



Service Provider Manual

Chapter 9: Billing and Accountability

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CHAPTER 9: BILLING AND ACCOUNTABILITY

Missouri Part C State Plan Section XV. (34 CFR 303.119)

Uniform Guidance (2 CFR 200.333 through 200.337)

Providers are paid to conduct a variety of activities in First Steps, including attending meetings and delivering services to First Steps families. Depending on the type of activity, the provider may be paid in one of the following methods:

- **Auto-Payment.** For Individualized Family Service Plan (IFSP) meeting and Early Intervention Team (EIT) meeting attendance, providers do not submit a claim for payment in the child's electronic record (i.e., WebSPOE). A transaction is automatically submitted when the Service Coordinator enters and confirms attendance in WebSPOE.
- **Monthly Invoice.** For mileage, providers do not submit a claim for payment in WebSPOE. Providers keep track of mileage and submit a monthly mileage invoice to the Central Finance Office (CFO).
- **Claim Submission.** For eligibility meeting attendance, evaluation/assessment, IFSP services, travel incentive and assistive technology devices, providers must submit a claim for payment in WebSPOE that corresponds with an authorization.

This chapter describes only the procedures for claim submission and payment of authorized activities, including how to submit a claim, provider payments, payment problems and monitoring provider payments.

SECTION I: CLAIM SUBMISSION

The Service Coordinator enters authorizations in WebSPOE for activities related to eligibility determination and IFSP services. Claims for First Steps services must be submitted through WebSPOE in accordance with the authorization. Providers cannot submit claims for First Steps services to the family's private insurance or Medicaid.

Providers must pay close attention to the details for each authorization and notify the child's Service Coordinator immediately if the authorization needs to be changed.

A. Claim Timeline

After a First Steps service has been delivered by the provider and documentation completed (e.g., progress notes), the provider submits a claim via the Claim Entry function in the *Provider Account Management* tab of WebSPOE.

Providers must submit the initial claim for payment within 60 calendar days from the date the service was delivered. Timely claim submission is critical in order for the Central Finance Office (CFO) to review the family's cost participation fee and seek reimbursement from private insurance and/or Medicaid.

B. Claim Entry

The claim for service must be entered accurately and in accordance with the authorization for service.

The following information is required to successfully enter a claim in WebSPOE:

- **Authorization Number.** The number must be entered exactly as it appears in the child's record or the number can be found by using the look-up function in the claim entry process.
- **Provider Name.** The name is pre-populated from the authorization and selected from the drop-down window in the claim entry process.
- **Service Date.** The date the service was delivered to the family. The date must match the date listed in the progress note. The date must also fall within the start and end dates of the authorization for service. In the event the authorization is discontinued or canceled, the date of service must be before or on the date it was discontinued or canceled.

For Evaluation/Assessments, if the test was conducted in more than one visit, the date the test was completed is the date entered in the claim.

For Assistive Technology Devices, the date the device was delivered is the date entered in the claim, not the date the device was ordered.

➤ **Second Visit on the Same Date**

If a First Steps provider completes two visits with the family on the same date of service and related to the same authorization (e.g., provider conducts a make-up visit), then the provider may need to enter two claims for the same date of service on the same authorization.

To submit a claim as a second visit, the provider checks the *2nd for Same Date* box in the claim entry process. The second visit will show a code *GG* after the CPT code in the claim details.

- **Units.** For authorizations with per episode or Assistive Technology devices, the unit is one. However, for visits with the child/family, a unit equals a 15-minute increment of time (i.e., 30 minutes equals two units). The amount billed must correspond to the actual, direct time spent in the visit and does not include time spent writing progress notes or traveling to/from the visit. To determine the amount of units when time is not equal to 15-minute increments, providers use the rounding rule: time between 1 and 7 minutes

would round down to the last unit and time between 8 and 14 minutes would round up to the next unit. The following is an example of rounding:

An occupational therapist conducts a home visit for 56 minutes, which is three units (i.e., 45 minutes) and an extra 11 minutes. This visit would round up to 60 minutes or four units because it falls within the 8 – 14 portion of the rounding rule. However, at the next visit the occupational therapist leaves after 37 minutes, which is two units (i.e., 30 minutes) and an extra 7 minutes. This visit would round down to 30 minutes or two units because it falls within the 1 – 7 portion of the rounding rule.

