IDD Waiver Billing/Technical Assistance Report (BTAR)

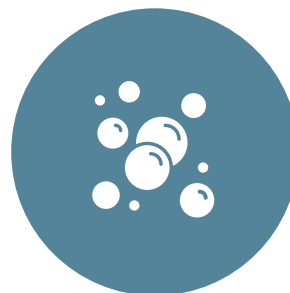A COLLABORATIVE TRAINING BY DHCF AND DDS

SEPTEMBER 2023

What is BTAR?

BTAR stands for Billing/Technical Assistance Report

DHCF and DDS created a more streamlined process to manage and track inquires received from providers regarding their billing and Prior Authorization (PA) inquiries

The BTAR replaced the previously used email inquiry process

All inquires **MUST** be submitted through the BTAR process. **No Exceptions!!!!!**

Benefits of Automation

TRACK AND TREND BILLING CONCERNS

IDENTIFY AND ADDRESS ROOT CAUSE AND SYSTEMIC ISSUES CAUSING BILLING CONCERNS

ASSESS TIMELINESS FOR RESOLUTION

When did the BTAR start?

Effective **October 1, 2020**

<u>ALL</u> providers are required to submit their inquires through this new process

Failure to comply results in delayed resolution of inquires

Have a billing or PA issue?....Here's where you start.....

From the URL link on MCIS, you will connect to open an inquiry form

Once in the form, simply follow each section and provide the requested information

Where's the URL link?....

