

P. Fiscal & Billing

Budget & Fiscal Instructions for Cost Reimbursement- Contracts Only

Financial Eligibility and Billing Procedures

Each provider is responsible for specific functions related to determining member financial eligibility, billing, and collections. The [Organizational Provider Financial Eligibility and Billing Procedures Handbook](#) is provided by CYFS for providers as a guide for determining financial eligibility, billing and collection procedures. These are “living” handbook/manuals that are revised as new processes/procedures are implemented.

Contractors prepare program budgets for County review and approval. The approved budget for each fiscal year serves as objectives and guidelines for contract performance, and determination of allowable and appropriate expenditures. The budget guidelines allow for flexibility within specified dollar limits, and states conditions when prior written County approval must be obtained before contractors are allowed to exceed the specified limits for discretionary variance from the approved budget. It is expected that budgets submitted by providers will include all expenses that are needed to support the program during the fiscal year.

Budget: The annual contract amount is specified in the contract and supported by an annual budget developed by the contractor. Contractor must obtain written prior approval from the County and a Contract Amendment must be executed before exceeding the fiscal year's approved budget. Unspent funds from one fiscal year may not be applied to subsequent fiscal year's expenditures unless authorized and supported by a Contract Amendment. If expenses are within the allowable limits stated below, no prior approval or change to the budget is required, though all expenses must always be reasonable and appropriate for the contracted services and are subject to subsequent review and disallowance. Any expenditures requiring written approval must be requested in advance and approved by the COR. Approval is not effective, and contractor should not incur any requested expense, until notified.

Invoice: Where the term "invoice is used in Service Agreement Article 4, "cost report" may be substituted as appropriate.

Total Direct Labor Cost

Reimbursable direct labor cost for direct labor and program management staff incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such cost in Exhibit C, Contractor's Budget. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Salaries and

Benefits category plus any allowable unexpended Operating Expenses without the prior written approval of the COR.

The contract does provide some flexibility to transfer funds between Direct Labor Costs and Other Direct Costs. An adjustment to Direct Labor costs is allowed if it results in no net change to the total annual contract maximum. Guidance for allowed budget adjustments is listed below.

Unexpended Salaries and Benefits (S&B), up to 10% of total annual S&B budgeted amounts with a dollar value up to \$100,000, may be applied to Operating Expenses. Budget adjustments greater than 10% to Direct Labor cost; or 10% or less than to Direct Labor but with a dollar value greater than \$100,000 require prior approval from the COR. Only budget adjustments up to 10% to Direct Labor cost with a dollar value up to \$100,000 do not require prior approval from the COR.

- *Example 1: The total Salaries and Benefits amount for a program budget equals \$500,000, and contractor expects to spend less than \$430,000. Of the \$70,000 in projected unspent funds for this category, up to \$50,000 (10% of the \$500,000 Total Approved Budget with the dollar value less than \$100,000), may be applied to Operating Expenses without requiring prior approval or change to the budget.*
- *Example 2: The total Salaries and Benefits amount for a program budget equals \$600,000, and contractor expects to spend less than \$570,000. The entire \$30,000 in projected unspent funds for this category, which is less than the limit of \$60,000 and with the dollar value less than \$100,000, may be applied to Operating Expenses without requiring prior approval or change to the budget.*

Unexpended Salaries and Benefits that may be applied to Operating Expenses may be from temporary vacancies of budgeted staff.

Contractor shall not purposefully keep positions vacant for the purpose of accruing savings to be used for Operating Expenses. When staffing levels are reduced due to reduced workloads, then it is expected that operating expenses would be similarly underspent. The intent is to fill all budgeted positions and to provide services to members. Unspent funds due to other reasonable circumstances may be applied to Operating Expenses.

Unexpended Salaries and Benefits may be applied directly to any temporary replacement staff and do not require prior County approval as long as costs do not exceed amounts budgeted for these positions.

