Agency for Persons with Disabilities

State of Florida

Provider Billing Information

Agency for Persons with Disabilities
State of Florida
Provider Billing information

Overview

It is the responsibility of the Agency for Persons with Disabilities (APD) and the Agency for Health Care Administration (AHCA) to assure that payments made to providers for the provision of services to individuals are paid in accordance with established rules, which includes assuring that payments are within authorized amounts and for authorized services.

For this reason, the Agency for Health Care Administration (AHCA) and the Agency for Persons with Disabilities (APD) designed a pre-payment "screening" for provider claims. Every day, a file is sent from the iBudget system to the Medicaid Fiscal Agent, HP, which includes all cost plan information currently in iBudget. Prior to running the weekly payment cycle, the APD Waiver providers' claims are checked against the information against this file. Claims passing the APD cost plan edit checks are processed through the regular payment process. Those not passing the edit checks post a denial, which is included on the providers' remittance advice in the Explanation of Benefits (EOB).

The annual cost plan and service plans are created in iBudget. Prior to the daily Gatekeeper file run, the iBudget files will pick up all service authorization updates in iBudget. These updates are sent to FMMIS prior to the Gatekeeper run.

The cost plan format in iBudget is the official cost plan document for the APD Waiver programs. This format is also the official service authorization, authorizing providers to be paid for services approved under the terms listed in the service authorization.

The need for Waiver Support Coordinators (WSCs) to keep cost plan information current and up to date is critical to the success of the pre-payment screening. The provider's part in this process is to adhere to the terms of the service authorization. If providers feel that the terms are not accurate, then they should contact the WSC before performing services. Failure to do so will result in providers not receiving payment for which they have been authorized, or providers receiving payment to which they are not entitled. This can also result in individuals being without services.

Agency for Persons with Disabilities
State of Florida
Provider Billing Information

iBudget

Providers must have a valid service authorization (SA) **BEFORE** beginning services. The SA is the approved agreement between APD and the service providers. If the SA is not received before services begin, then it must be obtained before billing for those services. After receiving an SA for an individual, providers should review the information on the SA for accuracy. Procedure codes and rates may be found on the iBudget Provider Rate Table located on the APD web site at http://apd.myflorida.com/. Providers should also review the "notes" section of the SA to verify the frequency, intensity, and duration of the service. If any discrepancies are found or clarification needed, providers should contact the Waiver Support Coordinator (WSC) immediately.

Providers who bill for services without a current and accurate SA, are taking a risk that their claims will be denied or be in danger of recoupment.

Except for an emergency situation, providers should **NEVER** accept verbal or handwritten service authorizations from a WSC. Emergency services are defined as services to alleviate a health and/or safety issue. A verbal agreement should be followed up with an e-mail or fax from the WSC stating the particulars of the emergency service. Providers should receive a valid and approved SA within days of the service start date. If the SA is not received, providers should contact the WSC or the APD local office.

During the course of the service period, it is possible to change the amount, duration and frequency of the service. Providers should not implement any changes to the service authorization without first notifying the WSC and receiving an approved SA from the WSC, with the changes noted on the SA.

If there are no specific notes entered on the SA, then the provider may adjust the units of service from month to month to meet the changing needs of the consumer. Providers must document how the individual prefers the service and that the individual was in agreement. The provider may bill up to the approved amount funded for the quarter.

Whenever a new or amended service authorization is received, providers should check the "Prior Authorization" (PA) option in the web portal before billing for services. If the PA information does not match the SA information, providers should contact the WSC immediately for resolution.

"Date Spanning" for the quarter is acceptable in the iBudget system. A WSC can place units in the first month of the quarter and the last month of the quarter and the provider would still be able to provide services throughout the 3 months of the quarter.

For example, an individual changes work hours frequently and does not need the same level of employment service every month. The WSC can place 10 units in January and 10 units in March, skipping February, with no specific note. The provider would be able to perform the 20 units of

service within those three months. Another example would be where a consumer does not always attend an ADT program full time every day of the month. The WSC would enter 180 hours in April, skip May and enter 180 hours in June. The ADT provider would still be able to bill up to the full 360 hours over the course of the three month period, including May.

