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**INTRODUCTION**

**INTRODUCTION**

The Health and Human Services Agency is responsible for management of the public mental health system for the County of San Diego. The provider network includes County operated programs and contract operated programs, which are known as organizational providers. The provider network also includes private practitioners such as psychiatrists and psychologists, which are known as individual fee for service (FFS) providers. Each of these provider groups is responsible for specific functions related to determining client financial eligibility, billing and collections. This handbook provides standardized procedures for organizational providers, who may be County or contract, operated programs. While many of the functions are the same for County and contract operated programs, contract programs have some additional responsibilities as United Behavioral Health (ASO) performs certain functions for County operated programs.

**UBH/San Diego**

UBH/San Diego provides the following financial management activities for the mental health system:

- Maintains the client and billing data Management Information System (MIS) InSyst;
- Coordinates billing and payment activities;
- Facilitates comprehensive reporting and error correction processes;
- Provides training and technical assistance;
- Monitors providers’ administrative compliance with policies and procedures; and

UBH/San Diego provides the following additional functions for County operated programs:

- Medicare, insurance and client billing, and collections;
- Correction of errors including Medi-Cal Error Correction Reports (ECRs)

Together the County and the ASO have developed the financial procedures detailed in this handbook, considered a cornerstone of the collaborative revenue enhancement efforts, with a focus on helping your program staff understand, correctly utilize, and benefit from the information management system—ultimately allowing you to better serve your clients.

This handbook is not intended to replace the InSyst Users Manual or intended to be a comprehensive “Insurance and Medicare Billing” guide. It is meant to augment existing resource materials.

For general information, United Behavioral Health, San Diego, can be reached at: (619) 641-6800.

## USING THE InSyst SYSTEM

## USING THE InSyst SYSTEM

Data entry for all client registration, episode, and service activities is done directly online using the InSyst System managed by the ASO. InSyst is a fully integrated network system that provides complete client tracking and billing functionality to authorized users, 24-hours a day, including:

- An On-line Client Locator
- Client Registration
- Assessment of the UMDAP (Uniform Method for Determining Ability to Pay)
- Online Medi-Cal Eligibility Verification
- Episode Opening and Closing Processes
- Service Recording and Historical Inquiry
- Service and Financial Reporting

The system allows for on-line financial assessments. It will perform Medi-Cal, Medicare, third party insurance, and client billing functions as well as accounts receivable and electronic payments processing. The system will also perform various validations to support accurate data entry.

### Managing Client Information

Organizational providers register clients, determine financial eligibility, and record episode and service activities through the InSyst system. For more detailed instructions on using the system, please refer to the InSyst User Manual.

### Program Set-Up

A Reporting Unit Setup/Update Form must be submitted to the ASO in order to define the program parameters correctly in InSyst. The form must be completed accurately and in its entirety for each reporting unit. It is also important that ASO be provided with any changes in the program's profile (e.g., address, services provided, billing rates, etc), at least 30 days prior to implementing the change, to ensure that the necessary system updates can be completed in a timely manner.

### User Account Set-Up

The ASO and San Diego County Health and Human Services Agency's Information Systems (HHS IS) Department coordinate access to San Diego County's computer systems. If program staff needs access to InSyst (the Mental Health Client database), an authorization form for the County (to establish a VAX account), and for UBH (to establish the InSyst User account) must be completed. Both forms can be obtained by contacting the UBH MIS Customer Service Desk at 1-800-834-3792. UBH will accept both forms for processing.

## **San Diego County Organizational Providers**

### **Adding or Changing Staff Information**

All staff that render direct or indirect client services must have a Staff ID Number in the InSyst System in order to capture the services they provide. To obtain a staff number for a new staff member, update an existing staff member's information (e.g., new licensure), or delete a terminated staff member, the Interim Access Request Form must be completed and can be obtained by contacting UBH. When adding a new clinical staff member, it is critical that information including the staff members' licensure, license number, Medicare Unique Provider Identification Number (UPIN), Medicare Provider Identification Number (PIN) and NPI number be provided to ensure accurate and appropriate claiming for reimbursement.

### **Connecting to the System**

Most County operated sites and some large contract provider sites are connected to the ASO systems via dedicated phone lines. Many sites, however, must dial into the system via modem. New providers should contact the ASO Customer Service Desk at 1-800-834-3792 to determine their best dial-in number.

### **Security and Confidentiality**

The ASO MIS and the SDMHS Client Database must be protected from unauthorized use. Only users with a business need to know, who have signed ASO Confidentiality Statements, should be permitted to access the database. All information contained in the database is confidential in accordance with California Welfare and Institutions Code 5328. Sharing of passwords or allowing unauthorized individuals access into the system is strictly prohibited. All terminals and computer screens should be protected from the view of unauthorized persons. Reports with confidential client information should be stored in a secure place and properly destroyed when no longer needed.

The ASO user authorization forms include a confidentiality statement that must be signed by the user and the Program Director.

## REGISTERING A NEW CLIENT

## REGISTERING A NEW CLIENT

Each client's identity must be established in the system prior to entering services. If the client cannot be located using the Client Locator in the InSyst system, the client will need to be registered into the system. Once the Registration process is complete, the system will assign a unique number to the client.

### Client Registration Form

The client's information may be entered into InSyst while the client is present, or a hardcopy of the InSyst Client Registration Form can be completed and entered into InSyst at a more convenient time. A copy of the Client Registration Form can be found in the Forms section (page 41) of this handbook.

To assist in ensuring that information is entered accurately, the form is divided into three separate sections to resemble the three separate screens used to capture client information in InSyst:

1. The Registration screen: used to collect general demographic data.
2. The Address screen: used to collect client address information.
3. The Significant Other screen: used to collect data on the client's significant other/emergency contact information, primary clinician or care coordinator.

In addition to using the form to record initial registration information, it can also be used to update existing information. If a hardcopy of the form is completed, it may be filed in the client's file for future reference.

Client registration should occur during the first visit to a program. If it is not feasible to complete the registration prior to or during the first visit, registration should occur no later than the next business day from the first day of service.

### Using the Client Registration Screens

To access the Client Registration screens, select "Register" from the Client Maintenance Menu in InSyst. Enter the information into the appropriate fields on the screen.

The most critical information that must be accurately entered during the initial online registration is the client's **name, birth date, and Social Security Number**. It is helpful to ask the client for a piece of identification that contains this information to verify its accuracy. Obtaining identification also ensures fictitious data is not being provided. If identification is obtained a photocopy should be filed in the client's medical record. *Once this information has been verified in the system, only the County Medical Records Department can modify it.* A Change of Information Form to modify this data is included on page 53 in the Forms section of this handbook. All other information in the client registration can be modified directly online at any time.

#### TAKE NOTE!

The most critical information you will need to enter correctly during initial registration is the client's:

- Name
- Birth Date
- Social Security Number

Once all of the required data has been entered, the system will prompt the user to verify the information and correct any invalid fields. Once the registration is complete and verified, the data is saved in the system, and a client number is displayed.

For detailed instructions on completing the InSyst client registration forms, or updating demographic information, please refer to the InSyst Users Manual.

### Opening the Episode

A client episode is the period of treatment from admission through discharge. Before service data for a client can be entered, an episode in the InSyst must be opened through the Episode Maintenance screens. In order to open an episode, a valid client and Reporting Unit number must be entered. Episodes should be opened no later than one business day after the first service.

The Opening date is a critical field. This information is reported to the State, and used in determining the Effective date of the client's UMDAP Liability period. For detailed instructions on opening an episode in InSyst, please refer to the InSyst Users Manual.

### Diagnostic Information

Diagnostic data should be provided by the clinical staff to the data entry staff in the appropriate DSM IV/ICD 9 formats. InSyst will accept any valid DSM IV codes for the appropriate Axis'.

Diagnostic information for five Axes' will also be required. On Axis I if more than one diagnosis is present, primary and secondary diagnosis must be specified. Axis II & III is optional, and is in ICD 9-code format. Axis IV is required, but only one value can be specified. The Axis V and past Axis V fields are for assessments of the client's current and past functioning using the Spitzer GAF Scale.

If the client's primary diagnosis is not determined (DSM IV V71.09) or deferred (DSM IV 799.9) at the time the episode is opened, program staff is responsible for updating the diagnostic information fields in InSyst when the diagnosis is determined. This information is critical to ensure InSyst data integrity and appropriate third party payor claiming.

### Clinician ID Numbers

Key data fields that must be entered correctly include the Clinician and Physician ID fields. The client's primary clinician/care coordinator and treating physician are captured in these fields. All care coordinators/clinicians should have a Staff ID number assigned to them. The use of generic Staff ID's is not permitted. If a care coordinator/clinician is not listed in the InSyst system, submit a request form to ASO. A copy of the New Staff/Provider Assignment requisition form can be found in the Forms section (page 38) of this handbook. All of the clinical reports sort by the Clinician ID field (Staff Caseload reports). If this field or the Physician ID field is left blank, the accuracy of claims and reports will be affected.

#### TAKE NOTE!

If the Clinician and/or Physician ID fields are left blank or filled in with invalid ID numbers, claims will be denied.

### NPI – National Provider Identifier

The NPI is a 10-digit number that will be used to identify you to your health care partners, including all payers, in all HIPAA standard transactions. The NPI has replaced the identifiers you currently use in HIPAA standard transactions that you conduct with Medicare and with other health plans. You will need an NPI prior to enrolling with Medicare. The compliance date became effective **May 23, 2007** to apply for an NPI. As of this date, the state departments of Health and Mental Health will not accept other provider numbers which effects revenue. Many questions that providers may have can be answered by the resources provided on the CMS NPI website. Their website address is: [www.cms.hhs.gov](http://www.cms.hhs.gov). Note – if you do not have an NPI, you will not be able to bill for services after the compliance date.

## San Diego County Organizational Providers

### Closing an Episode

The closing date for each episode of treatment provided in a Reporting Unit must be captured using the Episode Closing screen. Services may only be entered if the dates of service begin with the Episode Opening and end with the Episode Closing date. It is important to ensure that the Episode Opening and Closing dates are accurate. For detailed instructions on closing an episode in InSyst, please refer to the InSyst Users Manual. Episodes should be closed upon termination of treatment.

### Service Entry

Clinicians are required to provide medically necessary services to clients and maintaining accurate documentation standards in the client's medical record. Medi-Cal reimbursement criteria for Specialty Mental Health Services are set forth in Title 9. All services should be entered within one business day from the date of service. Case Management Program services should be entered within two business days from the date of service. At the end of each month, each program has five business days to ensure all services for the prior month have been entered. However, to enter services after the five-business day cut-off period, a late entry request must be made to the ASO Customer Service Desk at (619) 641-6928 to receive InSyst system authorization.

#### TAKE NOTE!

Only the Staff ID of the person actually rendering the service can be used when capturing data. The use of a Staff ID other than the person rendering the service can be considered fraudulent by third party payors.

### Service Entry Limits

No new total units may be entered into InSyst after the cut-off days for the Fiscal Years as listed on page 11 of Service Unit Deletion Limits. This restriction will assure that the PSP354 units listed for the cost report will not increase. This restriction does not apply to units which were previously entered as non Medi-Cal, but are later billed as Medi-Cal. The County may submit supplemental Medi-Cal claims for up to one year from the date of service (per State Policy).

### *Inpatient Services*

Inpatient services rendered in County operated programs are entered directly into InSyst. All services should be entered in InSyst within one business day from the date of service.

### *Outpatient Services*

All outpatient services rendered in County operated and Contractor operated programs are entered in the InSyst system. This allows ASO to provide required State Reporting, and Medi-Cal claiming. For County operated programs, this also allows ASO to process all third party claiming as well. All services should be entered in InSyst within one business day from the date of service.

### Recording Direct Services

InSyst allows direct service data entry in a number of ways:

1. *Single Service Entry* (for entry of a single service rendered to a specific client)
2. *Multiple Service Entry* (for repetitive data entry of up to 20 service lines)
3. *Daily Service Entry* (for inpatient, day treatment and 24 hour programs)

The following fields are required for entering service data in either the Single or Multiple service entry screens:

## San Diego County Organizational Providers

- Reporting Unit
- Client Number
- Service Date
- Procedure
- Staff
- Staff Duration
- Number in Group
- Location

Optional fields include Co-Staff, and Co-Staff Duration. Co-Staff is used when more than one clinician or waived staff member actively participate in rendering a service. This is most common in Group Therapy services.

The most frequent errors in recording services occur in the following situations:

- *The date of service* must be the same as, or after, the Episode Opening date, or the same as, or less than, the Episode Closing date, for the specified Reporting Unit.
- *A valid Clinician ID* must be entered in the staff fields. Generic Staff ID's should not be used. If the program utilizes interns, temporary, or per diem staff, a Staff ID form to add the staff member to InSyst must be completed and submitted to ASO.
- *Duration of time is in hours: minutes.* This is especially important when recording data for Group services. The Staff duration for group is Preparation time, Group time, and Charting time. Do not calculate the amount of time per client, the system will calculate this based on the Number of Staff, multiplied by the duration, divided by the Number in the Group.
- *Number in Group will default to 1.* This only needs to be changed if recording Group services. When recording Group services this should reflect how many clients actually attended on the date specified (not how many should have attended).
- *Location.* The system default is code 1 "Office". This is an extremely critical field for claiming and State reporting requirements. It indicates where the service physically occurred. Currently there are 9 valid codes that can be entered here, so please ensure the accuracy of this field before confirming the service data. Additional location codes are listed in Appendix E of the InSyst Users Manual.

### TAKE NOTE!

Do not calculate the amount of Group time per client. The InSyst system will calculate this based on the information entered.

The *Multiple Service Entry* screen makes it easy to enter repetitive data (i.e.: enter a number of services for one client or one staff person, or enter one type of service for a day, or record Group services). It allows the creation of user-defined defaults that populate the repetitive data fields automatically. When using this screen please remember to enter the letter "W" at the end of each line of service data to be saved. Please refer to the InSyst Users Manual for detailed instructions on using the service entry screens.

Information can be updated through the *Service Maintenance* screen, including staff, duration and location within fourteen days from the date of entry. Supervisor authorization is required to change the service date and procedure code. The client, reporting unit number, or service cost cannot be modified. If that information is not correct, the service data must be deleted and re-entered with the appropriate information.

The *Daily Screen* is used to capture Inpatient, Day Treatment, or Crisis Residential Program services. When the Date of Service and the Reporting Unit Number is entered, the system searches for all clients with an open episode as of the service date specified. The system will automatically populate the procedure code field. The user is responsible

### TAKE NOTE!

There is only a (14)-calendar day window from the date of entry in which to correct service data that has been saved in the system.

## San Diego County Organizational Providers

for validating the information displayed. This particular service entry screen does not allow for late data entry, therefore services that have not been entered by the cutoff date (usually the 5<sup>th</sup> working day of the month), must be entered via the Single or Multiple service entry screens.

### Recording Indirect/MAA Services

Senate Bill 910 enabled California local governing agencies to request federal reimbursement for certain Medi-Cal Administrative costs, effective July 1, 1992. This reimbursement process later became known as Medi-Cal Administrative Claiming (MAC). Effective 1995 this program was renamed to Medi-Cal Administrative Activities (MAA). The activities reimbursable under MAA include Medi-Cal and Mental Health Outreach, Screening and assisting with the application for Medi-Cal, Intervening in a crisis situation by referring to mental health services for non-open cases, Case Management of non-opened cases and Training for MAA related activities. Program planning and Contract Administration, can be claimed by County staff only.

In order to claim MAA, the Centers for Medi-Cal and Medicare (CMS) requires that each participating mental health claiming unit submit a comprehensive mental health MAA claiming plan as specified in the California Department of Mental health instruction manual. Prior to submitting claims for reimbursement the claim plan must be approved by the State Department of Mental Health and CMS.

In order to ensure all activities reimbursable under MAA are claimed they must be entered in InSyst. There are two types of Indirect Services Screens in InSyst, Summary screens and Detail screens. The Summary screen is used to collect hours of service performed by staff members on behalf of their programs. The recipient of the service is not a registered client. Up to 10 services can be entered at a time for a single staff member using this screen. The detail screen is **only** used to capture individual services for Alcohol/Drug programs. For detailed instruction on using the Indirect Service entry screens, please refer to the InSyst Users Manual.

### Service Deletions

As of April 1, 2007 providers will be able to self enter service deletions up to 14 calendar days after the date of services entry. After 14 days, any service deletions are restricted to the HHSA/FSSD MH Billing Unit. This is a change from the 7 days which was the current standard. A “*Service Deletion Request*” Form must be submitted electronically to the Financial Management Unit at “[Marie.Lopez@sdcounty.ca.gov](mailto:Marie.Lopez@sdcounty.ca.gov)”. Verbal requests cannot be accepted. Please note that if the HHSA/FSSD MH Billing Unit receives a request to delete a service that has already been billed then the HHSA/FSSD MH Billing Unit will also enter a disallowance in to the DCS as well as completing the deletion. Deletion requests should be limited to errors in data entry. Deletion request for service that occur more than 30 days after the service has been entered will often result in a disallowance as the service has most likely been billed.

