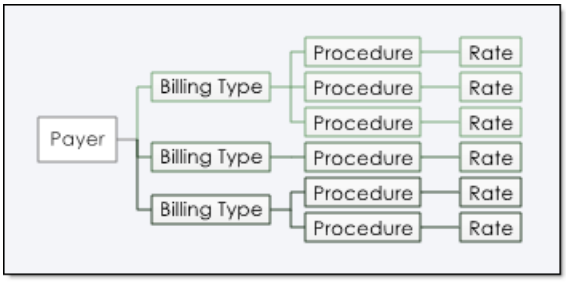
BillingBuilder Setup

AWARDS INSTRUCTION SHEET

The AWARDS BillingBuilder feature (located in the Fiscal/Program module) enables users to bill payers for services provided to clients and recorded in AWARDS. Payers can include Medicaid, Medicare, private insurances, self-paying clients, or any other third-party payer that accepts the 837I or 837P electronic billing file, HCFA paper claim forms, or printed invoices.

Prior to using the BillingBuilder for billing processing, you must complete several setup steps, including configuration of the payers your agency bills to, as well as configuration of billing types, procedures, program billing groups, program billing information, and rates.

This diagram illustrates the relationship between some of the billing setup components, each of which will be discussed in more detail later in this document.



REQUIRED PERMISSIONS

The BillingBuilder is accessed from within the Fiscal/Program module. Access to that module and feature are limited to users with the following permissions:

- Data Entry / Access – Unless you are a member of the Fiscal Staff or Executive Officer user groups, you must have the "Display Executive Administration Buttons" and "Display Fiscal Buttons" permissions.

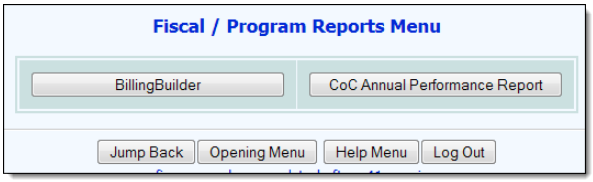
ABOUT THIS DOCUMENT

This document is intended to guide you through the seven-step process of setting up the AWARDS BillingBuilder so that it may be used for processing. Specific topics covered are:

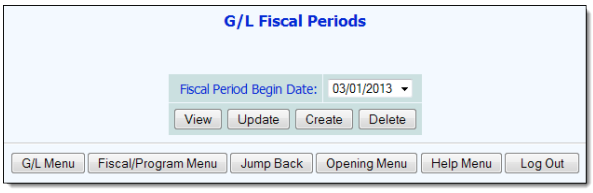
Information on the processing component of the BillingBuilder is not included in this document. For more information on processing see the "BillingBuilder Processing" instruction sheet available in Online Help.

STEP 1: CONFIGURE FISCAL PERIODS

The first step in the BillingBuilder setup process is configuring fiscal periods. To configure a fiscal period, complete the following steps:



1. From the *AWARDS Opening Menu* page, click **Fiscal/Program**. The *Fiscal/Program Reports Menu* page is displayed.



2. Click **BillingBuilder**. The *BillingBuilder Menu* page is displayed.
3. Click **Fiscal Periods**. The *G/L Fiscal Periods* page is displayed.

4. Click **Create**. The *G/L Fiscal Periods* data entry page is displayed.

   The Fiscal Period Begin date on this page defaults to the next fiscal period from the latest that exists.

5. Click the **Open to Entry** drop-down arrow and select "Open" so that transactions can be posted to the fiscal period.

   *If a previous fiscal period is to be closed, or locked down, select that fiscal period on the previous page and click **Update**, then select "Closed" from the **Open to Entry** drop-down list.*

6. Click **Save**. The fiscal period is saved and a confirmation message is displayed on the updated *G/L Fiscal Periods* selection page.

The process of creating a fiscal period is now complete.

*If it is later necessary to update or delete a fiscal period, complete steps 1 through 3 above, select the appropriate period from the Fiscal Period Begin Date selection list and then click **UPDATE** or **DELETE**, respectively.*

STEP 2: CONFIGURE PAYERS

The second step in the BillingBuilder setup process is configuring payers. Payers include Medicaid, Medicare, private insurances, self-paying clients, or any other entity from which your programs receive payments for services provided.

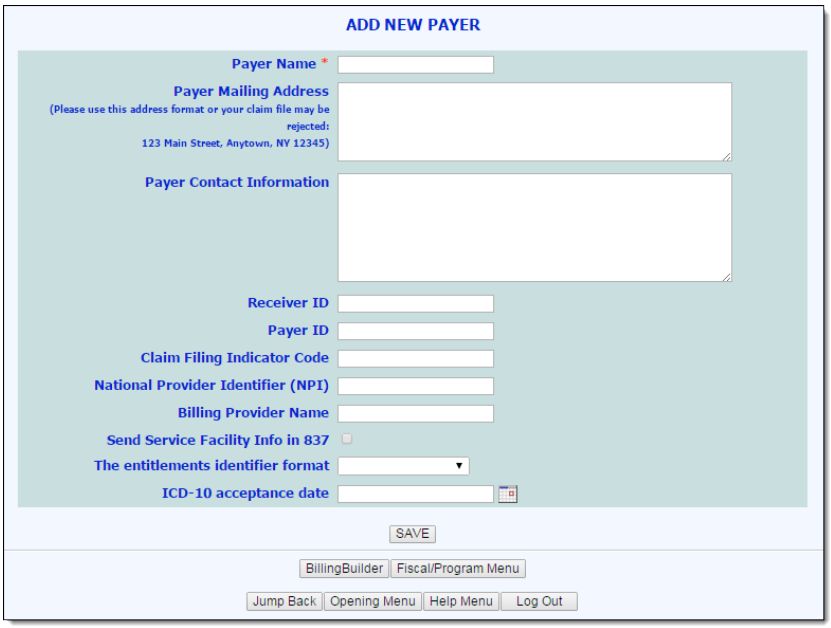
To configure a new payer, complete the following steps:

1. From the *AWARDS Opening Menu* page, click **Fiscal/Program**. The *Fiscal/Program Reports Menu* page is displayed.

2. Click **BillingBuilder**. The *BillingBuilder Menu* page is displayed.

3. Click **Configure Payers**. The *Configure Payers* page is displayed.

4. Click **ADD NEW PAYER**. The *ADD NEW PAYER* page is displayed.



5. Configure the fields and options on this page as follows:

   - **Payer Name –** In this field type the name of the payer; for example, "Medicaid." Be sure to enter the name carefully, as once saved it cannot be changed.

     If the payer is actually the client receiving the service, the Payer Name should be entered as "Self Pay."

   - **Payer Mailing Address –** In this field type the payer's mailing address.

   - **Payer Contact Information –** In this field type the payer's contact information.

   - **Receiver ID –** In this field type the receiver ID. This is an ID number belonging to the insurance company or payer.

   - **Payer ID –** In this field enter the payer's ID number. If nothing is entered here the receiver ID will be used as the payer's ID as well as the receiver ID.

   - **Claim Filing Indicator Code –** In this field type the code to submit in the 837 claim file. If no data is entered, AWARDS will submit the code as follows:

     - **MB –** If the payer is Medicare
     - **MC -** If the payer contains Medicaid
     - **ZZ –** If the payer starts with Tenncare
     - **BL –** If the payer contains "Blue" or contains "BC/BS"
     - **CH –** If the payer contains "Champus"
     - **16 –** If the payer contains "Healthfirst"
     - **ZZ –** for all other payer names

- **National Provider Identifier (NPI) –** In this field type the national provider identifier number. This is the agency's identifier for the insurance company or payer.

  If your billing is atypical, please contact your Foothold billing representative to ensure proper setup. In this case, you may not have an NPI.

- **Billing Provider Name** – If it is necessary to send this information in box 33 of the HCFA 1500 claim form, enter the agency name in this field. If left blank, the default (agency name seen at the top of the Opening Menu screen) will be used.

