**BHS Policies and Procedures**

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

1380 Howard Street, 5th Floor
San Francisco, CA 94103
415.255-3400
FAX 415.255-3567

POLICY/PROCEDURE REGARDING: **Handling of Patient Payments Received in BHS Programs**

Issued By: Jo Robinson, MFT
Director of Community Behavioral Health Services

Date: August 19, 2015

Manual Number: 2.03-18
References: CCSF, Office of The Controller

**(Technical revision. Replaces Policy 2.03-18 of 08/01/2011)**

**Purpose:** The purpose of these instructions is to provide guidelines to Short-Doyle funded BHS Mental Health (MH) and Substance Use Disorders (SUD) Clinics for handling of payments received at their sites. Most payments received at Clinic sites are for Patient fees, but may include misdirected Medicare or Insurance payments. Patient fees include: UMDAP or Sliding Fees payable, monthly Medi-Cal Share-of-Cost, Medicare or Insurance Co-payments and Deductibles, or the Cost of services the Client received on Private Pay accounts.

**Policy:** Section 23 of each Contract Provider's contract with the City and County of San Francisco authorizes the CITY to bill for and receive Medicare, health insurance and other third party payments for BHS Program services covered under this agreement. BHS Billing submits MH and SUD service claims to all third party payers. Any misdirected Medicare or Insurance payments received at Clinic sites should be sent to the BHS Billing Office so they can be posted against their accounts receivable record. Monthly Billing Statements are generated by the BHS Billing Office and sent to MH Patients' Responsible Parties. Patient fees collected by MH Clinics must also be sent to the BHS Billing Office.

BHS Clients who receive specialty MH services from SF General Hospital, Department of Psychiatry programs may pay their Patient Fees through the SFGH Site Cashier. SFGH Clinic payment handling procedures are in a separate section of this policy under, BHS SFGH UCSF Programs.

**Substance Abuse Treatment Programs:** SA Clinics are responsible for managing their Clients' accounts for collecting Patient fees payable, for accounting of payments received, and for reporting total Patient revenues collected each Fiscal Year to BHS and to the SFDPH Fiscal – Cost Reports Unit. Patient fee amounts that are collected from Medi-Cal and from Non-MediCal Clients are separately recorded on the AOD Cost Report at the end of each fiscal year.

**Mental Health Treatment Programs:** The California Department of Health Care Services (DHCS) states that Patient Fee payments should be arranged for and collected on a "per visit" basis whenever

possible[1] or, on a monthly basis. Further, UMDAP Liability amounts must be paid within Client's annual UMDAP period. To facilitate these collections, the State urges each county to establish a means to accept payments at each service site. The San Francisco City Charter and Office of the Controller's Departmental Guideline require payments received for City services to be deposited within 24 hours of receipt.

**Site Cashier**: Each Clinic Coordinator or Program Director shall designate two employees as Site Cashiers. The names, contact information and signature Samples of the Clinic's Site Cashiers are submitted to the BHS Billing Office, Attn: Patient Accounts Manager, 1380 Howard Street, San Francisco, CA, 94103, in a letter signed by the Program Director.

No clinic employee except the officially designated Site Cashiers shall receive payments from Clients.

The BHS Patient Accounts Manager or designee will supply each MH Clinic with two locked cash and receipts transport bags (high volume collectors can request for more than two bags on site), a book of numbered receipts, a SFDPH bank account Endorsement Stamp, and Clinic Payment Transmittal Report forms (BL-01, March 2010 version). Additional Payment Transmittal forms can be obtained from BHS Forms Control by phoning 415-255-3913.

BHS Billing records and monitors all Receipt Books and Receipt Numbers issued to Clinics. Additional Receipt Books can be requested in writing by sending an e-mail to: christine.chan@sfdph.org and cc'd to: nanalisa.rasaily@sfdph.org Missing funds, missing individual Receipts or lost Receipt Books must be reported immediately via the BHS Incident Report. In these situations, the Program Director is responsible for providing an Incident Report to the BHS Risk Manager, Behavioral Health Services, Office of Quality Management, 1380 Howard Street, 4th Floor SF CA 94103. A copy of the Incident Report is also sent to the BHS Patient Accounts Billing Manager for corrective action or follow-up needed.

