THE DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES

Division of Prevention and Behavioral Health Services

Billing Manual Training

Billing Manual Training

- The purpose of today's training on the NEW Billing Manual is to Highlight some of the major changes to our billing policies and procedures.
- Please note this is NOT the entire manual
- Please note some of the changes that have been made may NOT be in this presentation.
- Please refer to the Provider Billing Manual for a Complete explanation of the Billing Policies and Procedures.

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Billing Manager

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Acceptable Bill Submission Formats

- Secure Email- Providers can email their claims or bills to their billing representative, as long as their submissions are encrypted via use of secure email.
- 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
- Mail- Providers can mail their claims or bills to the attention of the Data Unit at the Delaware Department of Services for Children, Youth and Their Families, 1825 Faulkland Road Wilmington, DE 19805

Acceptable Bill Submission Formats

- In Person-Providers can bring bills to Murphy Cottage located at the above mentioned address; **It is the expectation of the Billing Unit that providers may either leave the bills with front desk staff in the lobby of Murphy Cottage, or the provider can request to have front desk staff call the billing representative to the lobby. If the representative is available, she will come and take the bills or claims from you in the lobby. However, providers are NOT permitted to bring the bills or the claims to the billing representatives' personal offices located at Murphy Cottage. To ensure safety within the building, visitors may not walk without escorts throughout the building.**

Acceptable Bill Submission Formats

- Electronic Direct Submission- Providers can request to have direct bill processing access to our billing payment system.
- 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

Screening Claims and Required Information

- On the next slide you will find the required information that MUST be in your bill, or claim.
- Without this information your claim is not a "clean" claim or bill and it will NOT be processed for reimbursement.
- If your bill or claim is "not clean" you will receive a Return to Provider Letter explaining what was missing and what you need to do to resubmit using the Re-submission Form.

Screening Claims and 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 (MM/DD/YYYY)
- Level of care (i.e., IOP, Behavioral Intervention-formerly known as Wrap, Crisis)
- Billing Code
- *Corresponding CPT code or Corresponding HCPCS codes*

Standard Billing Forms

- **The following standardized billing forms will not be sufficient evidence of service delivery**
- **For all bills or claims submitted to DPBHS, it is our expectation that the supporting clinical documentation will be readily available upon monitoring and/or site visit within 24 hours of date of service pursuant to contractual expectations and industry standards**

Standard Billing Forms

- On the next few slides you will find the standard billing forms that we require.

- **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 following forms.**

Standard Billing Forms
Billing Summary Form

- **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 through 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.

Standard Billing Forms
Client Billing/Activity Form

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

Standard Billing Forms
Monthly Style Billing Form

- **Monthly Style Billing Form**

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

Standard Billing Forms
Transportation and Translation Provider Forms

- **Transportation and Translation Services Billing Forms and Cover Sheets** (for providers who provide Transportation and Translation services only)

  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.

* **Please note**: *If your agency provides transportation in conjunction with treatment services, there is a specific location on the Client/Activity Form for mileage reimbursement*

Processing 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 form. The bill must be re-submitted within **the identified timely claim submission guidelines**.

Processing Claims

- 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. The provider may need to follow up with the required information, fix any errors that may have resulted in the denial, and resubmit the bill.
- (Example: If the agency submits their usual and customary which may be out of line with what is stated in the executed contract)

Processing Claims: Exception Reasons for Denial or Partial Payment

- Service date not authorized
  - Admission
  - Discharge
  - Authorization expired
  - End fund date expired
- Service authorization gap
- Duplicate claim submission; previously paid
- Service billed twice in the same day for the same client
- Error in total amount billed
- Client 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

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 a RA for the entire amount billed in accordance to the executed contractual rates.

Timely Claim Submission Requirements

- DPBHS requires that bills and claims **MUST** be submitted within **6** months of the original date of service (180 calendar days). Bills and claims submitted after this time frame will be denied. This may include re-submitted claims.

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**.

Coordination of Benefits/ Secondary Claims Submission continued

- 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 contract 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.

Coordination of Benefits/ Secondary Claims Submission continued

- 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.

Coordination of Benefits/ Secondary Claims Submission continued

- 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.

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.

Resubmitting Claims Vs. Reconsideration

- Re-submission- 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 re-submission form.**

Provider Claim and 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 your billing representative. Generally the billing representative can resolve the billing dispute within 5-7 business days.
- If the provider is not satisfied with the outcome from the billing representative, they can follow the appeal process using the Reconsideration Form.

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.

Time Intervals

- Units are rounded down to the nearest 15 minutes. If you render services to a client from 12:55P.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

Billing Monitoring and Documentation

- DPBHS monitors provider billing on an annual basis. DPBHS requires each claim or bill submitted for payment to have documentation to verify the claim. Thus, DPBHS requires the progress note to include the following items for **billing** documentation (for clinical expectations, please refer to the treatment services sections of the Provider Manual):
- Date the service was provided
- Client Name
- Subservice Type
- Start time
- End time
- Number of units billed

Billing Monitoring and Documentation

- 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 the service was provided
- 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

Billing Monitoring and Documentation

- 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.

Billing Monitoring and Documentation

- 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.

Program Funded Billing Monitoring

- 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 contract. 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.

Provider Error 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 or through direct check made payable to "The State of Delaware" and in the memo line, the client's initials 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.).

Division of Prevention and Behavioral Health Services
Billing Manual Training

- This PowerPoint Presentation will soon be on the Division website.
  - http://www.kids.delaware.gov/pbhs/pbhs_providers.shtml#pbhReqMHS
- Please note the Revised Billing Manual and all standard forms in this presentation will be viewable and available for the FY13 contract year, on the Division website at
  - http://www.kids.delaware.gov/pbhs/pbhs_providers.shtml#pbhReqMHS

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