Billing

General Billing

Some of the billing set-up is accomplished by completing the initial set-up as detailed in the Getting Started Chapter of this Guide. While program and staff definition and activity codes drive the daily services for billing, there remains some other billing issues to address. Additionally, the billing building blocks of fee schedules and insurance plans are described in the Billing Chapter of the companion User's Guide.

Data Files

The following data files define the interaction of the billing programs with the agency defined set-up.

- **BILLS.PRT** - Sets the default printer to which the HCFA-1500 and UB-92 bills will go.
- **CHKPRG.DAT** - When posting a group visit for clients in multiple programs, this file allows the activity code and program to be changed based on each clients program enrollment.
- **COMPNY.TTL** - Title to be printed on letterhead private insurance bills.
- **GENBIL.INI** - Switchboard to point to programs for generating bills.
- **GENBIL.ERR** – Contains error codes and their explanations.
- **MCRBIL.DAT** - Medicare deductibles and expected payment percentages.
- **MEDCAR.PRM** – Contains the parameters for dial up submission to Medicare.
- **MEDCAD.PRM** – Contains parameters for dial up submission to Medicaid.
- **MUTS.INI** – Contains program information for MUTS data.
- **PROGRM.CMP**- Contains billing header information like Provider ID, Group, Service group, etc. for Medicare and Medicaid.
- **SALMNT.DFT** - Gives the default values for the full activity information when using quick entry at **A-2 SS**.

- **AUTTRM.DFT** – Determines agency specific time intervals and reasons for automatically terminating inactive clients.
- **STDFEES.INS** – Contains a list of insurance plans and fee schedules.

System Level Definitions

- A default client fee schedule and level can be designated for the corresponding fields in **A-6/A-1**.
- The Agency Standard Fee Schedule must also be identified at the system level.
- If MD will be billed over dial-up modem, this must be designated.
- Denied Medicaid invoices can be treated in two fashions within the system. When an invoice is denied by Medicaid, it's status can be changed by the system from "B" to "D" and require that the agency operator prepare the invoice before it can be resubmitted to MD for billing. Or the system will automatically remove the "B" status from a billed and denied transaction, allowing it to automatically be included in the next batch.
- The creation of the on-line clinical progress note for each client service can be designated to create the billing records for services provided instead of billing records being completed by **A-2 SS** and/or **SC** or the Front Desk at **A-7**.

  If this option is used it is also necessary to designate whether any client on-account monies should be applied to the corresponding invoices at the time the note is completed.

  It is also necessary to designate whether any client progress notes after the first one per service date generates additional and subsequent invoices.
- Client check-in at the Front Desk at **A-7** can be designated to create the billing record instead of **A-2 SS/SC** or progress note creation.. This option makes a corresponding "C" (or closed/completed visit) entry in the designated staff calendar.
- It is possible to generate a Billing Summary Report and have corresponding enhanced G/L postings or no Billing Summary Report with simple G/L postings.
- It is possible to designate whether a Denial Remittance Report is produced.
- The over 90 day reason code for late submission on MD bills can be defaulted to the code usually used by the agency.
- The agency can designate a maximum amount in dollars to write off per client invoice for option **C-6**.
- IMA can be set-up to interface with SMS billing.
- The cash receipts database can be activated for utilization.
- The MD algorithm for double checking can be applied to Private Insurance bills.

- **C-1 CR** can have a starting date prompt to specify a date range or only an ending date prompt to include all open invoices before a designated date.
- The agency can designate whether, at the time **C-1** is completed, invoices with an expected of $0.00 will be marked as "R"(received) $0.00.
- Current billing data can be included or excluded in statistical reports.
- Profit and Loss estimates can be based on activity weight or activity duration as defined in the activity code.
- Residential Statistics for monthly billing statistics in residential programs is initialized with the premium Event Log menu at **B-8**.

Continued Day Treatment

Continued Day Treatment is a special billing scenario, requiring additional set-up by the agency for activity consolidation based on time and activity code switching.

- **BTNHLD.DAT** - Lists programs that use CDT billing consolidation.
- **BTHCON.DAT** - List of activity code combinations for CDT billing consolidation.
- **SALMNT.CHD** - Configuration for monthly hour tracking and code switching.
- **SALMNT.QED** - Configuration for weekly batch billing and monthly hour checking.
- A reminder for the **G-16 OV** Report can specified at the time of consolidation in **C-4**.
- An additional premium option is available at **A-12** with three versions for different levels of billing interaction with a barcode scanning record of client activities in a CDT program.

Article 16

Another special billing scenario includes programs defined under Article 16 and require a diagnosis be reported for each billable service.

- **A16PRG.DAT** - Lists the Article 16 programs.

Case Management

Case Management programs require definition for applicable required visits.

- **RESSRV.DAT** - The definition for each case management program. This includes the list of applicable programs, the activity codes that signify a face-to-face contact, and how many of these activities must occur for the month.

Managed Care

Some managed care companies

- **MEDICAID-MANAGED.DAT** - A list of insurance plans that are Medicaid managed care.
- **HCFA-FEE.DAT** - A list of insurance plans that should be billed at the agency standard fee and not at the actual expected amount.
- **P-<insurance plan code>.XLT** – Defines the code switching points per activity and staff type for managed care insurance plans for each insurance plan defined as managed care.
- **MNGCAR.DAT** – Lists the programs that are eligible to accept managed care clients.
- The premium Managed Care feature for tracking authorizations is activated for the agency at the system level.
- When billing under Managed Medicare, a default company code must be identified at the system level.