

PAYMENT AND BILLING BASICS

FORMS TO BE SUBMITTED TO DBH*:

- **BH-1** is the summary billing form. This form reflects all payment requested from the Region.
- **BH-2** is the form for Fee-For-Service (FFS) billings. The form reflects current rates and the number of units provided in each service for which payment is requested.
- **BH-3** is the form used for Non-Fee-For-Service (NFFS) billings. This form reflects requested payment based upon expenditures and unit or case rate.
- **Provider Reimbursement Form** is a billing form completed by providers, as well as the Region, to request reimbursement for behavioral health services provided during the billing period.
- **BH-4a** is an expense reimbursement form completed by the provider or Region. Information entered on this form should always reflect actual expenditures, even if 1/12th payment is requested, and is used by the Division when conducting Service Purchased Verifications on Expense Reimbursement basis.
- **BH-4p Prevention Reimbursement Form** is a billing form completed by or prevention providers/coalitions to request reimbursement for activities completed during the period. Funds requested must separate expenditures for each of the prevention strategies. Information entered on this form should always reflect actual expenditures, and is used by the Division when conducting Service Purchased Verifications on Expense Reimbursement basis.
- **BH-4h Housing Reimbursement Form** is a billing form completed for requesting reimbursement for activities related to the State Housing Related Assistance Program. Information entered on this form should always reflect actual expenditures and is used by the Division when conducting Service Purchased Verifications on Expense Reimbursement basis.

FORMS TO BE RETAINED BY REGION*:

- **BH-4b** is the roll up report for Flex Fund Expenditure for Community Support. Includes a summary of funds expended in each of the authorized categories for use of flex funds and number of persons served.
- **BH4-c** is the form used to reflect the individual breakdown of Flex Fund expenses for Community Support.

- **Authorization Turnaround Documents (TADs)** are documents from the Administrative Service Organization (ASO) system listing persons authorized for a service, units authorized, and units provided. The number of units provided must not exceed the number of units authorized.
- **Registration TADs** are documents from the ASO system listing persons registered for a service and the number of encounters for each consumer for that reporting period.
- **Authorization Modification Form** is a form completed and submitted to ASO to alter/correct information on a turnaround document. For the purposes of billing, the form must be attached with a corrected TAD before payment from the Division will be issued for any individual listed incorrectly on a previous TAD.
- **Emergency System Flex Funds** Individual and Monthly Summary forms are used and submitted monthly to DHHS as documentation for each individual benefitting from use of these funds. Consumer must meet criteria for at least one priority and outcome listed on the form.

*Regions should ensure that it and its providers are using the most current billing forms and statewide rates as reflected in the State to Region contract.

DOCUMENTS TO BE SENT UNDER SEPARATE COVER TO DBH

No provider logs, TADs, and/or any document containing personally identifiable information shall be included with the billing.

- **Provider Logs** are documents which list persons registered for a service not tracked by Magellan and the number of encounters for each consumer for that reporting period.
- **Professional Partner Monthly Financial Report** includes operational costs, wraparound costs, client tracking, and a description of individual services/supports relating to IFSP goals and costs. The form is a financial reporting form (not a billing document) and should be submitted monthly to the individual identified by the Division..

PROVIDER BILLINGS TO REGION

- a. Each provider must submit to the Region a Provider Reimbursement Form that includes an original signature by the provider.
 - If the Provider Reimbursement Form is incorrect, the Region must either alter the document by placing a line through the incorrect number(s) and writing in the corrected number(s) or request a corrected and signed Form from the provider.

- If the Region alters the document, the Region will indicate on the bottom of the form the reason for the alteration. The Region must notify the provider of the change and retain evidence of this notification in the billing file.
 - If a revised document is created, signed and submitted by the Region, a copy of the revised form with an original signature of the provider must be sent to the Division within two weeks of the billing submission.
- b. Each provider must submit to the Region monthly (as appropriate) the following items:
- All requests for payment for med management and all outpatient services must be accompanied by registration TADs with number of encounters electronically entered.
 - All requests for payment for FFS services must be accompanied by authorization TADs attached to support the number of units billed for the service. The provider will electronically enter the Units provided into the ASO System.
 - The number of units being reported for reimbursement on the Provider Reimbursement Form should match, or be less than, the total number of units provided to non-Medicaid individuals (MRO-No) on the TAD.
 - On Substance Abuse Waiver Services TADs, the provider will indicate consumers who are on Medicaid Managed Care and will not bill for those consumers. On Outpatient Substance Abuse TADs, the provider may indicate under the MRO YES section that is a consumer is “Medicaid Fee for Service” and request reimbursement for units provided to these consumers.
 - If a consumer’s information is incorrect on the TAD, the provider must complete an Authorization Modification Form and submit it to ASO. Payment will not be issued for any additional unit(s) provided to the individual until the corrected TAD with the Authorization Modification Form is submitted to the Region.
 - Information that is hand entered on TADs will not be processed.
 - A BH-4a for each NFFS service paid for on an expense reimbursement basis or by another Division-approved method should be completed by the provider to reflect actual expenses incurred for the billing period. All expenses claimed on the BH-4a must be reduced by any revenue received for the service by other sources (e.g., client fees, third party payers, refunds, etc.). If a provider is not being reimbursed actual expenses, before final payment is made for the contract year, the

Region must receive documentation of actual expenses for the year to ensure payments have not exceeded actual expenses.