- **Send Service Facility Info in 837** – Click this check box to send Service Facility Information in the 837I and/or 873P electronic claim file. The Service Facility Information data (address, city, state, zip code) is pulled from the System Setup > Agency Program Information > Address/Contact Information tab for a program. The Service Facility NPI data is pulled from the BillingBuilder > Program Billing Info > Service Facility NPI field.

- **The entitlements identifier format –** Click this drop-down arrow and make a selection to indicate whether the entitlements identifier format should be "numbers," "letters," or "numbers and letters."

  The entitlements identifier format set here will determine which format can be used when entering ID numbers using the Entitlements module Certified Entitlements feature. For example, if "numbers" is selected and users enter letters in an entitlement's ID field, they will receive an error and the information will not be saved.

- **ICD-10 acceptance date –** This option can be used to indicate when the payer will accept claims to be submitted using ICD-10 diagnosis codes. The valid date range is on or between 1/1/14 - 10/1/14.

6. Click **SAVE**. The payer information is saved and displayed on a confirmation page. Additionally, the payer name is automatically added to the list of eligibility types found in the Entitlements module Certified Entitlements feature.

7. Click **Back to Payers List**. The *Configure Payers* page is displayed, and the payer you have just added will be found in the Payer selection list found there.

8. Repeat steps 1 through 7 until all payers have been added.

The process of configuring payers is now complete.

*If it is later necessary to update or delete a payer, complete steps 1 through 3 above, select the appropriate payer from the **Payer** selection list, and then click **UPDATE** or **DELETE**, respectively. Keep in mind:*

- ***When updating** - The payer name cannot be changed but all other payer detail can be updated as needed. If any changes are made, you must be sure to click **SAVE** to have those changes applied.*

- ***When deleting** - A payer can only be deleted if there are no billing types, procedures, rates, or programs associated with it. If you choose to delete a payer with which none of those items are associated, you will be shown a confirmation page after clicking **DELETE**. Be sure to click **OK** on that page to complete the deletion process. Once deleted, a payer cannot be restored.*

STEP 3: CONFIGURE BILLING TYPES

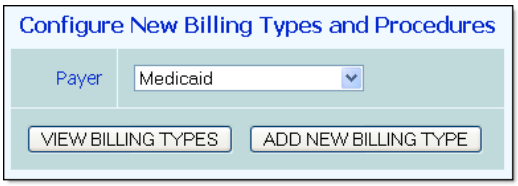
Once payers have been added to the system, billing types must be configured for each of them. In general, billing types correspond to different types of services. Keep in mind while completing this step that in some cases a single payer will need to have multiple billing types set up for it. (For example, Medicaid pays for clinic services and day treatment services, each of which would need to be configured as a separate billing type for Medicaid.) Also note that while multiple payers may have the same billing type, that type must be set up separately for each.

To configure a new billing type, complete the following steps:

1. From the *AWARDS Opening Menu* page, click **Fiscal/Program**. The *Fiscal/Program Reports Menu* page is displayed.

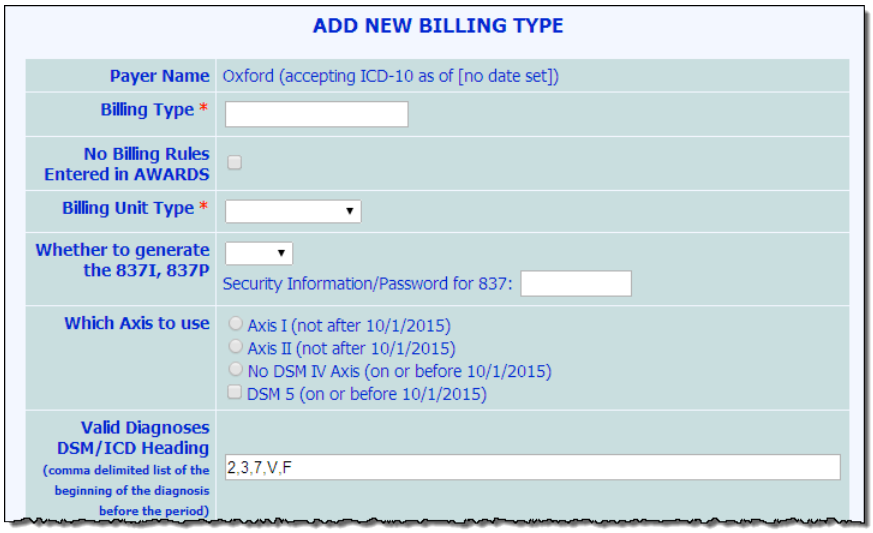
2. Click **BillingBuilder**. The *BillingBuilder Menu* page is displayed.

3. Click **Configure Billing Types**. The *Configure New Billing Types and Procedures* page is displayed.



4. Click the **Payer** drop-down arrow and select the appropriate payer.

5. Click **ADD NEW BILLING TYPE**. The *ADD NEW BILLING TYPE* page is displayed.



6. Configure the fields and options on this page as follows:

   IMPORTANT! *In order to complete a claim successfully, the Whether to generate the 837I, 837P, Sender ID/ETIN, Agency Tax ID, and Sender Location Code fields must be completed, in addition to the fields required by AWARDS.*

   - **Billing Type –** In this field, type the name of the billing type; for example, "Outpatient Clinic." Be sure to enter the name carefully, as once saved it cannot be changed.

   - **No Billing Rules Entered in AWARDS –** Click this check box if this billing type will have no procedures or documentation requirements entered in AWARDS.

   - **Billing Unit Type –** Click this drop-down arrow and make a selection to indicate whether the unit of service is "Monthly," "Daily/Per Diem," or "Fee for Service."

     The billing unit type does not refer to the frequency with which you will bill for services. It defines whether an invoice for a configured procedure will be generated daily (per diem), or when the service is rendered (fee for service) or once per month (monthly). For example, if you create a procedure for a certain service and have a per diem billing type, then there can potentially be an invoice created daily for a client. If the billing type is monthly, then there will only be one invoice created per month for the configured procedure.

- **Whether to generate the 837I, 837P –** Click this drop-down arrow and select "837I" or "837P" to indicate which of the two claim file formats should be generated, if any.

  The 837I and 837P formats are standard national file formats for billing claims. Most AWARDS agencies will use the 837I format, since the 837P is the format for services provided and billed by professionals, such as a doctor's office.

- **Security Information/Password for 837-** Some billing types require a password in order to submit claim files. If needed, enter the password in this field, which will accept up to ten characters.

- **Include Authorization Information in 837?** – If the 837P file type is selected, this check box appears as an additional option. Check this check box to include the password entered above in the claim fie generated.

- **Which Axis to include –** Select the diagnosis type that should be used for billing invoices. Options include:

  - **Axis I (not after 10/1/2015) –** select this radio button to use DSM-IV – Axis I for billing invoices.

  - **Axis II (not after 10/1/2015) –** select this radio button to use DSM-IV – Axis II for billing invoices.

  - **No DSM-IV Axis (on or before 10/1/2015)** – select this radio button to NOT use DSM-IV for billing invoices

  - **DSM 5 (on or before 10/1/2015) –** select this check box to use DSM 5 for billing invoices.

  The first three selections are radio buttons, so only one can be selected. The DSM 5 check box can be used in tandem with one of the first three options. This allows AWARDS to se either DSM 5 or DSM-IV diagnosis codes for billing invoices.

- **Valid Diagnoses DSM/ICD Heading** – In this field type a comma delimited list of the DSM or ICD diagnoses required for the billing procedure. For example, the DSM code 295.1 would just have 295 entered in this field.

- **Sender ID/ETIN –** In this field type the sender ID/ETIN (or Electronic Transmitter Identification Number). This ID belongs to the agency, and identifies the agency to the payers.