You can find it on MCIS under *"Dashboard Notifications."*

Section 1: Name of Individual

Enter the name of the person on your claim or PA in question

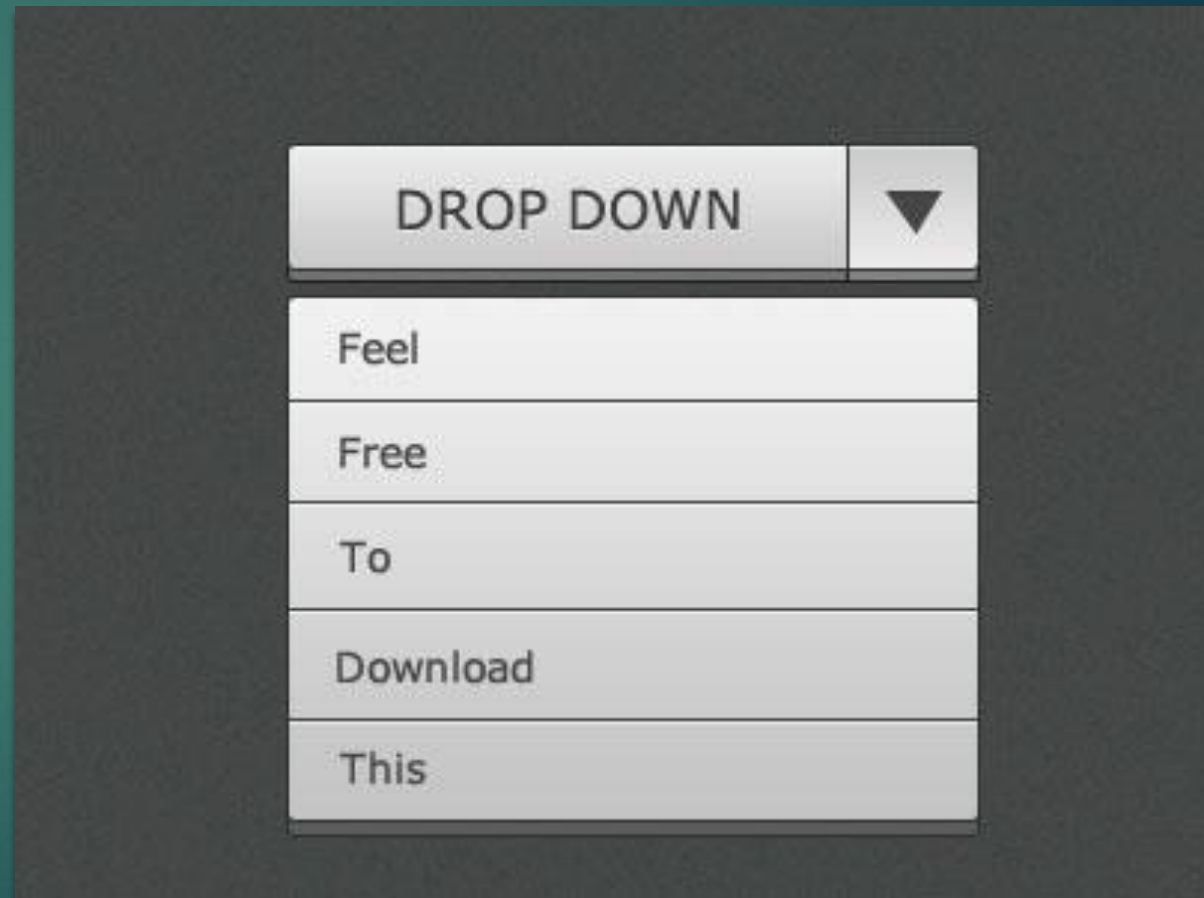# **Section 2:** Medicaid ID number

Enter the person's Medicaid ID number

It is an eight (8) digit number that begins with a "7" Can be found on the person's Medicaid insurance card or on the Service Authorization Form (SA) from DDS

Section 3:
Name of Service

▶ Select a service from the drop-down list

Section 4: Provider

👉 Select the name of your provider agency from the drop-down list

! If your agency is not listed, select "OTHER" and write in the name

Section 5: Provider ID

ENTER YOUR AGENCY'S MEDICAID PROVIDER ID NUMBER

THIS IS THE NUMBER THAT ALL ENROLLED PROVIDERS ARE ISSUED WHEN THEY FIRST ENROLL AND IS USED ON ALL CLAIMS

Section 6: Procedure Code/Modifier

01
Select the service procedure code/modifier that pertains to the inquiry being submitted

02
If the code/modifier is not listed, select "OTHER" and write in the procedure code/modifier

03
DO NOT enter the descriptive name of the service. It must be the procedure code and modifier

Section 7: Date Range of Service Auth (SA) – From Date
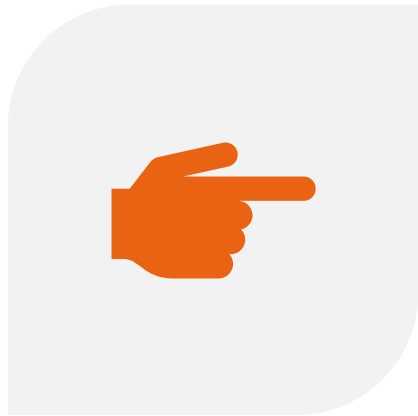
ENTER THE **START** DATE OF THE SERVICE AS REFLECTED ON THE SA FORM
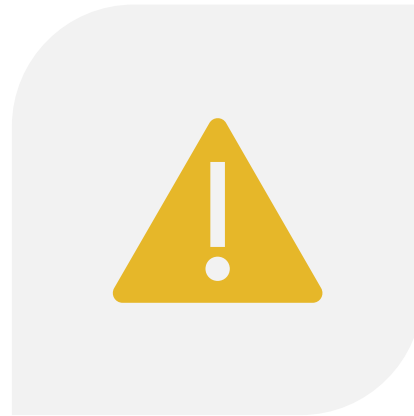
IF UNKNOWN, ENTER THE START DATE OF THE ISP PERIOD THAT THE SERVICE OR PROCEDURE CODE/MODIFIER EFFECTS
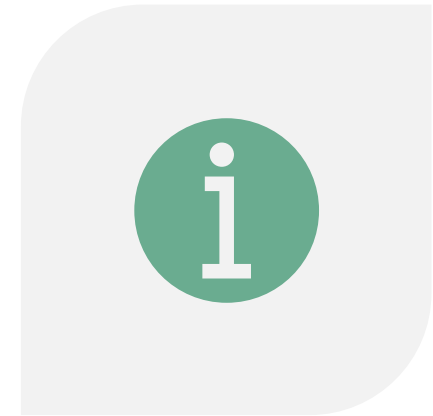
NOTE: THIS IS NOT THE DATE YOUR CLAIMS DENIED

