

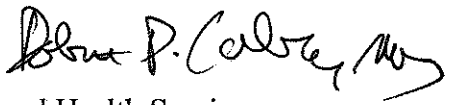
CBHS Policies and Procedures



City and County of San Francisco
Department of Public Health
Community Programs
COMMUNITY BEHAVIORAL HEALTH
SERVICES

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POLICY/PROCEDURE REGARDING: **Timely Submission of Documents and Data for Behavioral Health Billing Information Systems**

Issued By: Robert Cabaj, MD 
Director of Community Behavioral Health Services

Date: **January 31, 2010**

Manual Number: 2.03-11

References: Welfare & Institutions
Code, Title 22, Title 9 – CA Code of
Regulations, DMH Revenue
Development Policies & Procedures

(Technical revision. Replaces memo 2.03-11 of 4/18/06.) Effective January 31, 2010.

Background:

The Behavioral Health Billing Information System (BHBIS) is designed to collect patient and service data in order to:

1. Produce claims for reimbursement of Community Behavioral Health Services (CBHS) provider services (Mental Health and Substance Abuse) to the State Medicaid program, Medicare and other third party payers.
2. Fulfill reporting requirements defined by the California Dept. of Health Services, the Dept. of Mental Health and the Alcohol and Drug Program.
3. Enable accurate tracking of patients throughout Mental Health and Substance Abuse programs in order to facilitate patient care delivery
4. Provide management reports related to provider and clinic operations, Program contract payments, compliance, accounts receivables, and performance outcomes.

The clinical chart is the ultimate audit trail for the billing system. Therefore, patients' chart notes need to accurately reflect the service data that is entered into the BHBIS. Documentation must exist in the client's chart for all services that are billed.

The Welfare and Institutions Code, Section 14115 and Title 9 - CA Code of Regulations, Section 1840.110 require timely submission of service claims for Medi-Cal reimbursement. In cases when services are entered into BHBIS after the claims submission deadline, the Provider is required to complete a 'Good Cause Certification Letter' with the reason for the late billing. Short Doyle Medi-Cal automatically denies payment of services billed without an allowed late submission reason.

Policy:

Timely form completion and BHBIS data entry must occur for the following functions:

1. Registration of clients into the system
2. Opening and closing of treatment episodes
3. Accurate recording of service data
4. To meet mandatory and periodic reporting to the State and/or Federal government
5. Documentation of clients' financial and eligibility status (based on completed Payer Financial Information Forms)
6. Monthly verification of clients' Medicaid eligibility records
7. Clearing client's share of cost in accordance with established guidelines
8. Management and reporting of CBHS Programs' productivity and other performance measures.

Mental Health BHBIS Data Entry

- a. The Behavioral Health Billing Unit publishes a Medi-Cal Claim and Reports Cutoff Schedule annually. The monthly Medi-Cal cut-off schedule dates apply for purposes of billing services to Short-Doyle Medi-Cal (SDMC), State reporting, and for preparation of monthly management information reports. Services entered after the cut-off date will not be reported or billed to SDMC until the following month.
- b. Per the Welfare & Institutions Code, the provider must submit claims within two months from the date of service, and up to One year with a Good Cause Reason. Medi-Cal will not accept late claims from CBHS that are six-months from the date of service without an acceptable Good Cause reason as specified in Title 22, Section 51008. Acceptable late reasons are outlined in the EXPLANATION OF LATE SERVICE BILLING form completed by Providers for services that approved for late entry into the BHBIS system so a corresponding Good Cause Reason code may be entered on the Provider's Medi-Cal claim.
- c. To enter any services older than two months from the date of service, the Provider is required to complete an EXPLANATION OF LATE SERVICE BILLING form (Attachment 1) and submit it to the CBHS Executive Team.. This two-month cutoff allows time for the service posting and billing cycles, and for documentation to be prepared and processed for late claims. Providers have the responsibility to complete the form and to maintain supporting documentation in the client's chart or in Clinic files for a period of at least seven (7) years, in case of audit. The Provider sends a copy of the form to their CBHS Age Director for review and approval. A copy of the form with the CBHS representative's approval signature must be provided to the DPH-IT, BIS Unit so the corresponding "Late Reason Code" can be entered in BHBIS and in the Provider's electronic Medi-Cal service claims. Late claims submitted without an allowed reason code are automatically denied by the State.
- d. The DPH CBHS Age Director completes Good Cause Certification forms, MH1770 for mental health services and ADP6065 – for substance abuse treatment services. Completed forms are sent to the DPH-IT, BIS Unit or to the CBHS Billing Unit. The CA Dept of Health Care Services (DHCS) requires prior approval whenever Good Cause reason "E" or "D" are used. DPH IT – BIS Business Analysts or CBHS Provider Certifications Manager submit written requests for Good Cause prior approvals to DHCS, including a description of the circumstances for late claims submissions and/or supporting documentation for using Good Cause D or E on behalf of the Provider. For mental health service claims, requests are submitted to the DMH Medi-Cal Claims Customer Service Office. For Drug Medi-Cal claims, the completed ADP- Good Cause Certification form is submitted to the ADP County Liaison. (MH1770 and ADP 6065 forms attached)