- **Provider ID –** In this field type the provider's ID number.

- **Sender Address –** In this field type the sender's address using the following format: Street Address, City, State Abbreviation Zip Code.

  For example, a correctly formatted address would read: 123 Main Street, New York, NY 100036020.

- **Sender's Phone Number –** In this field type the sender's phone number.

- **Sender location code –** In this field type the sender's location code.

  The location code is a legacy value used by NY State Medicaid in the MMIS system, which has been replaced in the claim files by the CMS place of service code, except for MRDD – MSC claims. This field only applies to programs doing MRDD – MSC billing in the state of NY.

- **CMS place of service code –** In this field type the CMS place of service code. If the payer for this billing type is self pay, enter "0" in this field.

The CMS place of service code is a code that defines the type of facility where the service is being provided. For more information, including a table of these codes, please refer to the following website: http://www.cms.hhs.gov/PlaceofServiceCodes/

- **Monthly billing primary invoices invoice date –** Click this drop-down arrow and make a selection to indicate whether primary invoices should be dated with "The first day of the next month," "The first day of the current month," or "The last day of the current month."

  This option is only available when "Monthly" has been selected for the billing unit type.

- **Monthly billing add on invoices invoice date –** Click this drop-down arrow and make a selection to indicate whether additional invoices should be dated with "The invoice date of the primary invoice," or "The date of service."

  This option is only available when "Monthly" has been selected for the billing unit type.

- **All programs with this billing type use the same billing rates –** Click this check box if multiple programs use this payer and billing type, and if you will be entering rates for only one of the programs in this group.

- **Referring provider is required –** Click this check box if this billing type requires an external referring provider.

  The referring provider for each client is entered using the Support Services Contacts section of his or her face sheet.

- **Default Referring Provider ID –** In this field type the provider ID that should be used if no provider ID or license number is found for the Authorizing Psychiatrist/Nurse/Provider for the client in the Supportive Services Contacts information (located on the client's face sheet).

  This field is only available when the "Referring provider is required" option has been checked off.

- **Allow multiline invoices for add on procedures? –** Click this drop-down arrow and select "Yes" or "No" to indicate whether multi-line invoices should be allowed for this billing type. If this field is set to "Yes." in the **If yes, indicate the limit of multiple lines** field, enter a number value to indicate any limit on how many lines should be allowed. If no value is entered in this field, there will be no limit put in place. If applicable, click the **Create after hours modifier line using CPT/HCPCS** check box and enter the related code in the corresponding field to the right of the option label.

  These fields are only available when the Billing Unit Type has been set to either "Monthly" or "Daily/Per Diem." These fields apply to New York state clinic billing. If your agency does not need to use these options, leave them blank or set to "No".

- **No COB: Treat Payer as Primary** – Click this check box if this billing type does not allow COB (coordination of benefits) billing. All invoices associated with this billing type will be billed using the payer associated with this billing type as primary in the claim file (even if the payer is set as Secondary or Tertiary within the Entitlements feature for the client). Future batches are not allowed for this billing type/payer.

- **Create Split Invoices for All Responsible Parties** – Click this check box to create split self-pay invoices when the consumer has the additional "Self-Pay:" eligibilities entered in their entitlements. These additional eligibilities need to be added by the AWARDS Help Desk and need to be labeled with the prefix "Self-Pay:" but can contain any additional responsible party label at the end.

  For example, if your agency has multiple consumers where the mother and father are responsible for a portion of the consumer's invoices, your additional self-pay eligibilities could be "Self-Pay:Father" and "Self-Pay:Mother." When assigning these additional self-pay eligibilities to consumers, please be sure to do the following;

- Enter the percentage to be billed to the responsible party using the **Use Sliding Percent (%)** field.

- Set **Is Consumer Responsible Party** to No. Once set to No, ensure all needed info is filled in correctly for the responsible party info fields. This information will be used in place of the consumer's information on the consumer summary/statement for mailing purposes.

7. Click **SAVE BILLING TYPE**. The billing type information is saved and displayed on a confirmation page.

   The confirmation page includes a CONTINUE AND ADD PROCEDURES button, allowing you to begin part 4 in the BillingBuilder setup process directly from there. If you choose to add the procedures for this billing type at this time (rather than adding all billing types and then all procedures separately), click that button and proceed to number 8 under "Step 4: Configure Procedures" on page 8.

8. Click **BillingBuilder** and repeat steps 3 through 7 as needed until all billing types have been entered for all payers.

   IMPORTANT! *Even though multiple payers may have the same billing type, that billing type must be set up separately for each of them.*

The process of configuring a new billing type is now complete.

*If it is later necessary to update or delete a billing type, complete steps 1 through 4 above, and then click **VIEW BILLING TYPES**. On the page that follows, select the billing type and click **EDIT BILLING TYPE** or **DELETE BILLING TYPE** as appropriate. Keep in mind:*

- ***When updating** - The billing type name cannot be changed but all other billing type detail can be updated as needed. If any changes are made, you must be sure to click **SAVE BILLING TYPE** to have those changes applied.*

- ***When deleting** - A billing type can only be deleted if there are no procedures or program groups associated with it. If you choose to delete a billing type with which none of those items are associated, the deletion will occur as soon as DELETE BILLING TYPE is clicked. There is no confirmation page, and once deleted a billing type cannot be restored.*

STEP 4: CONFIGURE PROCEDURES

Procedure configuration follows billing type configuration in the setup process. In this step, each billing type must have one or more procedures created for it. For example, a "clinic" billing type may have a procedure called "individual counseling" set up for it.

Each procedure you create during this step will have documentation requirements that must be met in order to generate invoices. As a result, part of the procedure configuration process includes entering information about how services must be documented in AWARDS. For instance, for the "individual counseling" example there might be a requirement of a minimum number of minutes of face to face contact with a client in order for the procedure to be billable.

To configure a new procedure and set up its requirements, complete the following steps:

The following instructions assume that you are beginning the procedure configuration process from the AWARDS Opening Menu *page; however, they may also be configured immediately after the associated billing type is entered/updated by clicking **CONTINUE AND ADD PROCEDURES** from the billing type confirmation page. When proceeding from there, skip ahead to step 8 below.*

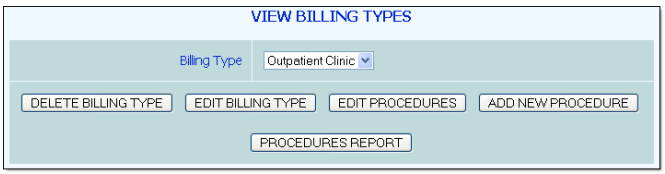
1. From the *AWARDS Opening Menu* page, click **Fiscal/Program**. The *Fiscal/Program Reports Menu* page is displayed.

2. Click **BillingBuilder**. The *BillingBuilder Menu* page is displayed.

3. Click **Configure Billing Types**. The *Configure New Billing Types and Procedures* page is displayed.

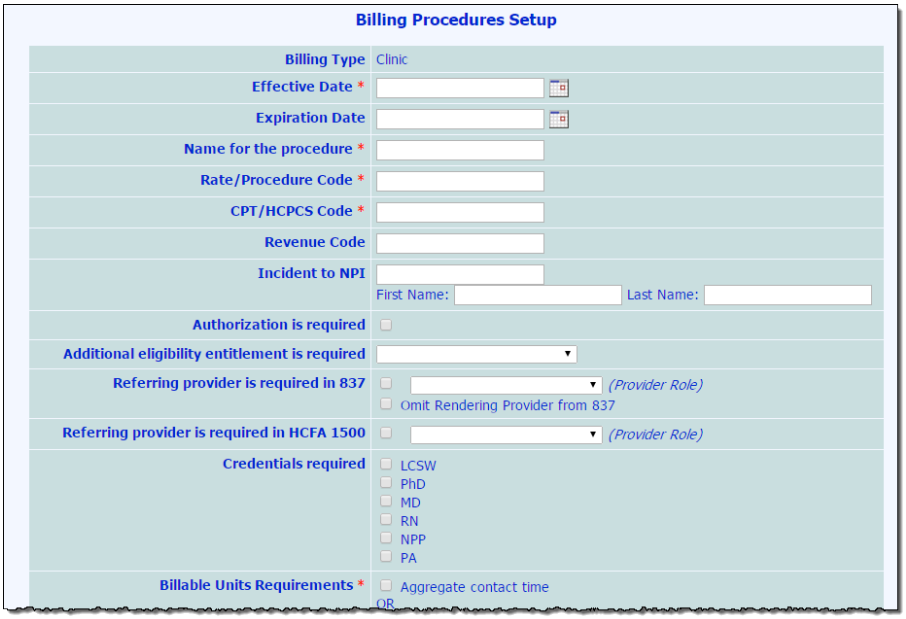
4. Click the **Payer** drop-down arrow and select the appropriate payer.

