pay Source Listing with addresses, to ensure the correct pay source is selected. In the event you cannot find the insurance company, please contact the BHS Billing Unit at (619) 338-2612 for assistance.

- If the Pay Source is Insurance/Medicare Risk/Cal MediConnect:
  - Enter the policy number from the card
  - Enter the effective date:
    - Use the first date of admission or effective date of Insurance, whichever is later
  - Example: If a client presents for the first time for treatment on October 10, 2007, and their Insurance card reflects they have Insurance coverage since January 1, 2000, the effective date entered into the BHS MIS system would be the 1st day of admission via the assignments screen.
    - **Note:** Use the first of the month for accurate billing since most insurances start on the 1st of the month. By using this date, you prevent any potential issues surrounding appropriate or inaccurate service billing.

- Enter the appropriate Pay Source Priority number from this table for billing purposes :

▪ Insurance - Primary	=	1
▪ Insurance – Secondary	=	2
▪ Insurance – Tertiary	=	3
▪ Medicare	=	4
▪ Insurance Secondary to Medicare	=	5
▪ Medi-Cal	=	6
▪ MCO FFS	=	7

The priority number is used to determine which payer will be billed first. In most cases, insurances should be entered with a priority # 2. This will allow for the entry of an additional insurance company as the primary, if it is found that the client had other Insurance. If the client has more than one insurance, the primary coverage should be entered as # 1 and the secondary coverage should be entered as # 2. Exceptions include insurance policies that are Medicare supplements. These should be entered with a priority #5. If you have questions about the correct priority number, please contact the BHS Billing Unit at (619) 338-2612 for assistance.

- Group Number: Enter group number or name from the card
- Policy Holder:
  - Relationship to Insured:
    - Search to select appropriate relationship
    - If other than the client, complete name, address, Date of Birth (DOB) and sex.

Example: If the insured is a parent and the client is a child, then the relationship to insured is Child.

- Main (2)
  - The "Ok to Bill" box should be checked at all times. In the event that the box is unchecked, notification to the BHS Billing Unit will be necessary for approval and documentation within the system is necessary in the comments field.

  - The Alias field in the 3rd party coverage view on Main (2) tab is used to record an alternate name that is used on client's insurance records. If the name on the clients' insurance card is different than the client's name in BHS MIS, enter the name on the insurance card in the alias field for that insurance coverage.

Example: Client name is "Smith-Johnson, Susan" however, with her insurance company she is known only as "Johnson, Susan". We can place the "Johnson" in the last name of the alias field to be used for billing to this particular insurance company, and the original name "Smith-Johnson, Susan" bills to all other insurance companies. Once the information has been entered, please provide the alias information to staff responsible for completing the demographics in the program to allow for entry into the alias section of the demographics module.

Once the alias information has been completed, open the Comments tab (5) and document the alias information and identify where the information was gathered and identified with the date, employee full name, staff id number and Unit/subunit.

- State Specific (3)
  - No Entry required for insurance clients

- Comments (5)
    - Additional comments concerning client insurance may be entered. ***When making entries into any Comment field, each comment shall be identified with the date, employee full name, staff id number, and Unit/sub-unit.***

After all entry has been completed click **SAVE.**

To add another insurance click button marked "CLEAR" at the bottom of the screen and repeat the process for additional insurance coverage entry.

To Edit Insurance Coverage

It may be necessary to edit previously entered insurance coverage due to a data entry error or termination of coverage. An effective date and reason for the change must be entered to keep an audit trail of the client's coverage information any time a change is entered.

Step 1 – To select Client

- Search for client using magnifying glass
    - Click on "ALL" button
    - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
    - Highlight appropriate client and click OK or double click

Step 2 - To Edit or Update Insurance Coverage

- Main (1)
    - The following areas may be edited:
        - Insurance Policy Number
        - Expiration Date (may be entered)
- Main (2)
    - Change Date: Enter date of entry for change
    - Document the reason for the change.
        - Include the unit/subunit
        - Include the full name and staff id number of the person making the change

Please note: If the effective date or name of insurance coverage needs to be edited, you must contact the BHS Billing Unit at (619) 338-2612 for assistance. Please refer to the Troubleshooting section in the manual for more information.

To Expire Insurance Coverage

If the Insurance coverage has expired, the Program staff shall enter the expiration date into the BHS MIS.

Step 1 – To select Client

- Search for client using magnifying glass
    - Click on "ALL" button
    - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
    - Highlight appropriate client and click OK or double click

Step 2 – To Expire Insurance Coverage

- Main (1)
    - Type in the Expiration Date of the Policy into the field designated.

- If the date entered is considered a future date, the priority box will reflect an "I" for inactive. Even though the policy will be effective until the expiration date arrives and will "technically" look as if it is inactive, billing will still occur appropriately.

- Main (2)
  - Change Date: Enter date of entry for change
  - Document the reason for the change.
    - Include the unit/subunit
    - Include the full name and staff id number of the person making the change.
- State Specific (3)
  - No Entry for Medicare Clients

- Comments (5)
  - Comments regarding client insurance may be entered. **Identify comments with the date of entry, employee full name, staff id number, and unit/sub-unit.**

After all entry has been completed click **SAVE**.

To Reactivate Insurance Coverage

If a client's insurance policy is reactivated after it has been already expired in the BHS MIS, the Program staff can reactivate the policy with a new effective date.

Step 1 – To select Client

- Search for client using magnifying glass
  - Click on "ALL" button
  - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
  - Highlight appropriate client and click OK or double click

Step 2 – To Reactivate Insurance Coverage

- Main (1)
  - Click on "ALL" button below the Insurance listing for the client. This will allow the program to see all of the active and inactive policies for the client.
  - Click on the appropriate insurance policy to be reactivated.
  - Press "Reactivate" at the bottom of the screen
  - Confirm the appropriate policy number for the client
  - Type in the new effective date for the policy in the "Effective Date" box.
  - Type in the appropriate Pay Source priority number

- Main (2)
  - Change Date: Enter date of entry for change
  - Document the reason for the change.
    - Include the unit/subunit
    - Include the name and staff id number of the person making the change.

- State Specific (3)
  - No Entry for Insurance Clients

- Comments (5)
  - Comments regarding client insurance may be entered**. Identify comments with the date of entry, employee full name, staff id number, and unit/sub-unit.**

After all entry has been completed click **SAVE.**

To Delete Insurance Coverage

Deletion of insurance Coverage shall only be completed by the BHS Billing Unit. Please contact the BHS Billing Unit at (619) 338-2612 for assistance. The Billing Unit will require a reason for the proposed deletion.

Medicare Policy Coverage Entry

Ask the client for his/her Medicare card, all Medicare clients have been provided a new Medicare card with a new Medicare ID number called a Medicare Beneficiary Identifier (MBI), Medicare will no longer accept claims with the old ID number as of 1-1-2020. Make a copy of the card and place in the client's chart. In the Client 3rd Party Coverage view:

Step 1 – To select Client

- Search for client using magnifying glass
  - Click on "ALL" button
  - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
  - Highlight appropriate client and click OK or double click

Step 2 – To complete 3rd Party Coverage

- Main (1)
  - Search for Pay Source
    - Medicare A only = 200
    - Medicare B only = 201
    - Medicare A & B = 202

Medicare policies must be documented appropriately. When the client has Medicare Coverage, they have coverage with one and only one of the Medicare Pay Sources. If the client has Medicare Part A only, use the policy number 200 (Medicare Part A); if the client has Medicare Part B only, use the policy number 201; and if the client has Medicare Part A and Part B, use the policy number 202 (Medicare Part A & B).

Medicare Pay Source entry is not based on services provided, but is based on the client's coverage. For example, if you are an outpatient program, and the client has Medicare Part A and Part B, the pay source entered into the BHS MIS system is 202 – Medicare A & B.

- If the Pay Source is Medicare:
  - Enter the policy number from the card. The Policy Number is 11 digits Alpha Numeric with 2,5,8 and 9 characters always Alpha, and you must use capital letters. The letters SLOIZ will never be used to avoid being interpreted as numbers.
  - Enter the effective date:
    - Use the first date of service via admissions tab or effective date of insurance, whichever, is later. **Note**: 1st day of verified month.
  - Priority:
    - Enter the appropriate Priority number for billing purposes:
      - Medicare = 4
- Main (2)
  - The Alias field in the 3rd party coverage view is used to record an alternate name that is used on client's insurance records. If the name on the clients' insurance card is different than the client's name in BHS MIS, enter the name on the insurance card in the alias field for that insurance coverage. Example: Client name is "Thorn, James",

however, with his insurance company he is known only as “Thorn Jr, James”. We can place the “Thorn Jr” in the last name of the alias field to be used for billing to Medicare, and the original name “Thorn, James” bills to all other insurance companies. Once the information has been entered, please provide the alias information to whoever completes the demographics in the program to allow for entry in the demographics module.

- QMB (Qualified Medicare Beneficiary) – Do <u>not</u> place a check mark in the box marked QMB, as this will affect the Medi-Cal billing in a negative manner. QMB is a special program for low income Medicare beneficiaries that do not apply to San Diego County Behavioral Health services.

- State Specific (3)
  - No Entry for Medicare Clients

- Comments (5)
  - Document the alias information, identifying where the information was gathered**,** the date, employee full name, staff id number, and unit/sub-unit.

When making entries into any Comment fields, each comment shall be identified with the date, employee name, staff id number and unit/sub-unit.

After all entry has been completed click **SAVE**.

To Edit Medicare Coverage

It may be necessary to edit previously entered Medicare coverage due to a data entry error or termination of coverage.

Step 1 – To select Client

- Search for client using magnifying glass
  - Click on “ALL” button
  - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
  - Highlight appropriate client and click OK or double click

Step 2 – To Edit or Update Medicare Coverage

- Main (1)
  - The following areas may be edited:
    - Medicare Policy Number - The Policy Number must be 1 1 characters
    - Expiration Date (may be entered)

- Main (2)
  - Change Date: Enter date of entry for change
  - Document the reason for the change.
    - Include the unit/subunit
    - Include the name and staff id number of the person making the change.

- State Specific (3)
  - No Entry for Medicare Clients

- Comments (5)
  - Any comments can be entered concerning the client.

After all entry has been completed click **SAVE**.

To Expire Medicare Coverage

If the Medicare coverage has expired, the Program staff shall enter the expiration date into the BHS MIS. This should only occur if the client is not showing any type of Medicare coverage with Noridian and has not assigned Medicare benefits to a plan such Risk-Advantage or Cal MediConnect.

Step 1 – To select Client

- Search for client using magnifying glass
  - Click on "ALL" button
  - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)

- Highlight appropriate client and click OK or double click Step 2 – To Expire Medicare Coverage
  - Main (1)
    - Type in the Expiration Date of the Policy into the field designated.
    - If the date typed in is considered a future date, then the priority box will reflect an "I" for inactive. Even though the policy will still be effective until the expiration date arrives and will "technically" look as if it is inactive, billing will still occur appropriately.
  - Main (2)
    - Change Date: Enter date of entry for change
    - Document the reason for the change.
      - Include the unit/subunit
      - Include the name and staff id number of the person making the change.
  - State Specific (3)
    - No Entry for Medicare Clients
  - Comments (5)
    - Any comments can be entered concerning the client.

After all entry has been completed click SAVE.

To Reactivate Medicare Coverage

If a client's Medicare policy is reactivated after it has been already expired in the BHS MIS, the Program staff can reactivate the policy with a new effective date.

Step 1 – To select Client

- Search for client using magnifying glass
  - Click on "ALL" button
  - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
  - Highlight appropriate client and click OK or double click

Step 2 – To Reactivate Medicare Coverage

- Main (1)
  - Click on "ALL" button below the Insurance listing for the client. This will allow the program to see all of the active and inactive policies for the client.
  - Click on the appropriate insurance policy to be reactivated.
  - Press "Reactivate" at the bottom of the screen
  - Confirm the appropriate policy number for the client
  - Type in the new effective date for the policy in the "Effective Date" box.

- Type in the appropriate priority number
- Press “Save”

- Main (2)
  - Change Date: Enter date of entry for change
  - Document the reason for the change.
    - Include the unit/subunit
    - Include the name and staff id number of the person making the change.

- State Specific (3)
  - No Entry for Medicare Clients

- Comments (5)
  - Any comments can be entered concerning the client.

After all entry has been completed click **SAVE**

To Delete Medicare Coverage

Deletion of Medicare Coverage shall only be completed by the BHS Billing Unit. Please contact the BHS Billing Unit at (619) 338-2612 for assistance. The Billing Unit will require a reason for the proposed deletion.

Process for Determining Medi-Cal Eligibility

Reviewing the client’s eligibility via the Medi-Cal eligibility website will provide information on the clients’ aid code and determine whether an individual is qualified to receive services as part of the Medi-Cal program. Program staff is responsible for ensuring that current Medi-Cal eligibility information is recorded for all clients who are Medi-Cal beneficiaries. For new clients, Medi-Cal eligibility should be entered prior to the delivery of services. In addition, Medi-Cal eligibility should be verified **each time** a client receives Medi-Cal covered services.

The BHS MIS system includes an upload of the State’s Monthly Medi-Cal Eligibility File (MMEF) which includes all of the Medi-Cal beneficiaries within the State of California. As another way to ensure that Medi-Cal eligibility is captured for all clients, this file is downloaded each month and matched against the clients registered in BHS MIS. This process is completed by the BHS Billing Unit on a monthly basis and programs are notified each month via email from OPTUM once the process is complete**.**

Monthly Medi-Cal Eligibility File (MMEF)

The Monthly Medi-Cal Eligibility File (MMEF) file is downloaded each month and matched against the clients registered in BHS MIS. This process is completed by the BHS Billing Unit on a monthly basis**.** The MMEF is received toward the end of the month and includes sixteen months of coverage information which equates to “the current month” and fifteen prior months data. The current month is the month following the month in which the MMEF file is received. An example: when MMEF is received in late November, the current month is considered to be December. This means that Medi-Cal eligibility will be automatically entered through this process for most existing clients. However, since the match process may sometimes contain errors, programs should not rely on this method of updating Medi-Cal eligibility.

Match Maintenance

The MMEF Match Maintenance is a monthly process conducted by the BHS Billing Unit. The MMEF file includes all the Medi-Cal clients within the County, not just those who are clients of the County MH system. Therefore, the BHS MIS allows a process by which the system can attempt to match each of the MMEF client records with a client in the BHS MIS system. Each client recorded in the MMEF file will be categorized as:

Match: The MMEF record can be automatically matched to a client in the BHS MIS system (i.e. with no human intervention required)

Potential Match: The MMEF record potentially matches a client in the BHS MIS system pending a manual determination (i.e., human intervention required)

No Match: The MMEF record does not match a client in the BHS MIS.

For the client who can be matched using this MMEF utility, the client coverage in the BHS MIS will be automatically updated to reflect the appropriate information. Note: prior to updating the client coverage record, a snapshot of the existing client coverage information will be permanently recorded to facilitate auditing.

Medi-Cal Policy Coverage Entry

Medi-Cal coverage shall be entered using information from the client's Medi-Cal card, either by going to: https://www.medi-cal.ca.gov/Eligibility/Login.asp on to Medi- Cal Eligibility or by matching to Monthly Medi-Cal Eligibility File (MMEF).

Ask the client for his/her Medi-Cal card. The following procedure should be used if the client has their Medi-Cal card.

In the Client 3rd Party Coverage view: Step

1 – To select Client

- Search for client using magnifying glass
  - Click on "ALL" button
  - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
  - Highlight appropriate client and click OK or double click

- Enter Pay Source as Medi-Cal

Step 2 – To complete Medi-Cal Coverage

- Main (1)
  - Search for Pay Source
    - Medi-Cal = 100
  - Enter the policy number from the card
  - Enter the effective date:
    - Use the first day of the month of service or effective date of Medi-Cal, whichever is later- check Medi-Cal eligibility by logging in site above to confirm that the client has active Medi-Cal on the date of service.

- Enter the appropriate Priority number for billing purposes:
  - Medi-Cal = 6
  - If you are entering Medi-Cal information for the first time meaning there is no history of Medi-Cal Eligibility in CCBH, go to the State specific tab and add the County of responsibility and aid code based on the eligibility response. If you are not able to enter the data on the State Specific screen and no County of responsibility or aid code is present contact the Billing Unit.

Step 4: To Save Updated Information

- Click Update at the bottom of the response screen to save information to BHS MIS.

