Procedure: 2017-04 Attachment M	**TITLE: Procedure for Identifying, Reporting, and Recovering Mental Health and Drug Medi-Cal Overpayments**	**Effective Date: July 2017**
Revision: 1	**Dept: Claims**	**Page 1 of 7**

Approval By:	**Date:**
Scott Gruendl, Assistant Director	
Doreen Avery, Billing Manager	
Clara Boyden, AOD Deputy Director	
Annual Review Date: 09-07-2024	

Authored By: Billing Manager and AOD Deputy Director
Pursuant To: TITLE 42, CODE OF FEDERAL REGULATIONS SECTION 438.608
Departments Impacted: Claims, MIS, Administrative Services

Purpose

This policy addresses the program integrity requirements contained in 42 CFR, section 438.608(d) of the need to identify Short Doyle overpayments, promptly report the overpayments to the state, and recover overpayment if passed along to a provider. If potential fraud is suspected, this will also be reported to the state. Below is San Mateo County's (SMCO) procedure for identifying Mental Health and Drug Medi-Cal overpayments.

Responsibility and Authority

The Billing Manager is responsible for overseeing the claims activity of the SMCO Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) and ensuring that claims are handled appropriately**.**

POLICY

This policy establishes procedures to avoid errors that may lead to overpayment and to monitor for overpayment. Furthermore, it establishes the requirement to promptly report overpayments to the DHCS analyst by emailing MedCCC@dhcs.ca.gov.

PROCEDURE:

The following procedures are followed in order to avoid situations that may result in Mental Health and Drug Medi-Cal overpayments

1. **CLAIMS ENTRY**
   The billing system (Avatar) is set up to only allow documentation for services assigned to the service delivery program.

Validation Reports

The MIS/Billing Unit runs monthly reports to identify potential errors in reporting. These reports include the negative balance report which identifies potential overpayments by the state which would require voiding and repayment of services; IMD reports to identify any billed claims which should have been blocked; and the duplicate services report identifying same day services billed in error which need to be voided and repaid to the State.

CHART AUDIT

Mental Health

BHRS Quality Management reviews clinic and contracted provider services to ensure they meet all Medi-Cal documentation requirements. Any services not meeting Medi-Cal criteria are disallowed and voided and submitted to the state.

Organized Delivery System (ODS)

BHRS Alcohol and Other Drug (AOD) Services Analysts review substance use treatment contractor providers charts annually to ensure they meet all Medi-Cal documentation requirements. For any disallowed services for which the provider has been paid, AOD Analysts will notify the MIS/Billing staff to void the claim and submit to the state.

DELETE AND VOID/REPLACE FORMS PROCESSING

Mental Health

1) The Delete Form and the Void and Replace Form were created for use by Mental Health contract agencies to report changes to, or deletions of, previously claimed mental health services. The form is included in this policy as Attachment A.
The form is completed by agency personnel and submitted to the BHRS Contracts Unit Management Analyst for review and disposition after the date of which overpayment was identified. Depending on the type of service, there may or may not be any resulting change to the payment of the claim to the contractor.

DMC-ODS Fee For Service Providers

a. BHRS shall reimburse contractor on a monthly fee for service basis for the DMC expenditures included in the contractor's agreement. For any disallowed services for which the provider has been paid, AOD Analysts will notify the MIS/Billing staff to void the claim and submit to the state. Contractor shall reimburse County for all overpayments identified by Contractor, County, and/or state or federal oversight

agencies as an audit exception within the timeframes required by law or Country or state or federal agency. The Contractor shall notify the County within 60 days in writing of any identified overpayments and the reason. Notification shall be emailed to the AOD reporting mailbox at HS_BHRS_AOD_Reporting@smcgov.org and cc BHRS Analyst. The Contractor shall return the overpayment to the County within 60 calendar days after the date on which the overpayment was identified or BHRS may offset the amount disallowed from any payment due to the Contractor under the Contract Agreement.

REPORTING REQUIREMENTS

2) The MIS/Billing staff void all approved Medi-Cal claims associated with overpayment recoveries from providers using the normal Short-Doyle Medi-Cal claim voiding process.