5. Click **VIEW BILLING TYPES**. The *VIEW BILLING TYPES* page is displayed.



6. Click the **Billing Type** drop-down arrow and select the appropriate billing type.

7. Click **ADD NEW PROCEDURE**. The *Billing Procedures Setup* page is displayed.



8. Configure the fields and options on this page as follows:

   - **Effective Date –** In this field type the effective date for this procedure.

     AWARDS will only bill for services that occur after the Effective Date entered here.

   - **Expiration Date –** In this field type the expiration date for this procedure.

     Entering an Expiration Date will discontinue the procedure, making it un-billable once the expiration date occurs. This is generally utilized when a procedure is no longer billable, but needs to be saved in case the agency wants to back-bill for it.

   - **Name for the procedure –** In this field type the procedure name.

   - **Rate/Procedure Code –** In this field type the procedure code.

     This may also be referred to as the "rate code" or "CPT code."

   - **CPT/HCPCS Code –** In this field type the HCPCS code.

     For more information, including a table of these codes, please refer to the following website: http://www.cms.hhs.gov/MedHCPCSGenInfo/

   - **Revenue Code** – In this field type the 837I revenue code that is associated with the CPT/HCPCS Code. If a revenue code is not captured in this field, the revenue code for invoices associated with this procedure will be pulled from the Program Billing Info > Revenue Code field.

- **Incident to NPI** – In this field enter the NPI, First Name and Last Name of the incident to provider that needs to be associated with the invoices for the procedure identified.

  Please note that this is a "hard override," meaning any data captured here will be placed on the invoice instead of the note writer's information (from Human Resources > Credentialing > National Provider Identifier) or any default medical provider information (from Program Billing Info).

- **Authorization is required –** Click this check box if the billing type requires prior authorization for this procedure.

  If authorization is required, a client's authorization information is entered in the "Insurance Authorizations" section of the Certified Entitlements feature, located within the Entitlements module or on the client's face sheet.

  If a billing procedure is configured to require authorization, then AWARDS will not bill for a client for that procedure unless there is a current authorization record found in that client's entitlements.

- **Do not send Authorization Number in claims** – Click this check box if an authorization number is NOT to be sent in the claim file. AWARDS will continue to decrement/count down the total remaining service/units as billable services are rendered.

- **Additional eligibility entitlement is required** – This drop-down list is populated with those insurances/eligibilities available for selection under Entitlements. If appropriate, use this option to select a second eligibility required in order to bill for this procedure.

- **Referring provider is required in 837** – Click this check box to have the referring provider name and NPI sent in the 837 electronic billing files alongside a rendering provider or in its place. Select a provider role from the corresponding drop-down list to have the name and NPI contained within the support services contacts section of a client's face sheet associated with the provider role you selected sent as the referring provider.

  In the 837 Institutional electronic billing file this is loop 2310F, segment NM1 and in the 837 Professional electronic billing file this is loop 2310A, segment NM1.

  Checking the "Omit Rendering Provider from 837" check box will remove any rendering provider information. In the 837 Institutional electronic billing file this will remove the rendering provider from loop 2310D, segment NM1 and in the 837 Professional electronic billing file from loop 2310B, segment NM1.

- **Referring provider is required in HCFA 1500** – Click this check box to have the referring provider name and NPI sent in the HCFA 1500 claim form in box 17 and 17b. Select a provider role from the corresponding drop-down list to have the name and NPI contained within the Support Services Contacts section of a client's face sheet associated with the provider role you selected sent as the referring provider.

- **Use program site/residence/other site CMS locations** – Click this check box to use the location saved in the note and not what is set in the billing type to determine what POS to send in the billing file.

- **Credentials required –** If applicable, click the check box(es) next to the credentials a provider must have in order to bill for this procedure. Any credentials set as required in this step must be assigned to the provider using the Human Resources module Credentialing feature.

  If there are required credentials used in your agency that are not listed, or you do not see the option to record credentials, contact your Client Services representative to have them added to the system.

- **Billable Unit Requirements –** Click the check box(es) next to the billable unit requirements for this procedure. Which selections are available differs depending on whether the billing type was configured to

be monthly, per diem, or fee for service. The Billable Units Requirements allow you to check off any one requirement alone, but you can also check off any of the following options in combination: Attendance days, Attendance hours, Days in program, Face to Face contacts count, and Face to Face contact days. And when you check off more than one, the billing logic will create an invoice if any of them is true without requiring that all of them be true. Both Bed nights with nightly absences and Transportation Ride cannot be combined with other options.

For **Monthly** billing types:	For **Per Diem/Daily** billing types:	For **Fee for Service** billing types:
- Attendance days - Attendance hours - Days in program - Face to face contacts count - Face to face contact days - Bed nights w/nightly absences - Transportation Ride	- Aggregate contact time - Attendance hours - Face to face contacts count - Bed nights w/nightly absences - Transportation Ride	- Face to face contacts - Reception desk attendance hours - Bed nights w/nightly absences - Transportation Ride

Bed night billing cannot be combined with any other requirements.

The Nightly Absences feature in the Housing module must be turned on by Foothold Technology at the agency level. Please contact your Senior Project Manager or the Help Desk with this request.

If "Bed nights with nightly absences" is selected, use the **Bed Night Types** checklist to indicate a specific billable bed night type. These codes are the same options provided within the Housing > Nightly Absences feature:

- **P** = Present
- **A/V** = Absent Hospitalized
- **A/H** = Absent Vacation
- **A/O** = Absent Other

If "Transportation Ride" is selected, please make a selection for either **Mileage Rate** or **Flat Rate**. If Mileage Rate is selected, the "Count by unit of measure" section on the second page of configuring the procedure needs to be completed so that the appropriate billing rate may be calculated (miles x rate = billing rate).

- **Primary Procedure** or **Add On Procedure** or **Required Condition to be Added to a Procedure –** Click one of the procedure radio buttons to indicate whether this procedure is primary or add on.

  This option is available for Monthly and Per Diem billing types only, where clients are theoretically limited to one invoice per day or per month. In reality, both Monthly and Per Diem billing types allow for multiple invoices, with one primary invoice and sometimes multiple add-ons. For example, a "counseling session" could be the primary procedure, but if it is done in the client's home an additional procedure could be added on and more money could be collected for an "at home visit."

  If the procedure is an add-on procedure the following additional options appear on the page:

  - **Create Invoice if ANY primary procedure or primary requirement is being billed** or **Create Invoice if this primary procedure or primary requirement is being billed** or **Create if this primary procedure is NOT being billed** – Select the appropriate radio button between these options, and if necessary select the primary procedure in the corresponding checklist.

  - **Create Invoice if no primary procedure is being billed** – Click this check box to bill the add-on procedure with no primary procedure.

- **Require service plan done date within __ days prior to date of service with __ electronic signature –** In the text box, enter an amount of days that a service plan must have been marked done in order to make the procedure billable. If the service plan must be electronically signed in order to be billable, check the check box that displays in this line as well.

