# DIVISION OF BEHAVIORAL HEALTH AND RECOVERY
# RESIDENTIAL BILLING INSTRUCTIONS

As a provider of DBHR funded residential services, you must use the TARGET system to record patient information (such as assessments, admission date, discharge date, funding source, and modality). The TARGET system must be used for all clients served, regardless of the origin of the payment.

As written in the *Billing and Payment* and *RSVP Billing* sections of your contract, DBHR uses the Residential Services Vendor Payment (RSVP) system, a subsidiary payment system to the primary TARGET system. If you have Title XIX funding, you will also use ProviderOne (Medicaid Management Information System) to bill for Title XIX services/clients.

The matrix below summarizes the billing/payment flow for DBHR services:

| Type of Service | Source of Funding | Payment Documentation | Mode of Payment | Client Info Entered into TARGET? |
|---|---|---|---|---|
| All | Title XIX **Note 1** | HCFA-1500 Claim Form | Provider One | Yes |
| Room & Board | State | HCFA-1500 Claim Form | Provider One | Yes |
| All | State | RSVP Invoice | RSVP System | Yes |
| All | SAPT | RSVP Invoice | RSVP System | Yes |
| All | TANF | RSVP Invoice | RSVP System | Yes |
| Group Care Enhancement | State | A19 Invoice Voucher | DBHR Direct | Yes |
| Adult Care Enhancement | SAPT | A19 Invoice Voucher | DBHR Direct | Yes |
| Family Hardship | State | A19 Invoice Voucher | DBHR Direct | n/a |
| Special Projects | State | A19 Invoice Voucher | DBHR Direct | n/a |
| Set Rates | State | A19 Invoice Voucher | DBHR Direct | n/a |
| Physical Exams | State | A19 Invoice Voucher | DBHR Direct | n/a |
| Assessments | State | A19 Invoice Voucher | DBHR Direct | Yes |

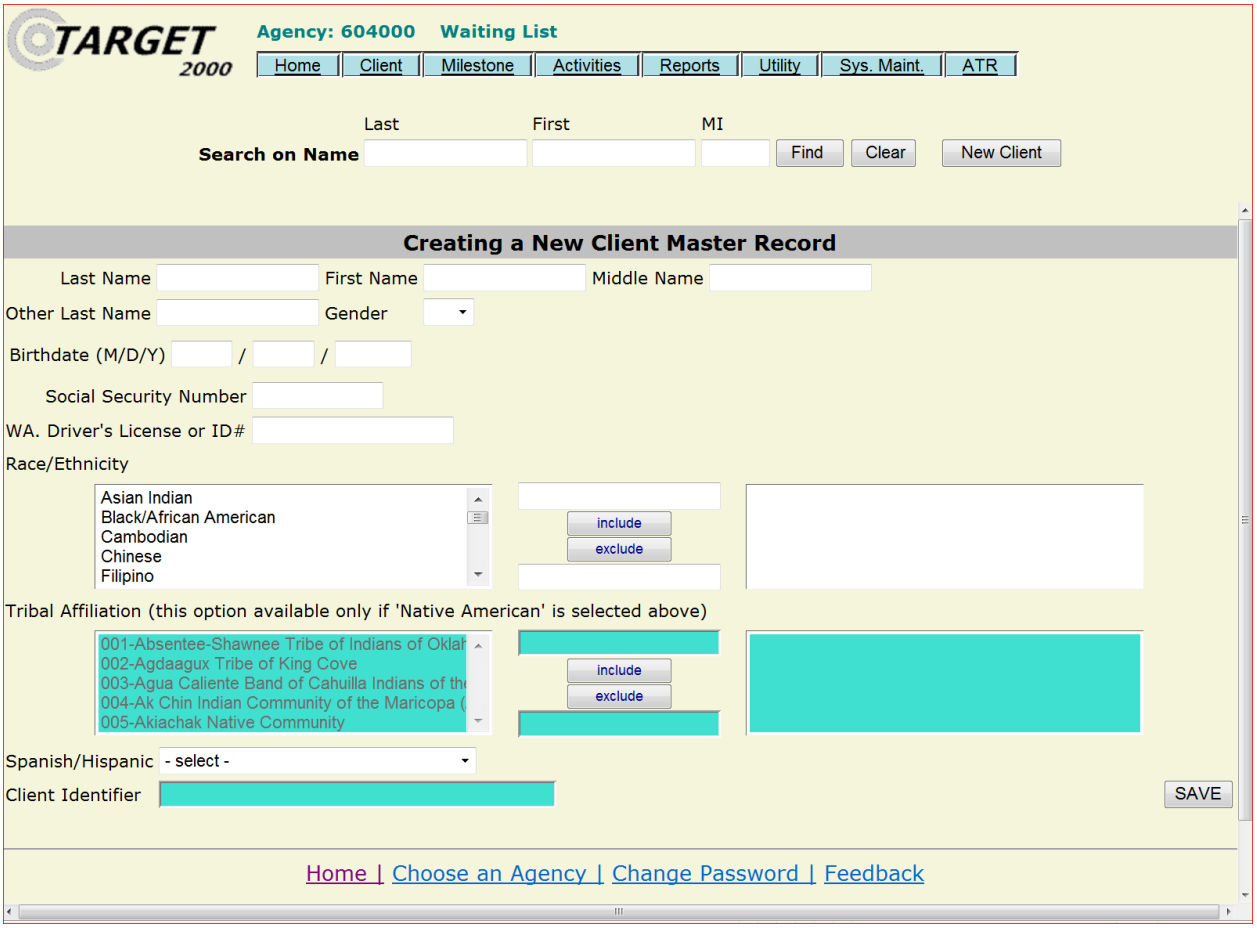
Note 1: See section below if Provider One claim is denied.

## TARGET System

Before you can bill for residential services, you must first ensure that patient information is entered into the TARGET system accurately.

