State of Florida

Budget Support and System Analysis

User Training Package

Provider Billing Information

User Training Package

Created By: *Agency for Persons with Disabilities*
Central Program Office
Operations and Systems Analysis
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Agency for Persons with Disabilities
State of Florida

Provider Billing Training Package

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. Each week, a file is sent from the ABC system to the Medicaid Fiscal Agent, HP, which includes all cost plan information currently in ABC. Prior to running the weekly claim payment cycle, the APD Waiver providers' claims are checked against the information in this file. Claims passing the 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 cost plan format in the Allocation, Budget, and Contract Control system (ABC) 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.

Tiers and Cost Plans

The Florida Legislature created four waivers for individuals who are receiving services under the DD/HCBS (Home and Community Based Services) Waiver and the CDC+ (Consumer Directed Care) Program. The Legislature also set eligibility requirements for the waivers and the Agency for Persons with Disabilities developed rules to apply those requirements, effective October 15, 2008. The four waivers and their annual spending are as follows:

Waiver	**Cap**	**ABC designation**
Tier 1 Waiver	No cap	DD1
Tier 2 Waiver	$55,000.00	DD2
Tier 3 Waiver	$35,000.00	DD3
Tier 4 Waiver	$14,792.00	DD4

Note: The Tier 4 Waiver is the Family and Supported Living (FSL) designation.

For the purposes of the ABC system there have been additional tier designations added to provide more information. Each of the Tiers (1, 2, 3, and 4) have also been made available to CDC+ enrollees with the same spending limits. These are designated in ABC as:

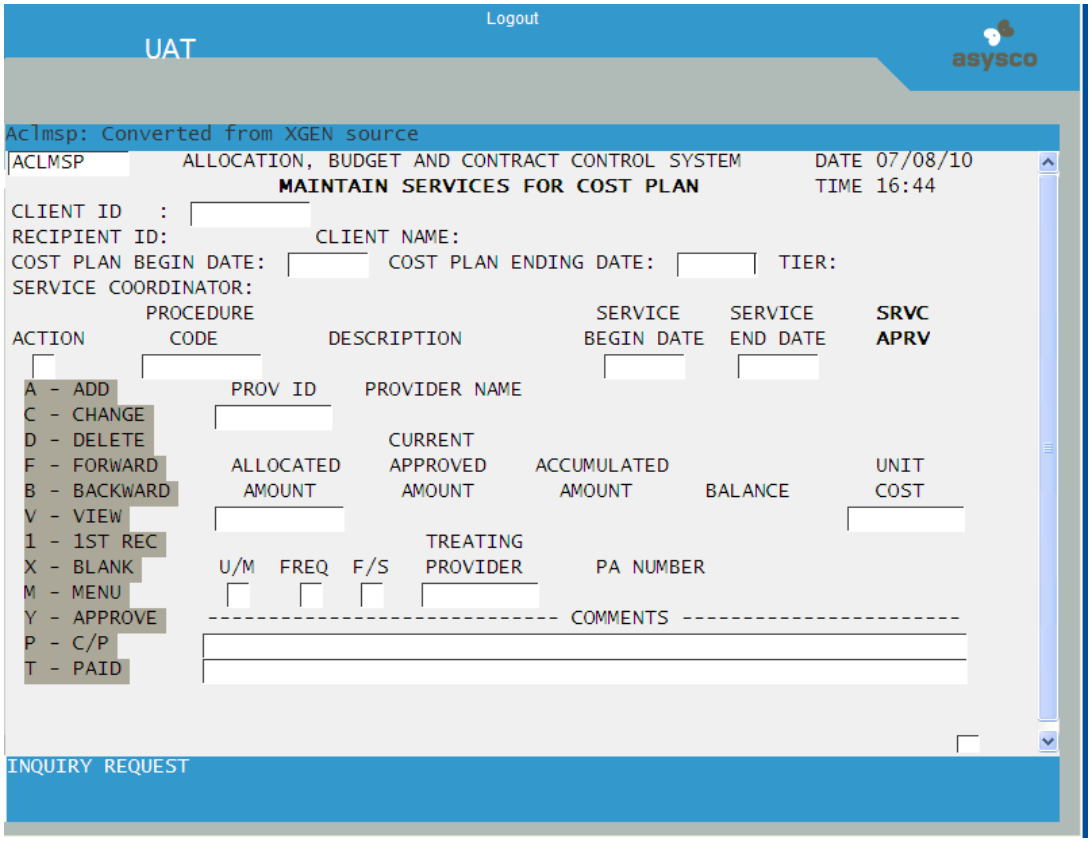
CDC1
CDC2
CDC3
CDC4

Because there are many individuals who have filed for a hearing on their tier assignment, and because there are situations where individuals may not be initially able to be assigned to a tier, an additional tier, **TBD** (To Be Determined) with no cap limits has been added for these situations.

The Service Authorization (SA)

In accordance with the Florida Medicaid DD Waiver Services Coverage and Limitations Handbook, before a service can be provided, it must be identified on the support plan and cost plan and be approved. Providers of DD Waiver services are limited to the amount, duration, and scope of the services on the current approved service authorization.

The printed screen of information contained in the ABC system on the Maintain Services for Cost Plan screen (ACLMSP) is the official service authorization form for the APD Waiver programs. Providers must have an approved service authorization prior to providing services for an individual. The approval amount is shown on the service authorization in the "Current Approved Amount" field. Providers should **not** provide services without an approved service authorization. Contact the individual's Waiver Support Coordinator to obtain the most current service authorization.



Reviewing Service Authorization Components

Recipient ID: This is the individual's Medicaid ID. Some people have a Florida PIN ID, a Current Medicaid ID and an ORIGINAL Medicaid ID. Providers should always bill using the Medicaid ID listed on the person's approved service authorization.

Tier Assignment: Tiers 1, 2, and 3 denote the HCBS Waiver. Tier 4 denotes the FSL waiver. This is important because some services that are available in Tiers 1, 2, and 3 are not available in Tier 4. Procedure Code modifiers and Provider IDs are also different under the two waiver categories.