BHS Patient Accounts Billing Unit is responsible for ensuring receipt books and receipts are issued sequentially, and that all unused and voided receipts are accounted for. An inventory control system is used to track all numbered receipt books issued to MH Clinics. BHS MH Clinic Directors and Site Cashiers are responsible for adhering to the CCSF requirement to issue payment receipts sequentially and to send back all voided receipts to BHS Billing. Any unused and voided receipts from the Clinic must be sent along with the day's payment transactions to the central BHS Billing office. Effective immediately, the BHS Billing Sr. Accounts Clerk will follow-up with the Clinic's Site Cashier if receipt copies received from the Clinic are not sequential.

**Skipped Receipt**: If a receipt is accidently skipped please do not void the receipt; instead, use it for the next payment.

**The Locked Bag**: Locked bags will be used by Clinics to transport payments, issued receipt copies, and transmittal report summaries to the BHS Billing Office. Each clinics will be provided two bags each in

[1] DMH Letter 85-21, DMH Revenue Policies & Procedures Manual, SDMC Billing Manual,

order to meet the Controller's requirement to send all payments received within one business day. Each clinic is directed to include payments received when the BHS Interoffice Courier arrives or when the Locked Bag is brought to the BHS Administrative Offices at 1380 Howard St. The Billing Office will return an empty, unlocked bag to the clinic on the next business day. These bags can only be unlocked in the BHS Billing Office.

**Payment Sign:** Clinics are required to display a sign at their Front Desk Reception area and in locations where Client payments are received, informing Clients and/or their Account Responsible Parties that a Controller's Numbered Receipt must be issued whenever a payment is made. The receipt is retained by the Client as proof of their payment.

**Endorsement Stamp: A SFDPH - BHS Bank** Endorsement stamp will be provided to each MH clinic. Patient fee payment Checks are made payable to the "**DEPARTMENT OF PUBLIC HEALTH - BHS**". The Site Cashier is responsible for stamping all Checks received as soon as possible and immediately endorsing it for bank deposit only. The central BHS Billing Unit is also required to immediately endorse checks it receives.

**Log Files:** Site Cashiers maintain a log file at their Clinic to record when their Locked Money Bag is transmitted and when it is received back. The Log is used for locating the Clinic's Money Bag at all times and for recording who had it last, in case the Bag is lost or missing. The Log should be initialed by the Interoffice Courier with the date when it is picked up; or, it is initialed and date entered by the Person bringing the locked Bag to the central Billing Office at 1380 Howard. The Site Cashier initials the Log when the Money Bag is received back in the Clinic. **DO NOT DATE OR SIGN FOR THE INTEROFFICE COURIER** prior to the bag being picked up. Note: a copy of the Clinic's latest Money Bag Log page is faxed to BHS Billing at the end of the work week, usually on Friday, to (415)255-3564, Attention to: BHS Patient Accounts Billing Clerk. If no payments are received for the week, the Site Cashier enters "No Payments Received" with the date of their entry. BHS Billing reconciles the Clinic Log to ensure all Money Bags are transmitted and received timely. These are subject to annual audits by the City Controller's Office; delays in receiving Clinics' Money Bags are documented and followed-up by BHS Billing.

**The Receipt Book**: Every payment received in the Clinic must be recorded and a numbered Receipt issued. Each receipt within every Receipt Book is numbered and should be used consecutively. **DO NOT SKIP NUMBERS FOR ANY REASON.** All receipts, including spoiled and voided, must be accounted for. Any changes or corrections made to the receipt itself **must be initialed and dated by the designated Site Cashier**.

The white, original copies of receipts issued by the Site Cashier must be sent in the Clinic's Money bag with payments (cash, checks, money orders) received, along with the white copy of the Clinic Payment Transmittal Report form. The locked bag is then sent to the BHS Billing Office, 1380 Howard Street 3rd floor, Attention: Patient Accounts Clerk. Always place the locked bag inside a regular Interoffice Mail envelope. Seal or secure the envelope before it is sent.

The canary, second copy of the receipt is retained by the Clinic inside the Receipt Book as a permanent record. The pink, third copy of the receipt is given to the person who makes the payment. All Department of Public Health Clinics are required by the City Controller's Office to issue receipts when payments are made. If a receipt is Spoiled or Voided, the **White** and **Pink receipt** copies must be sent to the BHS Billing Office with a notation as to why it was voided.