Temporary and/or replacement staff should be listed in the Salaries and Benefits category and are not subject to prior approval as long as the total of Salaries does not exceed the budgeted amount plus 10% with a dollar value less than \$100,000

Staffing changes, including addition or deletion of budgeted staff, shall require prior COR approval. Individual salaries may be exceeded up to 5% without prior COR approval. Adequate and appropriate staffing is normally the most important factor in the successful delivery of contracted services. Any permanent change to the number (FTEs) or classification of staff requires prior written approval. Salaries for each classification may be listed as averages, and individual salaries may be exceeded up to 5% without prior written approval by the COR, as long as the overall 10% rule is heeded. NOTE: Bonuses, incentive pay, and other types of special employee pay require prior written approval by the COR and must comply with Office of Management and Budget (OMB) Guidelines

Total Other Direct Cost

Reimbursable operating costs incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such expenses in Exhibit C. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Operating Expenses category plus any allowable unexpended Salaries and Benefits without the prior written approval of the COR.

The contract does provide some flexibility to transfer funds between Direct Labor Costs and Other Direct Costs. An adjustment to Other Direct costs is allowed if it results in no net change to the total annual contract maximum. Guidance for allowed budget adjustments is listed below.

Unexpended Operating Expenses (OE), up to 10% of total annual OE budgeted amounts with a dollar value up to \$100,000, may be applied to Salaries and Benefits. All budget adjustments greater than 10% to Operating Expense cost; or 10% or less than to Operating Expense Cost but with a dollar value greater than \$100,000 require prior approval from the COR.

- *Example: If the total Operating Expenses for a program budget equals \$300,000, any unspent amount, up to a maximum of \$30,000 (10% of the total budget for this category with the dollar value less than \$100,000), may be applied to Salaries and Benefits without requiring prior COR approval.*

The budgeted amounts for Operating Expenses line items may be exceeded up to the amount stated in Behavioral Health Services Administrative Adjustment Request (AAR) Guidelines as long as the total of all items does not exceed the total budgeted Operating Expenses (including any allowable unexpended Salaries and Benefits, except for asterisked line items. Overspending by more than the allowable amount per AAR Guidelines on these Operating Expense budget line items will require a one-page Administrative Adjustment Request (AAR) form. The AAR form must be submitted clearly describing the justification for overspending, the budget line items and amounts affected.

- Example: If \$1,000 is budgeted for Office Supplies AAR Guideline allowed to exceed up to \$5,000, a total expense to date of \$1,500, will not require prior approval or change to the budget unless the total Operating Expenses amount exceeds the approved amount in the budget. NOTE: all expenses must be reasonable and appropriate for the contracted services, and are subject to subsequent review and disallowance.

Consulting expenses shall be budgeted on Agreement Budget and shall not be exceeded without prior COR approval, with the exception of temporary staffing. All other consulting services or Subcontracts not previously budgeted shall require prior written COR approval.

Budgeted amounts for Leasehold Improvements, Consultants, Subcontracts, Interest Expense and Gift Cards and Depreciation shall not be exceeded without prior written COR approval. Budgeted amounts for the member's Flex Funds may exceed up to \$1,000. Costs above \$1,000 require prior written approval by the COR. No expense shall be allowed for any line item that does not have an amount currently budgeted.

Expenses without a budget require prior COR approval and detailed justification. Additional expenses due to emergencies and/or unforeseen circumstances for line item(s) that have a \$0 budget will be reviewed on a case-by-case basis. These expenses are not allowed to be claimed in other line items that were not intended for these types of expenses.

Total Indirect Cost

Reimbursable indirect costs incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such cost in Exhibit C. The sum of any and all such costs shall not exceed the total amount budgeted for the Indirect Cost category without the written approval of the COR. Reimbursable indirect costs shall be limited such that the ratio of actual total Indirect Cost to actual total Gross Cost shall not exceed the ratio of budgeted Indirect Cost to budgeted Gross Cost. *If the total budget is underspent, it is expected that Indirect Costs would decrease proportionately.*

Other Costs: Hiring Incentives and Premium Shift Differential Rates

Any HHS contractor that can demonstrate a critical workforce need that is or will imminently negatively impact the delivery of member services and contractual capacity requirements, may consider the following strategies:

Hiring Incentives: Contractor may choose to propose a program for hiring incentives for those positions that are in critical need. Proposed hiring incentive programs must include:

- Identification of the critical staffing needs and potential contractual impact absent any mitigation.
- A documented policy for implementation of hiring incentives to meet the immediate needs of the program and indicates there will be no contract increases that result from the sign-on bonuses.
- Hiring incentive program must be time-bound for immediate recruitment needs.
- Hiring incentive programs may include moving expenses and/or sign-on incentives which must be time bound and include repayment requirements if employment terminates prior to completion of time obligation
- Proposed hiring incentive policy will require the following:
 - Adequate justification
 - COR and HHSa program management approval
 - Line-item delineation on budgets/invoices and must properly account for any staff, identification of applicable positions, amount for each position. If cost flow to the next fiscal year – claim to County will only be up to the Contract Max (covered by savings the following fiscal year), or early employment termination implications.
 - Request at the beginning of the Fiscal Year by contractor:
 - Create a new Other line in the Operating Expense tab, label as “Other: Sign-On Bonuses: Max of *\$_____”. This will have a \$1 budget.
 - The amount on the description will be the max amount that is approved for invoicing. If this amount is exceeded, a new AAR will need to be submitted for another approval.
 - For mid-year or end of the year request by contractor:
 - Salaries and Benefits will need to be updated to reflect the number of months the position is vacant creating an unspent amount.
 - Create Other line in the Operating Expense tab “Other: Sign-On

Bonuses” and reflect the budgeted amount. Reflect zero bottom net change.

Premium Shift Differential Rates: Contractors may wish to consider premium shift differential rates for staff to support shifts that are difficult to recruit, hire, retain or fill. Premium shift rates would be proposed by contractor and require approval from COR. Premium shift differentials would typically be expected for consideration on overnight shifts and 24/7 facilities, but may, upon contractor proposal and approval by management and COR, be approved for certain service settings due to the acuity or high intensity of the setting. Employees receiving Premium Shift Differential Rates would be eligible for hiring incentives outlined above.

Mental Health Providers with Housing Budget: (applicable only for contracts that remained at Cost Reimbursement)

Member Housing Line Item: This amount is to be utilized exclusively for the member housing (i.e. ‘brick and mortar’) paid by the program and does not include Housing Staff and/or related costs. This line item will be reported in the Full Housing cost center. While all Housing Costs must be reflected in the Full Housing Cost Center, there will not be an amount specified in the allocation letter for the Full Housing Cost Center: programs will have the discretion to determine how much of the total program budget to allocate to the Full Housing Cost Center when completing program budgets. The goal is to increase flexibility for programs with regard to costs for Housing Staff (without reducing funding allocated to Member Housing), and to ensure the amount allocated for Member Housing is clear and consistent.

Mental Health Budget Template and BHS Housing Budget Instructions: All Housing costs must be reflected in the Full Housing Cost Center. The Operating Expenses budget now have a row labeled ‘Member Housing’. This line should match the Member Housing allocation amount and is asterisked. It cannot be changed without COR preapproval. The Operating Expenses budget tab now have a row labeled ‘Augmented Member Housing’ cost. This line is expected to be blank at the start of fiscal year and will only be filled with COR approval via an AAR when the program receives one-time funding for additional Member Housing funding and/or is approved to move money in an AAR to cover additional Member Housing costs. This line is also asterisked and can’t be changed without COR preapproval.

Fixed Assets

All fixed asset expenses shall be budgeted and itemized on the Agreement Budget, and no fixed asset budget line item shall be exceeded without prior written COR approval.

The purchase of fixed assets that are not listed on the budget require prior written approval. Fixed assets include all non-expendable property with a value of \$5,000

or more and a normal life expectancy of more than one year. Purchase of fixed assets that are budgeted on the itemized Supplemental A and any assets not currently budgeted require written notification to the COR.

Units of Service

Units of Service are the most critical element of the program budget, and the budgeted units of service may not be changed without prior written approval by the COR. Delivery of service below budgeted levels may be considered a performance matter and subject to corrective action.