Procedure Code and Related Modifiers: The procedure code identifies the type of service on a specific service plan. Procedure codes with the corresponding modifiers can be found on the Provider Billing Code Matrix.
Example: S5102U6: Adult Day Training

Dates of Service: Covers the time period for the service being performed on the service plan. January, March, May, July, August, October, and December have 31 days. April, June, September and November have 30 days. February has either 28 or 29 days.
Note: **Don't confuse the Cost Plan dates with the Dates of Service.**

Service Approval Status: This field indicates if the service is approved or not. "Y" for: Yes - approved **or** an "N" for: No – not approved. The amount shown in the "Current Approved Amount" field reflects available funds for billing.

Provider ID: This is the service provider's Medicaid provider id number assigned by the Medicaid Fiscal Agent (HP). If the Modifier is "U6", the Provider ID must be the HCBS Provider ID. If the modifier is "U9", the Provider ID must be the FSL Provider ID.

Allocated Amount: This field will display the total dollar amount allocated, for a particular service, for a certain time frame. This amount is determined by multiplying the number of units times the established rate.

Approved Amount: This amount indicates the total current approved funds that are available for billing. This amount may differ from the allocated amount.
Accumulated Amount: This field reflects the total dollar amount paid to the provider as of the date of the printed service authorization. New service authorizations will have an accumulated amount equal to $0.00.

Unit Cost: The unit rate has been established for the provider and can be found in the Provider Rate Table effective July 1, 2008 and the Billing Code Matrix revised April 1, 2010. Some services (i.e. transportation, certain assessments and medical supplies and equipment) are not listed in the Rate documents noted above and are individually negotiated.

Comments: The comment section should contain the frequency, intensity (level of care or ratio) and number of units. The terms of the service should be agreed upon by the individual or caregiver, the Waiver Support Coordinator and the Provider. Units of services should be expressed by the way they are billed, i.e., quarter hours, days or trips. Hours should **NEVER** solely be used.
Good example: 8 QTR HRS/DY, 5 DYS/WK, 36 Weeks, 1-2 ratio
Bad example: 360 HRS

Prior Authorization Number: Some providers' denials are related to timing issues. If providers bill immediately upon receiving a service authorization, they risk not being paid in a timely manner. APD and HP exchange service authorization information nightly. New SA's are assigned Prior Authorization (PA) numbers by HP. If HP has assigned the PA number, it will appear on the lower right side of the SA, above the comment section. If the PA number is not there, check the PA section on the web portal, FMMIS, before billing.
Note: Upon receiving a service authorization, wait at least one day before billing.

Service Authorization Changes: Many times services are changed due to changes in an individual's situation. When these changes occur, providers must be notified of these changes by receiving new SA's. This is especially critical if the changes reduce or eliminate services. Providers who know of these changes should receive a new SA or at a minimum, contact from the Waiver Support Coordinator, before billing. Ultimately, providers must have a new SA with the changes in service.

Temporary Approvals: Check the Service Dates on temporary approvals and remind the support coordinator to forward a copy of an updated SA before the current temporary SA expires. Providers should highlight the dates of service as a reminder that this is a temporary service authorization.

Billing Agents or Billing Departments:
Providers who have a billing department or use a billing agent should provide a back-up copy of the service authorization, in addition to any invoices and back-up documentation.

Once a service authorization is received and prior to initiating services, Providers should verify the following information:

1. **Recipient ID -** Make sure the Recipient ID (Medicaid Number) is the one that is used, when billing.

2. **Tier Assignment -** Tier assignment changes will automatically end a Service Plan.

3. **Procedure Code** - Providers should make sure that the procedure code and **ALL** modifiers are listed on the service authorization and that the Procedure Code modifier is appropriate for the individual's tier. When billing for Tiers 1, 2, or 3, the modifier should be "U6". For Tier 4, the modifier is "U9".

4. **Service Begin and End Dates (Service Plan) -** Providers may only bill for services provided within the beginning and ending date span of the service authorization.

5. **Service Approval Field -** Make sure that the service has been approved. There must be a "Y" in the Service Approved field, in order to receive payment for services.

6. **Provider ID -** Make sure that the Provider ID and Provider Name are correct. Make sure that the last two digits of the Provider ID are appropriate for the Procedure Code modifier.

7. **Allocated Amount –** Verify that the total allocated amount is the total of the number of units needed times the correct unit rate.

8. **Current Approved Amount –** Do the math. Make sure the total number of units of service multiplied by the unit rate equals the total approved amount. Example: 80 QH X $1.18/QH = $94.40. $94.40 is the dollar amount that should appear in the Approved Amount field.
9. **Accumulated Amount –** If an amendment to the service plan is done during the cost plan year, the provider should receive a new print out of the service authorization. The accumulated amount field will now indicate the amount that has been paid to the provider as of the date of the new print out.

10. **Balance –** This field reflects the remaining approved funds available for the approved service. This amount is current as of the date of the print out. Providers may not bill over the current balance on the SA.

11. **Unit Cost –** Providers may not bill above the unit rate approved on the service authorization. Make sure that the unit rate is correct for the service being provided. Check the Provider Billing Rate Matrix to verify the accuracy of the unit rate. The matrix can be found on the APD website, in the Provider Rates, Billing and Payment section.

12. **Unit Measure –** This field indicates the unit that is to be used when billing for services. The appropriate codes are: U – Unit, Q – Quarter, D – Day, M – Month, I – Mile, T – Trip, H – Hour. The UM **must** coincide with the procedure code found in the DD/HCBS Billing Code Matrix.

13. **Frequency –** Defines the frequency of the services and should only be populated with D – Daily, W – Weekly, M – Monthly or 1 – One Time Service. Additional details will be found in the "Comments" section.

14. **Funding Source –** Used by ABC to define which funding source should be used for specific procedure codes. The acceptable funding source codes are: W – Waiver, G – General, N – Natural/Family Support, C – Community, and O – Other State Agency. All Waiver services should contain a "W" in this field.

