

## INSTRUCTIONS FOR COMPLETING THE DPH LTAT BILLING RECORD REVIEW TOOL

1. These instructions describe how the tool is used by the Administrative Consultants in conjunction with the bi-annual Administrative Monitoring visit. Your agency may choose to use this tool for periodic reviews between monitoring visits, or to review other programs. These instructions may differ if the tool is used outside the monitoring visit.
2. Enter the site name beside "Site". If your agency has more than one site, we will review records and complete a form for EACH site.
3. There should be at least one Medicaid record, one insurance record, and three self pay records for each program reviewed. We may request additional records if your agency has a large patient base or if the first records which are reviewed have problems. We will review at least five records from each program. If there are no Medicaid or Insurance records, we will review additional self pay records. If there are no self pay records, we will review additional Medicaid or Insurance records.
4. Enter the program being reviewed beside "Program".
5. Enter the date range of the visits being reviewed beside "Date Range".
6. Patient identification numbers and dates of services are entered in the "Patient ID and Date of Service" column. The Medicaid record is entered on the first line, the Insurance record is entered on the second line, and self-pay records are entered on the subsequent lines.
7. Complete the columns from the financial information in the patient's record.
  - a. Note the Key in the upper right corner for indicating "Yes", "No", or "Not Applicable".
  - b. If the patient has requested "No Mail", then the Family Size should be 1 and only the patient's income should be considered.
  - c. Enter the family size and income from the patient's record which would apply to the visit date under review.
  - d. Under "Documented Percentage of Pay" enter the sliding fee percentage as indicated on the patient's financial record.
  - e. Both the Patient and the Interviewer should sign and date the financial record. Use the key to indicate if this was done correctly in the patient's record.
  - f. If your agency uses paper encounter forms, we will verify that the date on the encounter form matches the date that was keyed in the system. Use the key to indicate if this was keyed correctly.
  - g. If your agency uses paper encounter forms, we will verify that all services entered on the form were keyed in the system and that no services were keyed in the system which were not indicated on the form. Use the key to indicate if this was done correctly.
  - h. The patient's sliding fee scale percentage should be calculated based on their recorded family size and annual income. The calculated percentage should be compared to the "Documented Percentage of Pay" to verify that the patient was charged the correct percentage. Use the key to indicate if the two percentages match.
  - i. Once the sliding fee scale percentage has been verified, the patient's ledger should be examined to verify that the correct percentage was applied to all services for the date under review. Use the key to indicate if the patient was charged correctly.
  - j. For Insurance records, there are two additional items which are reviewed. We will verify that the services were billed to insurance and that any balance for which the patient is responsible (per the EOB) is applied to the verified sliding scale percentage.
  - k. For Medicaid patients, the only items which are reviewed are the paper encounter form (which is compared to what was keyed in the system) and verification that the claim was billed. The claim should either be paid or rebilled, if denied.