

Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) PROCEDURE	Procedure Number: SGFP-001
	Supersedes: New
Procedure Title: State General Funded Services (SGF) and Family Infant Toddler (FIT) Provider and Contractor Billing Procedure	
Effective Date: July 1, 2008	
Approved: SIGNATURE ON FILE	Date:

I. POLICY REFERENCE

SGF and FIT Billing Policy – SGF-001.

II. PURPOSE OF PROCEDURE

To outline the roles and responsibilities and timelines for SGF and FIT Provider billing.

III. APPLICABILITY

SGF and FIT Providers, DDSD Staff and Managers.

IV. DEFINITIONS

Billing: Means the process of a provider of a service submitting a request for compensation and the funding source in authorizing and making payment to said provider.

DDSD Contractor: Means any individual or agency that has a professional - technical contract for specified non-traditional services or deliverables (i.e., those that do not fall under any of the services standards utilized by the Department of Health). These contracts are negotiated as needed based on contract term. Negotiations will include both the scope of work for the contract and the nature of the compensation.

DDSD Contractor's Invoice: Means a form designed by each individual DDSD Contractor for compensation. The form must include the contract number, period of service, specifications of what cost or deliverable is to be reimbursed, total compensation requested, name of contractor, and remittance address contractor has registered with the Department of Finance Administration.

DDSD Invoice Form: Means the DDSD Invoice Form Number SGF-100, previously known as Form A, which is utilized by providers of traditional SGF services and non-client specific FIT-funded services to request payment. This is a standardized form that must be submitted on a monthly basis.

FIT Provider: Means any provider of Family Infant Toddler (FIT) Program services in accordance with DDSD Service Definitions and Standards and 7.30.8 NMAC Requirements for Family Infant Toddler Early Intervention Services.

FIT-KIDS: Means the statewide online data and billing system for the Family Infant Toddler Program. The acronym KIDS stands for Key Information Data System.

FIT-KIDS Invoice: Means the invoice generated from the FIT-KIDS (Key Information Data System) online data and billing system for the Family Infant Toddler (FIT) Program. FIT-KIDS invoices are generated in accordance with the published billing calendar.

SGF Provider: Means any provider of respite, adult residential or adult day services receiving funding through traditional State General Fund monies. These providers are responsible for implementation of the most current standards for State General Funded Services. These providers are chosen through a Request for Proposal Process. These providers will bill the Department of Health using standard unit rates set by the Department.

V. PROCEDURE

The roles and responsibilities outlined in this procedure must be completed according to the timelines specified below. Failure to follow this procedure will result in a delay in the provider reimbursement.

The following procedure applies to Provider Agreements for FIT direct services provided to children and families:

	Responsible Person / Agency	Actions	
1.	FIT Providers	A.	Enter delivered services data into FIT-KIDS (Key Information Data System) and mark records as ‘Ready to Bill’ by the 10 th of the month following the month of service. (Note: this date may have to be earlier at the end of the fiscal year).
		B.	Generate FIT-KIDS monthly invoice in accordance with the published FIT-KIDS billing calendar.
2.	FIT Staff	A.	Send letter to FIT Providers detailing retroactive claims submitted to Medicaid through FIT-KIDS on a quarterly basis.

	Responsible Person / Agency	Actions	
2.	FIT Staff (continued)	B.	Review claims against the Medicaid Remittance Advice (RA) to confirm which retroactive claims were paid by Medicaid.
		C.	Make adjustments to the provider's subsequent monthly FIT-KIDS invoice on a quarterly basis.
3.	FIT Providers	A.	Submit paper invoices (do not use DDS D Invoice Form) for delivered services not processed through FIT-KIDS due to duplicate claims or other circumstances approved by the FIT Program.
4.	FIT Staff	A.	Approve paper claims and make adjustments to the provider's subsequent monthly FIT-KIDS invoice.

The following procedure applies to Provider Agreements for SGF services, including: respite, adult day habilitation, residential, behavioral supports, etc. and FIT non-direct services including staff development and child find/public awareness.

	Responsible Person / Agency	Actions	
1.	FIT/SGF Providers	A.	<p>On the DDS D Invoice, enter the:</p> <ol style="list-style-type: none"> 1. Provider Name. 2. Provider Agreement/Contract Number. 3. Invoice Number. 3.a. Invoice numbers need to follow the convention DDS D-FYXX-the number of the months in the fiscal year that have passed; for example, in August of FY 09, the invoice number would be DDS D-FY09-02. 4. Month of Service. 5. Number of individuals served and number of units provided for each service type and confirm totals. 6. Complete the supplemental section of the DDS D Invoice for any revisions (including corrections) or additions to previous invoices submitted within the current fiscal year. 7. Provider Billing Contact Name and Phone Number. 8. Provider Remittance Address that is on file with DFA (Department of Finance and Administration). 9. Enter Submission Date.

	Responsible Person / Agency	Actions
		<p>B. Submit the electronic DDS D invoice via email to DDSD.invoices@state.nm.us with the month, fiscal year and invoice number in the subject line of the email by the 10th of the month following the month of service. Note end of fiscal year due dates may be moved up to meet required deadlines at the Department of Finance and Administration. DDS D will inform Providers of any changes in due dates as soon as possible.</p> <p>C. DDS D will process one DDS D Invoice per provider per month. Supplemental billing and Billing Revisions (including corrections) must be entered the following month as per Number 1.A.6. above.</p>

The following procedure applies to professional – technical contracts for deliverables / services that are not included in the DDS D Service Definitions and Standards.

