The Department of Services for Children, Youth and Their Families

Division of Prevention and Behavioral Health Services

Billing Manual for Treatment Service Providers

Claim Addresses and Telephone Numbers

Billing Unit Manager	Kimberly Scully	302-892-6433
Claim submission address	Delaware Department of Services for Children, Youth and Their Families Attn: DPBHS Billing Unit 1825 Faulkland Road Wilmington, DE 19805	
Secure Fax Number	302-622-4475	

Acceptable claim and bill submission formats

1. Secure Email - Providers can email their claims or bills to their billing representative, as long as their submission is encrypted via use of secure email.
2. Secure Fax - Providers can send their claims or bills to our secure fax number. Please put Attention Billing Unit on the fax cover sheet. 302-622-4475
3. Mail - Providers can mail their claims or bills to the attention of the Billing Unit at the Delaware Department of Services for Children, Youth and Their Families, 1825 Faulkland Road Wilmington, DE 19805
4. In Person - Providers can bring bills to the Administration Building for the Department of Services for Children, Youth & Their Families at the address listed above. **However, due to increased security measures in the building, you must use the external phone to gain access the building. Please have the receptionist call to your billing representative to drop off the bills. Visitors may not walk throughout the building without a DSCYF employee present.**

Please note if claims and bills are not submitted to this address, DSCYF and DPBHS can make no guarantee that payment will be received in a timely fashion and could delay the processing and payment of the claims and/or bills will be returned to the sender.

DPBHS Billing Representatives	Adriane Crisden	302-892-6464
	Eartha Hopkins	302-633-2570
	Vacancy	302-892-6418

The Billing Manual for Treatment Service Providers will be reviewed twice a year for possible updates or changes. These changes will be notated and posted on the billing page of the DPBHS website.

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1.1 Receiving and Screening Claims

When claims are received by a billing representative within DPBHS, they are then screened for missing information. Only "clean claim(s)" will be processed for payment. A clean claim is defined as a claim that can be processed without obtaining the "**required information**" listed below. A non-clean claim is a claim, or a bill that requires the "**required information**" listed below. As such, that claim will be returned to the provider with a Return to Provider (RTP) letter. The claim will NOT be entered into the claims processing system. The provider will have to enter the missing information using the Re-Submission Form and resubmit the claim.

Required information

- Billing Month
- Provider Name
- Service type (check box)
- Client Full Name (First Name, Middle Name, and Last Name)
- Authorization Number
- Service Date(s)
- Units of Service
- Unit cost as specified in executed contract (not your usual and customary rates)
- Client Date of Birth
- Level of care (i.e., IOP, Behavioral Intervention-formerly known as Wrap, Crisis)
- Billing Code
- Corresponding CPT code or Correspond HCPCS codes
- Admission date
- Billing activity date from
- Billing activity date to
- Applicable Place of Service code

1.2 Standard Forms required by providers when submitting bills or claims:

Billing Summary Form

This cover sheet **MUST** accompany all monthly bills from Routine Outpatient, Intensive Outpatient, and Behavioral Intervention (formerly known as Wrap-Around Services) **regardless** of submission type (i.e., paper submission, electronic submissions thorough direct entry into FACTS Provider Invoice module). It is the expectation that all claims and bills submitted for processing will have this Billing Summary Form. The billing total on this form must equal the total on the individual Client Billing/Activity Forms.

Client Billing/Activity Form

This form is referenced in the Provider Manual. It **MUST** be used by all unit-cost, Intensive Outpatient, Routine Outpatient, Behavioral Intervention (formerly known as Wrap-Around) Services and Urgent Response programs that are not billing electronically.

Monthly Style Billing Form

This form **MUST** be used by all unit or cost-reimbursable Residential and Day Treatment programs and providers that are not billing electronically.

Transportation and Translation Services Billing Forms and Cover Sheets
These forms should be used by all transportation and translation providers. Translation providers must use the translation billing form and cover sheet. Transportation providers must use the transportation billing form and cover sheet.

***** Without prior approval, the provider May NOT use any other forms.***Prior approval must be obtained from the billing manager. Additionally, it MUST contain ALL the requirements listed in the above forms. *****

1.3 Processing of Claims

Once a claim or bill has passed the screening as a "clean claim", it is sent for processing. One of the following actions will happen:

Payment- The provider will be reimbursed for payment based on contractual specifications.