  If no days are entered this requirement will not apply. The option for electronic signatures on service plans only applies when this option is activated for the agency.

- **This procedure is an exception to multiple-line limit set in the Billing Type configuration** – If appropriate, click this check box to indicate that the multi-line limit (if one was specified during the setup of the Billing Type) should be disregarded for this procedure.

If you create more than one primary procedure for a Per Diem billing type, then the following rules apply:

- *If both procedures are "face to face contacts counts," AWARDS will create an invoice only for the procedure with the higher rate if both procedures are provided to a single client on a given day.*

- *If one procedure is "attendance hours" and the other procedure is a "face to face contacts count" billing unit requirement, then only the face to face contact procedure is invoices. To be able to create an invoice for both procedures, one of them needs to be changed to an add-on procedure.*

- **Use sliding scale percent** – Click this check box if the rate to be charged for the procedure is a percentage of the procedure cost.

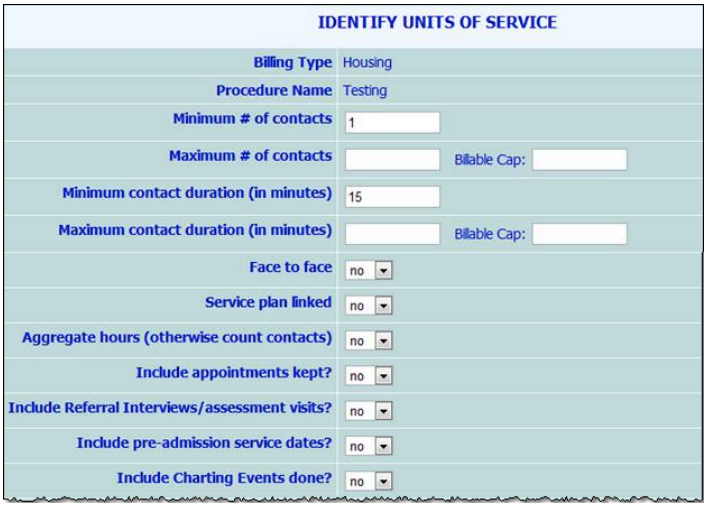
  This option is only recommended for "Self Pay" payers. If checked, a sliding scale rate for each client can be entered under "Insurance/Subsidized Payments Information" using the Entitlements module Certified Entitlements feature.

- **Program Type –** Click the radio button next to the program type to which this procedure applies.

  All programs in AWARDS belong to a particular program type. If you are not familiar with program types, please contact your Client Services representative.

  Program types selected here will determine which charting events and service types appear on the next page.

9. Click **UPDATE & IDENTIFY UNITS OF SERVICE**. The *Identify Units of Service* page is displayed. →



10. Configure the fields and options on this page as follows:

    IMPORTANT! *Which of the fields and options listed below you see will vary based on the combination of billing unit type and units of service requirements you previously selected. Not all fields/options will appear in all cases as documentation requirements will vary.*

    - **Minimum # of days in program / Maximum # of days in program** – If the number of days of program enrollment is the documentation requirement for billing, then in these fields type minimum and maximum days in program values to indicate the range within which a client's program days must fall for the procedure to be billable.

- **Minimum # of contacts** / **Maximum # of contacts** and **Billable Cap** – If contact is the documentation requirement for billing then in these fields type minimum and maximum number of contacts values to indicate the range within which a client's number of contacts must fall for the procedure to be billable. If there is a maximum number of contacts entered in the corresponding **Billable Cap** field, the procedure will be billed if the number of contacts equals or exceeds that maximum.

- **Minimum # of aggregate hours** / **Maximum # of aggregate hours** – If aggregated contact time is required for billing then in these fields type minimum and maximum number of aggregate hour values to indicate the range within which a client's hours must fall for the procedure to be billable.

- **Minimum contact duration (in minutes)** / **Maximum contact duration (in minutes)** and **Billable Cap** – If a contact must be of a minimum or maximum duration in order to be billable then in these fields type the minimum or maximum number of minutes a contact must be in order for the procedure to be billable. If there is a maximum contact duration entered in the corresponding **Billable Cap** field, the procedure will be billed if the contact duration equals or exceeds that maximum.

- **Minimum attendance time (in minutes)** / **Maximum attendance time (in minutes) -** If an attendance record must be of a minimum or maximum duration in order to be billable then in these fields type the minimum or maximum number of minutes an attendance record must be in order for the procedure to be billable.

- **Minimum days of contact** / **Maximum days of contact** – If the number of days of contact is the documentation requirement for billing then in these fields type the minimum and maximum number of days of contact values to indicate the range within which a client's contact days must fall for the procedure to be billable.

- **Minimum # of attendance days** / **Maximum # of attendance days** – If program attendance is the documentation requirement for billing, then in these fields type minimum and maximum attendance day values to indicate the range within which a client's attendance days must fall for the procedure to be billable.

- **Face to face** or **Face to face encounter** – Click this drop-down arrow and select "Yes" or "No" to indicate whether encounters must be face to face in order for the procedure to be billable.

- **Service Plan Linked –** Click this drop-down arrow and select "Yes" or "No" to indicate whether a service plan linked progress note must be documented to meet the requirements of this procedure. For more information on service plan linked progress notes, please refer to the "Entering / Updating a Progress Note" procedure in Online Help.

  Please note, this option was originally developed for CR and ACT Medicaid billing in New York state, therefore it may not be a suitable setting for other programs/payers/states.

- **Aggregate hours (otherwise count contacts) –** Click this drop-down arrow and select "Yes" or "No" to indicate whether an aggregate count of hours should be used to determine whether a procedure is billable.

- **Include appointments kept?** – Click this drop-down arrow and select "Yes" or "No" to indicate whether an appointment marked as kept on the AWARDS Calendar is sufficient documentation to bill, with or without corresponding documentation of contact (such as progress notes).

  Completed Medical Encounter Forms will also be counted as kept appointments when this option is set to "Yes."

- **Include Referral Interviews/assessment visits?** – Click this drop-down arrow and select "Yes" or "No" to indicate whether a referral interview scheduled and marked as held on the client's referral form or the

AWARDS Calendar is sufficient documentation to bill, with or without corresponding documentation of contact (such as progress notes).

- **Include pre-admission service dates?** – Click this drop-down arrow and select "Yes" or "No" to indicate whether services documented prior to the client's date of admission are billable.

  For example, if the client's Intake is processed and a progress note or group note is written, select "Yes" to count those services as billable.

- **Include Charting Events done?** – Click this drop-down arrow and select "Yes" or "No" to indicate whether an event scheduled on the Charting Timetable and marked as complete counts as documentation used for billing purposes.

  If "Yes" is selected and you only want charting events to count as billable events, excluding progress and group notes, make sure that you uncheck the "Individual One-on-One" and "Group" check boxes that appear further down on this page, as well as both the "Routine" and "Crisis" check boxes that appear in the "Crisis?" field.

- **List name/s of Charting Event/s** - This is a list of charting events available for the program type selected on the first *Billing Procedures Setup* page. Click the check box next to each chart event that counts towards billing for this procedure.

  *If no charting events are selected then **all** of the events listed will count towards billing.*

- **Minimum # of aggregate hours** and **Maximum # of aggregate hours** – If aggregate hours will be used to bill, then in these fields type the minimum or maximum number of aggregate hours a required in order for the procedure to be billable.

- **Billable Service Types** – Click the check box next to each service type applicable for billing in relation to this procedure. The list of service types available here is based on the program type selected on the first *Billing Procedures Setup* page.

  *If no billable service types are selected then **all** of the service types listed will count towards billing.*

- **Progress Note Types** – Click the check box next to each progress note type applicable for billing in relation to this procedure.