	Responsible Person / Agency	Actions
1.	SGF/FIT Contractors	<p>A. Contractors may develop and utilize any Invoice format, provided it contains the following information:</p> <ol style="list-style-type: none"> 1. Name of Contractor. 2. Contract Number. 3. Contractor Address on file with Department of Finance and Administration. 4. Period of service. 5. Specific cost or deliverable to be reimbursed. 6. Total Compensation Requested. 7. Agency contact person. 8. Date invoice is completed. <p>B. Submit the Invoice via e-mail to DDSD.invoices@state.nm.us with the month and fiscal year in the subject line by the 10th of the month following the month of service. Note end of fiscal year due dates may be moved up to meet required deadlines at the Department of Finance and Administration. DDS D will inform Providers of any changes in due dates as soon as possible.</p>

VI. LIST OF ATTACHMENTS

DDS D Instructions and Invoice Form Number SGF-100

INSTRUCTIONS FOR COMPLETION OF DDS D INVOICE

These instructions are intended to guide providers of both Adult State General Fund, Respite and non-direct Family Infant Toddler (FIT) Program services in completion of the DDS D Invoice. Please note that further reference can be made to Procedure SGFP-001.

1. Prior to the 10th of each month, the provider agency should compile an invoice reflecting documented services for the previous month. Only documented services may be billed. Please refer to the State General Fund Service Definitions and Standards for the current fiscal year to ensure that services are being provided and documented in accordance with requirements.
2. The invoice to be compiled must be filled completely and accurately per the table below for timely processing. Incomplete or inaccurate invoices will be returned to the billing provider for correction.

1. Provider Name.
2. Provider Agreement/Contract Number.
3. Invoice Number.
3.a. Invoice numbers need to follow the convention DDS D-FYXX-the number of the months in the fiscal year that have passed; for example, in August of FY 09, the invoice number would be DDS D-FY09-02.
4. Month of Service.
5. Number of individuals served and number of units provided for each service type. Confirm totals are accurate.
6. Complete the supplemental section of the DDS D Invoice for any revisions (including corrections) or additions to previous invoices submitted within the current fiscal year. <i>(See Below for instructions on completing the supplemental section).</i>
7. Provider Billing Contact Name and Phone Number.
8. Provider Remittance Address that is on file with DFA (Department of Finance and Administration).
9. Enter Submission Date.

3. Supplemental Billing and Billing Corrections for previous months of service must be entered into the Supplemental Section of the DDS D Invoice. For the Supplemental Section, the Billing Provider must indicate the month of the supplement/correction, the Service Unit, the Billing Unit, the Name of the Service, the Number of Individuals Served, the Number of Units to adjust up and/or down, the Unit Rate of the specific service and the Total Dollar Amount to be adjusted. Please note that there may be multiple months of supplemental billing that can be indicated on the form. Providers using the Supplemental Section must verify that the total of the amount of increase or decrease is reflected in the Invoice total at the bottom of the DDS D Invoice.
4. Only one DDS D Invoice will be processed per month for each provider.
5. The DDS D invoice must be e-mailed to DDS D.invoices@state.nm.us

**DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
MONTHLY INVOICE**

Invoice Number: DDSD-FY -

Provider Name: _____

Provider Agreement / Contract Number: _____ Month of Service: _____

Family Infant Toddler Program					
Service Unit	Service	# of Individuals Served	# of Units Provided	Unit Rate	Dollar Amount
700025	Staff Development	n/a		\$ 1.00	\$ -
700024	Child Find/Public Awareness	n/a		\$ 1.00	\$ -
				FIT Total	\$ -

Respite					
Service Unit	Service	# of Individuals Served	# of Units Provided	Unit Rate	Dollar Amount
700013	Respite (Age 0-3)			\$ 13.25	\$ -
700014	Respite (Age 3-21)			\$ 13.25	\$ -
700015	Respite (Adult)			\$ 13.25	\$ -
				Respite Total	\$ -

Adult Service					
Service Unit	Service	# of Individuals Served	# of Units Provided	Unit Rate	Dollar Amount
700016	Day Hab. / Supported Employment			\$ 739.00	\$ -
700017	Residential			\$ 1,530.00	\$ -
700018	Outcome Based			\$ 1.00	\$ -
				Adult Total	\$ -

Special Projects					
Service Unit	Service	# of Individuals Served	# of Units Provided	Unit Rate	Dollar Amount
700019	Behavioral Services			\$ 1.00	\$ -
700020	Adult Therapy Sevices			\$ 1.00	\$ -

**Supplemental Section
(for revisions / supplements to billing from previous months)**

Month: _____

Service Unit	Service	# of Individuals	# of Units Provided	Unit Rate	Dollar Amount
					\$ -
					\$ -
					\$ -

Invoice Total: \$ -

Provider Billing Contact Name: _____ Tel #: _____

Remit to address: _____ Date Invoice Submitted: _____

For questions regarding reimbursement, please contact Edwina Montano at 505.476.2407
Email Invoice directly to: ddsd.invoices@state.nm.us **SGF-100 Eff. 06/08**