### Service Deletion Tips

Data Entry errors are the most common identified errors. Most of these type errors should be identified within 14 days from the date the service was provided and corrected at the site by entering a deletion and the correct service. Data entry errors identified after 14 days and prior to the deletion cut-off date must be processed as a service deletion and the correct service re-entered. If the service has already been paid by Medi-Cal and the deletion is received within the cut-off date, the service will be deleted and disallowed and the correct service must be entered. If you do not re-enter the correct service, then the County will not be reimbursed for the service provided and the total unit of services for that provider will be reduced. If the data entry error is submitted for processing after the deletion cut-off date and a Medi-Cal paid service, the service will be disallowed and no deletion or re-entry of the correct service will be allowed. The most common data entry errors are listed below and suggested tips to avoid having to submit a correction:

## San Diego County Organizational Providers

- **The wrong date of service** – order MHS808 report daily, this report show all services entered for the data entry date, compare it against the billing logs.
- **Duplicate billing** – order MHS801 report daily, this report is detailed by service date. If a service is showing for the same therapist, same procedure code and same time, check with therapist to verify that a duplicate entry was not entered. Pay attention to duplicate entry alerts and follow up with therapist.
- **Wrong procedure code** – order MHS808 report daily, review it at least weekly, it shows how services were entered, compare what was entered to what was on the billing log. Clearly identify AB2726 services provided.
- **Wrong Therapist** – Order MHS801 and MHS808 reports and check billing record to confirm that the services were entered under the correct therapist. Clinical staff should review their activity report to ensure all clients and services listed were provided.
- **Wrong time entered** – Clinical staff should double check progress note to ensure that the correct time is recorded on billing record and write legible, data entry staff should order the MHS808 report daily and compare the amount billed against the billing log . Group services should be reviewed prior to data entry.
- **Wrong Client** – Data entry staff should confirm prior to submitting the billing that the client name and number matches. Check daily reports 801 and 808 to ensure that the client name and ID number matches. Pay attention to alerts. When confirming Medi-Cal eligibility check to ensure client name and ID number matches.
- **Wrong RU** – Review the PSP131 report that can be provided daily or MHS 831 report available twice monthly that provides a summary of services provided by a program and sorted by procedure code.
- **Wrong location code** – If a therapist provide services routinely at more than one location and did not specify, don't assume, check with therapist and require that location be provided on billing record.

### Service Unit Deletion Limits

The following dates are in effect as of December 5, 2007:

FY 05/06 or any prior fiscal years – Effective immediately, no service deletions accepted

FY 06/07 – the deletion cut-off date will be December 31, 2007

FY 07/08 – the deletion cut-off date will be October 15, 2008

Future years – October 15<sup>th</sup> will apply to all until a new process is in place

These deadlines will allow time for deletions to be made before the InSyst PSP354 report is generated for the State Cost Report. Any deletion submitted after the cut-off dates for a Medi-Cal paid service will only be processed as a disallowance, including billing errors found through a Quality Improvement (QI) Audit, provider Self-Report, a State Review, an EPSDT Audit or a Special Investigation.

### Disallowances

As of April 1, 2007, Provider Self-Report Disallowance and Deletion form shall be sent by email to the Financial Management Unit at “[Marie.Lopez@sdcounty.ca.gov](mailto:Marie.Lopez@sdcounty.ca.gov)”. FMU will review these forms. Incomplete forms will be sent back to providers. Requests for Disallowances that are received after a program has been informed of an EPSDT or QI Audit will not be processed. Provider may resubmit after the EPSDT or QI Audit is completed. If the disallowance is discovered during an audit, please do not re-submit, the QI unit will submit the paperwork for the disallowance. FMU will forward the completed forms to the HHSA/FSSD MH Billing Unit to be entered into the Department of Mental Health Disallowed Claims System (DCS).

## San Diego County Organizational Providers

FMU will send a notice to providers regarding the status of their disallowances:

- Items that have not yet been billed to Medi-Cal will not be disallowed but will be deleted and will be noted as “NB” (not billed).
- Items that have been billed to Medi-Cal but had errors that caused the services to be denied or pending will not be disallowed or deleted and will be noted as “NF-ECR” (not found – check ECRs).
- Items that have been billed to Medi-Cal but have not been approved and paid will be disallowed and deleted if they are approved and paid. “NAP” (not approved and paid). The HHSA/FSSD MH Billing Unit will retain information regarding these items until they appear in the DCS.
- Items that cannot be found in InSyst and /or the DCS will be noted as “NF” (not found) and will not be disallowed or deleted.

**Please note that all services that are disallowed will also be routinely deleted in InSyst by the HHSA/FSSD MH Billing Unit. Providers should not send a separate request to delete these services.** Providers are required to enter correct service data into InSyst after they have confirmed that items listed on the Provider Self-Report Disallowance and Deletion forms have been deleted from InSyst. Providers will be monitored to ensure that services are not being entered prior to service deletion. Providers should allow at least 21 calendar days for requests to be processed. Providers will be informed by the SDCMH Contracts Unit regarding reimbursing the County for disallowed services.

### Data Entry Reconciliation Process

To ensure all services have been properly entered an MHS 801, or MHS 808 Report should be generated each day for each reporting unit. The source documents for data entry should be compared against the reports to verify the data captured is accurate, and that all services have been entered. For additional information on performing the daily data entry reconciliation process, please contact the ASO Customer Service Desk.

#### TAKE NOTE!

MHS 801 Report can only be ordered overnight and after posting is completed for the day to be reconciled.

### Determining Financial Eligibility

In accordance with State Welfare and Institutions Code 5717 and 5718, all clients who are residents of the State receiving community mental health services, including involuntary admissions, are to be charged a fee according to their ability to pay, utilizing the Uniform Method to Determine Ability to Pay (UMDAP) Fee

Schedule. All programs must enter the financial eligibility information into the system to ensure accurate posting of services and reporting.

Government Code Sections 240-245 and SD County Admin. Code Section 240.4: UMDAP does not require that a person have a specific period of residence in the County or State to qualify for services, therefore, intent to reside will be considered a necessary condition for the client's liability to be determined by UMDAP. Without intent to reside, the client must be billed at full cost. Any client residing out of state (including foreign national regardless of citizenship) will be billed in full. The client's verbal declaration is sufficient to decide place of residency.

In accordance with Federal, State and County policy, persons who are known to be undocumented immigrants are eligible only for emergency services, i.e., services provided by an acute hospital or Emergency Psychiatric Unit (EPU) or the Emergency Screening Unit (ESU).

Following an initial client screening process in which financial information is gathered, the three Financial Information screens in the InSyst system must be completed:

1. Special screens for California Mental Health information under Uniform Method of Determining Ability to Pay (UMDAP) (Financial, Account): Income, allowable expenses, and family size are captured in this screen. The client's fee is calculated using this information.
2. Standard Financial Liability screens for Medi-Cal information (Financial, Eligibility, Medicaid): Medi-Cal eligibility records are inserted and maintained in this screen.
3. Medicare, and private insurance coverage information (Financial, Eligibility, Policy): Private Insurance and Medicare policy information is inserted and maintained in this screen.

**TAKE NOTE!**

If the financial screening forms are not accurately entered in InSyst, it may affect the system's ability to accurately claim for reimbursement and affect your program's revenue.

Based on the information entered, the InSyst system will automatically calculate the client's annual UMDAP liability. For detailed instructions on completing the InSyst Financial forms, please refer to the InSyst Users Manual.

Programs should routinely calculate UMDAP for *every* client prior to or during the first visit, as the annual UMDAP liability is due and payable by the client at the time of service. When a client visits a program for the first time, they must complete a Payor Financial Information (PFI) form, which identifies any available payor sources, and based on the sliding scale fee, is used to determine the amount the client or responsible party is obligated to pay for services. A copy of this form in English is located on page 44; there are copies of Spanish, Vietnamese, and Arabic on pages 45-47 in the Forms section of this handbook.

The financial screening process is required whenever there is a change in the client or family's income or allowed expenses. At minimum, it must be completed annually on the anniversary of the initial mental health screening.

**TAKE NOTE!**

For homeless clients, please be sure to mark the "Bad Address" field with an "X".

## San Diego County Organizational Providers

### Calculating UMDAP

UMDAP is determined by income, asset determination, allowable expenses, and family size, so it is imperative that it be as accurate as possible. Note: When calculating an UMDAP in InSyst using the payor screen, the number of dependents must include all children under 18 and parents.

Income includes gross monthly wages and/or salaries of all members of the family group. Under “other income” be sure to record total incomes from dividends, interest, rentals, support payments, and any other source of income.

Asset determination includes recording all liquid assets, such as savings accounts, stocks, bonds, and mutual funds. To determine the amount of the “excess liquid assets,” determine the total value of all of the liquid assets. Subtract the allowance from the “Schedule of Asset Allowances” included on the “State Department of Mental Health Uniform Patient Fee and Asset Allowance Schedule”. A copy of the schedule is located on page 59 in the Forms section of this handbook. Divide the remaining total of the liquid assets by 12 and apply the result to the monthly income of the family unit.

The only deductions from gross income allowed are:

- Court ordered obligations paid monthly
- Monthly child care expenses necessary to maintain employment
- Monthly dependent support payments
- Monthly medical expense payments
- Monthly mandated deductions from gross income for retirement plans

Subtract the total of the allowable monthly deductions from the total monthly income. The result is the monthly-adjusted gross income of the family unit. Use this information, as well as the number in the family unit to determine the UMDAP liability using the “State Department of Mental Health Uniform Patient Fee and Asset Allowance Schedule” included in the forms section of this handbook.

Program staff has the authority to request verification of any financial information given by a client or responsible party. In making an inquiry to sources other than the client or responsible persons, care must be exercised to insure confidentiality requirements (Welfare and Institutions Code, Section 5328). Obtaining a signed Authorization to Release Information is recommended when verifying information with sources other than the client. The State Department of Mental Health Revenue Manual lists the following sources for verification of financial data:

- Income Tax Returns
- Drivers License or State-issued Identification
- Unemployment Documents
- Current Earnings Statements
- Employer Identification Card

The client or responsible party must be informed of the amount of the financial responsibility assessed and a payment plan established. The agreed upon payment plan is to be recorded onto the PFI. A copy of the PFI should be provided to the client and/or Responsible Party to serve as confirmation of the payment agreement. The client must also be informed of their responsibility to inform program staff or the HHSA/FSSD MH Billing Unit of any change in financial circumstances.

Section 2.3.04 of the State Department of Mental Health Revenue Manual states that a client or responsible party has the right to refuse to give financial information; however, if such refusal is made, the client or responsible party shall be liable for the full cost of services received.

#### TAKE NOTE!

In programs using the InSyst system, the UMDAP liability will be automatically calculated when you populate the three financial screens previously discussed in this handbook.

## **San Diego County Organizational Providers**

### **Determining Responsible Party**

It is the responsibility of the person interviewing the client and completing the UMDAP to accurately determine and confirm who the responsible party is. If the client is being seen by someone other than the person performing the UMDAP, such as with case management cases, it is the staff person gathering the information from the client responsibility to **share** information regarding who the responsible party is and address to the UMDAP worker or any other staff who would be inputting account information into InSyst.

The locator screen should be reviewed when completing an UMDAP to determine if more than one person is linked to an account and the age of the client. If the client is the only person linked to the record and has turned 18 and his parent is showing as the responsible party, update the account to reflect the client as the responsible party. The only exception would be, if the client was included in the UMDAP as a minor and turned 18 during the UMDAP year and his parent has signed as the responsible party for that UMDAP period, do not change the responsible party information until the next UMDAP period. IF multiple persons are linked to the account such as siblings or parents, contact the HHSA/FSSD MH Billing Unit who will do the appropriate adjustment to assign the client a new account number. Remember, always check and reaffirm who should be recorded as the responsible party, if the client is divorced and the ex-spouse is showing as the responsible party, update the account to reflect the client as the responsible party. Note: All account adjustments should be completed by the HHSA/FSSD MH Billing Unit.

### **Collecting and Depositing of UMDAP Fees**

Effective July 1, 2008, the County of San Diego's Health and Human Services Agency (HHSA), Financial Support Services Division (FSSD) – Mental Health Billing Unit assumed the responsibility of billing mental health clients for contracted programs for their UMDAP balances.

Prior to July 1, 2008, contract providers were responsible for both the billing and collection of client fees (UMDAP balances). County-operated programs on the other hand, are currently responsible and will continue to be responsible for the collection of UMDAP fees while HHSA FSSD Billing Unit is responsible for the billing of client fees on UMDAP balances.

Mental Health Programs are the first-line and sometimes the only connection a client may have contact with; therefore, it is in the clients' best interest to pay for services where the services are rendered. Contract providers will not be required to send a patient statement to the client.

When a client is present at a program and would like to make a payment, the provider will allow the client the following three options:

#### **Options for Collection of Client Balances (UMDAP's)**

Option 1:

Client pays the Contractor for client balance or UMDAP and the Contractor deposits the money into the County's Wells Fargo Bank Account.

Deposit slips are identified by Legal Entity name and Legal Entity Number. Please use only the deposit slips supplied specifically for your Legal Entity. You may contact the Mental Health Billing Unit at (619) 338-2612 for questions and when your supply of deposit slips run low.

It is imperative that client payments are entered into the Mental Health MIS system in a timely manner, so that client accounts reflect a correct balance due. Therefore, deposits of client payments will be made on a daily basis, or weekly as appropriate and copies of the deposit information, client payment information, etc., will be forwarded to the FSSD MH Billing Unit daily, or weekly, as well.

## San Diego County Organizational Providers

The following procedures for depositing collections apply to both County and Contract programs:

1. Upon receipt of payment for client fees (cash, check or money order), indicate the client's InSyst number in the upper right hand corner of the check, money order or cash payment receipt.
2. Prepare a deposit slip and make a copy.
3. Deposit the collections to the nearest Wells Fargo Bank in your area.
4. Submit the following to HHSA/FSSD MH Billing Unit at the following address:

HHSA/FSSD MH Billing Unit  
PO Box 129153  
San Diego, CA 92112-9153  
Or at Mail Stop W403

- a. Copy of the check, money order or cash receipts
  - b. Copy of deposit slip
  - c. Collection of Client Accounts Log (found on page 58)
5. Collections should be deposited to the bank on a daily basis, or weekly if:
    - a. The aggregate of money collected is less than \$100.
    - b. The headquarters of the office or employee making collections is so located as to make daily deposit infeasible

### NOTE:

Offices or employees exempted from the daily deposit requirements will deposit accumulated collections on the last work day of each week, and by the last work day of the month. Checks and money orders should be made out to the "County of San Diego".

### Option 2 (Contractor Only Option):

Client pays the Contractor for client balance or UMDAP and the Contractor deposits the money into their own private bank account and writes a check to the County for the money received.

### Procedure:

Contractor provides their original check, collection log (found on page 58, if applicable) and copy of the client's checks/money orders to the HHSA/FSSD MH Billing Unit for processing within InSyst.

### Note:

As stated in Option 1, providers must deposit payments timely and forward the client payment information along with the check to the HHSA FSSD MH Billing Unit daily or weekly as well.

### Option 3:

Client presents at the Contractors program with a client payment and the Contractor provides the client with a self stamped envelope for the payment to be mailed to the HHSA/FSSD MH Billing Unit. When choosing this option, programs are required to assist the client with ensuring that the method of payment clearly identifies the client (InSyst or Account ID).

## Medi-Cal Referral Review

When UMDAPing clients, a review should be conducted to determine if they are potentially eligible for Medi-Cal. Any client who fit into the following categories has potential Medi-Cal eligibility and a Medi-Cal referral should be made.

1. An individual who is under the age of 21 may qualify for Medi-Cal, a referral would be appropriate if the child:
  - Do not have any other Health Insurance

## San Diego County Organizational Providers

- Maybe eligible to no SOC Medi-Cal
2. A parent or caretaker relative, who have children under the age of 21 living in the home and some type of deprivation exist.
    - Absence
    - Deceased
    - A disabled parent
    - Unemployed or (underemployed – depends on hours worked and income earned)
  3. Individuals between the ages of 21 and 64 who have consistently received mental health services for one year or longer and continues to be disabled and has not been denied SSI or Medi-Cal with the last Year.
    - A referral to SSI/SSP
    - A referral to Medi-Cal
  4. Individuals who are disabled or blind and/or receiving Social Security Disability Benefits who do not have Medi-Cal.
  5. Anyone 65 and over.
  6. Anyone who is pregnant.
  7. A pregnant woman and children under the age of 19 can qualify for Healthy Families if their income is too high for no SOC Medi-Cal for a small monthly premium.

See attached listing on page 59 for information regarding phone numbers and locations to apply for Medi-Cal and SSI/SSP.

### Screening for Other Potential Payor Sources

During the course of conducting the financial screening, program staff are responsible to review the information provided, to determine if the client may be eligible for a third party payor source such as Medi-Cal. If the client appears to be eligible, program staff is responsible for making the appropriate referrals and/or assisting clients with the application. ASO will assist programs in this function by providing a screening form and resource guide.

### Assignment of Insurance Benefits

In accordance with California State regulations, Medicare and/or other insurance must be billed prior to billing Medi-Cal. Contracted providers are responsible for all billing to Medicare and private insurance independently. The County Mental Health Billing Unit is responsible for billing Medicare and private insurance for County operated programs only.

In order to bill Medicare and/or other insurance companies, a signed “Assignment of Insurance Benefits” (AOB) is required. The client or responsible party has the right to refuse to sign the assignment of benefits, however, if such a refusal is made the client or responsible party shall be liable for the full cost of services received. An AOB authorizes the HHSA/FSSD MH Billing Unit or the contract provider to submit claims for reimbursement on behalf of the client and to receive payment directly. A “Release of Information” form should also be completed to allow the HHSA/FSSD MH Billing Unit to provide any clinical information required for claims processing by the third party payor. A copy of the front and back of the insurance/Medicare card

**TAKE NOTE!**  
Medicare requires that the client’s name appear on the claim EXACTLY as it appears on the Medicare Identification card. Please verify the spelling of the client’s name in InSyst against the Medicare ID card and request any necessary corrections.

