

 <p style="text-align: center;"><b>County of Sacramento</b>  <b>Department of Health and Human Services</b>  <b>Division of Behavioral Health Services</b>  <b>Policy and Procedure</b></p>	Policy Issuer (Unit/Program)	<b>QM</b>
	Policy Number	<b>QM-00-09</b>
	Effective Date	<b>10/01/2017</b>
	Revision Date	
Title: <b>Client and Family Billing</b>	Functional Area: <b>Administration – Client and Family Billing</b>	
Approved By: (Signature on File) <b>Signed version available upon request</b>		
Alexandra Rechs, LMFT, Quality Management Program Manager		

**BACKGROUND/CONTEXT:**

Pursuant to applicable regulations and statutes, the State of California mandates that clients and their families must pay, according to their ability, towards the cost of care that is received from any Community Mental Health Service under the County Short-Doyle Act. Specific client financial responsible amounts are determined based on health coverage including Medi-Cal pursuant to Medicaid Regulations. Clients and families with no insurance or other temporary financial hardships will have their ability to pay assessed according to the Uniformed Method to Determine Ability to Pay (UMDAP) fee schedule defined by the California State Department of Health Care Services.

**PURPOSE:**

The purpose of this policy is to establish the process to be followed by the Mental Health Plan to identify and communicate whether a client or family has an applicable self-pay requirement, the process that will be followed to collect any self-pay liability as well as the payment and reversal process for self-pay responsibility. This policy will ensure a consistent approach to determination of financial responsibility and ensure that all claims including client self-pay bills are accurate and compliant with regulatory requirements.

**SCOPE:**

The scope of this policy includes all Sacramento County Mental Health plan services including Contracted and County operated service providers. Providers are required to complete and follow the procedures outlined in this policy.

**DEFINITIONS:**

- **Full Scope Medi-Cal** – California’s Medicaid program. It provides physical and mental health care services to low-income individuals.
- **Share of Cost Medi-Cal** – A federally required monthly dollar amount which a client is required to pay, or obligate to pay, for health care costs before they becomes eligible with Medi-Cal. SOC must be cleared before Medi-Cal will pay for claims exceeding that amount for the given month. The SOC determination is based on criteria supplied by the client to their Eligibility Worker at the Department of Human Assistance.
- **Other Health Coverage (OHC)** - Private health coverage plan or policy that provides or pays for health care services.
- **Liability** – The associated costs of services
- **UMDAP** - “Uniform Method of Determining Ability to Pay (UMDAP)” established by the State Department of Health Care Services (DHCS). Welfare and Institution Code Section 5718 and subsequent applicable sections. This is the annual amount that is based on household size, income, assets, and allowable expenses.
- **Self-Pay Responsibility** – The liability required to be paid by the beneficiary for the cost of service based on eligibility and ability to pay.

- **Payment Arrangement** – An arrangement between the client and County of Sacramento to make installment payments for the balance owed. This does not reduce the liability owed, but rather extends the payment terms.
- **Liability Adjustment** – An arrangement between the client and County of Sacramento that reduces the amount of the outstanding liability. This can include a transfer to another guarantor or a write-off as determined by the County of Sacramento.

## **POLICY:**

It is the policy of Sacramento County to ensure accurate and compliant claiming for services provided by the Mental Health Plan, this includes the billing of clients and families as appropriate. The policy identifies the process for waived or reduced fees. Self-Pay responsibility will not be routinely waived. In order to ensure consistency the following procedures will be followed for all MHP Clients regarding self-pay liability determination.

### **I. Establishment of Self-Pay Liability:**

Establishment of self-pay liability will be determined in accordance with Federal and State requirements considering proper order of billing, coordination of benefits and State defined fee schedules.

Forms outlining the eligibility and applicable self-pay determination will be completed upon initial appointment at a Provider site. The review and completion of these forms ensures that clients are made aware of potential responsibility for payment prior to any services being rendered and the accrual of self-pay liability. Providers must verify eligibility prior to each service.

The forms are required to be updated annually, unless client eligibility or ability to pay indicates that a change in self pay responsibility needs to be re-determined. Examples of when to re-determine client responsible amounts include but are not limited to: A change in health coverage/change in scope of coverage, a change in employment/income, a change in number of household members.

- **Financial Information Form (FIF)** – This form outlines instances when a client can accrue client and Family responsibility for payment and documents agreement of the fees and terms. This form is used to obligate the client and family for applicable self-pay liability.
- **Advanced Beneficiary Notice (ABN)** – (Attachment A) For Medicare clients only, as required by Center for Medicare and Medicaid (CMS), this document informs the Medicare beneficiary that some specialty mental health services are not likely to be covered by their Medicare plan. For example, Rehabilitation services provided by non-Medicare staff would not be a covered benefit reimbursable by Medicare (See Attachment B). The ABN instructions can be found at [www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html](http://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html)
- **UMDAP** – This form is used when it has been determined that an UMDAP determination of financial responsibility is required. The information on this worksheet including annual UMDAP amounts are to be included on the Payer Financial Information Form to obtain the applicable signatures indicating agreement to pay. This information should also be used to complete the Family Registration Form in Avatar. Instances indicating assessment of UMDAP Liability can be found in the Client and Family Liability Determination table below.