Other Revenue Sources

Behavioral Health Services Contractor shall determine and claim revenues from all other applicable sources other than the County as reimbursement for the cost of services rendered to members pursuant to this Agreement and in compliance with all applicable rules and regulations (the current version of which can be found online at the [BHS Technical Resource Library](#)

For further guidance, please refer to the [Mental Health - Financial Eligibility & Billing Procedures Org. Providers Manual](#)

Multiple Programs/Cost Centers: In agreements that have multiple programs with separate budgets submitted for each program, any adjustment between individual program budgets shall have the prior written approval of the COR. Any excess funds shall remain and be utilized in the program where originally allocated or may be reallocated by the COR for other appropriate services.

Accounting System: Contractor shall use an accounting and timekeeping system for segregating, supporting, controlling, and accounting of all funds, property, expenses, salaries, wages, revenues, and assets for each County of San Diego contract distinct from other contractor activities. Contractor shall have the ability to provide assurance that the system is in accordance with generally accepted accounting principles and federal Office of Management and Budget (OMB) Circulars, located within the applicable Code of Federal Regulations. Accounting and timekeeping systems are subject to review during in-depth invoice reviews and audits conducted by the County.

Other Fiscal Instructions: Invoices are due 30 days after end of invoice month unless other due dates are required by specific funding sources unless otherwise instructed by COR.

Budget & Fiscal Instructions for Fixed Price or Fee-For-Service (FFS) Contracts: The approved budget for each fiscal year serves as objectives and guidelines for contract performance, and determination of allowable and appropriate invoicing within the fixed Price or FFS set by the State o contracts as agreed in the Exhibit C of the contract. The

Exhibit C provides budget guidelines that may allow flexibility within specified dollar limits, and states conditions when prior written County approval or amendment must be obtained before contractors are allowed to exceed the specified limits from the approved budget. It is expected that budgets submitted by providers will include all expenses that are needed to support the program during the fiscal year.

Budget: The annual contract amount is driven by the Fixed Price or FFS set by the State or agreed in the contract. If the rate is driven by the State, the rate is automatically adjusted to match the rate. If the rate is based on negotiated rate between the County and Contractor or a Fixed Price, a Contract Amendment must be executed before exceeding the fiscal year's approved budget. Unspent funds from one fiscal year may not be applied to subsequent fiscal year's expenditures unless authorized and supported by a Contract Amendment.

Invoice: The reimbursable invoice submitted to the County includes the agreed rate multiply the units of service or the billing milestone completed.

Ancillary Claims: Some contracts may allow ancillary expenses that can be claimed at cost. Please refer to your Exhibit C language for information of the ancillary expenses added to a FFS contracts.

Accounting System: Contractor shall have use of an accounting system for segregating, supporting, controlling, and accounting of all funds, expenses, and revenues for each County of San Diego contract distinct from other contractor activities. Contractor shall have the ability to provide assurance that the system is in accordance with generally accepted accounting principles and federal Office of Management and Budget (OMB) Circulars, located within the applicable Code of Federal Regulations.

Other Fiscal Instructions: Invoices are due 30 days after end of invoice month unless other due dates are required by specific funding sources unless otherwise instructed by COR. Contractor must comply with fiscal reporting requirements upon request by County, State, or Federal.

Budget & Fiscal Instructions for Hybrid Contract Only: Follow the requirements and guidelines under Cost Reimbursement and Fixed Price/ FFS Contract.

Behavioral Health Services Funding Source Requirements (Contractor Instructions)

Start-Up Funds (for Procurement Budget only)

Start-up funds shall be subject to available funding, negotiations and shall be at the sole discretion of the County. This shall be limited to one-time costs of newly awarded contracts and shall be used for the development and implementation of a new or expanded program or service.