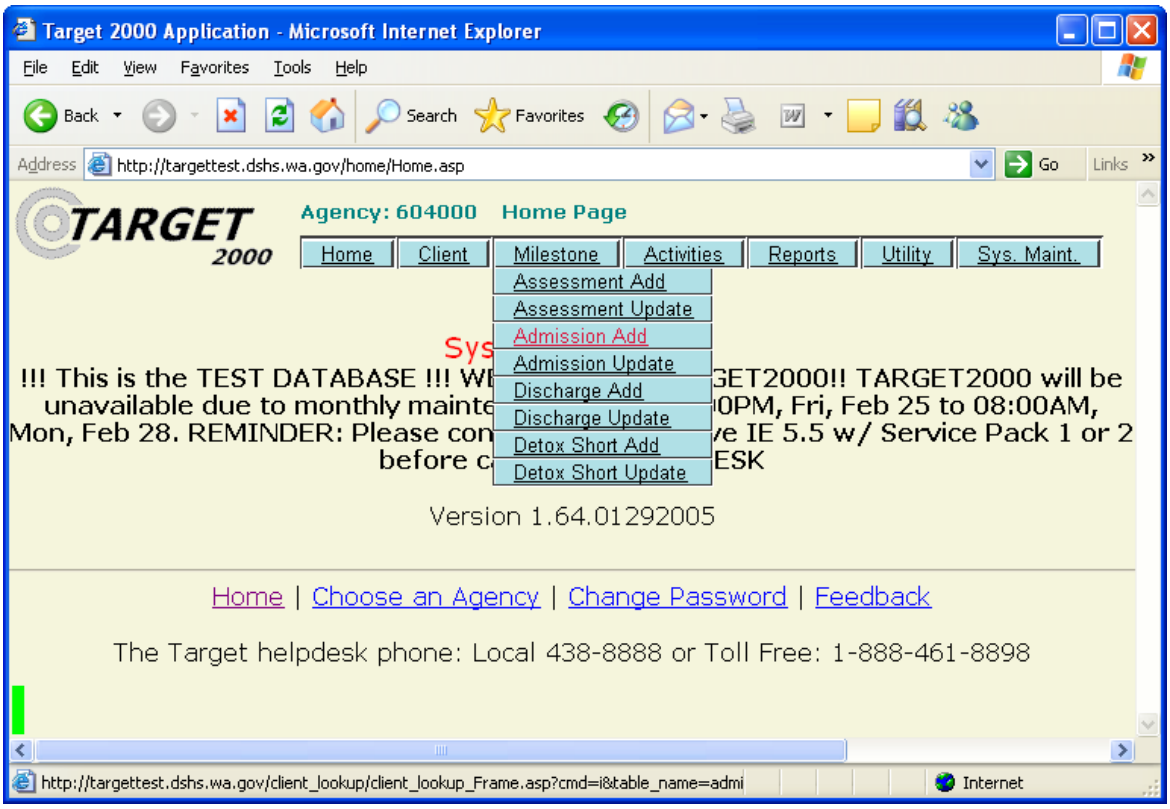
**Entering a patient into TARGET:**

1. Log into TARGET. Consult your residential contract or the TARGET Help Desk at 1.888.461.8898 for help with logging into TARGET.
2. If your agency has multiple facilities, select the appropriate agency number from the list.
3. To enter a person into the TARGET system, establish a record of Initial contact. Click on the Client menu and select Waiting List.
4. Complete the search function to assure that there is not already a record for this client.
5. Click on New Client.

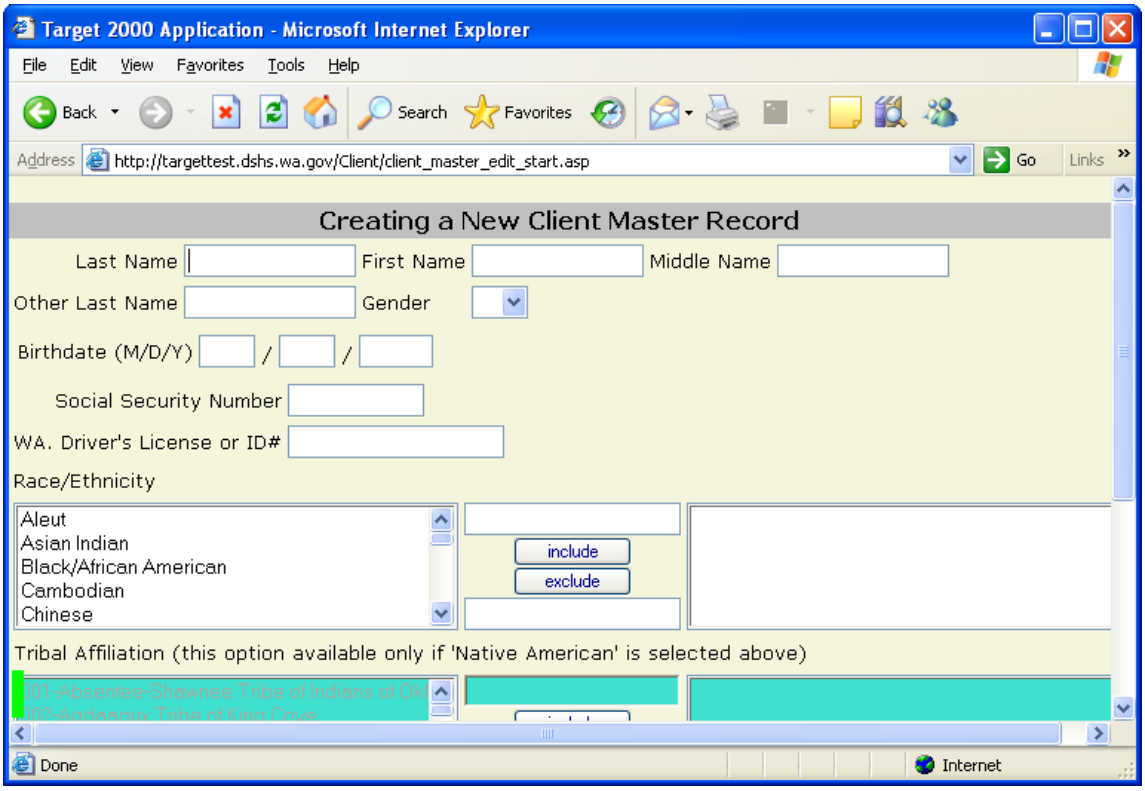

TARGET 2000
Agency: 604000 Waiting List
Home | Client | Milestone | Activities | Reports | Utility | Sys. Maint. | ATR
Last First MI
Search on Name
Find Clear New Client
Creating a New Client Master Record
Last Name First Name Middle Name
Other Last Name Gender
Birthdate (M/D/Y) / /
Social Security Number
WA. Driver's License or ID#
Race/Ethnicity
Asian Indian
Black/African American
Cambodian
Chinese
Filipino
include
exclude
Tribal Affiliation (this option available only if 'Native American' is selected above)
001-Absentee-Shawnee Tribe of Indians of Oklah
002-Agdaagux Tribe of King Cove
003-Agua Caliente Band of Cahuilla Indians of th
004-Ak Chin Indian Community of the Maricopa (
005-Akiachak Native Community
include
exclude
Spanish/Hispanic - select -
Client Identifier
SAVE
Home | Choose an Agency | Change Password | Feedback

6. Complete the information on the screen and click on Save.

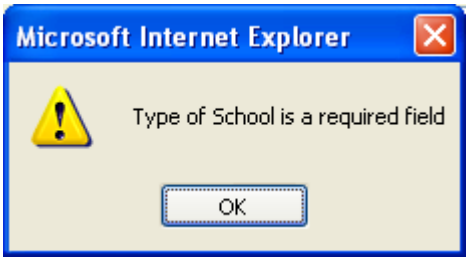

7. Complete the information on this screen and click on Save.
8. From the menu bar, click on Milestone and select Admission Add.




9. Click on the New Client button and enter the appropriate information or search for an existing patient.




10. Once you Save the record, you will see the Admission Setup screen. All fields are required. Note: If you forget to enter a field prior to clicking on the Next button, you will get an error message.




Additionally, the navigate window on the far left of the screen will show a red X on any sections of the admission setup that were not entered completely.


11. For billing purposes, the most important screen is the Admission Complete screen. The two critical fields are:

**Public Assistance Type**

Use this field to determine what type of patient you are treating. For example, if you are seeing a Medicaid Alternative Benefit Plan (ABP) client the Public Assistance Type for this patient would be ABP.

Use this field to determine what type of patient you are treating. For example, if you are treating a Medicaid client that is General Assistance: Unemployable, the Public Assistance Type for this client would be Medicaid or Title 19.

**Modality/Contract/Fund Source**

Use this field to determine these 3 separate components. For example, Intensive Inpatient/Medicaid or Title 19/State Direct represents an Intensive Inpatient modality (as defined in your residential contract); the contract type (as defined in your residential contract); and the fund source (as defined in your contract).

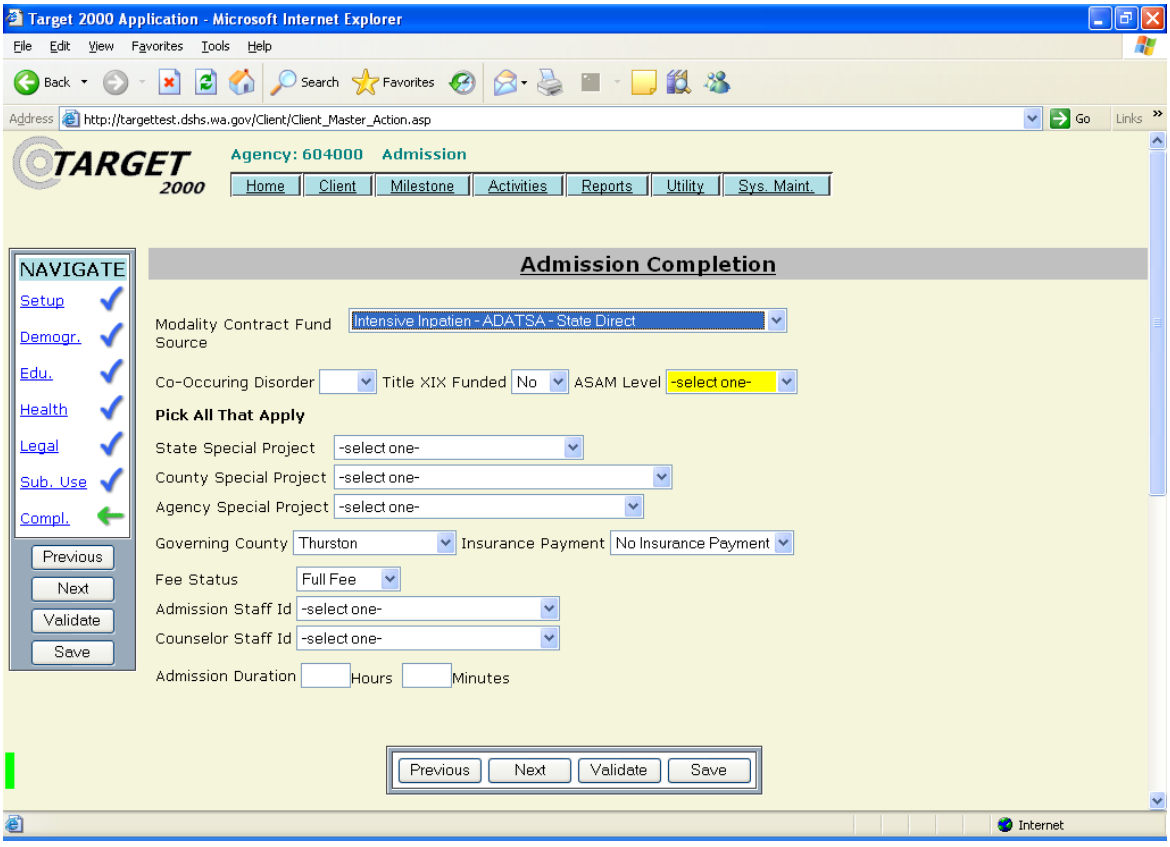
Use this field to determine these 3 separate components. For example, Intensive Inpatient/Adult Residential/State Direct represents an Intensive Inpatient modality for a treatment expansion patient or a TANF patient (as defined in your residential contract); the contract type (as defined in your residential contract – **please note that**

**the contract type for Treatment Expansion and TANF is Adult Residential)**; and the fund source (as defined in your contract and as defined by each patient).

**Is Title XIX Funding the Service?**

Use this field to determine whether a patient is Medicaid eligible, **and** their treatment services will be funded with Medicaid dollars. A **YES** in this field implies that the patient's services will be billed to the Provider One system. A **NO** in this field implies that the patient's services will be billed through the RSVP system or to DBHR directly. Note: MCTFS of Inpatient/PPW/State Direct would still be used to identify a patient that will be paid from Title XIX through Provider One. In this case, the only distinguishing field between a patient that is state funded and one that is Title XIX funded is the Title XIX Funded field.

Once the admission record is complete, click on the Save button.

