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March 1, 2010

ALL COUNTY DIRECTORS LETTER

RE: DUAL ELIGIBLE (MEDICARE- MEDI-CAL) CLAIMING IN SHORT DOYLE PHASE II

This is an update on the dual eligible (Medi-Medi) claiming issue. As you know, for quite some time the State has pursued guidance and direction from the Centers for Medicare and Medicaid Services (CMS) regarding a determination on appropriate implementation of the requirements that Medicare be the primary payer and billed prior to Medi-Cal for services provided to dual eligible beneficiaries. The State provided CMS information relevant to specialty mental health services and substance abuse treatment services in an outpatient setting (alcohol and drug program services) provided to dual eligible beneficiaries. In addition, CMS was provided with examples and descriptions of situations that illustrated the problems and challenges that arise when billing for dual eligible beneficiaries and demonstrated the importance of CMS granting appropriate flexibility. The intent of this request was not a workaround when services are covered by Medicare and should be billed to and reimbursed by Medicare, but rather meant for specific circumstances when the services would never be covered by Medicare.

For specialty mental health services, a primary issue is that most of the services provided through the waiver are authorized by the Rehabilitation Option, which provides significant staffing and service flexibility to assure beneficiary access to appropriate community based services, that may be provided in community based settings by multi-disciplinary teams. Some of these services are not covered by Medicare, but in some instances the services may not be covered because the rendering provider does not meet Medicare provider qualifications or because the location in which the service is provided will render the service non-eligible for Medicare reimbursement.

Below is a summary of what was agreed to by CMS.

- The state must gather documentation from a liable third party (Medicare) on their coverage to substantiate whether or not a service is covered. This

information must be verified yearly since third party liability coverage can change.

- ➢ CMS provided the following authoritative resources. Please use this link to access the manuals http://www.cms.hhs.gov/Manuals/IOM/list.asp, which includes Medicare and Medicaid internet-only manuals.

- For specialty mental health services, when the provided service is not eligible under Medicare due to the fact that one or more of the three key components (service, provider type, place of service/setting) does not meet the Medicare requirements, it is appropriate to put an edit in the system so that the need to bill Medicare for these specific services and receive a denial/rejection will not be necessary. [If A = service, B = provider type, and C = place of service/setting, then A, B and C must all exist in order to be a covered service under Medicare.]

- For services provided to dual eligible beneficiaries outside of the above examples, a rejection/denial from Medicare is required. A rejection will be accepted for denial purposes provided that the claim is rejected due to the ineligibility of one the key components and not rejected for procedural reasons such as coding or keying errors.

Next steps include appropriately implementing the flexibility afforded by CMS by determining policy direction and Short-Doyle Phase II system changes.

The Department of Mental Health (DMH) has tentatively identified the following Healthcare Common Procedure Coding System (HCPCS) as services not meeting the Medicare requirements and which therefore could be billed directly to Medi-Cal without seeking a denial from Medicare:

- H2011
- H2013
- H0018
- H0019
- S9484
- H2012 and
- H2019

DMH is currently in the process of verifying these HCPCS and will advise counties when verification is complete and when edits have been implemented into the Phase II system to allow direct billing to Medi-Cal.

DMH is also continuing to review and analyze the remaining HCPCS to determine which of the remaining codes might also meet these criteria. DMH and the

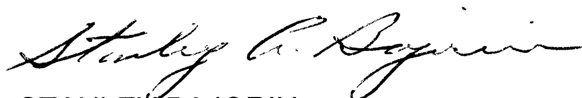
Department of Health Care Services (DHCS) will work with the California Directors Mental Health Association (CMHDA) IT SWAT Team to review the remaining HCPCS and explore strategies to identify and implement edits for the remaining codes as appropriate.

While DMH and DHCS continue to work expeditiously to implement the work outlined above, we acknowledge that this process will take additional time and effort. DMH is therefore advising counties that should a county decide not to submit claims for dual eligible (Medi-Medi) beneficiaries, pending the implementation of the Medi-Medi edits into the Phase II system, DMH will accommodate the county's decision. DMH will provide a delay reason code for the 6-month timely filing period and counties will be allowed to submit claims when the edits are in place. However, claims submitted over a year from the month of service will not be accepted and counties will need to manage their claims to ensure that claims for Medi-Medi beneficiaries are submitted within the required one year time period.

Finally, several counties have sought clarification on the question of whether a provider enrolled in the Medi-Cal program must be certified for participation in the Medicare program. DHCS is currently reviewing statute and regulation surrounding this issue and will issue guidance to counties on this question once a decision has been reached.

We will share information and provide timeframes for system changes as we move forward through the implementation process. Thank you for your patience as we continue to work through this very important issue to obtain a positive resolution.

Sincerely,



STANLEY BAJORIN
Acting Chief Deputy Director

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