State of California—Health and Human Services Agency
Department of Health Care Services

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DIRECTOR

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GOVERNOR

DATE: January 23, 2023

Behavioral Health Information Notice No: 23-002

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Clarification Regarding Determination of Usual and Customary Charges for Specialty Mental Health Services

PURPOSE: This Behavioral Health Information Notice (BHIN) provides clarification to Mental Health Plans (MHPs) regarding the requirement to bill at usual and customary charges, and the methodology for determining usual and customary charges when they and their contracted providers do not bill their usual and customary charges.

REFERENCE: Title 42, Code of Federal Regulations, Section 413.13; Title 9, California Code of Regulations, Section 1810.253.1; Title 22, California Code of Regulations, Sections 51480 and 51501

BACKGROUND:

The following regulations govern a provider's charges for services provided to Medi-Cal beneficiaries. Title 22, California Code of Regulations, Section 51480 prohibits providers from billing for services rendered to a Medi-Cal beneficiary in any amount greater than the usual fee the provider charges the general public. Title 22, California Code of Regulations, Section 51501 prohibits providers from charging Medi-Cal beneficiaries for any service or article more than would have been charged for the same service or article to another purchaser of a comparable service or article under comparable

circumstances. For a specialty mental health provider, the “usual fee” is the provider’s usual and customary charges.

For Specialty Mental Health Services, Title 9, California Code of Regulations, Section 1810.253.1 defines usual and customary charges as those uniform charges listed in the provider’s established charge schedule which are in effect and applied consistently to most patients. The California Medicaid State Plan defines “usual and customary charge” as the regular rates that providers charge both Medi-Cal beneficiaries and other paying patients for the services furnished to them.[1] The California Medicaid State Plan definition also incorporates Title 42, Code of Federal Regulations, Section 413.13, which defines “customary charges” as the regular rates that providers charge both beneficiaries and other paying patients for the services furnished to them.

“Usual and customary charges” are compared to the provider’s reasonable and allowable costs to determine appropriate reimbursement for Specialty Mental Health Services under the California Medicaid State Plan.[2] The Medicaid State Plan does not require this comparison for county operated non-hospital providers or nominal charge providers. The purpose of this information notice is to clarify how providers are expected to bill at usual and customary charges, and if they do not, how to determine their usual and customary charges for cost reporting purposes.

DISCUSSION:

Section 2604.3 of the CMS Provider Reimbursement Manual provides an expanded definition of customary charges:

> Customary charges are those uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement. Where a provider does not have an established charge schedule in effect and applied to most patients, the determined "customary charges" are the most frequent or typical charges imposed uniformly for given items or services. However, in either case, in order to be considered customary charges, they must actually be imposed uniformly on most patients and actually be collected from a substantial percentage of "patients liable for payment on a charge basis." Such charges must also be recognized for program reimbursement.

[1] California Medicaid State Plan, Attachment 4.19-A, p. 39.
[2] California Medicaid State Plan, Attachment 4.19-A, p.38; Attachment 4.19-B, p. 21.

A provider's rate for a particular service is considered "usual and customary" if it meets the following ***three tests***.

1. The rate must be the ***amount actually billed*** to most patients for a service rendered by the provider and recognized for Medi-Cal reimbursement. An "amount billed" may come from an established charge schedule, if a provider has one, or it may be the provider's most frequent or typical charge over the cost reporting fiscal year. An established charge schedule is a document that identifies the rate charged for each unit of service rendered to a patient. An established charge schedule may be produced from a provider's billing system.

2. The rate billed must be ***uniform***. A uniform rate is one that is ***imposed on most patients***, regardless of the type of patient served or the party responsible for payment of the service..

3. The amount billed must be ***collected*** from a ***substantial percentage*** of patients who are **liable for payment** for the services they receive.

    - **Collected** means that the provider received payment in the amount billed.

    - **Substantial percentage** is determined by DHCS based upon the facts of each case. The percentage of individuals who paid the uniform charge is equal to the number of patients liable for payment who actually paid the charge divided by the total number of patients liable for payment.

    - **Liable for Payment** means those individuals who are liable to pay the provider for the services received. Patients liable for payment do not include individuals enrolled in the Maternal and Child Health Program, the Medicare Program, Medicaid Program, or local welfare programs; individuals who are represented by a plan or agent under contract or agreement to make payment directly to the provider on a basis other than full charges; and individuals who are represented by a plan or agent under contract or agreement whereby the plan or agent rather than the individual is liable for payment.

1. Steps to Determine Whether a Charge is "Usual and Customary"

Step 1 – Identify the Rate Billed to Most Patients

- Has an established charge schedule

    - The rate billed to most patients is the rate in the established charge schedule for a particular type of service
- Does not have an established charge schedule
    - List of all services provided to patients who are liable for payment on a charge basis
    - List the rate for each service rendered
    - Sort the list by the rate billed for each service
    - Identify the rate most frequently charged for the particular type of service

Step 2 – Determine Whether the Rate Billed is Uniform

- Calculate the percentage of patients, regardless of type of patient or the party responsible for payment, that were billed at the rate identified in step 1
- If most of the patients were billed at that rate, it is considered to be a uniform rate[3]

Step 3 – Determine Whether the Rate Billed was Collected from a Substantial Percentage of patients liable for payment on a charge basis

- The numerator – number of patients liable for payment on a charge basis paying uniform charges
- The denominator – number of patients liable for payment on a charge basis regardless of whether they paid the uniform charges

2. Treatment of Providers That Do Not Satisfy the Usual and Customary Charge Requirements

Providers that do not satisfy the usual and customary charge requirements indicated by the tests described above must use the following method to convert the amount billed for each type of service provided to program beneficiaries into customary charges for comparison with reasonable cost.

[3] Providers that offer a Sliding-Scale Charge structure that meets the conditions described in section 2606.2(D) of the CMS Provider Reimbursement Manual may consider patients receiving an indigency allowance to pay the established charge when determining whether the rate billed to most patients is the established charge schedule.

Total charges for each type of service furnished beneficiaries	X	Total amount actually collected from patients, plus bad debts and/or indigency allowances[4] attributable to patients / Total charges uniformly imposed on patients liable for payment on a charge basis	=	Customary charges for services furnished program beneficiaries[5]

Section 2606.1(B) of the CMS Provider Reimbursement Manual provides examples demonstrating the determination of customary charges for comparison with reasonable cost.

"Customary charges for services furnished to program beneficiaries" should be divided by the total units associated with the "Total charges for each type of services furnished beneficiaries" to determine the Published Charge rates to report on the Specialty Mental Health (Short-Doyle/Medi-Cal) cost report MH 1901 Schedule A.

Providers must maintain documentation supporting an established charge structure, or the records and reports needed to determine "customary charges" to support rates reported in the cost report.

Please e-mail any questions regarding this BHIN to the Medi-Cal Claims Customer Services unit at MedCCC@dhcs.ca.gov.

Sincerely,

Original signed by

Brian Fitzgerald, Chief
Local Governmental Financing Division

[4] Allowable bad debts are those amounts where a reasonable collection effort has been made, as provided for in Sections 2606.1(A), 310, and 312 of the CMS Provider Reimbursement Manual. Indigency allowances are those discounts that meet the conditions described in Section 2606.2(D) of the CMS Provider Reimbursement Manual.
[5] CMS Provider Reimbursement Manual §2606.1(A).