Medicaid will not reimburse a provider for a service unless FMMIS (Florida Medicaid Management System) shows that a recipient is Medicaid eligible on the date of service. It is the provider's responsibility to verify a consumer's eligibility prior to providing any Medicaid service. It is the provider's responsibility to notify the WSC as soon as possible that the consumer has lost Medicaid eligibility.

As a reminder, in cases where a recipient has eligibility in multiple benefit plans, with one of the plans having a higher level of benefits (for example, Full Medicaid), the Full Medicaid plan takes precedence and more fully represents the recipient's eligibility.

There are two ways for providers to verify a consumer's eligibility. Providers may use the Automated Voice Response System (AVRS) by calling 1-800-239-7560 for self service. The second way to check Medicaid eligibility is to use the "eligibility" option on the web portal. After clicking on the web portal, the eligibility option is at the top of the page. Click on eligibility and then click on search. Enter the recipient ID (consumer's Medicaid number) and the dates of service (From DOS, To DOS) boxes. Click the search button on the right side of the page. Review the "Benefits Plan" section.

One of the following codes must be in the BENEFIT PLAN section, in order for the individual to be Medicaid eligible. Even if some other form of benefit plan appears, i.e. QMB, Medicare Part D or SLMB, one of the following codes must be present. Medicaid eligibility is valid for the entire month, even if only one particular date is entered.

MM S	MT A	MT C	MT D	MT S	MT W	MS	MW A	MW C	MX
				SSI	TXIX				

Per the DD iBudget Handbook, APD has a maximum number of units that may be utilized for each service. These maximum units may differ from the Medicaid allowable number of units. Combinations of services may also dictate the maximum number of units allowed. Checking the Provider Billing Code Matrix will inform providers of the maximum number of units that is allowed by APD. If the "Notes" section on a SA has a lower number of units than the Matrix, providers are not permitted to bill up to the maximum Matrix units, but instead, may only bill for those units as directed in the "Notes".

When providers contact the WSC's and do not receive a positive response, they should contact their respective APD Area Program Office for assistance in resolving any issues. The Regional Medwaiver Coordinator is usually the contact person for WSC issues.

Some services have two modifiers. When billing for these services, providers must ensure that the modifiers are entered on the claim in the same order as they appear on the SA.

An **example** would be Personal Supports by the day (S5130 UC SC). On the claim, enter the S5130 in the procedure code box. In the modifier box directly below the S5130, enter the UC. The SC modifier is entered in the modifier box to the right of the UC modifier.

When corresponding by e-mail or fax, providers must remember that due to HIPPA compliance, sites that are sending and receiving confidential PHI information must be secure.

After billing, providers are responsible for sending documentation to the WSC of the service(s) that were provided. Documentation regulations may be found in the Florida Medicaid iBudget Waiver Services Coverage and Limitations Handbook.

Providers should either maintain a log of the number of units of service that have been billed or check the PA balance on the web portal. This is critical, especially towards the end of the quarter or if any changes have been made to an existing SA. The PA balance in FMMIS is updated each time a provider bills. When the balance is critically low, providers should check their billing for any possible over billing. If that is not the issue, then the provider should contact the WSC immediately to have additional units added. Providers should never let the PA balance get to zero. This closes the PA to any future updates.

After receiving SA's, providers are required to verify all SA components before performing services. There are 14 parts of the SA that providers should review carefully. They are:

1. RECIPIENT ID
2. PIN
3. PROVIDER ID AND PROVIDER NAME
4. PROCEDURE CODE AND MODIFIER(S)
5. SERVICE RATIO
6. UNIT TYPE
7. ALLOCATED AMOUNT (APPROVED AMOUNT)
8. TOTAL NUMBER OF UNITS FOR THE QUARTER
9. SERVICE BEGIN AND END DATES
10. UNIT COST (UNIT RATE)
11. SA STATUS
12. PA STATUS
13. PRIOR AUTHORIZATION NUMBER
14. NOTES SECTION INFORMATION

Recipient ID:
Verify that the consumer's Medicaid ID number is correct.

PIN:
This is an internal number assigned by APD. Each PIN is different and identifies a particular consumer. It does not contain any PHI (protected health information). This is the number that should be used in any correspondence between a provider and APD or a support coordinator.