Denial- The claim or bill is denied payment because it does not meet program criteria and contractual specifications. Next, the provider will receive an exception report that details the reason(s) why the claim was denied in whole or part. It is the provider's responsibility to follow up with the required information, fix any errors that may have resulted in the denial, and resubmit the bill. The re-submitted bill must be re-submitted using the re-submission forms. The bill must be re-submitted within **the identified timely claim submission guidelines**.

Partial payment- Only a portion of the bill can be paid. Full payment cannot be made because the information supplied indicates the claim or bill does not meet program criteria or contractual specifications. Next, the provider will receive an exception report that details the reason(s) why the claim was denied in whole or part. It is the provider's responsibility to follow up with the required information, fix any errors that may have resulted in the denial, and resubmit the bill. The re-submitted bill must be re-submitted using the re-submission forms. The bill must be re-submitted within **the identified timely claim submission guidelines**.

Exception Reasons for denial or partial payment

- Service date not authorized
    - Admission
    - Discharge
    - Authorization expired
    - End fund date expired
- Duplicate claim submission; previously paid
- Service billed twice in the same day for the same client
- Error in total amount billed
- Not authorized for that level of service
- Agency not authorized for that level of service
- Billed at incorrect rate per contract – only paid services at contracted rate
- Not a DPBHS client
- Not a DSCYF client
- Transportation – client was not in treatment
- Service authorization gap

Electronic Billing- electronic direct submission providers can request to have direct bill processing access to our billing payment system. Any provider who is considering electronic billing must have a minimum of three months of "clean" bills before considering electronic bill submission. DPBHS reserves the right to

1. Revoke electronic bill submission if a provider demonstrates an inability to accurately submit electronic billing after several training(s) and information has been provided.
2. Deny a providers request to start electronic billing.

Basic Requirements

- Ask and receive approval from your Program Administrator
- Contact your DPBHS Billing Representative
- Provider must have direct deposit set-up
- Provider must identify only 2 users within their agency to enter claims
  - One (1) user is the primary billing person and the second person is the back-up
- Both users must sign into the system at least once per month or the account will be suspended for inactivity and eventually deleted
- Complete three forms and one training

1.4 Remittance Advice

After payment has been submitted to our fiscal department, we will send a Remittance Advice (RA) to the provider's billing representative. This document will describe how much of the bill submitted was paid, partially paid or denied. In the case of partial payment or denial, the RA will be on the exception report. If your entire bill was paid, without any exceptions, you will receive an RA for the entire amount billed in accordance to the executed contractual rates.

1.5 Timely Claim Submission Requirements

DPBHS requires that bills and claims must be submitted within 90 days of the original date of service . Bills and claims submitted after this time frame may be denied. This may include resubmitted claims. For more information about re-submitted claims see the re-submission section of this Manual.

1.6 Coordination of Benefits/Secondary Claims Submission

- DPBHS is typically the payer of last resort.
- In accordance with DPBHS policy #CS001 *Service Eligibility*, if a youth is hospitalized this Division does not function as a secondary payer for the purpose of funding insurance co-payment for the privately insured, with the following exceptions
  - If a youth is hospitalized in a DPBHS designated psychiatric hospital on a voluntary basis, or is hospitalized on an emergency basis with DPBHS authorization and the hospital is unsuccessful in obtaining reimbursement for the private insurance, then DPBHS may reimburse the Provider up to the allowable contract rate for up to **72 hours**.
  - If a youth has both private insurance and Medicaid, the private insurer is the primary payer and Medicaid is the secondary payer. However, if the youth is treated by a participating Medicaid provider, then the parent, legal guardian or other legally liable individual is not responsible for any co-pay amount and by federal regulation, private providers may not bill payments for the amount. In such a situation, Medicaid providers who have a contact with DPBHS may be reimbursed up to the Medicaid rate in cases pre-authorized by DPBHS. If the provider and Medicaid recipient wish to utilize any applicable Medicaid coverage to pay costs after the primary insurance has paid

allowable charges, the provider must obtain DPBHS authorization for the service prior to the initiation of the service, in addition to any other authorizations which may be required by other payers.

- DPBHS will pay the difference between the primary insurance payment and the DPBHS allowable amount. This is calculated by taking the DPBHS rate by the number of units serviced and subtracting the primary insurance payment amount.
- Providers cannot bill clients or their families for a covered service or missed appointment (i.e., "no show" billing) and cannot balance bill clients or families.
- If the primary insurance carrier denies the claim as a non-covered service, DPBHS may consider the service for primary benefits.