**Clinic Payment Transmittal Report (BL-01)**: Each MH Clinic and SFGH Department of Psychiatry are required to summarize all payments transmitted to the BHS Billing Office on the two-part, "Clinic Payment Transmittal Report" form BL-01 (see Attachment 2). The Transmittal includes information about the payment received, whether it was for a Medi-Cal or for a Non-Medi-Cal Client, the fiscal year AR (accounts receivable record) to credit, and the name and phone number of the Site Cashier who completed the form. The white, original copy is to be sent in the Locked Bag with the cash and/or check payments, and receipt copies. The yellow, second copy is to be kept in the Clinic and maintained as a permanent record, in case of an audit. Cash and Checks collected at the clinic site must be sent to the BHS Billing Office within 24 hours of receipt and no later than the next business day from the date payment was received from the Client or from their Account Responsible Party, per City Ordinance and CCSF Controller's policy. Please ensure all documents that are submitted to the BHS Billing Office are reviewed and signed by the Site Cashier and Clinic Program Director.

All BHS MH Clinics are required to send payment received within one (1) business day of receipt. Beginning July 1, 2015, the Patient Accounts Billing Manager is responsible to track, follow-up with Clinics that send their payment receipts late, document. Clinics that are late for more than three times during the Fiscal Year period, will be reported to their BHS Program Manager or Contract Manager to obtain a written Plan of Correction.

**BHS/SFGH/UCSF Programs:** BHS Clients who receive specialty MH and/or SA services in Clinics that are under the SFGH UCSF Department of Psychiatry pay their patient fees through the SFGH Site Cashier, located on the 1st floor of the Main Hospital building. The MH or SUD Inpatient hospital or outpatient Clinic staff complete the 3-part BHS SFGH Payment Slip and gives it to Clients who wish to make a payment. The BHS SFGH Payment Slip allows the SFGH Cashier to identify Patient Payments being made are for BHS Clients who received specialty MH or SUD services from the SFGH Department of Psychiatry. A payment slip is required every time a payment is made with the SFGH Site Cashier. Once the Patient payment is processed, the SFGH Site Cashier issues a Controller's Numbered Receipt to the Client and signs off on the copy of the payment slip for the Client to return to the Clinic. The first and second copies of the Payment Slip are used by the SFGH Cashier to transmit Clients' payment information to the SFGH Accounting Office and to the BHS Billing Office. SFGH Accounting Office staff enters the Accounts Receivable record in the FAMIS accounting system, and sends the first (white) copies of Clients' Payment Slips, a completed BHS Payment Transmittal form, and the white copy of the Controller's Numbered Receipt (FORM CMHS OR -1 REV 7/10 8702-7), to the BHS Billing Office.

**BHS Billing Office**: The Patient Accounts Billing unit is responsible for managing MH Patient Accounts, for processing all Medicare, Insurance, and Patient UMDAP payments, preparing daily bank deposits, entering revenue information into the Controller's financial accounting system, FAMIS; posting Client payments and adjustments in the BHS Avatar electronic health records system, generating reports,

and performing reconciliations. MH Patient Accounts Billing statements are generated monthly and mailed to Account Responsible Parties, as indicated on the Clients' Payer and Financial Information (PFI) records. Statements include accounts' Balance Forward amounts, UMDAP balances, Patient Accounts activities including current month's Service charges, payments received, adjustments posted and amounts due within the billing cycle.

**Contact Persons:** for Site Cashiers, Patient Payments, Controller's Numbered Receipt Books and other supplies, call the Sr. Patient Accounts Clerk at (415)255-3547. For Avatar Patient Accounts and monthly billing statements, call the Patient Accounts Assistant Supervisor at (415)255-3534; for other Patient Accounts Billing matters, contact the BHS Patient Accounts Manager at (415)255-3610.

**Distribution:**
BHS Policies and Procedures are distributed by the Health Information Management Department under the DPH Compliance Office

Administrative Manual Holders
BHS Programs
SOC Managers
BOCC Program Managers
CDTA Program Managers

ATTACHMENT

# CLINIC PAYMENT TRANSMITTAL REPORT

Transmittal #: _____ _____
Month Sequence

_____ _____
Clinic Name Reporting Unit Number

When submitting, please attach the green copies of receipts issued and adding machine tape to the form

| | Receipt Number (A NNNNN) | Date of receipt (Mo/Da/Yr) | Name of Responsibility Party (Please Print) | Account Number | Amount of Payment | Type of Payment (pls. check appropriate box and enter FY) |
|---|---|---|---|---|---|---|
| 1 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 2 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 3 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 4 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 5 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 6 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 7 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 8 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 9 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 10 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 11 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 12 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 13 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 14 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 15 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 16 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 17 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 18 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 19 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |
| 20 | _____ | __/__/__ | _____ | _____ | $ __,___.__ | SFHP Copay ☐ SOC ☐ UMDAP ☐ Full Pay ☐ FY: _____ |