- e. CBHS will not reimburse contractors for delivered units if CBHS is unable to receive reimbursement from the State as a result of the provider not meeting SDMC requirements for late claims submission or data entry deadlines for these service units.

Substance Abuse BHBIS Data Entry

CBHS Substance Abuse Providers have monthly data entry deadlines and Quarterly Open Windows throughout the fiscal year. The California Alcohol and Drug Program (ADP) has a strict 30-day billing period for Medi-Cal services. Services entered after the billing period or during the Quarterly Open Window require the Provider to document the reason for late billing for "Good Cause". Per the Welfare & Institutions Code Section 51490.1, the Provider must produce upon request for ADP audit or monitoring purposes, the documentation substantiating the Good Cause reason cited. In addition, the provider must also enter the corresponding "Late Reason Code" on the client's Medi-Cal eligibility record so it can be included in the month's claim. Late claims submitted without an allowed reason code are automatically rejected by the State.

Cost Report Reconciliation

Providers will be reimbursed for services based on the data that is entered in BHBIS. For Mental Health Programs, monthly MHS 580 reports are distributed to Providers summarizing the total units of service in BHBIS under each mode and service function code billed each month. The MHS 580 report is also used by the DPH - Fiscal Unit to reconcile BHBIS units of service to providers' monthly invoices. Providers are responsible for finding discrepancies between their actual service units and totals appearing on the MHS 580. BHBIS Liaisons are available to assist providers in finding certain errors and in determining appropriate corrective actions. At the end of the fiscal year, the DPH Fiscal - Cost Report Unit uses the MHS 580 report to prepare the annual cost report to the State. Organizational providers' final cost settlement is determined based on the total units of service appearing on the fiscal year's MHS 580 report generated after the August 31 deadline.

For Substance Abuse Programs, periodic reports and the Media Board contain information for tracking and monitoring service units entered in BHBIS. The DAS 800-DW Provider Service Summary Report is generated for the following periods: Monthly, Quarterly, Semi-annually, Preliminary and Final for the Fiscal Year. These reports are printed centrally and Providers are responsible for obtaining their reports in a timely manner. The DAS 800-DW Report is used by DPH-Fiscal to prepare the annual cost report to ADP and for settling individual Contract Providers' cost reports for all SA programs entering services in BHBIS.

Mandatory State and/or Federal reporting

Providers are required to enter BIS data for the County to meet California Dept of Mental Health and Alcohol & Drug Program, SAMHSA and other federal funding agencies' reporting requirements. Initial and periodic data are used for performance and outcomes measurements, to identify what is working well in the County's service delivery system, to provide accountability for funds received, and for future planning to ensure the availability and continuous quality improvement of mental health and substance abuse treatment and prevention program services. Client Services Information System (CSI) data is required by the Dept of Mental Health; and, CalOMS or California Outcomes Measurement System data is required by the Alcohol & Drug Program. Since the information is essential for overall accountability and evaluation, CBHS Providers must make every effort to ensure timely, accurate and complete data entry in BIS to allow reporting to these systems. Providers' data entry and reporting compliance are included in CBHS Program Reviews and

evaluations. Detailed information and BIS data entry instructions for meeting mandatory reporting requirements are included in the Insyst Users Manual and/or in correspondence sent to the CBHS Program Directors.