  *If no progress note types are selected then **all** of the note types listed will count towards billing.*

- **Progress Note Writer – Require NPI (National Provider ID)** – Check this check box to require that the note writer have an NPI (National Provider Identifier) captured within the **National Provider Identifier** field located on the "Credentials" tab of their Staff Information record within the Human Resources module.

- **Location** – If the procedure must take place in a specific location in order to be billable, click this drop-down arrow and select the appropriate location.

  *If no locations are selected then **all** of the locations listed will count towards billing.*

- **Individual One-on-One** and **Group** – By default both individual one-on-one and group contacts are billable. Uncheck either of these check boxes as necessary to indicate that only individual contacts or only group contacts are billable for this procedure.

- **Require Electronically Signed Notes** – Check this check box to require that a progress note be electronically signed before it can be used to generate an invoice.

- **Group Activity Types –** If a billable group needs to be a specific group activity type, check the check box(es) next to all applicable group activity types listed on this checklist.

- **Minimum Number of Consumers in the Group/Maximum Number of Consumers in the Group –** Enter the minimum and maximum number of consumer needed in a group note for the procedure to be billable.

- **Allow Multiple Services –** For per-diem billing click this check box to allow for billing more than one service in a given invoice for one day. For example, if there are five face-to-face contacts in a given day and this option is checked, then AWARDS will create one invoice which will include services for five face-to-face contacts.

- **Minimum of Age** and **Maximum of Age –** In these fields type, if applicable, minimum and maximum age values to indicate the range within which a client's age must fall in order for the procedure to be billable. The client's age is calculated based on his or her date of birth.

- **Minimum of GAF** and **Maximum of GAF –** In these fields type, if applicable, minimum and maximum GAF scores to indicate the range within which a client's GAF score must fall in order for the procedure to be billable. The client's GAF Score is entered in the Diagnoses section of the face sheet or using the Medical module Diagnoses feature.

- **Crisis? –** By default both crisis and routine contacts are billable. Uncheck either of these check boxes as necessary to indicate the requirements should be otherwise. The routine/crisis setting is found on individual progress notes.

- **Start Time** and **End Time –** If an encounter must be held during a particular time of the day then set the start and end times within which the encounter must be held in order to be billable.

- **Count by Unit of Measure –** Click this check box if billing at your agency is done by units of service, and complete the remaining fields listed as described:

  - **1 unit of measure = ____ minutes** – Enter the number of minutes that define a unit of measure, using decimals if needed.

  - **___ units of measure = 1 unit of service** – Enter the number of "units of measure" that define a unit of service. This number should be a whole number, or integer.

  - **Apply Rounding to Units of Service Remainder** – Select this radio button to round the invoice units to the nearest whole number.

  - **Apply Rounding to Units of Measure Remainder** – Select this radio button to round the invoice units to the nearest tenth of a unit.

  - **Drop Remaining Minutes** or **Count Remaining Minutes as Whole Units** – This functionality allows users to specify whether the total contact time should be rounded up (Count Remaining Minutes as Whole Units) or rounded down (Drop Remaining Minutes). Select the radio button next to the corresponding functionality you wish to use.

    For example, if the function is set to "Drop Remaining Minutes" with 7.5 minutes = 1 unit of measure = 1 unit of service, then a 20 minutes contact time will be 2 units of service. If the function is set to "Count Remaining Minutes as Whole Units" with the same settings, then a 20 minute contact time will be 3 units of service.

The invoice amount for units of service will be calculated using the following formula:

(Billing Rate) x (# of units of measure contained in the contact time, rounded up or down as configured) / (# of units of measure that define 1 unit of service)

For example, if 1 unit of measure = 7.5 minutes, and 2 units of measure = 1 unit of service, and the billing rate for the procedure is $50, the following formula would apply for a progress note of 15 minutes: 50 x 2 /2 = $50.

If there is more than one contact (progress note or group note) for a client in a Per Diem billing type, then all contact times will be aggregated and then divided into units of measure of a particular length as described above.

- **Billing Based on Acuity Scores** – Click this check box if this procedure should use a client's acuity score to calculate a claim amount and not service units. This option will only show within the configure procedures screen if the procedure is associated with a payer named "Medicaid" and the payers state is "NY."

  Since all clients may not have an individual acuity score, their billing should use the average acuity score, and it is required that a generic procedure be configured to accommodate this scenario. When creating this generic procedure, the following are required in addition to the required fields when configuring a procedure:

  Procedure name must be "Average Acuity Score"
  Procedure must be marked as a "Primary Procedure"
  Procedure must have Billable Units Requirements set to Face to Face contacts count
  Procedure must have Minimum # of contacts set to 999
  Procedure must have Billing Based on Acuity Scores check box clicked.
  Other settings are options.

  After the "Average Acuity Score" procedure has been properly configured, a billing rate (Fiscal/Program > BillingBuilder > Billing Setup > Billing Rates) must be configured to reflect the average acuity score.

- **Maximum number of invoices per week __ (Week begins __)** - Indicate whether there is a maximum number of invoices for the procedure that can be generated per week by entering an integer in the text box, and then indicate which day of the week should be used to calculate the start of the week by selecting the day of the week from the corresponding drop-down.

- **Require specific weekdays** – Select the weekdays on which the procedure is billable.

  This procedure option is only applied to Daily/Per Diem billing type procedures.

- **Program division enrollment is required** – If there are program divisions set up for programs in the program group, a procedure can require program division enrollment in order to be billable. Check this check box to activate this billing requirement.

  This option is only available for agencies that have program divisions set up within the Services module Group Schedule Setup feature.

11. Click **UPDATE & CONFIRM PROCEDURE SETUP**. The procedure and its units of service are saved and displayed on a confirmation page.

12. To add another procedure for this billing type, click **ADD NEW PROCEDURE** and repeat steps 8 through 12 until all procedures for the selected payer/billing type have been configured. At that time, click **FINISH** to return to the *VIEW BILLING TYPES* page.

13. Repeat steps 1 through 12 until all procedures have been entered for all billing types.

The process of configuring new procedures is now complete.

*If it is later necessary to update or delete a procedure, complete steps 1 through 5 above, select the billing type in question, and then click **EDIT PROCEDURES**. On the page that follows, select the procedure and click **UPDATE** or **DELETE** as appropriate. Keep in mind:*

- ***When updating** - If changes are made, be sure to click both **UPDATE & IDENTIFY UNITS OF SERVICE** on the* Billing Procedures Setup *page, and **UPDATE & CONFIRM PROCEDURE SETUP** on the* Identify Units of Service *page to have those changes applied.*

- ***When deleting** - The deletion will occur as soon as **DELETE** is clicked. There is no confirmation page, and once deleted a procedure cannot be restored. Procedures can only be deleted when there are no invoices created for that procedure.*

STEP 5: CONFIGURE PROGRAM BILLING GROUPS

Program billing groups are the next item to be configured in the setup process. They enable you to combine programs that share the same payer, billing type, procedures, and rates into one group and to bill for that group with a single invoice batch. Once you create a program billing group, you will be able to add programs to the group in the next step of the setup process.

Invoice batches are always created for program groups rather than for individual programs. As a result, even if there is only one program that does a particular type of billing, a program billing group must still be created for it.