15. **Treating Provider –** The Waiver Support Coordinator's Provider ID Number.

16. **Comment Section –** This section is an important part of the service authorization. It denotes the intensity of the service, such as "3 x weekly", or "30 days per year". It should also contain the total number of units, ratios, days of the week, hours within the day, and any additional information that is pertinent for performing and billing this service.

Providers are responsible for tracking expenditures against their service authorizations by maintaining the total number of units that have been billed **and** paid. By utilizing a tracking log that has a beginning total number of units authorized and deducting those units that have been paid, providers will know exactly how many units remain on the service authorization. Providers should not call the local liaison, the WSC, or the local APD Area office to check the balance remaining in the service authorization. If any amendments to the service authorization are approved, providers should receive an updated copy of the service authorization from the WSC.

In addition to the DD/HCBS Waiver, individuals may receive services from the Family and Supported Living Waiver or the CDC + Waiver. Providers should always check their service authorizations and bill with the correct provider ID numbers and procedure codes relative to each Waiver program.

MULTIPLE PROVIDERS OF THE SAME SERVICE FOR THE SAME INDIVIDUAL

If an individual receives the same service from more than one provider, each provider must have a specific service authorization. In these cases, the WSC must adjust the service authorization depending on the utilization of each provider. The WSC is not always aware of changes in service utilization between multiple providers, therefore in order to assure prompt payment it is the responsibility of the provider to notify the WSC when the total approved amount is close to being depleted. When this happens, the WSC should provide a new copy of the service authorization showing any changes to each provider whose service authorization has been amended.

MEDICAID ELIGIBILITY STATUS

Providers should be aware of the individual's eligibility status to ensure that each individual is indeed eligible to receive DD Waiver services. To verify Waiver eligibility, AHCA provides an Automated Voice Response System (AVRS) that can be accessed 24 hours a day by calling 1-800-239-7560 or 1-800-201-1500. Providers can also check Waiver eligibility on the Florida Medicaid Management Information System (FMMIS) web portal by clicking the 'Eligibility' tab when logged into FMMIS.

If an individual's eligibility has lapsed, it is the responsibility of the WSC to assist the individual to restore eligibility. Providers should notify the WSC as soon as they become aware that the individual's eligibility has lapsed. Providers should not continue to bill for services until the individual's eligibility issue has been resolved.

PRIOR SERVICE AUTHORIZATION

All cost plans require Prior Service Authorization (PSA). For services continuing into a new cost plan year or in the case of an emergency, one month of service **may** be approved at the Area level until the entire service plan amount is approved, amended or denied. Providers should always look at the **beginning** and **ending** dates of service on an authorization and make sure they contact the WSC to get an updated service authorization before providing services after the ending date showing on the service authorization. Key words to look for in the Comments Section for these temporary service authorizations are "pending approval" or "temporary approval." WSC's should provide an updated service authorization to providers every month until the PSA process is complete. To avoid billing problems, the provider should be pro-active with these cases and communicate often with the WSC.

Acronyms and Definitions

APD	**Agency for Persons with Disabilities**
AHCA	**Agency for Healthcare Administration**
ABC	**Allocation, Budget and Contract Control System**
APS	**Healthcare Contractor**
HP	**Hewlett Packard Enterprises/Medicaid Fiscal Agent**
FMMIS	**Florida Medicaid Management Information System**
WSC	**Waiver Support Coordinator**
CDC	**Consumer Directed Care**
DD/HCBS	**Developmental Disability/ Home and Community Based Services**
FSL	**Family and Supported Living**
PSA	**Prior Service Authorization**
CP	**Cost Plan**
SP	**Service Plan**
PA	**Prior Authorization**
TBD	**To Be Determined Tier**
SA	**Service Authorization**

Codes

Unit Measure

U	Unit
Q	Quarter
D	Day
M	Month
I	Mile
T	Trip
H	Hour

Frequency

D	Daily
W	Weekly
M	Monthly
1	One – Time Service

Funding Source

W	Waiver
G	General Revenue
N	Natural/Family Support
C	Community
O	Other State Agency

DS Waiver Denial Codes: 3053, 3054 & 3055

3053 – No DS Waiver Gatekeeper Approval Matrix Record Found for DS Waiver Claim - (no service plan found, procedure codes don't match, negative balance, not approved, dates of service don't match, provider ID's don't match, recipient ID's don't match)

3054 – Unit Rate on Claim is more than DS Waiver Gatekeeper Approval Allowed - (unit rate billed is greater than approved rate on service authorization)

3055 – Line Level Billed Amount Greater than Approved Amount on DS Waiver Gatekeeper Approval Matrix – (claim amount billed is greater than approved balance)

Note: The APD Statewide Published Rates and Billing Code Matrix as of April 1, 2010 may be found on the Providers section on the Agency for Persons with Disabilities website:

http://apd.myflorida.com/providers/rates-billing/

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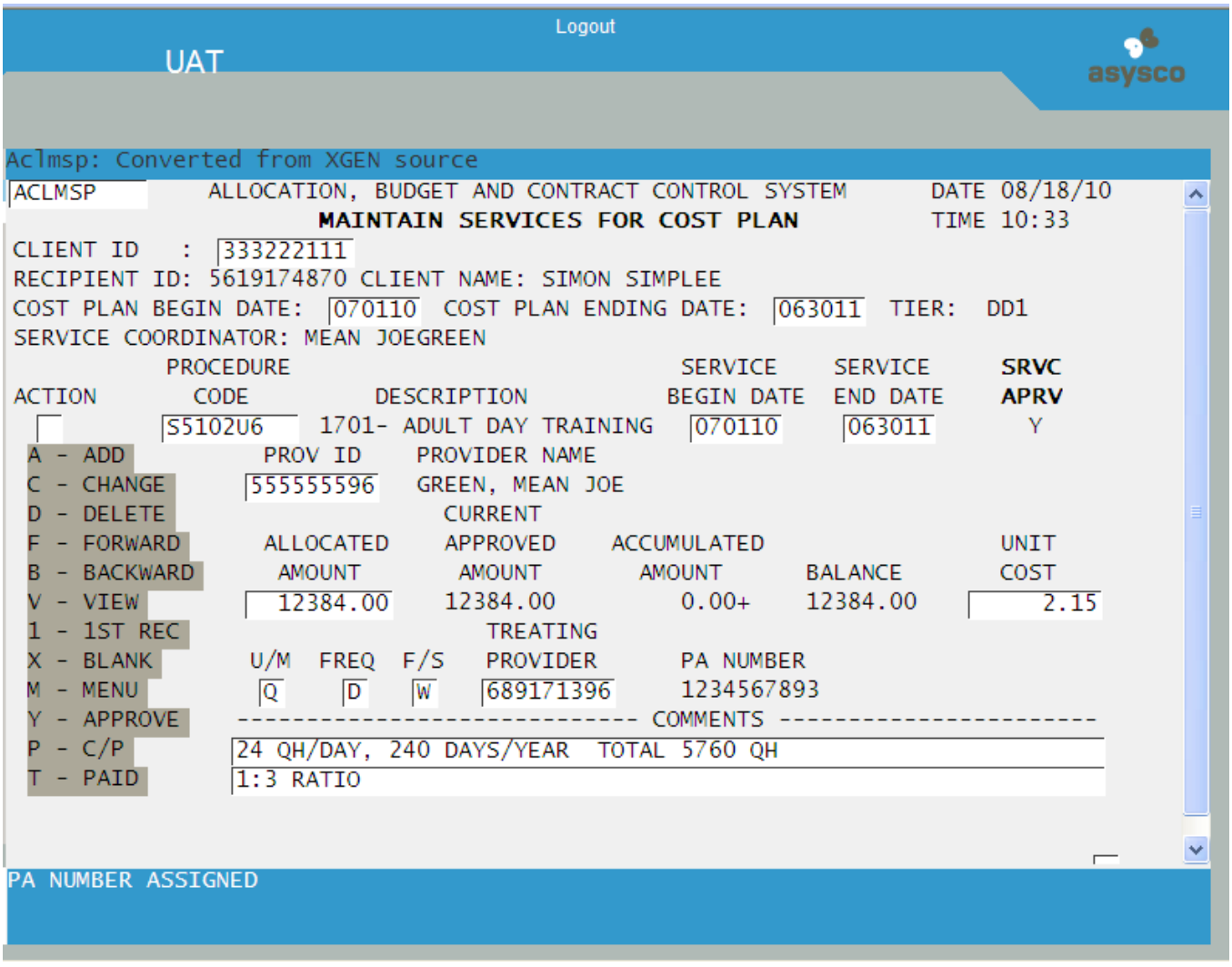
Provider Billing Training Package

Service Authorization Examples

Adult Day Training (Geographical Rate)