Episode Entry

A BHBIS episode must be entered within 24 hours whenever a CBHS client is admitted to a Psychiatric Inpatient unit or receives services from SFGH Psychiatric Emergency Services (PES). This is necessary so that notification can be made to primary therapists about their client via the MHS 120 – Morning Report that is generated from the Billing Information System. The report is also used by Program Administration for hospitalized clients' disposition planning. Contracted Provider's Exhibit A and Civil Service Programs' MOU's contain this requirement.

BHBIS episodes should be closed if there has been no recent face-to-face treatment or active contact with the Client. For Substance Abuse programs, the Alcohol and Drug Program has defined specific guidelines for each mode of service. For Mental Health programs, CBHS Quality Management has guidelines for closing episodes in BHBIS. These are published in CBHS Policy/procedures, administration letters and notices sent to Program Directors and Clinician staff. Client admissions are recorded in BHBIS thru Episode Openings; and, client discharges in Episode Closings. Episodes data are included in CSI and CalOMS reports.

Payer Financial Information

The Payer Financial Information or PFI process is a means for evaluating a Client's eligibility to receive services from DPH - Community Mental Health Services/ San Francisco Mental Health Plan (SFMHP) and their Responsible Party's (RP) ability to personally contribute towards the cost of services received. This includes: a financial assessment per the State's UMDAP policy and procedures and obtaining complete and accurate billing information about third party benefits they have in order to determine if they are potentially eligible for social welfare programs so they can be appropriately referred.

The Welfare & Institutions Code and Ca Dept. of Mental Health's Revenue Development Policy and Procedures require a PFI to be completed for all clients receiving services from county mental health programs. It is the goal of the SFMHP for all clients receiving services to complete a PFI at the time of their first visit. If this goal is not attained, measures must be taken to ensure eligibility and financial or UMDAP (Uniform Method for Determining Ability to Pay) screening interview takes place during a subsequent visit. As a minimum, Name, address, telephone number and Social Security Number should be obtained on all clients during their first visit.

The PFI UMDAP period is one year. For clients who are still in treatment, a PFI re-evaluation is performed annually. A PFI is also required whenever there is a change in the Client's or in their Account Responsible Party's financial situation or their insurance coverage.

The BHBIS is programmed to enforce DMH requirements for PFI. The PFI is used to set-up and annually update BHBIS Patient Accounts information for each client. If no PFI is received, all services entered during the UMDAP period are pended. Services will not be billed to Medi-Cal or to any other payer source, including the County.

A CalMEDS (California Medi-Cal Eligibility Data System) printout showing the client has Full-scope Medi-Cal benefits, no Share of Cost obligation and no other health coverage, can take the place of a PFI. The MEDS printout is sent to the CBHS Billing Unit in lieu of a completed PFI. Upon receipt, Billing will update

the client's account information so third party billing will not be blocked. A copy of the MEDS printout must also be kept in the client's chart to show State PFI requirements have been met.

The completed client PFI forms or CalMEDS printout are sent to the CBHS – Patient Accounts Billing section.

Monthly verification of clients' Medicaid eligibility records

Programs need to ensure clients' Medi-Cal eligibility information is captured in the billing information system, Insyst, so that the system can generate claims on a timely basis. MH Clients' eligibility information is on the MHS 500 – Caseload Report. Each program should carefully go over its MHS 500 report at least once a month. These reports are run late in the month to reflect Medi-Cal eligibility changes. Medi-Cal is a month-to-month benefit and Clients may lose or gain benefits depending on their eligibility status. If the MHS500 shows the client is eligible for Medi-Cal in the current month, there is nothing more you need to do for Medi-Cal billing to occur, unless the client has a Share-of-Cost obligation. If a client has a Monthly Medi-Cal Share-of-cost, the Provider must attempt to clear it soon after each visit.

