

Billing

An Overview

Billing is one of the more complicated processes that occur within an agency. Coordination of benefits, Managed Care, Medicare and Medicaid all require specific billing methods. The system must process each bill in a different way based upon the client's coverage, staff provider and agency contracts. The billing process within the IMA Workbench consists of the following parts:

- **The Building Blocks** -- A description of all the definitions and set-ups that are maintained by the system.
- **Tracking Services** – Tracking appointments in the system according to status through the IMA schedule.
- **The Billing Process** -- Recording services as they are performed and ensuring that they have been entered correctly.
- **Recording Payments** – Tracking receipts from clients and third party reimbursements.
- **Billing Reports** - Analyzing and reporting on past billing activity.
- **Managed Care Specific Items**- Tracking authorizations and changing co-pays from managed care contracts.
- **Special billing scenarios** - Programs that require billing that is different from the regular outpatient model.

The Building Blocks: Tables, Codes and Definitions

There are various fields and screens defined within the system that contain billing related information. It is important to have these definitions correct in order to obtain and maintain optimal billing performance. The areas that contain billing related information are:

- Activity Codes.
- Agency Standard Fees.
- Medicaid Rates.
- Medicare Rates.
- Insurance Plans.
- Programs.
- Staff Members.
- Self-Pay Sliding Scale.
- Client Billing Header.

The billing processes will reference these data based on the specific transactions taking place. Typically, many of these definitions will have previously been entered into the system as part of the system administration.

Activity Codes

All billing transactions revolve around activity codes. This means that any billable event within the agency must be defined as a billable activity within the system. Attached to each activity code there are numerous dollar amounts. The fields in activity code definitions, **H-8**, which relate to billing are listed below.

1. **Medicaid rate code:** The code used by Medicaid for the activity type.
2. **Medicare rate code:** The code used by Medicare for the activity type.
3. **Other insurance code:** There is room to enter 2 different codes. In insurance company definitions this code is referenced by line number 3 or 4.
4. **Medicaid payment:** The standard Medicaid reimbursement amount expected for this activity. If this amount differs by program, then the rate is defined in **C-23**.
5. **Suffix:** A code used when reporting to Medicare.
6. **Procedure code:** The ICD-CM procedure code.
7. **Visits:** This defines the number of corresponding managed care visits. The normal entry is "1".
8. **Allowed visits:** The activity's use can be limited to a specific visit number (first or second visit only). The default is that it is allowed for all visits. The entry for this is from "0" to "-1".

```

IMA Mental Health - Development Area Option:HB -SH
Activity codes

Activity code:001
Description:Regular clinic visit

Medicaid rate code:4301 Medicaid payment: 64.00
Medicare rate code:90806 Suffix:
Other Insurance code:90844 ICD-9-CM procedure code:9412
:WD-PAY

Billing required?Y Program type:??
Activity group:REG
Visits:1.00 Allowed visit - start: 0 / end:-1

Type of activity:
Regular?Y Crisis?M Brief?M Collateral?M Group?M No show?M

Activity duration:1:00 Weight:0.35

Activity code:
3 men ext hlp req

```

Activity code definition screen at H-8.

Agency Standard

Fee Schedules define the contracted or agreed upon fee amounts for possible reimbursement sources on any given activity. Table **FEESCH** in **H-2** determines the codes for the different fee schedules. Once defined, these fee schedules are populated in **C-22**.

An agency standard fee must be determined and listed for each billable activity code. This represents the official fee for the services that the agency provides. These are populated in menu option **C-22 AS**.

```

IMA Mental Health - Development Area Option:C22-AS
Fee schedules

Agency Standard Schedule:2 Pg. 1
Activity Code Rate
001 - Regular clinic visit 100.00
002 - Group visit 50.00
003 - Medication visit 75.00
004 - Any visit over 20 100.00
01 - Individual visit 30-45 min 90.00
012 - Psychiatric Eval: Pre-Admit 125.00
013 - Psychological Test: Clinic Pt. 100.00
014 - Psychological Test: Pre-Admit 45.00
015 - Crisis Visit 100.00
016 - Client Home Visit 100.00
017 - Case Management 45.00
018 - Case Management - BRIEF 75.00
019 - Off-Site Client Visit 75.00
01A - Individual visit min- $2 copay 90.00
01B - Individual visit min- $5 copay 90.00

7 men ext fpg fwd num req

```

Agency Standard Fee Schedule is C-22 AS.

Medicaid Payment

Because the Medicaid payment amount was already entered in the activity code screen in **H-8**, it is not necessary to re-enter it in **C-23**. However, if the rate changes per program, it should be set up and defined in **C-23**. These entries will override values entered in **H-8** for the designated activity per the designated program. This option defines Medicaid payment amounts for each activity code. Payments can also be dependent upon a set of locator codes.

COPS quarterly amounts are entered in **H-1 3**, and are coded by QNYY as in Q296, which refers to the second quarter in year 1996. Two values are entered for type 1 or type 2. These different values are referenced by the type specified in the program definitions.

Medicare Payment

For each activity code, the Medicare payment will differ depending on the service provider, i.e. Psychiatrist, Psychologist, Social Worker or Nurse Practitioner, as specified in the staff member definition in **H-7**. In **C-24** the system asks for an activity code and a location. Enter also the effective dates and the reimbursement rates for each provider type.

Insurance Plans

Insurance Company definition is important to both the clinical and billing parts of the IMA Workbench. They are defined in menu option **H-9** as follows:

1. **Insurance plan:** A 4-character code assigned to the Insurance company.
2. **Address & Phone Number:** The address to which to send claims and /or bills and the phone number to call with coverage and billing questions.
3. **General information:** Memo box for general plan information.
4. **Blue Cross/Blue Shield:** Designates if this insurance company is part of BC/BS.
5. **Plan group:** Group to which this plan belongs. Groups are set up in table **PLNGRP**.
6. **Staff member cross-reference:** Determines which level should be used in the fee schedule based on staff member provider type. The options for this field are as listed below.
 - a) **Y** - Yes tells the system to cross-reference every staff member to see if this company covers services from his/her provider type. This information is specified in staff member definition.
 - b) **N** - No will disable cross-referencing so all staff members will be recognized equally and level 7 of the fee schedule will be used.
 - c) **A** - All signifies that all agency staff members can provide services under this insurance company, so the appropriate provider type levels in the fee schedule are used.
7. **Provider ID:** Provider ID number identifies the agency to the insurance company.
8. **Fee Schedule:** Name of the fee schedule that is attached to the company based on its coverage.
9. **Form of Submission:** Identifies the required bill format that will be used when submitting bills to the company.
10. **Rate code in activity:** In activity code definitions, 4 billing codes can be entered. This field specifies which of these 4 codes should be used when billing the plan.
11. **Medicare Organization ID:** ID number assigned by Medicare for the insurance plan.

12. **Print agency standard fee:** The bill can contain either the agency standard fee or the expected amount for the plan.
13. **Managed Care:** Defines whether this is a managed care company.
14. **Medicaid managed care:** Defines whether this is a Medicaid Managed Care plan.
15. **Visits or Duration:** Controls if authorizations are entered based on number of visits or units of time.
16. **Provider type or staff authorization:** Determines if authorizations are entered by type of provider (Psychiatrist, Psychologist, and CSW) or for specific staff.
17. **Reauthorization in visits:** For insurance companies that limit the number of client visits, specify how many visits before expiration, notification by the system is desired.
18. **Reauthorization in days:** Specifies how many days before expiration notification by the system is desired.
19. **Case payment:** Identifies the plan as being a case payment plan. The next few fields are all connected to case rate type plans only.
20. **Payment amount:** Case rate for the plan.
21. **Average number of visits:** Number of visits on which that the rate is based.
22. **Upper threshold:** Upper threshold of number of visits after which additional reimbursement can be applied for.
23. **Lower threshold:** Lower threshold after which the case rate might be lowered.
24. **Managed Care Memo area:** Used to document special intake, authorization, and termination procedures that apply to managed care plans.

```

IMA Mental Health - Development Area Option:H9 -CH
Insurance plans

Insurance plan:AETW
Name/address:AETWA Life and Casualty
              :Distribution Center, MA 13
              :P.O. Box 4010
              :
City:Hartford      State:CT  Zip:06147-3212
Phone:1-419-321-2400

Phone/policy contacts
Submit weekly to Ted Knight's attention. Alpha-coding is preferred by client.

70 x 20 men ext scn bpg fpg bck fwd

```

Insurance Plan definition in H-9 page 1.

```

          IMA Mental Health - Development Area  Option:H9 -SH
          Insurance plans

Insurance plan:AETM  AETMA Life and Casualty

Blue cross-blue shield?Y          Plan group:
Staff member cross reference?A

Provider ID:                        Fee schedule:A
Form of submission:U              Rate code in activity to use:3
Medicare organization ID:12       Print agency standard fee on bill?W

Managed care?Y                   Medicaid managed care?W
Managed care visits or duration:U Provider or staff authorization:S
Reauthorization in visits: 4      Reauthorization in days: 2

Case payment plan?W
Case payment amount: 45.00        Average number of visits: 7
Upper threshold: 6                Lower threshold: 7

          men ext scn bpg fpg bck fwd req

```

Insurance Plan definition in H-9 page 2.

When insurance plans are defined they point to a specific fee schedule. This schedule sets the expected reimbursement rate for each billable activity code. Depending on how the plan is structured different rates may be set for different types of staff and co-pays might also apply. All of this is specified in the insurance plan's fee schedule. These fee schedules are set up in **C-22 IP**. The fees are most easily reviewed and modified using menu option **MO**.

```

          IMA Mental Health - Development Area  Option:C22-IP
          Fee schedules
          Pg. 1
Insurance plan:AETM  AETMA Life and Casualty  Schedule:A  Well Care schedu

Psychiatr Psycholog Social wo Nurse   Type 5   Type 6
001 - Regular Clinic visit              CPT code: 90044
Plan      90.00      80.00      70.00      60.00      60.00      60.00
Co-pay   12.00      12.00      12.00      12.00      12.00      12.00

002 - Brief Clinical visit              CPT code: 90043
Plan      75.00      75.00      75.00      75.00      75.00      75.00
Co-pay    0.00      0.00      0.00      0.00      0.00      0.00

004 - Any visit over 20                  CPT code: 90044
Plan      0.00      0.00      0.00      0.00      0.00      0.00
Co-pay    75.00      75.00      0.00      0.00      0.00      0.00

011 - Incident - Other                   CPT code: 90001
Plan      65.00      75.00      75.00      75.00      75.00      75.00
Co-pay    5.00      1.00      2.00      3.00      4.00      5.00
Code 6    does not exist in table PIPROU

          7 men ext scn fpg fwd del num

```

An Insurance Plan fee schedule for an activity group with designated co-pays and provider types in C-22 IP.

Self Pay Sliding Scale

All self-pay clients are attached to a fee schedule and level. These schedules are set up to reflect the amount that the client should be charged for each billable activity code. The first column in the schedule is that sliding scale amount. The second column applies to clients that have other insurance but are responsible for the remaining balance after insurance has been billed. The amount in the second column is the maximum responsibility for that activity.

```

IMA Mental Health - Development Area Option:C22-SH
Fee schedules

Schedule:1 0-6 Dollar Copay
Activity:001 Regular clinic visit



| Code | Client amt | Sweep amt |
|------|------------|-----------|
| 1    | 0.00       | 0.00      |
| 2    | 0.00       | 1.00      |
| 3    | 0.00       | 2.00      |
| 4    | 0.00       | 3.00      |
| 5    | 0.00       | 4.00      |
| 6    | 0.00       | 5.00      |
| 7    | 0.00       | 6.00      |



The specific schedule and level within the
schedule is specified in A1-C6.
The Client Amount is charged to the client
when the service is performed and
collected in A7.
The Sweep Amount is the maximum that would
be charged to the client in C5 after
all the 3rd party payors fail to fully
pay an invoice.

Schedule:1 Activity code:
3 men ext hlp bck req

```

A Self-Pay fee schedule for a designated activity code in C-22 SP.

Programs

Each program may have unique billing requirements. Specifics about each of these programs are defined in option **H-13**. The program definition fields that relate to billing are listed below.

1. **Diagnosis Type:** The system has a feature that allows a specific diagnosis to be excluded from being billed by a given program. This is accomplished by an entry in the **DSM** table that defines which group of programs **cannot** bill for that particular diagnosis. Any program that is then assigned to the excluded group will not be able to bill for that diagnosis. The entry in this field is usually a number from 1 to 9.
2. **Type of COPS:** This determines whether COPS payments apply to this program. The possible field entries are:
 - a. **1** - refers to the first value in the quarterly COPS definition in **H-13**.
 - b. **2** - refers to the second of these values.
 - c. **N** - no COPS apply.
3. **Location:** The default Medicaid locator code for activities performed in this program, as defined in table **LOCSEN**.
4. **Activity Type:** Determines which activity codes are valid for this program. Activity type in the program definition cross-references with program type in the activity code definition. This should initially be left at "?".
5. **G/L Index:** An optional 2-character code for use with the G/L system. It identifies to which ledger account bills are posted.

```

                                IMA Mental Health - Development Area Option:H13-SH
                                Program definitions
Program:SA
Description:Substance Abuse Clinic
Unit:CDC                               Location:03
Area:1                                 Organization type:CO
Data type:SA                           Tickler type:CO
Associated screening program:S          Diagnosis type: 1
Type of COPS/CSP(1-5,W):1             PRU number:12345
Facility code:                         Activity type:AA
G/L index:03
CDT program?W                          Article 16 program?W
Residential program?W                  Zip code:00000
County:                                Residence type:
Residential MD billing type?W
Program:■
                                2 men ext hlp req

```

The program definitions screen in H-13.

Staff Members

In Staff Member definitions, **H-7**, there are additional fields that relate to billing.

1. **Medicare provider type:** For Medicare reimbursement amount, the provider types of Psychiatrist, Psychologist, Social Worker or Nurse Practitioner can be designated, as well as the effective dates. Two such entries can be made if there has been a change in status.
2. **Private Insurance Provider type:** Since reimbursement amounts can differ by provider type, codes 1-6 may be specified here and defined in table **PIPROV**. This number corresponds to the appropriate level within the fee schedule. An effective date is also required.
3. **Medicare PIN:** If the staff member has been assigned a PIN number by Medicare, it is specified here.
4. **Medicaid MMIS:** An identification number from Medicaid.
5. **Medicaid Provider type:** A Medicaid defined code for the specified provider type.

```

                                IMA Mental Health - Development Area Option:H7 -SH
                                Staff members
Staff member:MS
Last name:Samel                       : First:Michael           Sex:M
S/S #:123456789                       OOB:05011954           Ethnic:1
Assignment:
Date of appointment:01011990           Team:AF                 Date of termination:
Staff classification:1                 Supervisor:              Charge account: 199-9
Salary: 0                             Budget: 0                Line item:1
Location:
Credentials:
Type of staff:W                        Degrees:U
Internship:Y                           Other certificates:U
Special skills:PF                       Languages:A 0
Curriculum vitae:Y                    CV date:01011990
References:Y                            Proof of residency:Y
                                men ext scn fpg fwd req

```

Staff member definition screen in H-7 page 1.

```

IMA Mental Health - Development Area Option:H7 -SH
Staff members

Staff member:MS Michael Samuel

Certification:
Medicaid provider type:01
Medicare prov. type:1 Date:01011980
P.I. prov. type:1 Date:01011990

Licenses, ID numbers:
Primary license:ST License #:11-22222 Expires:01011998
License #2: License #: Expires:
License #3: License #: Expires:
ECFMC cert. #: Board cert. #: DEA #:
MC billing PIW:1 MC personal PIW: MC UPIW:
MD MMIS #:

TYPE A1

MEN EXT SCN BPG FPG BCK FWD

```

Staff member definition screen in H-7 page 2.

Client Billing Header

Within the client billing header in **A-1 CB**, the billing order is specified. A typical client can have multiple coverages. Therefore, the billing header must be defined to address the order of billing. Up to four codes are allowed per client and should be entered in the sequence that the payors should be billed:

1. **CL** can only appear as the first order of billing. This code can be used in one of two cases:
 - Self-pay clients.
 - A method of charging a client up-front with a possible sweep amount before billing his other reimbursements.
2. **O1,O2,O3,O4** refers to other private insurance plans that are listed in the four lines available under the other insurance heading. Each company points to a specific fee schedule. Managed care clients need to be authorized before a visit can be billed. This is done in menu option **A-1 VS**.
3. **MC** is for clients with Medicare coverage. The reimbursement amount will be determined on the combination of provider type, activity code and location, which are defined in **C-24**.
4. Medicaid (**MD**) is the payor of last resort and sometimes requires a spend-down amount before reimbursements will be paid. These rates are defined in **C-23**.

```

IMA Mental Health - Development Area Option:A1 -CB
Client data
Client: 2651 Unique ID:CLIENT010565F0 Client. Test Pg.5
Responsibility (1.2):1 Medicaid spend-down (Y.N)?M
Client responsible for balance?Y Sources of income:8 I
Occupation:L Sources of reimbursement:C G
-- Self-pay work sheet --
Salary $21000
Other source: $ 0
: $ 0
Adjust due to:child suppor $-9000
Net available $12000
# of dependents: 3 Token:M
Last evaluation:11-15-97
Evaluation interval: 0
Eligible for fee of: 10.00/sch=B-3
Self-pay fee schedule
Fee Schedule Level Effective Expires Fee Schedule Level Effective Expires
0 3 11-15-97 03-15-98
0 1 03-15-98
REMARKS
Client is no longer covered by PI, MD
coverage only. 3-15-98
40 x 25 Men ext scn bpg fpg bck fwd del

```

Page 1 of client billing header information.

```

IMA Mental Health - Development Area Option:A1 -CB
Client data
Client: 2651 Unique ID:CLIENT010565F0 Client. Test Pg.6
Insurance:
Plan Number Group Holder Employer Effective Expires
AETM **5432y H03001 CLT 03-15-97 03-15-98
NC
MD AA12345A 03-15-98
Restricted Client ref #: Visits auth:
Date applied: Anniversary date:
Billing order:CL 01 MD
Client O/A: 5.00 via A7 by GB : Medicaid O/A:
Medicare O/A: 3rd party O/A:
Finished with billing header? (Y.N)
1 Men ext bck req

```

Page 2 of client billing header information.