## **San Diego County Organizational Providers**

should be made for both the Medical Record and for the HHSA/FSSD MH Billing Unit or contracted provider-billing department.

The AOB should be obtained during the first visit and updated every two years on the anniversary of the client's first visit or whenever a change in insurance has occurred. Each County and Contracted site is required to have the client fill out an AOB when the client first begins receiving services. If a signed AOB is recorded as received by a program, a copy of the signed AOB can be requested when the client begins receiving services from another County or Contracted Provider. The HHSA/FSSD MH Billing Unit does not collect Medicare and private insurance for contracted sites. A signed release of information form must be signed by the client and kept by each program that may be verifying insurance information. An English copy of the form to be used by County and contracted staff is located in the Forms section on page 49; also, the form is now available in Spanish, Vietnamese, Arabic and Tagalog on pages 50-53 of this handbook.

For the following payor types, please use these guidelines in completing the AOB:

### ***Insurance***

- Copy the front and back of the insurance card;
- Verify the insurance company's requirements regarding the effective period for the Assignment of Benefits/Release of Information. Some carriers require an Assignment of Benefits/Release of Information signed at each visit, while other carriers require it annually. This verification can be accomplished by calling the telephone number listed on the client's insurance identification card. Once obtained some insurance companies don't require an updated assignment of benefits or release of information, in this case a new one should be obtained every two years.
- To ensure the validity of the client's identity, obtaining a copy of the client's State issued identification is recommended.

### ***Medicare Beneficiaries***

- Copy the front and back of the client's Medicare card;
- Verify eligibility date of Part A and B coverage. If the client has only part A or part B coverage, it must be consistent with the service being provided in order to receive reimbursement from Medicare. Part A coverage is only for inpatient treatment and Part B is for outpatient treatment;
- Obtain the client's signatures on Assignment of Benefits and Release of Information forms.
- To ensure the validity of the client's identity, obtaining a copy of the client's State issued identification is recommended.
- The client's address must be entered into InSyst accurately. If a client is homeless or an address is not available, please mark bad address.
- A current address is needed in order to bill Medicare.

## **Overview of Financial Eligibility and Billing Process for Clients with Medi-Cal and Other Health Coverage Insurance (OHC):**

**Organizational providers are contractually responsible for billing primary Other Health Coverage (OHC) for clients who have Medi-Cal as a secondary payor and below are steps to take that allows Medi-Cal claims to be reimbursed;**

### **Steps to complete on new clients –**

1. Ask the client if he/she has OHC

## **San Diego County Organizational Providers**

2. Determine Medi-Cal Eligibility in InSyst and Insert Medi-Cal eligibility and verify OHC is active
3. Medi-Cal eligibility can be checked in InSyst from the main menu and EVC number verified
  - Financial Maintenance Menu
  - Eligibility Maintenance Menu
  - Medicaid Eligibility Maintenance
4. Check the Medi-Cal aid type to ensure it is an acceptable aid type for your program
5. Request a copy of the OHC ID card- Front & Back
6. Get a signed Assignment of Benefits (AOB) /Release of information form
7. If the OHC information is not showing in InSyst, input OHC information in InSyst using the date the client began receiving services at your program and an episode was opened
8. Mark the 3x's to confirm receipt of a signed AOB and to allow for the appropriate creation of claims lines in InSyst for OHC services.
9. Check to see if the client is receiving care somewhere else – coordination of benefit and notify that program of the OHC and that you have receipt of an AOB
10. Send claims to OHC using a CMS 1500 form and wait for a response in writing, an explanation of benefits (EOB).
11. Follow-up with the OHC until a response is received
12. Insert payment or denial in InSyst from OHC EOB to allow Medi-Cal to be billed as secondary payor.

## **Steps to complete when OHC is not identified upfront –**

1. Review MHS 115/116 report to identify clients with OHC, these reports show claim lines created in InSyst for clients whose OHC may have been determined in another program.
2. Review ECR report to identify claims in suspense due to OHC
3. Flag chart to alert staff, when the client comes in for the next visit, an AOB needs to be signed
4. Contact client by phone or mail to get AOB and release of information signed
5. If the name and address of the OHC is known, enter the OHC information in InSyst using the date your program opened an episode without marking the 3x's until AOB received
6. After confirming Medi-Cal eligibility in InSyst and OHC is populated and you are not able to identify the carrier, contact ASO for assistance
7. Check to find out if the client is receiving care somewhere else and if they have recorded receipt of an AOB.
8. Remember AOB's are universal and a copy can be shared with any program that the client is receiving services in San Diego County.
9. Once signed AOB is received, mark the 3x's in InSyst
10. Send claims to OHC using a CMS 1500 form and wait for a response in writing, an explanation of benefits (EOB).
11. Follow-up with the OHC until a response is received
12. Insert payment or denial in InSyst from OHC EOB to allow Medi-Cal to be billed as secondary payor.
13. If OHC information was identified on an ECR, correct ECR and turn into ASO to forward to DMH to allow Medi-Cal billing.
14. If it is past 96 days and the claim was denied, re-bill manually using DMH 1980 form – Medi-Cal can be claimed up to a year from the date of service

## San Diego County Organizational Providers

### Trouble shooting Tips –

1. Include an **AOB** form in all intake packets and make it a standard practice to have every client sign it at first visit. Explain to clients upfront, that you are having them sign the AOB, just in case it is identified that they have OHC.
2. When confirming Medi-Cal eligibility and it is identified that the client has OHC, insert the policy information right away in InSyst, to prevent ECR errors.
3. Review 115/116 report regularly to identify clients with outstanding claims lines and follow-up with the client to get the AOB signed or complete insurance information to allow billing.
4. When it is known that a client has Other Health Coverage and the program has a signed AOB on file, prior to providing services, contact the insurance company to get a pre-authorization, without a pre-authorization most insurance company's will not pay.
5. The longer the account is outstanding, the harder it is to collect on accounts and Medi-Cal will only pay up to a year. It is best to resolve outstanding issues as soon as possible.
6. Once an OHC error is identified on the ECR, the timeframe to fix the error is shortened and the claim could be denied requiring manual re-billing, therefore, when confirming Medi-Cal eligibility and OHC is identified, insert the policy information, following the steps above.
7. When claims are submitted to insurance companies follow-up within a reasonable time and keep contacting the OHC claims department until you receive a response.
8. If a program has documentation that numerous attempts have been made to obtain payment or denial from the primary OHC, and has not received a response and the provider has already received written confirmation from the primary payor that the service type/provider or location is not eligible for reimbursement, Medi-Cal may be billed as a secondary payee. The written documentation must be readily available in case of an audit.

### Special Issues/EPSDT Revenue Risk Contracts only –

1. EPSDT programs should pay careful attention to the aid type and confirm that the aid type is a Medi-Cal payable aid type or revenue could be lost. Example – Minor consent aid type 7P, is not eligible for EPSDT.
2. IF EPSDT program can't bill Medi-Cal because of a primary payor and no AOB received from client, the EPSDT provider will not be reimbursed for services that were not reimbursed by Medi-Cal. (loss of revenue)
3. AB2726 clients do not have to allow billing to their OHC and cannot be held responsible for payment of AB2726 services, therefore, EPSDT providers will not be reimbursed unless the primary payor claim has been resolved and will not be reimbursed for AB2726 services. Please refer to the Financial Billing Manual if you have questions.

### Process for Determining Medi-Cal Eligibility

InSyst Registration data is compared against the State Medi-Cal Eligibility Data System (MEDS) on a monthly basis to capture Medi-Cal Eligibility information. For records with 100% matching criteria (Name, Date of Birth, and SSN), eligibility records are automatically written to InSyst. If only 2 out of the 3 data elements match, a work file called the "Partial Match Report" is created. The Reimbursement Unit is responsible for correcting the Partial Match Report. Since discrepancies from MEDS require manual

**TAKE NOTE!**  
Medi-Cal requires the entry of the Beneficiary Identification Card (BIC) issue date as a method to combat fraud. It is important the program staff obtains a copy of the client's BIC and enters the accurate issue date to assist the State in this endeavor.

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correction, it is imperative to ensure correct and valid information at the time of initial registration.

Medi-Cal Eligibility records that are not captured automatically through the MEDS process must be recorded in InSyst by program staff.

To Check Medi-Cal eligibility in InSyst from the main menu:

1. Financial Maintenance Menu
2. Eligibility Maintenance Menu
3. Medicaid Eligibility Maintenance

Enter client's number – hit enter, if eligibility has already been verified for the month of service tab down to the month/year and enter "L" to look. Make sure that there is an EVC number. If no EVC number is present, there is **no** Medi-Cal eligibility for that month, enter "gold E" to exit. **Do not verify Medi-Cal eligibility for the month of service if it has already been verified.** If you are in the insert mode just read the eligibility message, do not confirm the eligibility at the bottom, enter "Gold E" to exit.

If eligibility has **not** been verified for the month of service, return to Medicaid Eligibility Maintenance, enter "Gold I" this will place you in the eligibility insert screen. Follow procedures below:

1. Enter client's number
2. Enter your reporting unit (RU) – hit enter
3. You are now at the eligibility number – if you have a copy of the card verify the eligibility number, if it is incorrect, you can type over to correct it.
4. Tab over to eligibility month enter the month & year of service you want to verify.
5. Tab over to card issue date (if you have a copy of the BIC card, use the issue date on the card) if not, enter the current date.
6. Tab over to the "Special Reason Code field", **if** the eligibility period being verified is for a **prior** month enter an "A" if not just hit enter.
7. At bottom of screen, Form OK: place a "Y" then hit the enter key. Wait a few seconds and the eligibility information will appear on screen.
8. The EVC number will be blinking (do not change any of the characters). Hit the enter key, this will take you to the bottom of the screen.
9. At the bottom of screen, it will ask to confirm: place a "Y" then hit enter key, you will then get a message successful insert (print copy of screen and attach it to your data.

Note: If "**No**" recorded eligibility for the month of service shows up, it will give you a message. For example: check for possible difference in birth date or social security number. It could be a variety of reasons why there is no recorded eligibility – you may have to call the client, the client's social worker, the responsible party or if child the client's parent to verify the information.

- InSyst will compare the data against the State Medi-cal eligibility file and will populate the following fields if the client has recorded eligibility for the month of service entered.

### TAKE NOTE!

Eligibility  
Verification  
Confirmation (EVC)  
number must be  
populated before  
confirming Medi-Cal  
Eligibility in InSyst.

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File Edit View Tools Session Options Help

**Eligibility Insert**

Client Number: 123456      RU: 987445      Eligibility Number: 90000000A

Name: Sue G Recipient	Birthdate: 05/20/1993	Sex: F
Social Security Number:	Sensitive:	CSI M/C:
Eligibility Period: 11/2007	Special Reason Code: A	EVC Number:
Card Issue Date: 1 /24/2008	Confirm Now: Y	Cnty Code: 37    Aid: 30
Street No.: 3255	Direction:	Name: Camino Del Rio S
City: San Diego	State: CA	Zip Code: 92108
	Type:	Apt:
	Ph #:	

PRIMARY AID CODE: 30. BIC: 90000000A95001 . ISSUE DATE: 20060907.

Confirm:      Confidential Information      USER:      Function

Confirm the EVC number.

1 (008,069)

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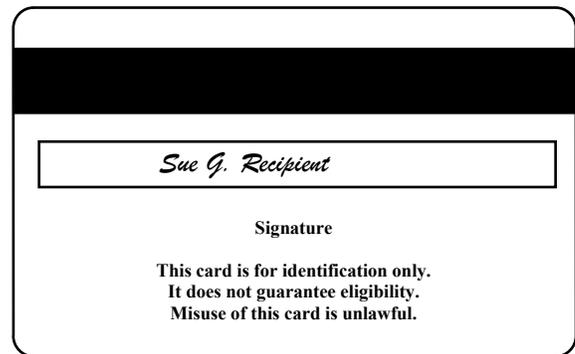
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- Eligibility Verification Confirmation (EVC) Number
- County Code (37 is San Diego County)
- Aid Code
- Determine if clients' aid code is appropriate for service. Please refer to the Department of Mental Health and Alcohol Drug Program Aid Codes Master Chart.
- Informational message that may contain Medi-Cal share of cost data.
- Beneficiary ID Card Number (BIC) which is the number on the Medi-Cal Card or Client ID number (CIN) the first 9 characters of the BIC and Issue Date.
- As of February 1, 2008 the State requires providers to bill for Medi-Cal Services using the BIC or CIN. It is prohibited to use the Social Security Number (SSN) for verification and billing.
- The eligibility Insert screen should contain the BIC or CIN. If the SSN numbers appears in the upper right hand corner of the "Eligibility Insert Screen; the provider should enter the CIN or BIC if known by typing over the SSN.
- Providers should keep a copy of the BIC on file and when the SSN appears replace with the first 9 numbers on the BIC. When there is no record of a BIC on file and the SSN is showing the Eligibility number field, providers can obtain the BIC number from the Medi-Cal eligibility screen in InSyst by entering the SSN in the InSyst system which will prompt a message at the bottom of the screen showing the BIC number. Note- the SSN number should only be used when trying to confirm the BIC. Do not confirm this transaction just copy the BIC, paste over the SSN with the CIN- first 9 characters of the BIC and refresh (Ctrl R) the screen. See copy of card below.

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**Gender**                      **Date of Birth**



- Note – you should always confirm Medi-Cal eligibility. The BIC is a Medi-Cal ID card only, and the BIC number is assigned exclusively to that individual; however, having a card does not confirm Medi-Cal eligibility.
- Determine when the client's share of cost has been met (*InSyst will provide the amount of the total Share of Cost and the current amount required to meet the Share of Cost*).
- If the share of cost has been met, confirm the eligibility record.
- If the share of cost has not been met, compare the share of cost amount to the current month total cost of service amount. Do not enter "Y" on confirm. If the current month total cost of service exceeds the share of cost, the share of cost can be cleared. For more information on Share of Cost, please refer to the next section of this handbook.
- The informational message may also contain primary insurance coverage data including the carrier name and policy identification number. Primary insurance information obtained from this process must be entered into InSyst through either the Financial Account Financial Information (FAF) screen or the Financial Eligibility Policy (FI EL POL) screen. The primary insurance information that cannot be obtained from the Medi-Cal eligibility screen such as insurance address and policy effective date, and a signed AOB, must be obtained from the client or responsible party.

### *Medi-Cal clients with a Share of Cost*

Medi-Cal offers health care coverage to individuals and families whose income exceeds the maximum allowable. Medi-Cal requires some of these beneficiaries to contribute to their health care by paying a share of the cost for the services they received.

Share of Cost is a term that refers to the amount of health care expenses a beneficiary must accumulate each month before Medi-Cal begins to offer assistance. Once a beneficiary's health care expenses reach a predetermined amount Medi-Cal will pay for any additional covered expenses for that month. Share of Cost is an amount that is owed to the provider of health care services, not to the State.

Share of cost is different from cost sharing. "Cost-sharing" requires a beneficiary to pay a set amount or percentage of each health care service received. "Share of cost" requires beneficiaries to take full responsibility for health care expenses up to a predetermined amount. Share of cost is not a premium; it is an amount that a beneficiary is financially responsible for each month in which Medi-Cal assistance for health care expenses is needed. The amount of the Medi-Cal Share of cost is determined by the Department of Social Services.

The State Department of Mental Health policy on the certification of Medi-Cal share of cost allows the Medi-Cal Share of Cost to be certified, or cleared, by using the full cost of services received by a client during a month. The client is only held financially responsible for the amount of their UMDAP liability. If the clients' monthly share of cost is less than their UMDAP, then the monthly share of cost amount is

## San Diego County Organizational Providers

collected until the total amount of their UMDAP has been satisfied. Each case must be reviewed to determine if the share of cost will be certified. If the client has received services in which the total cost meets or exceeds the share of cost, it should be certified. Never do partial clearing of the share of cost.

- If the client's share of cost is not certified then the client is not considered Medi-Cal eligible.
- If the client's share of cost is certified, a copy of the certification must be forwarded to the HHSA/FSSD MH Billing Unit in order to account for Share of Cost certification for reporting in the State Cost Report.

### *Minor Consent*

Clients enrolled in the Minor Consent Medi-Cal Program must meet the State Department of Mental Health's criteria for Sensitive Services. Individuals between the ages of 12 through 20 may apply for minor consent services through Medi-Cal without their parent's consent. They may also receive outpatient mental health treatment and counseling for:

- Being in danger of causing harm to self or others; or
- Being an alleged victim of incest or child abuse.

Mental Health services will not be billed to Medi-Cal.

Minor Consent Medi-Cal eligibility should not be entered into the InSyst system and their UMDAP liability should be set at zero. The UMDAP liability must be adjusted using "Write-Off UMDAP" adjustment discussed further in this handbook.

As of July 1, 1998 claims for specialty mental health services based on minor consent eligibility are no longer to be submitted to the Short-Doyle/Medi-Cal billing system. However, laboratory and pharmacy services are still a benefit of the Minor Consent program and are covered through the Minor Consent client's Medi-Cal card.

### *Medi-Cal HMO Clients*

Medi-Cal beneficiaries enrolled in a Prepaid Health Plan (PHP) are eligible to receive medical services through their HMO. These HMO policies do not cover Mental Health services. Therefore, these particular HMO's should not be entered into InSyst.

The following local Medi-Cal HMO's cover medical services only:

1. Community Health Group
2. CompCare Health Plan Inc.
3. Foundation Health, A California Health Plan
4. Great America Health Plan
5. Kaiser Permanente
6. Sharp Health Plan Advantage
7. Universal Care
8. Healthnet

### *Healthy Families Clients*

The Healthy Families Program (HFP) provides health insurance for children up to their 19<sup>th</sup> birthday whose family income is between 100 and 250 percent of the federal poverty level and therefore not eligible to

**TAKE NOTE!**

Minor consent  
Medi-Cal does not  
require Medi-Cal  
eligibility entry into  
InSyst effective  
7/1/1998.