Medi-Cal Client's monthly Share-of-Cost obligation

Some Medi-Cal recipients must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called a Share of Cost (SOC). Clinics must maintain a log of clients who have a Medi-Cal SOC to facilitate appointment scheduling as early in the month as possible. This will assist our clients in accessing their Medi-Cal benefits as soon as possible. Medi-Cal eligibility must be verified at every visit to determine if the Client has a SOC by using a POS device or via Internet look-up in the Medi-Cal website. If the Client has a SOC balance and once services are provided, Clinic Data Entry staff must enter a SOC clearance transaction in the BHBIS for Medi-Cal claim amounts to be accurately recorded and submitted. Detailed information and instructions for clearing clients' Medi-Cal SOC are included in the Insyst Users Manual.

Contact People*:

CBHS Program Administration, 255-3400,
CBBH Billing Information Systems: Pablo Munoz, 255-3926;
Provider Certifications - Jim Gilday, 255-3661;
DPH Fiscal - Behavioral Health Billing: Maria Jimenez Barteaux, 255-3536,
Cost Reports: Lizza Leviste, 554-2540

Attachment 1 – MHS EXPLANATION OF LATE SERVICE BILLING FORM

Attachment 2 – MH1770 – DMH Good Cause Certification form

Attachment 3 – ADP6065 Good Cause Certification form

Distribution:

CBHS policies and procedures are distributed by the Quality Management Section:
Administrative Manual Holders
Behavioral Health Associate Directors
CBHS Direct Treatment Programs
Policy Distribution Coordinator

* (as of date of policy)

EXPLANATION OF LATE SERVICE BILLING FORM

(Please type or print a separate form for each group of late services submitted)

Date: _____

Provider Name: _____ RU#: _____

Contact Person: _____

Phone Number: _____

This Explanation of Late services billing applies to:

Dates of service: _____

In a batch entered on _____ or for the following individual Clients:

Name: _____ BIS #: _____

Name: _____ BIS #: _____

Name: _____ BIS #: _____

The services were late due to the following checked reason(s):

- A - Patient or Legal Representative's failure to present Medi-Cal Identification
- B - Billing involving other coverage, including but not limited to Medicare or insurance.
- C - Circumstances beyond the control of the provider regarding delay or error in the certification of Medi-Cal eligibility of the beneficiary by the State or County.

I hereby certify that the services being billed are late for the reason cited above. Substantiating documentation for this reason is available at the Provider's premises and will be presented upon request to the San Francisco Mental Health Plan/Community Behavioral Health Services.

Program Director or Provider Representative's Signature

Date

Note: The completed form contains protected and confidential patient health information.

GOOD CAUSE CERTIFICATION LETTER

MH 1770 (5/85)

Submit to: Department of Mental Health
Accounting Section
1600 9th Street, First Floor
Sacramento, CA 95814

COUNTY USE ONLY

_____ requests a waiver of the two-month SD/MC billing
(County Name) limitations for the late claim entries on the attached MH 1980 forms:

(Write in the 7-digit number preceded by a letter on each MH 1980 page; e.g., M 0000012)

The boxes checked below (with corresponding alphabetical letter written in on the right-hand margin of MH 1980) are the applicable good cause reason(s) as specified in Title 22, Section 51008, for each late claim:

- A. Patient or legal representatives failure to present Medi-Cal identification.
- B. Billing involving other coverage, including but not limited to Medi-Care, Kaiser, Roos-Loos, or Champus.
- C. Circumstances beyond the control of the county/provider regarding delay or error in the certification of Medi-Cal eligibility of beneficiary by the state or county.
- E. Special circumstances that cause a billing delay such as a court decision or fair hearing decision.
- F. Initiation of legal proceedings to obtain payment of a liable third party pursuant to Section 14115 of the W & I Code.

I hereby certify that the late claim entries shown on the attached MH 1980's are submitted beyond the two-month billing limitation for the good cause reasons cited. Substantiating documentation for good cause is available at the provider's premises and will be presented upon request to the Department of Mental Health, except for good cause reason "D" below.