To configure a new program billing group, complete the following steps:

1. From the *AWARDS Opening Menu* page, click **Fiscal/Program**. The *Fiscal/Program Reports Menu* page is displayed.

2. Click **BillingBuilder**. The *BillingBuilder Menu* page is displayed.

3. Click **Program Groups**. The *SELECT PAYER* page is displayed.

4. Click the **Payer** drop-down arrow and select the appropriate payer.

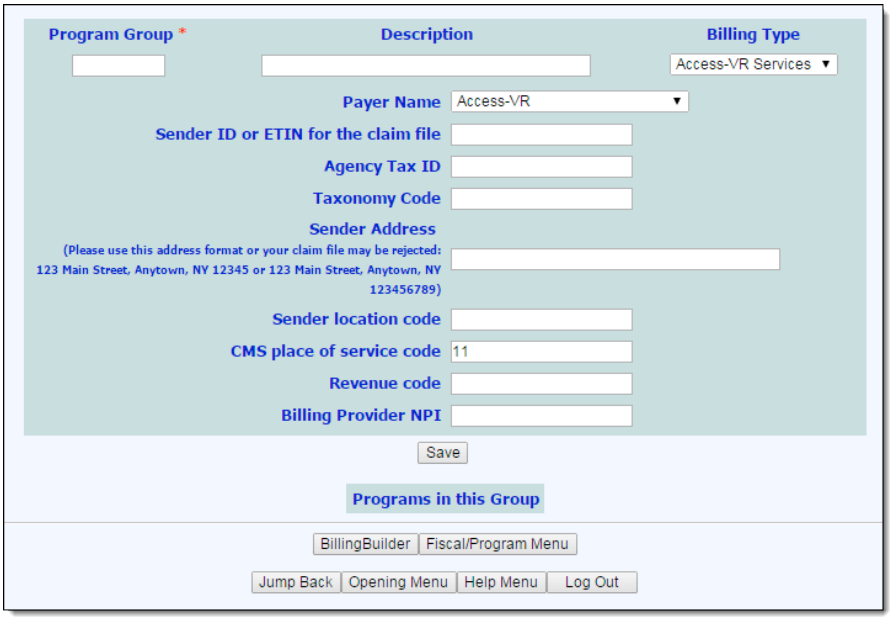
5. Click **Select**. The *Billing Program Groups* page is displayed.

6. Click **Create**. The program billing group configuration page is displayed. →

7. In the **Program Group** field type the name of the program group.

8. In the **Description** field, type a brief description for the group.

9. Click the **Billing Type** drop-down arrow and select the



appropriate type. When a selection is made the page is refreshed and values for the selected billing type are automatically dropped into the following fields IF values were entered for them during the billing type configuration process:

- **Payer Name**
- **Sender ID or ETIN for the claim file**
- **Agency Tax ID**
- **Taxonomy Code**
- **Sender Address**
- **Sender location code**
- **CMS place of service code**

If values are missing from any of these fields after the billing type has been selected, configure them at this time.

10. In the **Revenue code** field, type the appropriate code.

    The Revenue code is used to classify the type of service being provided.

11. In the **Billing Provider NPI** field, type the NPI of the billing provider.

12. Click **Save**. The program billing group is created and the *Billing Program Groups* page is re-displayed.

13. Repeat steps 1 through 12 until all program billing groups have been created.

The process of configuring new program billing groups is now complete.

*If it is later necessary to update or delete a program billing group, complete steps 1 through 5 above, select the program group in question, and then click **Update** or **Delete** as appropriate. Keep in mind:*

- ***When updating** - If changes are made, be sure to click **Save** on the program billing group configuration page to have those changes applied.*
- ***When deleting** – A program group can only be deleted if there are no programs in it. If you choose to delete an empty program group you will be asked to confirm your choice after clicking Delete. Be sure to click **OK** at that time to complete the deletion process. Once deleted, a program billing group cannot be restored.*

STEP 6: CONFIGURE PROGRAM BILLING INFORMATION

Every program that bills must have program billing information entered for it. That information, which is entered in step 6 of the setup process, consists of specific data required for electronic claim files or paper invoice forms.

*Programs can belong to only **one** program billing group at a time.*

To configure a program's billing information, complete the following steps:

1. From the *AWARDS Opening Menu* page, click **Fiscal/Program**. The *Fiscal/Program Reports Menu* page is displayed.

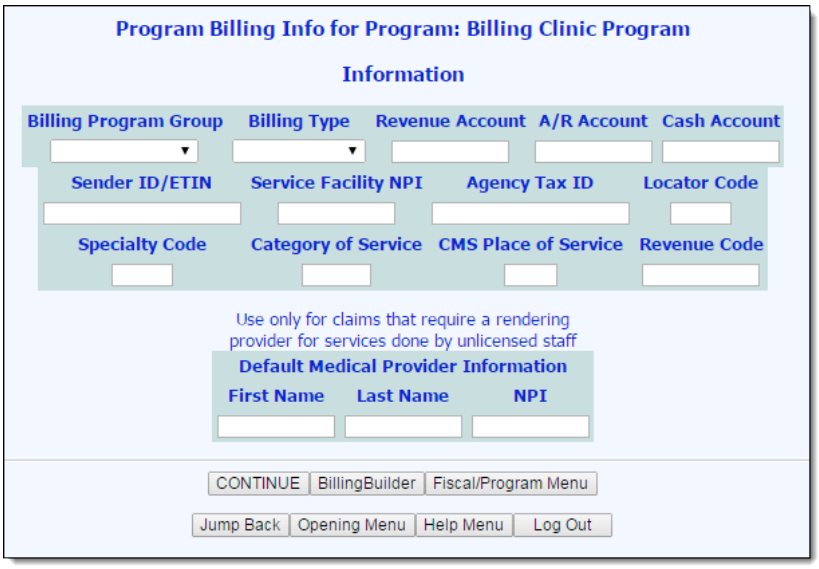
2. Click **BillingBuilder**. The *BillingBuilder Menu* page is displayed.

3. Click **Program Billing Info**. The *Program Billing Info* page is displayed.

4. Click the **Program** drop-down arrow and select the appropriate program.

5. Click the **Payer** drop-down arrow and select the appropriate payer.

6. Click **CONTINUE**. The *Program Billing Info* page is displayed. →



7. Configure the fields and options on this page as follows:

   - **Program Group –** Click this drop-down arrow and select the program group with which this program should be associated. When a selection is made the page is refreshed and values for the selected program group are automatically dropped into the following fields if they were filled out during the program group configuration process:

     - **Billing Type**
     - **Sender ID/ETIN**
     - **Service Facility NPI**
     - **Medicaid Provider Number**
     - **Locator Code**
     - **CMS Place of Service**
     - **Revenue Code**

     If values are missing from any of these fields/options after the program group has been selected, configure them at this time.

   - **Revenue Account –** If your agency is planning to use the AWARDS general ledger feature, type the program's revenue account number in this field.

     The account number entered here must already exist as a general ledger account. Please contact your Client Services representative for questions regarding the general ledger functionality.

   - **A/R Account –** If your agency is planning to use the AWARDS general ledger feature, type the program's A/R account number in this field.

The account number entered here must already exist as a general ledger account. Please contact your Client Services representative for questions regarding the general ledger functionality.

- **Cash Account –** If your agency is planning to use the AWARDS general ledger feature, type the program's cash account number in this field.

  Please contact your Client Services representative for questions regarding the general ledger functionality.

- **Specialty Code –** In this field type the program's specialty code.

  Specialty codes are also called taxonomy codes, and are the 9-digit numbers assigned under the HIPAA provisions to health care providers, in order to digitally encode their specialty in order to facilitate electronic billing.

- **Category of Service** – In this field type the program's category of service.

- **Default Medical Provider Information** – Enter values in the **First Name**, **Last Name**, and **NPI** number fields for use with claims that require a rendering provider for services done by unlicensed staff. When working with Medicaid, a **Medicaid Provider ID** field will need to be configured in this portion of the page as well.

IMPORTANT! *All fields on this page, with the exception of the account numbers, are required for the HIPAA 837 billing file or the HCFA 1500 paper claim form.*

8. Click **CONTINUE**. The program billing information is saved and displayed on a confirmation page.
9. Click **CONTINUE** to return to the *Program Billing Info* page.
10. Repeat steps 4 through 9 until the program billing information has been entered for all programs that will bill.

The process of configuring program billing information is now complete.

