

MBS and CMBS DATA ENTRY TIPS – Revised October 6, 2004

Listed below are recommended activities and tips to follow in preparing for and entering billing data into the MBS/CMBS software. History has shown that providers who confirm key header information with the correct source documents significantly decrease subsequent billing errors ... and headaches. The following information is organized by the order in which data should be entered when you get the software for the first time.

- **SYSTEM INFORMATION** (*File – System Information*)
Complete once. Review periodically and update as information changes.
 - System Information is the first screen you should fill out when you get the software for the first time.
 - PCID – Each copy of the software comes with its own PCID. It is pre-entered into the software and cannot be changed. CMBS numbers are in the 7000 range and MBS numbers are in the 8000 range.
 - Contact Information should be for the person who **actually does the billing** for the provider. This is the person DCFS Technical Support will contact when technical software-related issues need to be handled, including any Laplink data transfers or software upgrades. Fields include the billing contact's name, phone number and e-mail address.
 - The File Transfer Protocol (FTP) address, Port, User ID and Password information will be filled in when the provider receives the MBS/CMBS software from DCFS.

- **CONTRACT HEADER** (*File - New/Open - Contract*)
Complete once for each Medicaid contract per fiscal year. Update only as needed for new contracts, Medicaid rate changes, change of contract number, etc.
 - The provider contract number is ten-digits in length. Contract numbers change each fiscal year. It is important to confirm each contract number each fiscal year.
 - Source Document: DCFS Medicaid contract – first page, upper left hand corner.
 - Contract start and end dates are generally twelve months in length – even if the provider holds a multi-year contract.
 - Source Document: DCFS Medicaid contract – first page.
 - **MBS users only** – Eligibility Categories indicate the set of Medicaid services the provider is certified for; Category 2 = 132.150 services, Category 3 = 132.155 services, Category 4 = 132.165 services, Category 5 = 132.170 services. Even though there was a transition in certification due to the Rule 132 changes, providers should select the categories that applied as of July 1, 2004 (i.e., **before** the rule revisions were adopted)

and then retain those categories in the MBS software for the remainder of the fiscal year.

- Source Document: DCFS or DHS Medicaid certificate
- **CMBS users only** – Contract Type indicates Comprehensive Mental Health for the 132.150/165 service set or Comprehensive Rehabilitation for the 132.155/170 service set. Even though there was a transition in the service set due to the Rule 132 changes, providers should select the type of Comprehensive services that applied as of July 1, 2004 (i.e., **before** the rule revisions were adopted) and then retain that type of Comprehensive services in the CMBS software for the remainder of the fiscal year.
 - Source Document: Program Plan
- **CMBS users only** –For the Medicaid Rate section enter the **Medicaid portion** of the comprehensive rate into each box/month of the contract.
 - Source Document: DCFS Medicaid contract or, if applicable, a rate adjustment letter from DCFS.
- **LPHA HEADER** (*File - New/Open - LPHA*)
Complete once for every LPHA who will be directing services/signing off on ITPs in the program. Update with new LPHAs as needed.
 - All LPHAs signing ITPs – authorizing Medicaid services - must be entered in this header screen. This information feeds into a drop-down menu in the Client header information screen.
 - Source Document: Current ITP for each client receiving Medicaid services within the Medicaid contract(s).
 - The LPHA license number is nine-digits in length.
 - Source Document: The LPHA’s current certificate issued by the State of Illinois - Department of Professional Regulation.
- **SITE HEADER** (*File - New/Open - Site*)
Complete once for every site linked with Medicaid contracts/services. Update with new sites as needed.
 - The “Site Medicaid ID” number is also referred to as the “DPA Enrollment Number.” Each site has its own separate number. It is twelve-digits in length (*generally the provider’s FEIN # followed by three digits*).
 - Source Document: Illinois Department of Public Aid, Agreement for Participation in the Illinois Medical Assistance Program. The provider holds a copy of this document. IPI can also assist you in identifying the correct number for each site.
 - If the provider has multiple certified sites - confirm that each site address has its own Site Header, and that each site is linked with the correct “Site Medicaid ID” number.

- **CLIENT HEADER** (*File - New/Open - Client*)
*Complete once for every open/active client served in the Medicaid contract(s).
Update with new clients as needed.*
 - The “Active for Billing” designation identifies the client as active/open or discharged/closed from the contract. If the client has been discharged from the contract and all billing has been completed, the checkmark in the box at the top should be removed (the field will then say “No”) The client’s information will still be saved in the system and can be reactivated if the client returns to one of the provider’s DCFS Medicaid contracts.
 - Client name and client ID number (*also known as the DCFS ID # or case ID # - NOT the Family ID #*) must have an exact match with IMSA/CYCIS (*the DCFS data base*). The client’s DCFS ID number is eight-digits in length.
 - Source Document: For residential, foster care, and independent/transitional living contracts verify the client name and ID number against the Statement of Payments. Counseling contracts can verify the client name and ID number with the DCFS caseworker (*DCFS caseworkers have access to IMSA/CYCIS - the CR-01 and/or CR-04 screens confirm client name and ID number*).
 - The Recipient ID number (*also known as the client’s Medicaid number or green card number*) is nine digits in length. Counseling contracts billing for non-Medicaid clients should use 999999999 in place of the client’s recipient ID number.
 - Source Document: The client’s Medicaid card; if a copy of the client’s Medicaid card is not in the client’s record, then the client’s caseworker should be able to track down the card; for MAC clients, the child’s parent should have the Medicaid card.
 - The client’s primary diagnosis must be selected from the DCFS Medicaid diagnosis list provided in the drop-down menu.
 - Source Document: Current ITP, or consult with the LPHA responsible for approving the ITP and the client’s primary diagnosis. It is important that provider staff have a copy of the DCFS Medicaid diagnosis list so that only the approved primary diagnoses are used. V71.0 is allowed for billing for services **only** during the assessment phase. Once the MHA is completed (the date the MHA is signed by the LPHA), billing must not be submitted under V71.0.
 - Confirm that the correct DCFS contract, site address and LPHA are selected for each client. Each client must be linked with the correct site address/Site Medicaid ID number in the Client Header. For example, if John Doe is primarily served out of the certified site at 100 Pleasant Lane, then the Client Header for John Doe must indicate the site Medicaid ID number for 100 Pleasant Lane. However, there are some exceptions for

services delivered on a campus setting. *(If there are questions, contact your IPI consultant to help determine the appropriate number to use).*

- The client's DCFS Medicaid contract, diagnosis, site and LPHA may shift over time and must be adjusted in MBS/CMBS. Systematically reviewing these Client Information header items throughout the fiscal year is recommended.

- **ENTER NEW SERVICE RECORDS: MBS ONLY** (*Services – Enter Service*)
Complete every month for every client served in the program for that month.

- The client name, contract and site information must be selected from the drop-down menus provided.
- For each service type, the procedure drop-down menu shows the HIPAA Code for each service (with modifiers as appropriate), and the corresponding service description.
- To cover the transition from a code/rate table for services in July 2004 and a different code/rate table for services beginning August 1, 2004, the drop down menu includes entries from both tables. Providers must select the procedure code/service description that corresponds to the correct date range for the date the service was provided. Printing out the Procedure Code Table from the Reports menu will help providers identify which date ranges link with which procedure codes/service descriptions in the drop down menu. [Reports – Listings – Procedure Codes]
- For services provided August 1, 2004 and after, several services have different rates for different staff levels. The billing documentation must contain sufficient information about the credentials of the staff who provided the service so that the billing staff can select the correct procedure code/service description.
- The distinction between the on-site rate and the off-site rate occurs based on the designation in the Place of Service field—see below.
 - Source Document: Service Documentation must include the type of service, staff credentials, and location of the service.
- The Place of Service drop-down menu identifies the service location. If the Place of Service is identified as Home or Other Unlisted Facility, then the service will automatically be billed at the off-site rate. If the Place of Service is identified as Office, then the service will be billed at the on-site rate. The Psychiatric Residential Treatment Facility option is also an **on-site** rate, and is used ONLY for residential contracts that bill through MBS.
- Units: Different services have different amounts of time for a unit of service. Most services are based on a 15 minute unit. For those services, any session/contact lasting at least 7.5 minutes qualifies as a unit of service. For services based on a one hour unit, 30 minutes qualifies as a unit of service. For services based on an event-mode unit, the occurrence of the event qualifies as a unit of service.

- Source Document: Service Documentation must note the duration of each service episode by indicating start time and either end time or number of units. The assigned unit for each service appears in the Service Activity Crosswalk (distributed at training) and the DCFS tables (sent to providers with a Memo dated 9/21/2004).
 - The number of units specified for a particular service for a particular client on a particular date is locked once the billing data is **transmitted** to DCFS/MBS. Thus, it is very important to confirm service information **BEFORE** transmitting billings to DCFS/MBS. For example, if 2 units of on-site Therapeutic Behavioral Services for John Doe on September 1 are transmitted to DCFS, then the provider realizes that there were actually 5 units of on-site Therapeutic Behavioral Services delivered to John Doe on September 1, the provider will **not** be able to bill for the additional 3 units **unless** the original billing that was transmitted gets rejected at DCFS due to a billing error. The provider's "error" in forgetting the additional 3 units is not an MBS error. In a different scenario, if the provider realizes that there are additional units for a client for a particular service for a particular day **BEFORE** transmitting the billing record to DCFS, then the provider can adjust the number of units.
 - To edit an existing service, double click on the client whose service you wish to edit on the left side of the screen. The service records associated with that client will appear on the right side of the screen. Double click the service record you wish to edit. **If all areas of the service record are grayed out, then the service is not available for editing. Services that have been submitted to MBS and have not been returned in error are not available for editing.**
- **GENERATE NEW SERVICES: CMBS ONLY** (*Services – Generate For The Current Client/Generate For All Clients*)
 - When you have selected "Generate For the Current Client" or "Generate For All Clients" from the Services menu, a dialog box will open that lists the client name(s) on the left, followed by start date and end date. If you select "Generate For All Clients," all clients designated as Active will be listed. If you select "Generate for the Current Client," only the client name that was selected on the opening CMBS screen will appear in the dialog box. Start and End dates default to the current month, but can be changed as needed to identify gaps in service provision, or mid-month admission or discharge dates.
 - Comprehensive billing can include billings for a continual month(s) or a portion of a month. Keep in mind that the DCFS Board Payment System pays providers for the day of admission, but not the day of discharge. When entering dates for a client service period when the client has **not** been discharged, the start date should be the first date of service for that billing period and the end date should be the last date of service plus one. For example, if the client is in placement and receiving services for the