Tracking Services

Services may be tracked by the system according to status when appointments are scheduled within the system. At the beginning of each day, reports can be run showing all scheduled appointments. Similarly, at the end of each day, reports can be run to show all appointments that were successfully completed, as well as those which were no shows, cancellations or were rescheduled.

Scheduling

Individual staff calendars, in **D-2/A-4/Pop-up**, are the primary places where client appointments are scheduled. The scheduling involves entering an activity code for a specific client or client group which will occur at a given time on a given day. Appointments are initially scheduled with a status of **Scheduled** and progress through a series of status codes as the billing process advances.

Front Desk Check-In

When individual clients are checked-in through the Front Desk at **A-7**, the appointment status is automatically changed from **Scheduled** to **Checked In**. Client co-payment amounts or any other required client fees are displayed on the check-in screen, as well as the appointment information for this scheduled event. The money is collected, posted on account and a receipt is printed. If any appointment information needs to be changed, such as the activity code, staff member or appointment time, it can be done within this screen. Finally, clients that show up for appointments that are not on the schedule can also be checked in, and are then automatically added to the staff schedule with the appropriate information and status.

Reports

- Hard copies of individual staff schedules can be obtained by running a **D-5 IN** report. This report can be run for a specific staff member, staff group, or all and can include any combination of appointment statuses.
- The **D-5 DS** report will produce a composite daily schedule of activities which can be selected and run for an individual staff member, group, team or all. It can also be sorted by time, client name and staff member per client or per time.
- Report option **D-5 SL** is a selection by calendar status code. It is used for tracking No Shows, Cancellations, Rescheduled appointments and number of visits. This report lists appointment information by staff member, program, group or team.

Special Features

There is also an option within **D-5 SL** that will print a preset letter addressed to clients who were no shows for the defined period of time.

Note: See also the corresponding chapters in the User's Guide for detailed description of the operation and utilization of the above features: Schedule and Front Desk Manager.

The Billing Process: Recording the Services Provided

The billing process begins when a billing record is created for a particular visit in the billing database. The structure and content of this record is visible in the **C-21** screen. This record is first created by direct data entry in **A-2** or indirectly when writing progress notes in **B-1**. For a billable activity, both an **A-2** record (staff activity) and a **C-21** record (billing record) are created. For a non-billable activity, only the **A-2** record is created.

Posting Billable Activities

Posting billable activities means creating an entry in the billing transaction database. The creation of the billing record initially points only to the charges due directly from the client. All 3rd party charges are not posted on this record until the billing batch is run. There are four ways of accomplishing this:

1. **Add a new activity record in A-2 AD** - At any time, an operator can enter a single visit and print a bill for a client.

```
IMA Mental Health - Development Area Option:A2 -AD
Services-visits

Program:AT      Staff:DSF
Client: 2651 Client, Test
Member of group:      Location:C
Number in group: 1    On site:Y
Client present:Y      Team:AT
Unit:110
Date of activity:04301998 Activity:001
Appointment time:12:30 PM Type of contact:1
Service Modality:1
Next appointment:      Accident:W
Time:                  Crisis appointment:W
# of collaterals: 0

Amount billed to client now: 0.00 $ 100.00 is the standard fee amount:
Medicaid

Add the visit? (Y.N)M
1 men ext bck fwd def req
```

Add new activity record in A-2 AD.

2. **Single session batch entry in A-2 SS** – Activity and billing records are created with staff member, client and activity code. For agencies that have weekly billing setup, **A-2 WR** is available for weekly roster batch entry.

```

IMA Mental Health - Development Area Option:A2 -SS
Client contacts/census

On site:Y      Group:      Crisis:M
# in group: 1  Accident:
Type:0        Modality:1  # of collaterals: 0

```

Staff	Date	Present	Client	Program	Activity	Service	Diagnosis	Trans
GE	04301998	Y	2667	AT/	1	001		36
GE	04301998	Y	2668	S /	1	001		1
GE	04301998	Y	3000	AT/	1	002		37
GE	04301998	Y	1	CM/	1	001		1
GE	04301998	Y	2	AT/	2	002		38
GE	04301998	Y	2651	AT/	1	002		39
GE	04301998	Y	10	AT/	1	002		40
GE	04301998	Y						

6 Men ext hlp bck req

Single session batch entry of activities in A-2 SS.

3. **Upon completion of progress notes in B-1/2** - When the clinician writes the activity progress note in **B-1**, an activity code is added and the appropriate billing entry is triggered.
4. **Staff Schedules in A-2 SC** - When an event with a client or group of clients is scheduled on the system calendar, it can be billed by indicating the completion of the scheduled activity by verifying the new schedule status as **Completed** for each entry in **A-2 SC**. Visits can be changed to reflect other statuses as well, including **No show**, **(U)** cancellation and **Rescheduled**.

```

IMA Mental Health - Development Area Option:A2 -SC
Services/visits

Staff member:GE  Georgeanne Biancarosa      Date:04-28-98
Receipt date:04-28-98

```

Time	ACT	STS	Client	NAME
9:00 AM	001	C	2667	Tiger, Tony
10:35 AM	003	C	G-DDX1	Dual Dx - Access
12:30 PM	001	M	2651	Client, Test
2:00 PM	001	C	G-IDYA	Young Adult Intensiv
3:30 PM	11	U	2644	duck, donald
4:15 PM	CRT	R	2651	Client, Test

<bck><fwd>-position.<bp><fpg>-change pages.<return>-select.<scn>-staff change
1 Men ext scn fpg bck fwd

Schedule directed client posting of activities through A-2 SC.

Checking the Recorded Data

There are a number of ways to validate the data that is being entered into the system.

- **A-2 DS: Display List of Activities on Screen** - This display will give a listing per client of client number, date of activity, activity code and amount billed for each billable activity.

- **A-2 LS: Selected List of Records** - This will generate a paper report of the transaction data per activity with staff member, program, client number, date of activity and billed amounts.
- **A-2 WA: Weekly Activity Report** - For agencies with weekly billing, this will produce a weekly activity report with a breakdown by client or program for total visits per week and staff member name.

Note: The **A-2 LS**, **DS** and **WA** reports above are described in full detail in the Reports Chapter of this Guide.

- **A-2 WB: Weekly Billing Summary Report** – This is a report of selected service and/or activity records specifically for detail on weekly group activities in CDT programs as reflected from weekly batch entries in **A-2 WR**.
 - **Attendance is as of mm/dd/yy – check attendance?:** Yes or No.
 - **Include detail?:** Yes or No.
 - **Program:** A specific program or all.
 - **Number of holidays:** Type and <enter> the number of holidays for the week of the report.
 - **Starting Monday:** Type and <enter> the date for the week selected beginning on Monday.
 - **Use quick index or slow index?:** This question related to the speed of the report job. Accept the default **Quick index** by pressing <enter>.

```

IMA Mental Health - Development Area  Option:A2 -WB
Services-visits

Attendance is as of 05/22/98 - check attendance? (Y.N)Y
Include detail? (Y.N)Y
Program:AT  ACMHC Adult Treatment Program
Number of holidays:8
Starting Monday:05181998

Use quick index or slow index? (Q.S):Q

1 men ext bck req

```

The selection screen for the A-2 WB.

The columns on this report are defined below for both the Billing Detail and Summary for the selection criteria.

Billing Detail Report:

- **Client:** Number and Name of each client for each activity record for the week.
- **Date:** Date of service/activity.

- **Transaction:** Transaction number for that activity by program and staff.
- **Staff:** Staff assigned to client in program record.
- **Status:** Status of the service/activity record in the billing cycle.
- **Activity:** The activity code billed for the combined CDT services.
- **Weight:** The weight assigned the activity for the staff per individual service.
- **On site:** Yes or No, indicating whether the service occurred on site (Y) or not (N).
- **CXBCG:** Designations from the activity code "Type of Activity" definition in **H-8**, with a Yes or No answer for each type: C(Regular), X(Crisis), B(Brief), Collateral, and G(Group).

```

BILLING DETAIL FOR PROGRAM ACMHC Adult Treatment Program
Week starting 07-13-1998

IMA MENTAL HEALTH - DEVELOPMENT AREA  08-17-98  3:12 PM  GB      PAGE NO.  1

CLIENT          DATE   TRAMS. STAFF STATUS ACTIVITY WEIGHT DM SITE CXBCG
103 Test, Jeannie  07-13-98  250 MS  B/E/  001    0.35  Y  WWWVY
                  07-13-98  251 MS  B/R/  001    0.35  Y  WWWVY
                  07-13-98  252 MS  B/R/  001    0.35  Y  WWWVY
                  07-13-98  253 MS  B/R/  001    0.35  Y  WWWVY
                  07-15-98  254 MS  B/ /  001    0.35  Y  WWWVY
                  07-19-98  259 MS  B/D/  001    0.35  Y  WWWVY
                  07-18-98  260 MS  B/R/  001    0.35  Y  WWWVY
2651 Client, Test  07-13-98   57 GB  B/ /  001    0.35  Y  WWWVY
                  07-15-98   68 GB  B/ /  001    0.35  Y  WWWVY

Type <return> to continue (E to end, S to start over or P to print)
1 MEN EXT

```

The A-2 WB Billing Detail Report.

Billing Summary Report:

This report lists Monday through Sunday by date and day, including a weekly total with two columns underneath each day and the total heading. The first column reflects **Medicaid** and the other, **Other Sources**. The following are defined for each of those columns, which is a daily and then weekly total view.

Total served

- **Number of visits:** Total visits.
- **Equivalent units:** Weighted accounting of visits.
- **Dollars:** Billed amount.
- **Number absent:** Count of clients who are enrolled, but did not attend scheduled services.
- **Total enrolled:** Total number enrolled in program.

Activity: All applicable activities are listed by code and description.

- **Number of visits:** Total visits.
- **Equivalent units:** Weighted accounting of visits.

- **Dollars:** Billed amount.

Totals: per page, which combined should equal Total Served numbers from above.

- **Total visits:** Total visits for page.
- **Total units:** Total units for page.
- **Total dollars:** Total dollars for page.

Entering No Shows

Whenever an appointment must be changed on the schedule from a scheduled to no show status, the **S** must be changed to **N**. In addition, an agency can decide to implement a special no show activity code. Both the changing of the status and switching to a no show activity code are accomplished in **A-2 SC**.

Note: Once an activity record/billing record is created in **A-2 SS** or **SC**, it is considered a closed event. Changes to that record can then only be made in **A-2 CH**.

Submission of Billing Batches to Payors

The actual generation of bills for Medicaid, Medicare and 3rd party insurance is done within Menu option **C-1**. There are three basic stages in doing a billing run:

1. Create the billing batch.
2. Check for and correct errors.
3. Generate the actual bills.

Create Batch

C-1 CR will look at the dates specified, and group all billable activities into a batch. Each activity will be analyzed and the system will determine whom to bill and for how much. A batch can be created for all applicable payors, or specifically for Medicaid, Medicare, or 3rd party insurance.

Check for Errors

C-1 CH goes through all of the billing transactions in the batch and checks for any of the errors that would cause rejection.

Generate Bills

All bills that do not have errors can then be generated in **C-1 GE**. This option will create billing for all 3rd party insurance, print HCFA forms and/or print bills on the organization's letterhead. All of these processes do not have to be done at one time. If a batch was created but not yet checked for errors, or checked but the bills were not generated, the screen will give all of the details of the batch that was created, the dates included in it, and the last process that was done to the batch. After generating the bills, **C-1 CF** is available to prepare submissions on floppy disk or electronic files for Medicaid and Medicare.

```

IMA Mental Health - Development Area Option:C1
Generate bills

Last billing batch was created on 04/30/98 with 5 records
Includes all records 01/01/90-01/01/98 for unit 110
Last action on this batch was CH on 04/30/98

CR - create new billing batch file
CH - check this batch file for errors
GE - generate bills & magnetic record for the batch
CF - create submission file (floppy disk or dialup modem)

LE - print a list of error codes & definitions
CO - collection agency report and update

Option: 2 men

```

Generate bills sub-menu at C-1

Preliminary Billing Report for Period Ending 12/28/95
Medicaid

Client	Invoice Date	Invoice Number	Fee Amount	Invoice Amount	Activity	ID	Errors
Sample MH Agency	12/30/95	2:30 PM				Page No. 1	
Stern, Howard	10/12/95	34	100.00	35.00	001	123ACS	M16
Turner, Tina	10/16/95	52	75.00	43.00	003	ASDFJK	M20
Company Totals			275.00 / Rejected	175.00			

Billing error report.

Error Codes

When checking a billing batch for errors, the system generates a report listing each bill and the error associated with it. A sample of this report is shown below. There are three types of error codes that will be picked up by the system, major errors (**M codes**), warnings (**W codes**) and remittance errors (**R codes**). When the system detects a major error it will not submit the bill for that transaction. Additionally, some M errors automatically exclude an invoice so that the next payor can be billed. If a warning is found, the bill will still be submitted. The following is a list of the error codes that the system will use.

Major Errors

- ◆ M1 - Billing transaction does not exist.
- ◆ M2 - Billing transaction was already updated.
- ◆ M3 - Activity code does not exist.
- ◆ M4 - In activity code, either crisis, clinic, brief, collateral, or group must be yes.
- ◆ M5 - Activity code not billable to Medicaid. (Automatic Exclusion)
- ◆ M6 - Activity code not billable to Medicare. (Automatic Exclusion)
- ◆ M7 - Program record not found.
- ◆ M8 - SMS billing number is blank (SMS only).
- ◆ M9 - Activity code not billable to 3rd party insurance. (Automatic Exclusion)
- ◆ M10 - Medicaid or Medicare ID is blank.
- ◆ M11 - Date of birth is zero.
- ◆ M12 - Sex must be M or F.
- ◆ M13 - Primary diagnosis does not exist.
- ◆ M14 - Secondary diagnosis does not exist.
- ◆ M15 - Multiple visits on the same date. (Automatic Exclusion)
- ◆ M16 - Primary diagnosis excluded from Medicaid reimbursement.
- ◆ M17 - Primary diagnosis has bad ICD-9-CM format.
- ◆ M18 - Secondary diagnosis has bad ICD-9-CM format.
- ◆ M19 - Rate code has wrong format.
- ◆ M20 - Psychiatrist field is blank.
- ◆ M21 - 3rd party insurance company is blank or not found.
- ◆ M22 - Staff member does not exist.
- ◆ M23 - Type of provider is blank in staff member.
- ◆ M24 - Medicare payment record does not exist.
- ◆ M25 - Date of bill is before provider type effective date.
- ◆ M26 - Date of bill is before Medicare payment effective date.

- ◆ M27 - Date of bill is before deductible dates in **MCRBIL.DAT**.
- ◆ M28 - Number of years as type of provider is negative.
- ◆ M29 - Staff member is not qualified by Medicare. (Automatic Exclusion)
- ◆ M30 - For pay-down client, deductible has not been entered.
- ◆ M31 - No ICD-9-CM procedure code in activity.
- ◆ M32 - PIN is not defined for staff member.
- ◆ M33 - 3rd party procedure code for activity is blank (SMS only).
- ◆ M34 - Fee schedule for insurance plan can not be found.
- ◆ M35 - Location code does not exist.
- ◆ M36 - Locator code or place of service is blank.
- ◆ M37 - Remittance reference number is blank for void.
- ◆ M38 - No managed care authorization.
- ◆ M39 - Managed care authorization has expired.
- ◆ M40 - Managed care visit authorization has been exceeded.
- ◆ M41 - Managed care CPT codes do not match.
- ◆ M42 - Managed care plan does not match.
- ◆ M43 - No effective third party insurance.
- ◆ M 44 - Bill for residential program was not entered using **G-31**.
- ◆ M 45 - Cutoff date does not allow inclusion of all residential bills.
- ◆ M 46 - Residential programs can only be billed to Medicaid.
- ◆ M 47 - More than 5 events for per diem client.
- ◆ M 48 - Program not found in **PROGRM.CMP**.
- ◆ M 49 - Client record does not exist.
- ◆ M 50 - Billing header does not exist.
- ◆ M 51 - Locator codes do not match.

Warnings

- ◆ W1 - Billing transaction is older than 90 days.
- ◆ W2 - On previous Medicare entry, approved amount is less than amount received.
- ◆ W3 - Fee minus total received is negative.
- ◆ W4 - Approved amount is greater than fee amount.
- ◆ W5 - Approved amount is zero
- ◆ W6 - Medicaid pay-down applies to this visit.
- ◆ W7 - Medicare deductible applies to this visit.

Remittance errors

- ◆ R1 - Client record not found.
- ◆ R2 - Billing record not found.
- ◆ R3 - Billing entry is not a Medicaid bill.
- ◆ R4 - Billing entry has already been updated.
- ◆ R5 - Billing entry for adjustment has not been received.
- ◆ R6 - Billing entry status is not B or R for a void.
- ◆ R7 - Void entry does not indicate a void was done.
- ◆ R8 - Voided amount does not equal received and COPS amount.

Recording Payment and Remittance Notification

Applying On- Account Money

Once money has been received at the front desk it is placed on-account of the client ledger. Viewing the client ledger in **C-11** will show the full client balance with a per invoice breakdown of owed moneys. A comment line will show the most recently obtained on-account amount. On-account money can be applied in two ways:

1. When appointments are closed using **A-2 SC**, all on-account money for each client visit is automatically applied.
2. **C-2** and **A-3** provide a method of applying the money in a per client, per invoice method.
 - **Cash receipt or adjustment?** - To apply received money answer **Receipt**.
 - **Payment Source** - Answer **CL** for client.
 - **Client Number & date range** - Choose a client whose ledger to display.
 - **Amount Received & date** - If applying on-account money, this value is left at zero because the system already recognizes on-account money.
 - **Use on-account amount** - Answer **Yes**.
 - **Highlight invoice** - Choose the invoice for which to apply the money.
 - **Amount to Pay** - Enter the amount of money to apply toward this invoice.

When this process has been completed use the <scn> key and answer **Yes** if ready to update the cash journal.

Note: If this screen is exited before completing these transactions, the system will alert the user that none of the changes will take place and the process will be discontinued.