Step 5:

Main (2)

- The Alias field in the 3rd party coverage view is used to record an alternate name that is used on client's insurance records. If the name on the clients' insurance card is different than the client's name in BHS MIS, enter the name on the insurance card in the alias field for that insurance coverage. Example: Client name is "Smith-Johnson, Susan" however, with her insurance company she is known only as "Johnson, Susan". We can place the "Johnson" in the last name of the alias field to be used for billing to this particular insurance company, and the original name "Smith-Johnson, Susan" bills to all other insurance companies. Once the information has been entered, please provide the alias information to whoever completes the demographics in the program to allow for entry in the demographics module.

Once the alias information has been completed, open the Comment tab (5) and document the alias information, where the information was gathered, date, employee name, staff id number and unit/sub-unit.

Step 6:

State Specific (3)

- Add Primary Aid Code

Share of Cost (SOC) is determined by checking client's Medi-Cal coverage either through the Medi-Cal website or matching the Monthly Medi-Cal Eligibility File (MMEF). The outstanding SOC balance will be noted and this information is then entered into the Share of Cost/Spend Down view located on tab 3 under State Specific.

- Share of Cost/Spend Down
  - Subject to Share of Cost/Spend Down: Mark this box if the client is subject to share of cost/spend down amounts. This is determined through the client's Medi-Cal eligibility.
  - Monthly Share of Cost/Spend Down Amount: No entry needed this field will be automatically filled in by either the RTIE or MMEF upload. The process for the clearing of Share of Cost is noted below under the heading "Share of Cost Clearance process: page 31.
  - Share of Cost met by other providers for the Month: Enter the dollar amount of the share of cost amount that has been met for month by other providers based on information from the State website.

- County of Responsibility: The state identified County code (eg 37 = San Diego) should be populated based on the information provided from the client's Medi-Cal eligibility. If not populated contact the Billing Unit to update.

- Primary Aid Code : The state identified primary or secondary aid codes should be populated by the client's Medi- Cal eligibility, however, in the event that the Aid Code section is not populated, the Medi-Cal claim may **not** be claimed to the state. Contact the Billing Unit to update.

Note -Trafficking AID codes (R1, 5V, & 7V) have been added as additional State funded aid codes

Medi-Cal coverage shall be entered using information from the client's Medi-Cal card, either by going to: https://www.medi-cal.ca.gov/Eligibility/Login.asp on to Medi- Cal Eligibility or by matching to Monthly Medi-Cal Eligibility File (MMEF).

Ask the client for his/her Medi-Cal card. The following procedure should be used if the client has their Medi-Cal card.

In the Client 3rd Party Coverage view: Step

1 – To select Client

- Search for client using magnifying glass
  - Click on "ALL" button
  - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
  - Highlight appropriate client and click OK or double click

- Enter Pay Source as Medi-Cal

Step 2 – To complete Medi-Cal Coverage

- Main (1)
  - Search for Pay Source
    - Medi-Cal = 125
  - Enter the policy number from the card
  - Enter the effective date:
    - Use the first date of service or effective date of Medi-Cal, whichever is later
    - Enter the appropriate Priority number for billing purposes:
      - Medi-Cal = 6

Step 4: To Save Updated Information

- Click Update at the bottom of the response screen to save information to BHS MIS.

Step 5:

- Main (2)
  - The Alias field in the 3rd party coverage view is used to record an alternate name that is used on client's insurance records. If the name on the clients' insurance card is different than the client's name in BHS MIS, enter the name on the insurance card in the alias field for that insurance coverage. Example: Client name is "Smith-Johnson, Susan" however, with her insurance company she is known only as "Johnson, Susan". We can place the "Johnson" in the last name of the alias field to be used for billing to this particular insurance company, and the original name "Smith-Johnson, Susan" bills to all other insurance companies. Once the information has been entered, please provide the alias information to whoever completes the demographics in the program to allow for entry in the demographics module. Once the alias information has been completed, open the Comment tab (5) and document the alias information, where the

information was gathered, date, employee name, staff id number and unit/sub-unit.

Step 6:

- State Specific (3)

  Share of Cost (SOC) is determined by checking client's Medi-Cal coverage either through the Medi- Cal website or matching the Monthly Medi-Cal Eligibility File (MMEF). The outstanding SOC balance will be noted and this information is then entered into the Share of Cost/Spend Down view located on tab 3 under State Specific.

  - Share of Cost/Spend Down
    - Subject to Share of Cost/Spend Down: Mark this box if the client is subject to share of cost/spend down amounts. This is determined through the client's Medi-Cal eligibility.
    - Monthly Share of Cost/Spend Down Amount: No entry needed this field will be automatically filled in by either the RTIE or MMEF upload. The process for the clearing of Share of Cost is noted below under the heading "Share of Cost Clearance process: page 31.
    - Share of Cost met by other providers for the Month: Enter the dollar amount of the share of cost amount that has been met for month by other providers based on information from the State website.
  - County of Responsibility: The state identified County code (eg 37 = San Diego) may be populated based on the information provided from the client's Medi-Cal eligibility. If Not populated go to the State Specific Tab and update. If you are not able to Update contact the Billing Unit.
  - Primary Aid Code: The state identified primary aid code may be populated by the client's Medi-Cal eligibility, however, in the event that the Aid Code section is not populated, the Medi-Cal claim may **not** be claimed to the state. If there is no aid code populated, go to the State Specific tab and updated based on Medi-Cal eligibility. If unable to update contact the Billing Unit.

To Edit Medi-Cal Coverage

The majority of edits for Medi-Cal coverage occur with the MMEF file upload. Therefore, it may be a rare occurrence if a person would need to edit Medi-Cal coverage. If editing Medi-Cal coverage becomes necessary, please contact the BHS Billing Unit at (619) 338-2612 for assistance.

Step 2 – To Edit or Update Medi-Cal Coverage

- Main (1)
  - The following areas may be edited:
    - Medi-Cal Policy Number: Program staff shall check Medi-Cal eligibility via the internet and verify the accuracy of the Medi- Cal Policy number to ensure the client is Medi-Cal eligible. Do **not** just enter a policy number and save;
    - Expiration Date (may be entered)
    - Priority: Medi-Cal = 6

- Main (2)
  - The Alias field in the 3rd party coverage view is used to record an alternate name that is used on client's insurance records. If the name on the clients' Medi-Cal card is different than the client's name in BHS MIS, enter the name on the Medi-Cal card in the alias field for Medi-Cal coverage. Example: Client name is "Smith-Johnson, Susan" however, with her Medi-Cal, she is known only as "Johnson, Susan". We can place the "Johnson" in the last name of the alias field to be used for Medi-Cal billing and the original name "Smith-Johnson, Susan" bills to all other Insurance companies. Once

the information has been entered, please provide the alias information to whoever completes the demographics in the program to allow for entry in the demographics module

Once the alias information has been completed, open the Comment tab (5) and document the alias information, where the information was gathered, the date, employee name, staff id number and unit/sub-unit.

- Change Date: Enter date of entry for change
- Document the reason for the change.
  - Include the unit/subunit
  - Include the name and staff id number of the person making the change.
  - Ok to Bill box must remain checked

- State Specific (3)

Share of Cost is determined by checking the client's Medi-Cal coverage Medi-Cal eligibility via internet or matching to the Monthly Medi-Cal Eligibility File (MMEF). The outstanding SOC balance will be noted and this information is then entered into the Share of Cost/Spend Down view located on tab 3 under State Specific.

- Share of Cost/Spend Down
  - Subject to Share of Cost/Spend Down: Mark this box if client is subject to share of cost/spend down amounts. This is determined through the client's Medi-Cal eligibility.
  - Monthly Share of Cost/Spend Down Amount: No entry is needed. This field will be automatically filled in MMEF upload. The process for the clearing of Share of Cost is noted below under the heading: "Share of Cost Clearance Process".
  - Share of Cost met by other Providers for the Month: Enter the dollar amount of the share of cost amount that has been met for the month by other providers. This must be a confirmed amount.
- County of Responsibility: The state identified county code (e.g. 37 = San Diego) may be populated based on the information provided from the client's Medi-Cal eligibility. If not populated updated the County code in the State Specific tab.
- Primary Aid Code: The state identified primary aid code may be populated by the client's Medi-Cal eligibility. However, if the Aid Code section is not populated, Update the State Specific tab with the aid code, the Medi-Cal claim may **not** be claimed to the state.

- Comments (5)
  - Additional comments can be entered concerning the client. Note that comments must include date, name of staff, staff id number and unit/sub-unit number.

After all entry has been completed click **SAVE**.

To Delete Medi-Cal Coverage

Deletion of Medi-Cal Coverage shall only be completed by the BHS Billing Unit. Please contact the BHS Billing Unit at (619) 338-2612 for assistance. The Billing Unit will require a reason for the proposed deletion.

California Client Financial Review Form (UMDAP)

The California Client Financial Review Form is used to determine the amount the client or responsible party is obligated to pay for services under the Universal Method for Determining the Ability to Pay (UMDAP) requirements.

Programs should review for payment and or determine if an UMDAP needs to be completed during the clients first visit. If there is no existing UMDAP for the UMDAP period, the program should complete the UMDAP review, as the annual UMDAP liability is due and payable by the client at the time of service. Programs should be completing an annual UMDAP review for all clients confirming Medi-Cal eligibility and collecting required data for CSI reporting. Clients with Full Scope Medi-Cal shall not be required to complete an UMDAP or pay an UMDAP and providing financial information for an UMDAP is optional. However, it will be necessary to record an Assignment of Benefits(AOB) if signed in California Client Financial Review for all clients if they have Medicare Risk Insurance or Private Insurance.

Medi-Cal clients who have been determined by the State to have a Share of Cost shall be UMDAP'ed in the BHS MIS system in order to bill the client for their UMDAP in lieu of their share of cost amount (whichever is less). Program staff is responsible for verifying, communicating, and collecting the client's yearly agreed upon financial responsibility. The financial screening process is required for all clients who do not have full Scope Medi-Cal or whenever there is a change in the client or family income or allowed expenses. At minimum, an UMDAP must be completed annually within 30 days prior to or after the anniversary of the UMDAP date. Failing to assess the UMDAP date within the parameters identified above, the program will need to contact the BHS Billing Unit at (619) 338-2612 for entry.

UMDAP is determined by income, asset determination, allowable expenses, and family size, so it is imperative that it be as accurate as possible.

Note: When calculating an UMDAP in the BHS MIS, the number of dependents must include all children under 18 and parents. Income includes gross monthly wages and/or salaries of all members of the family group. Under "other income" be sure to record total incomes from dividends, interest, rentals, support payments, and any other source of income.

Asset determination includes recording all liquid assets, such as savings accounts, stocks, bonds, and mutual funds. Although the BHS MIS system automatically calculates the "excess liquid assets", the process to manually calculate assets has been included to assist those individuals who may be working in the field. "Excess Liquid Asset Calculation": To determine the amount of the "excess liquid assets," determine the total value of all of the liquid assets. Subtract the allowance from the "Schedule of Asset Allowances" included on the "State Department of Mental Health Uniform Patient Fee and Asset Allowance Schedule". Divide the remaining total of the liquid assets by 12 and apply the result to the monthly income of the family unit. A copy of the schedule is located on page 66 in the Forms section of this handbook.

The only deductions from gross income allowed are:

- Court ordered obligations paid monthly
- Monthly childcare expenses necessary to maintain employment
- Monthly dependent support payments
- Monthly medical expense payments
- Monthly mandated deductions from gross income for retirement plans

The manual calculations process has been provided for those staff that may not have access to CCBH System.

Subtract the total of the allowable monthly deductions from the total monthly income. The result is the monthly-adjusted gross income of the family unit. Use this information, as well as the number in the family unit to determine the UMDAP liability using the "State Department of Mental Health Uniform Patient Fee and Asset Allowance Schedule" included in the forms section of this handbook.

Program staff has the authority to request verification of any financial information given by a client or responsible party. Verification should be requested when staff has reason to suspect that the information provided is not accurate. In making an inquiry to sources other than the client or responsible persons, care must be exercised to protect the confidentiality of the client. (Welfare and Institutions Code, Section 5328).

A signed Authorization to Release Information should be obtained before requesting information from sources other than the client because by making the request for information, the program is revealing that the client is seeking mental health treatment. The State Department of Mental Health Revenue Manual lists the following sources for verification of financial data:

- Income Tax Returns
- Driver's License or State-issued identification
- Unemployment Documents
- Current Earnings Statements
- Employer Identification Card

A client or responsible party has the right to refuse to give financial information; however, if such refusal is made, the client or responsible party shall be liable for the full cost of services received.

After the UMDAP is completed, the client or responsible party must be informed of the amount of the financial responsibility assessed. If the client requests a payment plan to be established, the Program shall establish a payment plan in accordance with the requirements below:

- Payment plans must be at a minimum the total UMDAP amount divided by 12 months. Example: If a client's financial UMDAP amount is $250.00, the payment plan can be set up for $250.00 divided by 12 = $20.85 (approximately) per month.

- If the client requires a payment plan that is less than 12 equal payments for the year, then the program staff should refer the client to the BHS Billing Unit at (619) 338-2612 for approval of the payment amount.

- Programs are only authorized to approve payment plans that are equal to 12 payments for a year to pay off the UMDAP amount or balance of the client's account.
- Agreed Upon Payment Amount: Enter the amount of the payment plan amount that was agreed upon by the client. Identify that the payment is monthly**. Do not establish a payment plan on a "per visit" basis.**

Note: In order to view how much a client owes after the UMDAP has been completed and services have been provided, program staff shall use the Client Abstract view.

To Initiate a Client Financial Review (UMDAP)

Note: Prior to completing a financial review, it is important to determine if another family member is receiving services. If so, please refer to the Financial Review Type section below for specifics on handling individual and family UMDAP's.

In California Client Financial Review Maintenance View

Step 1 – to Select Client

- Search for client using magnifying glass or enter client identifying information into selection field (Case Number or Social Security Number)
  - Click on "ALL" button
  - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
  - Highlight appropriate client and click OK or double click

Step 2 – To Complete a Financial Review

- Click (Add) to add a new financial review for the client

- Review Date: Enter the date the information was collected, the BHS MIS defaults to "today's date", but can be changed to accurately reflect the date the information was collected.

  For Users without Administrator Access:
  - The review date must be later than the last Client Financial Review saved for the client.
  - **The review date must be no more than 30 days before or 30 days after start date for the UMDAP period.**
  - Financial reviews that do not adhere to these parameters will need to be completed by staff with Administrator Access to this view.

- Reviewed by: Enter the name of the staff that collected the information. This is no necessarily the same person as the staff entering the information into the system. The system defaults to the staff person entering the data, and should be changed to accurately reflect the staff person that collected the data.

- Financial Review Type:

  - Individual: indicates only one person in the family is receiving mental health services or there is only one person attached to the UMDAP.

  - Family: indicates more than one person in the family is receiving mental health services or the UMDAP is applicable to multiple family members.

    - Click (Add) to add the appropriate family members to the financial review.
      - Search for family member using magnifying glass
      - Click on "ALL" button
      - Either type in Sort Name (client name), Case Number, Date of birth

(DOB) or Social Security number (SSN)
- Highlight appropriate client and click OK or double click
- Please refer to the Link Family Members Client Financials section if multiple Individual Reviews have been entered for a single family.

- Program: Always use "M" for Mental Health

- Bill To: Select the "house" icon and check the appropriate "bill to" address for accuracy. This address should be the responsible party's address for mailing purposes. If this is an Individual Review this information can be selected from the client's address as it is entered on the demographic or can be manually entered. If this is a Family Review, the address for billing must be manually entered.

- Assignment of Benefits (AOB):
  - For Medicare Risk and Insurance, if there is a signed AOB, mark this box, click on the "Comment (4)" tab and add a note that states the date the Assignment of Benefits was signed and the unit/subunit that has the AOB on file. More information regarding the AOB is found on page 29.
  - If the client does not have Medicare or Insurance, do not mark the "Assignment of Benefits" box. Instead, click on the "Comment (5)" tab and add a note that states "AOB not needed", including reviewer initials and date.

- Financial Information Provided/Verified:
  - If the financial information was verified, mark the box and proceed to Financial (Tab 2).
  - If financial information is not provided or not verified, click on the drop down box to identify a reason:
    - N = N/A (use if verification was not requested)
    - P = Documentation Pending
    - R = Doc not provided/refused
    - U = Unemployed
  - Identify the appropriate reason from the list. If the reason is R- Doc not provided/refused, the client or responsible party becomes responsible for the full cost of services.