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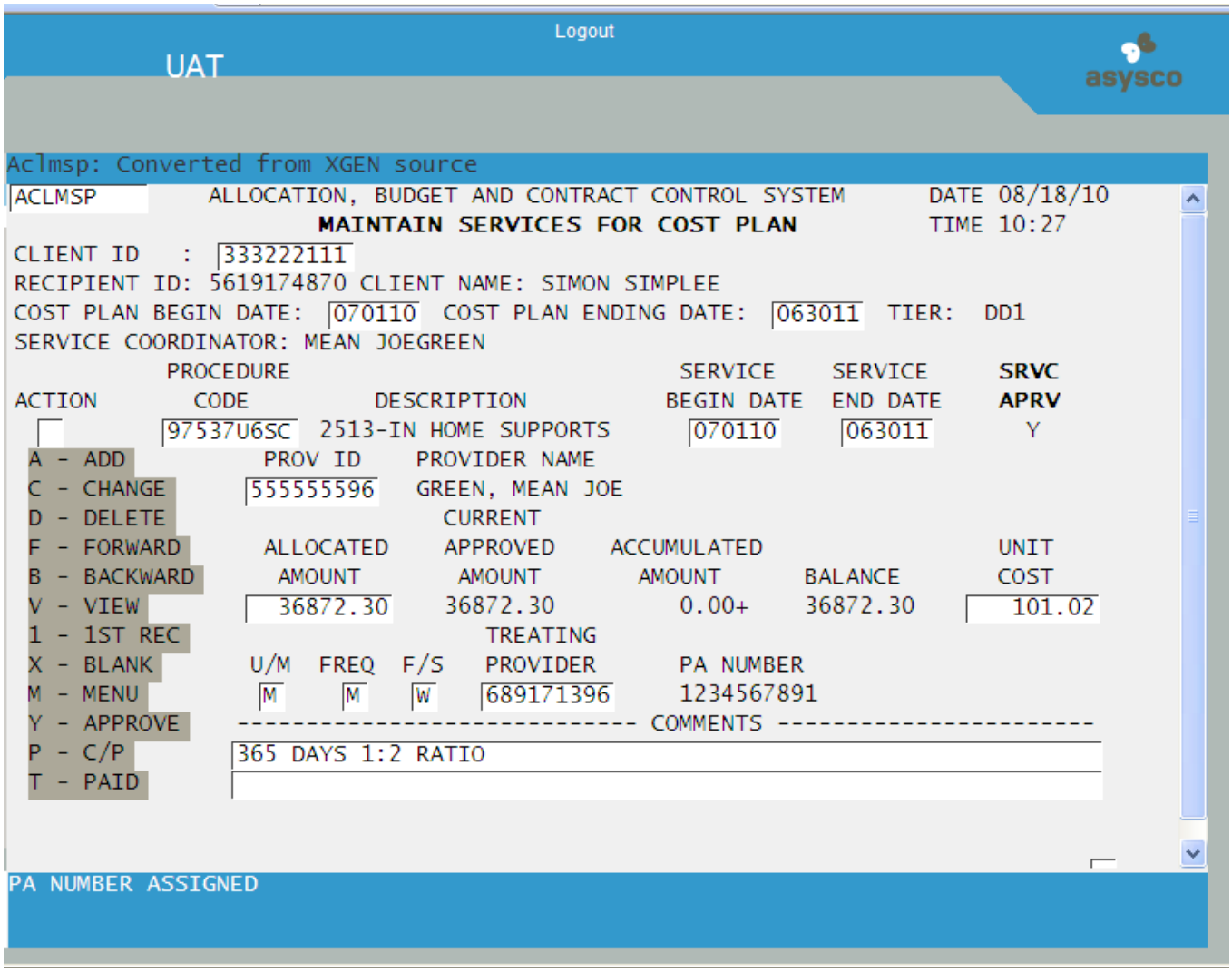
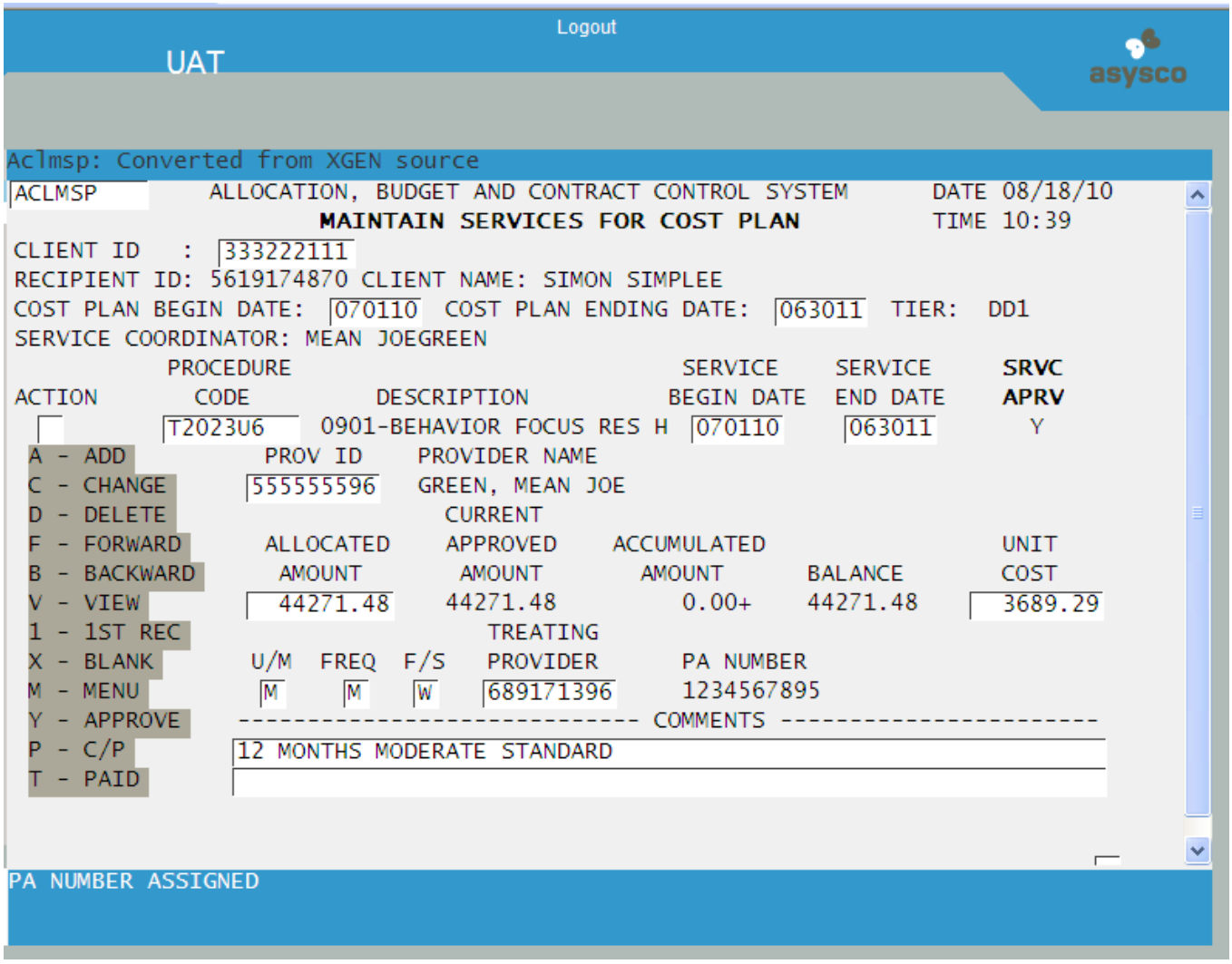
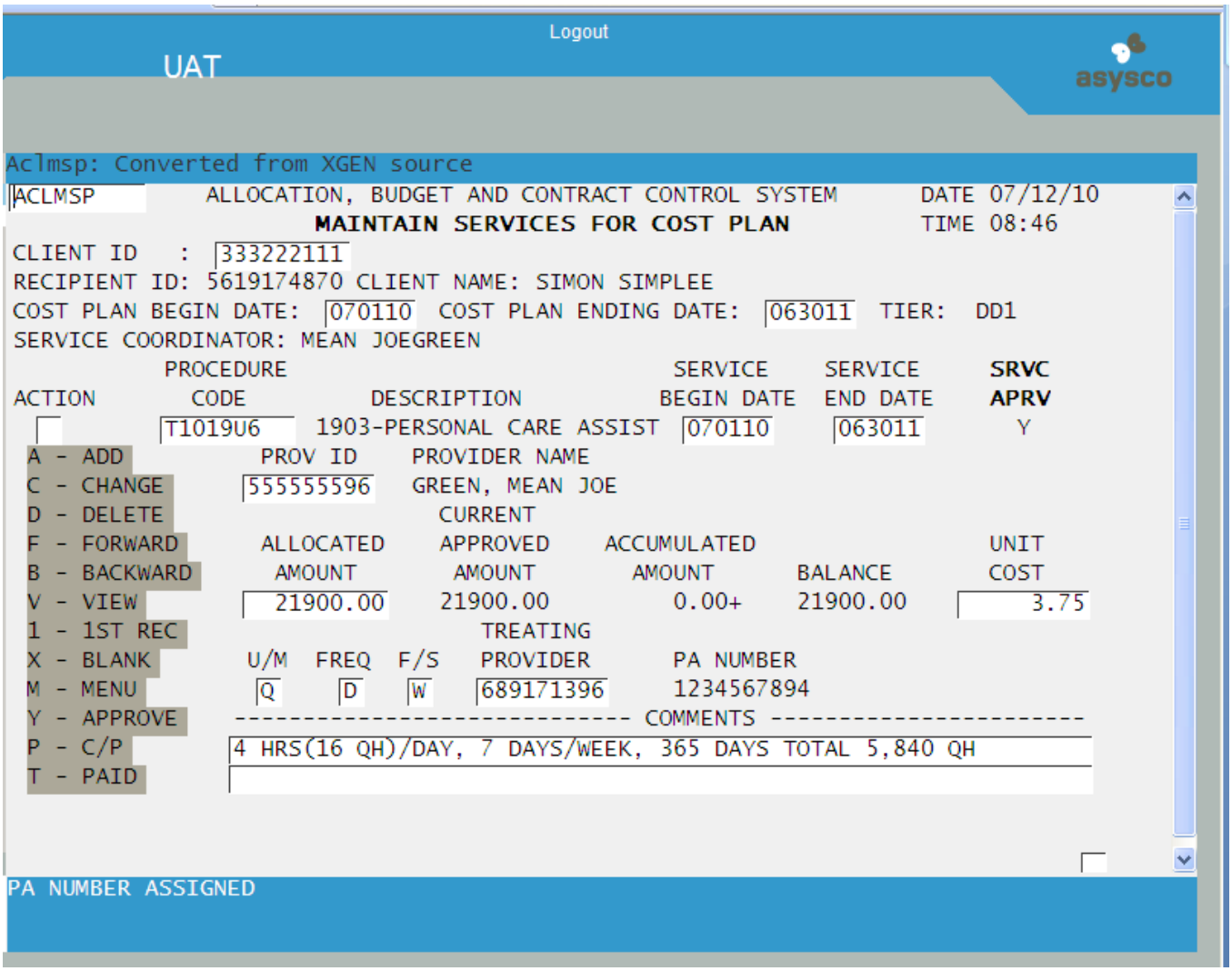
In-Home Supports (Geographical Rate)