TOTAL: $ __,___.__

_____ _____ _____ _____
Site Cashier - Signature Date Clinic Coordinator - Signature Date

_____
Site Cashier Phone #

BL-01 (March 2010)

CLINIC MONEY BAG LOG FILE

| | | Clinic Name: | | | | | |
|---|---|---|---|---|---|---|---|
| | Date Sent | Cashier: First & Last Name | Provider /Program Name | RU # | Bag # | Pick-Up Date | Pick-Up Staff: First & Last Name |
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
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| 5 | | | | | | | |
| 6 | | | | | | | |
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| 12 | | | | | | | |
| 13 | | | | | | | |
| 14 | | | | | | | |

## Adult and Older Adult QOC Form

City and County of San Francisco Department of Public Health
**COMMUNITY BEHAVIORAL HEALTH SERVICES**
Adult and Older Adult Services

☐ Update, Close & File
☐ File in Waiting for C.R.

# Incident and Quality of Care Report

Print Client's Full Name _____ BIS# | | | | | | | | | |

Names of others involved in incident _____

Date of incident _____ Location of incident _____

Name of Agency/Program where client has a care manager: _____
(if applicable) (PRINT, no Initials)

Name and Title of person reporting incident _____

Name of reporting agency _____ Date of reporting _____
(PRINT, no Initials)

☐ **Incident resulted in a referral for medical attention.**
☐ **Incident resulted in a 5150.**
} **If either of these, describe on back.**

**Then, please check one category that best describes the incident and describe on back.**

**Violent Behavior**
- ❑ Verbally or physically threatening behavior on part of a client (includes **Tarasoff**)
- ❑ Assault or physical altercation between clients
- ❑ Assault by a client on a staff member
- ❑ Damage to property as a result of client behavior
- ❑ Alleged homicide
- ❑ Other violent behavior

❑ **Client Injury, Accident, or Acute Medical Problem**

❑ **Alleged unprofessional/unethical conduct on the part of a provider** (i.e., inappropriate verbal, physical, sexual, social, business contact)

❑ **Client's Suicide Attempt**

**Client Death**
- ❑ Unexpected - resulting from medical problems
- ❑ Expected - resulting from medical problems (client had a known life-threatening illness)
- ❑ Result of complications of substance abuse
- ❑ Accidental death/fatal injury
- ❑ Suicide
- ❑ Alleged homicide
- ❑ Unknown cause

*CBHS 102-AOA (3-03-06)*

**Privileged and Confidential (cf. EC § 1175.6 WIC § § 4070, 4071, 5328)**
**A copy of this report should not be included in the client's clinical/medical record**

Client Name_____ BIS# | | | | | | | | | |



**Medication Issue**

- ❑ Client was allegedly administered wrong medicine
- ❑ Client was allegedly administered wrong dose
- ❑ There was an alleged issue with the timeliness of obtaining or the administration of a client's medication
- ❑ Other

**Alleged Abuse, client was the ❑ perpetrator ❑ victim ❑ neither**

- ❑ Child abuse
- ❑ Elder abuse
- ❑ Dependent abuse

- ❑ **AWOL**
- ❑ **Alleged Inappropriate Treatment, Delay in Treatment, Documentation, and/or Discharge**
- ❑ **Other Incident**

---

**Description of incident, including all who have been called/contacted** (attach if more room is needed)**:**

_____

_____

_____

_____

_____

**Program's Own Follow-Up and/or Corrective Actions:**

_____

_____

_____

_____

☐ **We are requesting a CBHS Critical Incident Review (CIR) of this incident.**

Signature of staff member completing this form:_____ Phone:_____

Program Director Signature: _____ Date:_____

**Please report incident by fax: 415-252-3033 (which is secured and protected), OR by mail to CBHS, Quality Management Office, 1380 Howard St. 2nd Floor, San Francisco 94103.**

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(To be completed ONLY by CBHS Administration) Attach CBHS Review/Action

Program Manager Signature_____ Date:_____

Quality Management Review and Action_____

_____ ☐ Reviewed and Filed

QM signature_____ Date:_____

*CBHS 102-AOA (3-03-06)*

**Privileged and Confidential (cf. EC § 1175.6 WIC § § 4070, 4071, 5328)**
**A copy of this report should <u>not</u> be included in the client's clinical/medical record**