



San Mateo County Mental Health and Alcohol and Other Drug Services  
 Procedure Manual

<b>Procedure:</b> 2017-04 <b>Attachment M</b>	<b>TITLE:</b> Procedure for Identifying, Reporting, and Recovering Mental Health and Drug Medi-Cal Overpayments	<b>Effective Date:</b> July 2017
<b>Revision:</b> 2	<b>Dept:</b> Claims	<b>Page 1 of 6</b>

<b>Approval By:</b>	<b>Date:</b>
Sheryl Uyan, Acting Compliance Officer	2/24/2026
Marie Fontana, Billing Manager	2/17/2026
Clara Boyden, AOD Deputy Director	2/20/2026
<b>Annual Review Date:</b>	February 2027

<b>Authored By:</b> Billing Manager and AOD Deputy Director
<b>Pursuant To:</b> TITLE 42, CODE OF FEDERAL REGULATIONS SECTION 438.608
<b>Departments Impacted:</b> 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 Organized Delivery System (DMC-ODS )overpayments.

**RESPONSIBILITY AND AUTHORITY**

The Billing Manager is responsible for overseeing the claims activity of the SMC 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/PROTOCOL**

**The following procedures are followed in order to avoid situations that may result in Mental Health and DMC-ODS overpayments**

**I. Claims Entry**

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

**II. 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 same day services report identifying same day services billed in error which may need to be voided and repaid to the State.

**III. 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.

**Drug Medi-Cal Organized Delivery System (DMC-ODS)**



Procedure: 2017-04 Attachment M	TITLE: Procedure for Identifying, Reporting, and Recovering Mental Health and Drug Medi-Cal Overpayments	Effective Date: July 2017
Revision: 2	Dept: Claims	Page 2 of 6

BHRS Alcohol and Other Drug (AOD) Services Analysts review substance use treatment contractor providers charts monthly 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.

**IV. Delete and Void/Replace Forms Processing**

**Mental Health**

Option 1:

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.

Option 2:

Mental Health contract agencies can notify MIS/Billing staff via email any void or service corrections request. The Contractor may be required to 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.

**DMC-ODS Fee For Service Providers**

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, the BHRS Analyst will notify the MIS/Billing staff to void the claim and submit to the state.

Contractor may be required to 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](mailto:HS_BHRS_AOD_Reporting@smcgov.org) and cc BHRS Analyst.

The Contractor may be required to 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.

**V. Reporting Requirements**

1. 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.
2. 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



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 Procedure Manual

Procedure: 2017-04 Attachment M	TITLE: Procedure for Identifying, Reporting, and Recovering Mental Health and Drug Medi-Cal Overpayments	Effective Date: July 2017
Revision: 2	Dept: Claims	Page 3 of 6

- 42 CFR, section 438.608(d) or;
  - All other Medi-Cal
3. 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](mailto: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 2025-2026**
  - **Annual Void Report-DMC-ODS-41-FY 2025-2026**
4. 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.



**SAN MATEO COUNTY HEALTH**  
**BEHAVIORAL HEALTH**  
**& RECOVERY SERVICES**

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**Procedure Manual**

<b>Procedure: 2017-04</b>	<b>TITLE: Procedure for Identifying, Reporting, and Recovering</b>	<b>Effective Date:</b>
<b>Attachment M</b>	<b>Mental Health and Drug Medi-Cal Overpayments</b>	<b>July 2017</b>
<b>Revision: 2</b>	<b>Dept: Claims</b>	<b>Page 4 of 6</b>

**Attachment A**  
**San Mateo County Programs**  
**Void and Replace Form**

- 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)

Provider Number: \_\_\_\_\_  
 Legal Entity Number: \_\_\_\_\_  
 Legal Entity Name: \_\_\_\_\_

Line #	RU #	RU Name	Client Last Name	Client First Name	Client Number	VOID ENTRY						CORRECT SERVICE INFORMATION						Comments		
						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
1																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
<b>TOTAL:</b>																				

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@smcgv.org](mailto:BRJohnson@smcgv.org)  
 and  
 Ranjana Prasad at [Rapasrad@smcgv.org](mailto:Rapasrad@smcgv.org)

Form no: FIN\_2005  
 Updated: 05/2016

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<b>Revision: 2</b>	<b>Dept: Claims</b>	<b>Page 6 of 6</b>

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:	County Name:
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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

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

Executed at: \_\_\_\_\_ Signature: \_\_\_\_\_