➤ **No-Show Visits**

If a First Steps provider arrives to the location to complete a First Steps visit but the child is not present, then the provider may claim one unit for the time attempted to complete the visit.

To submit a claim as a no-show, the provider checks the *Family No Show* box in the claim entry process. For more information on no-show visits, go to the DESE First Steps website – For Providers.

- **EI Code.** The code pre-populates from the authorization and selected from the drop-down window in the claim entry process.
- **CPT Code.** The code pre-populates from the authorization and selected from the drop-down window in the claim entry process.
- **Charges.** The amount requested for payment in accordance with the First Steps rate schedule.

➤ **Assistive Technology Devices**

For Assistive Technology Devices, the rate is the actual cost of the device. Actual cost of the device means the base price of the device plus any shipping and handling charges or mark-up. The total actual cost cannot exceed 25% of the base price.

- **Check Claim.** Select this button to preview the claim. If there is a problem with the claim, a preliminary denial reason is displayed and the claim can be corrected before it is submitted.
- **Submit Claim.** To submit the claim, select the *Submit* button and the claim is processed for payment.

C. Claim Status

After a claim has been submitted, the status of the claim is displayed in WebSPOE. The system automatically updates the status based on claim entry and payment.

A claim has three status types:

- **Awaiting Update.** The claim is waiting to be processed for payment. The claim can be adjusted, corrected or voided in WebSPOE as long as the status is Awaiting Update.
- **Updated.** The claim is pending payment. The claim cannot be adjusted or corrected in WebSPOE at this point.
- **Paid.** The claim has been paid to the payee. The actual value or amount paid is listed on the claim. If the claim was denied, the paid amount is \$0.00.

SECTION II: PROVIDER PAYMENTS

DESE has established a payment rate for each provider discipline. The rate reflects a higher reimbursement for services provided in the natural environment. For more information on the specific rates for each discipline and service setting, see the *Provider Rates Schedule* (Chapter 9 Documents).

A. Electronic Funds Transfer

Claims submitted by providers are received at the CFO and processed according to the First Steps reimbursement schedule. The schedule is a set time frame for payments to occur every two weeks. Providers must monitor the time frames for claims submission period and payment dates in order to know when payments will be made. To review the current reimbursement schedule, see the *Provider Reimbursement (Check Run) Schedule* (Chapter 9 Documents).

Provider payments are made via direct deposit. The payment is an electronic funds transfer (EFT) to the bank account identified by the provider on the EFT/Direct Deposit Authorization Form that was completed at the time the provider enrolled in First Steps. This form must be updated in the event there is any change to the provider's bank account number.

Payments are made to the *Payee Name* listed on the EFT/Direct Deposit Authorization Form. If the provider is an individual/independent payee, the person delivering the service is usually the same person submitting the claim and delivering the service. However, if the provider is part of an agency, the person submitting the claim may not be the person delivering the service. The agency is responsible for paying the person who delivered the service.

Regardless of the payee type, all requirements for claim submission must be completed as described in Section I in order for the payee to receive payment.

B. Payment Details

Once the EFT process for provider payment begins at the CFO, the payee can view the EFT details and other documentation to support the payment under *Payments* section of Billing Detail on the *Provider Account Management* tab in WebSPOE.

Once an EFT line is selected, the payee can view payment details for that EFT. Payments for evaluation/assessment, eligibility meeting attendance, IFSP services, travel incentive and AT devices appear in the *Claims List* under the *Payments* section of Billing Detail on the *Provider Account Management* tab. Payments for IFSP and EIT meetings, mileage and offline billing appear in the *Transaction List* under the *Payments* section of Billing Detail.

