



COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
EMERGENCY OUTREACH BUREAU
CALWORKS MENTAL HEALTH SUPPORTIVE SERVICES

DMH CALWORKS BULLETIN No. 05-04
GUIDELINES TO AVOID DPSS BILLING EXCEPTIONS

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TO: All DMH CalWORKs Mental Health Supportive Services Providers

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CalWORKs Program

SUBJECT: **GUIDELINES TO AVOID DPSS BILLING EXCEPTIONS**

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1. PURPOSE

The purpose of this bulletin is to assist providers to bill correctly for CalWORKs supportive mental health services and to avoid billing exceptions when services are delivered to non-eligible CalWORKs participants.

2. BACKGROUND

Under the DPSS reconciliation process implemented in fiscal year 2004-2005 and thereafter, DPSS is verifying that clients receiving CalWORKs mental health supportive services are on its list of eligible CalWORKs participants on the date that services were rendered. If a client is not on the DPSS listing of eligible CalWORKs participants, DPSS will disallow the claim for services and generate a billing exception.

In order to avoid billing exceptions – and the ensuing requirement to reimburse DMH for such services already paid – providers are advised to review the DPSS/GAIN documentation for their CalWORKs participants as well as to review the IS guidelines for data entry affecting CalWORKs billing.

3. BILLING EXCEPTIONS

Billing exceptions occur when services were billed to DPSS for clients who were not eligible for CalWORKs mental health supportive services. As a result of the DPSS billing reconciliation process, DPSS is checking the list of clients served by DMH mental health providers against its list of DPSS/GAIN CalWORKs participants. All billings for CalWORKs mental health supportive services must be for CalWORKs eligible cases only.

A. ELIGIBLE CALWORKS PARTICIPANTS

CalWORKs mental health supportive services billed to DPSS must be authorized by DPSS/GAIN and a supportive services component opened on the LEADER/GEARS system by a GAIN Services Worker. Providers can bill mental health services only for those participants who are:

- (1) Enrolled in GAIN with a signed Welfare-to-Work Plan and are in compliance;
- (2) Exempt from GAIN, but have volunteered for GAIN and a supportive services component has been opened by the GSW for the participant;
- (3) Timed-out, but have requested continuing mental health services and a supportive services component has been opened by the GSW for the participants; OR
- (4) Post-employment participants who are receiving services up to one year after being employed and terminated from CalWORKs, and have notified DPSS that they wish to receive post-employment supportive services.

When DPSS identifies clients that do not fit into any of the above categories, staff will generate a billing exceptions list and request written documentation supporting the claim. If the DMH provider was already reimbursed, but there is no supportive

documentation or if the documentation is not acceptable, then the provider will be required to reimburse DMH.

B. REASONS FOR BILLING EXCEPTIONS

A billing exception is generated when a DMH provider bills for a client that is not on the DPSS/GAIN list of CalWORKs participants. The reasons may be categorized as follows. The examples given are not exhaustive, and there are several possible examples why the client was not eligible.

- (1) Client may have been eligible, but DPSS/GAIN never authorized services by opening up a mental health supportive services component.

Examples:

- Provider sent in a PA 1923 (Treatment Services Verification) but never received a written response to the PA 1923 via the GN 6149 (CalWORKs PA 1923 Results Notification) or other written notice.
- Client never had a CalWORKs mental health services component added to his/her Welfare-to-Work program.
- Provider made the client exempt, but the client did not volunteer for GAIN so that a mental health supportive services component was never opened up for him/her.
- Client timed-out, but client never notified DPSS/GAIN he/she wanted to continue receiving mental health services and consequently, a supportive services component was never opened.

- (2) Client was eligible and had a mental health supportive services component open, but became ineligible during treatment.

Examples:

- Client was approved for SSI while on CalWORKs, but provider failed to stop billing CalWORKs.
- Client was sanctioned and a notice of termination (GN 6011 Termination Notice) was sent by DPSS, but provider failed to stop billing CalWORKs.
- Client became employed full-time and was terminated from CalWORKs, but post-employment services were not requested.

- (3) Client was never eligible.

Examples:

- Client was under 18 years of age.

- Client was GROW eligible, not CalWORKs eligible.
- Client was exempt from GAIN (e.g., client received CalWORKs cash aid, but never had a Welfare-to-Work Plan requirement).
- Client was always Medi-Cal eligible only (e.g., client was employed, received no cash aid, but received Medi-Cal benefits).