- The budget and timelines for expending start-up funds must be approved by the count.
- Shall not be available for option year
- Shall not exceed 10% of the annual budget of the first year of contract
- A separate cost center for start-up funds shall be included in the proposed budget for the initial contract period and expenditures shall be tracked separately from ongoing expenditures
- If multiple funding sources are identified within the contract, a plan to allocate the start-up costs amongst various funding sources shall be required and budgeted appropriately to reflect the funding ratios amongst the various funding sources
- Start-up costs will be reimbursed based on actual costs (cost reimbursement). Contractor shall comply with Cost Reimbursement Contract requirements.
- At a minimum, submit an acceptable Cost Allocation Plan and keep an Inventory List, according to Article 2.4 of the Service Template

Examples of expenditures that may be approved include:

- Costs of staff hiring
- Initial staff training and development related to a new program or operation (ongoing training and development should be included in the annual operating budget)
- Minor equipment
- Supplies and materials
- Licenses and permits
- Tenant Improvements

Start-up funds shall not be used:

- To supplant or supplement ongoing or routine operating expenses
- For ongoing or routine program activities
- To improve an existing program or service

- At the end of the determined start-up period, an evaluation of the start-up expenditures shall be made and remaining start-up funding may be rescinded at that time. Expenditures that do not meet the start-up criteria may be disallowed and subject to reimbursement.

Claiming to Other Funding Sources

Claiming other funding sources, such as MAA (if included in the contract budget), may be possible for a different set of activities and documentation requirements may also differ. Programs are responsible for knowing the requirements of the specific funding stream if the program receives funding from sources other than Children, Youth & Families SOC. Medi-Cal payments for an eligible member receiving claimable services may not be supplemented by other funding sources except as permitted in Title 9.

Uniform Method of Determining Ability to Pay (UMDAP)

If a Mental Health contractor provides mental health services and is not otherwise excluded from determining the financial eligibility of members they shall request, and assist in processing, UMDAP fees from members as set forth in this Paragraph and this Agreement and comply with the Organizational Provider Financial Eligibility and Billing Procedures Manual. Contractor shall base its fees upon the member's ability to pay for such services. Contractor shall determine the member's ability to pay in accordance with the "Uniform Method of Determining Ability to Pay" (UMDAP) promulgated by the State of California Department of Mental Health.

Contractor shall determine the appropriate UMDAP member fees for its members. In no event, however, shall the fees charged to members (or to other third-party payers) pursuant to this Agreement exceed Contractor's estimated actual cost for such services. No member shall be denied any services offered by Contractor under this Agreement because of inability to pay for such services.

Residency

The Uniform Method of Determining Ability to Pay (UMDAP) does not require that a person have a specific period of residence in the county or state to qualify for services. Intent to reside in San Diego County is a necessary condition and is established by the member's verbal declaration. This applies to foreign nationals, including individuals with immigrant or nonimmigrant status. Without intent to reside in San Diego County, any member must be billed at full cost. See *OPOH Section D* for additional information on the provision of specialty mental health services to Children/Youth Out of County Medi-Cal members.

Contractor Payments

Contractors will be paid in arrears. After the month for which service has been given, the BHS Strategy and Finance will process claims (invoice) in accordance with the contract terms.

Budgets, Claims (Invoices) and Supplemental Data Sheets

- Budgets, claims (invoices) and supplemental data sheets must comply with the established procedures and requirements
- Final claim is due by August 31 or as specified on year-end information notice.
- Quarterly claims for MAA, QA and Admin – sixty (60) calendar days after end of each service quarter and actual final actual cost in December which is six months after the end of the fiscal year for QA and Admin. MAA claim is due December 31 of each fiscal year for all quarterly claims.
- Final reconciliation for CalAIM Fee-For-Service contracts shall occur thirteen (13) months after the end of each contract term.

Gift Card Usage

Gift cards may be used to directly benefit members and program objectives (i.e., grocery store vouchers). Gift cards may not be used as an incentive for Drug Medi-Cal billed services (i.e., as prizes for opportunity drawings for group attendance).

Programs with cost reimbursement contracts or with gift cards being reimbursed at cost must comply with the following:

- Have adequate internal controls and procedures in place to mitigate misappropriation of Gift Cards
- Gift Cards maintained in a secured and locked environment accessible only to the designated Contractor employees
- Gift Cards are accounted for by receipts, tracking system, and follow the Contractor's internal purchase policies
- Disbursement of Gift Cards are accounted for by a tracking system that indicates at a minimum:
 - Full name of the recipient
 - Amount of the Gift Card

- Date disbursed
- Two full signatures (one of which must be a Contractor employee). If both signatures are those of contract employees, one must be a supervisor.

In the event Contractor discovers misappropriation of Gift Cards, Contractor must contact assigned BHS COR within one workday of the occurrence. Gift card purchase receipts, tracking log and internal policies shall be available to COR or Designee for review and inspection at any time. Records to support the use of gift cards shall be available for in-depth review visits. Gift Cards that are not used or disbursed at the end of their original approved contract year must be justified and pre-approved (again) prior to being used in the next or any future contract years. Bus passes that are purchased in advance will follow the gift card policy requirements.

Financial Eligibility and Billing Procedures for SOC Providers

Each provider is responsible for specific functions related to determining member financial eligibility, billing, and collections. The [Financial Eligibility and Billing Manual](#) is available on the Optum Public Sector website for providers as a guide to determine financial eligibility, billing, and collection procedures. This manual includes the following procedure categories:

- Determining financial eligibility
- Billing, collections and payment procedures
- Corrections, adjustments and special requirements

This manual is not intended to replace the EHR User's Manual or intended to be a comprehensive "Insurance and Medicare Billing" guide. It is meant to augment existing resource materials.

Claiming and Reimbursement of Mental Health Services

All rendering providers of specialty mental health services shall have a National Provider Identification (NPI) number prior to claiming for services. All providers are required to obtain NPI numbers as part of their staff account set up in the electronic health record. Providers may contact the MHMIS unit for questions.

When providing reimbursable mental health services, providers are required to utilize all available payor sources appropriate for reimbursement of services. Many members have one or more insurance sources (e.g., Medicare, indemnity, PPO, HMOs, Medi-Cal) and it is the responsibility of each program to appropriately bill and collect reimbursement from primary and secondary insurance sources.

For all members receiving mental health services, programs are required to be aware of all available payor sources, be able to verify eligibility and covered benefits, obtain an Assignment of Benefits (AOB), track and process Explanation of Benefits (EOBs) and primary insurance denials, in order to seek reimbursement from secondary payor sources. All billing and submission of claims for reimbursement must be in accordance with all applicable County, State and Federal regulations.

For detailed guidelines and procedures regarding insurance billing, claims processing, assignment of benefits, determining eligibility, and accounts collection and adjustment, please refer to the [Financial Eligibility and Billing Procedures - Organizational Providers Manual](#).

Coding and Billing Requirements

The Health Insurance Portability and Accountability Act (HIPAA) include requirements regarding transactions and code sets to be used in recording services and claiming revenue. UCRM forms reflect the required codes, and County QA staff provide training on the use of the Service Record forms. Additional requirements come from the State Agreement; these requirements determine the nature of chart reviews during a Medi-Cal audit and the items for which financial recoupment of payment for services will be made by State or County reviewers.

The following are current requirements and resources related to coding and billing:

- Services must be coded in compliance with the Management Information System User Manual, Organization Provider Operations Handbook (OPOH) and the Financial Eligibility and Billing Manual.

Diagnoses must be coded using the International Classification of Diseases (ICD-10). In general, a diagnosis is made using the fuller descriptions of the Diagnostic and Statistical Manual, and “cross-walked” to the correct service code for SmartCare by the clinician. The service code should result in the highest level of specificity in recording the diagnosis.

Services are recorded in the EHR through service note entry or if done on paper on the corresponding downtime form and maintained in the hybrid chart. If completed on paper, the document may be scanned into the EHR and viewed on the “Documents (Client)” page but is not required. The program should follow the [Administrative Service Entry instructions](#).

Documentation standards associated with coding and billing requirements can be found in the OPOH, *Section G*, UCRM, Financial Eligibility and Billing Manual, and the CPT Crosswalk, all located on the Optum website > BHS Provider Resources> *SMH & DMC-ODS Health Plans* page.

Medi-Cal Billing to the State

Direct service claims can be submitted to the State up to a year from the date of service. Replacement of the denied service can be submitted up to fifteen (15) months. If the service was denied and the error is with the State's system, services can be replaced up to thirty-six (36) months with a DRC 9. Errors can be process at any time and no limitation.