Also under the selected EFT line of the *Payments* section of Billing Detail, the payee will also see the **Explanation of Provider Payment (EOP)** that describes details of children for whom

services were delivered. When selected, the EOP document will display in a Report Viewer screen for the payee to view. The document can be exported as a PDF to print or save. See *Appendix A* for a sample copy of a payee's EOP.

Providers should reconcile each claim and payment as soon as possible after the EFT is complete in order to verify all First Steps services have been billed and paid accordingly.

Additionally, the child's parent or guardian who is listed in WebSPOE as the Head of Household receives an **Explanation of Benefits (EOB)** that describes the details of the provider payment, including dates of service and amount paid. See *Appendix B* for a sample copy of the parent's EOB.

SECTION III: BILLING OR PAYMENT PROBLEMS

When there is a problem with the authorization or the claim, a provider needs to know the reason for the problem in order to take the appropriate action to correct it. Depending on the reason for the problem, the provider may be able to correct the problem immediately in WebSPOE or the provider may have to submit an offline billing request.

A. Denial Codes

In the event a claim is denied, the provider is immediately notified of the denial code and description in WebSPOE.

The following is a list of denial codes and descriptions:

Code 3: Duplicate Charge

Claim denied because of duplicate charge for the same service date, authorization number and CPT code on one or more authorizations.

Code 4: Not Authorized on Date Indicated

Claim denied because service date was not within the authorization date range, which includes the start date through and including the end date.

Code 5: Child Not Eligible for the Program

Claim denied because service date was not during an active IFSP period; or claim denied because service date was before date parent gave consent for the service.

Code 6: Authorization Canceled/Discontinued

Claim denied because service date was not within the authorization date range, which includes the start date through and including the canceled or discontinued date.

Code 9: Service Date More Than 60 Days Old

Claim denied because service date was more than 60 days from submission date.

Code 12: Authorized Procedure Limit Exceeded

Claim denied because amount of units was more than amount available, which may result in a partial payment; or claim denied because no available units left on the authorization.

Code 13: Invalid CPT or Invalid EI Proc Code for Specialty

Claim denied because the CPT or EI procedure code is not valid for the provider's specialty.

Code 18: Provider No Longer Actively Enrolled

Claim denied because service date was during a period the provider's account was not active.

Code 26: Over Resubmission Filing Limit

Claim denied because service date was more than 180 days from current date for claim submission.

Code 31: Invalid Provider for Date of Service

Claim denied because service date was during a period that another provider was authorized for service on the authorization.

Code 32: Covering Provider Active on This Date of Service

Claim denied because service date was during a period a covering provider was authorized for service on the authorization.

Code 43: Invalid Specialty

Claim denied because the provider is not credentialed for the specialty associated with the service on the service date listed.

Code 50: Authorization Suspended on Service Date

Claim denied because service date was during a period the child's record was suspended due to overdue balance for family cost participation.

Code 100: Claim Line Voided

Claim line was voided.

Depending on the denial reason and status of the claim, the provider has several options to correct a denied claim, including: void a claim, correct a claim and offline billing.

B. Void a Claim

To void an erroneous claim and delete the claim completely, the claim must be in *Awaiting Update* status.

To void a claim, the provider selects the *Correct Claim* button in WebSPOE, which brings up the claim information. The provider clicks on the claim line for the claim that needs to be voided. The claim line screen displays and a *Void* button is located on the screen. The provider selects the *Void* button which changes the units to 0 and the charge amount to \$0.00. The provider then resubmits the claim in order for it to be voided.

When the *Check Claim* button is selected or the claim is resubmitted, the claim shows a denial reason of **Claim Line Voided**, which allows the provider to view claim lines that were voided.

C. Correct a Claim

To correct a claim, the provider must first review the denial code reason and the status of the claim.

