

## AVATAR Billing Providers Bulletin Medicare-MediCal Issue

### What is Medicare?

Medicare is a health insurance program for:

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease

**Part A Hospital Insurance** - Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care).

- In CBHS, only SFGH Dept of Psychiatry enters the Medicare Part A guarantor in Avatar. MH and SA Clinic Providers do NOT enter or use this guarantor.

**Part B Medical Insurance** - Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care when they are medically necessary.

- In CBHS, only Outpatient MH Providers who are Medicare certified sites can enter Medicare Part B as a guarantor for their Medicare Clients in Avatar.
- None of the SA Programs bill Medicare; therefore, Medicare guarantors are **not** entered in Avatar.

**Part D Prescription Drug Coverage** – Beneficiaries choose their drug plan and pay a monthly premium to private Insurance companies who provide their prescription drug coverage.

- Clients' Part D Insurance plans are **never** entered as guarantors in Avatar PM/ Financial Eligibility records.

**Part C Senior Advantage Programs** – Beneficiaries may choose a Medicare Advantage Plan as a way to get their Part A, Part B and Part D benefits and services covered under a single private insurance company, usually an HMO.

- In CBHS, **Medicare Advantage Plan enrollees are referred to their HMO Insurance for services.** Per Title 9 CCR, CBHS may provide services if there is proof or documentation, their HMO insurance plan does not cover the services they need or, their plan benefits are exhausted. Otherwise, a written authorization and a Single Case Agreement from the Medicare HMO is required before services can be provided. In addition, the Age Director approves HMO-insured Client admissions to CBHS Clinics.
- The CA Dept of Health Care Services (DHCS), Dept of Mental Health (DMH) and Alcohol & Drug Programs (ADP) considers Medicare Advantage coverage as Insurance OHC (Other Health Coverage) plans. SDMC requires OHC to be billed first because Medi-Cal is the payer of last resort. The OHC (HMO Insurance) will deny services if they are not prior-authorized or if "Provider is not part of their network". SDMC does not accept these insurance denial reasons and will deny CBHS service claims.

## AVATAR Billing Providers Bulletin Medicare-MediCal Issue

**Medi-Gap plans** are a form of private supplemental insurance that pay for part or all of Medicare's coinsurance and deductibles. Medi-gap plans do not cover healthcare services that are not covered by Medicare.

**Secondary Medicare Payers (MSP)** is the term used by Medicare when Medicare is not responsible for paying first. MSP are private health insurance plans that cover healthcare services. These MSP coverages are usually from the Client, or from their Spouse's current employer or from their previous employment.

- In these cases, the MSP Insurance plan is the Primary payer, Medicare is the secondary payer.
- It is very rare for MSP Medicare Clients to also have Medi-Cal benefits. Contact the CBHS Billing Office if you come across someone with MSP, Medicare, and Medi-Cal.

**Medi-Medi** - MediCal, the Medicaid program in California, provides health coverage to people with low-income and asset levels who meet certain eligibility requirements. Medi-Cal beneficiaries who also qualify for Medicare are individuals who are over a certain age and/or are disabled. People who qualify for both Medicare and Medi-Cal are known as "dual eligibles" or "Medi-Medi." Medicare is the primary payer for Medi-Medi Clients' services.

- In CBHS, Medicare and Medi-Medi Clients are referred to Medicare Providers, if at all possible. In this way, we are able to bill their services to Medicare and to SDMC. If Medicare covered services are provided by a Clinic that is not a Medicare site and/or by a Licensed Clinician who is not a Medicare provider, these services cannot be billed to Medicare and cannot be billed to Medi-Cal.
- Contact BHAC, the Behavioral Health Access Center for assistance with Medicare referrals.