- Flex funds BH-4b
- A BH-4p Prevention Reimbursement Form must be prepared by, signed and submitted for each Prevention Coalition, Provider or mini-grant recipient detailing the amount of expenditures by prevention strategy. The Region may require the provider to complete a BH-4a in addition to the Prevention Reimbursement Form.
- BH-4h Housing Related Assistance Reimbursement Form

RETRO PAYMENT FOR MEDICAID DENIALS

1. If there was a change in Medicaid status, such as a denial of eligibility, the provider must submit a copy of the denial along with the previous TAD within 60 days of the denial to request payment. Requests made after 60 days of denial will not be reimbursed by the Division.
2. If an individual has been denied Medicaid status and subsequently receives retroactive Medicaid approval, all funds received by the provider for the care of the individual for this retroactive period must be reimbursed to the Region. The Region must subtract these funds from any subsequent request for payment sent to the Division.

BILLING FOR CAPACITY DEVELOPMENT, CAPACITY ACCESS GUARANTEE, SERVICE ENHANCEMENT OR CAPACITY EXPANSION:

1. If the service under any of these categories is paid FFS or on a unit basis by the Region, units provided must be billed on the Provider Reimbursement Form and on the BH-2 or BH-3 for the service and individuals receiving service reflected on the TADs, as appropriate.
2. Any overage of funds expended should be billed under NFFS on the BH-3 and actual expenditures submitted on the BH-4a. Revenues from the service must be noted on the BH-4a in the "other expenses" category. The revenue is subtracted from the actual month's expenses on the BH-4a and the non-reimbursed amount billed.
3. The Provider's Capacity Development report should be included with the billing for the service (monthly, or as specified in the Contract).

REGIONAL ROLL UP AND SUBMISSION TO DBH

Each Region submits a Regional Roll up including a BH 1, 2 and 3 for all Services billed, indicating source of funds requested for each service. Additionally,

- A Provider Reimbursement Form.
- A BH-4a for each System Coordination expense billed on the BH 3 must be submitted. The BH-4a should reflect actual expenses, and only include expenses not reimbursed by other sources.
- All contracted amounts in the Column “Total Contract Funds” must match those in the current State to Region Contract or must current Amendment.
- Provider Reimbursement Forms for each provider for services being billed.

BILLING TIMEFRAMES

For billing timeframes and deadlines, please see the State to Region contract.

Turnaround Documents (TADs)

1. At the end of the billable month, the provider accesses the ASO web-site and enters encounter data.
2. The provider prints the TAD.
3. Medicaid Rehab Option Services, and Out Patient Services should be broken out by Yes and No. The provider will indicate on TADs for Substance Abuse Waiver services all consumers who are on Medicaid Managed Care and not bill for these individuals. Providers must check existing resources and identify those that are Medicaid eligible on the TAD. In the event that information is incorrect on a TAD, the provider must complete an Authorization Modification Form and submit it to the ASO for correction. The provider may NOT bill for additional units of service for any individual with incorrect information on the TAD.
4. Handwritten corrections of names or alterations which add units on TADs will not be accepted and payment will not be processed for any units claimed as such. Handwritten corrections which decrease the number of units billed may be made, but the provider must file appropriate documentation with the ASO to initiate permanent change of the record.

5. Providers should review TADs and verify discharges. Failure to do timely discharges on-line will result in TADs indicating numbers in excess of agency capacity. Division should monitor TADs for discharges quarterly.

Authorization Modification Report – This report is used when the ASO has made an error. This report will NOT be used if a provider did not enter a registration.

1. Beginning March 1, 2010, the authorization modification request form will be used instead of the E&O form.
2. The process for correcting an error once the authorization modification request form has been completed and accepted by ASO, can take up to 10 business days for ASO to make the correction.
3. It is the service provider's responsibility to initiate an authorization modification request form in the event a consumer's authorization does not appear on the TADs correctly.
4. Providers should check the TAD within the 10 days of submission of the authorization modification form and at a regular frequency prior to the end of the month run for billing.
5. Requests initiated after 60 days of the authorization date will not be processed.
6. Authorization Modification Form must accompany the corrected TADs when submitted for billing additional units. The individual name(s) should be clearly circled on the corrected TAD. Authorization Modification Forms are not required to be submitted with the billing if units are being deducted from the TAD. (See Authorization Turnaround Documents on Page 4 for further clarification.)