



Quality Assurance Bulletin

July 14, 2008 No. 08-2

Program Support Bureau

Los Angeles County, Department of Mental Health

GUIDELINES FOR TRANSFERRING/ MANAGING CLIENT AND CLAIM INFORMATION WHEN A CLIENT MOVES FROM ONE DMH PROVIDER TO ANOTHER DMH PROVIDER

The current agreement from the Executive Dashboard Committee is that we do not want directly-operated (DO) providers to void and resubmit Medi-Cal claims that have been submitted to the State and are in “forwarded” or “approved” status for the purpose of having the services under the new FSP/Wellness provider number. As long as the claims are appropriately claimed in a DO program as MHSA FSP or Wellness, the claims should remain where they were originally billed. For other non-Medi-Cal claims, those claims can also remain where they were originally entered because it is a time consuming process to void and reenter the claims. Please note that at the end of the fiscal year, all directly operated claims are rolled-up into summary data and individual provider claiming information is not provided.

The primary rules are:

- the claims must be entered with the correct plan so that the services may be allocated appropriately;
- for Medi-Cal, services must be claimed from the Provider # of the site where the services were delivered. In addition, Medi-Cal services should not be provided or claimed at a site until the MC Certification application is submitted to/received by the State DMH;
- for indigents, MHSA services do not require Certification, so services may be provided to an indigent client and claimed even prior to the MC Certification of the site;
- no client services should be delivered at a site that does not have its fire clearance in hand.

Scenario

An existing directly-operated (DO) provider is seeing clients under a new FSP or Wellness program. The new program begins delivering services at the existing Provider November 11, 2007. Staff move to a new site January 5, 2008 but neither a fire clearance or a new provider number has been obtained so the MC Certification application is not submitted to the State and

clients continue to be served at the original site. A unique provider number is requested and obtained and on February 14, 2008 a fire clearance is received. The program already has clientele so cases are opened and service delivery begins the next day, February 15, 2008. With all required elements now in place, the MC Certification application can be and is submitted, February 15, 2008. The assumption the Department makes is that February 15, 2008 will become the MC Certification effective date.

Situation:

1. Clients have an open episode under the existing DO provider number.
2. The existing DO provider has the required FSP/Wellness IS Plans available.
3. Clients are receiving services at the existing DO provider number, and the IS Plans selected for the services are consistent with FSP/Wellness.
4. Services entered in the existing DO provider number are as follows:
Dates of service are from 11/11/07 through 2/14/08.
5. The existing DO provider has billed Medi-Cal for the FSP/Wellness client services, when applicable.

Questions and Answers:

1. When should the new provider number open an episode when transferring a case from the existing provider number? How should the discharge date and the new admit date be identified? **Answer: Providing the MC application has been submitted to and received by the State, the episode under the new provider number should be opened on the date of the first service delivered at the new site. If the client will not be receiving any further services at the original site, the original episode should be closed as soon as it is determined that the client has made a successful transition to the new Provider.**
2. Should all claims from the original provider number be voided and then billed under the new provider number? **Answer: No. The presumption is that those services were provided at the original site so the notes and the claims belong to the original provider.**
3. Does the medical record identify the provider number in the chart notes? **Answer: There is a place for the Provider Number at the bottom of all clinical record forms (where the client name is entered). The Provider number should be filled in there. It is not necessary to include the number in each note.**
4. Would the chart notes need to be rewritten for the new chart if the claims were voided from the original episode and submitted in the new provider number/chart? **Answer: Since, in accord with these instructions, claims will not be voided, this question is not at issue.** Could the chart notes just be removed from the original chart and placed in the new chart or would the original chart be transferred? **Answer: For audit purposes, the**

notes must remain in the record under which they were claimed. The new provider can have copies of the notes and place them at the bottom of the Progress Note section of the record with a colored page on top noting that the notes below are from Provider (Name and Number).

5. How to handle claims that have already been billed to Medi-Cal under the old provider number – should the claims be voided and then billed under the new provider number?
Answer: No
6. Are there any reasons for the original provider not to leave FSP and/or Wellness Center services under the original provider number? (Note: there should be a termination date for the plan for the original provider so that claims may not be submitted using the wrong plan once the transfer has taken place.) **Answer: Leaving the services/claims in the original Provider is exactly the instruction provided in these Q&As. Service Area District Chiefs should have their staff submit PFARs to delete Plans as appropriate. DO providers should track the clients/claims that remain under the original provider number by the appropriate plan and report the information to their District Chief at the end of the fiscal year.**
7. What about the SFPR? **Answer: SFPR should be transferred to the new provider. Two options exist: the original provider can delete itself as the SFPR as soon as the transfer occurs so the new provider can enter itself as the SFPR when the episode is opened or the original provider may delete itself as the SFPR when it closes its episode and the new provider then enters itself as the SFPR. For Wellness Centers and FSP's, the SFPR field has a Special Program Designation (either FSP or Wellness Center).**
8. What about the Coordination Cycle Date? **Answer: Since this is an administrative transfer, the Cycle Date should be carried forward into the new provider unchanged.**
9. Can the assessment from the original provider be used in the new provider? **Answer: If the original assessment is more than 2 years old or there are significant changes in the client's status, a new *Initial Assessment* should be completed. If the *Initial Assessment* done by the original provider is less than 2 years old and there are no significant changes in the client's status, a copy of the original assessment can be used by the new Provider as its assessment. In addition to the copy of *Initial Assessment*, the new Provider should minimally: 1) document current mental status, based on a face-to-face contact with the client, and any other relevant changes on the *Assessment Addendum*; if there are no changes from the copy of the *Initial Assessment* being used by the new Provider a notation to that effect should be made in association with the documentation of the current mental status; 2) complete the *Diagnostic Information* form; and 3) note on a *Progress Note* the Assessment service provided and claim an Assessment contact.**

10. What other paperwork is needed?

- **Face Sheet - If the Face Sheet from the original Provider is the most current version of the form, a copy of the Face Sheet can be brought forward with changes documented on the form, such as address or Provider #. If the Face Sheet from the original Provider is not the most current version of the form, a new Face Sheet must be completed by the new Provider.**
- **Open Episode form – a new form must be completed.**
- **Consent for Services – a new Consent must be obtained.**
- **HIPAA Privacy Notice – the Privacy Notice must be given to the client and the *Privacy Notice Acknowledgement* completed and placed in the record.**
- **Patient Financial Information – either the original or a copy of the original should be brought forward to the new Provider and placed in both the clinical record (Section 1) and the patient’s Financial Folder.**

c: Executive Management Team	Department QA staff
District Chiefs	Compliance Program Office
Program Heads	Nancy Butram, Revenue Management
ACHSA	Donna Warren-Kruer, Network Org. Providers

**SERVICES
TRANSFERRED**

FROM

**FORMER PROVIDER NAME
PROVIDER # XXXX**

**(Documentation located below this sheet
were delivered by the above provider.)**

TO

**NEW PROVIDER NAME
PROVIDER # XXXX**