5. **VERIFICATION OF CALWORKS ELIGIBILITY**

The first step to avoid a billing exception is to check the client's eligibility for CalWORKs services the very first time the treatment provider meets with the client. This means that each CalWORKs participant must have at least one of the following documents when the case is opened, or very shortly thereafter. These forms are the provider's supporting documentation that the client is in fact a CalWORKs participant eligible for mental health supportive services.

- (1) Client referred by CASC
 - GN 6006B
- (2) Client referred by GAIN
 - GN 6006B
- (3) Existing client on provider's caseload (backdoor referral)
 - PA 1923 and GN 6149 Notification
 - PA 1923 and letter from DPSS/GAIN indicating the client is eligible for CalWORKs supportive services.
- (4) New client walk-in (backdoor referral)
 - PA 1923 and GN 6149
 - PA 1923 and letter from DPSS/GAIN indicating the client is eligible for CalWORKs supportive services

6. **MEDI-CAL AID CODES**

All CalWORKs participants are Medi-Cal eligible and can receive Medi-Cal services. Participants that choose not to inform their GSW that they are receiving mental health services can do so and will have their services paid by a Medi-Cal provider. All CalWORKs participants have Medi-Cal aid codes assigned to them, depending on their eligibility and status during a given month. In general, Medi-Cal aid codes of 30 and 35 are a good indicator that the client is eligible for CalWORKs supportive services. Other transitional aid codes are frequently noted. However, eligibility must be verified with the GSW.

Medi-Cal aid codes are indicators of the following:

- 30 or 35 – Strong probability eligible: Medi-Cal aid codes of 30 or 35 are good, but not absolutely certain, indicators that a client is eligible for CalWORKs supportive services.
- Aid codes starting with 3 – possibly eligible: Other aid codes that start with a 3 indicate that a client may be eligible, but that the provider should check the client's chart to confirm there is DPSS/GAIN documentation verifying mental health services.
- Other aid codes – Very strong probability not eligible: Aid codes that do not start with a 3 indicate the client is not eligible at all for CalWORKs supportive services. An example is an aid code of 60, which indicates the client is on SSI. The provider should immediately check the client file for any DPSS/GAIN documentation verifying authorization of services. If there is no supporting documentation, any services billed to CalWORKs will not be paid or the provider will be required to reimburse DMH for services already paid.

CAVEAT: A Medi-Cal aid code of 30 or 35 does not guarantee eligibility for CalWORKs mental health supportive services. The provider always must have the appropriate GAIN documents that substantiate that CalWORKs supportive mental health services have been authorized and a mental health component has been opened by the GSW for that particular participant. Consequently, providers need to check their client's eligibility on a monthly basis, including the Medi-Cal aid codes.

Medi-Cal certified sites have a PIN number issued to them by the State of California. This PIN number is needed to access the Meds system to verify Medi-Cal aid codes. When providers with PIN numbers input CalWORKs billing on the IS, the Medi-Cal aid codes will be shown. However, non-Medi-Cal certified providers without a PIN number can still input CalWORKs billing on the IS system, but the IS will not show Medi-Cal aid codes for the clients.

IMPORTANT: It is not essential that a Medi-Cal aid code, or even that only an aid code of 30 or 35, be seen on a Medi-Cal eligibility response in the IS in order to bill for CalWORKs. What is essential is that the provider has the written documentation from GAIN verifying that the client is eligible and that mental health supportive services have been authorized. Providers should bill only for those clients determined to be CalWORKs eligible.

7. CHECKING CLAIMS ON THE IS

Providers are advised to review their CalWORKs claims submitted on the IS on a monthly basis, at a minimum. This review will enable agencies to note any discrepancies in billing at an early date, so that corrective actions can be taken. Below are a list of common mistakes that occur in IS claims for CalWORKs services.

A. DATA ENTRY

- No social security number (SSN) entered. The SSN is required in order for DPSS to match the case. Without an SSN, the claim cannot be paid.
- Social security number of 888-88-888 or 999-99-999 entered. These SSNs are invalid for CalWORKs. Each CalWORKs participant has an SSN and the number must be entered.
- Client is under 18 years of age. Providers can bill CalWORKs only for adults age 18 years and older.
- Aid Code is not 30 or 35. When Medi-Cal eligibility is run or updated, if the aid code is not 30 or 35, staff should verify that the proper GAIN documents are in the client's file.

B. CLIENT ENROLLMENT IN CALWORKS PLAN

- Client not enrolled in CalWORKs Plan. The IS requires that each client be enrolled in a plan; the default plan is CGF (County General Funds). If the client is not specifically enrolled in the CalWORKs plan, the claims will default to CGF or another plan. Providers should run the IS 250 Report (Client List By Enrolled Plans) to be sure that all their CalWORKs clients have been enrolled in the CalWORKs plan.
- Contract agency or DMH clinic/program not authorized to bill CalWORKs. Only those agencies with a CalWORKs contract with DMH and those directly operated clinics/programs approved by the DMH CalWORKs Program may enroll clients in a CalWORKs plan and bill services to CalWORKs.
- Client no longer eligible for CalWORKs. When a client's eligibility changes, providers should update the client's CalWORKs plan with a termination date (performed on the Administrative functional area – update enrollment). If the provider is still seeing the client, the new payer and plan must be identified.

C. BILLING PROBLEMS

- Client services were not billed to CalWORKs Plan. Even though a client is enrolled in the CalWORKs plan, each service must be specifically billed to CalWORKs.
- CalWORKs client services were billed to Medi-Cal. Medi-Cal is a payer, not a plan; CalWORKs is a plan and the payer is DMH. For billing entered prior to May 1, 2005, claims may have mistakenly been sent to Medi-Cal when the Medi-Cal box was not manually unchecked

on the administrative side. As a result these services were not billed to CalWORKs, and Medi-Cal paid for these services.

- Non-authorized CalWORKs procedure codes were used. For example, COS case management support (procedure code 6000) is not authorized by CalWORKs. The DMH CalWORKs Bulletins No. 04-01 (Procedure Codes for CalWORKs Services) and No. 05-02 (New Approved CalWORKs Procedure Codes) list the procedure codes that are authorized for CalWORKs participants. Only the listed procedure codes can be used to bill for CalWORKs services.
- Agency is not authorized to bill for the service. This occurs when an agency bills for mental health services that are not in its DMH contract. The provider may bill only for those services that have been approved in the provider's contract. Examples of services that require special approval are psychological testing, crisis intervention, and medication support.
- Double billing. Data is entered twice.
- Amount of time (UOS and service time) are excessive. This may indicate an entry error.

8. CORRECTIVE STEPS

As soon as a problem with a claim is identified, providers should take corrective action to resolve the issue. Some common errors are described below:

- Claim incorrectly billed to Medi-Cal.
If a claim was incorrectly billed to Medi-Cal and the claim has not yet been approved and/or sent to Medi-Cal, the provider should:
 - (1) Void the original claim and
 - (2) Submit a new claim by re-entering the data correctly.

If the claim was incorrectly billed to Medi-Cal and the provider has already been paid, the provider must:

- (1) Void each and every claim sent to Medi-Cal and
- (2) Submit a new claim by re-entering the data correctly.

If a provider chooses not to void the Medi-Cal Claim and not to submit a new claim, then these services will not be reflected in the agency's CalWORKs billing and will not count against their CalWORKs allocation.

- Claim incorrectly billed to CGF or other plan.
 - (1) Void the original claim
 - (2) Submit a new claim by re-entering the data correctly

- COS claim incorrectly billed to CGF or other plan.
(1) Complete and submit the form supplied by Provider Reimbursement to change the funding source of a COS.
- Ineligible participant.
If a claim was submitted for an ineligible client (e.g., SSI recipient or child), the provider should
(1) Void the incorrect claim and
(2) Reenter the claim and submit it against the correct plan
- Agency not authorized to bill for the service (not in agency's DMH contract).
The claim will be denied immediately by Rules in the IS.
- Claim not an authorized CalWORKs service (non-CalWORKs procedure code).
All services EXCEPT community services will be denied if an incorrect procedure code is used. Providers will need to remove CalWORKs and find a funding source that allows the procedure code they are using for the service.
- Missing data.
Missing data, such as social security numbers, should be inserted where appropriate.
- Incorrect data.
Incorrect data, such as social security number or date of birth, should be updated or corrected.