IMA Mental Health - Development Area Option: A3
Receipt of payment/individual

Client: Test (2651) Client payment
Phone: / Billing sequence: CL 01 MD

Client				Payor 1/3		Payor 2/4		
Date	Billed	Received	Due	Billed	Received	Sts	Received	Sts
02/26/98				50.00	MD	0.00	0	

Balance:	0.00	0.00	0.00	0.00
- On account:	5.00	-5.00		
Balance:	27.02	0.00	0.00	0.00
Amount received:	5.00	left:	5.00	

Receipt date: 021098 Use on account amount? (Y.N)
1 men ext bck req

Applying on-account money in client ledger in A-3.

Third Party Receipts

When payment is received from third party reimbursement sources, it can be applied in a per client, per invoice fashion by the **A-3** or **C-2** screens. Choose a client to display and enter the total amount received with the date it was received. Move through the invoices and enter the amount to pay on a per invoice method.

Medicaid Remittance

- When a Medicaid remittance tape is received it must be transferred from the floppy disk to a system file. This is done in **C-3 RF**. The next step is to check the file for any possible error and produce a printed list of the file. This is done in option **CH**. The amounts can then be applied to the individual client ledgers by running option **UP**.
- In the event that the system file must be created manually and not from a floppy disk, the file is created in option **CR**. The above steps can be followed to subsequently check the file and update the client ledgers (options **CH** and **UP**).

```
IMA Mental Health - Development Area  Option:C3
Post Medicaid reconciliation

RF - read remittance file from floppy-tape
CH - check file for errors and print list
UP - update client ledgers from this file
CR - create remittance file from keyboard

Option:█

2 men ext
```

The Medicaid Remittance screen in C-3.

Medicare Remittance

- When a Medicare remittance tape is received it must be transferred from the floppy disk to a system file. This is done in **C-3 RF**. The next step is to check the file for any possible error and produce a printed list of the file. This is done in option **CH**. The amounts can then be applied to the individual client ledgers by running option **UP**.

```
IMA Mental Health - Development Area Option:C3
Post Medicare reconciliation

RF - read remittance file from floppy/tape
CH - check file for errors and print list
UP - update client ledgers from this file

Option:

2 men ext
```

The Medicare Reconciliation screen at C-3.

Cash Receipts

The cash receipts journal can be viewed in two ways:

1. A daily view of what cash has been entered into the system on any given day is accomplished in **C-15**. This report can be selected based on the following criteria:
 - **Start and End receipt date** - Range of dates for receipts to include.
 - **Bank** – A specific bank account or all bank accounts.
 - **Program or organization type** – Select for a specific program or specific organization type or for all programs or all organization types.
 - **Source** – Select receipts from the Client, MD, MC, or Private Insurance only or all receipts.
 - **Client** – Select a specific client or all clients.
 - **Operator** – Select a specific operator or all operators.
 - **Sort** – Determine first, second, third and fourth priorities for sort from **Date**, **Operator**, **Client**, **Source** and program/organization type (**T**).
 - **Totals only?** – **Yes** for a summary report or **No** for detail.

```

          IMA Mental Health - Development Area  Option:C15
          Daily client related cash receipts report

Start receipt date:08121998  End:08121998
Bank:all

Program or organization type? (P,D)0
Organization type:all
Source (CL,MC,MO,PI):all
Client:all
Operator:all
Sort - first:D  second:T  third:S  fourth:C
Totals only?#

Use <def> for all banks

          4 men ext scn hlp bck fwd def req

```

The report selection screen for cash receipts at C-15.

This report lists the receipts for the given date range by the designated sort criteria. It also shows the receipt amount, operator and option where receipt was given and the memo text from the cash receipt comment.

2. **F-23** provides an option to display cash journal entries by different selection criteria of dates, customer/company, record type, comment and department/division.

```

          IMA Mental Health - Development Area  Option:F23
          Display Cash journal entries

          JE - Display a particular JE number
          GL - Display a particular G/L number
          DA - Select by dates
          CD - Select by customer/company code
          TY - Select by record type
          CM - Select by comment
          SD - Select by department/division/account
          SF - Select cash journal files
          SC - Print on screen
          PT - Print on printer instead of screen
          CL - No selection criteria

Display - all entries
Display on screen

Option:

          2 men

```

The F-23 menu for displays of cash journal entries.

Posting denials and Resubmission

When a receipt is received from a payor there are two possible outcomes: either payment has been granted or the bills were denied. Moneys denied can be dealt with in a variety of ways:

1. **Accept denial** - Move to the next payor in the client billing header by changing the status for the billed payor to **R** with a received amount of **0.00**. This can be done in the **A-3** screen or in **C-21 DN**.

2. **Resubmit denials** - There are two options when resubmitting denials to the current payor. Each agency decides which option to adopt and the system is configured to act accordingly to the method employed.
 - **Resubmit bills right away** - This is a one step process in option **C-21 RB** where the denied transaction is completely disregarded and the bill is resubmitted anew. This is in assumption that the billing error will be corrected before the next billing batch is created.
 - **Freeze bill until error correction** -In this two step process, the billed status is changed to **Denied** and awaits correction. This is done in **C-21 SD**. In any billing batches created before this error has been corrected, the bill is ignored due to its frozen status. Once the necessary revision is made, the billing status is returned to **Billed** in **C-21 RD** where suspended transactions are resubmitted.
3. **Voiding Paid Bills** - In the event that Medicaid paid bills must be voided, this can be amended to the next Medicaid billing batch in option **C-21 VD**.

```

IMA Mental Health - Development Area Option:C21
Billing record maintenance

Processing changes:
DW - post payment denial           DB - add client opening balance
SD - suspend item pending denial   UD - void a medicaid invoice
RD - resubmit a suspended item     RV - rebill a medicaid void
RB - resubmit a billed item        SW - switch exclusions
EX - exclude a transaction from billing
RE - resubmit a previously excluded transaction
PD - permit billing with errors on this transaction

Data changes:                      Lookup:
CC - change COPS amount            SH - show a billing transaction
CP - change CSP amount            DS - display list of transactions
CR - change received amount       LS - list trans. on the printer
CA - change allowance amount
CW - change write-off amount
CH - change a transaction
CS - change self pay amount

Option:■                               2 men

```

The C-21 Menu for billing record maintenance.

Other Billing Processes

- **C-5 Client Sweeps** - For any given invoice, when submission to all available sources has been done and the full fee remains unsatisfied, the balance due is charged to the client subject his/her sliding fee schedule. Any balances beyond the limits of the fee schedule are written-off. A report is produced with details of each transaction.

```
IMA Mental Health - Development Area  Option:C5
Client balance sweep

First activity date:12311997
Last activity date:01311998
Client:all
Program:all
List only? (Y,N)W
1 - Sweep only clients with 3rd party payors
2 - Close also the invoices of CL only clients
3 - Close the invoices of CL only clients
Select (1-3)?

B men fwd def req
```

The C-5 selection screen for setting parameters for client sweeping.

- **C-6 Client Balance Write-off** - Lists clients that haven't paid their balances within a given period and writes-off the balance if it is below an agency specified amount.

```
IMA Mental Health - Development Area  Option:C6
Client balance write-off

Last activity date:01311998
Only inactive clients?W
Client:all
Program:all
List only? (Y,N)W

B men fwd def req
```

The selection screen for parameters in C-6 for client balance write-off.

- **C-8 Self-pay Accrual & Report** - This is used only if the G/L option is activated. It creates the G/L postings for self-pay invoices.

```
IMA Mental Health - Development Area Option:CB
Self pay accrual and report

Last date to include:05011998
Client:ml

6 men hlp bck fwd def req
```

Selection screen in C-8 for the Self-Pay Accrual and Report to coordinate with G/L feature.

Billing Reports

During the billing process, some reports can be printed automatically and directly at **C-1**.

- **Preliminary 3rd Party Billing Reports - CR & CH** - These options will create a new billing batch file and then produce a report list of all of the billing transactions in the batch that were processed. The ones with errors are marked and all transactions are summarized by source of reimbursement.
- **Final Billing Report - GE** - The above report is printed again in final form. It is the same as before except that all items with errors are omitted. Additionally, the **Billing Submission Report** is printed if the G/L option is initialized. This report summarizes the data by G/L account and also details the error items that are posted to a suspense account and the non-billable items which are posted to a special write-down account.
- **Disk Report - CF** - This gives a list of the floppy disks that will be made, a label, the number of claims, and the dollar amount contained in each disk. Also printed automatically are the actual bills to those payees that require submissions on paper. These can be printed on the organization's letterhead or onto the HCFA form.
- **Aged suspense A/R Report - AR** - This lists accounts receivable with fatal errors that could not yet be cleared.

Additional reports that can be generated in the **C** sub-menu:

- ◆ **C-13** - Aged A/R report.
- ◆ **C-14** - Client ledger printing.
- ◆ **C-19** - Billing reports.
- ◆ **C-20** - Audit Reports.
- ◆ **C-25** - Case payment tracking.
- ◆ **C-26** - Insurance coverage reports. (See Managed Care Section of this Chapter.)

Below are details on some of the above listed reports.

Aged A/R Report – C-13

Selection criteria

- **Date for report** - The date of the report is the date that will be printed on the report header. The calculations for the aging columns will be based on this date.
- **Include receipts through** - Only items with a billing date to the specified source of reimbursement through this date will be selected. When this date is limited and multiple sources are specified, it generally includes only a subset of all such bills.
- **Payor: Medi(C)are, Me(D)icaid, Plan or Plan Group** – Select a specific payor or all payors.