- When the client or responsible party becomes responsible for the full cost of services, the UMDAP, when viewed through the Client Financial Screen will reflect $37.00; however, the client's actual balance is reflected on the Client Abstract View.

- Suppress Printing Statements: Check this box if statements are not to be mailed to the client. Please note that checking this box means the client/responsible party will still be responsible for charges incurred, although a billing statement will not be printed and mailed.

- Suppress Reason: If the Suppress Printing Statements Box is checked, select the appropriate reason from the drop down menu:
  - H = Homeless
  - N = No Permanent Mailing Address
  - B = Bad Address
  - BK = Bankruptcy
  - CR = Client Request

Financial (2)

Step 3 – To calculate the UMDAP

- Number of Dependents: The number of dependents must include parent(s) and all children under the age of 18 who the parent/legally responsible party is financially supporting over 50%

- Gross Family Income: Gross family income means the total family income before allowances for taxes and other deductions. In the case of self-employed persons, this is the total income after business expenses have been deducted. Note: If client claims no income, ask how they are supporting themselves.
  - Responsible Party: Enter client's monthly or annual gross income, if they are self-supporting. If the client is a child, enter parent's/legal guardian's monthly or annual gross income.
  - Spouse: Enter spouse's income, if any. Leave blank if none.
  - Other: This may include SSA, Cal-Win, child support, spousal support, dividends, and interest and rental income.
  - Total Gross: Automatic calculation by BHS MIS based on income identified from above.

- Liquid Assets:
  - Checking Account: Enter the average checking account balance, if none enter zero.
  - Savings Account: Enter the average savings account balance, if none enter zero.
  - Other: Enter any assets that are personal or real property which can readily be converted into cash. This includes stocks, bonds and mutual funds.
  - Total Liquid Assets: Automatic calculation by BHS MIS based on liquid assets from above.

- Asset Allowance:
  - Asset allowance is automatically calculated by BHS MIS based on the State approved Asset Allowance schedule of 1989.

- Allowable Expenses:
  - Court Ordered Obligations: Enter any deductions ordered by the court. This can include child support.
  - Child Care: Enter child care amount when parent or client is seeking employment or is necessary to maintain employment.
  - Dependent Support: Enter the financial support amount being expended on supporting a dependent more than 50%.
  - Medical Expenses: Enter the monthly cost for medical, dental and vision. This may include medical Insurance premiums.
  - Medical Expenses in Excess of 3% Gross Income: This section automatically calculates in BHS MIS based on the medical expenses entered and the gross income already identified in the system.

- Mandated Deductions for Retirement Plans: Enter the monthly mandated deductions from gross income for retirement plans. This may include 401K and Deferred Compensation

- Total Allowable Expenses: Automatic calculation by BHS MIS based on the expenses identified above.

Max Annual Liability: This yearly amount is automatically calculated from the UMDAP scale based on the information noted above.

- For Period: This is the beginning date of the UMDAP year**.** The BHS MIS system automatically defaults to the first day of the month that the review is entered. If this is not the correct UMDAP period, the date must be changed by someone with administrator access to this view. Note: Once the date is established, this becomes the UMDAP date for all subsequent UMDAP anniversary periods.

Comments (4)

- Identify the date of the Assignment of Benefits was signed and the unit/subunit that has the AOB on file or if client does not have insurance or Medicare, indicate AOB not required. Include your name and date of the comment entry for recordkeeping purposes.

After all entry has been completed click **SAVE**.

Full Pay (UMDAP)

In the BHS MIS system a client is considered to be a "Full Pay" client if he/she does not respond to request for financial information or refuses to provide financial information or verification, if requested. This is recorded by not placing a checkmark in the box for the financial information provided/verified and entering R= not provided/refused in the reason list.

When the client or responsible party becomes responsible for the full cost of services, the UMDAP, when viewed through the Client Financial Screen will reflect $37.00; however, the client's actual balance will be the full cost of services received and will be reflected on the Client Abstract View.

To Edit a Client Financial

Step 1 – To Select Client

- Search for client using magnifying glass or enter client identifying information into selection field (Case Number or Social Security Number)
    - Click on "ALL" button
    - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
    - Highlight appropriate client and click OK or double click

Step 2 - To Edit a Financial Review

- Click Edit to access the current financial review that requires editing.

In the Edit mode you have the ability to update the following information pertaining to the Client's Financial Review.

- Bill To: Check the bill to address section for accuracy. This address should be the responsible party's address for mailing purposes.

The editing of a Client Financial Review by program staff is intentionally very limited. This prevents the entry of inaccurate information that may affect the clients UMDAP balance and/or client account. Therefore, if additional edits are needed, the program staff must contact the County of San Diego BHS Billing Unit at (619) 338-2612 for further assistance.

To Delete a Client Financial Review

It may be necessary to delete a Client Financial Review if an entry was made for the wrong client.

To delete a Client Financial Review from the BHS MIS, you must contact the County of San Diego BHS Billing Unit for assistance at (619) 338-2612.

Link Family Members Client Financial Reviews

If separate financial reviews have been established for clients who are members of the same family unit, it will be necessary to link their financial reviews. Per Section 5718 of the California Welfare and Institutions Code, a family unit is defined as a husband (man) and/or wife (woman) and their dependent minor children. A dependent is defined as a person who is dependent on the family income for over 50% of their support. Therefore, family members must meet the above criteria in order to link their financial reviews.

Access the Client Financial Review in BHS MIS Step

1 – To Select for Client

- Search for client using magnifying glass or enter client identifying information into selection field (Case Number or Social Security Number)
    - Click on "ALL" button
    - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
    - Highlight appropriate client and click OK or double click

Step 2 – To Link Client to other Family Members

- Click (LINK) which introduces another screen entitled, "Link Client to Financial Review"
    - The current client is displayed on the top line
- Search for Family Member

- Search for family member using magnifying glass or enter client identifying information into selection field (Case Number or Social Security Number)
    - Click on "ALL" button
    - Either type in Sort Name (client name), Case Number, Date of birth (DOB) or Social Security number (SSN)
    - Highlight appropriate client and click OK or double click

- The Family Members Client Financial will appear in the box below the clients.
    - If this is the appropriate family member and client financial then check the box entitled, "Select".
    - Once the "Select" button has been marked, the "OK" button will be enabled to complete the transition.
    - Select "OK" to save the Linkage of Client Financials.

Linking Family Members overwrites the current UMDAP and applies the "linked to" family members UMDAP as active.

Medi-Cal Referral Review

During the course of conducting the financial screening, program staff are responsible for reviewing the information provided to determine if the client may be eligible for a third party pay source such as Medi-Cal Individuals listed below may qualify for Medi-Cal: A referral should be made to one of the family resources identified on Page 61 or click on the Pub 68 below for more information.

• Expanded Medi -Cal

• Expanded Medi-Cal provides medical coverage to adults ages 21-64. Individuals may qualify for Expanded Medi-Cal if their Modified Adjusted Gross Income (MAGI) is less than 138% of the **Federal Poverty Level** (FPL).
• To apply call 1-800-300-1506 or TTY 1-888-889-4500.
• If you do not qualify for Expanded Medi-Cal, you may qualify for other health coverage through **Covered California**

- 65 or older
- Blind
- Disabled
- Under 21
- Pregnant
- Diagnosed with breast or cervical cancer
- In a skilled nursing or intermediate care facility
- Parent or caretaker relative of a child under 21 and
    - The child's parent is deceased or does not live with the child, or
    - The child's parent is incapacitated, or
    - The child's parent who is the primary wage earner is unemployed or underemployed.

You may be eligible for Medi-Cal if you receive cash assistance under one of the following programs:

- SSI/SSP (Supplemental Security Income/State Supplemental Program)
- CalWORKs (California Work Opportunity and Responsibility to Kids). Previously called Aid to Families with Dependent Children (AFDC)
- Refugee Assistance
- Foster Care or Adoption Assistance Program.

For more information on Medi-Cal eligibility and benefits please see **Medi-Cal: What it means to you - PUB 68 (pdf)**.

• See attached listing on page 61 for information regarding phone numbers and locations to apply for Medi-Cal, and SSI/SSP. SSI Advocacy Services assist clients with completion of the SSI and Medi-Cal application process. Clients who receive case management services may also be referred to their case manager for assistance with applications for benefits.

Assignment of Benefits (AOB)

In accordance with California State regulations, Medicare and/or other insurance must be billed prior to billing Medi-Cal. Contracted Program Providers are responsible for all billing to Medicare/Medicare Risk, Cal MediConnect and insurances. The County of San Diego BHS Billing Unit is responsible for billing Medicare/Medicare Risk and Cal MediConnect and insurances for County operated programs only.

In order to bill Medicare Risk and/or other Insurance companies, a signed "Assignment of Benefits" (AOB) is required. When presenting a client with a generic AOB, programs must explain to the responsible party or recipient of services by signing the AOB that they are giving providers within County of San Diego network of care permission to bill any insurance company they may be covered with. Programs should notate on the AOB prior to the client signing that the AOB covers any and all insurances. They have a right to refuse to sign the AOB. However, if such a refusal is made the client or responsible party shall be liable for the full cost of services received. An AOB authorizes all County and contracted organizational providers to submit claims for reimbursement on behalf of the client and to receive payment directly. Clients or the responsible party can sign the generic AOB which gives permission for the County of San Diego Organizational Providers to bill whatever insurance the client has or may obtain during the course of treatment.

As a general guideline, the AOB should be obtained during the first visit. **Once the AOB has been completed and signed by the client or responsible person, the program staff must note the completion of this form in the BHS MIS system. If the program is accepting a Generic AOB in the comment section, the program must note Generic AOB, date received, unit and subunit and the initials of the person obtaining the AOB. In the California Client Financial Review Maintenance view, there is a check box which identifies if the AOB has been signed. Place a checkmark in this box. Failure to mark this box appropriately affects the billing of the services. NOTE: ALL providers should add "Any and ALL insurances" to the generic AOB in the section of the AOB that has Insurance company name.**

A "Release of Information" (ROI) form should also be completed to allow the provider of service, county or Contract Provider, to provide any clinical information required for claims processing by the third party payer. A copy of the front and back of the Insurance/Medicare/Medicare Risk/Cal MediConnect card should be made for both the Medical Record and for the County or contracted provider-billing unit. The AOB/ROI must be completed with the specific third party payer name that the release of information is being provided to. The comment section should be updated to indicate the name of the third party payer and the date the AOB/Release was obtained with the unit/sub-unit and initials. If the AOB is being used in conjunction with the release of information, it is recommended that it be updated every two years on the anniversary of the client's first visit or whenever a change in Insurance has occurred. Please note: Programs are responsible for determining if an AOB/ROI is needed prior to the two years noted above. An insurance company or Medicare Risk company may have a different requirement than what is noted here; so it remains the responsibility of the programs to ask the insurance company for their specific requirements.

Each County and Contracted site is required to have the client fill out an AOB when the client first begins receiving services at the program unless an AOB is already on file. If a signed AOB is already on file, a copy of the signed AOB can be requested when the client begins receiving services from another County or Contracted Provider.

For the following payer types, please use these guidelines in completing the AOB when using as a Release of Information and when updating the information in the system to ensure the Insurance listing is correct:

Insurance/Medicare Risk

- Copy the front and back of the insurance card.
- Please review card to determine where behavioral health billing will be sent. It is normally different than the medical claims address.
- Complete the AOB form in full. Ensure that the company address for the mailing of Behavioral Health claims is accurate and the appropriate policy numbers and group numbers are identified on the form.
- Verify the insurance company's requirements regarding the effective period for the Assignment of Benefits/Release of Information. Some carriers require an Assignment of Benefits/Release of Information signed at each visit, while other carriers require it annually. This verification can be accomplished by calling the telephone number listed on the client's insurance identification card.
- Obtain the client's/responsible party's signature on Assignment of Benefits and Release of Information forms.
- To ensure the validity of the client's identity, obtaining a copy of the client's State issued identification is recommended.
- If an authorization for treatment is required, please contact the insurance company directly for authorization prior to the provision of Services.

Medicare - only needed as a release of information, Medicare billing information is the same for all clients.

- Copy the front of the client's Medicare card;
- Verify eligibility date of Part A and B coverage. If the client has only part A or part B coverage, it must be consistent with the service being provided in order to receive reimbursement from Medicare. Part A coverage is only for inpatient treatment and Part B is for outpatient treatment;
- Optional - obtain the client's/responsible party's signature on Assignment of Benefits and Release of Information forms.
- To ensure the validity of the client's identity, obtaining a copy of the client's State issued identification is recommended.
- A current address is needed in order to bill Medicare.

The client or responsible party may sign an Assignment of Benefits (not required for Billing Medicare) & Authorization to Release Medical Information form which is used to approve the electronic claiming of services to insurance companies and to allow for the release of medical information to said insurance companies if additional information is needed for billing purposes. AOB is a standard form to assign insurance benefits. Programs can use their own release of information Copies of these forms are in several languages and form filled in the OPTUM website under forms.

Medi-Cal Clients with Share of Cost (SOC)

Medi-Cal offers health care coverage to individuals and families whose income exceeds the maximum allowable by requiring these beneficiaries to contribute to their health care by paying a share of the cost for the services they received. Share of Cost is a term that refers to the amount of health care expenses a beneficiary must accumulate each month before Medi-Cal begins to offer assistance. Once a beneficiary's health care expenses reach a predetermined amount Medi-Cal will pay for any additional covered expenses for that month. Share of Cost is an amount that is owed to the provider of health care services, not to the State.

"Share of cost" requires beneficiaries to take full responsibility for health care expenses up to a predetermined amount. Share of cost is not a premium; it is an amount that a beneficiary is financially responsible for each month in which Medi-Cal assistance for health care expenses is needed. The amount of the Medi-Cal Share of Cost is determined by the Department of Social Services.

The State Department of Mental Health policy on the certification of Medi-Cal share of cost allows the Medi-Cal Share of Cost to be certified, or cleared, by using the full cost of services received by a client during a month. The client is only held financially responsible for the amount of their UMDAP liability. If the clients' monthly share of cost is less than their UMDAP, then the monthly share of cost amount is collected until the total amount of their UMDAP has been satisfied. If the client has received services in which the total cost meets or exceeds the share of cost, it should be certified. Each case must be reviewed to determine if the share of cost will be certified.

- If the client's share of cost is not certified then the client is not considered Medi-Cal eligible.

Share of Cost Clearance Process

This is a centralized process in the County of San Diego BHS Billing Unit.

A client who has a share of cost (SOC) responsibility must have their SOC cleared in the State system and BHS MIS in order to facilitate billing to the State for services appropriately.

Please note that the services that are used to clear the SOC are not reimbursed by Medi-Cal. The services used to clear a Medi-Cal SOC are based on the dates of service (i.e., clearance begins with the first service date of that particular month to be certified.) Therefore, multiple services from different programs may be used to meet a share of cost amount.

County and Contracted Programs that have clients who have a Share of Cost (SOC) and require clearance will be required to submit a Share of Cost clearance form to the County of San Diego BHS Billing Unit and complete the UMDAP. The Share of Cost clearance form will be required to be completed at the beginning of the client's services with the Program and a copy of the form can be found on page 55 of this manual.

California Share of Cost Claiming Report

On a bi-monthly basis, the County of San Diego BHS Billing Unit will run the California Share of Cost Claiming Report from the BHS MIS system.

The report will be used to identify the clients who have an outstanding Share of Cost balance and have received Services within the identified claiming period. This report will show the procedure codes and dates of services for the time period requested.

The County of San Diego BHS Billing Unit will use the information from the report to determine the appropriate accounts to be cleared of their share of cost balance through the State system and the documenting of that clearance in BHS MIS for the entire system of care.

This process moves the appropriate balances from the Medi-Cal Pay Source to the Client for collection. Any amount over and above the Client's Share of Cost amount will then be claimed to Medi-Cal.

The Share of Cost Claiming Report is used in conjunction with the Share of Cost Clearance form provided by the County or Contracted program

Minor Consent Medi-Cal

California Family Code provides that minors between the ages of 12 through 20 who may be eligible for Medi-Cal services may receive a number of "sensitive services" including outpatient behavioral health treatment without parental consent due to:

- Being in danger of causing harm to self or others; or
- Being an alleged victim of incest or child abuse.

New Clients:

Clients meeting the definition of sensitive services as defined above should be referred to a Family Resource Center (FRC) to apply for minor consent Medi-Cal. A list of FRC's may be found on page 81 of this manual.

