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HIPAA 5010
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each. The HIPAA Rules serves to:

- Create better access to health insurance information
- Limit fraud and abuse
- Reduce administrative costs

The California Department of Health Care Services (DHCS), the Department of Mental Health (DMH), and the Department of Alcohol and Drug Program (DADP) recently updated its **Short-Doyle MediCal Claiming System** to accept and process mandated HIPAA electronic transactions in the new 5010 version. Most of the HIPAA 5010 changes for electronic transactions will be handled in the Avatar system. The CBHS Billing Unit is working with the State to ensure MH and SA Providers' electronic Claims and Remittance Advice transactions are processed correctly and meet SDMC Claiming System requirements. The following are important changes Providers need to be aware of for HIPAA 5010.

Pregnancy Indicator
A "Pregnancy Indicator" is required on Medi-Cal claims for all SA Perinatal services and when billing covered mental health and substance abuse treatment services to pregnant Medi-Cal Clients with Restricted Aid Codes.

Medi-Cal beneficiaries are assigned an Aid Code to designate their benefit program. Some beneficiaries have Full Scope benefits, while others are restricted to pregnancy or emergency services only. The Pregnancy Indicator allows Providers to notify Medi-Cal that services rendered are related to the Clients' pregnancy so they can be approved for payment.

Please see the separate CBHS Billing document titled, "5010 Pregnancy Screens" containing further information and instructions for entering the Pregnancy Indicator for Clients in Avatar.

Client Address
1) Address information submitted on electronic transaction files must include the Zip Code plus four-digit extension. Please see instructions for updating Clients' Address information in Avatar, on the DPH - CBHS website
2) for Homeless Clients, enter "HOMELESS" in Address Line 1 and your Clinic's City, State, and Zip Code + 4-digit extension.   Additionally, please select the appropriate homeless category under "Client's Living Arrangements" on page 2 of the Admission's tab.

CBHS Billing will enter zip code updates to existing Clients' address information.   Providers enter new Clients' Addresses with the Zip Code 4-digit extension.   If the Zip Code extension is unknown, a default value of '0000' should be used.

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Case Management while the MH Client is in an Inpatient Hospital
SDMC requires a Discharge Date whenever Case Management services are billed for Clients who were in a psychiatric Inpatient hospital setting (location code 21) or in a Psychiatric Health Facility (PHF - location code 51). The Discharge Date must be within 30 days of the Case Mgmt service(s), as required under Title 9 regulations. CBHS Billing will be tracking these CM services based on Service Codes entered by Clinicians.

Three MH service codes for Case Mgmt were created to facilitate accurate billing and reporting by CBHS Providers for Clients who are hospitalized. **T1017P** – Case Mgmt for the purpose of placement within 30 days of discharge rendered to a Client in a SDMC Inpatient hospital (i.e., in SFGH Psych IP Ward or another County's SDMC Hospital); **T1017N** - Case Mgmt not billable, when SDMC requirements are not met; and, **IPT1017** - Case Mgmt in a FFS Hospital or in another County's Psychiatric Health Facility.

If the Case Mgmt service is within 30 days of the Client's Discharge date, they will be claimed to SDMC. If not within 30 days of Discharge, these services will be General Fund.

Billing Updates:

All Providers are reminded to verify Clients' Medi-Cal, Medicare, and Insurance eligibility before entering guarantor information in Avatar Financial Eligibility records . A large number of SDMC claims are denied because Insurance and Medicare were not billed for services as the primary payer. It is also a violation of compliance rules if Providers routinely submit Medi-Cal claims for Client who do not actually have Medi-Cal benefits.

Providers enter Financial Eligibility information in Avatar, and claims are generated based on the information entered. If you copy or "default" another Financial Eligibility record for your Client, always review the guarantor information is accurate for your program's episode.

PFI – Payer and Financial Information

A PFI is required to be completed for all behavioral health service Clients. In Avatar, PFI information is entered in the Financial Eligibility (FE) screen and in Family Registration (FR) screens. Funding sources (the payers) for each Client's services are entered in Financial Eligibility records. Payers are called "guarantors" in the Avatar system.

