CBHS Centralized Financial Eligibility

Frequently Asked Questions - Part II

REMINDER:

**** Family Registration MUST be completed immediately in the Avatar system, if a client agrees to pay UMDAP Sliding Fee. ****

1. **What should be entered as the "Effective Coverage Date" on the EGI Form?**
   For Medicare and for Medi-Cal Clients, enter the first day of the month (e.g. 01/01/2013) as the 'Effective Coverage Date' on the EGI Form, even if the episode opening date is later in the month. For example, if the Client has Medicare and/or Medi-Cal when their episode is opened on 01/15/2013, the 'Effective Coverage Date' for the Client's Medi-Cal and/or Medicare guarantor is 1/1/2013. For HSF/SF PATH, and for private insurance plans, the 'Effective Coverage Date' entered is the true beginning date of coverage. For UMDAP, the 'Effective Coverage Date' is determined by the effective date of UMDAP in Family Registration screen.

2. **Do we need to enter "Termination Date" on the EGI Form?**
   'Termination Date' refers to existing Client's insurance or healthcare benefit coverage end date. If the Client lost their coverage or Medi-Cal benefit, then let CBHS Billing know by submitting an EGI Update form and enter their insurance or benefit "Termination Date"; otherwise, this field should be left blank for Clients who are still covered.

3. **What is the difference between 'HSA Foster Care' and 'DHS Work Order' in Other Funding Source option?**
   The "Other Funding Source" option differentiates, HSA for 'Human Services Agency' and DHS stands for the 'San Francisco Department of Human Services'. 'HSA Foster Care' is used only for Foster Care clients.

4. **I can only Read but cannot update our Clients' Avatar FE record; what should I do?**
   Basically, the EGI form replaces the Financial Eligibility screen. Complete the EGI Form to enter or update guarantor information in Clients' FE records.

5. **What is the process of getting CBHS Age Director's approval before providing mental health services to clients with private health insurance coverage or Medicare Part C (HMO) coverage?**
   The HMO is responsible for providing healthcare services to their Enrollees. If the HMO is unable to provide the services the Client needs because the mental health or substance abuse treatment services are not covered in the Client's HMO plan, or because benefits are exhausted, then written documentation from the HMO plan stating this is required. This documentation is submitted to the CBHS Age Director (Edwin Batongbacal for Adult/Older Adult Programs, and Kenneth Epstein for Children's Program) before the HMO insured Client can be admitted to a CBHS program.
   TIP: *SDMC can be billed for Medi-Medi Clients only if (1) benefits are exhausted, or (2) services are not covered. Medi-Cal does not cover (and cannot be billed for) services, if the HMO denial reason is "not prior authorized" or because the "Provider is not part of the (HMO) plan's network".*

6. **What should I do, if the client has Medi-Cal Full Scope (No SOC) benefit coverage?**
   When a new client is admitted to a program, a new EGI and Consent for Billing form must be completed. The EGI informs CBHS Billing about the Client's healthcare benefit or insurance coverage; the Consent for Billing form is signed by the Client authorizing you, as the Provider and CBHS, to release their healthcare information for billing purposes. **NOTE:** Medi-Cal eligibility is month-to-month and benefits may change. It is a good idea to verify your Clients' Medi-Cal coverage every month.

7. **What should I do if a client has Medi-Cal with a Share-of-Cost (SOC)?**
Please refer to the separate handout that provides an explanation about Medi-Cal Share-of Cost. As a Provider, you need to verify your client's Medi-Cal eligibility every month to determine what kind of benefit he/she has and the amount of SOC the Client has left to pay / spend-down for the month. Share-of-Cost is a monthly amount that the Client pays or is obligated to pay before their Medi-Cal benefits become available. (Medi-Cal deducts this amount from claims submitted for these Clients.) Determine if the Client can pay their SOC amount. If the Client cannot pay their monthly SOC, then complete the Avatar Family Registration form to determine their UMDAP Sliding Fee annual amount. Note: the UMDAP amount covers the cost of mental health or substance abuse treatment services received from CBHS programs for a one-year period. You can divide the amount by twelve to determine their monthly UMDAP amount. Obtain the Client's signature on the 'Consent for Billing' form. Once the Client pays their SOC for the month or their UMDAP, CBHS Billing will "clear" Clients' SOC with Medi-Cal using the services the Client receives during the month.