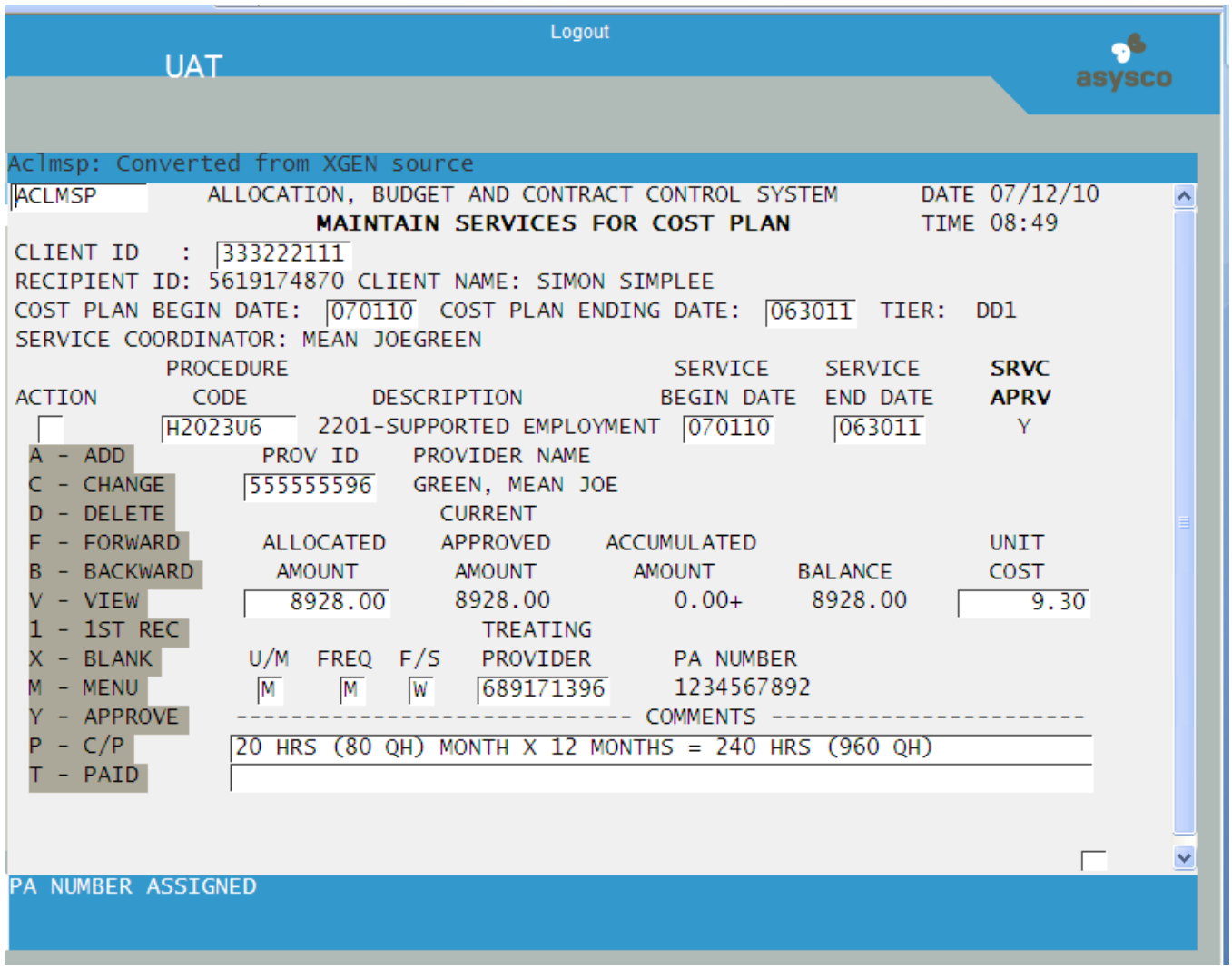
Standard Residential Rehabilitation (Geographical Rate)