For MH Clients who have a Patient Fee liability, their financial assessment information for UMDAP is entered in the Avatar Family Registration screens. Once the FE and FR screens are completed, a PFI Consent Form is printed and signed by MH Clients or their Responsible Party, giving authorization to release information and for assignment of benefits. *Substance Abuse programs enter Financial Eligibility information for their Clients, but they do not enter UMDAP*

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information in the Avatar Family Registration screens because they have (should have) a separate system for managing, collecting and reporting their SA Program's Patient amounts and actual fees collected. Also, 42CFR requires a specific authorization for release of SA information, including for billing purposes. Drug Medi-Cal programs do not use the Avatar PFI Consent form for Clients who have Insurance Other Healthcare Coverages.

Mental Health PFI UMDAP Due Report

A new Avatar report, "PFI Due Report" for MH programs is now in production. There are three versions available to Avatar Users: by Program, by Client, and by Family.   A description of the report and detailed instructions for how to generate the report is now posted on the CBHS Avatar website (address below), under the Billing Documentation section.

   http://www.sfdph.org/dph/comupg/oservices/mentalHlth/BHIS/avatarUserDocs.asp

CBHS is scheduled to begin sending MH Client Billing Statements in June, 2012. Clients with a Patient Liability will begin receiving billing statements showing services received and amounts due. Patient liability amounts include: their UMDAP sliding fee, or Medicare deductible /copays, or their obligated Medi-Cal Share-of-Cost amounts, or the cost of services received (Full-Pay, no UMDAP).   A new report for Providers to review their Clients' Account Receivables is being piloted and will be released soon.

Medicare – for MH and SA programs

The State issued ADP Bulletins (for SA Programs) and DMH Information Notices (for MH programs) to clarify SDMC policy for Medicare and Medi-Medi billing requirements.   Please read them because they contain important information.

Substance Abuse programs and Mental Health treatment programs that are not Medicare certified, do not enter Medicare as a primary guarantor for their Clients. Only Outpatient Mental Health service Clinics that are Medicare certified, enter the Medicare Part B guarantor (#37) in Avatar for their Medicare Clients.

Important Reminder:
The Center for Medicare and Medicaid Services (CMS, formerly HCFA) requires Medicare beneficiaries to be notified in advance, if services will not be covered or not paid by the Medicare program.   The Medicare Advanced Beneficiary Notice or ABN form must be completed to document the Client notification and about their decision to receive services from your program.   If you have Medicare Clients, including Medi-Medi (dually eligible with Medicare and Medi-Cal benefits), please complete the ABN because most CBHS services are not covered by Medicare. Maintain a copy of Medicare Clients' ABN on file in case of an audit. ABN forms are available from CBHS Forms Control. An electronic copy and detailed instructions for completing the ABN are on the CMS website, www.CMS.gov.

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MH Vocational and Socialization Services

Mental Health Vocational and Socialization services are entered in AVATAR in <u>hourly</u> increments.   A Unit of Service is defined as 60 minutes.   These services are not Medi-Cal claimable. However, DMH defines them as Mode 10 MH treatment services.   All Clients who receive mental health treatment services, regardless of payer sources, are subject to the State's CSI (Client and Services Information) reporting requirements.

Preventing Unbilled MH and SA services

Please make sure your Clients' Guarantor effective dates in Financial Eligibility records are correct and accurate.   Services with dates <u>before</u> the guarantor effective date are NOT billed.

The same goes for Clients' Diagnosis dates!   Services with dates before the diagnosis effective date are rejected from Medi-Cal claims. Please ensure your Clients' **Admission Diagnosis** effective date covers their initial services.

Services entered under Agency level "Master Episodes" or "Conversion Program" episodes are not posted to the Program.   Please remind Clinicians to select the correct Reporting Unit episode when entering their progress notes or services.

ABOUT Guarantors….

The Avatar Guarantor Names for the two Patient Fee guarantors: Self Pay UMDAP (#36) and Full Pay No UMDAP (#39) was changed to **UMDAP (#36)** and **Full Pay (#39)**.   The guarantor numbers have not changed.   CBHS Mental Health service Providers add one of these Patient Fee guarantors to the Avatar Financial Eligibility record when Clients will be charged a Sliding Fee amount for services received (use Guarantor #36 – UMDAP).   Guarantor #39 – Full Pay is used when a Client chooses to pay either, the full cost of services received at CCSF Board of Supervisors' Rates or, their actual Monthly Medi-Cal Share-of-Cost amount.