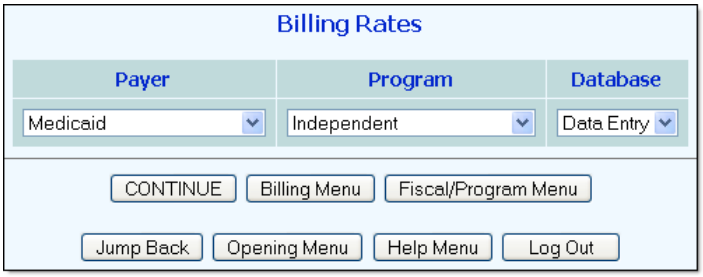
If it is later necessary to update a program's billing information, use the same procedure outlined above.

STEP 7: CONFIGURE BILLING RATES

The last step in the setup process requires you to enter rates for each procedure for each program. Those rates can be updated as needed in the future, and AWARDS keeps a history of previous values.

To configure billing rates, complete the following steps:

1. From the *AWARDS Opening Menu* page, click **Fiscal/Program**. The *Fiscal/Program Reports Menu* page is displayed.
2. Click **BillingBuilder**. The *BillingBuilder Menu* page is displayed.
3. Click **Billing Rates**. The *Billing Rates* page is displayed.



4. Click the **Payer** drop-down arrow and select the appropriate payer.

   If "Self Pay" is selected as the payer, all invoices for that payer will be created with the procedure

rate entered during this procedure. Any self pay rate entered within a client's entitlement records will not be used if a procedure rate for the self pay payer exists in the system.

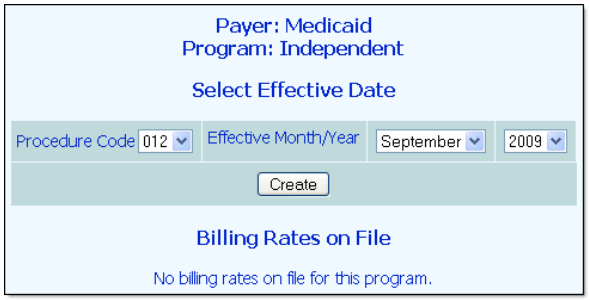
5. Click the **Program** drop-down arrow and select the program for which the billing rates are to be configured.

   *If the **All programs with this billing type use the same billing rates** check box was checked off during the process of configuring the billing type, then the rates set for this program will apply to all programs in the billing program group.*

6. Confirm that the **Database** selection is "Data Entry" (the default).

7. Click **CONTINUE**. The *Select Effective Date* page is displayed.

   Any existing billing rates on file for this payer and program are displayed on this page under "Billing Rates on File."



8. If the selected payer is Medicaid and the billing type for the selected program has a procedure that is set to do billing based on acuity scores, the **Acuity Scores** button is displayed on this page. Click this button to manually enter the acuity scores for consumers.

9. Click the **Procedure Code** drop-down arrow and select the procedure for which the billing rates are to be configured.

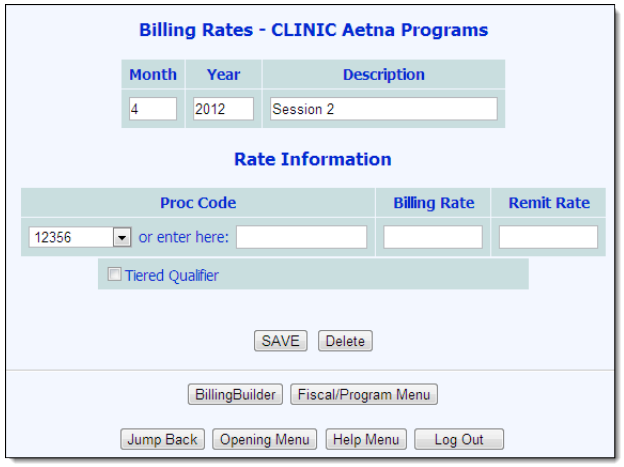
10. Click the **Effective Month/Year** drop-down arrows and specify the month and year in which the billing rates became effective.

11. Click **Create**. The *Billing Rates* page is displayed.

    The Month and Year fields on this page indicate the effective date of the billing rate as selected on the previous page.

    The Description field displays the procedure name that was created when it was configured.

    The Proc Code displayed is the procedure code assigned to the procedure's name when it was configured.



12. In the **Billing Rate** field, enter the rate for the selected procedure.

13. In the **Remit Rate** field, enter the expected rate for the selected procedure.

14. Click the **Tiered Qualifier** check box if different rates are in effect for the same procedure based on different credentials. If checked, the page refreshes and a checklist of credentials is displayed. Each credential will have corresponding **HCPCS Modifier** and **Rate** fields. Click the check box for any credentials being billed and type the different HCPCS modifiers and rates in the corresponding fields.

For example, if a counseling session is billed for $100 if it is provided by a social worker and $150 if it is provided by a psychiatrist, enter both rates here. AWARDS will then apply the correct rate based on the staff member's credentials as entered in the Human Resources module, Credentialing feature.

15. Click **SAVE**. The rate information is saved and displayed on a confirmation page.

16. Click **Return to Data Entry** to return to the *Select Effective Date* page, and then repeat steps 8 through 15 until all procedures for the selected billing type have rates entered for them.

17. Repeat steps 1 through 16 until all procedures for all billing types have rate information entered for them.

The process of configuring billing rates is now complete.

*If it is later necessary to update or delete billing rates, complete steps 1 through 10 above, and then either make the necessary changes and click **Save**, or click **Delete** to delete the rates entirely.*

When updating a billing rate, simply choose the procedure and a new effective date, enter the new rate and save the page. The old billing rate is then archived. AWARDS will assign the new rate to any services with a service date on or after the effective date of the new rate, and will use the old rate for service dates before the effective date of the new rate.

FREQUENTLY ASKED QUESTIONS

The following frequently asked questions regarding the setup component of the BillingBuilder feature can be a useful reference when you have your own questions about the functionality.

HOW DO I UPDATE CHANGING BILLING UNIT TYPE REQUIREMENTS TO BE EFFECTIVE ON A FUTURE DATE (I.E., CHANGING FROM "MONTHLY" TO "FEE FOR SERVICE")?

If billing unit type requirements will be changing on a future date, create a new billing type and configure that new type with the upcoming requirements. The procedures within the new billing type should have Effective Dates that correspond to the date the new billing type will be in effect. On the procedures in the billing type that will be phased out, enter Expiration Dates that correspond to the date the billing type will no longer be in effect. Leave the program groups as-is until the date of the switch. On the day the new billing rules become effective, place the appropriate programs in a new program group, which is set to use the new billing type. After this time, if you need to generate invoices for a date in the past using the previous rules, put the program back into the old group.

I CANNOT DELETE A BILLING PROCEDURE. WHY NOT?

A procedure can only be deleted when there are no invoices created for that procedure.

WHAT SHOULD BE DONE IF A BILLING RATE NEEDS TO BE UPDATED?

If a billing rate has changed and a new one needs to be entered, follow the steps outlined in "Step 7; Configure Billing Rates" on page 20 of this document. Choose the procedure that requires the rate update and enter a new effective date, then enter the new rate and save the page. The old billing rate is then archived. AWARDS will assign the new rate to any services with a service date on or after the effective date of the new rate, and will use the old rate for service dates before the effective date of the new rate.

WHY IS A SERVICE NOT BEING BILLED FOR BY THE BILLINGBUILDER FOR A PARTICULAR PROGRAM?

If a service is not being billed for by the BillingBuilder for a particular program then you must investigate the program-specific setup options in the Billing Menu. Pay specific attention to the configuration of Program Billing Info and Billing Rates.

WHY IS ONLY ONE SERVICE FOR A CONSUMER BEING BILLED FOR BY THE BILLINGBUILDER PER DAY?

If only one service is being billed for by the BillingBuilder per day, investigate the Billing Type configuration. If the Billing Unit Type for a particular Billing Type is Per Diem, then it will prevent Fee For Service billing types from being billed for that program for that day (so long as they are less in value).