Personal Care Assistance (Non-Geographical Rate)



Supported Employment (Non-Geographical Rate)



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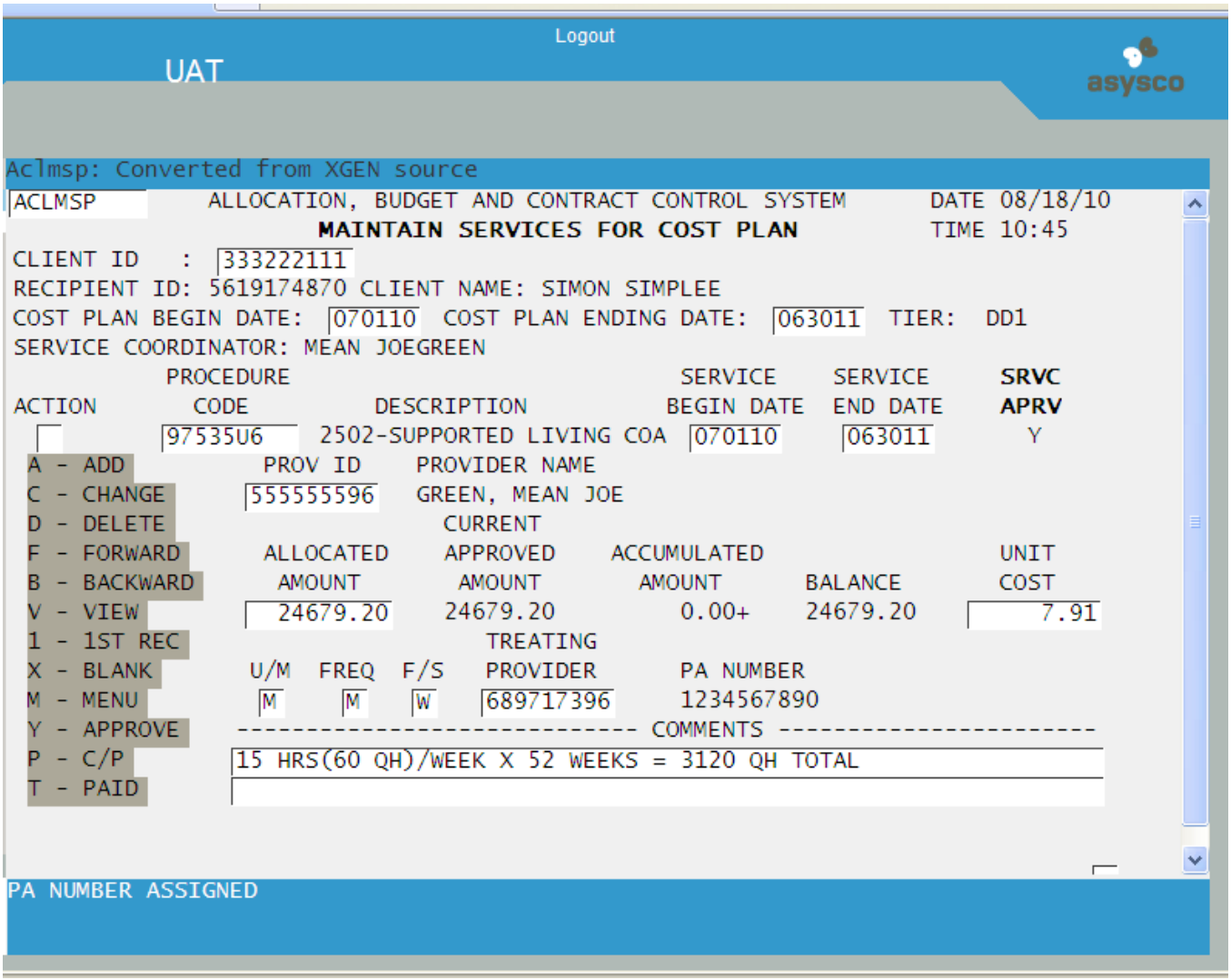
Supported Living Coach (Non-Geographical Rate)



Provider Billing Training Package

Provider Training Highlights

1. Providers must have a service authorization BEFORE beginning services. If the service authorization (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 compare the information on the Billing Code Matrix for accuracy. If any discrepancies are found, providers should notify 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.

2. Providers should NEVER accept verbal or handwritten service authorizations from a WSC. An exception to this rule would be an emergency situation. Even in an emergency situation, a service authorization should be received within 2 weeks.

3. All cost plans require Prior Service Authorization (PSA). For services continuing into a new cost plan year or in the case of emergency, one month of service may be approved at the Area level until the entire service plan amount is approved, amended or denied by the appropriate approving entity. Providers should check every month with the WSC before billing to ensure that enough funds have been approved for the time period for which the service took place. Request a new print out of the service authorization with the new approved amount.

4. Due to Medicaid limitations on the number of units that may be billed per claim line, providers should check the Billing Code Matrix to verify how many units of service can be billed per line. Providers who bill for more than the Medicaid allowable units per claim line will only be reimbursed for the maximum allowable units. The balance of the units will have to be billed on a new claim with a different date of service.

