Episode Guarantor Information Guide

Purpose:
The Episode Guarantor Information form collects healthcare and benefit coverage information for Mental Health and Substance Abuse Clients for SFDPH – Community Behavioral Health Services to determine eligibility and to obtain reimbursement for services received by the Client.

How do you get to Episode Guarantor Information Form?
Authorized Avatar system Users, including Intake Coordinators, and Clinical Staff have access to the Episode Guarantor Information form (EGI). The EGI is a stand-alone form in Avatar and is also a part of the Admission Outpatient Bundle in CalPM.

Menu Path -> Avatar PM > Client Management > Account Management > Episode Guarantor Information

In MyAVATAR, go to the “Search Forms” option and type “episode”; select “Episode Guarantor Information” from the dropdown list and press Enter. If accessed as part of the Admission Outpatient Bundle, the top portion of the form is pre-populated.

In the “Client ID” field, enter client ID # or type in LastName,FirstName. Click on the magnifying button to activate search. The dropdown list will display the client meeting the search criteria. Select the client by double clicking on the name or by using the arrow keys to move to the desired client and press Enter.

NOTE: The EGI form displays eight subsections on the top left side margin:
1. Select the “Program Type”, either “Mental Health” (MH), or “Alcohol Drug Program” (ADP) on the top.
2. Select the “Submission Type”, either “New Eligibility Record”, or “Update an Existing Record”.
3. Enter the current date. NOTE: If it is an update for an existing client, enter the “Change of Coverage Effective Date.”
4. Click the desired option from the left site menu, which selects and expands the section on the right side of the form. A user must checkmark the desired checkbox from the “Benefit Coverage” summary section in order to activate the input fields and different elements of coverage section.

TIPS:
- Each section can be collapsed and expanded by clicking on the arrow buttons displayed on the section sub headers.
- Do not enter a ‘Termination Date’ unless you have confirmation their healthcare coverage has been terminated.
- If you unselect a checkbox on the “Benefit Coverage” section, it deactivates the corresponding summary section.

Episode Guarantor Information

The form contains the different benefit options which are displayed like a site menu on the left side of the form. They are
1) Medi-Cal
2) Medicare
3) SF Health Access Program
4) Patient Fee Liability
5) Private Health Insurance
6) SF Health Plan
7) Other Funding Sources, and
8) Assignment of Benefits, Release of Information, and COB.
Select the applicable benefit checkboxes or radio buttons to indicate health benefits the Client has. Based on your selection(s), the system will highlight the EGI fields for you to enter the Client’s healthcare coverage or eligibility information. When all information has been entered, click the Submit button on the left side bar to save the data you entered.
**Medi-Cal Benefit Coverage**

Click ‘Medi-Cal’ option on the left side menu bar to select and expand the ‘Medi-Cal’ section (green highlight). Or select the ‘Medi-Cal’ checkbox on the “Benefit Coverage” summary section above to activate input fields in ‘Medi-Cal’ section.

- Select appropriate radio button from Medi-Cal options. Enter Medi-Cal ID # or CIN, and Coverage Effective Date.

Select the appropriate type of Medi-Cal coverage the Client has: Share-of-Cost, Full Scope, Restricted or Out-of-County.

Clients with a Share-of-Cost (SOC) obligation are required by the Medi-Cal program to pay their Monthly SOC amount for services they received, before they become eligible for Medi-Cal benefits for the rest of the month. This is similar to a deductible and is an out-of-pocket expense for the Client or their Responsible Party. The UMDAP (Uniform Method for Determining Ability to Pay) Sliding Fee option is available if the Client is unable to pay their SOC amount because of financial hardship that creates a barrier to receiving medically necessary mental health or substance use treatment services. Obtain substantiating information for their financial hardship and be sure to document their situation in the Client’s Chart or CWS Progress Note in case of an audit. *(See Appendix A for additional information about UMDAP and the 1989 DMH UMDAP Fee Schedule)*

Select the Out-of-County Medi-Cal plan if the MC eligibility verification system or MEDS (Medi-Cal Eligibility Data System) shows the Client has a “Responsible County” other than San Francisco County - 38. If this is selected, the system requires you to enter the name of the County in the next input field. Per Title 9 CCR, written authorization from the Client’s Medi-Cal Responsible County must be obtained before planned (e.g., non-urgent) services can be rendered. *(See Appendix B for the list of California Counties and their contact Information).*

Restricted Medi-Cal benefits are available for Sensitive services or for undocumented California residents. If the MC eligibility verification system indicates the Client has restricted benefits, please select the “Restricted” Medi-Cal coverage on EGI. MC benefits are limited but may include: Inpatient or Outpatient treatment services that are directly related to an Emergency medical condition*; Pregnancy related (pre-natal, delivery and post-partum care), Minor Consent or Sensitive Services for Minors age 12 to 21. All other services are not covered. Additional information is required before SDMC claims can be submitted for services rendered.