## San Diego County Organizational Providers

Medi-Cal. Children and youth of eligible families are enrolled with a HFP health plan that provides basic health services. The mental health benefit includes twenty mental health outpatient visits and thirty days inpatient hospitalization annually to enrollees. For those HFP children and youth who meet the qualifications for being designated Seriously Emotionally Disturbed (SED), specialty mental health services are provided by the County and contracted programs. Upon determination by Children's Mental Health services that the enrollee is SED, the full range of medically necessary mental health services are available through Short Doyle/Medi-Cal Services to the extent resources are allowed.

HFP enrollees that are seeking basic mental health services at County or contracted programs shall be referred back to the HFP health plan. The only HFP enrollees that would be receiving services at County and contracted programs are those HFP enrollees who have been determined to be SED by ESU and referred to that program.

The billing for Healthy Families for Mental Health services will be conducted by ASO to the State Department of Mental Health Short/Doyle Medi-Cal system. The Human Service Specialist at ESU will confirm HFP eligibility, and go into InSyst and terminate the HFP health plan policy so that billing will be allowed to Short-Doyle/Medi-Cal. ESU will provide ASO with a diskette monthly that identifies all new HFP that have been determined SED. Healthy Family clients can be identified through their aid code, which is 9H. Each County and contracted program are required to confirm eligibility monthly by verifying that the client is still an active HFP with an aid type of 9H.

### AB2726 Clients

Chapter 26.5 of the Government Code made the County Department of Mental Health responsible for providing mental health services. AB2726 stipulates that appropriate services are to be brought to the students rather than encouraging more restrictive placement in non-public schools. The AB2726 program is a Children's mental Health program that provides mental health assessments and counseling for school-aged children and youth in order for them to benefit from their special education program. This allows students to receive highly specialized mental health services.

#### **TAKE NOTE!**

A signed AOB is required to claim a third party payor for services rendered to any clients, however, AB2726 legislation specifically forbids claiming without appropriate authorization.

Because these services are a school related service, the services are provided free of charge, unless the parent consents for their private insurance to be billed. A signed AOB is required to claim a third party payor for services rendered to any clients, however, AB2726 legislation specifically forbids claiming without appropriate authorization. Emergency services and medication costs remain the responsibility of the parent, as those are not services provided through AB2726.

The local AB2726 programs refer clients to other providers if they are in need of additional mental health services. A special fund was designed by the State of California to pay for services not covered by other payor sources. For additional, information please call the AB2726 local office at (619) 758-6227.

### CalWORKs Eligibility

California's public cash assistance program is called the California Work Opportunity and Responsibility to Kids (CalWORKs). CalWORKs applicants must meet state and federal regulation requirements to qualify for cash assistance. Caretaker relatives may also be eligible for benefits. Verification of the relation to the child will be required. Potential CalWORKs eligible clients should be referred to their local Family Resource Center.

Non-citizens are subject to specific regulation requirements and may wish to inquire about potential eligibility to CalWORKs. If a family provides all the necessary facts, eligibility should be determined

## **San Diego County Organizational Providers**

within 45 days of the date of application. Persons with drug related felony convictions since January 1, 1998 are not eligible for CalWORKs.

CalWORKs mental health services are funded on a cost reimbursement basis. To ensure accurate tracking of all services and associated costs, special reporting units have been established in InSyst to track services to CalWORKs beneficiaries. Only programs authorized to render services to CalWORKs beneficiaries have been given access to those reporting units. Services provided by other programs are not eligible for CalWORKs reimbursement. If a client who is not eligible for CalWORKs mental health treatment may be in need of mental health treatment, please refer the client to the ASO Access and Crisis Line for an appropriate referral. The Access and Crisis Line, telephone number (800) 479-3339, is available 24 hours a day, seven days a week.

### **Private Pay (Short/Doyle) Clients**

Clients who are not covered under a third party payor source should be interviewed to determine if they might be eligible for a potential funding source, such as Medi-Cal. Clients are financially responsible for the cost of service up to the amount of their UMDAP liability. If the client does not become eligible for a third party payor source, the County absorbs the cost for treatment using Realignment, Grants, and other limited funding sources.

### **Insurance Clients**

Clients covered under a private insurance company policy are financially responsible for the cost of treatment up to the UMDAP liability. Amounts paid by private insurance companies may not be applied to UMDAP liabilities. The amount paid by the insurance will reduce the cost of treatment. Many insurance policies will pay for a portion of the cost of mental health services up to an annual maximum number of visits or an annual maximum dollar amount. To determine the amount of insurance coverage, for which a client may be eligible, you must contact the insurance company at the telephone number listed on the client's insurance identification card.

Most insurance policies require services be pre-authorized. This information can also be verified when contacting the insurance company. The pre-authorization process requires an exchange of clinical information substantiating the client's need for treatment. Under most insurance policies, treatment that has not been authorized is not reimbursable under the terms of the policy. Be sure to have a client sign an authorization of release of information form prior to contacting the insurance company.

### **Private Insurance Company Updates**

When completing the Financial Eligibility Policy screen in InSyst, you must select the insurance company name and address that is listed on the client's insurance company identification card. If the insurance company name or correct address is not in InSyst, it must be added by the HHSA/FSSD MH Billing Unit. County and Contracted Providers are required to complete a "Request for Insurance Addition" form, and forward it to the HHSA/FSSD MH Billing Unit for processing. A copy of this form is located on page 55 in the Forms section of this handbook. The ASO will notify the requestor when the insurance company has been added so the client account information can be updated.

### **Medicare Clients**

Medicare Part B reimburses eligible outpatient services at 80% of the established Fee Schedule after an annual \$110 deductible. (This changes yearly.) The deductible is based on the calendar year. The client is only held financially responsible up to the amount of their UMDAP liability. Medicare currently reimburses services rendered by a Physician (MD); Psychologist (PhD); Licensed Clinical Social Worker

## **San Diego County Organizational Providers**

(LCSW); Physician Assistant; Nurse Practitioner and Clinical Nurse (RN). Services rendered by a Marriage Family Child Counselor (MFCC) or non-licensed staff is not reimbursable by Medicare.

### **Account Adjustment Requests**

Account adjustments are required whenever a client account balance must be modified. The account balance is the amount for which the client is financial responsible. Authorization to enter account adjustments is limited to a number of clerical/financial staff in the programs and the HHSA/FSSD MH Billing Unit. In the event an adjustment is required and program staff does not have the necessary authorization, (please contact the HHSA/FSSD MH Billing Unit).

Below is a description of the various account adjustments. For detailed instructions on posting any of these adjustments in InSyst, please refer to the InSyst Users Manual.

### **Therapeutic Adjustment**

This adjustment is utilized when a clinician determines that a client's financial obligation needs to be altered from the UMDAP fee schedule due to clinical reasons. Clients must be re-evaluated for their ability to pay each UMDAP year. The clinician must determine the amount of the therapeutic adjustment and document the reason in the client record. The following are reasons a therapeutic adjustment may be considered:

- The client or responsible relative has verbally expressed an inability to pay the UMDAP and is exhibiting mental or emotional distress over continue pursuit of collections.
- The client or responsible party will not return for treatment, participate or allow the client to participate with the follow-up recommended treatment because of his/her inability to pay the UMDAP, and without treatment the client's mental health will diminish.
- Based on the clinician's assessment of the client, continued collection efforts may result in the client, or the client's immediate family, to suffer a serious crisis which is likely to compound the problem.

Do not enter a "*Therapeutic Adjustment*" to a full pay account. Any account in full pay status must have an UMDAP completed and a reversal of the full pay status before a Therapeutic Adjustment can be initiated. A "*Deductible Adjustment Request*" form must be completed and approved by the Program Manager/Director. This form is then submitted to the HHSA/FSSD MH Billing Unit for processing. A copy of this form can be found in the Forms section (page 56) of this handbook.

### **Bad Check Charge**

Clients are charged a \$25.00 fee for a returned check. Usually checks are returned due to insufficient funds. When a check is returned, the UMDAP amount that was credited will be considered not paid. For County programs, fiscal will bill the client the \$25.00 returned check fee. Fiscal will notify the ASO that the check has returned. The ASO will add the amount of the returned check to the UMDAP balance owing. If the account is in collections, the ASO will notify Revenue and Recovery of the increased collection amount.

### **Initiate Full Pay**

Often a client's financial information is not received, incorrect or incomplete and the appropriate UMDAP liability cannot be properly assessed. In these situations, the account should be set to full pay. This adjustment is used to put the account in full pay status, which makes the client responsible for the full cost of all services provided on the account. This "Full Pay" status remains in effect for the entire UMDAP period unless it is reversed using the "Reverse Full Pay" adjustment.

## **San Diego County Organizational Providers**

### **Reverse Full Pay**

When a client's financial information is updated, and the UMDAP liability can be accurately determined, the "full pay" status must be reversed. This adjustment is used to cancel "Full Pay" status on an account and establish a new liability amount. This adjustment cancels the "Full Pay" status for the entire UMDAP period. However, any payment made on a full pay status will not be applied to the UMDAP after reversal.

### **Merge Account**

Merge account is used when two accounts must be merged into one. For example, if a new account is created in the system for a client who already is attached to an existing account, information from the new account must be merged to the existing account. The adjustment removes the new account from the system and updates the account number in the client record for all clients attached to the account. All liabilities, services, payments, and claim records are moved to the existing account.

A system-generated account may be merged into a user-created account. However, a user-created account may not be merged into a system-generated account.

In the Adjustment Maintenance screen, the adjustment is visible through the existing or destination account number. The ASO recommends this type of adjustment be referred to the HHSA/FSSD MH Billing Unit.

### **Patient Refund**

Patient refunds are requested by the client or the Insurance Company, and are issued due to an overpayment on an account. Patient overpayments are included on the unapplied payment report (PSP143) which is generated monthly or as needed. The HHSA/FSSD MH Billing Unit will review the account and determine whether the client or Insurance Company is due a refund. If it is determined that a refund is due, the back up documentation and refund request is forwarded to Health and Human Services Agency Fiscal Dept. for issuance of the refund.

### **Write-off UMDAP**

In the event that a client's payment liability is not automatically written off due to eligibility for Medi-Cal, use the Write Off UMDAP adjustment. This will reduce the client's current account balance to zero. Enter the first day of the liability period requiring adjustment as the effective date. This adjustment requires UMDAP adjustment authorization. If program staff, do not have authorization to enter this type of adjustment, the account should be referred to the HHSA/FSSD MH Billing Unit. Do not use this adjustment on a Full Pay Account.

## **CLAIMS, BILLING AND PAYMENT POSTING PROCEDURES**

### **Medi-Cal Claims**

### **CLAIMS, BILLING AND PAYMENT POSTING PROCEDURES**

When claims submitted to Medicare and private insurance carriers have been paid or denied, the residual amount is claimed to Medi-Cal. If the client does not have a primary payor source, the services are billed to Medi-Cal whenever a client has eligibility for the month of service recorded in InSyst. Eligibility data is entered by users and automatically matched against Department of Social Services and Social Security Administration eligibility data. Services to clients whose eligibility is not verified in InSyst through these processes are not claimed to Medi-Cal through the regular monthly Medi-Cal claiming process.

## San Diego County Organizational Providers

There are two ways the ASO claims Medi-Cal:

1. Regular Monthly Medi-Cal Claims
2. Monthly Supplemental Medi-Cal Claims

ASO is responsible for processing all data for Medi-Cal claims for all organizational providers.

### 1. Regular Monthly Medi-Cal Claims

**ASO completes the following processes:**

- Posts services daily
- Reviews all posting log files to ensure each module completed successfully
- Reviews the “SEQ\_LIS” files to identify services that have not successfully completed posting
- Generate a TEST Medi-Cal Claim, and:
  - Reviews the log file to ensure successful completion.
  - Reviews and compares the current Medi-Cal claim totals with previous months.
  - Analyzes Report MHS 150 to determine if the totals are within normal range.
  - If the claim total is below normal range researches to determine problem.
  - Runs the various Medi-Cal eligibility processes.
  - Contacts individual program sites that are claiming below normal range.
  - Submits Medi-Cal eligibility (POE) and service posting modules.
  - Submits final Medi-Cal claim
  - Reviews log file to ensure successful completion.
  - Prints Report MHS 150, Medi-Cal Claim Analysis, and Medi-Cal Claim form MH 1980

### 2. Monthly Supplemental Medi-Cal Claims

All Medi-Cal services that were not paid through the Regular monthly or Social Security Number claiming process will be submitted through the supplemental Medi-Cal process, which generates a monthly claim for prior fiscal year services.

### Medi-Cal Error Correction Reports

The State of California distributes Medi-Cal Error Correction Reports (ECRs) to the HHSA/FSSD MH Billing Unit for services that do not clear the billing edits. The HHSA/FSSD MH Billing Unit manages all ECRs. When ECRs are received, they are logged into a tracking system and disbursed to programs for correction the day after it is received by the HHSA/FSSD MH Billing Unit.

As required by the State, all corrections to the ECR must be completed in “*GREEN INK.*” The *original document* must be returned to ASO within 10 business days. In the event ECRs are not resubmitted to ASO by their due date, a call is placed to the agency contact person to determine the status of the ECR. If the ECR is not completed in a timely manner, ASO will notify the Program Manager. If necessary, ASO will also notify the Contractor’s Chief Financial Officer (CFO). Medi-Cal will deny payment for services on the ECR that are not corrected and resubmitted to the State within the designated time frames. Failure to complete the ECR will result in ASO sending a letter to the provider stating the program is in non-compliance with the terms of the contract.

#### TAKE NOTE!

Medi-Cal will not be billed for services rendered to a client with a primary payor source until a payment or denial of the primary payor source claim line has been entered in InSyst.

#### TAKE NOTE!

All corrections to the ECR must be completed in GREEN INK as required by the State. The ORIGINAL must be returned to ASO within 10 business days.



## San Diego County Organizational Providers

If the service has already been billed to private insurance but payment was denied, enter “P” in the correction box for field 22.

If private insurance has been billed and made payment, enter “P” in correction box for field 2 and enter the net amount (total billed less payment in field 21 boxes.

/ / / P

/ 0/0 /0 /8 /7. /0 /0 /

**Note: An “X” in the override bracket next to any line will immediately remove that claim from the MSD/EDIT System.**

### 4. Ineligible in MO/YR (Field 10)

Error Message indicates that there was no match found in the MEDS system. Verify the client’s eligibility in InSyst:

- Go to the Financial Eligibility Medicaid screen in InSyst and use the GOLD I function to verify the month of service eligibility. If the client does not have an Eligibility Verification Code (EVC) number, DO NOT CONFIRM with “YES”. You must confirm with “NO” or Gold-E to exit screen.
- If the client is eligible, enter a “W” in the override code on the ECR.
- Verify the Social Security Number on the ECR matches the number in InSyst. If there is a discrepancy, note the correct number on the ECR.
- Write in the County and Aid code in the first four spaces provided in the correction field.
- If the Social Security Number (SSN) is correct but the client does not have eligibility put an “X” in the override code.

At times the error message “INELIGIBLE IN MO/YR” may appear due to the client having an unmet Share of Cost (SOC). To determine the client’s SOC amount:

- Verify the month of service eligibility in InSyst. If the client does not have recorded eligibility, DO NOT CONFIRM!
- Go to the Service Maintenance screen to determine if client has sufficient services for the month to certify the SOC.
- If the cost of services total less than SOC, enter an “X” in the override code to cancel the claim from Medi-Cal.
- If services total more than SOC, clear client’s SOC. (For more information on Share of Cost Certification, please refer to the Medi-Cal Share of Cost section of this handbook). To correct ECR write the SSN on field 10 and write “SOC” to the right of the error message.

### 5. Invalid Code (Field 10)

The Medi-Cal BIC (Benefit Identification Card) changed as of 01/01/05 to a 14 character Alphanumeric ID. By 7/01/05, the Social Security Number will be removed from all BICs.

- Determine if there is a discrepancy in the SSN.
- Leave the override code blank.
- Correct SSN in the correction field 10.

### 6. Not on Eligibility File (Field 10)

## San Diego County Organizational Providers

This error message indicates that client's SSN is incorrect.

- Verify the client's correct SSN and check eligibility for the month of service.
- Leave the override code blank and use the correction field to enter correct SSN.
- Verify the month of service eligibility in InSyst Eligibility Insert screen. If the client does not have an Eligibility Verification Code (EVC) number, DO NOT CONFIRM with "YES". You must confirm with "NO" or Gold-E to exit screen.

### 7. *No Secondary Match*

This error message coincides with "NOT ON ELIGIBILITY FILE." If the SSN is incorrect, all other related information will be incorrect as well. Use the correction field to enter all the correct information (i.e. Last name, sex or year of birth).

- Submit a "Change of Information" (see the Forms section of this handbook) to County Medical Records Staff, specifying the Name, Date of Birth and SSN from MEDS.

### 8. *Provider Not on File (Field 3)*

- Correct the provider number.
- There is no override for this error.

### 9. *Patient Name (Field 8)*

This error message indicates that there is "NO MATCH FOUND" in the MEDS file.

- Verify the month of service eligibility in InSyst Eligibility Insert screen. If the client does not have an Eligibility Verification Code (EVC) number, DO NOT CONFIRM with "YES". You must confirm with "NO" or Gold-E to exit screen.
- Verify the client's name and check for spelling errors.
- If the name is incorrect, make the corrections in the correction field of the ECR.
- If the last name is different use the name provided in the MEDS file.
- Submit a "Change of Information" (see the Forms section of this handbook) to County Medical Records Staff, specifying the Name, Date of Birth and SSN from MEDS.