Please note, it is the provider's responsibility, to obtain the primary insurance carrier's explanation of benefits (EOB) or the remittance advice for services rendered to clients that have other insurance coverage, in addition to DPBHS. Providers must bill and obtain an Explanation of Benefits (EOB) from any other insurance or source of health care coverage prior to billing DPBHS. The primary carriers' EOB or remittance advice **MUST** accompany any secondary claims submitted to DPBHS for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier's EOB or remittance advice. This information is essential for DPBHS Coordination of Benefits. The information must be calculated and present on each individual claim, as outlined below:

- Line 1 -DPBHS Rate x number of units
- Line 2 - Primary Payer amount paid
- Line 3 - Amount request from DPBHS

The EOB and claim must be submitted within 180 calendar days from the date of the service. Claims will be denied if they are not submitted without an EOB, or if the other insurance carriers' requirements are not met.

1.7 Resubmitting Claims Vs. Reconsideration

Providers have 6 months from the date of service to correct and resubmit claims or bills that received with a RTP letter and or an exception report with the "required information". Thus, the provider is re-submitting a claim or bill with the information we require that was missing from the bill or claim. A "reconsideration" is the process a provider uses when he/she has a dispute with the payment of a claim. Reconsideration is the DPBHS billing appeal process.

Resubmission- A claim originally denied because of missing documentation, incorrect coding, etc., that is now being resubmitted with the required information

Reconsideration- A request for the review of a claim that a provider believes was paid incorrectly or denied because of processing errors. Please see the Appeal process for detailed information for reconsideration

A resubmission must be on the resubmission form.

1.8 Claim Inquiries

DPBHS billing unit accepts telephone, written, and e-mailed inquiries from providers concerning claim or billing issues as long as all forms of communication are in compliance with HIPAA standards and maintain appropriate confidentiality. Please be sure to use the "Claim Inquiry" form when requesting information in writing.

1.9 Time intervals

Units are rounded down to the nearest 15 minutes, when applicable. For example, if you render services to a client from 12:50P.M. -2:15P.M., that would be 1 hour and 15 minutes or 1.25 units. Also please note you must submit time in quarter increments:

- 15 minutes is .25
- 30 minutes is .50
- 45 minutes is .75
- 60 minutes is 1.0

For some of the newly implemented codes in place, there are specified units and time intervals built into the actual description of the CPT code. Please be mindful of those changes as you begin billing with the new CPT codes. For a detailed list of the codes by service level, please refer to the Addendum to the Billing Manual.

2.0 Billing Monitoring and Documentation

DPBHS monitors provider billing on an annual basis. DPBHS requires each claim or bill submitted for payment have documentation to verify the claim. Thus, DPBHS requires the progress note to include the following items for billing documentation only (for clinical expectations, please refer to the treatment services sections of the Provider Manual):

- Date(s) of service delivery
- Client Name
- Subservice Type/HCPCS codes billed
- Start time
- End time
- Number of units billed

Additionally, if your program bills for mileage reimbursement or for flex fund reimbursement, DPBHS requires that documentation will be in the client chart. DPBHS requires the documentation for transportation and/or flex funds to have:

- Date(s) of service delivery
- Client Name
- Subservice Type
- Start time
- End time
- Number of units billed
- # of miles traveled for this claim (includes start and arrival location)
- Name of DPBHS representative who authorized/approved flex fund expenditure

Please note, each individual client sub-service is considered a claim. Each claim **MUST** have documentation to support its existence on the date billed for the number of units billed to DPBHS. It is also the expectation of DPBHS that ALL required documentation be in the client chart within 24 hours of the service provided.

Please note that without proper documentation, a claim cannot be verified; as a result, the money paid for that claim must be returned. Returning the money paid for these claims resolves only the

overpayment. It does not impact any other investigation relating to the particular claims identified, nor will it impact any resulting civil, criminal or administrative action undertaken.

For any provider that is currently operating under a program-funded or cost-reimbursable contract, please be sure to have supporting documentation for the services you bill in your cost reimbursable/program funded contacts. Thus, during an audit you should be able to provide documentation that corresponds with each expense line in your contractual "budget form", for each bill that was submitted to DPBHS for reimbursement.

2.1 Provider Claim or Bill Appeal Process

A provider may submit a claim for reconsideration. This claim reconsideration must be submitted within 30 days after the initial denial is received. The first step in disputing a claim payment or decision is to contact their billing representative. Generally the billing representative can resolve the billing dispute within 5-7 business days.