### **Medicare Deductible and Co-Insurance / Medi-Cal Monthly Share-of-Cost**

Medicare beneficiaries pay a monthly insurance premium amount based on their income level when they enroll in the Medicare program. Beneficiaries have a \$140 annual deductible under the Part B plan. The deductible is the amount they must pay before Medicare pays its portion of their medical bills. In addition, beneficiaries also have a 20% Co-insurance amount payable for services, based on the Medicare fee schedule. If available, beneficiaries' Supplemental or their Medi-gap plan will pay the Medicare deductible and co-insurance amounts.

Some Medi-Cal beneficiaries are dually eligible with benefits under the federal Medicare program (Medi-Medi). For covered services the Client receives, Medicare requires a deductible and/or coinsurance that, in some instances, is paid by Medi-Cal. Dually eligible full-scope Medi-Cal Clients with no monthly Share-of-Cost, and receive only Medicare covered services from Medicare certified Sites and Clinicians, and/or services that are directly billable to SDMC, do not have a patient fee liability.

## AVATAR Billing Providers Bulletin Medicare-MediCal Issue

Some Medi-Cal beneficiaries are required to pay or incur a certain amount of medical expenses each month before Medi-Cal pays for their health services. This amount is called a “Medi-Cal Share of Cost.” This is similar to a deductible amount they need to pay before Medi-Cal benefits become effective. Medi-Cal benefits are not available until their SOC amount is actually “cleared” by using services received by the Client. In CBHS, monthly Client SOC clearances or “spend-down” processing is done by the central Billing Office.

Some dually eligible Medi-Medi Clients have a monthly Medi-Cal Share-of-Cost (SOC) amount. The CBHS Billing office will bill these Clients or their Responsible Party, their Medicare deductible and co-insurance amount for covered services received during the month. If the Client received non-Medicare covered services, the Client will be billed the cost of services received, up to their monthly Share-of-Cost amount. If the Client has an UMDAP determined for the current annual period for services, CBHS will bill their UMDAP amount or the cost of services received, whichever is less.

It is against Federal laws and State regulations to automatically waive Patient fees payable. Many Medicare and Medi-Cal beneficiaries may not access health care services needed because their share of cost far exceeds their ability to pay. The SDMC program allows MH and SA Providers to use the UMDAP (Uniform Method for Determining Ability to Pay) Fee Schedule to determine a sliding fee amount for medically necessary CBHS services. In these situations, please include documentation in the Client’s chart or CWS progress note about their financial hardship whenever UMDAP is used. UMDAP information is entered for MH Clients in Avatar PM/ Family Registration screens. **SA Programs do not enter UMDAP in Avatar.** Instead, SA Providers use a separate system for calculating UMDAP, for managing patient receivables, and for reporting patient revenues received, for fiscal year cost reporting.

### Services Covered /Not Covered by Medicare

Medicare Part B covers outpatient mental health and medication management services that are provided by the following types of Clinicians, provided they have a Medicare number and services are rendered in a Medicare certified CBHS or SFGH Dept of Psychiatry Outpatient Clinic.

- Psychiatrist or Medical Doctor/ Physician (Provider Taxonomy prefix is 207 or 208)
  - Psychologist (Provider Taxonomy prefix is 103)
  - Licensed Clinical Social worker (Provider Taxonomy prefix is 104)
  - Clinical Nurse Specialist (Provider Taxonomy prefix is 364)
  - Nurse Practitioner or Physician Assistant (Provider Taxonomy prefix is 363)
- Services rendered by MFT (Marriage Family Therapists), Clinician Interns, Pharmacists, Occupational Therapists, or Unlicensed workers are not covered by Medicare.

## AVATAR Billing Providers Bulletin Medicare-MediCal Issue

- Services are directly billed to SDMC if they are rendered by Clinicians with Provider Taxonomy code prefixes other than those listed above.
- Contact the CBHS Performance and Compliance Office for information or assistance with Medicare Clinic site or Staff certifications.