Signature—County Representative

Date

STATE USE ONLY

- D. Circumstances beyond the control of the county/provider regarding delays caused by natural disaster and willful acts by an employee, delays in provider certification, or other circumstances that have been reported to the appropriate law enforcement or fire agency when applicable.

I have checked Box D above and hereby approve the attached county/provider's substantiating documentation for good cause reason D.

Signature—Service Area Chief or Designee

Date

COMPLETION INSTRUCTIONS FOR GOOD CAUSE CERTIFICATION 6065**GENERAL**

The ADP Good Cause Certification form is used by a Drug/Medi-Cal Provider to request a waiver of the 30-day Drug Medi-Cal billing limitation.

* Do not complete or send this form to ADP unless the specified claims require pre-approval for Delay Reason Codes 4, 11 and 8.

* Retain a copy of the form at the provider site for auditing or monitoring purposes. Note: For county-contracted providers, send the original form to the county.

* Supporting documentation is required prior to submitting this form for Delay Reason Codes 4, 11 and 8. See the ADP DMC Provider Billing Manual for details.

DELAY REASON CODES (see CCR Title 22, Section 51008.5)

Reason Code 1 (time limit: one year plus 60 days): Patient or legal representative's failure to present Medi-Cal beneficiary identification.

Reason Code 2 (time limit: one year): Initiation of legal proceedings to obtain payment of a liable third party pursuant to Section 14115 of the Welfare and Institution Code.

***Reason Code 4 (time limit: one year):** Determination by the Director of the DHCS, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control, where the circumstance is either delay in the certification or recertification of the provider to participate in the DMC program by the State or delay by DHCS in enrolling a provider.

Reason Code 7 (time limit: one year or 60 days): Billing involving other coverage, including/not limited to Medi-Care, Kaiser, Ross-Loos, or Champus.

***Reason Code 8 (time limit: one year):** Determination by the DHCS Director, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the control of the county/provider regarding delay or error in the certification of Medi-Cal eligibility of the beneficiary by the state or county. This includes retroactive Medi-Cal eligibility.

Reason Code 10 (time limit: 60 days from resolution of circumstances causing delay): Special circumstances that cause a billing delay such as a court decision or fair hearing decision.

***Reason Code 11 (time limit: one year):** Determination by the Director of DHCS, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control, specifically due to:

- Damage to or destruction of the provider's business office or records by a natural disaster; includes fire, flood or earthquake, or
- Circumstances resulting from such a disaster have substantially interfered with processing bills in a timely manner;
- Theft, sabotage or other deliberate, willful acts by an employee;
- Other circumstances which may be clearly beyond the provider and/or county's control and have been reported to the appropriate law enforcement or fire agency when applicable.

***NOTE:** For Reason Codes 4, 11, and 8, providers should provide supporting documentation prior to submission of this form.

HEADING INSTRUCTIONS

- a. SERVICE FACILITY LOCATION NPI: enter the NPI for this service facility location.
- b. COUNTY/DIRECT PROVIDER: if submitter is a county, enter the county name; if submitter is a direct provider, enter the direct provider name.
- c. ITWS FILE NAME: enter the name of the ITWS 837P file.

COLUMN INSTRUCTIONS

- a. SUBMITTER'S CLAIM ID NUMBER: for each claim listed, enter the unique claim ID number.
- b. CLAIM FOR MO/YEAR: for each claim listed, enter the month and year of the claim.
- c. DELAY REASON CODE: for each claim listed, enter the appropriate delay reason code.
- d. STATE USE ONLY: submitters should not enter any information in this area. It is for State use only.

SIGNATURE BLOCK INSTRUCTIONS

- a. SIGNATURE: only authorized county or direct provider representatives should sign.
- b. PHONE NUMBER: enter the area and code and phone number of the representative signing the form.
- c. DATE: enter the date the form was signed by the authorized representative.
- d. STATE USE ONLY: submitters should not enter any information in this area. It is for State use only.