## Insurance Billing

The HHSA/FSSD MH Billing Unit is responsible for billing private insurance carriers for all County operated program. Contract providers are responsible for retaining adequately trained billing staff and producing claims to insurance carriers. Claims should be generated, at minimum, on a monthly basis. The CMS 1500 form must be completed in its entirety. If authorization for treatment was obtained from the insurance company, the authorization number should be referenced on the CMS 1500 form. The business standard for resolving outstanding account receivables is 120 days from the date of service.

Below are general guidelines, which apply to most third party payor billing:

- Ensure the subscriber identification number on the claim matches the number of the member's insurance identification card. Although the identification number is usually the subscriber's social security number, this is not always the case.
- The claim must clearly indicate that the Assignment of Benefits form is completed. This is accomplished by entering "Signature on File" in the Assignment area of the CMS 1500.
- If the provider of service is enrolled as a provider in an HMO or PPO and has been assigned an identification number, that number should be referenced on the claim.

## San Diego County Organizational Providers

- If a client no longer has “other health coverage” and this has been confirmed, staff needs to “terminate the policy” in InSyst. This will avoid a claim line from being created.

## Medicare Billing

Providers are to ensure accurate and appropriate claiming for Medi-Cal reimbursable services and to implement a process of monitoring by the Mental Health Plan of all San Diego County operated mental health services. Mental Health Services will be monitoring providers to ensure that compliance with accurate Medi-Cal billing is followed. The program manager is responsible for development and implementation of internal program policies, procedures, and monitoring systems which may include but are not limited to the following:

- Identify staff that are Medicare-eligible providers and ensure that these identified staff obtains necessary certification as Medicare Providers.
- Medicare/Medi-Cal (Medi-Medi) insured clients shall be identified at the time of enrollment for program services
- Medi-Medi insured clients shall be provided and/or referred to Medicare-approved providers for Medicare-approved services
- Reimbursable Mental Health Services shall be claimed in a timely and accurate manner with Medicare and/or Other Health Coverage (OHC) billed first as the primary payor.
- Ensuring that Medicare and OHC are billed prior to claiming Medi-Cal. Reviewing the Explanation of Benefits (EOB) and ensuring that payments and denials are entered into the system appropriately to allow accurate claiming to Medi-Cal. A review of the EOBs will be conducted by the County’s Behavioral Health Services to ensure that programs are posting payments and denials appropriately prior to billing Medi-Cal.
- Error Correction Report (ECR) for **Contractors** is sent to the programs to identify errors that were made on claims submitted to Medi-Cal. (i.e. Such as the client having Other Health Coverage (OHC), wrong DOB, no eligibility on file, etc). This report is sent directly to programs from the HHSA/FSSD MH Billing Unit. Programs have 10 days to correct the errors on the ECR report in green ink and/or explain future actions/follow up on the ECR summary form. Both the ECR report and summary form shall be returned to the HHSA/FSSD MH Billing Unit within 10 days. The program manager needs to indicate on the ECR correction summary form how the errors have been corrected and what corrective action measures are put in place to avoid the errors from happening in the future. The HHSA/FSSD MH Billing Unit will monitor the provider for timely return of ECRs, and if necessary, send a letter to each provider who is out of compliance and notify the COTR.
- Error Correction Report (ECR) for the **County** is sent to the programs to identify errors that were made on claims submitted to Medi-Cal. (i.e. Such as the client having Other Health Coverage (OHC), wrong DOB, no eligibility on file, etc). This report is sent directly to programs from the HHSA/FSSD MH Billing Unit. Programs have 10 days to review the ECR report and/or explain future actions/follow up on the ECR summary form. The ECR summary form shall be returned to the HHSA/FSSD MH Billing Unit within 10 days. The program manager needs to indicate on the ECR correction summary form how the errors occurred and will be corrected and what corrective action measures are put in place to avoid the errors from happening in the future. The HHSA/FSSD MH Billing Unit is responsible for editing the error correction report and updating the system with the corrections that need to be made if necessary; otherwise, the program is responsible for follow up with the corrective action indicated on the ECR summary form. The HHSA/FSSD MH Billing Unit identifies the corrections made on the ECR report in green ink and submit to the State. The HHSA/FSSD MH Billing Unit will monitor the provider for timely return of ECR correction form, and if necessary, send a letter to each provider who is out of compliance and notify the Program Monitor.

## San Diego County Organizational Providers

- Assignments of Benefits (AOB) - It is the programs responsibility to get a signed AOB form from the client so that the OHC/Medicare can be billed prior to billing Medi-Cal. Every month, programs receive a list (PSP577) from the ASO of all clients who have outstanding AOBs.
- Contract Program Manager or Designee is responsible for monitoring the Aged Accounts Receivable Report monthly posting and making appropriate posting into InSyst.
- For more complete details on Medi-Cal Billing Monitoring Plan – The Organizational Provider Operations Handbook Appendix J.10.

## Account Collections

The most effective way to resolve outstanding accounts receivable balances is to follow up billings with a telephone call to the insurance carrier. At minimum, follow up should occur for all outstanding claims every 30 days.

Below are some general guidelines that may assist in this process:

- If the insurance carrier indicates they did not receive the claim, ask if the claim can be faxed. This will alleviate unnecessary delay of re-submitting the claim by mail.
- If the insurance carrier states they could not identify the client, provide them with the information from the client's identification card. If necessary, fax a copy of the insurance card.
- If the insurance carrier indicates the client was not eligible for benefits, provide them with the name of the individual in their organization that verified benefits and eligibility (if applicable).
- If the insurance carrier indicates the services were not authorized, determine if program staff obtained authorization. If so, provide the carrier with the authorization information.
- If the insurance carrier indicates there is a primary payor, obtain that information. Contact the carrier they indicated was primary to determine if the client is eligible for coverage.
- The business standard for resolving outstanding claims is 120 from the date of service.
- When utilizing the InSyst MHS115 and MHS116 reports as a follow up tool, note an asterisk (\*) indicates the client has Medi-Cal as a secondary payor. Medi-Cal will not be claimed until the primary claim line has been closed through entry of a payment or a denial.

Client fee collection for all providers should be conducted, at minimum, once every 30 days. The most effective collection method for patient fees is to discuss their financial obligation with them when they are present for treatment. In no case should the client be denied treatment based on financial issues.

Effective July 1, 2008 for all programs, client billing statements are generated quarterly by the HHSA/FSSD MH Billing Unit. The HHSA/FSSD MH Billing Unit will collect quarterly on all outstanding accounts until they become delinquent. All delinquent accounts will be referred to the Office of Revenue & Recovery (ORR). A delinquent account is one in which payment is not received by Mental Health Services(MHS) within 45 days from the date the client statement for the final account balance (UMDAP amount or final UMDAP liability period balance) was generated by the HHSA/FSSD MH Billing Unit on expired UMDAPs.

## Insurance/Medicare Payment Posting

This process is utilized to capture payments in InSyst for all payor sources except client payments. After a series of processing steps, payments are applied to the corresponding claim lines. Through the "Payment Entry" screen, payments can be targeted to specific claim lines or divided and applied to several claim lines. Payment entry, through the payment entry screen, is the first stage of payment processing, whereby a

## San Diego County Organizational Providers

payment or portion of is linked to a claim line. If no services are located, the payment will be held in an “Unapplied Status.” Payments should be entered into InSyst daily.

### 1. The steps in posting insurance or Medicare payments are as follows:

- Go to the Financial Revenue Enter screen.
- Key an “X” next to the appropriate payor type (Medi-Cal, Medicare, and Insurance).
- Key a “Y” on “FORM Y/N”, and press the enter key.
- If the payment is from Medicare:
  - Type the Eligibility Number (which is the Medicare Number showing on the EOB).
  - If the record cannot be found, type the Client name (*Last name first, then the First Name*).
  - A list of client’s names will be displayed. Key an “X” on the appropriate name.
  - Key in the Service dates from the Remittance Advice.
  - If a claim was generated, enter the EOB date, and receipt Number. Press the Tab key.
  - If the claim line was denied prior to an appeal payment, the claim line must be re-opened through the Financial Claim Claim (FI CL CL) screen.
  - Key in the Total Approved Amount and Total Payment Amount (*if there is only 1 claim line, press the enter key, then enter “Y” on FORM Y/N*).
  - If the payment is for more than one claim line, enter the appropriate amount of the payment on each claim line.
  - Key a “Y” when complete to enter a payment for another client. If there are no additional payments, exit the payment entry screen.

### If the payment is from Private Insurance:

- Key an “X” on Insurance, and then key a “Y” on FORM Y/N.
- Type the Eligibility Number, the client number, or the client’s name.
- Type the service date from the Explanation of Benefits (EOB).
- Select the claim or claim lines and enter the EOB date and the receipt number.
- Press the Tab key to the Total Payment Amount field and enter the amount of the payment. (*If there is only one claim line, press the enter key to move the cursor to the FORM Y/N, and enter “Y”. Otherwise, key in the payment for each claim line*).
- Press the enter key. The cursor will go to FORM Y/N prompt. Key a “Y” to confirm, and press the enter key.

## Client Payment Posting

All client payments must be captured in InSyst to ensure clients are held financially responsible only up to their UMDAP liability and to ensure accurate revenue reporting. The HHSA/FSSD MH Billing Unit is responsible for posting client payments for all programs. Contract operated programs must report client payments received to the ASO via the “Collection of Client Account” form for posting to the InSyst system. A copy of this form is on page 57 in the Forms section of this handbook.

County operated programs should process client payments in accordance with San Diego County Policies and Procedures.

## Insurance and Medicare Denials

In the event that an insurance company denies a payment, consider the reason. If the company does not provide a satisfactory explanation or the denial appears questionable, request clarification by calling the insurance company.

A request for reconsideration of payment is referred to as an appeal. An appeal is usually a letter, submitted with a claim and clinical documentation supporting the medical necessity for the services rendered that have been denied.

## San Diego County Organizational Providers

The following list of denial reason codes for entry into InSyst are recommended for appeal:

1. **E:** No pre-authorization for emergency visits. Need to request additional information from Medical records.
2. **C:** Policy does not cover services. Provide documentation of the Medical necessity and send it to the insurance company, if available.

These denial reason codes are recommended for rebilling or submission to the appropriate insurance carrier:

1. **F:** Coverage canceled. Determine if there is a new active insurance policy.
2. **A:** Maximum insurance benefits paid. Determine if there is a secondary payor.
3. **B:** Applied to deductible. If applicable, the secondary payor is responsible for the billed amount.
4. **I:** Patient not enrolled; and **D:** primary carrier covers services. Usually, the denial letter will state the name of the insurance company who will handle the claim and an address where to send it.
5. **G:** No record of concurrent physician. Provide physician information.

For detailed instructions on entering denials into the InSyst system, please refer to the InSyst Users Manual.

## Payment Audit Procedures

Contracted providers are responsible for posting payments and denials in InSyst to ensure that accounts receivables are tracked and available for reporting. In addition, as all Medi-Cal claiming is conducted through InSyst, primary payor source payment and denial information must be entered in InSyst to ensure appropriate claiming to Medi-Cal. Once payment posting has been completed, the MHS 172 report is printed automatically at the provider's printer queue. All payments must be reviewed for accuracy and verified on this report. If all payments posted are correct, the report is signed and forwarded to the HHSA/FSSD MH Billing Unit. The HHSA/FSSD MH Billing Unit will move the payments from a "To Audit" status to a posted status upon receipt of the MHS 172.

The MHS 171 is a report that shows the ASO all aged payments that have not moved to the final posting process. This report is also necessary to make sure that all payments are posted, ensuring that all Medi-Cal claims (secondary claims) are billed. This report serves as a tracking report to ensure all MHS 172 reports are confirmed and received by the ASO.

## Provider Tracking Report

The ASO is responsible for tracking the contracted providers' billing functions and providing summary information to the County of San Diego of their status and provide detail information to the Contractor via the Provider Tracking Report. This report is reviewed by County Program Monitors to ensure that programs keep the numbers to a minimum. The monthly tracking report includes information pertaining to the following:

- Identify outstanding amounts Medicare/Insurance claim lines that need to be satisfied via a payment or denial entry to ensure billing of secondary payor.
- Ensure that all potentially billable services have an active account/UMDAP
- Ensure that service posting is timely and accurate
- The number of deletions requested by the Provider.
- The number of incomplete Insurance Policies.

The following InSyst reports are utilized by ASO staff to evaluate each contracted provider's financial activity:

- *MHS 115* – is a summary report used to determine the focus and level of collection efforts. This report also allows users to focus on the crossover claims so they can bill the residual amount to Medi-Cal within the designated time frames of one year from the date of service.

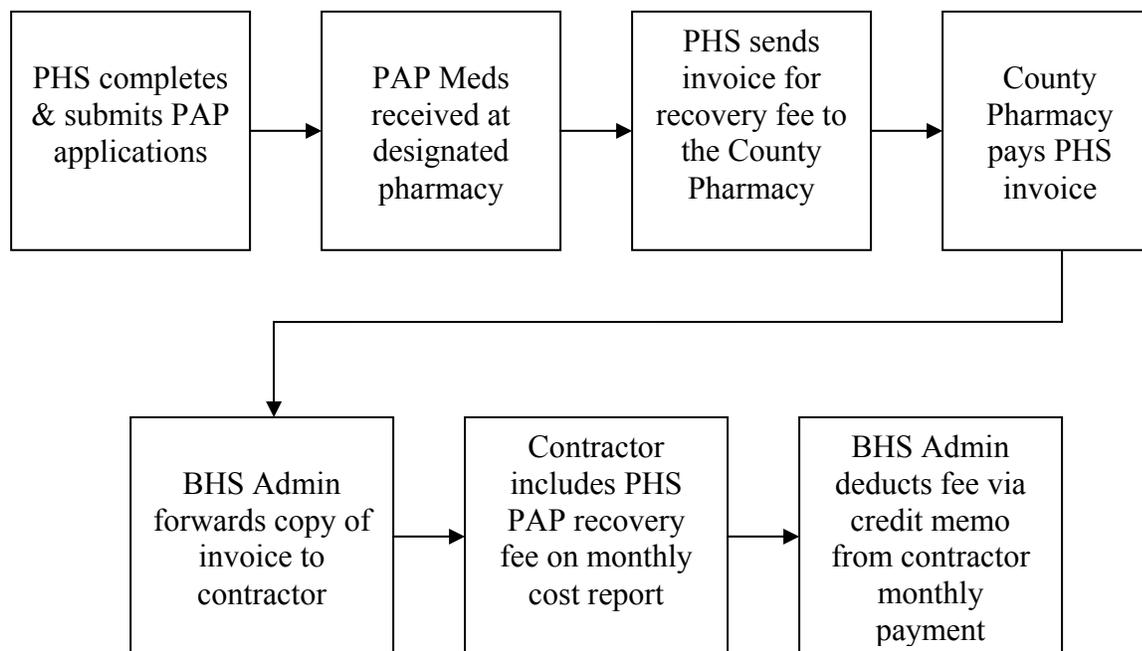
## San Diego County Organizational Providers

- *MHS 116* – is a detailed report used to determine the focus and level of collection efforts. This report also allows users to focus on the crossover claims so they can bill the residual amount to Medi-Cal within the designated time frames of one year from the date of service.
- *PSP 131* - used to audit service entry and program productivity.
- *PSP 138* - used to monitor the timeliness of data entry into the system.
- *MHS 173* - used to monitor monthly Medicare and Insurance payments entered.
- *PSP 577* – used to monitor missing or incomplete AOBs.
- *MHS 164* – used to identify which UMDAPs are due to be renewed in the next calendar month.
- *MHS 158* – used to monitor missing UMDAPs.

## Pharmacy Healthcare Solutions Patient Assistance Program Fiscal Process

If applicable to the program, Pharmacy Healthcare Solutions (PHS) staff complete and submit applications for Patient Assistance Program (PAP) medications for mental health clients. Medications are received at a designated pharmacy and are checked in by designated pharmacy staff. PHS includes contract program's PAP Recovery Fee on a monthly invoice sent to the County Pharmacy. The County Pharmacy pays contract's PHS invoice using Behavioral Health Services Contract Fiscal - Provider Reimbursement Unit's accounting information. The pharmacy sends copies of invoices to Behavioral Health Services Contract Fiscal – Provider Reimbursement Manager who forwards copies to the contractors and keeps the invoices on file for verification. Contractors do not pay the invoices but do include the PHS PAP recovery fee on their monthly cost report.

Upon receipt of the monthly cost report from the contractor, the BHS Contract Fiscal – Provider Reimbursement Unit verifies that the correct fee account is reflected and submits a credit memo deducting the amount of the PHS PAP recovery invoice that has already been paid by the County Pharmacy (against the BHS Contracts Fiscal – Provider Reimbursement Unit's accounting information).



## **TRAINING & TECHNICAL ASSISTANCE**

It is very important for any program staff that will use InSyst to attend ASO's comprehensive training course to learn how to use the system correctly. The training is free of charge, and is necessary in order to receive data entry authorization.

InSyst Basic Screens training is offered every month. Reports training or special module training is also available. To register for classes, or to obtain a copy of the training schedule, please call the ASO help desk Financial Training at (619) 641-6928.

The ASO MIS Customer Service Desk is also available to assist program staff with technical support or special requests.