5. Maximum number of allowable units may be less depending on service combinations.

6. Maintain a log of how many units have been billed and **PAID** by Medicaid. This log could also show how many dollars have been paid. This should prevent any confusion over how many units and the amount of funds remaining on the service authorization (SA). This log could be as simple as having a beginning number of units with subtractions being made for **PAID** services every week of month. This log could also be more detailed and contain the beginning and ending dates for each service authorization for each individual, dates of birth, Medicaid numbers, types of services performed, procedure codes with all modifiers, approved rates, and approved number of units. Please refer to the sample tracking logs. Check with the WSCs at least one (1) month before the current SA expires to see if the new SA has been or is being created. The WSC must have the new SA to their respective providers 10 days before the current SA ends.

7. If providers have more than one Medicaid Provider ID number, make sure that the Provider ID on the SA is the same Provider ID that will be used when billing for services.

8. For procedures based on a monthly unit of service, when entering the dates of service in the electronic billing system, always use the last day of service in the "from" and "to" boxes on the Medicaid claim form. Never use the actual first and last dates of services. For example, Provider A bills once a month for services. If the provider is billing for services in March and the actual dates of service are 03/01/2010 through 03/29/2010, then Provider A would enter 03/29/2010 in the "**from**" box and 03/29/2010 in the "**to**" box.

9. Billing for several days on one claim line is only permissible if the services are performed on consecutive days. If the services are not provided on consecutive days, then each date of service must be billed on a separate claim line.
Examples:

Provider A bills for a service performed on Monday, Wednesday, and Friday. Each day must be billed on a separate claim line, for a total of 3 claim lines.

Provider B bills for a service performed Monday through Friday. The entire 5 days may be billed on one claim line, using the last day (Friday) in both the 'From' Date of Service and 'To' Date of Service fields.

Note: Each service has a maximum number of units that Medicaid will pay per date of service. Check the billing Code Matrix for the maximum number of units allowable per date of service.

10. When entering the place of service in the electronic billing system, always enter 99 as the place of service on the Medicaid claim form.

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

12. Respite by the **Day** (more than 39 QH per day) is now limited to 30 days per year. Providers of Respite by the Quarter Hour (up to 39 QH per day) may bill up to 2880 qtr. hrs. per year.

13. The maximum number of ADT units that providers may bill is 5,760 quarter hours per cost plan year (240 days / 24 qt. hrs. per day). Providers can bill for all days that an individual is present in the program up to the 5,760 maximum units in a year. However, if the maximum number of units is billed prior to the end of the year, the provider is expected to continue to provide the service and not bill. If an individual leaves the program before the service plan end date, providers should contact the WSC to inform hum/her of the number of units (quarter hours) that must remain on the SA for billing purposes.

14. Multiple providers of the same service for the same individual on the same day should not be a problem. HP, the current fiscal agent for Medicaid puts the second provider's claim in "suspend for review" status. When HP recognizes that the claims are for the DD Waiver, they should pay the second claim. If there are problems with these claims, please notify your ABC Technical Support Liaison.

15. Make sure that the Provider name and Provider ID are correct. Make sure that the last two digits of the Provider ID are appropriate for the Procedure Code modifier. If the modifier is "U6" then the appropriate Provider ID must be the one used for billing Tier 1, 2, or 3 services. If the modifier is "U9", then the appropriate Provider ID must be the one used for billing Tier 4 services.

16. Providers who bill on a weekly basis have a special note. If the week that a provider enters a claim splits between two (2) months, the provider must remember to enter the number of days for each month separately for the claim. **Example:** Provider A bills on a weekly basis for Residential Habilitation. December 1 falls on a Wednesday, which is the last day of Provider A's billing cycle. When Provider A enters a claim for payment, Provider A should create 2 lines on the claim. The first line of the claim would have 3 dates of service for November (28, 29, and 30). The second line would have 4 dates of service for December (1, 2, 3, and 4). **Failure to follow this procedure could result in a denial code (Procedure code exceeds units of service limit).**

17. Behavior Therapy providers should pay careful attention to the procedure codes and modifiers on the service authorization. There is one procedure code and three different modifiers. According to the DD Handbook, these modifiers correspond to the provider's qualifications.

Level 1 (intensive)	H2019 HP U6
Level 2 (moderate)	H2019 U6 HO
Level 3 (standard)	H2019 U6 HN

18. When calling about a billing problem (denial code 3053, 3054, 3055) please speak slowly and clearly. Please leave your name, Provider ID, and the telephone number where you may be contacted. **Always have a copy of your service authorization available when speaking to your ABC Technical Support Liaison.**

19. When corresponding by email or fax, providers must remember that due to HIPPA compliance the sites that are sending and receiving information that contains confidential data must be secure.

20. Providers are responsible for sending documentation to the WSC that the service was provided **before** billing. Documentation regulations can be found in the Florida Medicaid DD Waiver Services Coverage and Limitations Handbook.

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Provider Billing Training Package

Examples of Medwaiver Consumer Service Authorization and Expenditure Tracking Logs

Basic

Res. Hab.	Units	
7/1/05 – 6/30/06	350	
7/31/2005	-29	Paid
	321	Balance
8/31/2005	-29	Paid
	292	Balance
9/30/2005	-29	Paid
	263	Balance

Detailed

Consumer Name	Medicaid#	Service Begin Date	Service End Date	Service Provided	Procedure Code	Approved Rate	Approved Units	Approved Amount	YTD Units Billed/Paid	YTD Expenditures	Remaining Units	Remaining Funds
Consumer A	2468-13-5790	9/1/2004	8/31/2005	ADT QH	S5102 U6	$1.24	5,760	$7,412.40	1,440	$1,785.60	4,320.00	$5,356.80
Consumer B	4441-23-4698	7/1/2004	6/30/2005	RH DAY	H0043 U6 SC	$104.28	350	$36,498.00	87	$9,072.36	263.00	$27,425.64
Consumer C	4567-89-1230	11/1/2004	10/31/2005	Trans. Trip	T2003 U6	$8.80	480	$4,224.00	480	$352.00	440.00	$3,872.00
Consumer D	3216-54-7870	1/1/2003	1/1/2004	PCA QH	T1019 U6	$4.02	4,160	$16,723.20	4,160	$14,472.00	560.00	$2,251.20