The following table outlines how to determine client and family responsibility based on Medi-Cal eligibility and scope of coverage.

**Client and Family Liability Determination**

<b>Third-party Insurance</b>	<b>Medi-care Part B</b>	<b>Medicare Advantage</b>	<b>Medi-Cal Scope of Coverage</b>	<b>Client And Family Responsibility</b>
X			Full	No Client and Family responsibility amount
			Full	No Client and Family responsibility amount
X	X		Full	No Client and Family responsibility amount
	X		Full	No Client and Family responsibility amount
		X	Full	No Client and Family responsibility amount
X			Share of Cost	Responsible for cost of services up to the Share of Cost amount <u>unless identified as Minor Consent</u>
	X OR	X	Share of Cost	Responsible for cost of services up to the Share of Cost amount.
X	X		Share of Cost	Responsible for cost of services up to the Share of Cost amount.
X		X	Share of Cost	Responsible for cost of services up to the Share of Cost amount.
X			None	Responsible for Client and Family Annual liability in accordance with UMDAP Calculations <u>unless identified as Minor Consent</u>
			None	Responsible for Client and Family Annual liability in accordance with UMDAP Calculations <u>unless identified as Minor Consent</u>
	X		None	Responsible for Client and Family Annual liability in accordance with UMDAP Calculations. May be responsible for any Medicare Co-pay amount and/or 20% of the cost of service.

\*When a client/family has indicated that they are unable to meet their Share of Cost obligation due to a financial hardship. It is appropriate to assess for UMDAP responsibility once appropriate documentation of financial hardship has been established. Beneficiaries should be encouraged to have their Medi-Cal Share of Cost evaluated if unable to afford the Medi-Cal SOC determination.

\*\*In circumstances where financial information is refused and/or benefits cannot be verified clients will incur self-pay liability up to the total cost of service. It is important to encourage clients to obtain and provide this information.

**See P&P QM-00-01 Uniform Method of Determining Ability to Pay (UMDAP) for guidelines regarding Frequency of Determination and Waiver/Fee Reduction Requests.**

**II. Collection of Self-Pay Liability:**

1. Client and Family bills are generated and sent on a monthly basis by Sacramento County Behavioral Health Services (BHS).
2. Client and Family Bills are sent via US Mail to the address on file within the Avatar system. It is the responsibility of the Provider to ensure mailing addresses are verified at each visit and updated as necessary.
3. UMDAP liability is determined for all family members receiving services and family bills based on UMDAP determination may contain information for more than one household member.
4. Client and Family bills will include any previous balance and payments made since the last statement.
5. Family bills based on UMDAP determination will discontinue once the annual UMDAP liability has been satisfied, and resume at the beginning of the subsequent determination period.
6. For bills that are returned via US Mail for inaccurate addresses, BHS Billing Service Unit will contact the provider to research and make appropriate corrections in preparation for the next monthly billing cycle. Providers will update the addresses as soon as possible to ensure subsequent mail is delivered to an appropriate mailing address.
7. Mental Health Plan Providers should not collect payment for services provided and all claims including client and family bills will be made by BHS via a central billing unit.
8. BHS Billing Services Unit will address all client inquiries regarding bills.

### III. Payment Self-pay Liability

1. BHS Billing Services Unit receives and posts payments to client accounts.
2. Payment is due 30 days from the date the statement is sent. Payment arrangements can be made by calling Member services (916) 875- 6069 or (916) 875-8853 for TTY/TDD
3. Payment can be made via personal check, cashier's check, money order or cash.
4. Checks returned due to insufficient funds will be subject to a returned check fee per Sacramento County Code 1369, Section 2.01.030 and Section 2.0.035
5. Credit/Debit cards are not accepted at this time.
6. Payment can be sent via US Mail to:  
**7001-A East Parkway Suite 500**  
**Sacramento, CA 95823**  
**Attn: BHS Billing Unit**
7. Payment can be made in person at:  
**Monday-Friday 8:00am to 3:30pm Excluding County Holidays**  
**7001-A East Parkway, Front Desk**  
**Sacramento, CA 95823**

### IV. Reversal of Self-Pay Liability

It may be necessary to reverse a client/family payment and refund self-pay monies collected. It is important to identify billing errors and resolve them as quickly as possible.