Telephone: 1-800-834-3792  
Facsimile: (619) 641-6975  
E-mails from the Internet: [helpdesk@sdUBH.com](mailto:helpdesk@sdUBH.com)

All requests for the ASO MIS Customer Service Desk will be logged into a tracking system, and a Technical Support Specialist will be assigned to assist with the request.

The ASO Training Department provides a full range of provider training on topics related to the provision of services in the San Diego County Mental Health System.

### **User Manual and Reports Manual**

Every County operated and contractor operated program using InSyst should maintain an updated copy of the InSyst Users Manual and the InSyst Reports Manual that were sent to all programs during system implementation. New programs or existing programs with a need for new manuals may request them from UBH by calling 1-800-834-3792.

The appendices to the User Manual contain important information related to data codes allowed in the system. These appendices are updated from time to time and mailed to providers. Managers should ensure that the appendices are updated in the Manual and that personnel are aware of the changes.

## **San Diego County Organizational Providers**

### **QUICK REFERENCE LIST**

ACCESS AND CRISIS LINE	(800) 479-3339
PROVIDER LINE	(800) 798-2254
<b>MIS CUSTOMER SERVICE DESK</b> E-mails from the Internet: helpdesk@sdubh.com	(800) 834-3792
<b>FAX</b>	(619) 641-6802
Clinical	(619) 641-6729
Provider Services and Quality Improvement	(619) 641-6979
<b>UNITED BEHAVIORAL HEALTH, SAN DIEGO</b>	(619) 641-6800
Finance Trainer	(619) 641-6849
HHSA/FSSD MH Billing Unit	(619) 338-2612
BEHAVIORAL HEALTH ADMIN.	(619) 563-2745
PATIENT ADVOCACY PROGRAM	(619) 260-7660
<b>COUNTY CONTACT</b>	(619) 584-5014

## **San Diego County Organizational Providers**

### **FORMS**

- InSyst Client Registration Form
- Episode Opening/Closing Form
- Payor Financial Information Form (PFI)
  - a. PFI in Spanish
  - b. PFI in Vietnamese
  - c. PFI in Arabic
- Assignment of Insurance Benefits Form (AOB)
  - a. AOB in Spanish
  - b. AOB in Vietnamese
  - c. AOB in Arabic
  - d. AOB in Tagalog
- Change of Information Form
- Deductible Adjustment Request Form
- Request for Insurance Company Addition
- Collection of Client Accounts
- UMDAP Fee Schedule
- Medi-Cal Information Numbers

**San Diego County Organizational Providers**

**Valid Ethnicity Codes**

<b>A</b> = White	<b>L</b> = Filipino	<b>W</b> = Ethiopian
<b>B</b> = African American	<b>M</b> = Other Asian	<b>X</b> = Somali
<b>C</b> = Native American	<b>N</b> = Other	<b>Y</b> = Iranian
<b>D</b> = Mexican American/Chicano	<b>O</b> = Korean	<b>Z</b> = Iraqi
<b>E</b> = Other Latin American	<b>P</b> = Pacific Islander	<b>1</b> = Amerasian
<b>F</b> = Puerto Rican	<b>Q</b> = Korean	<b>2</b> = Samoan
<b>G</b> = Chinese	<b>R</b> = Hmong	<b>3</b> = Asian Indian
<b>H</b> = Vietnamese	<b>S</b> = Cuban	<b>4</b> = Hawaiian Native
<b>I</b> = Laotian	<b>T</b> = Dominican	<b>5</b> = Guamanian
<b>J</b> = Cambodian	<b>U</b> = Salvadoran	<b>6</b> = Multiple (only valid in subfield B)
<b>K</b> = Japanese	<b>V</b> = Sudanese	

**Valid Language Codes**

<input type="checkbox"/> English	<input type="checkbox"/> Mandarin Chinese	<input type="checkbox"/> Hebrew
<input type="checkbox"/> Spanish	<input type="checkbox"/> Cantonese Chinese	<input type="checkbox"/> French
<input type="checkbox"/> Tagalog	<input type="checkbox"/> Other Chinese	<input type="checkbox"/> Polish
<input type="checkbox"/> Japanese	<input type="checkbox"/> Hmong	<input type="checkbox"/> Russian
<input type="checkbox"/> Filipino Dialect	<input type="checkbox"/> Farsi	<input type="checkbox"/> Portuguese
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Arabic	<input type="checkbox"/> Italian
<input type="checkbox"/> Laotian	<input type="checkbox"/> Other Sign Language	<input type="checkbox"/> Samoan
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Armenian	<input type="checkbox"/> Thai
<input type="checkbox"/> Sign Language	<input type="checkbox"/> Ilacano	<input type="checkbox"/> Unknown/ Not Reported
<input type="checkbox"/> Other	<input type="checkbox"/> Mien	
<input type="checkbox"/> Korean	<input type="checkbox"/> Turkish	

**San Diego County Organizational Providers**

**CLIENT REGISTRATION FORM**  
(Revised: 13-Jun-2006)

\_\_\_ Initial Data Collected By: \_\_\_\_\_  
 \_\_\_ Update Date: \_\_\_\_\_

MEDICAL RECORDS

CLIENT NUMBER:		REPORTING UNIT:	
LAST:	FIRST:	MIDDLE:	
GENERATION:	BIRTHDATE:	SEX:	SSN:
CIN:			

EDUCATION:	OTHER FACTORS:	OTHER ID:
DISABILITY:	SERVICE GROUP:	LOCAL CODE:
PRIMARY LANGUAGE:	PREFERRED LANGUAGE:	PRIMARY RU:
ETHNICITY:	CHART LOCATION:	PROGRAM CODE:
HISPANIC ORIGIN:	REF. STAFF ID:	RESEARCH ITEM:
MARITAL STATUS:	CARE GIVER UNDER 18:	18+:
FAMILY SIZE:	ANNUAL INCOME:	

ALIASES	LAST	FIRST	MIDDLE

CLIENT BIRTH NAME:			
LAST:	FIRST:	MIDDLE:	GENERATION:
BIRTH PLACE: (County – State – Country)		MOTHER FIRST NAME: (Leave blank if unknown)	

User can update the information in this portion. Medical Records must be contacted prior to updating the Name, Social, DOB, Sex and SSN fields.

**CLIENT REGISTRATION FORM**  
(Revised: 13-Jun-2006)

\_\_\_ Initial

Data Collected By: \_\_\_\_\_

\_\_\_ Update

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

ADDRESS SCREEN

STREET NUMBER:

CITY:

DIRECTION:

STATE:

ZIP CODE:

NAME:

TYPE:

PHONE NUMBER:

APARTMENT:

BAD ADDRESS:

SIGNIFICANT OTHERS SCREEN

NAME LAST:

FIRST:

EFFECTIVE DATE:

RELATIONSHIP TO CLIENT:

EXPIRATION DATE:

STREET NUMBER:

CITY:

DIRECTION:

STATE:

ZIP CODE:

NAME

COUNTRY:

TYPE:

HOME PHONE:

APARTMENT:

WORK PHONE:

COMMENT:

\_\_\_ EMERGENCY CONTAC

\_\_\_ CLIENT'S GUARDIAN

\_\_\_ FAMILY MEMBER

\_\_\_ DON'T DISPLAY ON RPTS

\_\_\_ PRIMARY CAREGIVER

**EPISODE OPENING/CLOSING FORM**  
(Revised 13-Jun-2006)

\_\_\_ **Initial** **Data Collected By:** \_\_\_\_\_  
 \_\_\_ **Update** **Date:** \_\_\_\_\_

CLIENT NAME:	CLIENT NUMBER:	RU:
STREET NO.:	DIRECTION:	STREET NAME:
TYPE:	APT:	CITY:
STATE:	ZIP CODE:	PH#:

OPENING DATE:	REFERRAL FROM:	LEGAL:	Initial Diagnostic Impression TRAUMA:
AXIS 1: P/S	AXIS 2: P/S	AXIS 3:	AXIS 4:
AXIS 1: P/S	AXIS 2: P/S	AXIS 3:	AXIS 5:
SUBSTANCE ABUSE/DEPENDENCE ISSUE:			Enter "Y" or "N"
DIAGNOSIS:			PAST:
(If "Y", enter substance abuse/dependence diagnosis)			
CLINICIAN ID:	LIVING SITUATION:	ADMISSION HOUR:	SCHEDULED (FOR IP ONLY):
PHYSICIAN ID:	EMPLOYMENT STATUS:	LEGAL CONSENT:	DNR:
SOURCE OF INCOME:	TYPE OF EMPLOYMENT:	RESEARCH ITEM:	
PATIENT LOCATION:	EFFECTIVE:		

OPENING DATE:	CLOSING DATE:	TRAUMA: (Y or N)	Final DSM-4 Diagnostic Impression
AXIS 1: P/S	AXIS 2: P/S	AXIS 3:	AXIS 4:
AXIS 1: P/S	AXIS 2: P/S	AXIS 3:	AXIS 5:
SUBSTANCE ABUSE/DEPENDENCE ISSUE:			PAST:
DIAGNOSIS:			
CLINICIAN ID:	LIVING SITUATION ENTRY:	REFERRAL SOURCE:	
PHYSICIAN ID:	LIVING SITUATION EXIT:	ADMIT HR:	DISCH HR:
LEGAL ENTRY:	EMPLOYEMENT STATUS ENTRY:	LEGAL CONSENT:	
LEGAL EXIT:	EMPLOYEMENT STATUS EXIT:	REASON FOR DISCHARGE:	
SOURCE OF INCOME:	REFERRALS:	RESEARCH ITEM:	
TYPE OF EMPLOY:	DNR:	SCHEDULED:	
PATIENT LOCATION:	EFFECTIVE DATE:		

EPISODE OPENING

EPISODE CLOSING

**San Diego County Organizational Providers**

Registration  Update

Client Name: _____	Client No. / Account No. _____ / _____
UMDAP Liability Period From: _____ / ____ / ____	To: _____ / ____ / ____
Number of Dependents: _____	Undetermined Liability: _____

A. Monthly Income	B. Total Assets	C. Monthly Expenses
1. Self \$	1. Checking \$	1. Court Ordered \$
2. Parent/Spouse \$	2. Savings \$	2. Child Care \$
3. Other \$	3. Other \$	3. Dependant Support \$
4. Total Income \$	4. Total Assets \$	4. Retirement \$
5. Adjusted Income \$	5. Asset Allowance \$	5. Total Medical \$
6. Annual Liability \$	6. Met Assets \$	6. Excess Medical \$
7. Quarterly Payment (County) \$	7. Monthly Assets \$	7. Total Expenses \$
Monthly Payment (Contractor) \$		

**Employment Information**

Responsible Party (RP) Employer	Spouse's Employer
Name _____	Name _____
Address _____	Address _____
City _____, State _____, ZipCode _____	City _____, State _____, Zip Code _____
Phone _____	Phone _____

**Insurance Information**

1. Medi-Cal Number _____	Eligibility Period _____
2. Medicare Number _____	Part A Effective Date _____ Part B Effective Date _____
3. Name of Insurance _____	ID Number _____
Billing Address _____	
Group Number _____	Effective Date _____
Policy Number _____	Expiration Date _____
Insured Person's Name _____	Insured Person's Gender: <input type="checkbox"/> Male or <input type="checkbox"/> Female
Insured Person's Social Security Number _____ / ____ / ____	Relationship to Insured _____
<input type="checkbox"/> Employment Related	<input type="checkbox"/> Assignment of Benefits <input type="checkbox"/> Release of Information <input type="checkbox"/> Information Complete

**Signatures**

I understand that I am obligated to pay the established UMDAP deductible or the actual cost of services received during the UMDAP contract year, whichever is less. I understand that I am obligated to pay for the cost of care up to the UMDAP deductible regardless of when treatment is terminated.	
Responsible Party Name (Print)	Interviewer's Signature
Signature of Responsible Party	Date

County of San Diego  
 Health and Human Services Agency  
 Mental Health Services  
**InSyst Payor Financial Information**  
 HHSA-MHS 932 (01/2005)

Client: \_\_\_\_\_  
 MR/Client ID#: \_\_\_\_\_  
 Program: \_\_\_\_\_

**San Diego County Organizational Providers**

**Información financiera InSyst Payor**

Cuenta nueva   
 Re-determinación anual   
 Revisión de la UMDAP actual/existente

Nombre del cliente: _____	Número de cliente / Número de cuenta: _____ / _____
Período de responsabilidad UMDAP De: _____ / _____ / _____	De: _____ / _____ / _____
Número de dependientes: _____	Responsabilidad indeterminada: _____

A. Ingresos mensuales		B. Total activos		C. Gastos mensuales	
1. Personales	\$	1. Cheques	\$	1. Ordenado por el tribunal	\$
2. Padres/cónyuge	\$	2. Ahorros	\$	2. Manutención infantil	\$
3. Otro	\$	3. Otros	\$	3. Manutención a dependientes	\$
4. Total de ingresos	\$	4. Total activos	\$	4. Jubilación	\$
5. Ajuste a ingresos	\$	5. Activos permitidos (sin impuestos)	\$	5. Total Medical	\$
6. Responsabilidad anual	\$	6. Activos cumplidos	\$	6. Excedente de Medical	\$
7. Pago trimestral (condado)	\$	7. Activos mensuales	\$	7. Total de gastos	\$
Pago mensual (contratista)	\$				

**Información del trabajo**

Empleador, persona responsable (RP)	Cónyuge del empleador
Nombre: _____	Nombre: _____
Domicilio: _____	Domicilio: _____
Ciudad, estado, código postal: _____	Ciudad, estado, código postal: _____
Teléfono: _____	Teléfono: _____

**Información del seguro**

Número de Medi-Cal: _____	Período de elegibilidad: _____
Número de Medicare: _____	Fecha efectiva Parte A: _____ Fecha efectiva Parte B: _____
Nombre del seguro: _____	Número de identificación: _____
Domicilio para cobranzas: _____	
Número de grupo: _____	Fecha efectiva: _____
Número de póliza: _____	Fecha de caducidad: _____
Nombre de la persona asegurada: _____	Sexo de la persona asegurada: <input type="checkbox"/> Masculino <input type="checkbox"/> Femenino
Número de Seguro Social de la persona asegurada: _____ / _____ / _____	Relación con el asegurado(a): _____
<input type="checkbox"/> Relacionado con el trabajo <input type="checkbox"/> Cesión de beneficios <input type="checkbox"/> Divulgación de información <input type="checkbox"/> Información completa	

**Firmas**

Yo entiendo que estoy obligado a pagar el deducible de UMDAP establecido o el costo real de los servicios recibidos durante el año contrato de UMDAP, lo que sea menor. Entiendo que estoy obligado a pagar por el costo de atención médica hasta el valor del deducible de UMDAP sin importar cuando se termine el tratamiento.

Nombre de la parte responsable (letra de imprenta): \_\_\_\_\_ Firma del entrevistador: \_\_\_\_\_

Firma de la parte responsable: \_\_\_\_\_ Fecha: \_\_\_\_\_

County of San Diego  
 Health and Human Services Agency  
 Mental Health Services

**InSyst Payor Financial Information**  
 HHSA-MHS 932 (01/2005)

Client: \_\_\_\_\_

MR/Client ID#: \_\_\_\_\_

Program: \_\_\_\_\_

**San Diego County Organizational Providers**

**InSyst Payor Financial Information**

New Account   
 Annual Re-determination   
 Revision to Existing UMDAP

Tên Thân Chủ: _____	Số hồ sơ: _____ / _____
UMDAP Thời gian chịu trách nhiệm Từ: _____ / _____ / _____	To: _____ / _____ / _____
Số người quý vị phải cấp dưỡng: _____	Không rõ ai chịu trách nhiệm: _____

A. Lợi tức hằng tháng	B. Tổng số lợi tức	C. Chi phí hằng tháng
1. Quý vị \$	1. Chương mục tiêu xài \$	1. Tiền trả do tòa án định \$
2. Cha mẹ/chồng hay vợ \$	2. Chương mục tiết kiệm \$	2. Tiền giữ trẻ \$
3. Người khác \$	3. Những thứ khác \$	3. Tiền cấp dưỡng \$
4. Tổng số lợi tức \$	4. Tổng số tài sản \$	4. Tiền hưu dưỡng \$
5. Lợi tức đã điều chỉnh \$	5. Tài sản được có \$	5. Tiền trả Medical \$
6. Tiền nợ hàng năm \$	6. Tài sản qui định \$	6. Tiền phụ trả Medical \$
7. Lương tam cá nguyệt \$	7. Tài sản hàng tháng \$	7. Tổng số chi phí \$
Lương tháng (Hợp đồng) \$		

**Chi Tiết Nghề Nghiệp**

Chủ Nhân của Người chịu trách nhiệm trả tiền (RP)	Chủ Nhân của người chồng/vợ
Tên: _____	Tên: _____
Địa chỉ: _____	Địa chỉ: _____
Thành phố, Tiểu bang, Số vùng: _____	Thành phố, Tiểu bang, Số vùng: _____
Điện thoại: _____	Điện thoại: _____

**Chi Tiết Bảo Hiểm**

Số thẻ Medi-Cal : _____	Thời gian hợp lệ: _____
Số thẻ Medicare _____	Phần A, hiệu lực từ ngày: _____ Phần B, hiệu lực từ ngày: _____
Tên Bảo Hiểm: _____	Số Chứng Minh cá nhân: _____
Địa chỉ gửi hóa đơn: _____	
Số mã Nhóm Bảo Hiểm: _____	Hiệu lực từ ngày: _____
Số mã của Hợp đồng: _____	Hết hạn ngày: _____
Tên người được bảo hiểm _____	Phái tính của người được bảo hiểm: <input type="checkbox"/> Nam <input type="checkbox"/> Nữ
Số an sinh của người được bảo hiểm _____ / _____ / _____	Liên hệ gì với người được bảo hiểm: _____
<input type="checkbox"/> Liên hệ đến công việc	<input type="checkbox"/> Chi định lợi ích
<input type="checkbox"/> Tiết lộ chi tiết	<input type="checkbox"/> Chi Tiết đầy đủ

**Signatures**

Tôi hiểu là tôi bắt buộc phải thanh toán khoản khấu trừ trả trước (deductible) của UMDAP hay trả đúng giá của dịch vụ trong thời gian hợp đồng 1 năm với UMDAP, điều nào ít hơn. Tôi hiểu là tôi bắt buộc phải trả chi phí dịch vụ trừ khoản khấu trừ trả trước UMDAP, không kể khi việc trị liệu bị chấm dứt.