3) As an addition to the normal claim voiding process, and per the new requirements of 42 CFR, section 438.608(d), BHRS will submit a void report using the template in Attachment B, listing all voided claims in a Microsoft Excel spreadsheet format with the following headers:
   a. Payer Claim Control Number
   b. Client Index Number
   c. Health Care Provider National Provider Identifier
   d. Payment Amount
   e. Federal Financial Participation Amount
   f. Recovery Type Classification
      - 42 CFR, section 438.608(d) or;
      - All other Medi-Cal

4) The excel spreadsheet void report must be sent to DHCS on an annual basis no later than the last day of February, following the close of every state Fiscal Year (FY) to MedCCC@dhcs.ca.gov with the subject line in the following format: "Annual Void Report-Plans Program Type (MHP or DMC-ODS)-2 Digit County Code-FY XXXX-XX". See the examples below that uses "41" as a two-digit county code for San Mateo County and "FY 2018-19" as the year of the void report:
   Annual Void Report-MHP-41-FY 2023-2024
   Annual Void Report-DMC-ODS-41-FY 2023-2024

5) BHRS will submit a signed certification in accordance with 42 CFR, section 438.606 using the approved DHCS certification form. The approved template is included in this policy as Attachment C.

Attachment A

San Mateo County Programs
Void and Replace Form

Provider Number: _____

Legal Entity Number: _____

Legal Entity Name: _____

Reason Codes

1. Duplicate Service
2. Documentation
3. No Medical Necessity*
4. No Progress Note**
5. Incorrect Date of Service
6. Incorrect PC/Time
7. Incorrect Client #
8. Other (attach documentation)

						VOID ENTRY								CORRECT SERVICE INFORMATION						
Line #	RU #	RU Name	Client Last Name	Client First Name	Client Number	Svc. Date	Service Type	*Units/ Time	Staff Number	No. in Group	Location	Reason Code	Billing Unit Action	Svc. Date	Svc. Type	*Units/ Time	Staff Number	Location	No. in Group	Comments
1																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
					TOTAL:															

Prepared by: _____

* Outpatient Services are measured in staff hour and minute only - include co-staff time
Inpatient, Residential and Day Treatment Services are measured in client day

Phone No: _____

Email: _____

Address: _____

Date Submitted: _____

Provider Approval: _____

Please send completed form to:
Brad Johnson at BRJohnson@smcgov.org
and
Ranjana Prasad at Raprasad@smcgov.org

form no: FIN_2005
Updated: 05/2016

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Attachment B

Department of Health Care Services

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

42 CFR 438.608: Overpayment Recoveries - Annual Void Report

PCCN	CIN	Provider NPI	Recovered Amount	FFP Amount	Recovery Type

Attachment C

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY — Department of Health Care Services

42 CFR 438.608: Overpayment Recoveries - Annual Void Report

Date of Report:		Fiscal Year: 2023-2024	County Name:	

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said claimant; that I am authorized to sign this certification on behalf of the County; that I have not violated any of the provisions of Section 1090 et sec. of the Government Code; that the report herein is in accordance with section 438.606 of Title 42, Code of Federal Regulations; and is based on best information, knowledge, and belief; and the data, documentation, and information is accurate, complete, and truthful. The County further certifies under penalty of perjury that: all claims for services provided to county mental health clients have been provided to the clients by the County; the services were, to the best of the County's knowledge, provided in accordance with the client's written treatment plan; and that all information submitted to the Department is accurate and complete. The County understands that payment of these claims will be from Federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. Pursuant to Section 433.32 of Title 42, Code of Federal Regulations (CFR), the County agrees to keep for a minimum of three years after final determination of costs is made through the DHCS reconciled Cost Report settlement process and retained beyond the three-year period if audit findings have not been resolved, a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The County agrees to furnish these records and any information regarding payments claimed for providing services, on request, within the State of California to the California Department of Health Care Services (DHCS), the Medi-Cal Fraud Unit, California Department of Justice, Office of the State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives. The County also certified under penalty of perjury that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, or physical or mental disability.

Date: Print Name & Title:
Local Mental Health Director

Executed at: Signature:

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY — Department of Health Care Services

42 CFR 438.608: Overpayment Recoveries - Annual Void Report

Date of Report:		Fiscal Year: FY 2023-2024	County Name:		

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Date: Print Name & Title:
County Auditor Controller or City Financial Officer

Executed at: Signature: