



MONTHLY RES HAB – WHEN CAN YOU SUBMIT INVOICES FOR THE MONTH?

I wanted to mention this because last month several providers called inquiring whether invoices could be submitted on the 23rd of the month. I think there were even some emails being passed around that appeared to have been generated from APD giving the impression that it was okay to submit monthly res hab prior to the 24th of the month. In April, the 24th fell on a Saturday, which meant that providers could not submit invoices until Monday the 26th, making the payment date May 6. However, if providers were able to submit on the 23rd, payment date would have been April 29 (a week earlier). I definitely get where providers are coming from, wanting to get paid a week earlier...unfortunately it's not allowed.

According to the Handbook, the monthly res hab rate covers **a minimum** of 24 days per month. As you are all aware, if a resident is in your facility **less than 24 days**, a daily rate authorization must be approved in order to bill for that month.

Medicaid guidelines state that services cannot be billed until they are **completed**. Unfortunately, in this case, services are **NOT** completed on the 23rd and it would be against Medicaid guidelines to submit invoices on the 23rd. Unfortunately the fiscal agent does not have this information in their system and would allow payment if the claim was submitted on the 23rd. HOWEVER...just because the claim will pay, doesn't mean it's okay.

As you are all aware, Medicaid Program Integrity is conducting random audits of providers going back 5 years. This is definitely an issue that would be discovered by MPI...maybe not today or tomorrow, but at some point, which would most likely result in recoupment. As your billing agent, we must comply with Medicaid guidelines and submit claims accordingly.

Here is a perfect example to contemplate...If you did PCA on Saturday, you wouldn't submit an invoice for those services on the Friday before. Res hab is the same thing because the rate is set up for a **minimum of 24 days/month** so billing after only 23 days would be considered billing before the service was completed.

Feel free to contact your local APD office for further clarification.

PCA FOR CLIENTS 21 AND UNDER

It looks like this is finally here! It appears that all PCA for clients 21 and under will be billed directly to the Medicaid State Plan effective 7/1/10.

We are attending the training in our area this month and will be ready to bill directly when needed. However, I would highly suggest providers attend the training in their areas because if the approval process is through the Keypro system like it is anticipated, providers may be forced to obtain their own authorizations. I'll email more info after attending the training in our area.

ARE YOU RECEIVING YOUR REMITTANCE VOUCHERS IN THE MAIL?

Many of you have mentioned recently that you have not been receiving your remittance vouchers in the mail. Remember that these are your payment records and it is important to retain copies for audit purposes.

All of you are signed up for the webportal so the vouchers are available online. There are approximately 3 months of vouchers available at any given time. We do realize that the majority of you never go online since we are doing your billing. However, please note that we do not, and cannot possibly, pull the vouchers for every provider. We can pull them when there is an issue, but do not do this on a regular basis nor do we retain copies.

We encourage all providers to login to the webportal and print their vouchers for each payment. If you are uncomfortable with this process, we suggest you contact EDS and request that your vouchers be mailed to you. Remember that once the vouchers are removed from the webportal, you have to request copies from EDS and they charge \$.50 per page.

2010-2011 BUDGET

Looks like the managed care bill did not pass this session! YEA!! I'm sure though that it will be something that is presented each year so it will be an ongoing fight.

Key highlights of the new budget:

- ⇒ The budget passed in HB 5001 totaled \$1.013 billion in funding for APD. Of that total budget, \$805 million will go toward the Medicaid waiver.
- ⇒ The agency's conforming bill to the budget specifies that APD has deemed the Individual Cost Guidelines (ICG) and the Questionnaire for Situational Information (QSI) as reliable and valid assessment instruments to be used in determining individual tier placements.
- ⇒ Age is a client characteristic to be used in the tier placement process as well.
- ⇒ Tier 1 expenditures are capped at \$150,000 per client each year. However, expenditures for clients in Tier 1 with a documented medical necessity requiring intensive behavioral residential habilitation services, intensive behavioral residential habilitation services with medical needs, or special medical home care, as provided in the *Developmental Disabilities Waiver Services Coverage and Limitations Handbook*, are not subject to the \$150,000 limit on annual expenditures.
- ⇒ **Due to a provider rate cut of 2.5%**, the caps of Tiers 2, 3 and 4 are reduced 2.5%. Tier 2 will go from \$55,000 to \$53,625, Tier 3 from \$35,000 to \$34,125 and Tier 4 from \$14,792 to \$14,422.
 - Support coordination, transportation, DME, CMS and therapies are excluded from the rate cut.
 - The tier reduction is to the cap, not the total dollar amount being used. For example, if your client is on Tier 4 but only using \$10,000 in services, there would be no reduction in services.
- ⇒ Behavior assistant services will continue in group homes.
- ⇒ The geographic rate differential paid in Palm Beach, Broward, Dade and Monroe counties will continue.
- ⇒ The creation of section 393.0622 in Florida Statutes establishes the iBudget Florida system and specifies allocation methodologies, a phase-in process for enrollment, training, and education to inform individuals on the iBudget system, and an evaluation process for the implementation of iBudget.
- ⇒ Hearing rights are defined for Medicaid programs administered by APD. Any developmental services applicant or client, or his or her parent, guardian advocate, or authorized representative, may request a hearing in accordance with federal law and rules applicable to Medicaid cases and has the right to request an administrative hearing pursuant to sections 120.569 and 120.57. These hearings shall be provided by the Department of Children and Families pursuant to section 409.285 and shall follow procedures consistent with federal law and rules applicable to Medicaid cases.
- ⇒ The Services for Children with Developmental Disabilities Task Force is created to make recommendations and develop a plan for the creation of, and enrollment in, the Developmental Disabilities Savings Program.

PLEASE REMEMBER providers should be reviewing the remittance voucher to ensure that the claims were processed correctly and paid in full. If there are any discrepancies, contact us immediately rather than waiting for the error to be discovered in an audit.

If you are unsure how to pull your voucher and think your payment was not accurate, just give us a call. We can pull your voucher and research the issue.



Do we have your correct contact info?

Regular Office Hours

Monday-Thursday 8:30-4:30 pm / Friday 8:30-11:00 am

Holiday Hours

Monday, May 31, 2010 closed for Memorial Day

Monday, July 5, 2010 closed for 4th of July