Provider ID and Provider Name:
Verify that provider ID and provider name are correct.

Procedure Code and Modifier(s):
Verify that the procedure code and modifier(s) are correct for the service being performed.

Service Ratio:
Verify that the service ratio is appropriate for the consumer being served.

Unit Type:
Verify that the billing unit is correct for this service (quarter hour, hour, day, etc.).

Allocated Amount (Approved Amount):
This is the total quarterly approved funds available for this service authorization. It is a product of the total quarterly units multiplied by the unit cost.

Service Authorization Units:
This is the total approved units for this service authorization. Verify that the total units approved, equals the total units in the "notes section".

Service Begin and End Dates:
Each month on the SA has a begin date and an end date. Verify that both dates for each individual month are correct. Do not confuse these dates with the cost plan dates.

Monthly Units:
This is the total units approved for each month.
Note: If the units are spanned over the entire quarter, these units may be higher than the actual number of units for each month.

Unit Cost:
This is the per unit rate for the service. This is an established rate from the iBudget Provider Rate Table (Matrix). Rates are based on whether the provider is solo or an agency and the area of the state where the service is performed.

SA Status:
This should be Approved, Edited or Cancelled.

PA Status:
This must be approved. If not, providers must contact the WSC.

PA Number:
This is a number assigned by the FMMIS system. If no PA number appears, do not bill. Please contact the WSC immediately.

Notes:

This section is critical. It provides all information pertaining to the intensity, frequency and duration of the service. It must contain how the service is to be performed. It should also confirm the total number of approved units in the body of the SA.

Following are **examples** of service authorizations for various services. They should be reviewed by providers to get acquainted with the different areas on a service authorization. The important items are shaded. If providers do not understand or disagree with the terms of the service authorization, they should contact the respective WSC immediately, especially before starting or continuing services.

The following SA represents "Date Spanning". Note that the middle month does not have any units approved. This type of SA is used for those services that are not necessarily performed at the same frequency every day. Providers are approved to use the units over the entire quarter, up to the maximum total approved units on the SA. The more common services include ADT, Transportation, Dental, CMS, DME, Respite and Supported Employment. Other services may be approved in this manner and should be reviewed on a case by case basis, by the consumer or their legal guardian, the WSC and the provider.

Service Authorization For Ima Consumer for Life Skills Development - Level 3 (ADT) - Facility Based (Hour)

Authorization Details

Consumer	IMA CONSUMER	Recipient ID	1234567890
Provider	ADT PROVIDER, INC.		
Provider ID	000000096	WSC	A. WSC
Fiscal Year	2012-2013	Quarter	October-December
Begin Date	10/01/2012	End Date	12/31/2012
Description	Life Skills Development - Level 3 (ADT) - Facility Based (Hour)		
Procedure Code	S5102UC	Service Level	Facility Based
Service Ratio	1:10	Unit Type	Hour
Allocated Amt	$1598.4	Units	360

Monthly Details

Month 1

Begin Date	10/01/2012	End Date	10/31/2012	Units	180
		Unit Cost	$4.44	Amt	$799.20

Month 2

Begin Date		End Date		Units	
		Unit Cost		Amt	

Month 3

Begin Date	12/01/12	End Date	12/31/2012	Units	180
		Unit Cost	$4.44	Amt	$799.20

Prior Authorization Data

SA Status	New		
PA Status	Approved	PA Number	9876543210
Rejected Reason		PA Assign Date	09/15/2012

Notes

Approximately 120 hours per month for three months - 360 hours total for the quarter

The following service authorization is used for those services that are performed on a regular basis and at a set frequency. The frequency is outlined in the "Notes" section at the bottom of the SA. Providers are only approved to perform the service as indicated. Any change to the frequency, must be approved by the WSC. The WSC must change the "Notes" to indicate the new frequency of the service and must provide an updated SA to the provider. Providers who bill outside the parameters of the "Notes" are at risk of recoupment of funds.

