

AVATAR Billing Providers Bulletin

CBHS Mental Health & Substance Abuse Tx Programs

Payer and Financial Information (PFI)

The Welfare & Institutions Code requires County Behavioral Health Systems to obtain Payer and Financial Information (PFI) for all Clients receiving mental health and/or substance abuse treatment services. A PFI is also required whenever there is a change in the Client's financial or eligibility status or, with their healthcare coverage information. The following information is about SFDPH – CBHS PFI procedures, including when UMDAP is used or applicable.

The CA Dept of Health Care Services (DHCS) enforces Regulations and provides policies and procedures for County behavioral health systems' PFI and UMDAP. UMDAP stands for "Uniform Method for Determining Ability to Pay," which includes the DMH 1989 Sliding Fee schedule, still in use today. Note, while all CBHS Clients are required to have a PFI, not all of them have an UMDAP. Please refer to the section in this bulletin that describes this further.

Episode Guarantor Information

SFDPH - CBHS Providers now use the "Episode Guarantor Information" process to meet the State's PFI requirements. Providers complete the Episode Guarantor Information screen (EGI) in My Avatar/CalPM when the Client is admitted to their Mental Health or Substance Abuse Treatment Program; and, at least annually thereafter if the Client continues to receive CBHS services. A paper EGI form can be used for gathering a Client's PFI information; however, **the information must be entered into the CBHS Avatar system EGI and the Clients' Consent for Billing must be obtained, in order for PFI requirements to be met.**

An EGI is required for every Provider episode(s) the Client has with CBHS. This is because Clients may have different Payer sources for services they receive from different Providers at different times. Payer sources for the Client's episode services may not be the same as for another Provider's episode for various reasons. Medi-cal is a month-to-month benefit and information or conditions for a Client's eligibility may be different or changed.

An annual PFI is required by DHCS for County MH and SA Clients who are continuing to receive treatment services. Providers may use their Clients' Episode Opening date or the Plan of Care (POC, aka treatment plan) date as the PFI anniversary date. Please complete the EGI for Clients at the same time you complete their POC, as well as their CSI Periodic Update report. This should ensure your Clinic program meets the DHCS annual PFI requirements for CBHS Clients.

Clients or Client's Responsible Parties who refuse to provide accurate and complete PFI information are billed the full cost of services they received from CBHS per DHCS Policy & Procedures. We use the SF Board of Supervisors' billing Rates for SF Dept. of Public Health services when services are billed. A copy of the Fiscal Year SF Board Rates for CBHS services is available. Please contact the **CBHS Billing Office** for information or assistance with PFI and the UMDAP process. Program Staff may leave a message on the Billing Inquiry Line at (415)255-3668 or better yet, send an e-mail with your request or questions to Nanalisa, CBHS Patient Accounts Manager: Nanalisa.Rasaily@sfdph.org

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UMDAP - Uniform Method for Determining Ability to Pay

The UMDAP process is used for determining a Sliding Fee Amount for Clients or their Account Responsible Parties (RP) when they are unable to pay the regular fee amounts charged or, instead of their normal portion of the cost of treatment services received from CBHS and its Providers. Per State PFI policy/procedures, the Client pays the UMDAP amount determined, or the cost of services received less any third party payments and adjustments during their annual (one-year) UMDAP period, whichever is less. The separate “UMDAP Sliding Fee Determination” CBHS Billing form is used for gathering the Client or their RP’s financial information, to record the Client’s UMDAP amount payable, and their Consent for CBHS billing.

It is against Federal laws, State regulations, and the CBHS Code of Conduct to **automatically** waive or reduce Patient Fees payable. Documentation of financial hardship or therapeutic reason must be entered in the Client’s Progress Notes or Chart anytime UMDAP is used because the Client or their RP is unable to pay their monthly Medi-Cal Share-of-Cost, Medicare annual Deductible and service Co-pay amounts, or any healthcare out-of-pocket expenses.

The UMDAP process is also used for determining Patient Fee amounts payable for uninsured Clients who are not eligible for any government entitlement programs. Providers are advised to obtain accurate and complete information, including documents required for verification of income and assets, to determine the appropriate UMDAP amount payable for CBHS services.

UMDAP is the maximum amount Clients pay as their share of the cost of treatment services they receive during their annual UMDAP period. Although UMDAP is a Sliding Fee, the Client’s UMDAP amount can be further adjusted for therapeutic reasons by their Clinician and/or the Program Director. Documentation about the therapeutic reason for the UMDAP adjustment must be entered in the Client’s Progress Note or Chart. The adjusted UMDAP amount is noted in the “UMDAP Sliding Fee Determination” form signed by the Client.

Who does not have an UMDAP?

The following Clients do NOT have an UMDAP, and are not required to complete the UMDAP form because they have no Patient Fee liability. There is no need to complete the My Avatar/CalPM/ Family Registration screens:

1. Clients who have Full-scope Medi-Cal and no monthly Share-of-Cost.
2. Clients who are Homeless¹

¹ Federal Register published 12/5/2011 includes the HEARTH Final Rule which defines

Homeless as: (1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an Individual who resided in an emergency shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily resided; (2) individuals and families who will imminently lose their primary nighttime residence; (3) unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; and (4) individuals and families who are fleeing, or are attempting to flee,

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3. Healthy San Francisco and SF PATH Enrollees who have incomes that are less than 100% of FPL.
4. Healthy Families Program Clients who are SED (per completed SED Certification form)
5. Clients who are receiving ERMHS services that are included in their annual Individualized Education Plan (IEP)
6. Special Funded Program Clients – CBHS designated programs that have been approved as exempt from Patient Billing and UMDAP; examples include: MHSA, IHBS, SB785, etc.