Ongoing Clients:

Behavioral health services for clients identified as minor consent are not billed to Short/Doyle Medi-Cal. However, laboratory and pharmacy services are still a benefit of the minor consent program and are covered through the minor consent client's Medi-Cal. Therefore, programs may refer clients to receive pharmacy and laboratory services using their Medi-Cal coverage. Minor consent clients do not need to be UMDAP'ed.

Note: Entry of minor consent eligibility is not required, as the services are not billable to Short/Doyle Medi-Cal. However, eligibility may be entered automatically through the MMEF file or by staff who were unaware that the client had minor consent Medi-Cal. The BHS MIS billing has been set up to prevent billing of these services.

Medi-Cal HMO

Medi-Cal beneficiaries enrolled in a Prepaid Health Plan (PHP) are eligible to receive *medical* services through their HMO. These HMO policies do not cover specialty behavioral health services. Therefore, these particular HMOs should not be entered into BHS MIS as a pay source or insurance company.

To learn more about the Medi-Cal Managed Care plans, program staff can visit California's Medi-Cal Managed Care website at:
http://www.dhs.ca.gov/mcs/mcmcd/htm/MedicalManagedCareHealthPlans.htm#San_Diego

The following local Medi-Cal HMO's cover medical services only:

1. Community Health Group Partnership Plan (CHG)
2. Blue Shield Promise formerly - Care 1st Partner Plan, LLC
3. Health Net Community Solutions
4. Kaiser Permanente Cal, LLC
5. Molina Healthcare of California Partner
6. United Health Care (UHC)
7. Aetna Better Health

CAL- MediConnect – Managed Care Plans for Medicare/Medi-Cal (Medi/Medi) beneficiaries –

1. **Blue Shield Promise MH curve out to-Beacon Health Plan**
2. **Communicare Health Plan (CHG)**
3. **Health Net (MHN)**
4. **Molina Healthcare**

Cal-MediConnect is a pilot program designed to promote care coordination with Medi/Medi beneficiaries who have elected to sign up for one of the four managed care plans. This is a joint venture in conjunction with the County of San Diego, the State of California and the four listed Medi/Medi providers above in San Diego County. The County of San Diego and the Adult contractors contract with the managed care plans to ensure coordination of care and payments of benefits.

Medi-Cal Reimbursement Requirements Specific to Day Treatment/Crisis and Adult Residential

Day treatment, Crisis and Adult Residential are reimbursable through Short-Doyle/Medi-Cal when the client meets medical necessity criteria and the ASO has determined service necessity criteria have been met. Day treatment providers must submit a Day Program Request form to the ASO to request authorization for day treatment services and any ancillary services that may be required. Crisis and Adult Residential programs starting 7-1-19 must submit a request for authorization to the ASO. If the ASO determines the client meets day treatment, crisis and adult residential service necessity criteria, ASO staff will enter an authorization in the BHS MIS. The provider should review the client's record to verify that an authorization has been entered prior to providing services. If the authorization has not been entered to cover the dates of service, the day treatment services and or Crisis and Adult Residential services will be held in suspense and will not be billed to Medi-Cal until the authorization is updated in the system. Once the Authorization is updated, the suspense will be released. Ancillary services without an authorization will not be automatically suspended.

To View an Authorization for Day Treatment or Crisis and Adult Residential in the BHS MIS System

Programs that provide Day Treatment services or Crisis and Adult Residential can verify authorization of services by viewing one of three screens in the BHS MIS:

- Client Chart
- Client Abstract under Authorization
- Client Display Services Authorization Option

CalWORKs Eligibility

California's public cash assistance program is called the California Work Opportunity and Responsibility to Kids (CalWORKs). CalWORKs applicants must meet state and federal regulation requirements to qualify for cash assistance. Caretaker relatives may also be eligible for benefits. Verification of the relation to the child will be required. Potential CalWORKs eligible clients should be referred to their local Family Resource Center.

Non-citizens are subject to specific regulation requirements and may wish to inquire about potential eligibility to CalWORKs. If a family provides all the necessary facts, eligibility should be determined within 45 days of the date of application. Persons with drug related felony convictions since January l, l998 are not eligible for CalWORKs.

CalWORKs behavioral health services are provided only by designated programs identified by specific Unit/Subunits. Services provided by other programs are not eligible for CalWORKs reimbursement.

Billing, Collections and Payment Procedures

County and Contracted programs are responsible for ensuring accurate and appropriate claiming for all reimbursable services. All allowable payers must be billed sequentially and any primary payer, such as Medicare/Medicare Risk/Cal MediConnect or insurance must be billed prior to Medi-Cal.

The BHS Billing Unit is responsible for claiming to Medicare/Medicare Risk/Cal MediConnect and insurance carriers for all county operated programs. Contracted providers are responsible for producing claims to Medicare/Medicare Risk/Cal Medi-Connect and insurance carriers at least monthly through their own business system and must also provide payment and denial information explanation of benefits (EOBs) to the BHS BU who will enter the information in the MIS system for coordination of benefits and accurate billing to Medi-Cal as the secondary insurance. When Medicare/Medicare Risk/Cal MediConnect and/or an insurance coverage has been entered for a client who receives covered services from a contracted provider, the BHS MIS system "stages" the service to that payer pending the entry of payment and denial information entered by the BHS BU. Services will not move to a secondary payer until the primary payer has been satisfied in the BHS MIS.

Billing Rate Set Up

Billing rates for BHS MIS are established in the following manner:

- ***Medi-Cal Rate***: The rate in the MIS System is determined by BHS Administration who provides the billing unit with the rate to bill for contractors each year. The State determines the CMA rate for each County every year. The BHS billing unit updates the system yearly once the rates have been determined.

- ***Medicare and Insurance Rate***: The billing rates for County programs are based on the CMS published with a percentage. Contracted providers bill based on their internal agreed amount.

- ***Client Rate***: The client rate is based on the current billing rate that is in the system not to exceed the cost of service.

The Billing rates used in the BHS MIS are not intended to represent or replace Contract Provider published charges. Contract Providers should follow their own business practices for the billing of insurance and Medicare/Medicare Risk/Cal MediConnect. Based on the rate setups, contract providers may experience a discrepancy in the dollar amount of claims billed from their own billing system and the amount shown in the BHS MIS system.

Billing Process

The guidelines provided below are intended to assist contracted programs with the billing process, but do not constitute billing procedures. Contracted programs are responsible for the development and implementation of internal program policies, procedures that conform to behavioral health billing rules and regulations, for implementing monitoring systems to ensure the accurate claiming and for maintaining adequately trained billing staff. Contracted providers are subject to monitoring by the County to ensure that contract programs are in compliance with regulations including coordination of benefits for Medi-Cal services. This monitoring may include but is not limited to review of payment explanation of benefits for services, review of 3rd party coverage ledgers, etc.

Below are general guidelines which apply to most third party payer billing:

- The subscriber identification number on the claim must match the number on the member's insurance identification card.

- The claim must clearly indicate that the Assignment of Benefits form is completed by entering "Signature on File" in the Assignment area of the CMS 1500.

- If the provider of service is enrolled as a provider in an HMO or PPO and has been assigned an identification number, that number should be referenced on the claim.

- Claims should be submitted no later than 30 days from the date of service.

Program managers are responsible for development and implementation of internal program policies, procedures, and monitoring systems which may include but are not limited to the following:

- Identify staff that are Medicare-eligible providers and ensure that these identified staff obtains necessary certification as Medicare Providers.
- Medicare/Medi-Cal (Medi-Medi) insured clients shall be identified at the time of enrollment for program services
- Medi-Medi insured clients shall be provided and/or referred to Medicare-approved providers for Medicare-approved services
- Reimbursable Behavioral Health Services shall be claimed in a timely and accurate manner with Medicare/Medicare Risk/Cal MediConnect and/or Other Health Coverage (OHC) billed first as the primary payer.
- Ensuring Medicare/Medicare Risk/Cal MediConnect and OHC are billed prior to claiming Medi-Cal. Reviewing the Explanation of Benefits (EOB) and ensuring that EOBs are submitted timely to the BHS BU for posting of payments and denials. If you have billed the OHC and have not received a response within 90 days from the date the claim was submitted and appropriate follow-up was conducted (no payment or denial), you must contact the BHS BU to confirm that a response has not been received so that Medi-Cal can be billed.

Medicare

Medicare Part B provides benefits for psychiatric services which are medically necessary for the diagnosis or treatment of an illness or injury. Physicians, psychiatrists, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners and physician assistants are recognized by Medicare Part B to provide diagnostic and therapeutic treatment. Coverage is limited to those services that the behavioral health professional is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the state in which such services are performed for the diagnosis and treatment of mental illnesses.

In accordance with the Omnibus Budget Reconciliation Act of 1989, all providers of services and suppliers must submit complete and valid claims on behalf of Medicare beneficiaries for services furnished on or after September 1, 1990. Therefore, county and Contract Provider operated programs are required to submit claims for services in an appropriate and timely manner.

Below are general guidelines which apply to the claiming of Medicare services:

- Medicare must be billed prior to billing Medi-Cal for services that have been identified by the State as billable to Medicare. The system is set-up to bypass Medicare for services that are billable directly to Medi-Cal.
- Medicare claims may either be billed electronically through an electronic 837P (outpatient) protocol or claims can be billed manually on an original CMS-1500 claim form that is printed in red ink. Photocopies of the CMS-1500 claim form cannot be accepted.
- Medicare provides a course that will provide a complete overview of the CMS 1500 form instructions.
- Providers are required to resubmit claims rejected due to incomplete and/or invalid claim data. A denial based on invalid or incomplete information is not considered to be valid for entry in the BHS MIS system. Programs must re-submit the claim accurately for processing.
- Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from Centers for Medicare & Medicaid Services (CMS).
- It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare policy guidelines, mandated by the Centers for Medicare & Medicaid Services (CMS), are revised or implemented.
- If a client shows enrollment in a Medicare Risk program (HMO) or Cal MediConnect, services should no longer be billed to Medicare. Programs should follow the normal protocol for billing OHC when billing the Medicare Risk provider and provide EOBs to the BHS BU

Insurance/Medicare Risk/Cal MediConnect

Many insurance carriers provide benefits for behavioral health services which are medically necessary for the diagnosis or treatment of an illness or injury. Generally, insurance carriers will reimburse for services provided by licensed behavioral health practitioners. Covered services are generally more limited than the array of services covered by Short-Doyle/Medi-Cal.

Below are general guidelines, which apply to most insurance claiming:

- Verify the insurance policy prior to services being provided to determine appropriate start date for policy or termination date.
- Obtain pre-authorization for services by contacting the insurance company at the number noted on the card. If the card is unavailable, request specific insurance carrier information from the client prior to the first appointment.
- Identify the correct address for submitting claims for behavioral health services. The address may be different for medical claims and behavioral health claims.
- Make a copy of the insurance card for the client's record.
    - A signed Assignment of Benefits (AOB) form must be obtained from the client prior to billing insurance.

Depending upon the programs billing system set up, claims may either be billed electronically through an electronic 837P (outpatient) protocol or claims may be billed manually on a CMS-1500 claim form.

Medi-Cal

The County of San Diego BHS Billing Unit is responsible for processing all data for Medi-Cal claims for all organizational providers. For clients who have Medi-Cal as a secondary payer, the residual amount may be claimed to Medi-Cal after payments or denials have been entered into the BHS MIS system by the Billing Unit for claims submitted to Medicare and insurance carriers. If the client does not have a primary payer source, the services are billed directly to Medi-Cal whenever a client has eligibility for the month of service recorded in BHS MIS.

Programs are responsible for correcting services that are suspended due to incorrect or missing data. The County monitors reports which includes suspense items and missing elements will either be given to the programs to complete, or the programs will be instructed to print the documentation at their facility. Additional information concerning reports can be used by programs to monitor their financial workload can be found in the section entitled, "Provider Self-Monitoring Reports" in this manual.

Client

Effective July 1, 2008, the County of San Diego's Health and Human Services Agency (HHSA), will no longer require programs to consider UMDAP's paid and or received by clients a source of revenue. The anticipated UMDAP revenue will be part of contracts and any and all collected UMDAP payments received from clients will be forwarded to the County of San Diego's Health and Human Services Agency (HHSA), Financial Support Services Division (FSSD) – BHS Billing Unit. The BHS Billing Unit will post UMDAP payments received in the MIS billing system and deposit the payments into the County's bank account. County and Contracted ORG providers are responsible for notifying clients of their obligation to pay UMDAP and collecting UMDAPs at the time the client receive services and forwarding all collected UMDAPs to the County of San Diego BHS Unit. Because of errors with billing statements, clients will not receive a statement until further notice. This does not negate the client's obligation to a pay UMDAP. Contract Providers

will continue to be responsible for billing and collecting client room and board fees for residential services.

UMDAP client billing statements at this time are not being generated monthly by the BHS Billing Unit. Clients still have an obligation to pay and the outstanding patient accounts (UMDAPs) will be considered delinquent for each UMDAP period not paid. When UMDAP patient accounts have been determined to be delinquent, the accounts may in the future be transferred to the County's Office of Revenue and Recovery (ORR) for continued collection efforts. All County and Contract Provider operated programs are responsible for assisting with the collection of any UMDAP balances for clients served by their program. Programs should discuss the client's financial obligation with them at least once every 30 days when a client presents for treatment.

Payments of UMDAPs at County and Contract Programs

Behavioral Health Programs are the first-line and sometimes the only connection a client may have contact with; therefore, it is in the clients' best interest to pay for services where the services are rendered. As previously indicated, Contract providers will not be required to send a patient statement to the client.

A new bank account has been opened with Chase Bank for the deposit of collections from both County-operated and contract providers. Deposit slips are provided to programs based on request. Please do not use any other bank deposit slip other than the ones issued specifically to your program by BHS Billing Unit.

It is imperative client payments are entered into the Behavioral Health MIS system in a timely manner, so that client accounts reflect a correct balance due. Therefore, deposits of client payments will be made on a daily basis, or weekly as appropriate and copies of the deposit information, client payment information, etc., will be forwarded to the FSSD BHS Billing Unit daily, or weekly, as well.

The following procedures for depositing collections apply to both County and Contract programs:

1. Upon receipt of payment for client fees (cash, check or money order), indicate the client's number in the upper right hand corner of the check, money order or cash payment receipt.
2. Prepare a deposit slip and make a copy.
3. Deposit the collections to the nearest Chase Bank in your area.

4. Submit the following to HHSA/FSSD BHS Billing Unit at the following address:

HHSA/FSSD BHS Billing Unit
PO Box 129153
San Diego, CA 92112-9153
Or at Mail Stop W403

a. Copy of the check, money order or cash receipts
b. Copy of deposit slip
c. Collection of Client Accounts Log (found on page 57)

5. Collections should be deposited to the bank on a daily basis, or weekly if:
    a. The aggregate of money collected is less than $100.
    b. The headquarters of the office or employee making collections is co-located as to make daily deposit infeasible.

Note: County programs should send payments received via county mail MS 403 Fiscal. County programs should use provided county receipt booklet and follow the miscellaneous receipt procedure.

Contract Provider Options for Collection of Client Balances (UMDAP's)

Option #1: Client pays the Contract Provider for client balance or UMDAP and the Contractor deposits the money into the County's Chase Bank Account.

- **Requirement**: The Contract Provider would provide a copy of the deposit slip, collection log (page 56) and copy of the check(s)/money order(s) to the County BHS BU for processing.

Option #2: Client pays the Contract Provider for client balance or UMDAP and the Contractor deposits the money into their own private bank account and writes a check to the County for the money received.

- **Requirement:** The Contractor would provide original check, collection log and copy of the client's check(s)/money order(s) to the County BHS BU for processing.

Option #3: Client presents at the Contract Provider with a client payment and the Contract Provider provides the client with a self-stamped envelope for the payment to be mailed to the County BHS BU.

Offices or employees exempted from the daily deposit requirements will deposit accumulated collections on the last work day of each week, and by the last work day of the month. Checks and money orders should be made out to the "County of San Diego".

You may contact the BHS Billing Unit at (619) 338-2612 for questions and when your supply of deposit slips runs low.

Client Account Adjustment Requests/Therapeutic Adjustments

Clients must be re-evaluated for their ability to pay the UMDAP amount each year. When a clinician determines a client's financial obligation needs to be altered from the UMDAP fee schedule due to clinical reasons, the client's account may be adjusted accordingly the clinician must determine the amount of the therapeutic adjustment and document the reason in the client record.
The following are reasons a therapeutic adjustment may be considered:

- The client or responsible party has verbally expressed an inability to pay the UMDAP and is exhibiting behavioral or emotional distress over continued pursuit of collections.