1. Denial Codes 13, 18 and 43

To correct denial codes 13, 18, and 43 (i.e., denied claims related to the provider's account or specialty), providers must use the following procedures:

- Check the status of the provider's account who is delivering services compared to the dates of service. For information about the status of a provider's account, contact the CFO Provider Enrollment office at:

CFO Provider Enrollment
PO Box 29134
Shawnee Mission, Kansas 66201-9134
(866) 711-2573 extension 2
mofsenroll@csc.com

- Contact the child's Service Coordinator if authorization changes are necessary. Depending on the problem, the Service Coordinator may be able to correct the authorization in WebSPOE by entering a new authorization or changing the authorization details.

2. Denial Codes 3, 4, 5, 6, 12, 18, 31, 32 and 50

To correct denial codes 3, 4, 5, 6, 12, 18, 31, 32, and 50 (i.e., denied claims related to service dates not corresponding to authorizations for service or authorization date ranges), the provider should check the service date entered in the claim compared to the actual date of service delivered to the child and family.

Providers must use the following procedures to correct denials related to service dates and authorizations:

a) Correct the Date of Service

If a date of service was entered incorrectly, the provider may be able to correct the date and resubmit the claim.

- For a denied claim in *Awaiting Update* status, the provider can correct the claim data in WebSPOE and resubmit the claim.
- For a denied claim in *Updated* or *Paid* status, the provider must submit a copy of the claim and a letter explaining the billing problem or request for correction. Providers must clearly mark the correction that needs to be made on the copy of the claim, including any correction to the date of service or number of units. The letter must be submitted to:

b) Correct the Authorization

If the service date was entered correctly, but the problem is with the authorization, the provider must contact the child's Service Coordinator immediately. Depending on the problem, the Service Coordinator may be able to correct the authorization in WebSPOE by entering a new authorization or changing the authorization details.

- **Resubmit in WebSPOE.** If the Service Coordinator can correct the authorization problem in WebSPOE, the provider can resubmit a claim in WebSPOE using the correct authorization.
- **Offline Billing.** If the Service Coordinator attempted to correct the authorization in the WebSPOE but cannot (due to child's record closed, IFSP period ended, etc.), then the provider completes an *Offline Billing Request* form (see Chapter 9 Documents) in order to be paid for the service delivered.

3. Denial Codes 9 and 26

To correct denial codes 9 or 26 (i.e., denied claims related to timely submission), providers must complete an offline billing request.

D. Offline Billing Request

In the event a claim cannot be successfully submitted through WebSPOE, the provider may request an offline billing. An offline billing request is only used when all other alternatives for billing in WebSPOE have been exhausted because offline billings require manual tracking in the First Steps budget.

The provider must have documentation for a service delivered in First Steps. If documentation can be entered in WebSPOE (e.g., progress note, evaluation report), then it must be entered before requesting an offline billing payment. If the documentation cannot be entered in WebSPOE (e.g., an assistive technology device), then it must be attached to the offline billing request.

The provider submits a completed offline billing request with supporting documentation for the delivered service to the SPOE or the First Steps Area Director to be processed for payment.

An offline billing request must be submitted within one year of the date of service. Requests for payments over one year will not be processed for payment.

The offline request and supporting documentation may also be submitted to the state office at:

DESE First Steps Program
Attn: Offline Request to Area Director
PO Box 480
Jefferson City, Missouri 65102
Fax: (573) 526-4404

The Area Director reviews the offline billing information to determine if the request is appropriate and the documentation is sufficient for payment. The Area Director may contact the provider if there are any questions about the request.

Once the offline billing request has been reviewed and approved, payment for an offline billing is made via direct deposit as described in Section II.

SECTION IV: AUDITS AND MONITORING

All First Steps services are subject to federal, state and local audits and provider monitoring. Providers must participate in routine audit and monitoring of the services delivered to First Steps families. Participation in an audit or monitoring may include involvement in self-assessment, on-site monitoring, data collection, reporting requirements, record or chart audits, financial audits, complaint investigations and customer satisfaction surveys.

As a part of any audit or monitoring, providers must provide to state staff, or their designee, all required documentation and information in a timely manner.