Service Authorization For Ima Consumer for Personal Supports

Authorization Details

Consumer	IMA CONSUMER	**Recipient ID**	1234567890
Provider	PERSONAL SUPPORTS PROVIDER, INC.		
Provider ID	000000096	**WSC**	A. WSC
Fiscal Year	2012-2013	**Quarter**	October-December
Begin Date	10/01/2012	**End Date**	12/31/2012
Description	Personal Supports		
Procedure Code	S5130UC	**Service Level**	Quarter Hour
Service Ratio	1:1	**Unit Type**	Quarter Hour
Allocated Amt	$3598.4	**Units**	1040

Monthly Details

Month 1

Begin Date	10/01/2012	**End Date**	10/31/2012	**Units**	346
		Unit Cost	$3.46	**Amt**	$1,197.16

Month 2

Begin Date	11/01/12	**End Date**	11/30/12	**Units**	346
		Unit Cost	$3.46	**Amt**	$1,197.16

Month 3

Begin Date	12/01/12	**End Date**	12/31/2012	**Units**	348
		Unit Cost	$3.46	**Amt**	$1,204.08

Prior Authorization Data

SA Status	New		
PA Status	Approved	**PA Number**	1212343456
Rejected Reason		**PA Assign Date**	09/15/2012

Notes

4 hours (16 QH) per day, 5 days per week, 13 weeks (1040 QH total) for the quarter

average 4.33 weeks per month

The following service authorization is used for Residential Habilitation. Each level of Residential Habilitation has a unique set of modifiers. Providers should note these modifiers when reviewing and billing for services. Providers can only bill the monthly rate when a consumer resides in the group home for 24 days or more. Providers must contact the WSC immediately, when a consumer will not be residing in the home for at least 24 days. The WSC will reduce this SA and create a new SA for the daily Res Hab rate, for the number of days needed.

Service Authorization For Ima Consumer for Residential Habilitation - Moderate (month)

Authorization Details

Consumer	IMA CONSUMER	**Recipient ID**		1234567890
Provider	RESIDENTIAL HABILITATION PROVIDER, INC.			
Provider ID	000000096	**WSC**	A. WSC	
Fiscal Year	2012-2013	**Quarter**	October-December	
Begin Date	10/01/2012	**End Date**	12/31/2012	
Description	Personal Supports			
Procedure Code	T2023UCU4	**Service Level**	Month	
Service Ratio	None	**Unit Type**	Month	
Allocated Amt	$9883.44	**Units**	3	

Monthly Details

Month 1

Begin Date	10/01/2012	**End Date**	10/31/2012	**Units**	1
		Unit Cost	$3,294.48	**Amt**	$3,294.48

Month 2

Begin Date	11/01/12	**End Date**	11/30/12	**Units**	1
		Unit Cost	$3,294.48	**Amt**	$3,294.48

Month 3

Begin Date	12/01/12	**End Date**	12/31/2012	**Units**	1
		Unit Cost	$3,294.48	**Amt**	$3,294.48

Prior Authorization Data

SA Status	New		
PA Status	Approved	**PA Number**	8989676754
Rejected Reason		**PA Assign Date**	09/15/2012

Notes

Moderate rate for months, must reside in group home for 24 days or more.

If not in the group home for at least 24 days, contact WSC for new daily Res Hab SA.

The following service authorization is an example of an edited SA. When changes to an original SA are needed, such as adding or reducing units, the WSC will make the changes and send a new file to FMMIS to update the PA balance. Changes to an SA are reflected in the "Notes" at the bottom of the SA. Providers must receive a copy of the edited SA and attach it to the original one.

Service Authorization For Ima Consumer for Respite - (Day)

Authorization Details

Consumer	IMA CONSUMER	**Recipient ID**	1234567890
Provider	RESPITE PROVIDER		
Provider ID	000000096	**WSC**	A. WSC
Fiscal Year	2012-2013	**Quarter**	October-December
Begin Date	10/01/2012	**End Date**	12/31/2012
Description	Respite - (Day)		
Procedure Code	S5151UCSC	**Service Level**	Day
Service Ratio	1:2	**Unit Type**	Day
Allocated Amt	$1026.9	**Units**	14

Monthly Details

Month 1

Begin Date	10/01/2012	**End Date**	10/31/2012	**Units**	4
		Unit Cost	$73.35	**Amt**	$293.40