Section 8: Date Range of the Service Auth (SA) – To Date

| | Enter | Enter the **END** date of the service as reflected on the SA Form |

| | Enter | If unknown, enter the end date of the ISP period that the service or procedure code/modifier effects |

| | **Note** | This is **NOT** the date your claims denied |

Section 9: Action Date

- **Enter the date the <u>SA was approved by the Waiver Unit staff</u>**

- ***Note:*** *This is **NOT** the service period or date range that the service was effective. In some cases, a service may be approved and be effective the entire length of the ISP year*

- *This is the date from the SA Form where the Waiver staff signed their approval (See sample on next page)*

Sample SA Form – Approved Date
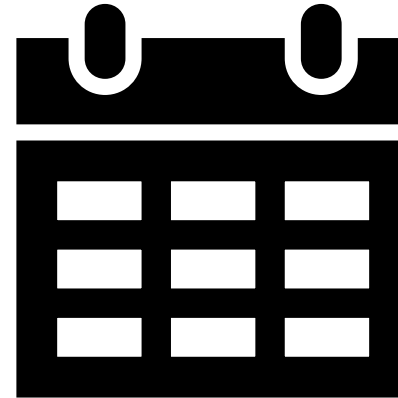
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

Home and Community Based Waiver
RECORD OF REQUESTED SERVICES
(ONLY PRIOR-AUTHORIZED SERVICE (S) WILL BE REIMBURSED)

Person Data
Person: **Medicaid #:**
Address:

DDS Service   **Phone #:**
Coordinator :

As a certified Medicaid Provider for the Home and Community Based Waiver Services for people with Intellectual and Developmental Disabilities, you have been selected to provide the following services to the above named Person. Services are only prior authorized for up to one year, based upon the date of the plan of care.

Agency Data	Agency Address	Waiver Service(s)	status	Code	Units	Start Date	End Date	Approved date	Frequency Comments
		RW Parenting Supports Professional (1:1)	Approved	S9444-U4	4	8/7/20	9/7/20	08/04/2020	Assessment

All above authorized services must have an approved Plan of Care prior to service delivery. I certify that the above listed service(s) have been requested by the Department on Disability Services (DDS).

Sample Signature   08/04/2020   Medicaid   202-730-
                                                   Waiver   1700
_____   _____   Specialist   _____
                          Approved   _____
                           date   Title   Phone

A formal Prior Authorization with a Prior Authorization Number online claiming, based on this services request, will be forwarded to the District of Columbia's Medicaid agency.)

Section 10: PA

ENTER THE PA NUMBER FOR THE SERVICE

NOTE: PLEASE DOUBLE CHECK YOUR NUMBER TO ENSURE IT IS COMPLETE. *THIS IS AN 11-DIGIT REFERENCE NUMBER*

Section 11: TCN

ENTER YOUR TRANSACTION CONTROL NUMBER AKA TCN NUMBER. *(YOU WILL ONLY HAVE THIS IF YOU SUBMITTED A CLAIM)*

THE TCN IS A 17 NUMERIC CHARACTER REFERENCE FOUND ON EVERY CLAIM

IT CAN BE FOUND ALONG THE TOP OF THE CLAIM INQUIRY SCREEN ON THE MEDICAID PORTAL OR ON YOUR RA. IT WILL BE **LABELED "TCN"**

TCNS ARE ASSIGNED TO ALL ORIGINAL AND ADJUSTMENT CLAIM SUBMISSIONS

Section 12: Comments

Enter any additional information that is relevant to your inquiry

Note: *This field is **NOT** a replacement or alternative to entering the required information from the previous fields*

Only intended to inform the reviewer of additional information that supplements or supports what was entered in Sections 1-11

Questions and Answers