

**Office of Behavioral Health (OBH)
Finance & Data Protocols**

Protocol Number: 3 Page: 1 of 2	Subject: Billing Adjustments for OBH Clients
Effective Date: July 1, 2013 Distribution Date: June 1, 2013 Scheduled Review Date: February 1, 2014	Related Mandates, Statutes, Standards or Executive Orders:
	
Approved by: OBH Administrative Services Director	
	
Approved by: OBH Chief Financial Officer	

Background/Purpose: This procedure is intended to provide OBH contractors with a specific protocol for making billing adjustments for clients who have been funded by OBH and subsequently found to be eligible for Medicaid or CHP+.

This protocol was recommended by the Colorado Department of Human Services, Audit Office, through a review of expenditures for the period of July 1, 2010 through September 30, 2010. The review stated:

“Section 24-103.5-101(3), C.R.S., states that the department must designate at least one person who will be responsible for contract monitoring. The State Procurement Manual further states that this individual generally exists at the program level and requires specific guidelines to ensure the monitoring process is consistent, effective, and equitable. Contract monitors need to review detailed performance standards, vendor reports, and payments to effectively monitor contracts. Independently reviewing the contractor’s determination of eligibility should be one component of contract monitoring.”

As a result of this finding the Office has implemented this billing adjustment protocol in order to align State eligibility and payment systems for OBH/CDHS providers including Community Mental Health Centers, Behavioral Health Organizations, Managed Service Organizations and other agencies that are funded by the Office of Behavioral Health.

This billing adjustment protocol will impact encounters attributed to OBH, which are funded through a combination of state funds and federal block and or other federal grants.

A. Requirements for Checking Eligibility:

1. Clients with Medicare coverage only (no secondary) can qualify for OBH funding based on target status and income.

2. Clients with commercial insurance coverage that does not cover mental health services can qualify for OBH funding based on target status and income;
3. Clients covered under commercial insurance with mental health benefits, CHP+, or Medicaid do not qualify for OBH funding.
 - a. Medicaid eligibility may be done via the HCPF web portal or through the receipt of batch eligibility reports from HCPF, and;
 - b. Medicaid Coverage only: Due to retro-eligibility, Medicaid coverage will be re-verified for all OBH funded clients before submitting encounters to OBH.
 - i. Correct encounter file as necessary during the current fiscal year for retro-eligible Medicaid clients by May of each year.
4. All of the above coverage and qualification documentation must be kept on file for inspection by the State.

B. Procedures for Changing Previously Submitted Claims:

Option #1:

Replacement Record:

On the claim record (CLM), CLM05 Data Element 1325 (located on pages 173 and 174 of the 837 manual), enter code 7. The record must match an existing 837 record previously submitted and accepted by OBH. A match will be determined by using a distinct transaction record. Once a match has been accepted the original record will be marked in the database with a “R” so that those records will be preserved but not used in analysis reports.

A match will be determined by using a distinct transaction record (see below).

Page 402	Loop 2400	Seg REF	Data element 02	Reference Description Reference Identification	Comments Provider’s internal service unique ID
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Option #2:

Void Record:

On the claim record (CLM), CLM05 Data Element 1325 (located on pages 173 and 174 of the 837 manual), enter code 8. The record must match an existing 837 record previously submitted and accepted by OBH. A match will be determined by using a distinct transaction record. Once a match has been

accepted the original record will be marked in the database with a “V” so that those records will be preserved but not used in analysis reports.

A match will be determined by using a distinct transaction record (see below).

Page 402	Loop 2400	Seg REF	Data element 02	Reference Description Reference Identification	Comments Provider’s internal service unique ID
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