Please submit all claims (invoice) for payment and questions regarding claims to:
Email: BHSClaims.HHSA@sdcounty.ca.gov / Fax: (858) 999-8929

Overpayment: In the event of overpayments, excess funds must be returned or offset against future claim payments.

Short- Doyle Medi-Cal

Definitions

- *Provider* means the program providing the mental health services. It is part of a legal entity on file with the State Department of Mental Health.
- *Federal Financial Participation* per Title 9 CCR Chapter 11 means the federal matching funds available for services provided to Medi-Cal beneficiaries under the Medi-Cal program.

Medi-Cal Revenue

The Fiscal Services Unit will bill Medi-Cal for covered services provided to Medi-Cal beneficiaries by Short-Doyle Medi-Cal certified programs. The State will deny services that do not clear the billing edits, programs have 15 months from the date of service to fix denied services. Once the program has fixed the error, in order to rebill for the service, the program must complete the current Replace Service Request form located on the Optum Website at and email the form to the email addresses stated on the form.

After the form has been received and the replace processed, the program will be faxed back the form, this serves as notification that the replace was processed. If the reason for the denial is for Other Health Coverage or Medicare, the explanation of benefits (EOB) must be faxed to the billing unit with a copy of the denial report – fax to BHSBU/F (858) 467-9682.

County of San Diego HHSA – Mills Bldg.
Behavioral Health Services Billing Unit Fiscal Services (BHSBU/F)
1255 Imperial Ave. San Diego, CA 92101
Attn: Fiscal Services 6th Floor Rm. 633

Medi-Cal Requirements

Invoices for Payment of Medi-Cal Services. Contractor shall enter required data based on eligibility and services rendered to each Medi-Cal member into the appropriate County- designated County Data System. Contractor shall enter data on each member or group within the time required by the County.

The validity of Contractor's data input is subject to State, County, Federal or other funding source review and approval. County will make payments in advance of the State, Federal or other funding source review and approval, and in advance of the reimbursement by the State, Federal or other funding to County for sums expended thereunder. In the event the State, Federal, other funding source or County disapprove any billing, whether previously paid to Contractor, Contractor shall take all necessary actions to obtain approval of the disallowed billing. If Contractor is unsuccessful, Contractor shall reimburse County in the full amount of the disallowed billing within thirty days of County's request or, at the sole discretion of County, County may withhold such amounts from any payments due under this Agreement or any other agreement, including successor agreements, County has entered into or will enter into with Contractor.

Penalty for Failure to Qualify Short-Doyle/Medi-Cal & Drug Medi-Cal Visits

If County experiences a payment reduction in a Short Doyle/Medi-Cal & Drug Medi-Cal claim due to Contractor's failure to qualify the visit under Short- Doyle/Medi-Cal & Drug Medi-Cal program (failure to claim or failure to respond to inquiry) then County will reduce Contractor's reimbursement by an amount commensurate with Contractor's budgeted unit cost and the prevailing Federal Financial Participation (FFP) of Medi-Cal and EPSDT for the Agreement period.

MH UMDAP Requirements Paragraph

Behavioral Health Services, Mental Health Requirements: Mental Health contractors who utilize the electronic Mental Health Information System shall comply with the Organizational Provider Financial Eligibility and Billing Procedures Manual.

Billing for Peer Support Services

Certified Medi-Cal Peer Support Specialists may only submit claims to Short Doyle Medi-Cal (SD/MC) for Medi-Cal Peer Support Services: Self-Help/Peer Services and Behavioral Health Prevention Education Services (H0038 and H0025). Beginning July 1, 2022, per [BHIN 22-019](#), peer support services provided by a Certified Peer Support Specialists must be based on an approved plan of care. The plan of care shall be documented within the progress notes in the member's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.