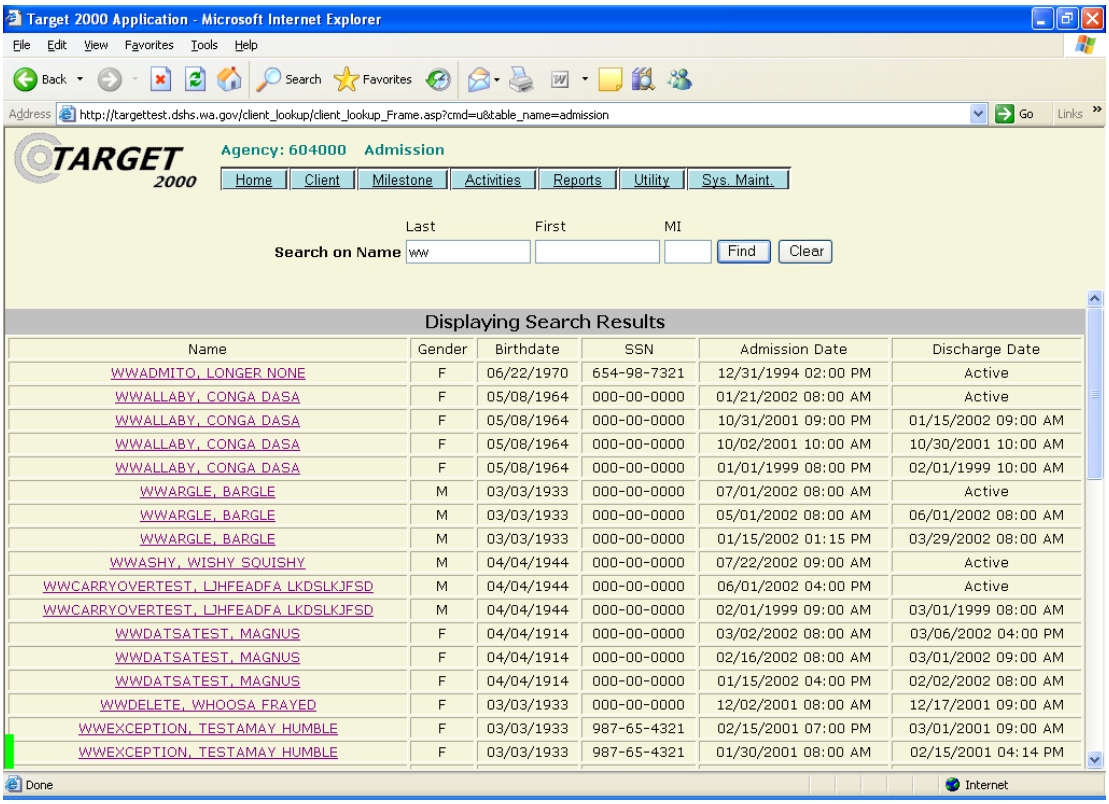


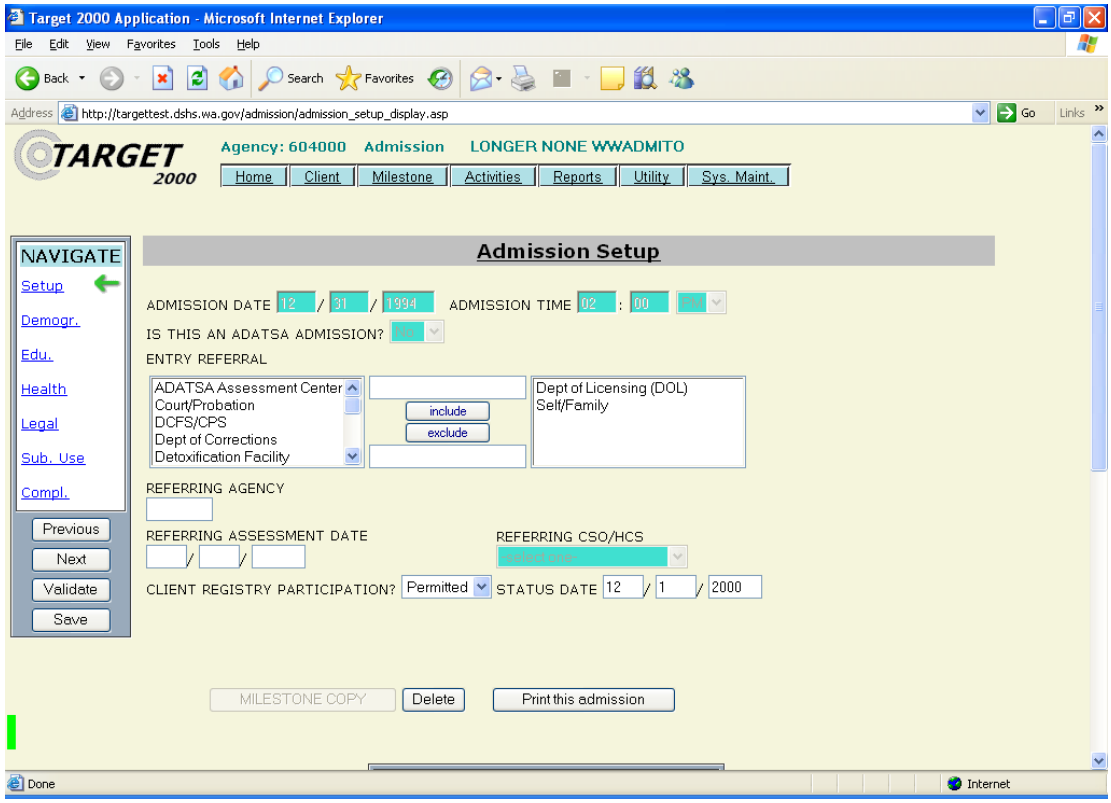
## Editing an Existing Admission Record in TARGET

1. From the menu bar, click on Milestone and select Admission Update.

2. Enter the patient's last name and first name (you must select at least 2 characters in the last name field).

From the query results, select the correct patient and click on the link on their name to get to the edit screen.