Level 1 Appeal

If the provider is not satisfied with the reconsideration decision made by the billing representative, they must file a Written Level 1 Appeal to the Billing Manager. Please submit this appeal using the Level 1 Appeal Form. Please send this appeal within 30 days of the initial denial from the billing representative. Send the form and any supporting documentation to:

Delaware Department of Services for Children, Youth and Their Families
Attention: Billing Manager
1825 Faulkland Road
Wilmington, DE 19805

DPBHS will notify providers of the Level 1 decision in writing within 30 days of receipt of the appeal, unless we request additional information. If we need additional information we will send the Level 1 Appeal decision within 30 days of receipt of the additional requested information.

If the Level 1 Appeal decision is in the providers' favor, we will recalculate and reprocess the claim or bill affected by the decision. If the Level 1 Appeal decision upholds DPBHS's original position, the provider can appeal to Level 2.

Level 2 Appeal

If the provider is not satisfied with the Level 1 Appeal decision, they must file a Written Level 2 Appeal to the Manager of Provider Services. Please submit this appeal using the Level 2 Appeal Form. Please send this appeal within 30 days of the Level 1 Appeal denial letter. Send the form and any supporting documentation to:

Delaware Department of Services for Children, Youth and Their Families
Attention: Manager of Provider Services
1825 Faulkland Road
Wilmington, DE 19805

DPBHS will notify providers of the Level 2 decision in writing within 30 days of receipt of the appeal, unless we request additional information. If we need additional information, we will send the Level 2 Appeal decision within 30 days of receipt of the additional requested information.

If the Level 2 Appeal decision is in the providers' favor, we will recalculate and reprocess the claim or bill. The decision of the Level 2 Appeal is the final decision.

2.2 Provider Errors and Notification to DPBHS

If a provider realizes that they have submitted a bill for payment in error, they must contact the Billing Manager ***as soon as they have become aware*.** These errors include incorrect; units, dates, sub service or clients etc. The provider is required to use the "Submitted in Error" form. The provider may also be required to return payment to DPBHS for the claim or billing error. The two payback options would be recoupment through future claims and documented by exception report, or through direct check made payable to The State of Delaware and in the memo line, the client's initial and date of service that was billed in error. For multiple errors and multiple dates billed in error, a letter must accompany the check to specify what the check covers (which clients, which dates of service, etc.).

2.3 Dual Therapist Billing

The time entered for the length of the session should equal the time the *client/family* was served, not the combined number of therapist hours. If two therapists provide one hour of service in the same session, only 60 minutes may be submitted.

2.4 Fiscal Year End Close Out At the end of each fiscal year (June) our fiscal department *closes down*. This means they cannot process payments until the fiscal system *opens back* up in mid to late July. DPBHS will notify providers in advance by e-mail and at the provider forums. It is the provider's responsibility to adhere to the dates and requirements to ensure proper and timely payment during this period. Please be advised no advance payment can be made for future claims.

2.5 Service Codes

Direct Service Codes – These are codes that DPBHS uses in its client payment system to categorize direct care services. Direct services are those in which approved program staff/therapists meet with the client and/or any member of the client's family. Family includes, parents, siblings, extended related family, foster family and other caretakers, surrogate family and significant others in the client's residence. Direct Service codes can be in the agency office or out of the agency office.

We are moving towards complying with industry standards for billing practices. As such, as we continue towards our upgrade to our new information systems (FACTS II) scheduled to go live next fiscal year, we will no longer be able to accept self-defined codes as previously outlined in the new FACTS II system.

To ensure that we are moving everyone towards these industry practices, please refer to the Billing Manual Addendum for a complete list of old/former self-defined codes and the crosswalk to the CPT/Revenue/HCPCS codes for each level of care.

Service Codes Key Points

- Use an "Intake" code ***only once*** per admission (service episode). The total number of Intake codes should equal the number of admissions the program has had in a given month.
- **Two of the same codes may not be listed for the same day.**
- Except for psychiatric services and groups, do not subdivide a session. For example, if a therapist sees the parents for most of the time and the client for a part of the time within the session, just enter one session for "family."
- Please be mindful that some of the newly implemented CPT codes have specific timeframes for them.
- PT (transportation) is not counted as direct treatment service. BUT – When transporting client(s) and/or family(ies), therapists may be providing treatment. This may be coded as an out-of-office treatment session, if a progress note is written which addresses the clinical content and is related to the treatment plan.

