CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
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June 30, 2009

DMH INFORMATION NOTICE NO: 09-09

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH ADMINISTRATORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: CHANGES TO THE SHORT-DOYLE II MEDI-CAL (SD/MC) II SYSTEM
- BENEFICIARY INELIGIBILITY
- DISALLOWED CLAIMS SYSTEM
- REPLACEMENT CLAIMS SUBMISSION
- GROSS BILLING
- MEDICARE/MEDI-CAL DUAL ELIGIBILITY
- STATE GENERAL FUND PAYMENT FOR OUT OF COUNTY SERVICES

This notice informs Mental Health Plans (MHPs) of changes to the Short-Doyle/Medi-Cal (SD/MC) II system that impact claim payments. This Information Notice supersedes all previous Department of Mental Health (DMH) Information Notices and Letters that address the specific subjects noted above.

Beneficiary Ineligibility

Claims submitted in the SD/MC Phase II system will be denied if the Medi-Cal Eligibility Data System (MEDS) does not show the beneficiary as eligible to receive services on the date(s) that services were provided. DMH will not allow an override in the SD/MC II claims payment process to bypass eligibility adjudication edits in cases where a claim is denied due to beneficiary ineligibility. MHPs should resolve beneficiary eligibility issues with the Department of Health Care Services (DHCS). Once the eligibility issues are resolved, the MHP may submit the claim through the SD/MC system.

Disallowed Claims System (DCS)

The DMH Disallowed Claims System (DCS) will be available for the purpose of identifying, disallowing and eliminating from the audit sample inappropriately claimed services submitted in the SD/MC Phase I system until June 30, 2010.

Current procedures for the use of the DCS will remain in effect until June 30, 2010, and Phase I claims that are disallowed prior to June 30, 2010 will be eliminated from the audit sample. MHPs are reminded that the DCS can only be used to disallow approved claims and cannot be used to re-bill claims or make corrections or adjustments.

The DCS will be available for the purpose of identifying and disallowing inappropriately claimed services submitted in the SD/MC Phase I system after June 30, 2010. However, claims that are disallowed through the DCS will **not** be eliminated from the audit sample and will be considered during the audit process for the purposes of extrapolation. DMH will invoice MHPs for the disallowed claim amount; however any overpayment findings identified during the audit process will be reduced by previously recovered amounts.

Replacement Claims Submission

Pursuant to Regulation Section 1840.110 (c) Claims Submission, the Department must resubmit a claim that has been returned by DHCS for correction or additional information no later than three months after the month in which the claim was returned by DHCS. Accordingly, MHPs will have up to 97 days from the date that the claim is returned to the county to resubmit a claim.

The SD/MC II system will provide MHPs with the information necessary (errors causing denial) to make the corrections necessary on a denied claim for resubmission purposes. County MHPs will have up to 97 days from the date that the claim is returned to the county (i.e., the date on which DMH sends the corresponding 835 transaction) to identify errors, correct and resubmit the claim. Claims submitted to replace a denied claim after 97 days will be rejected.

Gross Billing

The SD/MC II system will use gross billing calculations to determine the maximum amount that the State will pay for a service reduced by any amounts paid by prior payers and any amount paid by the patient to clear their share of cost. MHPs will be required to claim for total amount billed for the service rendered, including any amounts that have already been accepted to clear share of cost paid by a prior payer. If the claim has been adjudicated by a prior payer, the MHP is required to accurately describe how the claim was adjudicated, what amounts were paid and any adjustments that were made.

Examples of gross billing calculations will be posted in the DMH SD/MC II Companion Guide appendix.

Medicare/Medi-Cal Dual Eligibility

The SD/MC II system will support claiming Targeted Case Management (TCM) services to Medi-Cal without prior billing to Medicare. For all other services, providers must bill Medicare and receive a denial prior to billing Medi-Cal. Medicare may make changes to their program and providers cannot assume that a previously denied service would continue to be denied by Medicare.

State General Fund Payment for Out of County Services

SD/MC II will support the payment of State General Fund (SGF) to the county submitting the claim for services. For purposes of calculating the SGF share of Early and Periodic Screening and Diagnostic Services (EPSDT) specialty mental health services, DMH will use the county of responsibility percentage. Responsibility for the purposes of the authorization of services and cost settlement remain with the county of origin.

SD/MC II will no longer support the County of Financial Responsibility (CFR) File. MHPs should implement systems and/or procedures that will enable the MHP to track EPSDT mental health services that are provided to children/youth by host counties.

If you have any questions, please contact your County Programs Technical Assistance representative. A current list of assignments can be found at http://www.dmh.ca.gov/Services_and_Programs/Local_Program_Support/County_Technical_Assistance.asp

Sincerely,

Original signed by

STEPHEN W. MAYBERG, Ph.D.
Director