- The client or responsible party will not return for treatment, participate or allow the client to participate with the follow-up recommended treatment because of his/her inability to pay the UMDAP, and without treatment the client's behavioral health will diminish.

- Based on the clinician's assessment of the client, continued collection efforts may result in the client, or the client's immediate family/caregivers suffering a serious crisis.

The *"Deductible Adjustment Request"* form must be completed and approved by the Program Manager/Director. This form is then submitted to the BHS Billing Unit for processing. A copy of this form can be found in the Forms section page 59 of this manual.

- Enter current annual/monthly UMDAP amount and contract year.

- An adjustment of a correctly determined annual deductible or UMDAP liability can only be made for therapeutic reasons and must be documented in the client record.

    - The clinician or their designee will discuss with the client or responsible party the circumstance that may require a therapeutic adjustment and determine the amount the client or responsible party is able to pay. The clinician or their designee may request documentation of proof of hardship from the client.

    - Once the form is completed and signed by all required staff, it shall be forwarded to the County BHS Billing Unit for processing:

County of San Diego/HHSA
BHS Billing Unit
P.O. Box 129153
San Diego, CA 92112-9153
(619) 338-2612
MS W403

    - A copy of the submitted Deductible Adjustment Request Form must be filed in the client chart.

If the request for a therapeutic adjustment is denied by the clinician or program manager, the client may appeal the decision to the Local Behavioral Health Director or his/her designee.

All therapeutic adjustments shall expire at the end of the client's UMDAP liability period. The Deductible Adjustment Request process must be re-initiated for any extensions.

Account Collections- Insurance and Medicare/Medicare Risk/Cal MediConnect

The most effective way to resolve outstanding accounts receivable balances is to follow up billings with a telephone call to the insurance carrier. At minimum, follow up should occur for all outstanding claims every 30 days.

Below are some general guidelines that may assist in this process:

- If the insurance carrier indicates they did not receive the claim, ask if the claim can be faxed. This will alleviate any unnecessary delay of re-submitting the claim by mail.

- If the insurance carrier states they could not identify the client, provide them with the information from the client's identification card. If necessary, fax a copy of the insurance card.

- If the insurance carrier indicates the client was not eligible for benefits, provide them with the name of the individual in their organization who verified benefits and eligibility (if applicable).

- If the insurance carrier indicates the services were not authorized, determine if program staff obtained authorization. If so, provide the carrier with the authorization information.

- If the insurance carrier indicates there is a primary payer, obtain information of the primary payer. Contact the carrier they indicated as primary to determine if the client is eligible for coverage, and submit claims accordingly.

- The business standard for resolving outstanding claims is 90 days from the date of service or the date the claim was submitted.
  - If you do not receive a response from the insurance company within 90 days from the date the claim was billed and followed up was made to the insurance company, submit a copy of the CMS-1500 that was used to bill with a note that no response was received from the insurance company and the BHS billing unit will cross the service to Medi-Cal for reimbursement.

Insurance/Medicare/Medicare Risk/Cal MediConnect Payment Entry Process

Insurance/Medicare/Medicare Risk/Cal MediConnect payments and denials for County and Contract Provider services are managed by the County BHS Billing Unit.

For each payment or denial, Contract Providers are required to submit the following to the BHS Billing Unit on a weekly basis:

- Copy of the Explanation of Benefits (EOB) received from Medicare/Medicare Risk/Cal MediConnect or Private Insurance, the EOB needs to be legible and client number written on the EOB so that the client can be identified

BHS Billing Unit staff will enter the payments and denials. Programs can review the payment tab in display client services for posting of payments and denials. If the client has Medi-Cal the pay source will change to 100 in the pay source column.

Corrections, Adjustments and Special Requirements

Invalid Services- formerly Service Deletions

In order to maintain a complete audit trail, services entered in BHS MIS cannot be deleted. An invalid service can be corrected as long as it is in its original state, meaning it has not been claimed to a payer or had a payment or denial posted to it, this can be corrected by the program. If an invalid service has billing activity; such as clearing a SOC, and or crossed over to Other Health Coverage (OHC) or Medicare, an applied UMDAP, the program must complete a deletion form to invalidate the service. The service should be reprocessed as non-billable if the service should be counted in the TUOS. If the service was denied and should not count in TUOS such as a denial for a code 18 duplicate service, the program should submit the deletion form to mark the service as invalid. If the service is attached to a progress note, review the progress notes packet for instructions on how to proceed, it can be found in the OPTUM Web-site.

Note that voided services and services marked as an invalid service will be filtered out of all reporting of total units, including those used for the cost report. If a service has been denied by Medi-Cal and subsequently determined to be an invalid service, the billing unit staff will require the program to submit the deletion form and will mark the service with the denial code 33 to identify that the service is invalid and the units should be excluded from the total units of service.

Disallowance/Deletion

A request to remove a non-Medical service that has been disallowed or denied because of a providers review and the service doesn't qualify as a valid service. See form to submit to BHS BU Optum website under forms-
https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/orgpublicdocs.html

Void or Replace

Replacement

A replacement is an action taken to address a service that was entered incorrectly. For example, the numbers were reversed and 12 minutes is entered instead of 21 minutes. In order to replace a claim the billing provider EIN and Subscriber CIN must be the same between the original claim and the replacement claim and at least two of the following four elements must be the same:

- Procedure Code
- Place of service
- Date of Service
- NPI Number

Void

A void is an action taken to address a service that is not Medi-Cal billable which is being disallowed because the documentation does not meet the standards of billing the specific service. BHS BU follows the information provided by the programs that is outlined in the reason for disallowances, the standard State criteria to determine which services do not meet the criteria to be billed and must be voided. Services must have been already claimed and paid by the State before a service can be voided. If it is noted on the reason for disallowance instruction form, the voided service can be re-entered as non-billable. Once the BHS BU has notified the program the service has been voided, the program may re-enter the service as non-billable using the appropriate non-billable code for the specific service.

The State implemented Void or Replace functionality for the SD/MC claiming system. Using existing HIPAA 837/835 transactions, counties have the ability to perform the following:

1. Void erroneous approved claims (disallow or adjust Medi-Cal units) using an electronic claim transaction (HIPAA 837 P/I). This transaction will eliminate the need for using the manual Disallow Claims System (DCS) process – programs must complete the void Request form before the BHS BU will process a void, go to OPTUM website under forms
   https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/orgpublicdocs.html

2. Replace paid or denied claims by using an electronic claim transaction (HIPAA 837 P/I) while utilizing the original claim's received date up to 15 months from the month of service. The BHS BU will replace services based on the replaced form request, see form at OPTUM website

3. Correct previously denied claims by using an electronic claim transaction (HIPAA 837 P/I) while utilizing the original claim's received date up to 15 months from the month of service. This transaction eliminates the need for using the manual Error Correction Report (ECR) process. Programs must submit a replace form request to the BHS BU along with the denial report to identify denied services to be replaced. If service denied for code 22 or 22-N479 or 16-N479 an EOB must be submitted with the request.

Medi-Cal Denied Services – The BHS Billing Unit will provide a denial report to programs.

Programs can Run the Payment Application report denied services template but it will not provide the details with the alpha numeric number as provided on the faxed report- see below.

The State eliminated the process of suspending services that do not meet the edit/eligibility requirements. If a service is deemed by the State to be ineligibility for reimbursement, the service is denied right away. The following are denied reason codes and steps a program must complete in order to replace a denied service.

Denial Code 97/M86 – The service appears to be a duplicate. The program will need to review the chart and if the service was not a duplicate complete the replacement form and provide a copy of the denial report indicating which services should be replaced and the correct procedure modifier code that needs to be on the claim to replace. See modifiers below –

- **59** – Distinct procedure code - There was 2 different services provided (different service codes for the same date and amount of time) when the services were billed to the State, they appeared to be the same because of the same HCPCS codes such as (collateral and a psychotherapy both H2015 MHS)
- **76** – Repeat procedure code by the same person (rendering provider) when the service code is the same and was provided by the same provider for the same date, amount of time and service code.
- **77** – Repeat procedure by different person (rendering provider) when the service code is the same and was provided by 2 different providers on the same date and amount of time.

Note – If the service is truly a duplicate service and the wrong service was paid by the State and is not attached to the progress note, the paid service must be voided and the denied service must be processed as a replacement.

Denial Code 22 – According to State database Medi-Cal eligibility the client has OHC, the State denied the claim because the insurance was not billed prior to billing Medi-Cal. The Other Health Insurance must be billed and the program must provide the BHS BU with an EOB with either denied or paid claim. In order for claim to be replaced, program must submit a replacement form along with a copy of the denial report identifying each claim that needs to be replaced and the corresponding EOB.

Note - In order to avoid future code 22 denials programs should follow the steps below:

- Get a signed AOB from the client and enter into CCBH System and bill the OHC
- If no signed AOB and no verification of OHC, go to the State's eligibility response web-site and verify what insurance company is listed for the client
- Enter the insurance information on the Third party screen, this prevents future claims from being denied and the services will suspend
- Contact the client and verify whether the insurance is still active. If client still has coverage, schedule the client to come in to sign AOB. If client no longer has coverage, instruct the client to bring termination letter.
- Once termination letter is received, fax a copy to the State to remove the insurance from the State's database. Please go to http://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx for OHC

Reporting/Correction Procedures from the State.

Denial Code 22 /N479 – This is a Medi/Medi client and according to the State data base the client has Medicare as their primary insurance. Confirm Medicare eligibility and bill Medicare. Once Medicare has been billed submit a replacement form along with denial report and the EOB that either paid or denied the claim to BHS Billing Unit.

Denial Code 16/N479 – This client is enrolled in a Medicare Risk Advantage Plan or Cal MediConnect. Bill the Plan and once an EOB has been received provide replacement form along with denial report and EOB to the BHS Billing Unit.

Denial Code 96 - M86/N362 – Services exceed maximum allowed for a day. Confirm the total amount billed in one day for MEDs services do not exceed 4 hours, for crisis intervention 8 hours and for crisis stabilization 20 hours. Check chart and the time entered into the system. Generally this happens when there is an error with the time entered into the system. Submit replacement form with the correct time. If the time truly went over the billable time, after submitting replacement to correct the billable time any excess time should be recorded as non-billable.

Denial Code 177 – Beneficiary not eligible. MEDS is not showing the client is eligible to Medi-Cal for the month billed. Many reasons for this code – There is no eligibility, Aid Code is invalid (check aid code listing), client has a SOC that has not been cleared, client is only eligible to emergency and/or pregnancy related services. Client is showing in an institution, such as jail, this client should be referred to contact the County Medi-Cal worker to update his/her information. CIN is incorrect, re-verify eligibility, such as CIN or Name. Contact BHSBU to verify name and or CIN is correct. If there is an error and the information is not correct on the claim contact BHS BU for further instructions.

Denial Code 16/N327 – The clients Date of Birth (DOB) billed does not match the DOB in MEDs. Re-verify the client's DOB with client or parent. Contact the Billing office to verify the DOB is MEDs. If information in system is wrong, submit a correction on BHS -025 Form A to the County HIMD. If MEDs is incorrect, request the client to contact the County Medi-Cal office to correct DOB.

Denial Code 16/MA39 – The Gender does not match what is in MEDs. Programs should check to verify that the correct Gender was entered in the demographics. Contact BHSBU to confirm the gender in MEDs. If MEDs in incorrect, the client needs to contact the County Medi-Cal office to update with the correct information. If information in system is wrong, submit a correction on form BHS-025 Form A to County HIMD.

Denial Code 16/N294 – The service was provided at home and there is not a valid address pulling from the physical address in the Demographics form. If a Clinician is providing services at the client's home address, the physical address should be updated to reflect the home address where the service is being provided. If the client has a valid address or moved and currently do not have a valid home address and the service was provided at the client home address, notate on the denial report(Health Care Claim Payment/Advice 5010 File Control Report), the address where the service was provided so that the service can be replaced and re-billed to Medi-Cal with the correct address. If the service indicator is incorrect and the service was not provided at home, notate on the denial form, the correct place of service. Fax denial report with updates to BHS Billing Unit at 858 467-9682.

Denial Code B7/N570 – Services are denied with this code when there is a set-up issue such as the place of service, NPI or program is not showing Medi-Cal certified with the State. Contact BHS BU to confirm correct provider information at the State. The BHS BU will try to resolve set-up issues and will replace services that are deemed to be replaceable. If you have any questions, please contact the BHS BU at 619 338-2612.

Denial Code 96/M80 - Denied because a program billed for a service at the time of lockout (see lockout regulations). If there is no evidence that the client received services anywhere else in San Diego County, contact the Billing Unit to follow-up with State, another County may have claimed services in error.

Denial Codes 96/N30- changed to 96/MA43- This denial indicates that the client is PRUCOL or a Qualified non-Citizen and is eligible to County funds only.

New Denial codes effective 10/01/2015 related to ICD10.

Short/Doyle MH claims that are denied because the claim an appropriate ICD-10 diagnosis or inpatient procedure code will receive the following claim adjustment reason codes and remittance advice remark codes:

Diagnosis Code Denial: CO 16/M76 – The claim did not contain an appropriate ICD-10 code

Procedure Code Denial: CO 16/M51 – Inpatient procedure code is invalid, only revenue codes accepted

Note – please submit replacement forms and any documentation for the replacement to the BHS BU via email mhbillingunit@sdcounty.ca.gov or fax to 858 467-9682.

Provider Self-Monitoring Reports

County and Contract Provider operated programs are required to run the following reports and complete follow up work on a weekly or monthly basis, as noted for each report. The reports are designed to assist programs to self-monitor and improve their program's performance on program financial functions. Some reports are designated for Contract Providers only. Detailed instructions for running the reports are included in the BHS MIS Reports Manual which can be found on the OPTUM web-site. The following is a summary of each report.

Client Services Report - There is a template in the client service report to audit services that are staging to 998. Click on load to access the 998 client progress note audit report, review to ensure all needed data elements are in the report, add as needed and provide a date range for period you are reviewing (print to review report after report is complete). When services have been claimed to the State and have been identified as non-billable to Medi-Cal because of an error, while waiting on the service to be adjudicated by the State, Clinical Staff enters a 998 service code. The 998 service code is a temporary placeholder and should be deleted once the service is paid or denied. Once the service is paid, a void request should be completed and submitted to the BHS BU. When the BHS BU has processed the void, the void request will be sent back to the program so the program can delete the 998, review and update with non-billable code if appropriate. The BHS Billing unit reviews the report bi-monthly to ensure the 998s are being updated and provides a copy to designated staff with the Adult and Children System of Care.

There is template labeled Client Progress Note Audit-Billing Audit. This report should be run monthly to monitor the total time each staff provided in a day per client. Red Flag - when reviewing the report any time at or above 480 miins per client is excessive, check for data entry error, such as 10 mins entered as 10 hours. If reviewing the Clinician time and the total time for the day exceed 480 mins, confirmed with Clinician that the time is correct. Report should be reviewed for no server time. If there is no server time entered, confirm with Clinician if a service happened. If no service occurred, update with the appropriate indicator such as, no show. If there was a service, update with service time. Even if there is no direct contact with the client, service provided on behave of the client should

be recorded as client service time. Doc time should be the time used to document the service and should not include the client service time.

Account Receivable Report - Other Health Coverage (OHC) and Medicare Outstanding Receivables Report (Monthly) – Contract Providers Only

This report identifies outstanding receivables for Private Insurance and Medicare. Contract Providers are required to bill these payers within 30 days of providing the services and actively follow up until payer has paid or has issued a final denial for the claim. The summary report is a tool for managers to oversee this process and determine whether additional action is required. Managers should follow up with staff regarding any services that are more than 120 days old. This report is found on page 19 of the CCBH System Reports Manual.

Aged Accounts receivable report Other Health Coverage (OHC) and Medicare Outstanding Receivables Detailed Report (Monthly) Contract Providers Only

This report identifies outstanding receivables for Private Insurance and Medicare. Contract Providers are required to bill these payers within 30 days of providing the services and actively follow up until payer has paid or has issued a final denial for the claim. The detailed report is a tool for billing staff to follow up with payers on outstanding claims. In addition, the detailed report may be used to identify services that have not yet been billed and should be billed ASAP. This report is found on page 19 of the CCBH System Reports Manual.

California Client Financial Review Report (UMDAP Anniversary Report (Monthly)

This report identifies clients with an upcoming UMDAP Review Anniversary. Program staff responsible for completing UMDAPs should run this report monthly to identify those clients whose

UMDAP should be scheduled. Only the most recent review will show. Programs will need to verify that the review date showing is the actual UMDAP date. The original UMDAP date will remain the same as when the client was originally opened for the first time. This report is found on page 27 of the CCBH System Reports Manual.

California Client Financial Review Report UMDAP Outstanding Review Report (Monthly)

This report identifies clients who need an UMDAP, including those who do not have Medi-Cal (without a Share of Cost) that do not have a Financial Review (UMDAP) entered into the system or who have an expired UMDAP. Program staff responsible for completing UMDAPs should run this report monthly to identify those clients whose UMDAP should be completed ASAP. This report is found on page 27 of the CCBH System Reports Manual.

Client Services Management Report (Monthly)

This report provides a mechanism for Program Managers and COTRs to review dollar amounts of Services currently in Suspense to monitor the volume of errors causing services to suspend and timeliness of corrections. Two report templates were created, one monthly that provides a summary of the overall volume of errors and the second “priority monthly” that focuses on services that older than 90. These items should be prioritized for correction. This report is found on page 68 of the CCBH System Reports Manual.

Client Insurance Eligibility Report (Monthly)

This report identifies clients who may have insurance coverage that has not been entered into the system. Program staff should run this report monthly and then contact clients to verify that the client is not eligible for coverage or update the client's coverage. Regular working of this report will reduce denials for failure to bill the client's primary coverage prior to Medi-Cal. This report is found on page 45 of the CCBH System Reports Manual.

Medicare Eligibility Report (Monthly)

This report identifies clients, who based on their age, may have Medicare coverage that has not been entered into the system. Program staff should run this report monthly and then contact clients to verify that the client is not eligible for coverage or update the client's coverage. Regular working of this report will reduce denials for failure to bill the client's primary coverage prior to Medi-Cal. This report is found on page 45 of the CCBH System Reports Manual.

Client Third Party Coverage Report

This report identifies clients that may have had a change in Medi-Cal Coverage in the specified date range. Program staff should run this report monthly and then contact the client to complete an UMDAP and, if appropriate, provide assistance in reacquiring their Medi-Cal coverage. This report is found on page 32 of the CCBH System Reports Manual.

Duplicate Services Monthly Report (Weekly)

This report identifies clients who have had more than one service of the same type recorded on the same day. Program staff should run this report weekly and review services to assure they have not been recorded twice. Services that have been entered in error twice should be deleted if identified prior to Billing. page 90 of the CCBH System Reports Manual.

Authorization Notification Report (Weekly) - Day Treatment Services without Authorization

This report provides a listing of clients who have had Day Treatment Services without an authorization or with an expired authorization. This report is found on page 25 of the CCBH System Reports Manual.

Payment Application Report – Select Medi-Cal Denied Claims Report Template

Provide mechanism to identify denied Medi-Cal claims that may need to be replaced. This report currently does not meet the BHS system of care needs, as it does not provide the Alpha Numeric denial codes as indicated on pages 43-45. The BHS BU has substituted this report by sending the actual denial report (Health Care Claim Payment/Advice 5010 File Control report) downloaded in a PDF file to designated staff at the programs.

3rd Party Billing Suspense Report (Weekly)

This report lists services that are suspended from billing for one or more reasons. Program staff should review each item and make necessary corrections to client's record in BHS MIS on a weekly basis. Once the data has been corrected the service will be ready for billing and will not appear on the next suspense report. Corrections for Items in Suspense can be found on page 49 (see instructions for correcting errors identified by each suspense code).

Correcting Items in Suspense

The following table summarizes how to correct errors identified by each suspense code listed in the Program Billing Suspense Report. The table only includes those suspense codes activated for current use or planned for future use in BHS MIS.

Suspense Code	Suspense Description	How To Correct
A B	No Valid Diagnosis No Diagnosis of Billing Type	Enter Diagnostic Review with a valid diagnosis covering date of service. If unable to fix call OPTUM help desk at (800) 834-3792
D	No Final – Approved Progress Note	Program should run suspense reports daily to ensure progress notes are approved within the 14 days. **(When D is showing Progress note has not been final approved) Final approve the existing progress note. If past 14 days make non- billable
E	No Policy Number	Program can fix. Enter Policy # for all payers in 3rd Party Coverage Maintenance.
F J	Service is older than # days No active insurance coverage	No correction for this item but indicates another suspense item needs to be corrected ASAP. Call BHS BU at (619) 338-2612 Program can fix. Enter coverage in 3rd Party Coverage Maintenance View with effective date covering date of service.
L	Server 3rd Party Billing Suspended	Find out why QI ordered suspension of billing for the server, correct problem and request resumption of billing. Call BHS-MIS at (619) 584-5090.
M	Unit 3rd Party Billing Suspended	Find out why County ordered suspension of billing. Call assigned COTR.
V	No Assignment of Benefits (AOB) signed	Obtain signed AOB for Private Insurance and fax BHS BU an updated CA Client Financial Review Form with AOB box checked. Indicate what insurance the AOB is for in the comments section. BHS BU fax#(858) 467-9682
W	Insurance Flagged as Unbillable	Program can fix. Determine why insurance flagged as unbillable, if done in error, turn off flag 3rd Party Coverage Maintenance screen. If unable to correct call BHS BU at (619)338- 2612.
Z	Not Authorized	For Medi-Cal day treatments or Crisis & Adult Residential follow up to obtain authorization from ASO/OPTUM. Programs to check Client Abstract or Display Client Services to verify there is an authorization. If an authorization is showing or not showing for your program contact OPTUM at (800) 798-2254 Option 4 to find out why the services are in suspense.
1	No Server provider number	For Medicare – Program must obtain Medicare Server provider number and fax to BHS MIS unit at (858) 467-0411 to be recorded in staff record.

2	Requires Re-calculation	May be corrected when BHS BU runs monthly re-calculation process. Please contact BHS BU at (619) 338-2612 if recalculation process has occurred and still showing suspended.
3	No NPI	Program needs to obtain server NPI and fax to BHS MIS unit at (858) 467-0411 to be recorded in staff record.
!	Duplicate Service	Programs can fix. For 24-hour programs only- research why client is showing open to two 24-hour programs at the same time. Make corrections as needed to assignments.
p	Service Not Authorized	Program should FAX the suspense report with code P to the BHS BU for correction. BHS BU FAX # (858) 467-9682
R	Authorized Limits Exceeded	For Medi-Cal Day Treatment follow up to obtain authorization from ASO/ OPTUM. Program is authorized to provide day treatment services for a specific number of days. If you feel there is an error check with the Optum Health Provider Line phone # (800) 798-2254 Option 4, to ensure your program is authorized to provide day treatment for the days that are suspending
T	More than 20 hours of Service Billed for Crisis Stabilization to this Benefit Plan. More than 4 hours of medication services provided on the same day	For Crisis Stabilization, if total hours exceed 20 hours in a day, correct data entry of service duration by re-entering up to a total of 20 hours of billable service. Anything over 20 hours can be fixed by re-entering service as non-billable. For Medication Services, program should check the total medication services for the day. If total exceeds 4 hours, program should correct and only re-enter the service time that totals up to 4 hours for the day. All other medication services that exceed the 4 hours total, should be re-entered as non-billable.
Y	Service concurrent with an Admission Assignment	Indicates client is open to 24-hour program at same time as receiving outpatient treatment service. Program must research and make corrections to the assignment or services as needed. If assignments and services are correct, identify services on the report to be claimed with "CLAIM IT ANYWAY" and fax to QI Matters at Fax # 619-236-1953 for determination. QI Matters will forward the approved report to BHS BU for processing. Once processed, BHS BU will fax the completed report to the Program for continuation of internal process, if needed.
AQ	Service Diagnosis Not Supported	Program must research and make corrections to the Diagnosis Sheet for corresponding date of service. If unable to correct contact OPTUM help desk (800) 798-2254.

Multiple Services and Lock Out

HCPCS	H2015	H0046	H2013	H0018	H0019	H2012	H2012	H2012	H2012	T1017	T1017	H2015	H2019	H2010	H2011	S9484	H2015
CR Mode / SDMC Mode of Service	05 / 07-09	05 / 07-09	05 / 05	05 / 05	05 / 05	10 / 12, 18	10 / 12, 18	10 / 12, 18	10 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18
Service Function	10-18	19	20-29	40-49	65-79	81-84	85-89	91-94	95-99	01-06, 08-09	07	10-19, 30-56, 59	58	60-69	70-79	20-29	57
HCPCS/ Procedure Codes	Hospital Inpatient	Hospital Inpatient Admin Day (6)	PHF	Adult Crisis Residential	Adult Residential	Day Tx Intensive Half Day	Day Tx Intensive Full Day	Day Rehab Half Day	Day Rehab Full Day	CM / Brokerage (4)	ICC (4)	MHS (5)	TBS (5)	Med Support (1)	Crisis Intervention (2)	Crisis Stabilization ER & UC (3)	IHBS (5)
H2015 Hospital Inpatient	L	L	A	A	A	A	A	A	A	I	I	A	A	A	A	A	A
H0046 Hospital Inpatient Admin Day (6)	L	L	L	L	L	L	L	L	L	I	I	L	L	L	L	L	L
H2013 PHF	A	L	L	A	A	A	A	A	A	I	I	A	A	A	A	A	A
H0018 Adult Crisis Residential	A	L	A	L	A	A	A	A	A			A	A		A	A	A
H0019 Adult Residential	A	L	A	A	L							I	I			T	T
H2012 Day Treatment Intensive: Half Day	A	L	A	A		L	L	L	L			T	T			T	T
H2012 Day Treatment Intensive: Full Day	A	L	A	A		L	L	L	L			T	T			T	T
H2012 Day Rehabilitative: Half Day	A	L	A	A		L	L	L	L			T	T			T	T
H2012 Day Rehabilitative: Full Day	A	L	A	A		L	L	L	L			T	T			T	T
T1017 Case Mgmt/Brokerage (4)	I	I	I							O							
T1017 ICC (4)	I	I	I								O						
H2015 MHS (5)	A	L	A	A	I	T	T	T	T			O				T	
T2019 TBS (5)	A	L	A	A	I	T	T	T	T				O			T	
H2010 Medication Support (1)	A	L	A											O		T	
H2011 Crisis Intervention (2)	A	L	A	A											O	T	
S9484 Crisis Stabilization ER & UC(3)	A	L	A	A	T	T	T	T	T			T	T	T	T	T,O	T
H2015 IHBS (5)	A	L	A	A	T	T	T	T	T							T	O

I	Institutional Limitations: Audit
L	Lockout: Services that may not occur on the same day
A	Lockout: Except for day of admission and day of discharge
T	Lockout: During actual time service is provided - audit, not a computer edit
O	Override allowed for duplicate services with procedure modifier code
	Multiple services may be allowed on the same day, limited by the maximum time allowed.

(1) Maximum of 4 hours (240 Minutes) per day
(2) Maximum of 8 hours (480 minutes) per day
(3) Maximum of 20 hours per 24 hour period
(4) Maximum of 24 hours (1440 minutes) per day
(5) Maximum of 2878 minutes per day
(6) An Administrative Day may not be billed on the day of admission

Trouble Shooting and Questions

Service Question

The service for my program did not bill to correct payer source. How can I correct this?

- Step 1:
  - Check the effective date of the policy to ensure it is within the time frame for the service; if this is accurate, then move to step 2 below:
- Step 2:
  - If a service was entered into the BHS MIS before the insurance policy was completed, the service will not bill to the insurance company until the BHS Billing Unit runs a process known as re-calculation also known as re-calc prior to claiming for services. Inform the BHS Billing Unit of the issue so re- calc could be run earlier if appropriate. If this still does not answer your question, move to step 3 below:
- Step 3:
  - Contact the BHS Billing Unit for assistance at (619) 338-2612.

Payer Source Questions

I'm trying to enter an insurance company, and it is not in the payer source drop down menu…what do I do?

- Complete the Add Insurance Company Request from page 70 of this manual and fax it to the BHS Billing Unit using the number on the form. The BHS Billing Unit will notify you when the insurance has been added.

- I'm looking for an insurance company, and it doesn't show in the BHS MIS…what do I do?
  - Check to ensure you clicked the "ALL" button. This will allow you to see active and inactive insurance policies.

- An insurance company policy was entered in the BHS MIS with a future expiration date; however I can no longer see the policy even though the termination date is not effective yet.
  - Step 1:
    - Click to ensure you clicked the "ALL" button, to view all payer sources whether they are active or inactive policies.
  - Step 2:
    - If the future date is used the priority will reflect "I" for inactive – even though the policy is technically still active and will bill appropriately till the termination date. It can only be viewed when you click either "ALL" or "Inactive".

What is a BIC Card and what number do I use to verify eligibility?

Program Staff should enter the first 8 digits and the alpha character as the policy number, this is the CIN that is used to verify Medi-Cal eligibility thru the internet.

The Benefits Identification Card is a white plastic card with blue lettering and the State seal. It has the client's name, date of birth, Medi-Cal identification number, and the card issue date on the front.

The Department of Health Care Services (DHCS) issues a plastic Benefits Identification Card (BIC) to each Medi-Cal recipient. In exceptional situations, county welfare departments may issue paper cards to individuals. It is the provider's responsibility to verify that the person is eligible for services and is the individual to whom the card was issued. Eligibility verification should be performed prior to rendering a service.

Benefits Identification Card (BIC)

Possession of a BIC is not proof of Medi-Cal eligibility because it is permanent form of identification and is retained by the recipient even if he or she is not eligible for the current month. See sample BIC cards below.

Sample Benefits Identification Card (BIC).

(Actual card size = 3 ⅛ x 2 ⅜ inches; white card with blue letters on front, black letters on back.)

Second ID Helps Confirm Recipient's Identification – Please note that future cards will remove sex

If a recipient is unknown to a provider, the provider must make a "good faith effort" to verify the recipient's identification before rendering Medi-Cal services.

A "good faith effort" means verifying the recipient's ID by matching the name and signature on the Benefits Identification Card against the signature on a valid California driver's license, a California identification card issued by the Department of Motor Vehicles, another acceptable picture ID card, or other credible document of identification.

Exception: The requirement does not apply when a recipient is receiving emergency services, is 17 years of age or younger or is in a Long Term Care facility.

Temporary Benefits Identification Card (BIC)

Senate Bill (SB) 25 (Statutes of 2003, Chapter 907) required the removal of the Social Security Number (SSN) from the Medi-Cal BIC's and prohibits the use of the SSN in certain situations and on certain documents.

Assembly Bill (AB) 3029 (Statutes of 2004, Chapter 584) prohibits the use of the SSN when billing Medi-Cal. As a part of the expanded BIC-Identification (ID) number project, in November 2005 the Medi-Cal paper card was changed to display the new 14-digit BIC ID when the beneficiary was already known to the Medi-Cal Eligibility Data System (MEDS) or the client index number (CIN) was entered on the transaction.

For new beneficiaries without CIN's, the nine-digit MEDS-ID (SSN or pseudo-id plus check digit), is currently printed. Because AB 3029 prohibits the use of SSN's, the paper card process is being changed to display only the BIC-ID. And, since in most cases providers will need the BIC-ID when billing Medi-Cal, the beneficiary must have either a plastic or paper BIC containing the BIC-ID to receive services.

Patient Assistance Program (PAP) Fiscal Process

If applicable to the program, Pharmacy Healthcare Solutions (PHS) staff complete and submit applications for Patient Assistance Program (PAP) medications for mental health clients. Medications are received at Health & Human Services Agency (HHSA) Pharmacy and are checked in by designated pharmacy staff. Pharmacy took on the fulfilling of PAP due to low volume. This is part of the pharmacy services for county clinics and contracted clinics. This is incorporated into the pharmacy operating budget and BHS is not charged for any services rendered.

Quick Reference List

COUNTY OF SAN DIEGO

- **BHS BILLING UNIT** — PHONE: (619) 338-2612
  FAX: (858) 467-9682
  MHBILLINGUNIT.HHSA@SDCOUNTY.CA.GOV
- **MIS CUSTOMER SERVICE DESK** — Phone: (619) 584-5090
  Fax: (858) 467-0411
- **QI MATTERS** — Fax: (619) 236-1953
  QIMATTERS.HHSA@SDCOUNTY.CA.GOV
- **PATIENT ADVOCACY PROGRAM** — PHONE: (619) 260-7660
- **SAN DIEGO MHP MENTAL HEALTH ADMIN** — PHONE: (619) 563-2745

OPTUM HEALTH

- **ACCESS AND CRISIS LINE** — PHONE: (888)724-7240
- **PROVIDER LINE** — PHONE: (800)798-2254
- **OPTUM HELP DESK** — PHONE: (800) 834-3792
  Fax: (619) 641-6975
  SDHELPDESK@OPTUMHEALTH.COM

Share of Cost Clearance Request Instructions

A client that has a share of cost (SOC) responsibility must have their SOC cleared in the State system and BHS MIS in order to facilitate billing to the State for services appropriately.

Please note that the services that are used to clear the SOC are not payable by the State.

County and Contracted Programs that have clients who have a Share of Cost (SOC) and require clearance, will need to contact the County of San Diego BHS Billing Unit at (619) 338-2612.

- Date
  - The date submitting your requesting
- Unit/Subunit
  - (Reporting Unit)
- Share of Cost Amount
  - Total amount of share of cost
- Requested By
  - Name of the person requesting clearance

- Clients Name
  - Name of the client
- BHS MIS Clients Number
  - Client number provided by BHS MIS
- Clients DOB
  - Birth date of client

- Services Code
  - Enter the service code used in BHS MIS
- Date of Service
  - Service date
- Price
  - Price of service shown in BHS MIS
- Comments
  - Any comments needed to clarify SOC clearance

BHS Billing Unit Only
DO NOT USE THIS SECTION

Collection of Client Accounts Instructions

Client fee collection for contracted providers should be conducted, at minimum, once every 30 days. The most effective collection method for patient fees is to discuss their financial obligation with them when they are present for treatment. In no case should the client be denied treatment based on financial issues.

All client payments must be captured in BHS MIS to ensure clients are held financially responsible only up to their UMDAP liability and to ensure accurate revenue reporting. The Behavioral Health Services Billing Unit is responsible for posting client payments for all programs. Contract operated programs must report client payments received to the BHS Billing Unit via the "Collection of Client Accounts" form for posting to the BHS MIS system or via deposit information.

- BHS MIS Case Number
  - This is number issued by BHS MIS
- Client Name
  - Last Name, First
- Date Received
  - Date program received payment from client
- Amount
  - Dollar amount received by program
- Check # / Money Order
  - Check number or money order numbers.

- Fiscal Use ONLY Check Received
  - DO NOT USE THIS FIELD

County of San Diego/HHSA
BHS Billing Unit
P.O. Box 129153
San Diego, CA 92112-9153
(619) 338-2612
MS W403

MONTHLY AT $_____

Deductible Adjustment Request Instructions

- To: Name of Program/Regional Manager of the clinician seeking adjustment
- Mail Stop: Mail Stop of program/regional manager
- Date: Date submitting adjustment
- From: Person requesting adjustment
- Title: Title of person requesting adjustment
- Mail Stop: Mail Stop of person requesting adjustment
- Re: Client name (Last Name, First Name)
- BHS MIS Case Number: Client number issued in BHS MIS
- UMDAP Annual Deductible $: Current UMDAP Annual amount
- Monthly Rate $: Current UMDAP Monthly amount
- Contract Year: Year for contract
- Criteria: State reason why patient not able to pay in accordance with policy and procedures if not listed below.
- Therapist signature: Therapist who approves exception
- **Amount Client will pay:**
    - Annual $: Re-determined UMDAP **Annual** amount
    - Monthly $: Re-determined UMDAP **Monthly** amount

- **STATEMENT: (Further justification if needed)**
    - Any questions needed to clarify adjustment

- Human Service Specialist Recommendation: (If needed)
    - HSS will approve, disapprove, or give no recommendation then sign.

Adjustment Review

- This section is for the program/regional MGR to approve or disapprove then sign.

Final and/or Appeal Review: The form must be signed by the administrator with the recommended UMDAP amount.

County of San
Diego/HHSA BHS Billing
Unit
P.O. Box 129153
San Diego, CA 92112-
9153 (619) 338-2612
MS W403

- Route cc: Eligibility Review: A copy shall be provided to the HSS
- Fax to: BHS Billing Unit at (858) 467-9682

SYSTEM ID#_____

California Client Financial Review Maintenance

Main

(1)

Client Name	Last Name, First
Case Number	Client Number
SSN	Social Security Number
DOB	Date of Birth
Status	New, update, or annual UMDAP
Date	Date information was collected, maybe different from UMDAP date.
Financial Type Individual vs. Family Notes: The UMDAP will cover the whole family for a year of mental health services as long as the family members are U.S. Citizens or Registered Legal Aliens. Undocumented clients are only eligible to receive emergency services at EPU and ESU. The UMDAP will cover the whole family for a year of emergency mental health services only.	Individual meaning only one person receiving Mental Health Services. Family meaning more than one person receiving Mental Health Services. (If you mark Individual and find out later that they have someone in their family receiving services you can link the two acct. this is a CCBH SYSTEM feature.)
Program	Always Mental health
Family Members	All family members in the mental health system and write their case number beside their name. (If known)
Bill to	The responsible party that would receive the bill. This includes client.
Assignment of Benefits signed	Mark if you have an AOB on file with signature. Also, AOB is NOT needed for Med-Cal clients.
Financial Information Provided	If the financial information was verified, check this box.
Reason Not Verified	If the financial information box is not checked, please indicate reason: N-N/A P-Documentation Pending R-Doc not Provided/Refused U-Unemployed
Suppress Printing Statements	Check this box if statements are not to be printed/sent to client.
Suppress Reason Note: Client can request suppress printing statement does NOT mean client will not be responsible for UMDAP.	If “Suppress Printing Statements” box is checked, please indicate reason: CR- Client Request H-Homeless N-No Perm Mail Address MC- Minor Consent

FINANCIAL (2) TAB

Number of Dependents	The number of dependents must include parent(s) and all children under the age 18 which the parent is financially supporting over 50%.
Gross Family Income (Box A) **Notes:** NOTES: Gross Income means total family income before allowances for taxes and other deductions. In the case of self-employed persons, it is total income after business expenses have been deducted. If client claims no income, ask how they are supporting themselves.	(Line 1) Responsible person, if self-enter client's monthly or annual gross income. If client is a child enter parents/legal guardian's monthly or annual gross income.
	(Line 2) Spouse's income, if any. Leave blank if none.
	(Line 3) Other income. This can include income from SSA, CalWIN, Child support, Spousal support, Dividends, Interest & Rental income.
	(Line 4) Total Gross income. Add lines 1, 2 and 3 to get your gross income.
Liquid Assets (Box B) Note: The clients' income maybe deposited in the acct. So always use the average balance when using checking or saving accounts to avoid counting the clients income twice.	(Line 1) Savings Account. Average Savings balance, if none enter zero.
	(Line 2) Checking Account. Average Checking balance, if none enter zero.
	(Line 3) Other Assets. Any Assets personal or real property which can readily be converted into cash and may increase ability to pay. This can include stocks, bonds and mutual funds
	(Line 4) Total Liquid Assets. Add lines 1, 2 and 3 to get your total.
	(Line 5) Asset Allowance. Refer to 1989 Asset Schedule. It is based on family size. Enter the Asset Allowance amount on line 5.
	○ If the amount on line 5 (Asset Allowance) is **greater than** line 4 (Total Liquid Assets) put a zero on line 6 (Net Assets) and a zero on line 7 (Liquid Monthly Assets). This means that their assets are not going to affect their monthly gross income. (See Example 1) ○ If the amount on line 5 (Asset Allowance) is **less than** line 4 (Total Liquid Assets) subtract line 5 from line 4 to get the amount that will go into line 6 (Net Assets). Now divide the Net Asset amount by 12 to get the amount that will go into line 7 (Monthly Liquid Assets). You will need to round off the amount on line 7 to the nearest dollar. Now add the amount from Box B – line 7 to Box A – line 3 as other income. This will give you your new total gross income. (See Example 2).

UNIFORM PATIENT FEE SCHEDULE
COMMUNITY MENTAL HEALTH SERVICES
EFFECTIVE OCTOBER 1, 1989

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
	MEDI-CAL ELIGIBLE AREA**				
0-569	37	33	30	27	24
570-599	40	36	32	29	26
600-649	45	40	36	32	29
650-699	50	45	41	37	33
700-749	56	50	45	41	37
750-799	63	57	51	46	41
800-849	71	64	58	52	47
850-899	79	71	64	58	52
900-949	89	80	72	65	59
950-999	99	90	80	72	65
1000-1049	111	100	90	81	73
1050-1099	125	112	101	91	82
1100-1149	140	126	113	102	92
1150-1199	156	140	126	113	102
1200-1249	177	159	143	129	116
1250-1299	200	180	162	146	131
1300-1349	226	203	183	165	149
1350-1399	255	230	207	186	167
1400-1449	288	259	233	210	189
1450-1499	326	293	264	238	214
1500-1549-	368	331	298	268	241
1550-1599	416	374	337	303	273
1600-1649	470	423	381	343	309
1650-1699	531	478	430	387	348
1700-1749	600	540	486	437	393
1750-1799	678	610	549	494	445
1800-1849	752	677	609	548	493
1850-1899	835	752	677	609	548
1900-1949	927	834	751	676	608

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
1950-1999	1029	926	833	750	675
2000-2049	1142	1028	925	833	750
2050-2099	1268	1141	1027	924	832
2100-2149	1407	1266	1139	1025	923
2150-2199	1562	1406	1265	1139	1025
2200-2249	1734	1561	1405	1265	1139
2250-2299	1925	1733	1560	1404	1264
2300-2349	2136	1922	1730	1557	1401
2350-2399	2371	2134	1921	1729	1556
2400-2449	2632	2369	2132	1919	1727
2450-2499	2922	2630	2367	2130	1917
2500-2599	3275	2948	2653	2388	2149
2600-2699	3482	3134	2821	2359	2285
2700-2799	3695	3326	2993	2694	2425
2800-2899	3915	3524	3172	2855	2570
2900-2999	4139	3725	3353	3018	2716
3000-3099	4370	3933	3540	3186	2867
3100-3199	4607	4146	3731	3358	3022
3200-3299	4850	4365	3929	3536	3182
3300-3399	5099	4589	4130	3717	3345
3400-3499	5458	4912	4421	3979	3581
3500-3599	5830	5247	4722	4250	3825
3600-3699	6214	5593	5036	4532	4079
3700-3799	6610	5949	5354	4819	4337
3800-3899	7018	6316	5684	5116	4604
3900-3999	7438	6694	6025	5423	4881
4000-4099	7870	7083	6375	5738	5164
4100-4199	8314	7483	6735	6062	5456
$ 4200 and above add $ 400 for each $ 100 additional income					

- *Monthly Gross Income after adjustments for allowable expenses and asset determination from computation made on the financial intake form.
- ** Medi-Cal eligible. The shaded Medi-Cal eligible area identifies income levels presumed eligible if client meets Medi-Cal eligibility requirements.
- Prepared and published by the California Department of Mental Health in accordance with Sections 5717 and 5718 of the Welfare and Institutions Code. (ATTACHMENT C)

10/20/89

FPL see link - https://www.coveredca.com/pdfs/FPL-chart.pdf- Medi-Cal Information-
Family Resource Centers that accept Medi-Cal Applications:

Fallbrook Community Resource Center 130 E. Alvarado Street, Fallbrook, CA

Family Resource Center - El Cajon: 220 South First Ave, El Cajon, CA

Family Resource Center - Lemon Grove: 7065 Broadway, Lemon Grove, CA

Family Resource Center - North Coastal: 1315 Union Plaza Ct., Oceanside, CA

Family Resource Center - North Inland: 620 East Valley Parkway, Escondido, CA

Family Resource Center - Northeast #2: 5001 73rd Street, San Diego, CA

Family Resource Center - Southeast: 4588 Market Street, San Diego, CA

Mills Building/Trolley Towers: 1255 Imperial Ave. San Diego, CA

North Central Family Resource Center: 5055 Ruffin Rd., San Diego, CA

Ramona Community Resource Center: 1521 Main Street, Ramona, CA

South Region Center: 690 Oxford Street, Chula Vista, CA

If you have any questions or are requesting a MAIL-IN application, you may contact ACCESS either of the information provided below::

By phone at 866-262-9881 or 2-1-1or TDD hearing impaired 858 514-6889
Web: www.accessbenefitsSD.com or www.mybenefitscalwin.org
E-mail: pubassist.hhsa@sdcounty.ca.gov fax 858 467-9088 Applications and/or verifications may be mailed to the following address: Document Processing Center P.O. Box 85025 Lemon Grove CA 92186-5025

SSI Advocacy Services for Mental Health Clients and Clubhouses:

Friendship clubhouse: 286 Euclid Ave #103 San Diego (619) 955-8217

The Corner Club house:2864 University Ave San Diego (619) 683-7423

The Meeting Place Club House: (SSI)2553 State St, San Diego, CA. Phone (619) 294-9582

East Wind Clubhouse: 8745 Aero Dr ste 330 San Diego Ca (858) 268-4933

East Corner Clubhouse: (SSI)1060 Estes ST ste 104 El Cajon CA (619) 420-8603

Casa Del Sol Clubhouse: (SSI) 1157 30th Street, San Diego, CA. Phone (619) 429-1937

Vison Clubhouse: 226 Church St Chula Vista CA (619) 420-8603

Mariposa Clubhouse: (SSI)1701 Mission Ave ste 120, Oceanside, CA. Phone (760) 439-2769

Escondido Clubhouse: (SSI)474 W. Vermont Avenue, Escondido, CA. Phone (760) 737-7125

Oasis Clubhouse Youth 16-25: 3330 Market ST ste C San Diego CA 92101 (858) 300-0470

DCS Clubhouse DEAF 205 National City Blvd, Nat'l City CA (619) 618-0501

Corrections 2 Community clubhouse(C2C) Homeless: (SSI) 101 16th st San Diego CA 619 955-8217

HEALTHCARE BILLING TERMS

A

Actual Charge - The amount of money a doctor or supplier charges for a certain service or supply. This amount is often more than the amount an insurance plan may approve.

Adjustment - A transaction that increases or decreases an accounts receivable balance. A debit increases the balance and a credit decreases the balance.

Advance Beneficiary Notice (ABN) - A notice the hospital or doctor gives you before you're treated, telling you that Medicare will not pay for some treatment or services. The notice is given to you so that you may decide whether to have the treatment and how to pay for it.

Amount Charged- how much a doctor or hospital bills a client.

Amount Paid - The dollar amount that a client may have paid for the doctor or hospital visit.

Amount Payable by Plan- The amount an insurance plan pays or covers for a client's treatment, less any deductibles, coinsurance, or charges for non-covered services.

Amount Not Covered- What a client's insurance company does not pay. It includes deductibles, co- insurances, and charges for non-covered services.

Amount Not Covered - The amount billed that the insurance company will not pay. It may include deductibles, coinsurances, and charges for non-covered services.

Amount Payable by Plan- How much a client's insurer pays for a client's treatment, minus any deductibles, coinsurance, or charges for non-covered services.

Ancillary Service- Services you need beyond room and board charges, such as laboratory tests, therapy, surgery and the like.

Appeal- A process by which a client, their doctor or the hospital can object to your health plan when you disagree with the health plan's decision not to pay for the clients care.

Applied to Deductible - Portion of a client's bill, as defined by the insurance company, that the client owes the doctor or hospital.

Approved Amount - The amount of the hospital's charge that a payer will recognize in calculating benefits. (Under Medicare, also called "Medicare Allowable Charge")

Approved Amount (Medicare) - The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Assignment- An agreement you sign that allows a client's insurance to pay the doctor or hospital directly.

Assignment (Medicare) - Assignment is an agreement between Medicare and doctors, other health care providers, and suppliers of health care equipment and. Doctors and suppliers who agree to accept assignment accept the Medicare-approved amount as payment in full for Part B services and supplies. The client may owe

a coinsurance and deductible amount. If assignment **isn't accepted**, then the amount the client may owe is often higher. This means the client may have to pay the entire charge at the time of service because Medicare will

then send the payment of the services directly to the client. There is a limit on the amount a doctors or providers can bill the client. The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment is called the limiting charge. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment. There are three ways to handle assignment:

1. Always accept assignment, which means they participate in Medicare.
2. Accept assignment on a case-by-case basis and accept it in this case.
3. Never accept assignment, or choose not to accept assignment in this case.

Assignment does not work with a private contract.

Assignment of benefits- An agreement in which a client instructs their insurance organizations to pay the hospital, physician or medical supplier directly for their medical services.

Attending Physician Name - The doctor who certifies that the client is in need of treatment and is responsible for their care.

Authorizations- Authorizations may be required for certain procedures.

