DAUPHIN COUNTY MH/MR PROGRAM
POLICY AND PROCEDURE

Department  

\[ \text{MH} \quad \text{MR} \quad \text{Admin} \quad \text{Crisis} \]

Policy No. 02-08

Effective Date July 1, 2002

Revision Date

Approved

Note: This policy, together with Policy Number 02-09 titled Program Funding Billing, replaces Policy Number 98-08 concerning claims for services rendered.

Title: Fee-for-Service Billing

Policy: The Dauphin County MH/MR Program will process and pay claims on a fee-for-service basis according to established procedures. Claims for services rendered must contain all required information for payment to occur.

Definitions: Services Rendered Invoice (SRI) form – see form attached

Claim/Invoice Rejection Notice form – see form attached

Procedure:

1. A Services Rendered Invoice form (SRI – see attached) has been developed by the Dauphin County MH/MR Program for use by providers to invoice the County Program for consumer specific services. The Provider may develop their own form as long as their form clearly provides all of the required elements. The County Program will consider alternative methods of fee-for-service billing on a Provider specific basis.

2. It is the responsibility of the Provider to ensure that all required information is included when submitting an invoice to the County Program for payment.

3. The Provider must submit invoices to the County Program by the 15\textsuperscript{th} of the month following the month that the service was provided with the exception of Waiver bills, which are due to the County Program by the 10\textsuperscript{th} of each month. All invoices must be sent to the attention of the MH/MR staff contact that is identified on the Contract Appendix A.
4. Providers should contact the MH/MR Fiscal Office at 780-7050 for instructions on submitting Intensive Case Management (ICM), Resource Coordination (RC), Family-Based (FB) invoices, and all invoices submitted electronically.

5. When a Provider submits an invoice for payment, either electronically or hard copy, each claim will undergo some or all of the following integrity checks: duplicate claim, valid authorization, number of units, unit rate, third party coverage, provider and program number, month/year of service, status of Provider contract, authorized signature, etc.

6. If any of the above integrity checks fail, the claim may be returned to the Provider with a Claim/Invoice Rejection Notice form (see attached) for resubmission. The form will state the reason for the rejection. It is the Provider’s responsibility to correct the claim and to re-bill. The Provider must re-bill within 30 days of receiving the rejection notice. Claims re-submitted beyond the 30 day limit may not be paid. The June 30 fiscal year end billing deadline is July 31. Any bills (or re-bills for previously rejected claims) submitted after August 15 may not be paid.

7. Dauphin County MH/MR may at its discretion correct a claim and notify the Provider of the corrections that need to be made on future billings. In these instances, it is the Provider’s responsibility to correct their records or to notify the County Program if they disagree with the County Program’s determination. Additionally, in these instances, the Provider should not resubmit the claim.

8. When a claim is rejected due to lack of authorization, it is the Provider’s responsibility to secure the authorization from the CMU and re-bill. A copy of the authorization must be attached to the re-bill. When a claim is rejected because the consumer has another third party coverage, a copy of the third party rejection must be attached to the re-bill.

9. The Dauphin County MH/MR Program provides instructions to providers that describe the parameters for authorizations. It is the Provider’s responsibility to bill for authorized services only when a MH/MR authorization for service is required.

10. Instructions for the completion of the Services Rendered Invoice are as follows (the letters below correspond to lettered fields on the attached Sample Services Rendered Invoice):

   A. Provider Number – As identified on the Contract Appendix A.

   B. Program Number – As identified on the Contract Appendix A – only one program number per page is permitted.

   C. Unit Rate – As identified on the Contract Appendix A.

   D. Provider – Provider name.

   E. Program – Description of the program as identified on the contract Appendix A.

   F. Unit of Service – The description of the unit per the Appendix A, i.e., Quarter
Hour.

G. Month – Number of the calendar month that the services were performed – only one month per page is permitted.

H. Year – The calendar year that the services were performed.

I. Number – Provider generated number - this number will be entered as the invoice number into the system (Optional).

J. Waiver ID – Number assigned by MH/MR for Waiver Services only.

K. Name – Client full name – last name first.

L. BSU number – The six digit number assigned by the CMU.

M. Begin Date of Service – List the first day of the month that the client received services. For continual services such as residential the date would be the first day of the month, i.e. July 1.