The following is a potential list of reasons that liability and/or payments may need to be reversed and refunds issued:

1. **Identification of Insurance Coverage:** If it has been determined that insurance coverage existed that was not identified prior to the client and family receiving a bill it will be necessary to reverse the self-pay liability and refund any payments made as appropriate.
2. **Retro-Active Establishment of Eligibility:** In the instances where Medi-Cal or another insurance provider issues retro-active coverage for services, it is necessary to refund monies previously paid by the client or family.
3. **Correction of Claims:** In the event clients receive a bill for a service later determined to be incorrect, all payments associated with the incorrect service should be evaluated and refunded as appropriate.

When a refund is believed to be appropriate or a billing issue is identified it is important that the Billing Resolution process be followed. This will help ensure any action necessary can occur as soon as possible. See Client and Family Billing resolution process below.

**V. Client and Family Billing Dispute Resolution:**

BHS Billing Services Unit (BSU) will identify a liaison to work with designated MHP Quality Management (QM) Beneficiary Protection staff in the event of a dispute. Dispute issues that are received by QM Beneficiary Protection will be forwarded to the BHS Billing Services Unit liaison for research, investigation and resolution.

BHS BSU will complete the following steps in their problem resolution process:

1. Verify client was eligible for Medi-Cal for the period of time services were provided and/or billed.
2. Obtain management approval to issue refund to client.
3. Adjust client account.
4. Issue payment to client.
5. Inform designated QM Problem Resolution staff, if the disputed issue was forwarded from QM, of the dispute resolution.
6. If billing error is noted, correct balance for the next monthly billing cycle.
7. Maintain a tracking mechanism for dispute resolution.

**REFERENCE(S)/ATTACHMENTS:**

- W&I Code Section 5718
- MHP Contract with DHCS
- Forms: Financial Information Form, ABN Form, UMDAP Worksheet, Request for Fee Waiver/Reduction

**RELATED POLICIES:**

- Uniform Method of Determining Ability to Pay – QM-00-01
- Conlan vs Bonta No. 03-10
- Problem Resolution No. 03-01

**DISTRIBUTION:**

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff		
X	Mental Health Treatment Center		
X	Adult Contract Providers		
X	Children’s Contract Providers		
X	Alcohol and Drug Services		
	Specific grant/specialty resource		

**CONTACT INFORMATION:**

- QMInformation  
[QMInfomration@saccounty.net](mailto:QMInfomration@saccounty.net)
- Avatar Fiscal  
[Avatar-Fiscal@saccounty.net](mailto:Avatar-Fiscal@saccounty.net)

# Attachment A

County of Sacramento Health and Human Services  
7001A East Parkway, Suite 1000  
Sacramento, CA 95823

Phone (916) 875-2002  
Fax (916) 875-1283  
www.saccounty.net

Patient Name: \_\_\_\_\_ Identification Number: \_\_\_\_\_

## Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for the service(s) listed below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the service(s) listed below.

Service(s)	Reason Medicare May Not Pay:	Estimated Cost

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the service(s) listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

### OPTIONS: Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the service(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the service(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

**OPTION 3.** I don't want the service(s) listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**Additional Information:** \_\_\_\_\_

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

## Attachment B

Services Covered	Staff Classifications for Medicare Coverage					
	Psychiatrist	Clinical Psychologist	Clinical Social Worker	Nurse Practitioner	Physician Assistant	MD, Psychiatric Resident, Licensed
Assessment <b>Without</b> Medication Services		X	X			
Assessment <b>With</b> Medication Services	X			X	X	X
Individual Therapy	X	X	X	X	X	X
Group Therapy	X	X	X	X	X	X
Group Session – Meds	X			X	X	X
All E&M Codes	X			X	X	X
Add on Psychotherapy	X			X	X	X
Interactive Complexity	X	X	X	X	X	X
Crisis Intervention (and add on code)	X	X	X	X	X	X
Crisis Residential Services	X					X

How to calculate anticipated services:

Using your contracted unit rate for those services that are not covered by Medicare, multiply by the maximum amount of time per month. This calculation must be done and included on the ABN to provide the client all available information to make an informed decision about whether to get potentially non-covered services and accept financial responsibility if Medicare does not pay.

Example:

**F. Estimated Cost**

Rehabilitation: 4 hours (240 minutes) x 1.50 = \$360.00 per month

Case Management: 5 hours (300 minutes x 1.15 = \$345.00 per month

Assessment (not by Covered Classifications): 90 minutes x 1.50 = \$135.00 per year

You can also use this formula and set a provider maximum to use on all ABN forms. For example:

Rehabilitation: Most services provided per month – 6 hours (360 minutes) x 1.50 = \$540.00

**F. Estimated Cost**

Rehabilitation: No more than \$540.00 per month