Tên người chịu trách nhiệm trả tiền (Chủ in) \_\_\_\_\_ Chữ ký của người phỏng vấn: \_\_\_\_\_  
 Chữ ký của người chịu trách nhiệm \_\_\_\_\_ Ngày tháng \_\_\_\_\_

County of San Diego  
 Health and Human Services Agency  
 Mental Health Services

**InSyst Payor Financial Information**  
 HHSA-MHS 932 (01/2005)

Client: \_\_\_\_\_  
 MR/Client ID#: \_\_\_\_\_  
 Program: \_\_\_\_\_

San Diego County Organizational Providers

اسم العميل: _____	رقم العميل/ رقم الحساب: _____
فترة المسؤولية ضمن برنامج ( UMDAP ) تبدأ اعتباراً من: _____	لغاية: _____
عدد الأشخاص المعتمدين مالياً على العميل: _____	المسؤولية الغير المحددة: _____

أ. الدخل الشهري		ب. الأموال المنقولة و الغير المنقولة		ج. المصاريف الشهرية	
1. الذات	\$	1. الحساب الجاري	\$	1. قرارات المحكمة	\$
2. الوالدين/أو (الزوج أو الزوجة)	\$	2. حساب التوفير	\$	2. الرعاية بالأطفال	\$
3. أخرى	\$	3. أخرى	\$	3. الإعتماد بالمعتمدين عليك مالياً	\$
4. الدخل الكلي	\$	4. مجموع الأموال	\$	4. التقاعد	\$
5. الدخل المعدل	\$	5. الأموال المسموح بها	\$	5. مجموع التكاليف الطبية	\$
6. المسؤولية المالية السنوية	\$	6. رأس المال الصافي	\$	6. الزيادة على التكاليف الطبية	\$
7. الدفعات الفصلية (المقاطعة)	\$	7. الأموال الواردة شهرياً	\$	7. مجموع المصاريف	\$
الدفعات الشهرية (المتعاقدين)	\$				

بيانات العمل	
مستوظف الطرف المسؤول	مستوظف (الزوج أو الزوجة)
الإسم: _____	الإسم: _____
العنوان: _____	العنوان: _____
المدينة، الولاية و الرمز البريدي: _____	المدينة، الولاية، و الرمز البريدي: _____
رقم الهاتف: _____	رقم الهاتف: _____

بيانات التأمين الصحي

رقم التأمين الصحي الحكومي ( MediCal ) : _____	فترة التأهل للخدمات: _____
رقم التأمين الصحي الحكومي ( Medicare ) : _____	تاريخ نفاذ الجزء أ: _____
إسم شركة التأمين: _____	تاريخ نفاذ الجزء ب: _____
العنوان البريدي: _____	رقم هوية تعريف الشخصية ( ID ) : _____
رقم المجموعة: _____	تاريخ النفاذ: _____
رقم عقد التأمين: _____	تاريخ الإنتهاء: _____
إسم الشخص المؤمن عليه: _____	جنس الشخص المؤمن عليه <input type="checkbox"/> ذكر <input type="checkbox"/> أنثى
رقم الضمان الإجتماعي للشخص المؤمن عليه: _____	العلاقة بالشخص المؤمن عليه: _____
<input type="checkbox"/> متعلقة بالعمل	<input type="checkbox"/> توزيع المنافع
<input type="checkbox"/> السماح بتداول البيانات	<input type="checkbox"/> إكمال البيانات

التوقيع

I understand that I am obligated to pay the established UMDAP deductible or the actual cost of services received during the UMDAP contract year, whichever is less. I understand that I am obligated to pay for the cost of care up to the UMDAP deductible regardless of when treatment is terminated. أنني أعلم بأنني ملزم بدفع المبالغ المقررة حسب برنامج UMDAP أو الكلفة الكاملة للخدمات التي حصلت عليها خلال عام التعاقد مع UMDAP. إنني أعلم بأنني ملزم بدفع تكاليف الرعاية الصحية ضمن الحد الذي تعد أنت مسؤول عنه ضمن برنامج UMDAP بغض النظر على تاريخ إنتهاء العلاج.

إسم الطرف المسؤول (يرجى الكتابة بوضوح): \_\_\_\_\_

توقيع الطرف المقابل: \_\_\_\_\_

توقيع الطرف المسؤول: \_\_\_\_\_

التاريخ: \_\_\_\_\_

Client: _____	County of San Diego Health and Human Services Agency Mental Health Services
MR/Client ID#: _____	
Program: _____	<b>InSyst Payor Financial Information</b> HHSA-MHS 932 (01/2005)

**San Diego County Organizational Providers**

County of San Diego  
Health and Human Services Agency  
Mental Health Services

**ASSIGNMENT OF INSURANCE BENEFITS  
AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I/We \_\_\_\_\_ Patient M.R. \_\_\_\_\_ F/P# \_\_\_\_\_

Policyholder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

do hereby assign to the County of San Diego, or agencies contracted by the County of San Diego, any covered Insurance Benefits payable. (Please refer to your insurance policy or contact your insurance agent for assistance in completing the following.)

INSURANCE COMPANY \_\_\_\_\_

COMPANY ADDRESS \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ CERTIFICATE/MEMBERSHIP NUMBER \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_\_ ENROLLMENT CODE \_\_\_\_\_ PATIENT'S BIRTHDATE \_\_\_\_\_

PATIENT'S SOCIAL SECURITY NUMBER \_\_\_\_\_

POLICYHOLDER'S SOCIAL SECURITY NUMBER \_\_\_\_\_

POLICYHOLDER'S BIRTHDATE \_\_\_\_\_ UNION LOCAL NUMBER \_\_\_\_\_

***PLEASE SIGN IN BOTH PLACES BELOW***

***FOR GROUP INSURANCE***

Insurance companies must have the following information, in addition to any of the above that may apply, before payment on insurance claim can be made.

Name of Employer \_\_\_\_\_

Address of Employer \_\_\_\_\_

Group Policy Number \_\_\_\_\_ Certification/Membership Number \_\_\_\_\_

I understand and agree that I/We are responsible to the County of San Diego or Contracted Agency for all charges not paid by this agreement or as determined by Uniform Method of Determining Ability to Pay (UMDAP).

I/We authorize the release of information regarding care received at the County of San Diego Mental Health Services or a Contracted Agency in San Diego County, as requested by the Insuring Agency.

By signing this form, you are giving permission for all mental health programs provided by the County of San Diego, or its contractors, to bill your insurance for services rendered. A copy of this release will be forwarded to each program within the County of San Diego from which you receive services.

Date \_\_\_\_\_ Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_ Policyholder's Signature \_\_\_\_\_

County of San Diego  
Health and Human Services Agency  
Mental Health Services

**ASSIGNMENT OF BENEFITS**

HHSA: MHS-071 (03/2006)

**Client:** \_\_\_\_\_

**MR/Client ID#:** \_\_\_\_\_

**Program:** \_\_\_\_\_

Condado de San Diego  
 Agencia de Servicios Humanos y de Salud  
 Servicios de Salud Mental

**CESIÓN DE BENEFICIOS DE SEGURO MÉDICO Y AUTORIZACIÓN  
 PARA LIBERAR INFORMACIÓN MÉDICA**

Yo/Nosotros \_\_\_\_\_ Paciente M.R. \_\_\_\_\_ F/P# \_\_\_\_\_

Asegurado \_\_\_\_\_ Relación con el paciente \_\_\_\_\_

Por este medio cedo/cedemos al condado de San Diego, o a las agencias contratadas por el condado de San Diego, cualquier beneficio de seguro médico cubierto pagadero. (Por favor consulte su póliza de seguro o contacte a su agente de seguros para que le ayude a completar los siguientes datos.)

COMPAÑÍA DE SEGUROS \_\_\_\_\_

DOMICILIO DE LA COMPAÑÍA \_\_\_\_\_

NÚMERO DE PÓLIZA \_\_\_\_\_ CERTIFICADO/NÚMERO DE MEMBRESÍA \_\_\_\_\_

FECHA DE VIGENCIA \_\_\_\_\_ CÓDIGO DE INSCRIPCIÓN \_\_\_\_\_ FECHA DE NACIMIENTO DEL PACIENTE \_\_\_\_\_

NÚMERO DE SEGURO SOCIAL DEL PACIENTE \_\_\_\_\_

NÚMERO DE SEGURO SOCIAL DEL ASEGURADO \_\_\_\_\_

FECHA DE NACIMIENTO DEL ASEGURADO \_\_\_\_\_ NÚMERO DEL SINDICATO LOCAL \_\_\_\_\_

***POR FAVOR FIRME EN LOS DOS LUGARES A CONTINUACIÓN***

***PARA SEGURO DE GRUPO***

Además de la información anterior que corresponda, las compañías de seguros deben contar con la siguiente información antes de que se efectúe un pago a una reclamación de seguro.

Nombre del empleador \_\_\_\_\_

Domicilio del empleador \_\_\_\_\_

Número de la póliza de grupo \_\_\_\_\_ Certificación/ Número de membresía \_\_\_\_\_

Entiendo y estoy de acuerdo en que Yo/Nosotros somos responsables ante el condado de San Diego o agencia contratada de todos los cargos que no sean pagados por este acuerdo o como se determina por el Método Uniforme de Determinación de Habilidad de Pago (UMDAP, por sus siglas en ingles: *Uniform Method of Determining Ability to Pay*).

Yo/Nosotros autorizamos que se divulgue información en relación a la atención recibida de los Servicios de Salud Mental del condado de San Diego o de la agencia contratada en el condado de San Diego, como lo solicitó la agencia de seguros.

Al firmar este formulario usted está dando su autorización para que todos los programas de salud mental que el condado de San Diego proporciona, o sus contratistas, envíen a su compañía de seguros la factura por servicios prestados. Una copia de este formulario de autorización será enviada a cada programa del cual usted recibe servicios y que se encuentre dentro del Condado de San Diego.

Fecha \_\_\_\_\_ Firma del paciente \_\_\_\_\_

Fecha \_\_\_\_\_ Firma del asegurado \_\_\_\_\_

County of San Diego  
 Health and Human Services Agency  
 Mental Health Services

**ASSIGNMENT OF BENEFITS**

HHSA: MHS-071 03/2006)

**Client:** \_\_\_\_\_

**MR/Client ID#:** \_\_\_\_\_

**Program:** \_\_\_\_\_

Quận Hạt San Diego  
Cơ Quan Sức Khỏe và Nhân Sinh  
Dịch Vụ Sức Khỏe Tâm Thần

**CHỈ ĐỊNH CÁC QUYỀN LỢI BẢO HIỂM  
VÀ GIẤY ỦY QUYỀN TIẾT LỘ CHI TIẾT Y KHOA**

Tôi/Chúng tôi \_\_\_\_\_ Bệnh nhân M.R. \_\_\_\_\_ F/P# \_\_\_\_\_  
Tên người đứng tên hợp đồng bảo hiểm \_\_\_\_\_ Liên hệ gì với bệnh nhân \_\_\_\_\_

Xin chỉ định cho Quận Hạt San Diego, hay các cơ quan hợp đồng với Quận Hạt San Diego, được nhận lãnh bất cứ phúc lợi trả từ bảo hiểm. (Xin vui lòng đưa số hợp đồng hay liên lạc với nhân viên bảo hiểm để được giúp đỡ điền đơn dưới đây)

TÊN CÔNG TY BẢO HIỂM \_\_\_\_\_  
ĐỊA CHỈ CÔNG TY \_\_\_\_\_  
SỐ HỢP ĐỒNG \_\_\_\_\_  
SỐ THẺ HỘI VIÊN \_\_\_\_\_  
CÓ HIỆU LỰC NGÀY \_\_\_\_\_ MÃ SỐ GHI DANH \_\_\_\_\_  
SỐ AN SINH XÃ HỘI CỦA THÂN CHỦ \_\_\_\_\_  
SỐ AN SINH XÃ HỘI CỦA NGƯỜI ĐỨNG TÊN HỢP ĐỒNG \_\_\_\_\_  
MÃ SỐ CỦA CÔNG ĐOÀN ĐỊA PHƯƠNG \_\_\_\_\_

***XIN VUI LÒNG KÝ TÊN VÀO HAI CHỖ DƯỚI ĐÂY***

***ĐỐI VỚI NHÓM BẢO HIỂM***

Ngoài những chi tiết bên trên, các hãng bảo hiểm phải có thêm những thông tin dưới đây, trước khi hóa đơn của hãng được trả tiền.

Tên của Chủ Nhân \_\_\_\_\_  
Địa chỉ của Chủ Nhân \_\_\_\_\_  
Số Hợp đồng của Nhóm Bảo Hiểm \_\_\_\_\_  
Số Chứng chỉ/Hội viên \_\_\_\_\_

Tôi hiểu rõ và đồng ý là Tôi/Chúng tôi có trách nhiệm với Quận Hạt San Diego hay Cơ quan có Hợp đồng về những chi phí không được thanh toán căn cứ vào bản thỏa hiệp này hoặc được quyết định của Phương Cách Trả Tiền Dựa Vào Khả Năng (UMDAP).

Tôi/Chúng tôi cho phép được tiết lộ chi tiết về việc chăm sóc mà tôi đã nhận tại Dịch Vụ Tâm Thần của Quận Hạt San Diego hay từ một Cơ quan Hợp đồng ở Quận hạt San Diego, dựa vào yêu cầu của Bảo Hiểm.

Khi quý vị ký tên vào đơn này, quý vị sẽ hưởng tất cả quyền lợi về những chương trình thuộc sức khỏe tâm thần được cung cấp bởi Quận hạt San Diego, hoặc bởi những nhà thầu, để thanh toán, hoàn trả với bảo hiểm việc phục vụ cho quý vị. Bản sao của đơn này sẽ gửi tới những chương trình hoặc nơi mà quý vị nhận sự phục vụ, chữa trị trong phạm vi Quận hạt San Diego.

Ngày tháng \_\_\_\_\_ Chữ ký của thân chủ \_\_\_\_\_  
Ngày tháng \_\_\_\_\_ Chữ ký của người đứng tên hợp đồng \_\_\_\_\_

County of San Diego  
Health and Human Services Agency  
Mental Health Services

**ASSIGNMENT OF BENEFITS**  
HHSA: MHS-071 (09/2004)

**Client:** \_\_\_\_\_

**MR/Client ID#:** \_\_\_\_\_

**Program:** \_\_\_\_\_

مقاطعة سان دييغو  
وكالة الخدمات الصحية و الإنسانية  
برنامج خدمات الصحة النفسية  
إختيار منافع برنامج التأمين  
و التحويل لتداول البيانات الطبية

أنا/نحن \_\_\_\_\_ رقم المريض \_\_\_\_\_ F/P \_\_\_\_\_

أسم صاحب عقد التأمين: \_\_\_\_\_ صلة القرابة بالمريض: \_\_\_\_\_

أقر هنا بأنني قد اخترت مقاطعة سان دييغو أو الوكالات المتعاقدة مع مقاطعة سان دييغو، لإستلام أي منافع يدفعها برنامج التأمين الصحي. (يرجى أن تقوم بمراجعة عقد تأمينك أو ممثل شركة التأمين للحصول على المساعدة في تعبئة البيانات التالية.)

إسم شركة التأمين: \_\_\_\_\_

عنوان الشركة: \_\_\_\_\_

رقم عقد التأمين \_\_\_\_\_ رقم الشهادة أو العضوية: \_\_\_\_\_

تاريخ النفاذ: \_\_\_\_\_ رمز الإشتراك: \_\_\_\_\_ تاريخ ميلاد المريض: \_\_\_\_\_

رقم الضمان الإجتماعي للمريض: \_\_\_\_\_

رقم النقابة المحلية: \_\_\_\_\_

**يرجى أن توقع في كلتا الخاتين أدناه**

**خاص بشركات التأمين الجماعية**

يجب على شركات التأمين أن تقدم البيانات التالية، بالإضافة الى البيانات الواردة أعلاه التي قد تنطبق على شركة التأمين، قبل أن يتم دفع مبلغ المطالبة من قبل شركة التأمين.

رقم صاحب العمل: \_\_\_\_\_

عنوان صاحب العمل: \_\_\_\_\_

رقم عقد تأمين المجموعة: \_\_\_\_\_ رقم الشهادة أو العضوية: \_\_\_\_\_

إنني أعلم و أقر بأنني أتحمل المسؤولية المالية تجاه مقاطعة سان دييغو أو الوكالات المتعاقدة معها إذا لم يتم دفع تكاليف الخدمات المقدمة ضمن هذا العقد أو كما يتم حساب تلك التكاليف بالطريقة المنظمة لتحديد القدرة على الدفع ( Uniform Method of Determining Ability to Pay (UMDAP)).

إنني أخول تداول البيانات المتعلقة بالرعاية المقدمة من قبل مديرية خدمات الصحة النفسية في المقاطعة أو من قبل إحدى الوكالات المتعاقدة معها في مقاطعة سان دييغو، عند طلب ذلك من قبل شركة التأمين الصحي.