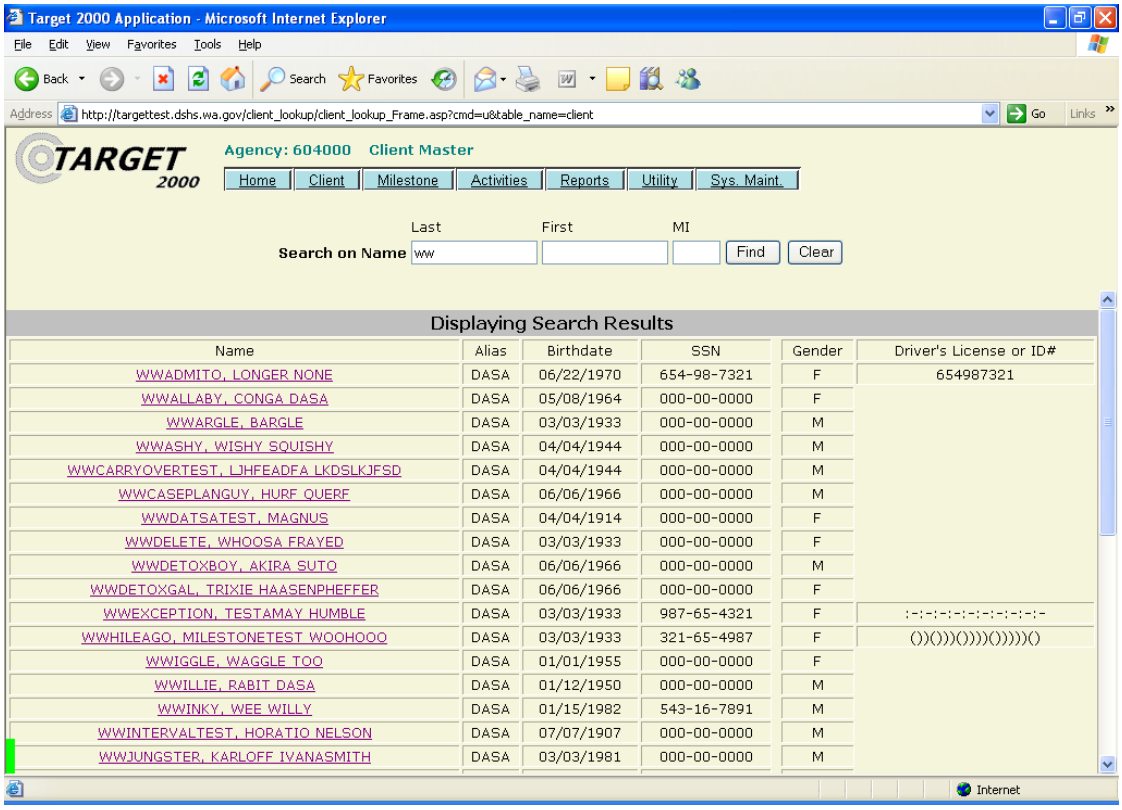

3. Edit the information as needed and click on the Save button. Note: You cannot edit the admission date and time. If an error is found in these fields, you must delete the incorrect record and establish a new record.

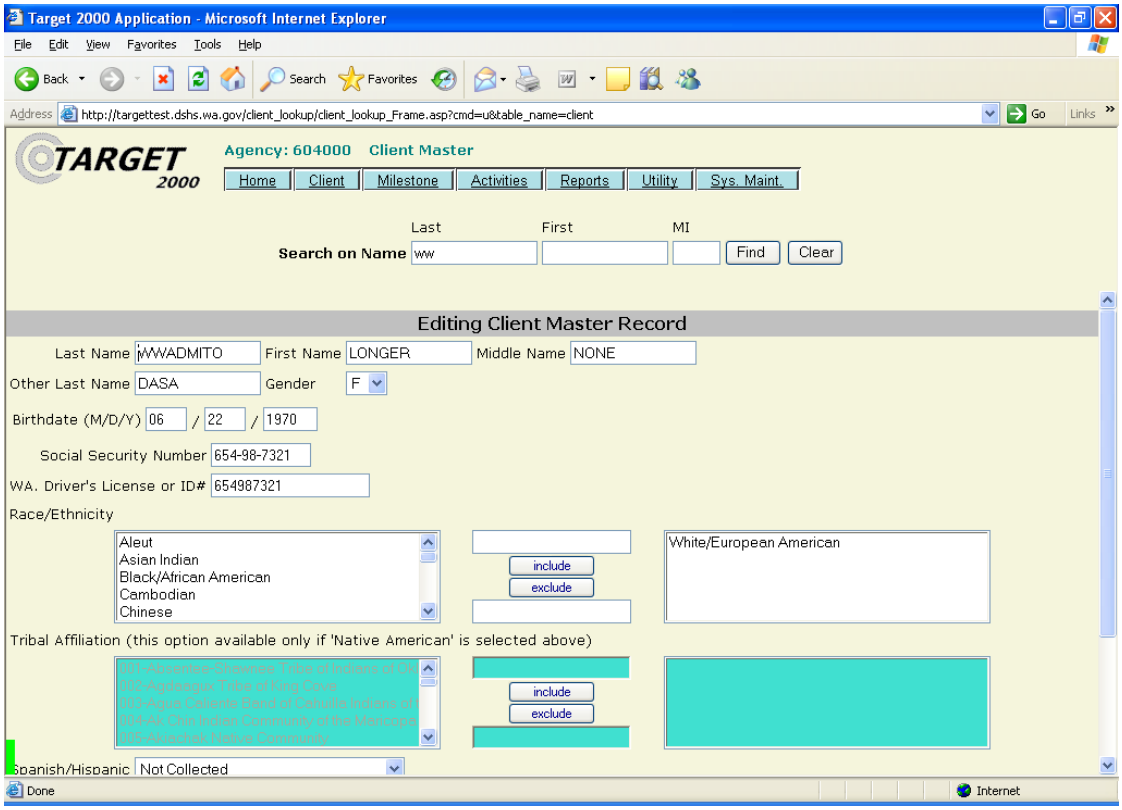
## Editing Patient Information in TARGET