Authorization Number- A number stating that the client's treatment has been approved by their insurance plan. Also called a Certification Number or Prior-Authorization Number.

Authorized Provider- An authorized provider is a doctor or other individual providers of care, hospitals or suppliers who have been approved by the insurance company to provide services.

B

Bad debt- Debt that is uncollected after several attempts.

Balance - Amount outstanding on a client's account. A client's statement will indicate who currently owes the balance.

Balance Bill- How much doctors and hospitals charge's a client after the health plan, insurance company, or Medicare has paid its approved amount.

Beneficiary- Person covered by health insurance.

Beneficiary Eligibility Verification - A way for doctors and hospitals to get information about whether you have insurance coverage.

Beneficiary Liability - A statement that you are responsible for some treatments or charges.

Benefit- The services that are covered under a client's insurance plan.

Benefits Period- Starts the day you are admitted to a hospital or skilled nursing facility (SNF) and ends when you haven't received hospital inpatient or SNF care for 60 consecutive days.

Bill/Invoice/Statement- Printed summary of a client's medical bill.

C

Centers for Medicare and Medicaid (CMS)- The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.

CHAMPUS- CHAMPUS is the former name of the military healthcare program that is now TRICARE.

Charge itemization- A list of all items, medications, room charges and procedures. This does not necessarily indicate amount owed by the client or their insurance.

Claim- A form submitted to the insurance organization for payment of benefits.

Claim Number- A number given to a medical service.

Clean Claim- A claim that does not have to be investigated by insurance companies before they process it.

CMS 1500 or HCFA 1500 - The health insurance claim form. It is submitted by individual professional providers of medical care or institutions billing professional services.

Coding of Claims - Translating diagnoses and procedures in a client's medical record into numbers that computers can understand.

Coinsurance - The cost sharing part of the bill that you have to pay. For Medicare, the percent of the approved charge that you have to pay either after you pay the Part A deductible, or after you pay the first $100 deductible each year for Part B

Coinsurance (Medicare) - The amount you may be required to pay for services after a client pays their Medicare deductible. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the deductible for Part A and/or Part B. Note: Terms in red are defined in the Glossary section of the FAQ database.

Coinsurance Days (Medicare) - Hospital Inpatient Medicare coverage from day 61 to day 90 of continuous hospitalization. You are responsible for paying for part of those days. After the 90th day, you enter a client's "Lifetime Reserve Days."

Collection Agency- A business that collects money for unpaid bills.

Consent (for treatment) - An agreement a client signs that gives their permission to receive medical services or treatment from doctors or hospitals.

Contractual Adjustment- A part of your bill that your doctor or hospital must write off (not charge you) because of billing agreements with your insurance company.

Coordination of Benefits (COB) - A way to decide which insurance company is responsible for payment if you have more than one insurance plan.

Coordination of benefits- How insurance organizations determine the primary payment source when you are covered under more than one insurance organization or group medical plan. Many insurance contracts state that if you are covered under more than one insurance plan, benefits will be coordinated so that total benefits paid will not be more than 100% of the bill.

Co-payment/Co-pay- A set fee established by the insurance company for a specific type of visit. This amount is due from the guarantor. This information can routinely be located on the insurance card and will be different amounts according to the type of visit. For example, Emergency Room Visit - $50, Inpatient Stay - $100, Physician Office Visit - $20.

Covered Benefit- A health service or item that is included in a client's health plan, and that is paid for either partially or fully.

Covered Days - Days that a client's insurance company pays for in full or in part.

Covered services- Specific services or supplies for which a client's insurance reimburses the client or their health care provider. These consist of a combination of mandatory and optional services and vary by state.

CPT Codes- A coding system used to describe what treatment or services were given to you by a client.

D

Date of Bill- The date the bill for a client's services is prepared. It is not the same as the date of service.

Date of Service (DOS)- The date(s) when you were provided healthcare services. For an inpatient stay, the dates of service will be the date of a client's admission through your discharge date. For outpatient services, the date of service will be the date of the service or visit.

Deductible- The agreed amount you must pay before your insurance organization will pay a claim. Usually, you have 12 months to meet your deductible. Eligible expenses after you meet your deductible are then paid for the rest of that 12-month period.

DEERS - The Defense Enrollment Eligibility Reporting System (DEERS) is a computerized data bank that lists all active and retired military members and their dependents if they meet the eligibility requirements. Active and retired military members are automatically listed but must take action to list their dependents and report any changes to family members' status (marriage, divorce, birth of a child, adoption, etc.) along with changes to mailing addresses.

Description of Services- Tells what your doctor or hospital did for you.

Diagnosis Code- A code used for billing that describes your illness.

Diagnosis-Related Groups (DRGs) - A payment system for hospital bills. This system categorizes illnesses and medical procedures into groups for which hospitals are paid a fixed amount for each admission.

Disallowed amount- The difference between the charge and the amount your insurance organization approves. If your health care provider is under contract with your insurance organization to accept the approved amount, you aren't billed for the difference. If your provider is not under contract, you may be billed for this difference.

Discharge Hour- Hour when you were discharged.

Discount - Dollar amount taken off your bill, usually because of a contract with your hospital or doctor and your insurance company.

Drugs/Self-Administered - Drugs that do not require doctors or nurses to help you when you take them. You may be charged for these. You will need to check with your doctor or hospital regarding their policy on this.

Due from Insurance - How much money is due from your insurance company.

Due from Patient - How much you owe your doctor or hospital.

E

Eligible Payment Amount - Those medical services that an insurance company pays for.

Emergency Care - Care given for a medical emergency when you believe that your health is in serious danger when every second counts.*

Emergency Room - A special part of a hospital that treats patients with emergency or urgent medical problems.

Explanation of Benefits (EOB) - This is a notice you receive from your insurance company after your claim for healthcare services has been processed. It explains the amounts billed, paid, denied, discounted, uncovered, and the amount owed by the patient. The EOB may also communicate information needed by the insured in order to process the claim.

Estimated Insurance- Estimated cost paid by your insurance company.

Enrollee - A person who is covered by health insurance.

Estimated Amount Due- How much the doctor or hospital estimates you or your insurance company owes.

Explanation of Benefits (EOB/EOMB) - The notice you receive from your insurance company after getting medical services from a doctor or hospital. It tells you what was billed, the payment amount approved by your insurance, the amount paid, and what you have to pay.

F

Financial Responsibility- How much of your bill you have to pay.

Fiscal Intermediary (FI) - A Medicare agent that processes Medicare claims. The government directs FIs through federal regulations and guidelines. At times a Fiscal Intermediary may subcontract Claims Processors to adjudicate claims.

Fraud and Abuse- Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by the insurance plan. This is not the same as fraud.

G

Group number- The number of your insurance organization group. See your insurance card.

Guarantor or Responsible Party- The individual responsible for paying this bill. Patient statements are addressed to this person.

H

HCFA 1500 or CMS 1500 - The health insurance claim form. It is submitted by individual professional providers of medical care or institutions billing professional services.

HCPC Codes- A coding system used to describe what treatment or services were given to you by your doctor.
Health Care Financing Administration (HCFA)- Former name of the government agency now called the Centers for Medicare & Medicaid Services.

Healthcare Provider- Someone who provides medical services, such as doctors, hospitals, or laboratories. This term should not be confused with insurance companies that "provide" insurance.

Health Insurance- Coverage that pays benefits for sickness or injury. It includes insurance for accidents, medical expenses, disabilities, or accidental death and dismemberment.

Health Maintenance Organization - An insurance plan that pays for preventative and other medical services provided by a specific group of participating providers.

HIPAA- Health Insurance Portability and Accountability Act. This federal act sets standards for protecting the privacy of your health information.

Hospital Inpatient Prospective Payment System (PPS) - A federal system that pays a fixed fee for inpatient care.

I

Ineligible expense- A charge your insurance organization will not pay because it is not covered by your insurance plan. If your health care provider is under contract with your insurance organization, this charge may be billed to you.

Inpatient (IP) - Patients who stay overnight in the hospital.

Insurance Company Name- Name of the company that your claim will be sent to.

Insured Group Name- Name of the group or insurance plan that insures you, usually an employer.

Insured Group Number- A number that your insurance company uses to identify the group under which you are insured.

Insured's Name (Beneficiary) - The name of the insured person.

Internal Control Number (ICN) - A number assigned to your bill by your insurance company or their agent.

L

Limiting Charge (Medicare)- In the Original Medicare Plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who **don't accept assignment**. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

Long-Term Care- Care received in a nursing home. Medicare does not pay for long-term care unless you need skilled nursing or special rehabilitation.

M

Managed Care Plans- A insurance plan that requires patients to see doctors and hospitals that have a contract with the managed care company, except in the case of medical emergencies or urgently needed care if you are out of the plan's service area.

Medi-Cal- A state administered federal and state funded insurance plan for low-income people who have limited or no insurance.

Medical Record Number- The number assigned by your doctor or hospital that identifies your individual medical record.

Medicare- A health insurance program for people age 65 and older, some people with disabilities under age 65, and people with end-stage renal disease (ESRD).

Medicare + Choice - A Medicare HMO insurance plan that pays for preventive and other healthcare from designated doctors and hospitals.

Medicare Approved- Medical services for which Medicare normally pays.

Medicare Assignment- Doctors and hospitals who have accepted Medicare patients and agreed not to charge them more than Medicare has approved.

Medicare Number- Every person covered under Medicare is assigned a number and issued a card for identification to providers.

Medicare Paid - The amount of your bill that Medicare paid.

Medicare Paid Provider- The amount of your bill that Medicare paid to your doctor or hospital.

Medicare Part A- Usually referred to as Hospital Insurance, it helps pay for inpatient care in hospitals and hospices, as well as some skilled nursing costs.

Medicare Part B- Helps pay for doctor services, outpatient care, and other medical services not paid for by Medicare Part A.

N

Network- A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members

Non-availability Statement (NAS)- A NAS is a certificate from a local military treatment facility (MTF) that states it can't provide the care that the patient needs. TRICARE Standard beneficiaries are required to obtain a NAS for inpatient mental health. With the exception of inpatient mental health care, the NAS requirement has been all but eliminated, except in limited circumstances when an MTF applies for a NAS waiver. MTFs may not apply for a NAS waiver for maternity, meaning the NAS requirement for maternity is removed completely.

Non-Covered Services- Services not covered under the patient's insurance plan. These charges are the patient's responsibility to pay.

Non-participating health care provider- A health care provider who is not under contract with an insurance organization to accept patients and receive the insurance organizations approved amount on all claims. You pay the difference between its approved amount for a service and this health care provider's charge.

Non-Participating Provider (Medicare) - A doctor or supplier who doesn't participate in Medicare. The doctor or supplier can choose to accept assignment on a **case-by-case basis**.

Non-Participating Provider (TRICARE) - A non-participating provider does not agree to the TRICARE Maximum Allowable Charge (TMAC) as the final payment on the claim. The beneficiary is responsible for paying up to 115% of the TMAC. TRICARE payment is made directly to the beneficiary.

O

Out-of-Pocket Costs- Costs you must pay because Medicare or other insurance does not cover them.

P

Paid to Provider- Amount the insurance company pays your medical provider.

Paid to You- Amount the insurance company pays you or your guarantor.

Part A (Medicare) - Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Part B (Medicare) - Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.

Participating Health Care Provider - A health care provider who contracts with an insurance organization to accept patients and receive the insurance organization's approved amount on all claims.

Participating Provider- A doctor or hospital that agrees to accept your insurance payment for covered services as payment in full, minus your deductibles, co-pays and coinsurance amounts.

Participating Provider (Medicare) - A doctor or supplier who agrees to accept assignment on all Medicare claims. By accepting assignment, these doctors or suppliers agree to accept the Medicare-approved amount as payment in full. Medicare participating providers can't try to collect more than the proper Medicare deductible and coinsurance amounts from you.

Participating Provider (TRICARE) - A doctor or supplier who agrees to accept the TRICARE allowable charge as full payment. These doctors or suppliers may bill you only for TRICARE deductible and/or cost shares.

Patient Amount Due- The amount charged by your doctor or hospital that you have to pay.

Patient Type- A way to classify patients--outpatient, inpatient, etc.

Pay This Amount -How much of your bill you have to pay.

Per Diem- Charged or paid by the day.

Physician- Person licensed to practice medicine.

Physician Practice- A group of doctors, nurses, and physician assistants who work together.

Physician Practice Management- Non-physician staff hired to manage the business aspects of a physician practice. These staff include billing staff, medical records staff, receptionists, lab and X-ray technicians, human resources staff, and accounting staff.

Place of service- The facility where service is performed.

Policy holder- The name of the person who took out or purchased the insurance policy. This person owns the policy. Also called a subscriber or guarantor.

Policy Number- A number that your insurance company gives you to identify your contract.

Pre-Admission Approval or Certification- An agreement by your insurance company to pay for your medical treatment. Doctors and hospitals ask your insurance company for this approval before providing your medical treatment.

Pre-authorization (pre-certification) - The process of getting permission from your insurance organization for certain services before they are provided so that the services can be considered eligible expenses. Usually required for hospital and outpatient services.

Pre-Authorization Number- Authorization given by a health plan for a member to obtain services from a healthcare provider. This is commonly required for hospital services.

Pre-Certification Number- A number obtained from your insurance company by doctors and hospitals. This number will represent the agreement by the insurance plan that the service has been approved. This is not a guarantee of payment.

Preferred Provider Organizations (PPO) - An insurance plan that has a contract with providers to provide healthcare services at a discounted rate. These services may require prior pre-certification, authorization, and/or referrals.

Prepayments- Money you pay before getting medical care; also referred to as preadmission deposits.

Primary Insurance Company- The insurance organization with first responsibility for paying eligible insurance expenses for your medical service (after you have paid your deductible and co-payments). If you have additional insurance, those organizations would work with your primary insurance organization to cover eligible expenses according to your insurance policies.

Privacy Act - The Privacy Act of 1974 is a federal law that was established to provide a safeguard for individuals against invasion of personal privacy.

Procedure Code (CPT Code) - A code given to medical and surgical procedures and treatments.

Provider- A doctor, hospital or other person or place that provides medical services and/or supplies.

Provider Name, Address, and Phone #- Name and address of the doctor or hospital submitting your bill.

Psychiatric/Psychological Treatments- Nursing care and other services for emotionally disturbed patients, including patients admitted for inpatient care and those admitted for outpatient treatment.

R

Reasonable and Customary (R & C) - Billing charges that insurers believe are appropriate for services throughout a region or community.

Referral- Permission from your primary care doctor to see a certain specialist or receive certain services.

Release of Information- A signed statement from patients or guarantors that allows doctors and hospitals to release medical information so that insurance companies can pay claims.

Responsible Party- The person(s) responsible for paying your hospital bill--usually referred to as the guarantor.

Revenue Code- A billing code used to name a specific room, service (X-ray, laboratory), or billing sum.

Room and Board Private- Routine charges for a room with one bed.

Room and Board Semiprivate- Routine charges for a room with two beds.

S

Secondary insurance- The insurance organization with second responsibility for paying eligible insurance expenses for your medical service (after you've paid your deductible and co-payments). This insurance would work with your primary insurance organization to cover eligible expenses according to your insurance policies. This insurance organization is billed second — after your primary insurance organization has been billed.

Service Begin Date- The date your medical services or treatment began.

Service Code- A code describing medical services you received. **Service End**

Date- The date your medical services or treatment ended. **Statement Covers**

Period- The date your services or treatment begin and end.

Subscriber- The person who purchased the insurance. Also known as a policyholder or guarantor.

Subscriber- The person responsible for payment of premiums or whose employment is the basis for eligibility for a health plan membership.

Submitter ID- Identification number (ID) that identifies doctors and hospitals who bill by computers. Doctors and hospitals get an ID from each insurance company to whom they send claims using the computer.

Supplemental Insurance Policy- An additional insurance company that handles claims for deductibles and coinsurance reimbursement. Many private insurance companies sell Medicare Supplemental Insurance.

T

Tertiary insurance- The insurance organization with third responsibility for paying eligible insurance expenses for your medical service (after you've paid your deductible and co-payments). This insurance would work with your primary and secondary insurance organizations to cover eligible expenses according to your insurance policies. This insurance organization is billed third — after your primary and secondary insurance organizations have been billed.

Total Charges- Total cost of your medical services.

U

UB-04 - A form used by hospitals to file insurance claims for medical services.

UMDAP – Uniformed Method for Determining the Ability to Pay (sliding scale fee)

Units of Service - Measures of services, such as the number of hospital days, minutes of service, etc.