- **Starting & Ending client** – Designate a specific client, a range of clients or all clients.
- **Starting & Ending billing date** – Designate a range of dates for the receivables.
- **Starting & Ending service date** – Determine a range of dates for the billed services.
- **Program, Unit Organization or Area** – Select a specific program, unit, organization or area or all programs, all units, all organizations or all areas.
- **Staff** – Select all staff or a specific staff, indicating as either Service provider or Primary.
- **Terminated clients** – Specify to Include, Exclude or report Only on terminated clients.
- **Minimum balance** – Specify a minimum balance to include or none.
- **Maximum balance** – Specify a maximum balance to include or none.
- **Include COPS in Medicaid A/R?** - Choose to include or exclude COPS payments in Medicaid A/R.
- **Include 3rd Party A/R for Swept Invoices?** – Choose to include or exclude swept invoices in 3rd party A/R.
- **Sort by client (N)umber or (A)lphabetic?** – Select a numeric or alphabetic sort for clients.
- **List by (P)lan or plan (G)roup?** – Select primary sort by plan or plan group.
- **Report option:** - Select a report with detail or totals only.

```

IMA Mental Health - Development Area Option:C13
Aged A/R report

3rd party or Client report (3.C)?3
Date for report:08121998 Include receipts through:last

Payor:Medi(C)are, Me(D)icaid, (P)lan or plan (G)roup?all
Starting client:first Ending:last
Starting billing date:first Ending:last
Starting service date:first Ending:last
(P)rogram, (U)nit, (O)rganization, (A)rea:P Program:all
Staff:all (S)ervice provider or (P)rimary?S
Terminated clients - (I)include, (E)xclude, (O)nly?I
Minimum balance:none Maximum balance:none
Include: COPS in Medicaid A/R?Y 3rd party A/R for swept invoices?W
Sort by client (N)umber or (A)lphabetic?W
List by (P)lan or plan (G)roup?P
Report option:2
1. Detail report
2. Totals only

B Men ext scn fpg bck fwd req

```

The C-13 selection screen for the Aged A/R Report.

Column definitions: 3rd party

- **Receipts** - This includes the total of all payments received on this service from all other sources EXCEPT from this source. It is for information only and has no impact on the calculation of the A/R amount from this source.

- **On-account** - Any moneys that have been received for this client account but have not been applied to a specific invoice. This is for information only and has no impact on the A/R calculation on this report. Generally, this is used for the client ledger in order to reduce the amount due on the self-pay account.
- **Due amounts** - This is the amount due from this source and it is shown under the A/R column. If the source is Medicaid, and this invoice was returned with a **Pending** status, then it is listed under the pending column.
- **Aged by service date** - The amount due will be listed under any one of the three available aged columns depending on the age of the item as measured from the service date to the date specified on the top of the report.
- **Billing 90+ days** - This will list only those items with a billing date that is earlier than 90 days from the date on the top of the report.

Column definitions: client

The following differences exist when dealing with a client:

1. Items are listed even if they have an **R** status if the amount received is less than the billed amount.
2. The amount in the A/R column is not the billed amount but the net of the billed amount less the amount already received from the client and applied to this invoice.
3. The **on-account** column may be used on the totals lines to evaluate the net due as the A/R amount less the on-account amount.

Client Ledger -- C-14

This report from the client ledger will print the client portion of each invoice within the designated ranges.

Selection criteria

- **Full, open or receipts only ledger** - All invoices (**F**), open invoices only (**O**) or receipts only (**R**) may be specified.
- **Service date** – A specific date or a range of dates maybe specified for the services provided.
- **Billing date** – A specific date or a range of dates may be specified for the billing cycle.
- **Receipt date** – A specific date or a range of dates may be specified for receipts.
- **Client** - A specific client or a range of clients may be determined.
- **Type of Ledger** – The client (**CL**), Medicare (**MC**), Medicaid (**MD**) or private insurance (**PI**) can be selected.

```

IMA Mental Health - Development Area Option:C14
Client ledger printing

Full, open, or receipts only ledger? (F.O.R.)
Service date - start:first      end:last
Billing date - start:first      end:last
Receipt date - start:first      end:last
Client - start:first           end:last

Type of ledger (CL,MC,MD,PI):

1 MEN EXT SCH FND REQ

```

The selection screen for the C-14Client Ledger Report.

Billing Reports – C-19

Selection criteria

1. **Type of report** - 3rd party or Client detail: A different report layout is selected and generated for each.
2. **Source of reimbursement** - Selected items may be limited to be only those associated with a single specified source of reimbursement or a combination of sources by indicating **Yes** or **No** at each field. Medicare, Medicaid and other 3rd Party payors may be selected with an additional designation for a specific 3rd party company or all other 3rd party companies.
3. **Date ranges** - Items may be limited to only those within the following designated date ranges:
 - A specified service date range from – to.
 - A specified billing date range for these services from – to.
 - A specified payment receipt date range for these services from – to.
4. **Client** - Items may be limited to a single client number or a range of client numbers.
5. **Unit/Activity/Staff**
 - Services performed within a specified unit or program or all units or all programs.
 - Services performed with in a specific activity group or a specific activity or all activity groups or all activities.
 - Services performed by a specific staff member or group of staff or all staff or all staff groups.
6. **Billing status code** - Include only items that match at least one of the status codes listed below:
 - Billed **B**

- Received **R**
 - Excluded **E**
 - Void **V** (valid only for Medicaid)
 - Denied **R** with received amount = 0.00
 - Suspended **D** (denied by payor but not yet accepted by agency)
 - Pending **P** (valid only for Medicaid)
7. **Include Items not yet billed? COPS payments? BAL invoices?** – Unbilled items (designated by a U in this report) can be selected as a billing status to include for this report. COPS payments for Medicaid invoices can be selected for inclusion in this report. Opening balance invoices may also be included in this report.
 8. **Sort options** - Three sort levels may be specified between client, activity, staff and program.
 9. **Sub-total options** - The variable that is being used for the primary and the secondary sort keys may also be specified to produce subtotals while selecting the sort keys above.
 10. The report may also be run in a **totals only option** and can be sorted by client name or number.
 11. This report can also be exported to a spreadsheet program with the appropriate set-up.

```

IMA Mental Health - Development Area  Option:C19
Billing reports
Type of report:      3rd party or client detail? (3.C)3
Source:             Medicare:Y Medicaid:Y 3rd party:Y company:all
Dates & client range:
Service date - start:first end:last
Billing date - start:first end:last
Receipt date - start:first end:last
Client - start:first end:last
Program/Activity/Staff:
Program or unit?P Program:all
Activity or group?A Activity:all
Staff or group?S Staff:all
Billing status:
Billed?Y received?Y excluded?Y void?Y denied?Y
suspended pending denial?Y pending from medicaid?Y
Include:
Items not yet billed?M
Include COPS?M Include BAL invoices?M
Sort/subtotal:
first:P/Y second:A/Y third:C #numbers (C.B.A.W):C
Totals only?M Sort client by name?Y Spreadsheet?M

1 men ext scn bpg fpg bck fwd req

```

The C-19 selection criteria for Billing Report options.

General comments relating to the report layout

- The columns in the 3rd party report are different from those of the client report.
- A summary totals section is always provided at the end of the report by source of reimbursement, program and primary sort key.
- In the totals only option, only the summary totals are presented.

- A single line in the detail section represents all the sources of reimbursement for that service, e.g. it represents the full billing data record. If any one data element in this billing record qualifies by the selection criteria, the whole record is presented in the report.
- When the report is run to include items that have not yet been billed the following applies:
 1. Only items that have not yet been billed to the primary 3rd party source are included (first in billing order). If the item has already been billed to the primary source but not to the others, it is not considered to be not yet billed.
 2. These items are shown with a status **U**. This is not an actual billing status code. It is defined here strictly for identification purposes.
 3. These items will be evaluated at the standard fee rate and summarized separately in the summary totals section at the end of the report.

Column definitions: 3rd party detail

- **Client number and name** – Each client service will be listed with detail per invoice in the defined time period.
- **Invoice number** – Each invoice will be listed separately with service date, staff from the activity record and client program.
- **Fee amount** - This is the standard fee that has been established by the agency for this activity code. It is shown in **C-21** as the insurance fee.
- ***Payor 1* (2, 3, or 4)** - Up to four column sections are shown for the maximum number of 3rd party sources for a single activity. Four data columns are provided within each of these sections:
 1. **Comp** - Company code for the reimbursement source in this section.
 2. **Expect**- The amount expected to be received from this source.
 3. **Stat** - The billing status of this item such as **B, R, P, V, E** or **D**, as defined on the previous pages.
 4. **Rcv'd** - The amount that has been received and posted against this item.
- **Sub-totals** - The **fee amount, expect** and **rcv'd** columns are subtotaled by the specified sort keys.
- **P & L** – is calculated per invoice based on the expected amount or revenue (**P**) for the service minus the cost of the service (**L**) as defined in staff statistics in **H-7**.