entire month of January and continues to be a client in February, then the start date is January 1 and the end date is February 1. The following month's billing (under similar circumstances) would include a start date of February 1 and an end date of March 1. By contrast, if the client was discharged on January 20th, then the end date in CMBS should be January 20th for that client.

- There are two basic options for removing non-service days from the billing submission, as follows:
 - **OPTION ONE:** As you are entering Start and End dates in the Generate For The Current Client screen, enter multiple start and end dates to not bill for the days with no documented service. For example, if no services were provided for two days during a client's home visit (July 10th and 11th, 2004) but the client was still in placement and receiving services every other day for the month of July, services would be noted as 7/1/04-7/10/04 (last service day plus one), followed by 7/12/04-8/1/04. *NOTE: This cannot be done using the Generate for All Clients option.*
 - **OPTION TWO:** Generate services for every day of the month using either of the two Generate Services options. Once service records for every day have been generated, go to the Services menu and select Delete a Service That Has Not Been Submitted. All service records that are eligible for deletion will be listed in the Delete screen. Select/highlight and delete the appropriate dates and click the Delete button. This must be completed **BEFORE** submitting the billing data to DCFS/MBS.
- Bed hold days can be submitted for billing as long as a Medicaid service has been provided and documented and the client will return to the placement. These days will be marked and returned as errors until DCFS has approved the 906-5 Residential Care Bed Hold Payment Request(s). It is important to keep track of the client(s) and dates billed so that those days can be identified to reconcile against payments and billing. It is also an option to hold all bed hold days from Medicaid billing until DCFS has approved those bed hold days for payment. In either case, tracking the clients and days billed (*or not billed*) **must** occur.
- **TRANSMITTING SERVICES TO DCFS (*Service - FTP Transfer Services*)**
 - When you select FTP Transfer Services you will have three options;
 - **One: Send a New Group of Records.** Choose Send New Group of Records at the end of each monthly billing period to transfer billings entered into MBS/CMBS to DCFS for processing;

- **Two: Recreate Previous Submission.** Choose Recreate a Previous Submission only under the direction of MBS Technical Support; and
 - **Three: Check for Return File Only.** Choose Check For Return File Only to download reports from MBS. The option to Transfer will appear on your screen. Once the billing data has been transferred/downloaded go to the REPORTS header of the MBS/CMBS software to review or print the data available (e.g., an error report).
 - The Medicaid Billing Processing Schedule indicates, among other important dates, the cutoff date for FTP file submission. The cutoff date is the last date for providers to submit the previous month's service billings for processing. For example, if the cutoff date for FTP file submission is 3/31/xxxx, then billings for services in the month of February (and any earlier months) should be submitted for processing. It is highly recommended that providers only submit billings with service dates within the service billing period being processed. Billings received that have service dates **after** the service billing period being processed will be held, and not edited, until the following month.
 - Source Document: Medicaid Billing Processing Schedule.
 - To retrieve your "return data," the information must be downloaded into your system through FTP Transfer Services - select the Check for Return File Only option then select Transfer. Once the data has been transferred/downloaded go to the Reports header of your MBS/CMBS software. Your Error Report can be accessed as well as an All Files Processed report indicating the files that have been processed and indicating if they were accepted or returned as an error.
- **MBS/CMBS Signals**
 - The icon to the immediate left of each service record identifies that record's status, as follows:
 - Green Light: Ready to be sent to DCFS
 - Envelope: Has been sent to DCFS and not yet returned
 - Blue Check: Has been sent to DCFS and returned free of errors/accepted
 - Yellow Yield Sign: Has been sent to DCFS and returned in error
 - Yellow Yield Sign with a Red Check: Voided record that has been returned
 - Red Stop Sign: Error that needs special attention.
 - **ERROR TIPS**
 - Some errors will cause 100% of the billing to be rejected. The most common of these are 404 (contract rate) and 114 (Medicaid certification number). To make corrections of this type, you will need to correct the

information in the contract or site headers first, then select the option to mark all errors as corrected. You will not need to correct each service record individually. When all errors have been marked as corrected, the Yield signs will turn back into green lights to indicate the records are ready to be re-sent.

- Keep an error correction log so that corrections and patterns of errors can more easily be identified. Remember that errors in the Client, Contract, LPHA and Site Information screens carry over into the Services screen and must be corrected in both places before the errors are completely addressed. Errors that remain in services held/not processed by DCFS will not appear until the billings for that service period are processed.