1. From the menu bar, click on Client and select Client Master Update.

2. Enter the patient's last name and first name (you must select at least 2 characters in the last name field).

3. From the query results, select the correct patient and click on the link on their name to get to the edit screen.




4. Edit the information as needed and click on the Save button.

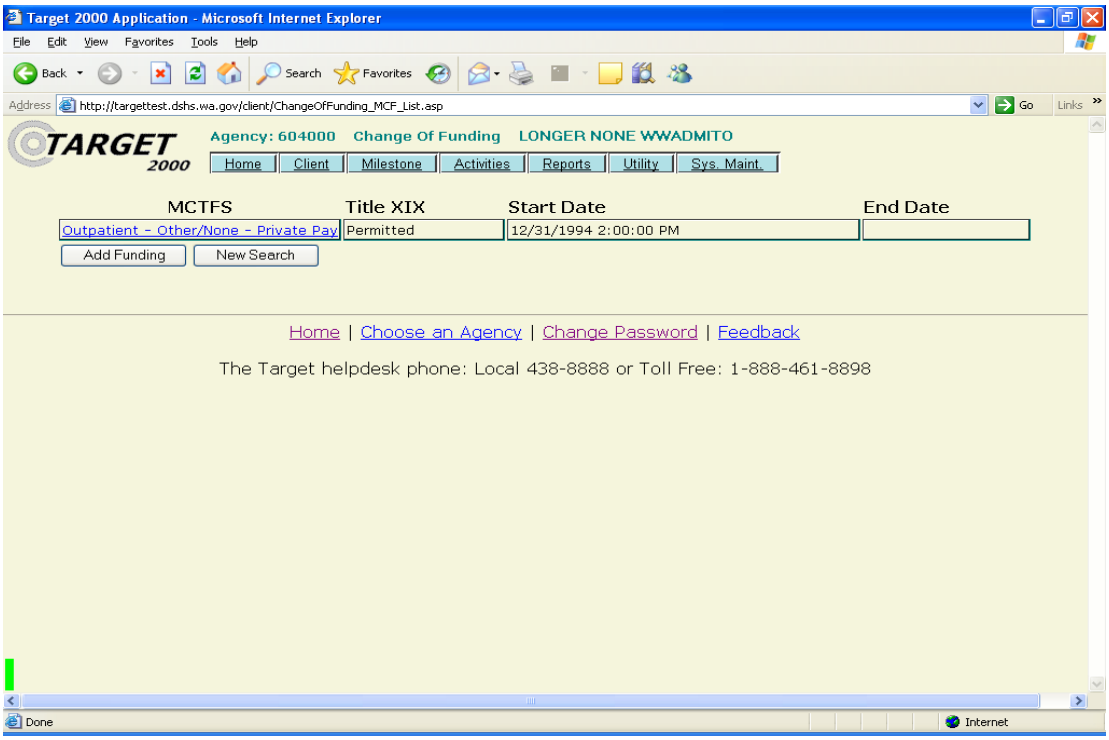
## Editing Patient Funding in TARGET

To edit an existing patient funding record in TARGET, perform the following:

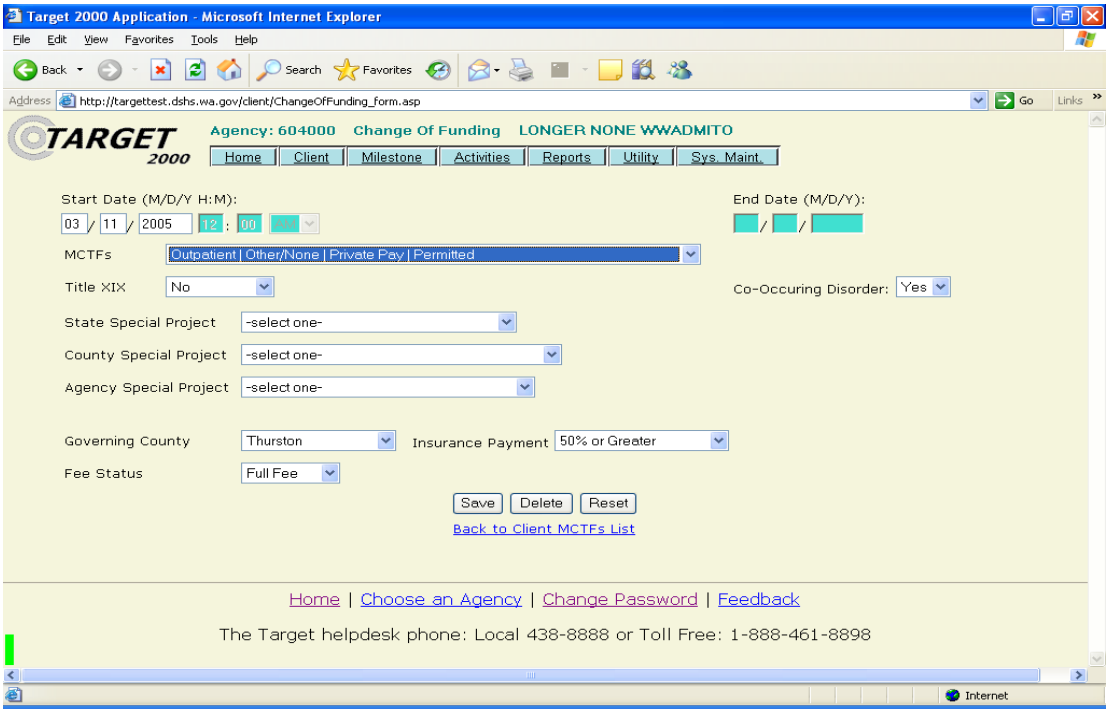
1. From the menu bar, click on Client and select Change of Funding.

2. Enter the patient's last name and first name (you must select at least 2 characters in the last name field).

3. From the query results, select the correct patient and click on the link on their name to get to the funding screen.




4. Click on the MCTFS (Modality/Contract/Fund Source) stream to edit the existing funding or click on the Add Funding button to create additional funding streams. Note: Funding streams cannot overlap. If you create another funding stream, the system will automatically end the existing stream prior to the start date of the new funding stream.




5. Click on the Save button to enter the new record.

## ProviderOne System

If your residential contract specifies compensation to be paid by Title XIX funds (CFDA 93.778) or for room and board, you must first bill the ProviderOne System. Even though you will receive payment from the ProviderOne system for Medicaid-eligible services, you must enter the patient information into TARGET.

See the TARGET System section for information on how to enter or edit a client using this system.

### ProviderOne Billing

In order to bill to Provider One, you must be issued a ProviderOne Profile. The Healthcare Authority (HCA) will provide this number to you. Once the provider number is activated, you can begin billing ProviderOne for authorized services. ProviderOne billing can be done through the internet or through a paper HCFA-1500 (Health Insurance Claim Form) form.

ProviderOne billing instructions or Medicaid Provider Guides for Chemical Dependency Treatment can be found at:
http://www.hca.wa.gov/medicaid/provider/Pages/providerone_billing_and_resource_guide.aspx.
Refer to your contract for the correct billing rates.