N. Service date – Required when the actual date of service must be billed (i.e., outpatient, early intervention services).

O. Discharge date – Enter the last date of service only when the client has been officially discharged for that specific service by the Provider.

P. Units – Actual units of service provided.

Q. Total Cost – The Unit Rate times the Units must equal the Total Cost.

R. Revenues – Include all revenues from other sources – enter description.

S. Due from the County – Calculation of Total Cost minus Revenues.

T. Contact – Person completing the bill who can be contacted for questions.

U. Phone number – Contact’s phone number.

V. Provider signature, title, date – Provider’s certification that the services have been rendered and that the billing is accurate to the best of the Provider’s knowledge.
SERVICES RENDERED INVOICE (SRI) - SAMPLE

<table>
<thead>
<tr>
<th>PROVIDER #: (A)</th>
<th>PROGRAM #: (B)</th>
<th>UNIT RATE: (C)</th>
<th>PROVIDER: (D)</th>
<th>PROGRAM: (E)</th>
<th>UNIT OF SERVICE: (F)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME:</th>
<th>BS#</th>
<th>BEGIN DATE</th>
<th>SERVICE</th>
<th>DISCHARGE</th>
<th>TOTAL</th>
<th>REVENUES</th>
<th>REVENUES</th>
<th>DUE FROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>(K)</td>
<td>(L)</td>
<td>(M)</td>
<td>(N)</td>
<td>(O)</td>
<td>(P)</td>
<td>(Q)</td>
<td>(R)</td>
<td>(S)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONTACT:</th>
<th>NUMBER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(T)</td>
<td>(U)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIGNATURE:</th>
<th>TITLE:</th>
<th>DATE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(V)</td>
<td>(V)</td>
<td>(V)</td>
</tr>
</tbody>
</table>

MONTH: (G) NUMBER: (I) YEAR: (H) WAIVER ID: (J)
CLAIM/INVOICE REJECTION NOTICE

DATE: January 31, 2003   PROVIDER:   ATTENTION:
FROM:   PHONE:
E-MAIL:

The attached claim/invoice(s) is being denied payment for the following reasons:
☐ Clients eligible for third party coverage (MA, Blue Cross, Other)

If, in the process of billing a third party for the above services, the carrier rejects your invoice, kindly attach a copy of the rejection to the invoice and re-bill Dauphin County MH/MR for the payment.

☐ Service not authorized*
☐ Client Unknown to MH/MR System
☐ Child is not age eligible
☐ Claim/Invoice incomplete, or incorrect (see below)
☐ Duplicate Claim/Invoice
☐ Service date not within authorized period*
☐ Waiver ID missing
☐ Exceeds contract CAP
☐ Units exceed authorization

*INQUIRIES SHOULD BE DIRECTED TO THE CASEMANAGEMENT SUPERVISOR

MISSING OR INCORRECT

☐ Provider Number ☐ BSU #
☐ Provider Name ☐ Total Units per Client
☐ Provider Phone # ☐ Total Fee per Client
☐ Provider Contact Person ☐ Revenue Source per Client
☐ Program Name ☐ Revenue Amount per Client
☐ Program # ☐ Total Units—All Clients
☐ Date of Service ☐ Total Fees—All Clients
☐ Month of Service ☐ Total Revenue—All Clients
☐ Year of Service ☐ Total County Due—All Clients
☐ Unit of Service ☐ Incorrect Rate (please refer to your Appendix A
☐ Begin Date of Service ☐ Other:

Provider has the right to appeal claim within 30 days of the receipt of this notice

Revised 11/06/02

J/FISCAL/MANUAL SECTION/FORMS/Claim Rejection