Substance Abuse and Narcotic Treatment Program (NTP) services are not covered by Medicare. However, if the Client has a Medicare Advantage Plan thru an HMO Insurance, services are billable to their Insurance. CBHS bills Insurance for SA services rendered by Drug Medi-Cal programs.

Rehabilitation services are not covered by Medicare. Case Management, Crisis Intervention, Intensive or Rehab Day Treatment, Crisis Residential Treatment, Adult Residential, Crisis Stabilization, Therapeutic Behavioral Services, and Inpatient Administrative Day services are all billed directly to SDMC.

- CPT code services are usually billed to Medicare and Insurance; including: 90801, 90804-90815, 90862, M0064, 90853, 90857, Consultation, Eval & Mgmt, etc.
- Never use CPT codes to bill Services that were not Face-to-Face with the Client.

Places of Service /locations:

- Phone, School, and Mobile service locations are not covered by Medicare.
- Specialty MH services provided in the community are not Medicare reimbursable. When a service is provided in the “community” and no other appropriate place of service code applies, the place of service code should be 99 (Other).
- Telepsychiatry or Telemedicine services differ from services provided by telephone. Telepsychiatry services may be covered by Medicare if provided from a Clinic through interactive voice and visual interface between the provider and the client.

### **Advanced Beneficiary Notice of Noncoverage (ABN)**

The Center for Medicare and Medicaid Services (CMS, formerly HCFA) requires an Advanced Beneficiary Notice (ABN) to be given to Medicare beneficiaries to let the Client know Medicare is not likely to pay for certain services they receive from your Clinic. **The notice must be given to the patient before services are performed.** The ABN form and instructions are available on-line. ABN forms are required for all Medicare Clients because the majority of CBHS program services are not covered, including SA treatment services. Dually eligible Medi-Medi or Insurance-Medicare Clients in CBHS programs may receive services which are not covered by Medicare.

CMS revised and updated the ABN form. Please use the 2012 version of the form (ABN form CMS-R-131). The form is completed annually, along with the Client’s Treatment Plan and PFI (Payer and Financial Information). For CBHS Clients who have a Patient Fee liability, the maximum amount payable for services not covered by Medicare is their UMDAP amount or

## AVATAR Billing Providers Bulletin Medicare-MediCal Issue

Share-of-Cost amount, if the dually eligible Medi-Cal Client chooses to pay their SOC instead. Providers retain their Medicare Clients' completed ABN, in case of an audit.

### **CBHS Billing Notes to Providers:**

- Medicare certified MH Clinic programs are the only Providers who may enter Medicare Part B as a Guarantor in Avatar FE records for their Clients' services.
- SA Programs do NOT enter Medicare guarantors.
- SFGH Dept of Psychiatry is the only CBHS provider who can bill Medicare Part A for Inpatient services.
- **Please do not delete or move guarantor information** in the Avatar billing system; instead, call the CBHS Patient Accounts Billing Office for assistance, (415)255-3610

**The DMH website has a “Frequently Asked Questions” about Medi-Medi billing, on their website, here’s a link: <http://www.dmh.ca.gov/MedCCC/Medi-MediBillingFAQs.asp>**

In addition, the following websites contain much more information about Medicare and Medi-Cal for your reference:

**Medicare.gov** – this is the official Medicare website. Search function is very good!

**Medi-Cal.ca.gov** – this is the official Medi-Cal website. Most info pertains to the regular Medi-cal program, though there are some references applicable to SDMC.

**DMH.ca.gov** and **ADP.ca.gov** – CA Dept of Mental Health and the Alcohol and Drug Programs administer the Short-Doyle Medi-Cal programs for specialty mental health and substance abuse treatment services. These websites have a section for current and prior years' DMH Information Notices and ADP Bulletins

**Palmettogba.com** – Palmetto GBA is the Medicare plan administrator and fiscal intermediary for the western region, including California

**CMS.gov** –the official website for the federal *Center for Medicare and Medicaid Services*, formerly HCFA