9. REVIEWING IS REPORTS

Providers are encouraged to review the IS reports for their agency on a regular basis to check that claims are being entered correctly. Some questions to ask when reviewing the IS reports include:

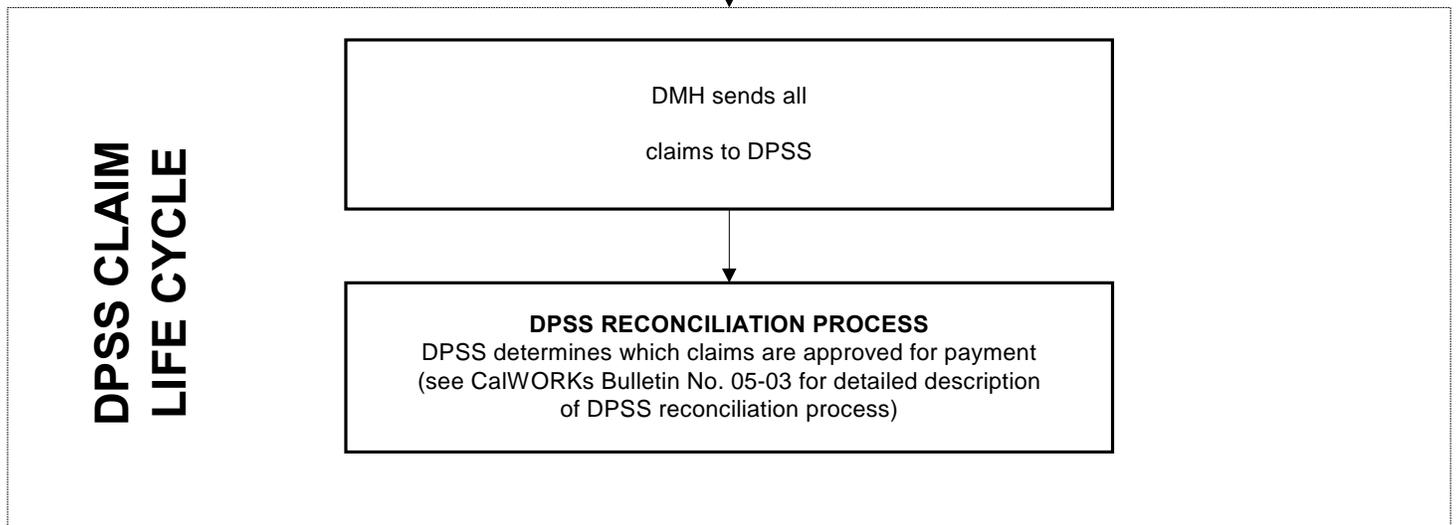
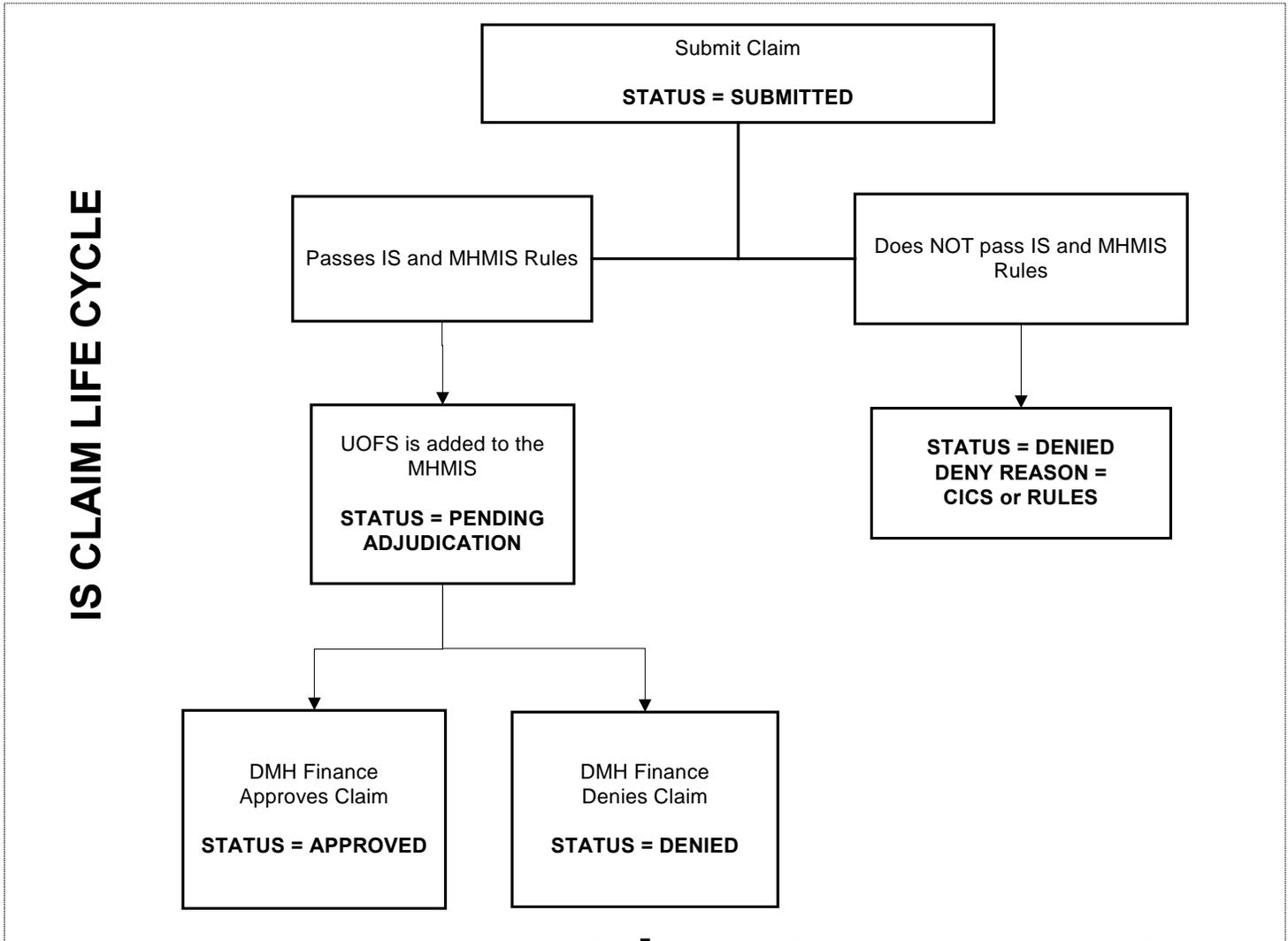
- Does the report list all the agency's CalWORKs clients?
- Are there clients on the list who are not CalWORKs?
- Is a valid social security number listed for each client?
- Is the Medi-Cal ID number listed?
- Is the person 18 years and older?
- Is the Medi-Cal aid code not one billable to CalWORKs?
- Is the client receiving SSI? (Indicated in client chart or Medi-Cal aid code)
- Has an incorrect procedure code been billed?