A. Fiscal Monitoring

Providers are required to meet and maintain all standards, guidelines and policies of the First Steps program, including proper billing practices. The state conducts regular fiscal monitoring activities in order to verify providers are documenting and claiming services in accordance with state guidelines and instructions.

The following are examples of fiscal monitoring activities related to provider billing practices:

- **Number of Hours Billed.** The state reviews the number of hours in a single day that providers claimed for First Steps services. State staff review claims and progress notes to verify there is sufficient documentation to justify payments to providers.
- **No-Show Visits.** The state reviews the amount of no-show visits that providers claimed in a specified period of time (e.g., a month). In accordance with state guidance and instructions for no-show visits, state staff review claims and progress notes to verify there is sufficient documentation to justify payments to providers.
- **Travel Incentive Payments.** The state reviews the number of travel incentives that providers claimed in a specified period of time (e.g., a day). In accordance with state guidance and instructions for travel incentive payments, state staff identify potential overutilization of the travel incentive and notify the provider accordingly.
- **Timely Claims Submissions.** The state monitors the timeliness of claims that providers submitted in a specified period of time (i.e., month). State staff review claims to verify providers filed in accordance with state guidance and instructions for claim submission (i.e., within 60 days from date of service).
- **Billing Investigations.** The state investigates complaints about provider billing practices through the use of the *Report a Billing Issue* function in the WebSPOE. As complaints are received, state staff process the complaint and review authorizations, claims and progress notes to verify there is sufficient documentation to justify payments to providers.

In the event the provider's claims or progress notes do not support the payment made to the provider, additional documentation will be requested from the provider. After a review of the documentation, a monitoring result is decided by state staff. A monitoring result of *Passed* indicates there was sufficient documentation to justify the provider payment. A monitoring result of *Failed* indicates there was not sufficient documentation to justify the provider payment.

In the event of a *Failed* result in a fiscal monitoring, the state may recover funds from the provider. Providers must make full reimbursement of any duplicate or erroneous payment billed or received as an act or omission of the provider who delivered the service or claimed the service. Providers will have an opportunity to respond to a recovery of funds. The state may also require the provider participate in technical assistance or training regarding recordkeeping and billing practices. Additionally, *Failed* reviews are subject to follow-up fiscal monitoring and a review of additional documentation to verify the provider's billing practices are in accordance with federal and state guidance and instructions.

B. Compliance Monitoring

Providers are to comply with all state regulations governing the First Steps program in the Missouri State Plan for Part C of IDEA, including the delivery of services in accordance with the child's IFSP.

The state conducts annual compliance monitoring activities in all ten SPOE regions in order to verify services are delivered to families in accordance with state regulations. Compliance monitoring procedures may include a desk review of individual child records, SPOE and provider interviews and/or on-site visits.

The following are examples of compliance monitoring activities related to IFSP service delivery:

- **Timely Services.** The state monitors the delivery of new IFSP services to verify services were delivered in accordance with federal and state regulations for timely services (i.e., the first visit was within 30 days from the date of written parental consent). State staff review IFSP documentation, authorizations, progress notes and claims to determine if services were timely.
- **Services in Accordance with the IFSP.** The state monitors the delivery of IFSP services to verify services were delivered in accordance with federal and state regulations for IFSP services. State staff review IFSP documentation, authorizations, progress notes and claims to determine if services were delivered in accordance with the IFSP.

In the event the provider's claims or progress note documentation does not support the IFSP team decision for services, additional documentation may be requested from the provider or the child's Service Coordinator. A compliance monitoring result of *Yes* indicates there was sufficient documentation to verify services were in accordance with federal and state regulations. A compliance monitoring result of *No* indicates there was not sufficient documentation to verify

services were in accordance with federal and state regulations. Providers must correct any areas of noncompliance identified by the state within timelines specified.

In the event of a *No* result in a compliance monitoring review, the state may require the provider participate in technical assistance or training regarding federal and state regulations. Additionally, all *No* results are subject to follow-up compliance monitoring and a review of additional documentation to verify the provider's practices for delivering IFSP services are in accordance with federal and state regulations.