Month 2

Begin Date	11/01/12	**End Date**	11/30/12	**Units**	6
		Unit Cost	$73.35	**Amt**	$440.10

Month 3

Begin Date	12/01/12	**End Date**	12/31/2012	**Units**	4
		Unit Cost	$73.35	**Amt**	$293.40

Prior Authorization Data

SA Status	Edit		
PA Status	Approved	**PA Number**	9012345678
Rejected Reason		**PA Assign Date**	09/15/2012

Notes

4 days per month (12 days total)

Need 2 extra days in November for thanksgiving weekend. (new total 14 days)

When billing, providers may receive claims that are denied. The reason for the denial appears at the bottom of the claim in the form of an Explanation of Benefits (EOB) code. There are certain denial codes that are specific to APD claims

These APD Waiver denial codes are 3053, 3054 and 3055.

3053 – DS Waiver not approved: (no service plan found, procedure codes do not match, zero balance on the PA, service not approved, dates of service do not match, provider or recipient ID's do not match).

3054 – Unit rate not allowed: (the rate used to calculate the charges on a claim does not match the rate on the SA).

3055 – Billed amount invalid: (claim amount is greater than the balance on the PA).

If the need arises to bill for services that exceed the 12 month filing limit (see Provider Reimbursement Handbook), certain steps must be taken by providers.

A. Providers must create a letter with the provider's letterhead, requesting payment for dates of services that are over 12 months old. The letter must outline the details for providers not being reimbursed in a timely manner. These details should include items such as, service authorizations, denied claim ICNs, communications to WSCs or APD Area office staff and any other pertinent information to indicate that the provider attempted to get reimbursed, but was denied due to circumstances beyond the control of the provider.

B. Providers must complete a CMS-1500 claim form. These may be purchased on-line from the AHCA fiscal agent or any office supply store. On the fiscal agent's web site is an example of a completed CMS-1500 Medwaiver claim. Go to http://www.mymedicaid-florida.com/. Click on public information for providers, then provider support, then training. Click on "Professional Waiver Claim Form Presentations", then on CMS-1500 Paper Claim Submission. At the end of the presentation is an example of a completed claim.

C. Another form that must be completed by providers is the "Provider Request for Force Payment" form. This can be found on the home page of the provider's local Area Medicaid Program Office/AHCA. Click http://www.mymedicaid-florida.com/. Click on the appropriate Area Medicaid Office and then click on the Provider Request for Force Payment form.

D. The next step is for providers to submit all of the above documentation to their local APD Area office for review and approval. After APD staff has reviewed the request and documentation, they will either approve or deny the request. If approved, the APD office will submit the approval in a letter on APD letterhead to the provider.

E. After all of the above steps are completed, providers must submit all of the original documentation from steps A, B, C and D to the local Medicaid/AHCA area staff who handles Medwaiver issues. The Medwaiver contact staff will review and submit the claims to the fiscal agent/HP for processing. The processing of these claims can take up to 90 days or more after the fiscal agent has received them.

New business protocol starting January 14, 2013.

If you are e-mailing regarding a denial code 3053, 3054, 3055 or to ask about a billing issue, please go to the website **http://support.apd.myflorida.com**. to access the Help Desk System or call the Help Desk at (850) 488 - 4357.

We strongly recommend using the web portal before calling the Help Desk. The Help Desk Hours of Operation are Monday – Friday 7:30 AM – 6:00 PM EST.

For any other denial codes, please contact HP @1-800-289-7799 (option 7).

IMPORTANT! **PLEASE REMEMBER *NEVER* TO INCLUDE PROTECTED HEALTH INFORMATION (PHI) WHEN SUBMITTING SERVICE REQUESTS! USE PIN NUMBERS WHEN IDENTIFYING CONSUMERS INSTEAD OF PHI.**

Examples of PHI information: Consumer's name (first and last), initials, Social Security Number and Recipient ID number.

USE THE PIN NUMBER WHEN IDENTIFYING A CONSUMER. PIN numbers will be located on the service authorizations or can be obtained from the consumer's support coordinator.

Information that is *Not* considered PHI: ICN# (Internal Control Number), PA# (Prior Authorization number) and provider ID number.

This information can be used for denied claims and other billing issues.