Biling for Crisis Stabilization Services

The maximum number of hours for claimable for Crisis Stabilization in a twenty- four (24) hour period is twenty-three (23) hours. [CCR Title 9 1840.368](#)

Medi-Cal Recoupment and Appeals Process

DHCS Requires overpayments to be reported within 60 days of being identified as a disallowance to be recouped. The Payment Recovery Form (PRF) is required for reporting overpayments identified in various reviews (QAPRs, internal/peer reviews, etc) to BHS QA and the BHS Billing Unit to initiate the recoupment. Programs should fill out the PRF located on the Optum website > *Billing* tab. A tip sheet on how to use the form is on the second tab of the PRF excel form.

In alignment with DHCS Compliance Monitoring requirements and CalAIM Medi-Cal Transformation initiatives, recoupment shall be focused on identified overpayments and patterns in documentation suggestive of fraud, waste or abuse. Fraud and abuse is defined in CFR, Title 42, [section 455.2](#). [W&I, section 14107.11, subdivision \(d\)](#) also addresses fraud. Definitions for “fraud,” “waste,” and “abuse,” as those terms are understood in the Medicare context, can also be found in the [Medicare Managed Care Manual](#).

Evidence of fraud, waste, abuse may include but is not limited to:

- Billing for services not rendered or not medically necessary
- Billing separately for services that should be a single service
- Falsifying records or duplicate billing
- Overpayment may include but is not limited to:
 - Missing documentation of allowable service
 - Services not billable under Title 9
 - Medical Necessity
 - Claims submitted for service during a lock out

For disallowances during the QAPR process, the programs will complete the PRF with the QA identifying all disallowed billings based on the DHCS reasons for recoupment criteria. If the provider disagrees with a Medi-Cal recoupment, QA has developed a 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision. Providers must submit their appeals in writing to the QA Unit within required timelines. The appeal process is described in the final Quality Assurance Program Review (QAPR) Report received by the program.

Billing Disallowances – Provider Self Report

The policy of San Diego County Behavioral Health Services Administration (SDCBHS) is to recoup payments for disallowed units identified and reported to the SDCBHS by the Contracted Organizational Providers in accordance with documentation standards as set forth in the current California State Department of Mental Health “*Reasons for Recoupment of Federal Financial Participation Dollars.*”

Provider Requirements

Providers are required to conduct internal review of medical records including paid service verifications, on a regular basis (i.e., monthly) in order to ensure that the documentation meets all County, State and Federal standards and that billing is substantiated. If the review of a Medi-Cal member’s chart results in a finding that the clinical documentation does not meet the documentation standards as set forth in the current California State Department of Health “[FY 24-25 Reasons for Recoupment SMHS](#)” the provider shall be responsible for addressing the issue by filing a self-report of billing disallowances with San Diego County BHS. To file a self-report of billing disallowances request, providers should fill out a PRF and reach out via QI Matters. If claims have already been paid and invoiced to the County, further coordination with the billing unit is needed.

Services requiring corrections because of clerical errors including but not limited to start date/time, program selected, location, , procedure codes, etc, may be self-corrected within SmartCare in some instances. If unable to be self-corrected, or progress note status has moved to “complete” the provider should follow the current processes as indicated on the Optum Website SmartCare Tab.

BHS Strategy & Finance (S&F) Procedure

On a monthly basis, BHS S&F staff process invoices based on Year-To-Date units. Any disallowances adjusted out from the Electronic Health Records will automatically reduce the payment to the providers. In any circumstances that disallowance can’t be adjusted out from the Electronic Health Record, a manual disallowance calculations will be prepared and will prepare a letter pertaining to disallowances that will be sent to Contractors indicating that the County shall be entitled to recoup the disallowances.

Within thirteen (13) month after end of the fiscal year, S&F staff will reconcile units to ensure that all disallowances are included in the calculation of the year-end provider payment settlement. Notices will be sent to all Contractors that are entitled to additional payment or are subject to recoupment because of overpayment to the Contractor.

Contractors that have been overpaid may elect to repay the recoupment via check or an offset from future payments. If the contractor pays by check, the check is received by S&F Fiscal Team staff and will forwarded to S&F Budget Team staff for deposit. The payment is logged in the contract file along with a copy of the payment. If no check is

received by S&F within fifteen (15) business days from the date of the letter to the Contractor; the recoupment amount is deducted from the next scheduled provider payment.