Glossary of Terms

Admission Date
This date is the date when DPBHS services begin for the child and family. In most cases, it is the date of first face-to-face contact (Intake) with the child. On rare occasions the parent may be seen alone for the first appointment, and the client and family in subsequent appointments. The first appointment is still considered the admission date (Intake). **Note: Billing for services prior to the admission date or after the discharge date will not be accepted.**

Authorization Date From ….
This date is the beginning date of the current authorization period. This is not applicable for Urgent Response (Foster Child Screening).

Authorization Date To……
This date is the ending date of the current authorization period. This not applicable for Urgent response (Foster Child Screening).

Authorization Number
Enter the authorization number that is listed on the most recent authorization form the provider has received from DPBHS. This is not applicable for Urgent Response (foster child Screening).

Billing Summary
This cover sheet **MUST** accompany all monthly bills from Routine Outpatient, Intensive Outpatient, and Behavioral Intervention (formerly known as Wrap-Around Services) **regardless** of submission type (i.e., paper submission, electronic submissions thorough direct entry into FACTS Provider Invoice module). It is the expectation that all claims and bills submitted for processing will have this Billing Summary Form. The billing total on this form must equal the total on the individual Client Billing/Activity Forms.

Bill
A bill or invoice is a written document with one or more claims.

Billing/Activity Date From
Enter the *first* activity/service date (in chronological order) that is entered on this bill.

Billing/Activity Date To
Enter the *last activity/service* date (in chronological order) that is entered on this bill.

Claim
is a request from a provider to be reimbursed for a behavioral health services that was provided to a an individual client on a specific date for a specified number of units.

Claim Inquiry Form- This is a form used to research a claim. You may submit this form to your billing representative or they may ask you to fill this form out so they may research a claim inquiry that you have.

Client Billing/Activity Form
This form is referenced in the Provider Manual. It **MUST** be used by all unit-cost or cost-reimbursable Crisis, Intensive Outpatient, Routine Outpatient, Behavioral Intervention (formerly known as Wrap-Around) Services and Urgent Response programs that are not billing electronically

Client Name

Names of clients must not deviate from the legal name listed on the birth certificate, unless the name has been legally changed. No nicknames are to be used. This must be the same name used on all requests for authorization, intake forms, etc. submitted to DPBHS.

Diagnosis

Bills will not be processed without a diagnosis. This should be the same diagnosis as entered on the admission form, if this form is required as a deliverable in the Provider Manual.

Only correct DSM-IV Diagnoses codes will be accepted. (No v-codes)

A code for deferred diagnosis is not permissible.

DOB

Birth Date of the client: Enter as mm/dd/yy.

Exception Report-A report you will receive if we have not received the required documentation or need more information on the documentation you have submitted.

Monthly Style Billing Form
This form **MUST** be used by all unit or cost-reimbursable Residential and Day Treatment programs and providers that are not billing electronically.

Program Many organizations provide more than one level of care for DPBHS. Please indicate whether this authorization and activity/service being reported is for:

- IOP Intensive Outpatient
- Behavioral Intervention Wrap-Around or Aide Services
- CRISIS Crisis Intervention
- OP Routine Outpatient
- UR Urgent Response

Remittance Advice-This is a document you will received after you bill has been processed and sent to fiscal for payment. It details what clients were paid for each bill and the number of units paid for that client.

Resubmission Cover Sheet - Form that should be placed on top of ANY bill or claim that is being resubmitted for payment.

Return to Provider Letter Letter sent to providers when a claim is not "clean" and the required information is not in the bill or claim.

Service Date
Enter each date on which client received direct service by mm/dd/yy. *Direct services are those in which the therapist meets with the child who is the identified client and/or the parents or legal guardians of the identified client to plan for treatment or to continue goals stipulated in the client's treatment plan.* These services may be provided on-site (at the agency) or off-site (at home, school or other setting). There must be a progress note in the client record for each date billed.

Submitted in Error Form If you make an error after you have submitted a bill to us this the form that will start the correction process and get that claim fixed.

Transportation and Translation Services Billing Forms and Cover Sheets

These forms should be used by all transportation and translation providers. A translation or transportation provider **ONLY** provides translation or transportation. If you provide a client transportation as a part of a therapy or treatment session **DO NOT USE THIS FORM**. Translation providers must use the translation billing form and cover sheet. Transportation providers must use the transportation billing form and cover sheet.