بالتوقيع على هذه الإستمارة، فأنت ستقوم بمنح كافة برامج الصحة النفسية المقدمة من قبل مقاطعة سان دييغو، أو المتعاقدين معها، الحق بمطالبة شركة تأمينك الصحي بتكاليف الخدمات التي تم إستخدامها. سيتم إرسال نسخة عن هذه الإستمارة إلى كل برنامج ضمن مقاطعة سان دييغو من البرامج التي قد حصلت على خدمات منها.

التاريخ: \_\_\_\_\_ توقيع المريض: \_\_\_\_\_

التاريخ: \_\_\_\_\_ توقيع صاحب عقد التأمين: \_\_\_\_\_

County of San Diego  
Health and Human Services Agency  
Mental Health Services

**ASSIGNMENT OF BENEFITS**

HHS: MHS-071 (03/2006)

Client: \_\_\_\_\_

MR/Client ID#: \_\_\_\_\_

Program: \_\_\_\_\_

**San Diego County Organizational Providers**

Distrito ng San Diego  
Ahensiya ng Kalusugan at ng Makataong Serbisyo  
Serbisyo sa Kalusugan ng Pangkaisipan

**PAGTATALAGA NG BENIPISYO NG SEGURO**  
**AT PAGPAPAHINTULOT NA IPAHAYAG ANG KAALAMANG MEDIKAL**

Ako/Kami \_\_\_\_\_ M.R. ng Pasyente \_\_\_\_\_ F/P# \_\_\_\_\_

Humahawak sa Patakaran \_\_\_\_\_ Kaugnayan sa Pasyente \_\_\_\_\_

Ay itinalaga sa County ng San Diego, o mga ahensiyang kinontrata ng County ng San Diego, and alinmang bayarin na sakop ng Benepisyo ng Seguro . (Tingnan ang policy ng seguro, tawagan o makipagkita sa iyong kinatawan ng seguro para sa tulong sa pagkompleto ng mga sumusunod na impormasyon.)

KOMPANYA NG SEGURO \_\_\_\_\_

ADRES NG KOMPANYA \_\_\_\_\_

NUMERO NG POLICY \_\_\_\_\_ SERTIPIKO/NUMERO NG PAGKAKASAPI \_\_\_\_\_

PETSA NG PAGKAROON NG BISA \_ KODIGO NG PAGPAPALISTA PETSA NG PAGSILANG NG  
PASYENTE \_\_\_\_\_

NUMERO NG SOSYAL SEKYURITI NG PASYENTE \_\_\_\_\_

NUMERO NG SOSYAL SEKYURITI NG HUMAHAWAK SA POLICY \_\_\_\_\_ LOKAL NA NUMERO NG UNYON \_\_\_\_\_

***PAKIPIRMA SA MGA KAPWA LUGAR SA IBABA***

***PARA SA SEGURO NG GRUPO***

Ang mga kompanya ng seguro ay dapat magkaroon ng sumusunod na impormasyon, karagdagan ng anomang impormasyon na magagamit sa taas ng papel na ito, bago gawin ang anumang hinihinging kabayaran ng seguro!  
Pangalan ng Pinagtrabahuhan \_\_\_\_\_

Adres ng Pinagtrabahuhan \_\_\_\_\_

Numero ng Grupo ng Seguro \_\_\_\_\_ Sertipiko/Numero ng pagkakasapi \_\_\_\_\_

Aking naiintindihan at sang-ayon na Ako/Kami ay may pananagutan sa County ng San Diego o Nakakontratang Ahensiya para sa lahat na mga na hindi nabayaran kasunduang ito o ang napagpasiyahang kabayaran sa pamamagitan ng Magkatulad na Paraan ng Pagpapasiya sa Kakayanang Kabayara-Uniform Method of Determining Ability to Pay (UMDAP).

Aking/Aming pinahintulutan ang pagpahayag ng impormasyon tungkol sa natatanggap sa County ng San Diego ng mga Serbisyo ng Kalusugang Pangkaisipan o ang Nakakontratang Ahensiya sa County ng San Diego, na hiniling sa pamamagitan ng Nagpaseguro na Ahensiya.

Sa pagpirma ng pormang ito, ikaw ay nagbibigay ng pahintulot para sa lahat ng mga programa ng kalusugang pangkaisipan na pinagkaloob ng County ng San Diego, o nitong mga nangongontratang ahensiya, upang mapadalhan ng kuwenta ang iyong kompanya ng seguro para sa mga serbisyong ibinigay sa iyo. Ang kopya nitong pahayag ay ipapadala sa bawat programa sa loob ng County ng San Diego na kung saan ka tumanggap ng serbisyo

Petsa \_\_\_\_\_ Pirma ng Pasyente \_\_\_\_\_  
Petsa \_\_\_\_\_ Pirma ng Humahawak ng Patakaran \_\_\_\_\_

County of San Diego  
Health and Human Services Agency  
Mental Health Services

**ASSIGNMENT OF BENEFITS**

HHSA: MHS-071 (03/2006)

**Client:** \_\_\_\_\_

**MR/Client ID#:** \_\_\_\_\_

**Program:** \_\_\_\_\_

**County of San Diego  
Health and Human Services Agency  
Mental Health Services**

**CHANGE/ADDITION OF INFORMATION**

**Change From**

**Change To**

Patient's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Medical Record # \_\_\_\_\_

Client Number (S#) \_\_\_\_\_

Social Security # \_\_\_\_\_

Race \_\_\_\_\_

Sex \_\_\_\_\_

Telephone # \_\_\_\_\_

Address \_\_\_\_\_

Justification for Making Change:

\_\_\_\_\_ Medi-Cal Verified/Sticker Received (Date) \_\_\_\_\_

\_\_\_\_\_ Other Verification Documents Received/Verified (Date) \_\_\_\_\_

List Documents \_\_\_\_\_

\_\_\_\_\_ Personal Identification (Date) \_\_\_\_\_

By Whom \_\_\_\_\_

Remarks \_\_\_\_\_

\_\_\_\_\_

Originator (Name/Location) \_\_\_\_\_

Date \_\_\_\_\_

Phone # \_\_\_\_\_

Distribution:

Original – Mental Health Medical Records Services (P-531)

1<sup>st</sup> Copy – MIS (P-531E)

2<sup>nd</sup> Copy – File Copy for Originator

3<sup>rd</sup> Copy – Service Program (Therapist)

HHSA:MHS(02/2005)

**San Diego County Organizational Providers**

County of San Diego – Health and Human Services Agency  
Mental Health Services

Route via (#) below  
as necessary

**DEDUCTIBLE ADJUSTMENT REQUEST**

**TO:** Program/Region Mgr \_\_\_\_\_ Mail Stop(MS#) \_\_\_\_\_ Date \_\_\_\_\_  
**FROM:** \_\_\_\_\_ Title \_\_\_\_\_ (MS#) \_\_\_\_\_

**RE:** Patient Name \_\_\_\_\_ Acct # \_\_\_\_\_ Client # \_\_\_\_\_

**CRITERIA:** (Check those applicable for Deductible Adjustment)

\_\_\_\_\_ Stated inability to pay due to \_\_\_\_\_

UMDAP Annual Deductible \$ \_\_\_\_\_ Monthly Rate \$ \_\_\_\_\_ Contract Yr \_\_\_\_\_

\_\_\_\_\_ Will not return for recommended treatment and without treatment the client's mental health will diminish

\_\_\_\_\_ Without treatment, patient may become suicidal and/or injure self or others.

\_\_\_\_\_ Recommended by Therapist that reduction be granted. Therapist \_\_\_\_\_

Signature

**Amount Patient will pay:** Annual \$ \_\_\_\_\_ Monthly \$ \_\_\_\_\_

**STATEMENT: (Further justification)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Continue on attached sheet if necessary

**Eligibility Recommendation (If Needed):**  APPROVAL  DISAPPROVAL  NO RECOMMENDATION

\_\_\_\_\_

Signed \_\_\_\_\_

**Adjustment Review:**  Disapproved  
 Approved For

Annual Deductible \$ \_\_\_\_\_

Payable Monthly at \$ \_\_\_\_\_

Program/Region Mgr. Signature \_\_\_\_\_

Fax To: ASO

Route cc: Eligibility Review

Request Unjustified – Denied  Request Justified Reduce To Recommended Amount

**Final and/or  
Appeal Review:**

ADMINISTRATOR \_\_\_\_\_ ANNUAL \$ \_\_\_\_\_ MONTHLY AT \$ \_\_\_\_\_

HHSA:MHS-661 (9/2006)

Fax Form: To HHSA/FSSD MH Billing Unit for UMDAP updating  
cc: Eligibility Review

**San Diego County Organizational Providers**

Insurance Company Name: \_\_\_\_\_

Street Address 1: \_\_\_\_\_

Street Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Name: \_\_\_\_\_

**Telephone Number:** (    ) \_\_\_\_\_

**Requested By:** \_\_\_\_\_ **Tel. No.:** \_\_\_\_\_

**Please fax this request to:**

**Anselma Danque**  
**(619) 237-8472 (Fax)**

Should you have any questions, please contact Anselma directly at (619) 338-2906. You will be notified as soon as the insurance policy is inserted.

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

Time: \_\_\_\_\_

Person Notified: \_\_\_\_\_

**San Diego County Organizational Providers**

**Collection of Client Accounts**

**Program Name:** \_\_\_\_\_

**Reporting Unit** \_\_\_\_\_

**Client Payment Record**

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

	<b>Account #</b>	<b>Client Name</b>	<b>Date Received</b>	<b>Date Sent to MH Billing Unit</b>	<b>Amount</b>	<b>Check, Money Order or Cash Receipt Number</b>
1.					\$	
2.					\$	
3.					\$	
4.					\$	
5.					\$	
6.					\$	
7.					\$	
8.					\$	
9.					\$	
10.					\$	
11.					\$	
12.					\$	
13.					\$	
14.					\$	
15.					\$	
16.					\$	
17.					\$	
18.					\$	
19.					\$	
20.					\$	

San Diego County Organizational Providers



UNIFORM PATIENT FEE SCHEDULE  
COMMUNITY MENTAL HEALTH SERVICES  
EFFECTIVE OCTOBER 1, 1989



MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
<b>MEDI-CAL ELIGIBLE AREA**</b>					
0-569	37	33	30	27	24
570-599	40	36	32	29	26
600-649	45	40	36	32	29
650-699	50	45	41	37	33
700-749	56	50	45	41	37
750-799	63	57	51	46	41
800-849	71	64	58	52	47
850-899	79	71	64	58	52
900-949	89	80	72	65	59
950-999	99	90	80	72	65
1000-1049	111	100	90	81	73
1050-1099	125	112	101	91	82
1100-1149	140	126	113	102	92
1150-1199	156	140	126	113	102
1200-1249	177	159	143	129	116
1250-1299	200	180	162	146	131
1300-1349	226	203	183	165	149
1350-1399	255	230	207	186	167
1400-1449	288	259	233	210	189
1450-1499	326	293	264	238	214
1500-1549-	368	331	298	268	241
1550-1599	416	374	337	303	273
1600-1649	470	423	381	343	309
1650-1699	531	478	430	387	348
1700-1749	600	540	486	437	393
1750-1799	678	610	549	494	445
1800-1849	752	677	609	548	493
1850-1899	835	752	677	609	548
1900-1949	927	834	751	676	608

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
1950-1999	1029	926	833	750	675
2000-2049	1142	1028	925	833	750
2050-2099	1268	1141	1027	924	832
2100-2149	1407	1266	1139	1025	923
2150-2199	1562	1406	1265	1139	1025
2200-2249	1734	1561	1405	1265	1139
2250-2299	1925	1733	1560	1404	1264
2300-2349	2136	1922	1730	1557	1401
2350-2399	2371	2134	1921	1729	1556
2400-2449	2632	2369	2132	1919	1727
2450-2499	2922	2630	2367	2130	1917
2500-2599	3275	2948	2653	2388	2149
2600-2699	3482	3134	2821	2359	2285
2700-2799	3695	3326	2993	2694	2425
2800-2899	3915	3524	3172	2855	2570
2900-2999	4139	3725	3353	3018	2716
3000-3099	4370	3933	3540	3186	2867
3100-3199	4607	4146	3731	3358	3022
3200-3299	4850	4365	3929	3536	3182
3300-3399	5099	4589	4130	3717	3345
3400-3499	5458	4912	4421	3979	3581
3500-3599	5830	5247	4722	4250	3825
3600-3699	6214	5593	5036	4532	4079
3700-3799	6610	5949	5354	4819	4337
3800-3899	7018	6316	5684	5116	4604
3900-3999	7438	6694	6025	5423	4881
4000-4099	7870	7083	6375	5738	5164
4100-4199	8314	7483	6735	6062	5456
\$ 4200 and above add \$ 400 for each \$ 100 additional income					

- \*Monthly Gross Income after adjustments for allowable expenses and asset determination from computation made on the financial intake form.
- \*\* Medi-Cal eligible. The shaded Medi-Cal eligible area identifies income levels presumed eligible if client meets Medi-Cal eligibility requirements.
- Prepared and published by the California Department of Mental Health in accordance with Sections 5717 and 5718 of the Welfare and Institutions Code. (ATTACHMENT C)

10/20/89

**QUICK REFERENCE**

**MEDI-CAL ELIGIBILITY**

All clients with monthly income at or below the Medi-Cal Family Budget Unit (MFBU) and have assets at or below the asset allowance area are presumed eligible if they meet aid eligibility requirements.

Maintenance need levels by Medi-Cal Family Budget Unit (MFBU) are:

MFBU	1. \$ 602	3. \$ 934	6. \$ 1,417	9. \$ 1,825
	2. \$ 750	4. \$ 1,100	7. \$ 1,550	10. \$ 1,959
	2. \$ 934 (Adults)	5. \$ 1,259	8. \$ 1,692	

Asset allowances for 1989 are:

Persons	1. \$ 2000	4. \$ 3300	7. \$ 3750
	2. \$ 3000	5. \$ 3450	8. \$ 3900
	3. \$ 3150	6. \$ 3600	9. \$ 4050

Aid categories commonly found in community mental health are:

<b>REFUGEE-</b> First 18 months in the U.S.	<b>DISABLED-</b> Meeting Federal definition of disability.
<b>AGED-</b> 65 years of age and over	<b>AFDC-</b> Aid to Family with Dependent Children.

**MEDI-CAL SHARE-OF-COST**

Persons with an extended treatment prognosis who are within a few hundred dollars of asset allowance and maintenance need levels may be eligible for Medi-Cal with a share-of-cost and/or real or personal property spend down.

For Example: A single 70-years of age man would be eligible for Medi-Cal except his income is too high. He has a \$ 1,000 medical bill. He meet low asset levels, but his income from retirement is \$1,000 per month. His income is \$ 1,000 minus the standard \$20 disregard and the \$ 24.90 payment for the Medicare Part B, leaving a “net” of \$ 955.10. His “share-of-cost” for Medi-Cal is \$ 955.10 minus \$ 602 (“need level”) or \$ 353.10. Medi-Cal will pay the remainder of the \$ 1,000 medical bill for that month and other months when he obligates the share-of-cost above \$ 353.10. His eligibility will be re-determined by Social Services each year.

All persons with property and income within a few hundred dollars of the Medi-Cal limits and are expected to have substantial treatment cost must be referred to Social Services for eligibility determination. Persons on Medi-Cal, SSI or incomes in the shaded area don not have an annual deductible.

## San Diego County Organizational Providers



### Medi-Cal Information Numbers:

Medi-Cal Mail-In Applications & Info. Public Assistance Unit	1-866-262-9881
San Diego Kids Health Assurance Network (SDKHAN)	1-800-675-2229
Healthy Families	1-800-880-5305
Healthy-e-App	1-866-861-3443

### Family Resource Centers that take Medi-Cal Applications:

Family Resource Center – Southeast 4588 Market St. San Diego CA 92102; (619) 236-7501	Family Resource Center – Northeast 5001 73 <sup>rd</sup> St. San Diego CA 92115; (619) 464-5701
Family Resource Center – North Coastal 1315 Union Plaza Ct. Oceanside CA 92054; (760) 754-5757	Family Resource Center – North Inland 620 East Valley Pkwy. Escondido CA 92025; (760) 741-4391
Family Resource Center – Lemon Grove 7065 Broadway Lemon Grove CA 91945; (619) 464-5114	Family Resource Center – Kearny Mesa 5201 Ruffin Rd. San Diego CA 92123; (858) 565-5598
Family Resource Center – El Cajon 220 S. 1 <sup>st</sup> St. El Cajon CA 92021; (619) 579-4335	Mills Building/Trolley Towers 1255 Imperial Ave. San Diego CA 92101; (619) 338-2555
South Region Center 690 Oxford St. Chula Vista CA 91911; (619) 427-9660	Fallbrook Community Resource Center 130 E. Alvarado St. Fallbrook CA 92028; (760) 723-5681
Ramona Community Resource Center 1521 Main St. Ramona CA 92065; (760) 738-2438	Family Resource Center – Mission Valley 7947 Mission Center Ct. (Granted Cases Only) San Diego CA 92108; (619) 767-5206

### SSI Advocacy Services for Mental Health Clients:

Casa Del Sol Club House 1157 30 <sup>th</sup> St. San Diego CA 92154; (619) 429-5205	Mariposa Club House 560 Greenbrier, Suite 102 Oceanside CA 92054; (760) 439-6006
Episcopal Community Service 1009 G St. San Diego CA 92101; (619) 238-8201	The Meeting Place 4034 Park Ave. San Diego CA 92103; (619) 294-9582