Column definitions: 3rd party totals

For each designated source of reimbursement and designated sort key the following columns are printed:

- **Not yet Billed** – Items designated as status **U** on the detail report.
 1. **Numbers** – Count of activities/services.
 2. **Total Fee** – The expected fee for all invoices not yet billed.

- **Billed Services** – All billed invoices for the designated time period and payors.
 1. **Numbers** – Count of those activities/services designated.
 2. **Expected** – The expected revenue form these services.
 3. **Received** – The amount received for these services during the designated time period.
 4. **Other Sources** – The total amount expected from other sources for these services.
- **Reconciliation** – Compares the Agency Standard Fee to actual revenue and cost of providing services for a Profit and Loss estimate.
 1. **Fee Amount** – The cumulative Agency Standard Fee for the services designated.
 2. **Revenue** – The total of the invoiced receipts and receivables for these services.
 3. **Cost** – The cost of these services as defined in staff statistics portion of the staff definitions.
 4. **P & L** – The Cost total subtracted from the Revenue total for a Profit and Loss estimate.

Column definition: client

This report has two sections of data columns. The first relates only to the client ledger. This includes the self pay and co-pay amounts, amount received directly from the client, write-offs and the final status of the billing for this service in terms of sweeping the balance to the client and running the client accruals. The second relates to the associated 3rd party charges for this service and how the total combined reimbursement compares to the standard agency fee for this service.

The client ledger section:

1. **Billed** - The amount billed directly to the client. In **C-21**, it is shown as the client fee. It may be generated from either a client self pay schedule or a co-pay amount in an insurance plan schedule. It may also be the sum of any one source and the amount swept into the client account as part of the sweep process in **C-5**.
2. **Woff** - This is the amount written off in **C-2** and then **C-5** or **C-6** subject to a sliding scale limit.
3. **Rcv'd** - Amount applied against this invoice. This includes actual receipts and also write-offs that have been applied to it.
4. **SWP** - Status of the swept flag for this item. It may be **N** when it has not yet been processed at all, **Y** if the item has already been swept or **B** when it was already swept and the client accrual program, **C-8**, has also been run against it.

The reconciliation section:

1. **Reimb** - Total amount that was charged to all 3rd parties that are available for billing this item.

2. **Balance** - A test number as defined above that should be close to zero. It is calculated here as **fee amount** less **allow** less **client net** less **reimb.**

C-20 – Audit Reports

Audit Reports are available for selected views of the billing and receivables data. Billing Suspense A/R Reports, Activity, Excluded and Denied Items Audit Reports, COPS and CSP Reports and Revenue Summary Reports are available. The COPS and CSP (**CO**), Denied Items (**DN**), Revenue Summary (**RS**) and Billing Suspense (**SU**) Reports will be discussed in the following sections.

C-20 CO – COPS and CSP

The **C-20 CO** report lists the Medicaid invoices with the COPS and CSP received and the designated rates for each. The selection criteria is as follows:

- Starting and Ending Activity date range.
- Starting and Ending Receipt date range.
- **Unit or Program** – A specific Unit or Program may be designated or all units or all programs.
- Totals only? Answer **Yes** for a totals report or **No** for a detail report.

```

IMA Mental Health - Development Area Option:C20-CO
Audit reports

Starting activity date:01011998      Ending activity date:03311998
Starting receipt date:first          Ending receipt date:last
Unit or program? (U.P)P Program:all

Totals only? (Y.N)N

Ready to continue? (Y.N)

1 men ext bck req

```

The selection screen for the COPS and CSP Report in C-20 CO.

The columns for the report are as follows:

- **Client** - Name and Number.
- **Invoice** – Number of the invoice.
- **Activity date** – Date of service.
- **Basic Rate** – The basic rate for the service expected contracted and from Medicaid.
- **Basic Received** – The amount of that basic rate received from Medicaid.
- **COPS Received** – The amount of COPS payment received for that invoice.

- **CSP Received** – The amount of CSP payment received for that invoice.
- **COPS Rate** – The contracted COPS Rate with Medicaid.
- **CSP Rate** – The contracted CSP Rate with Medicaid.
- Totals are provided per program with a grand total at the end.

C-20 DN – Audit of Denied Items

The **C-20 DN** report provides analysis on denied invoices with statuses of Denied and Received 0. Denied items are those items that are suspended until some designated error is corrected and the bill can then be resubmitted. Received 0 invoices are those that have 0 in the last line of the invoice for the designated payor and there is another third party payor to bill. If there is not another third party payor, the invoice is not listed on this report.

The selection criteria is as follows:

- Starting and Ending Activity date range.
- Starting and Ending Billing date range.
- **Unit or Program:** A specific unit or a specific program or all programs or all units.
- Starting – Ending Client.
- Include status: **Denials**, **Received = 0** or **Both**.
- **Plan or Plan Group:** A specific plan or a specific plan group or all plans or all plan groups.
- Error code: A specific error code or all error codes.
- Totals only? Answer **Yes** for totals only report or **No** for a detail report.

```

      IMA Mental Health - Development Area  Option:C20-DN
      Audit reports

Starting activity date:01011998      Ending activity date:01311998
Starting billing date:01011998      Ending billing date:01311998

Unit or program? (U,P)P Program:AT  ACMHC Adult Treatment Program
Starting client:first      Ending client:last
Include denials, received=0, or both (D,R,B):B
Plan or plan group? (P,G)P Plan (MC,MO,PI,<plan>):all
Error code (code,R=0):all

Totals only? (Y,N)M

      1  MEN EXT  BCK  FWD  DEF  REQ
  
```

The selection screen for the C-20 DN Report on Denied Items.

The columns for the report are as follows:

- **Client** - Name and Number.
- **Comp** – Insurance company code.
- **Sequence** – Sequence number for client invoice for program for payor.

- **Service date** – Date of activity.
- **Billing Date** – Date billing batch created.
- **Error Codes** – Error codes from designated invoice.
- **Expected Amount** – The expected amount to be received from this payor.
- **Next Bill** – Invoices marked as Received = 0 and are moving to the next payor.
- **Research** – Invoices in Denied status with errors for resolution.
- **Older than 90 Days** – Total amounts for invoices older than 90 days in corresponding column.
- **Older than 1 year** – Total amount for invoices older than 1 year.
- **Older than 2 years** – Total amount for invoices older than 2 years.
- **Client Total** – Total amount expected on this invoice for this client.

For reports run with detail, totals are determined for each program and/or unit. Errors are also totaled per program and/or unit and then for all errors. The columns on the totals pages are the Expected Amount, Next Bill, Research, 90 Days +, 1 Year + and 2 Years + as defined above. The final Number column indicates the count of services that the line represents.

C-20 RS – Revenue Summary Report

The Individual Plan Performance Report/Plan Payment History Report provides analysis of each invoice. The client's billing header is compared against the billing information to determine the invoice's status by payors. This report is run for revenue analysis by individual plan performance.

The selection criteria is as follows for the Individual Plan Performance Report/Plan Payment History Report:

- Starting and Ending Service date range.
- **Program, Unit, Organization or Area:** A specific program, unit, organization or area or all programs, all units, all organizations or all areas.
- **Plan or Plan Group:** A specific plan or plan group or all plans or all plan groups.
- **Staff:** A specific staff member or all staff members.
- **Sort for page break:** **Date, Staff, Unit, Program, Organization or Area.**
- **List by PPlan or Plan Group.**
- **Include COPS and CSP in A/R? Yes or No.**
- **Totals only? Answer Yes for a totals only report or No for a detail report.**

```

IMA Mental Health - Development Area Option:C20-RS
Audit reports

Starting service date: first      Ending date: last
Selection
(P)rogram, (U)nit, (O)rganization, (A)rea:P
    Program:all
(P)lan or plan (G)roup:P
    Plan (MC,MO,<plan>):all
    Staff:all
Sort
Sort for page break:P           List by p(L)an or plan (G)roup:L
Include COPS and CSP in A/R? (Y,N)Y

Totals only? (Y,N)N
Use <def> for first date

      B men ext scn  bck fwd def  req

```

The selection screen for C-20 RS Individual Plan Performance Report/Plan Payment History Report.

The columns for the report are as follows:

- **Client** – Number.
- **PRG** – Code of client program enrolled in.
- **Staff** – Staff code from invoice/service provider.
- **Invoice Number** – The number of the invoice.
- **Service Date** – The activity/service date from the billing record.
- **ACT** – Activity code from invoice/service provided.
- **NUM CLTS** – Unique clients, more meaningful in summary numbers and totals.
- **NUM INV** – Number of invoices, more meaningful in summary numbers and totals.
- **Not Billed** – Agency Standard for invoices that have not yet been billed. Invoices waiting to be re-billed will also show-up in this column.
 - **Num** – Number of invoices not billed.
 - **Dollars** – Agency Standard dollars contained on invoices not billed.
- **A/R** – Expected amount from payor that has been billed, but no reply has been recorded from payor.
 - **Num** – Number of invoices that have been billed with no response from payor.
 - **Dollars** – Dollar amounts expected from payor.
- **Received** – Payor has paid this invoice and this column shows the received amount. Included invoices will be those that are received greater than 0 and those where received and expected are both 0.
 - **Num** – Number of invoices that have been paid.
 - **Dollars** – Amount received for invoice.