- Has an incorrect number of UOS or minutes been billed?
- Are there double entries for the same service?
- How many of the agency's claims have been "approved"?
- Are there a large number of claims listed as "pending adjudication" or "denied"? What is the agency doing to clear up these claims?

10. CALWORKS IS/DPSS CLAIM LIFE CYCLE

The flow chart on the following page shows the life of a CalWORKs claim as it goes through the IS and then is reviewed by DPSS.

CalWORKs CLAIM LIFE CYCLE



11. SUMMARY

In order to avoid billing exceptions, it is recommended that providers:

- ▶ First, check that the client is eligible for CalWORKs mental health supportive services at the time of intake, or submit a PA1923 and review the GN 6149 to verify eligibility shortly thereafter. Providers should stay in constant contact with the GSW regarding eligibility status as well as submit the GN 6008 (progress report) every three months as required.
- ▶ Second, check the Meds system to review the client's Medi-Cal aid code or do the eligibility check on the IS to review the Medi-Cal aid code. For aid codes other than 30 or 35, providers should ensure that proper GAIN documentation is included in the client's chart. Verify Medi-Cal eligibility each month.
- ▶ Third, follow the IS policies and procedures to input data correctly for mental health services for eligible CalWORKs participants.
 - (1) Perform a Medi-Cal eligibility check to verify the aid code (if the Provider has a Medi-Cal PIN number).
 - (2) Submit the claim and check the "bill Medi-Cal" checkbox on the Admin/Claim/Payer tab.
 - (3) Make sure CalWORKs is listed as Plan 1 in the list of plans to be billed in the claim.
- ▶ Lastly, review the IS reports on a regular basis for any errors or omissions.

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