* Medi-Cal’s definition of an emergency medical condition: A person shows acute symptoms of sufficient severity such that an absence of immediate medical attention could reasonably be expected to place the patient’s health in serious jeopardy or result in serious impairment of bodily functions or serious dysfunction of any bodily organ or part. For MH Programs, a 5150 is considered an emergency situation.
**Medicare Benefit Coverage**

Click ‘Medicare’ option on the left side menu bar to select and expand the ‘Medicare’ section on the right side. Select the appropriate ‘Medicare’ checkbox on the “Benefit Coverage” summary section above to activate input fields in ‘Medicare’ section.

- Checkmark appropriate checkbox. Enter client’s Medicare ID or HIC #, and Coverage Effective Date.

**Advance Beneficiary Notice (ABN)**

ABN forms are required for all Medicare Clients because the majority of CBHS program services are not covered, including Rehab MH and Substance Abuse treatment services. (Medicare Clients should be referred to Medicare providers to the extent possible.) Dually eligible Medi-Medi or Insurance-Medicare Clients in CBHS programs receive services which may not be covered by Medicare. **The notice must be given to the patient before services are performed.**

**NOTE:** ABN is a yearly **REQUIREMENT** for all Medicare Clients (MH and SA). Click Medicare ABN Form, if you need the form or obtain instructions on how to complete the form with your Clients.

**Part C - Senior Advantage Plan (HMO)**

In CBHS, Medicare Advantage Plan enrollees are referred to their HMO Insurance for services. CBHS services may be provided if there is proof or documentation that (a) their HMO insurance plan does not cover the services they need, or (b) their plan benefits are exhausted. Otherwise, written prior authorization from the HMO plan and their agreement to pay for CBHS services, a Single Case Agreement from the Medicare HMO is required before services can be provided. In addition, the **CBHS Age Director’s** approval for the HMO-insured Client to be admitted to a CBHS Clinic is required.

**San Francisco Health Access Program**

Click ‘SF Health Access Program’ option on the left side menu bar to select and expand ‘SF Health Access Program’ section on the right side. Select ‘SF Health Access Program’ checkbox on the “Benefit Coverage” summary section above to activate input fields in ‘SF Health Access Program’ section.

- Select either HSF (Healthy San Francisco) or SF PATH radio button. Enter client’s Policy # and Coverage Effective Date.
NOTE: All HSF and SF PATH beneficiaries must complete the Avatar Family Registration Form to obtain their “Point-of-Service” Fees payable for specialty MH and SA services received from CBHS Providers. Their POS fee is their UMDAP annual liability amount less their HSF or SF PATH annual Participation Fee amount. TIP: Contact CBHS Patient Accounts Billing – HSF Coordinator for assistance with this.

Patient Fee Liability
Click ‘Patient Fee Liability’ option on the left side menu bar to select and expand ‘Patient Fee Liability’ section on the right side. Select ‘Patient Fee Liability’ checkbox on the “Benefit Coverage” summary section above to activate input fields in ‘Patient Fee Liability’ section.

![Patient Fee Liability Form]

✓ Check the appropriate boxes, enter information needed, and obtain Client’s agreement to pay the Patient fee.

TIP: See Appendix A for information about UMDAP, the UMDAP Sliding Fee Schedule, and which coverage has UMDAP and which ones do not have an UMDAP.

NOTE: It is against SFDPH and Contract Agency’s Code of Conduct to automatically waive Patient Fees that are payable. The UMDAP Patient Liability amount depends upon his/her “ability to pay”. UMDAP is based on their monthly income, assets, allowable expenses, and the number of family members in their household who depend on their income for support. The CA State SDMC Revenue Policy and Procedures requires the County to bill Clients, the lesser of either their account balance (the Cost of Services less any third party payments and adjustments) or their UMDAP amount.

San Francisco Health Plan - HK, HW, HF, or SED
Click ‘SF Health Plan’ option on the left side menu bar to select and expand ‘SF Health Plan’ section on the right side. Select ‘SF Health Plan’ checkbox on the “Benefit Coverage” summary section above to activate input fields in ‘SF Health Plan’ section.

![SF Health Plan Form]

✓ Select appropriate radio button. Enter the Subscriber’s Policy #. Enter ‘Coverage Effective Date’. 
Private Health Insurance (PPO & HMO Plans)

Click ‘Private Health Insurance’ option on the left site menu bar to select and expand ‘Private Health Insurance’ section on the right side. Select ‘Private Health Insurance’ checkbox on the “Benefit Coverage” summary section above to activate input fields in ‘Private Health Insurance’ section.

- Select appropriate radio button ‘Yes’ or ‘No’ for Authorization. If “Yes”, enter “Authorization Number.”

Enter the Insurance Name, Subscriber’s Name, Policy # and Coverage Effective Date.

If a client has Private Secondary Insurance Information, enter it on the right side of the section.

**NOTE:** Insured Clients require a written prior authorization or documentation of their Insurance denial of coverage and CBHS approval before non-emergency services are provided.
Services are funded by a Grant, Work Order, or Other Payer sources

Click ‘Other Funding Sources’ option on the left site menu bar to select and expand ‘Other Funding Sources’ section on the right side. Select ‘Other Funding Sources’ checkbox on the “Benefit Coverage” summary section above to activate input fields in ‘Other Funding Sources’ section.