- **Denied** – This includes those invoices that are suspended Denied for error correction, and those where received = 0. The amount is the expected amount from the payor.
 - **Num** – Number of invoices that have been denied.
 - **Dollars** – The expected amount from the payor.
- **Excluded** – Invoices that have been excluded from a payor
 - **Num** – Number of invoices that have been excluded.
 - **Dollars** – The amount represented by the excluded invoices.
- **Co-Pay** – Invoices that have co-pays from all invoices counted.
 - **Num** – Number of invoices that have a co-pay.
 - **Dollars** – Depends upon status: for those billed, the expected amount is shown and for those received, the receipt amount is shown.
- **Other Sources** –The invoices that have also received monies from other sources.
 - **Num** – Number of invoices that also have received payments from other sources.
 - **Dollars** - Depends upon status: for those billed, the expected amount is shown and for those received, the receipt amount is shown.
- Totals are provided per sort criteria and payor with final grand totals.

C-20 SU – Billing Suspense A/R Report

The **C-20 SU** Report lists the invoices with M errors which are put into suspense and await correction, so that they can return to the billing cycle. The selection criteria for this report is as follows:

- Totals only? Answer **Yes** for a summary report or **No** for a report with detail.
- **Unit or Program?** A specific unit or program may be designated or all units or all programs.
- **Source** – A specific source (**MC, MD, PI**) may be specified on which to report or all sources.
- **Starting and Ending Date** range for the activities invoiced.
- **Error code** – A specific error code or all error codes may be selected.

```

                                IMA Mental Health - Development Area  Option:C20-SU
                                Audit reports

Totals only? (Y,N)N
Unit or program? (U,P)P  Program:all
Source (MC,NO,PI):all
Starting date:01011998  Ending date:03311998
Error code:all

Ready to start the report? (Y,N)N
                                1 Men ext bck req

```

The selection criteria screen for the Billing Suspense A/R Report in C-20 SU.

The columns for the detail report are as follows:

- **Client** – The client number and name.
- **Date of Service** – Date of the service provided.
- **Transaction** – The number of the transaction from the billing record.
- **Error Codes** – The M Errors that prevent this bill from being generated at this time.
- **Suspense** – The items placed in suspense for the current year and the past year, respectively.
 - **Current** – In suspense for less than one year.
 - **Past Year** – In suspense for more than one year.
- **Received Amount** – The total amount received on this invoice from all sources.
- **Current** – The total amount in suspense that is current/less than 30 days.
- **30->60** – The total amount in suspense between 30 and 60 days.
- **61->90** – The total amount in suspense between 61 and 90 days.
- **90+** - The total amount in suspense that is over 90 days.
- **Client Total** – The total of all suspended invoices for each client.

The report also prints sub-totals per page and per designated payor and program. A summary for programs, error codes by programs and all errors is also presented at the end of the report.

Managed Care Specific Items

There are various components to address when dealing with managed care insurance companies. These elements include client authorization, varying co-payment amounts and detailed reporting functions.

Client Authorization

Authorization necessary for managed care companies is documented in **A-1 VA**. In this screen the authorization code, effective dates for authorization, number of visits allowed and frequency of this visit type are entered. The frequency for this authorized visit can be daily, weekly, bimonthly, monthly or unlimited. The number of visits already used by the client is calculated by the system, but can also be adjusted manually if necessary. Under each authorization line there are also fields to enter any limited authorized CPT codes, as well as any designated provider type of the staff member who can render services. Authorized visits that can be provided for all codes or for all providers without restrictions can be designated by leaving these fields blank.

Whenever a client visit is being scheduled or when recording billing entries, the system will check that the authorization is withstanding. Warning messages will appear on the screen if visit numbers exceed authorized limits. The system will also find the client records whose authorization is close to expiration when the **C-26 TK** report is run. On the bottom of the **A-1 VA** screen there are fields to flag, defining when notification should take place. It can be by a certain number of days or visits before expiration. Initially, these fields are pre-filled by the numbers entered in the insurance company definition for this managed care company, but they can be changed in this screen, if desired.

When the authorization is close to expiration by time or when the number of authorized visits comes within the reauthorization number specified, a request for extension needs to be issued to the plan. The **C-26 TK** report will list all the items that require such requests. Issued requests are recorded in **A-1 ER**. For each item entered, the status code is changed to **R** and the status date is adjusted to reflect the entered date. When reauthorization is received they are entered in **A-1 EA**.

```
IMA Mental Health - Development Area Option: A1 -VA
Client data
Client: 2651 Unique ID: CLIENT010565F0 Client, Test

Status Authorization Authorization #
08/15/97 TC2651y I 06/30/97 12/31/97 25 W 25.00 01
CPT:
12/15/97 TC2651yy E 01/01/98 03/31/98 18 W 18.00 01
CPT:
03/15/98 TC2651yyy E 04/01/98 09/30/98 30 W 5.00 01
CPT:
CPT:
CPT:
Termination initiated: Terminated:
Reauthorization in visits: 4 Reauthorization in days: 2

7 men ext scn bpg fpg hlp bck fwd
```

The managed care authorization screen at A-1 VA.

Reporting

A specific set of reports relating to managed care coverage is available under **C-26** as follows:

1. **Managed Care Ticklers (TK)** - This report can be used to find all clients who are due for authorization for all or one specific managed care company. It can also be used generally to find all clients who have managed care coverage. The report can be sorted in a variety of ways, as selected.
2. **Client Coverage List (CV)** - This report will track all client reimbursement. It can be run on one specific reimbursement source or all. It also has the capability of finding only primary sources of coverage, if desired.
3. **Service and Revenue Analysis (BL)** - This is a detailed analysis report that will average the bill amount per visit based on the criteria selected. It will also find the frequency distribution of visits over various breakdowns in time.

Code Switching

There are times when the same activity needs to be referred to by different activity codes in different situations. In all of these cases, the system will be able to carry through code switching based on data files which are created in **H-12 MC**. Layout of these files will be explained below. Code switching can occur in the following cases:

1. Managed care co-pay amounts vary by visit number. Once a specific visit number is reached the system will process this same activity as a different activity code with a different fee schedule attached to it. In the **A-1 VS** screen there is a managed care visit to date look-up screen. This is where the system keeps track of the number of visits already used up for each client. If used visits need to be back-filled, it can be done in this screen.
2. There are times when managed care company coverage differs based on staff member provider type. In this case, the company needs to be billed with a new CPT code. Again, the way to address this is by code switching from one activity to a new activity with the appropriate codes.
3. There are managed care companies that may always need to be billed with a special set of CPT codes. An example of this may be the case of Medicaid-Managed care clients when Medicaid requires billing with a new CPT code.

Managed Care Data Files

Every managed care insurance company defined in the system that needs to have code switching must have its own data file defined. Files already made can be seen by pressing the <hlp> key at the prompt '**Insurance plan:**' prompt in **H-12 MC**. All files will have an **.XLT** extension and are edited in the chosen text editor. The first useful line in the file will hold the number of lines that follow. Each activity code that needs to be code switched will be on its own line. On that line, four pieces of data are required: old activity code, visit, staff provider type and new activity code. Visit determines the number of visits after which the new code needs to take effect. Provider type specifies the code of the provider type that should trigger the switch. In cases where code switching needs to occur for all instances of visits, provider types or both of these, an asterisk can be placed in the appropriate corresponding field.

For example, in the file shown below the first line specifies that up to 11 visits, AND if the provider is a psychiatrist, change the 01 activity code to a 001. Line 2 specifies a similar switch for all other provider types.

```
IMA Mental Health - Development Area Option:H12-NC
Edit control files

File /u/wh.deu.sco.admindata/P-AETM.XLT
! File to translate activity codes for Managed care for plan AETM
! Starting Month for plan year
2
! Old act.(+).visits(+).staff provider type(+).new activity
01.11.1.001
003.3.+001
```

120 x 1000 mem ext

Managed Care code switching data file.

Special Billing Scenarios

There are a number of programs that require special handling by the billing system. The implementation of these programs is explained below.

Continuing Day Treatment

Continuing Day Treatment billing has two primary features that differentiate it from regular outpatient billing. The IMA Workbench handles each of these:

1. Monthly hours - Medicaid billing requires those rate codes to change as the client reaches a certain number of program service hours per month. Billing for more than 50 hours in the month switches rates. The rates shift again when the client surpasses 80 hours.
2. Daily consolidation - The client might receive many services during a particular day. However, for billing, only a single invoice is generated for that day with the total number of hours of the services provided during the day.

Case Management Services

In order to bill for a month of case management services, a specified number of face to face contacts must occur. A special report is available that can be set up for each case management program. This report will look for the specified number of services for a given month and list either all those clients who have the required number of contacts, or only those that do not yet have the required number of contacts.

The report for this is the Restorative Services Report at **G-6**. The set-up file for this report is **RESSRV.DAT**.

Residential Services

This billing is very different from the standard outpatient model. It requires daily attendance, and tracking of the specific services received during the month.

Article 16 Clinics

The special feature needed for billing for Article 16 clinics is that the diagnosis is specific to the visit that is being billed. Standard billing uses the diagnosis that is in the client's program enrollment record. If a program is identified as an article 16 program, a diagnosis can be entered when each visit is posted. The list of Article 16 programs is in the file **A16PRG.DAT**.