When billing ProviderOne, it is important you use the correct billing/procedure code for the service being billed. Incorrect billing will result in additional workload to subtract the incorrect procedure code and to bill the correct procedure code.

The correct Title XIX billing/procedure codes and rates can be found in your residential contract.

**REMINDER: When billing ProviderOne, you cannot include the discharge date as a payment day. You are not eligible for payment on the day of discharge. The accuracy of the days billed is subject to verification during a contract monitoring and compliance review.**

## Therapeutic Childcare

Therapeutic childcare is limited to five billing days per week.

## Title XIX Claims Denied by Provider One

If a Title XIX claim, which was billed through the HCFA-1500 Claim Form, is subsequently denied by the ProviderOne because the patient was not Medicaid-eligible, it should be billed to DBHR as a state funded item on a separate Form A19 Invoice Voucher. The Invoice Voucher will be emailed to you at the time your contract is executed. Contact the DBHR Office of Financial Services for assistance or for additional information.

The A19 must contain the following information:

- ✓ Client(s) Names
- ✓ Start/End Date
- ✓ Procedure Code Billed
- ✓ Amount Denied
- ✓ Copy of the ProviderOne Remittance Advice showing the denial and the applicable reason code.

You will not be reimbursed by DBHR for Title XIX charges that are denied due to late filing.

**ProviderOne Billing Errors**

If you discover that a billing error has been made (e.g., you used the wrong procedure code), you must correct the error via an Adjustment Request form.

For additional information about ProviderOne, contact the DSHS ProviderOne at 1-800-562-3022 or http://www.hca.wa.gov/medicaid/Pages/contact.aspx

## Residential Services Vendor Payment (RSVP) System

As specified in the matrix above, the RSVP system is used to pay for all state, SAPT, Treatment Expansion (includes SSI,ABP, medical assistance only, or TANF), or TANF funded residential services, **except for** family hardship, physical exams, assessments, group care enhancement, adult care enhancement, special projects, and set rates.

The patient information must be entered into TARGET by the 7th calendar day (or the next business day if the 7th day falls on a weekend or holiday) of the next month. For example, to be paid for February services, you must enter all the patient information into TARGET by the 7th of March. On the 8th day of each month (or the next business day if the 8th falls on a weekend or holiday), DBHR exports the data from TARGET and imports it to RSVP to create the RSVP invoices.

**Note: For providers with multiple TARGET provider numbers, it is very important you use the correct provider number. If you need to verify which provider number to use, please contact the TARGET Help Desk at 1.888.461.8898.**

The RSVP invoices contain a high-level summary of the TARGET information as follows:

**Note: The contract type for ABP, TANF, Treatment Expansion and SSI is now Adult Residential.**

| Field on RSVP Invoice | Content | | |
|---|---|---|---|
| Client Name | Clients Name (Last, First, Middle) as entered into TARGET. | | |
| Modality | Type of Service being provided. | | |
| Total Service | The total number of days the person has been in treatment since the date of admission. | | |
| Service Period | The beginning and ending dates service was provided for the month (will include the discharge date). | | |
| Amount Authorized | The total month's payment based on the days in treatment multiplied by the daily rate. | | |
| | A | = | Adult Residential |
| | P | = | Pregnant/Parenting Women |
| | Y | = | Youth |
| Public Assistance Type (PAT) (mandatory field) | B | = | ABP |
| | I | = | Applicant |
| | M | = | Medical Assistance Only |
| | N | = | None |
| | P | = | Supplemental Security |

| | | | |
|---|---|---|---|
| | | | Income (SSI) |
| | R | = | Refugee |
| | T | = | Temporary Assistance for Needy Families (TANF) |
| | | | |
| | | | |
| | | | |
| | G | = | Aging, Blind, Disabled |
| Funding Source (FS) | A | = | Agency Funded |
| | C | = | County Community Services |
| | F | = | Federal Direct |
| | 0 | = | Other |
| | P | = | Private Pay |
| | S | = | State Direct |
| | Identifies the payment type to which the services will be charged (e.g., Youth, PPW, ABP, etc.). | | |
| | This is a unique, TARGET-generated field composed of the patient's last name, first name, and middle initial. | | |
| | The rate authorized in your contract for that modality/service. | | |
| Payment Type | Payment to the provider is based on this number, which is the numeric calculation of the service period during the month less the discharge date if the patient was discharged during the month. **The date of discharge is not a paid day.** | | |
| Client Identifier | The provider uses this field to certify that the number of reported days is accurate and agrees to the patient's folder or other supporting documentation. | | |
| Rate | This field should be used to indicate the total amount of monies received by third parties (e.g., the patient's primary insurance) if less than the amount paid by or owed by DBHR. DBHR will calculate equivalent patient days based on the rate in order to adjust the amount owed. If the amount | | |

| | |
|---|---|
| | of monies received from third parties exceeds the amount paid by or owed by DBHR, the provider is authorized to retain the excess. |
| Reported Days | |
| Actual Days | |
| Insurance Amount | |

Upon receipt of the RSVP invoice, each agency should certify that the data is correct and accurate. Adjustments to the data are allowed as follows:

**Number of Reported Days**

Changes to the number of reported days shown on the report should be indicated in the Actual Days field. If no changes are needed, you can leave the Actual Days field blank. Any changes to the number of days must be adjusted for in TARGET as well.

Changes to the RSVP invoice can be made as long as it doesn't involve adding a resident or splitting the client into several reported rates. Adding a client or splitting a client into several reported dates will require a Write-in.

**Reminder: Pursuant to your residential billing contract, you are not paid for the discharge day. If a patient is discharged during the month, RSVP will automatically calculate the correct number of paid days.**

**Insurance Payments or Other Third Party Payments**

Use the Insurance Days field to enter the total amount that was provided by third parties. Pursuant to the Billing and Payment section of the contract, third party payments are to be netted against the amount owed by DBHR. The amount shown in the Insurance Days field will be used to deduct an equivalent number of days served. This amount may be subject to verification during a contract monitoring and compliance review.

For example, let's assume that Patient A was treated for 12 days during the month at an intensive inpatient rate of $67.64/day. Before consideration of third party payments, the amount that would be paid to the provider is $811.68 ($67.64 * 12).

If, after receiving the full payment from DBHR, the patient's insurance company paid $400.00 towards the care of Patient A, the provider will indicate $400.00 in the Insurance Days field on the RSVP invoice.