The AB3632 guarantor #84 is now called, <u>AB3632 ERMHS</u>.

MH Providers use the Minor Consent guarantor (#109) for Sensitive Service or Minor Consent Clients. SDMC does not accept MH service claims for these Clients; however, Drug Medi-Cal claims are allowed for Medi-Cal beneficiaries with Aid Code 7N.   Send an e-mail to the <u>Avatar Help Desk</u>, or call the Billing Inquiry Line at 255-3557, if you have questions or need additional information.

An updated Guarantor Cheat Sheet is included with this bulletin and posted on the CBHS Avatar website, under the Billing User Documentation section.

<u>PLEASE DO NOTs:</u>
Do Not collect payments from a client
- If he/she is a **Full Scope Medi-Cal** beneficiary.
- If Client is enrolled in Healthy Families Program and receiving SED services.
- If he/she has a Medi-Cal Aid Code of **'6G'.** These Clients have a monthly Medi-Cal premium amount that is deducted by DHCS from their monthly SSI entitlement

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Do Not add Patient Billing Accounts in Avatar/PM/Family Registration for Medi-Cal clients with Full Scope benefits and no monthly Share-of-Cost and no other healthcare coverage (Medicare or Insurance).
   o However, the PFI Form (Avatar/ PM/ Forms/ PFI form) must be printed and signed by all clients or their Responsible Party authorizing Release of Information for billing purposes and for Assignment of benefits to SFDPH.
   o Enter an Account in Avatar/PM/Family Registration for Clients who will have/have an UMDAP liability.   Please see if there is an Account already set-up before creating a new Account.   Enter the Client's **LastName and FirstName** (LASTNAME,FIRSTNAME) in their Family Account record so it can be found when a Search is performed.   Please use **uppercase letters** when entering client information like name, address etc.

Do not add UMDAP (#36) guarantor for
   o **Full Scope Medi-Cal**
   o **Healthy Kids (HK)**
   o **Healthy Families (HF)** and
   o **Healthy Worker (HW)** clients

Do not enter any Selfpay guarantors (#36 & #39) for **Substance Abuse Treatment Clients.**

Do not **DELETE** or **CHANGE** Client's Guarantor sequence
   o email Nanalisa at nanalisa.rasaily@sfdph.org or call 255.3610 for further information

Do not forget to enter **County General Fund (#35)** as the last guarantor in Clients' Avatar Financial Eligibility records.

Do not enter Medicare as the primary guarantor if your Clinic or Program Site is not certified for Medicare.   You may add Medicare as a guarantor AFTER the County General Fund guarantor (#35) if your Client has Medicare benefits, for information and care coordination only.   Ideally, Medicare and dually eligible Medicare-MediCal Clients who need Outpatient MH services receive them from a Medicare Provider so we may bill Medicare and SDMC for their services. Please contact the CBHS Behavioral Health Access Center for assistance in referring Medicare Clients to a Medicare Provider.

Note: Refer Medicare beneficiaries who are enrolled in a Medicare HMO plan (aka Medicare Senior Advantage Plan) to their Insurance carrier for services.   Specialty MH services must be prior authorized by their HMO before they can be provided.   SDMC will not pay for M/C Clients' services if the primary payer's (Medicare or Insurance) denial reason is not one of the following: 1) Services are not covered or, 2) Benefits are exhausted.

Healthy Families Program SED Workflow:

When a Healthy Families Program Client is assessed for SED, please:
   – Enter the HFP SED SDMC guarantor (#34). This is the payer for HFP SED Assessment service(s) the Client receives.
   – Complete an SED Certification Form and send it to Nina daSilva, CBHS - Children's Program, 1380 Howard, SF.

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- A completed SED Certification form is required, even if the HFP Client does not meet SED criteria.
- Refer to CBHS Policy/procedure 3.03-15 for additional information about the Healthy Families Program.