☐ Select the appropriate checkbox indicating Funding Sources for the Client’s Episode services.
☐ Enter information that may be helpful for your Program services to tie to the correct funding source in “Comments”

NOTE: Federal and State Grants may fund CBHS Staff time used for providing specialty services. Select “Other Grant” if the Client’s services will be from Federal or State Grants. State and federal regulations prohibit billing Medi-Cal for these services.

Client Consent for Billing

Click ‘Assignment of Benefits…’ option on the left site menu bar to select and expand ‘Assignment of Benefits…’ section on the right side. Select ‘Assignment of Benefits…’ checkbox on the “Benefit Coverage” summary section above to activate input fields in the ‘Assignment of Benefits…’ section.

TIP: Fields with red labels are required. Please select an Option [Y/N] before submitting the form.

Click button on the left side bar to save the data you entered. Or Click button to “Exit”.

Click button on the left side bar to save the data you entered.
Quick Guidelines on how to select options:

If you select Medi-Cal option
Select one option: SOC, Full Scope, Restricted or Out-of-County
NOTE: If the Client has a Share-of-Cost obligation,
1. Ask Client if they can pay their monthly SOC amount; if not, then use UMDAP
2. If UMDAP is used, complete the Avatar Family Registration Form and determine the amount they can pay for services
3. If UMDAP is not used, Client will be expected to pay their monthly Share-of-Cost amount
4. Enter the Patient Fee Liability guarantor on the EGI
5. Select either, Monthly, All Now, or Other option from “Client Agrees to Pay” List
6. Obtain Client’s agreement to pay their Patient Fee amount

If you select Medicare option
Select appropriate coverage the Client has: Part A, Part B, Part C and/or Part D
**CAUTION**: Only Part B Outpatient option is applicable for MH Services, Medicare does not cover SA Services
IMPORTANT: ABN (Advance Beneficiary Notice) option is a yearly REQUIREMENT
NOTE: All Medicare beneficiaries have a yearly deductible ($147.00 in 2013 for Part B) and a 20% co-insurance. The Client is responsible for paying his/her annual Medicare deductible and 20% co-insurance amount.

If you select SF Health Access Program
Select one option: HSF or SF PATH
1. HSF and SFPATH have a Point of Service Fee. For specialty CBHS services, it is based on UMDAP.
2. Complete Family Registration Form
3. Select either, Monthly, All Now, or Other option from “Client Agrees to Pay” List
4. Obtain Client’s agreement to pay their Patient Fee amount

If you select SFHP (HK, HW, HF & SED) option
1. Select either HK ($5), HW ($3), HF ($5), or SED (No Fee) option
2. Select per Visit option from “Client Agrees to Pay” List

If you select Patient Fee Liability option
1. Select appropriate options: UMDAP Sliding Fee, Medi-Cal Monthly SOC, HSF POS, SFHP Co-pay, Insurance Deductible, and/or Full Cost/Private Pay

If you select Private Insurance option
1. Refer the Client to their Insurance or HMO plan for services. The Client may request his/her Insurance or HMO Primary Care provider for a referral to CBHS. The Insurance or HMO must prior authorize and agree to pay services CBHS provides to their insured.
2. Approval from the CBHS Age Director is required before HMO or Insured Clients are admitted to a CBHS program.
3. Provide the Insurance or HMO’s written authorization and agreement to pay, to the CBHS Billing Office

If you select Other Funding Sources option
1. Verify the funding source for Clients’ services with your Program Manager or Director
2. Choose the correct funding source from the options listed.
   *(TIP: Clinicians must use the Non-billable Service Codes if services are not billable to SDMC)*

NOTE: Full Cost/Private Pay option may be applicable for Clients who have a Flexible Spending Account or Employer funded medical services account. Select the “Private Pay” option and enter any coverage comments for this. If the Full Cost of Services will be paid by the Client, the Avatar Family Registration is not required to be completed.

<table>
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<tr>
<th>Medi-Cal:</th>
<th>Full Scope</th>
<th>Share-of-Cost</th>
<th>Restricted</th>
<th>Out-of-County</th>
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<tr>
<td>Medicare:</td>
<td>ABN Completed</td>
<td>Part A (Hospital)</td>
<td>Part B (Outpatient)</td>
<td>Part C (HMO)</td>
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<td>SF Health Access Program:</td>
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<td>SF PATH (Provides Access to Healthcare)</td>
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<td></td>
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<tr>
<td>SF Health Plan:</td>
<td>Healthy Kid (HK)</td>
<td>Healthy Worker (HW)</td>
<td>Healthy Family (HF)</td>
<td>HF with SED</td>
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<tr>
<td>Patient Liability:</td>
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<td>Co-pay per visit</td>
<td>Insurance Deductible</td>
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<tr>
<td>Private Health Insurance:</td>
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<td>HMO</td>
<td>Authorization</td>
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<tr>
<td>Other Payer Source:</td>
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<td>DHS Foster Care</td>
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<tr>
<td></td>
<td>Conservator</td>
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<td>County General Fund</td>
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<td>Victim Witness #</td>
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