GA or County General Assistance Clients who do not have Medi-Cal benefits are not exempt from UMDAP. They have a nominal UMDAP amount, usually \$37 or up to a \$174 annual liability amount depending on their monthly income and household size. The same is true for anyone who is uninsured and has income/assets less than the Federal Poverty Level or FPL. Please refer these Clients to Healthy San Francisco/ SF PATH to obtain low or no cost healthcare coverage that includes primary care, prescription drug, mental health and substance abuse treatment benefits.

SFHP Co-payments and HSF Point-of-Service Fee

The San Francisco Health Plan includes: Healthy Families Program (except if SED), Healthy Kids, and Healthy Workers plan enrollees who have a Per Visit Co-pay amount that is due at the time of service. If the Client forgets to pay or is unable to pay their Co-pay, please make a note on their Patient record or Progress Note. If the Client is always unable to pay the Co-pay because of financial hardship, please refer the Client to the SF Health Plan to have their Co-pay amounts reduced or eliminated. The Client may be eligible for an entitlement program or another program that does not include a patient fee. Otherwise, it is a SFHP, CBHS, and Managed Care requirement for these per-visit Copayment amounts to be collected.

Healthy San Francisco (HSF) enrollees include working Individuals whose Employers chose the City's plan for their employees and SF residents who have signed up for low or no cost healthcare coverage. HSF enrollees who have incomes above 150% FPL (Federal Poverty Level) have a Point-of-Service (POS) Fee that is payable at time of service. HSF enrollees who have income levels above FPL, and receive specialty services from CBHS are assessed a POS fee amount that is different than POS fees charged in Primary Care Clinics. This is because the CA Dept of Health Care Services (DHCS) requires CBHS to use UMDAP. DHCS allows SFDPH - CBHS to deduct the Clients' HSF Participation Fee (i.e., the annual premium paid for HSF coverage) from their UMDAP annual liability amount. This adjusted annual UMDAP amount is divided by 12 (months). The resulting amount is the HSF Client's monthly POS fee for CBHS services.

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There is no need for Providers to obtain financial information for their HSF Clients. The UMDAP Determination form is completed by the Provider with CBHS Billing. Contact Carla Hurtado, CBHS Billing - HSF Specialist at (415)255-3542 for assistance with this. The Client or their RP signs the completed UMDAP Determination and Consent for Billing form.

Re: CBHS Clients who have an UMDAP

Substance Abuse Providers use the same DHCS UMDAP Fee Schedule for determining their Clients' sliding fees and are responsible for collecting patient amounts payable. However, SA Providers do NOT enter UMDAP information into the My Avatar/Family Registration screens. Medi-Cal Share-of-Cost, UMDAP and Non-Medi-Cal Patient fees collected by SA Providers are reported on their FY Cost Reports. Therefore, SA Providers maintain a Patient Fee tracking, collection and payment process for their Client accounts.

Mental Health Providers enter their Clients' UMDAP information into the My Avatar/ CalPM/ Family Registration screens. One CBHS Patient Account is created for all Family members receiving Mental Health services from CBHS. The CBHS Billing Office is responsible for processing Patient Fee Payments received from Clients, and for sending monthly Client billing statements listing services received and patient amounts due. Please see the CBHS Policy/procedures for Client Billing and, Handling Patient Payments received in MH Clinics.

Low-Income Health Plan (LIHP)

Please encourage your uninsured, low-income Clients to enroll in SF PATH, the San Francisco County Low-Income Health Plan. LIHP member automatically become Medi-Cal when this portion of Healthcare Reform becomes effective on January 1, 2014 (aka Medi-Cal Expansion). The SF PATH program information and enrollment guide is available online at SFPATH.org; or you can download this brochure from:
<http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Deliv/SanFran/15.3Brochure.pdf>

Other IMPORTANT INFORMATION (please share with Clinic Staff!)

Medi-Cal HIPAA 5010 edits are very strict! Medi-Cal and Medicare will deny Services if the Client's Name does not match their records. Beneficiaries' names must match their Medi-Cal or Medicare record. Please verify your Clients' eligibility and information before entering/updating their record in Avatar.

Advanced Beneficiary Notice

CMS requires Providers to notify their Medicare Clients in advance about medically necessary services that are not covered by Medicare. CBHS mental health rehab services, particularly those rendered by non-Medicare Clinicians or by non-Medicare Programs, and substance abuse treatment services are not covered by Medicare; therefore, CBHS Providers complete the ABN for Clients with Medicare benefits. CMS recently revised its ABN Instructions. These new

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instructions and the ABN form can be accessed in the following website.
<http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>

A Government Insurance Program

The Pre-existing Condition Insurance Plan (PCIP) is a short-term health insurance program that is currently in effect and will end on December 31, 2013. It is funded by the federal government as part of the larger Affordable Care Act. California has more PCIP enrollees than other states, but enrollment is still low and that has to do with the premium cost which is high. These individuals are generally high users of health care because they have pre-existing medical conditions. The PCIP provides healthcare services to their enrollees within their Provider Network. If the PCIP enrollee obtains services from an Out-of-Network provider (such as your Clinic), their out-of-pocket costs will be much higher. Note, Healthy San Francisco (HSF / SF PATH) is the County Health Access Program. HSF is discontinued when PCIP enrollment becomes effective.

If your Clinic provides services to a PCIP enrollee, please check, “Other Unlisted Insurance” or indicate “PCIP” in the EGI comments section. Contact the PCIP for prior authorization or obtain Insurance documentation of denial before you provide planned services. As with all other insured Clients, please provide a copy of the Client’s insurance card to CBHS Billing, 1380 Howard, 3rd Floor or fax a copy to: (415)255-3564.

CBHS Billing wishes all Program Staff and Clients a Happy, Green and safe St. Patrick’s Day!