**Changes to Start/End Dates**

If you decrease the start or end date, a corresponding decrease should be reflected in the Actual Days field. Increases must be requested via a Write-in, see below.

**PPW State Funded Treatment through RSVP - With Children vs. Without Children**

An Agency Special Project code has been created for all PPW contracts to differentiate between patients with children and those without children. Use the state special project code (PPW with children) to flag any patients that have children. If the patient's status changes during their treatment, you must edit the Client Change of Funding screen in TARGET to remove the special code, indicating that they are now without children, or adding the special code, indicating that they are now with

children. Correct usage of the agency special project code will ensure the correct rate is used on the payment.

**Certification of the RSVP Invoice**

Once adjustments, if any, have been made to the RSVP invoice, a representative from your agency must sign and date each page of the detail certifying that the charges are correct, all services billed have been provided by the agency, and that the services billed were not paid by a secondary source of funding. Each page must be signed individually.

Any changes to the RSVP invoice must also be noted on the TARGET Invoice Rollup summary page.

## WRITE-INS

Because the TARGET system compiles and exports to RSVP only the details for the month that has just ended, only client information entered into TARGET by the 7th of the following month will appear on the RSVP Invoice.

Write-ins may be necessary in the following examples:

- Information for February entered the 12th day of March would not be picked up in TARGET in time for the February RSVP reporting (unless this was included on the RSVP invoice prior to submitting to Finance).
- Client information entered into TARGET for any month prior to the month being processed would not appear on the RSVP Invoice.
    - Example 1: January information entered during the month of February would not be picked up in TARGET.
    - Example 2: A resident initially reported on the RSVP invoice as 15 days without their child, adjusted to 20 days without child and 10 days with, would require an A19 for the 10 days with their child. The adjustment to the number of days without their child can be made to the RSVP invoice .

No Write-in is needed if corrections are made to the RSVP invoice prior to submitting to DBHR Finance with no additional clients added.

For these examples an A19 Invoice Voucher would need to be prepared as follows:

- Complete an A19 Invoice Voucher ensuring that all required fields are addressed.
- Generate the Target C3 Report (use the last day of the month for both the Start and End Date) and D6 Report (use the first and last day of the month for the Start and End Date, respectively). Filter both reports for the appropriate Modality, Contract Type, and Fund Source. Place a check-mark by any client's name that associated with the write-in.
- Send the A19 Invoice Voucher and TARGET Reports for the write-in to your DBHR Treatment Manager. The treatment manager will verify, approve, and then forward the A19 and attachments to DBHR Finance for payment.
- It is necessary to provide the Client initials; Dates of service; Reason for Write-in; and Client Eligibility which includes: Modality, Contract Type, and Fund Source on the A19.

Questions regarding the write-in process should be directed to your DBHR Behavioral Health Program Manager. If an A19 is needed, contact DBHR Finance at (360) 725-3755.

**REMINDER: When billing a write-in to RSVP, you cannot include the discharge date as a payment day. The accuracy of the days billed is subject to verification during a contract monitoring and compliance review.**

## Estimated PAYMENTS THROUGH RSVP

To assist with cash flow, providers may request an estimated payment if services have already been provided for the period covered by the estimate. Providers may submit an estimated payment each month, based on 75% of your primary non-Medicaid funding source from the previous month, if all patient days have been used as specified in your contract. This payment is for charges already incurred during the month, not for future costs.

The estimated payment **is optional** and is not offered on Title XIX services. DBHR will subtract the estimated payment from the month's certified RSVP invoice and process a payment for the difference. If an estimated payment exceeds the RSVP invoice amount and results in a net credit, providers must send a check for the credit amount to DSHS/DBHR. If credit amounts are not submitted timely, you may lose the ability to submit estimated payments in the future.

To receive an estimated payment:

- Use the A-19 form provided by our finance office to estimate a payment based on 75% of the previous month's billing.
- Enter your data in the blue-highlighted cells only.
- Add your signature to certify services were provided.
- Submit your completed form to the DBHR program manager no earlier than the 22nd of each month.

## THIRD PARTY RECOVERIES

### Third Party Recovery (through RSVP)

Third party recoveries, usually payments from the patient's insurance company, must be netted against the total amount owed/received if the amount received is less than the amount paid by or owed by DBHR. If the amount received is more than the amount paid by or owed by DBHR, the excess amount can be retained.

As an example, let's assume that Patient A was admitted on July 10 and discharged July 29. Through the RSVP system, you billed/received payment of $1,285.16. In August you received $500.00 from the patient's insurance company.

The correct way to reflect this is to show a write-in on the August RSVP invoice for a reduction of 7.39 patients days ($500.00 ÷ $67.64 (the modality's rate). Do not show a rate reduction (e.g., $1,285.16 - $500.00 ÷ 19 (the number of days served) = $41.32) as the RSVP system is not designed to accept alternate rates.

If you received $1,500.00 from the patient's insurance company, you would show a write-in for a reduction of 19.0 patient days and a total of $1,285.16 (19 * $67.64 = $1,285.16). The excess amount of $214.84 ($1,500.00 - $1,285.16 = $214.84) is to be retained.

### Third Party Recovery (through Provider One)

Follow the DSHS Medical Assistance Administration billing instructions regarding adjustment of claims for third party reimbursement.

## CONTRACT MONITORING AND COMPLIANCE REVIEWS

During the course of the contract period, a contract monitoring and compliance review will be performed by DBHR staff. This review is designed to verify whether the provider is in compliance with the terms of their residential contract and billing requirements.

You will be notified by letter 30 days before the review.

## Assessments

DBHR will pay Adult Residential providers for an assessment for patients upon admission who meet the following criteria:

1. The person is a treatment expansion clients (includes SSI, GAU, GAX, Medical Assistance only, or TANF).

2. An assessment has not been performed on the client in the last 30 days.

When billing DBHR for assessments, the provider must submit the following with the Form A19 Invoice Voucher:

1. The attached *Assessment Form* which identifies the client, where the client was referred from, has the client received a prior assessment and why it is necessary to conduct another assessment, and

2. The *TARGET M-2 Report*.

Payments for non-ADATSA Assessments <u>are</u> included in the maximum consideration of your residential contract.

**ASSESSMENT FORM**

| Client Name | For Each Client define Referral Source* | Did Client Receive Assessment from a different agency? If yes, please explain. |
|---|---|---|
| | | |
| | | |
| | | |