8. **What are the requirements, if the client has Medi-Medi (with SOC) benefit coverage?**
It's the same as in #7 (Medi-Cal with SOC) and in addition, an Advanced Beneficiary Notification form is also required.
TIP: *ABN (Advanced Beneficiary Notice) must be signed by the client on a yearly basis. This is a Medicare requirement. The same rule applies for UMDAP update in Family Registration too.*
Also, if there is a change in client's benefit coverage, in client's income level, EGI, Family Registration, and/or UMDAP Sliding Fee Determination Form must be completed.

9. **What should I do, if a client has Healthy San Francisco or SF PATH coverage?**
Complete EGI, UMDAP Sliding Fee Determination Form, and Consent for Billing.
TIP: *Client's benefit may change from HSF to Medi-Cal or vice versa. Also, Clients who fail to pay their quarterly Participation Fee are automatically dis-enrollled. That is why you should verify your client's coverage every month.*

10. **What should we do with all the completed forms?**
File them in respective clients' charts in your Program's files. **DO NOT** send the completed paper forms to CBHS.

11. **What should be done, if the client receives treatment services from different Provider agencies or when the client has different admission periods within the same agency?**
The EGI provides information to CBHS Billing about the Client's guarantor or funding source for each Program's Episode services. Different agencies may have different funding sources, and/or the Client's funding source or guarantors may change during different periods; therefore, a separate EGI is needed for each agencies' episode or when the Client has different admission periods within the same agency. A single EGI can completed if the same agency opens different episodes, i.e. for Outpatient and for Day Tx, under different RU's, within the same period.

12. **Why are there two versions of "Consent for Billing" forms?**
There are two versions of the "Client Consent for Billing" forms. One is a half-sheet NCR form used for Clients who do not have an UMDAP. Clients who do not have an UMDAP include, Full-scope Medi-Cal with no monthly SOC and no other health coverage, Medi-Medi with no SOC, SF Health Plan enrollees with co-pays, etc. The other form containing the "Consent for Billing" is on the bottom of the "UMDAP Sliding Fee Determination" form. This form is used by Clients who have an UMDAP. Clients need to sign only one "Consent for Billing" form.

13. **Why do Clients need to sign "Consent for Billing" forms?**
All mental health and substance abuse treatment Clients need to give their explicit consent for you (as their Service Provider) and CBHS to release their protected health information for

billing purposes. MH and SA programs have a higher level of privacy and confidentiality (per 42CFR); the standard release under the HIPAA Privacy and Transaction Rules do not apply.

14. As to Medi-Cal clients, do Clinics verify eligibility or does CBHS verify this?

Medi-Cal is a month-to-month benefit; therefore, it is important for Providers to verify their Clients' Medi-Cal benefits coverage every month.

15. The paper version of EGI (Episode Guarantor Information), UMDAP Sliding Scale Determination & Consent for Billing, do these need to be performed annually and do we need to keep paper forms on file?

The EGI paper form is used by Providers to gather their Client's healthcare coverage information so this data can be entered in Avatar at a later time. It is optional for Providers to use this form; therefore, it is not really required to keep this paper form on file.

The UMDAP Fee Determination and Consent for Billing forms are signed by the Client. Original copies of these completed forms should be kept on file by Providers.

The W&I Code, DMH Revenue Policy & Procedures for the SDMC Program, and CBHS p/p require the annual determination of Clients' payer and financial information or PFI. The PFI is also required to be completed anytime there is a change in Client's financial or healthcare coverage information.

16. Is there a change in UMDAP determination process?

The UMDAP or Uniform Method for Determining Ability to Pay has remained unchanged since 1989. All you need to determine UMDAP is the Client's Income, Assets, Allowable Expenses and Household Size. All you need to do is enter these elements into Avatar CalPM, in the Client's Family Registration screen. The system will then do the calculation for UMDAP. The documentation on UMDAP is available online on Avatar Documentation page.

UMDAP Sliding Fee Scale

http://www.sfdph.org/dph/files/CBHSdocs/BHISdocs/UserDoc/UMDAPSlidingFeeSchedule.pdf