APPENDIX A – SAMPLE EXPLANATION OF PROVIDER PAYMENT

Explanation of Provider Payment

Payee: Service Company

SAMPLE

Date: 6/7/2016
Check #: EFT-XXXXXX
Statement Date: 5/26/2016

Amount: \$340.00

Provider ID : ** *****
Provider Name: Joe Provider
Program: Early Intervention

Service Category	Services Dates	Amount Billed	Amount Denied	See Note	Amount Disallowed	Paid Previously	Amount Paid
Child: Baby Boy		Parent/Guardian: FATHER BOY			Claim: 222222-22222-20002		
Child ID: 123456789					Account:		
Occupational Therapy	04/01/2016	68.00	0.00		0.00	0.00	68.00
Occupational Therapy	04/12/2016	68.00	0.00		0.00	0.00	68.00
Occupational Therapy	04/22/2016	68.00	0.00		0.00	0.00	68.00
Occupational Therapy	04/29/2016	68.00	0.00		0.00	0.00	68.00
		Sub-Totals	\$272.00	\$0.00	\$0.00	\$0.00	
Paid to Provider:							\$272.00
Patient: Baby Girl		Parent/Guardian: MOTHER GIRL			Claim: 333333-33333-10003		
Child ID: 987654321					Account:		
Occupational Therapy	04/3/2016	68.00	0.00		0.00	0.00	68.00
		Sub-Totals	\$68.00	\$0.00	\$0.00	\$0.00	
Paid to Provider:							\$68.00
Patient: Toddler Child		Parent/Guardian: FATHER CHILD			Claim: 444444-44444-10004		
Child ID: 234567891					Account:		
Occupational Therapy	04/01/2016	68.00	68.00	3	0.00	0.00	0.00
Occupational Therapy	04/11/2016	68.00	68.00	3	0.00	0.00	0.00
Occupational Therapy	04/27/2016	68.00	68.00	3	0.00	0.00	0.00
		Sub-Totals	\$204.00	\$204.00	\$0.00	\$0.00	
Paid to Provider:							\$0.00
		Provider Totals	\$544.00	\$204.00	\$0.00	\$0.00	
Total Paid to Provider:							\$340.00

APPENDIX B – SAMPLE EXPLANATION OF BENEFITS

SPOE Region
1100



SAMPLE
Explanation of Benefits

ID No.	Participant Name	For Provider Payments Occurring
110012345	JANE DOE	7/01/2016 To 7/30/2016

JOHN DOE
4567 XYZ STREET
JEFFERSON CITY, MO 65102

For inquiries regarding information please call:
(866) 711-2573

This is NOT a bill.

The service dates and amounts below were paid to your child's First Steps provider.

Service Type	Service Date	Amount Billed	Amount Denied	Amount Disallowed	Amount Paid
Provider: Provider A					
Claim: 12345-12345-10000					
Occupational Therapy – Support Joint Visit	7/10/2016	\$68.00	\$0.00	\$0.00	\$68.00
Provider Payment Date:	10/03/2016	\$68.00	\$0.00	\$0.00	\$68.00
Provider: Provider A					
Claim: 12345-12345-10001					
Occupational Therapy – Provider Travel Service	7/10/2016	\$68.00	\$0.00	\$0.00	\$68.00
Provider Payment Date:	10/03/2016	\$68.00	\$0.00	\$0.00	\$68.00
Provider: Provider B					
Claim: 12344-12344 – 20002					
Physical Therapy – Support Joint Visit	7/10/2016	\$68.00	\$0.00	\$0.00	\$68.00
Physical Therapy – Direct Child Service	7/20/2016	\$68.00	\$0.00	\$0.00	\$68.00
Provider Payment Date:	10/03/2016	\$136.00	\$0.00	\$0.00	\$136.00
Totals:		\$272.00	\$0.00	\$0.00	\$272.00