



COMMISSIONER
Chris Traylor

March 30, 2011

To: Day Activity and Health Services (DAHS) Providers
Subject: Information Letter No. 11-18
Billing for DAHS when an Individual is Hospitalized

The Department of Aging and Disability Services (DADS) has been made aware that, in a recent DAHS audit by the Centers for Medicare and Medicaid Services (CMS) Medicaid Integrity Group (MIG), duplicate payments were found for the same dates when DAHS claims were matched against hospital claims. These were **not** one-day overlaps with begin/end dates on the same day, but dates entirely contained within the hospital stay.

Additionally, some providers billed for the total number of units authorized in their Medicaid Eligibility Service Authorization Verification (MESAV) instead of billing as required only for actual services provided. Providers should be aware that billing for services that have not been provided constitutes fraud, as supported by the rules cited at the end of this letter.

The following are two examples of inappropriate billing by DAHS providers.

1. Claims for DAHS while an individual is in the hospital

A claim for DAHS had a beginning date of 4/17/06 and an ending date of 4/21/06. When the claim was matched with a hospital claim, the individual was found to be in the hospital for the dates of 4/13/06 – 4/26/06. Since the DAHS date range (4/17/06 – 4/21/06) is contained within the hospitalization dates, the individual could not have been out of the hospital and in the community to receive DAHS as claimed. The provider's daily attendance record also showed the individual to be absent from the facility during the DAHS claim dates.

The provider must adjust the DAHS claim as shown below and reimburse DADS for the days the individual was in the hospital:

DAHS = 4/1/06- 4/12/06
Gap = 4/13/06 - 4/26/06
DAHS = 4/27/06 - 4/30/06

The provider should bill **only** for those days and units of service when the individual actually received DAHS.

Providers may bill for services the day the individual was admitted to the hospital or was discharged from the hospital if services were actually provided to the individual on that date and for a minimum of three hours (one unit).

2. Submission of claims for units authorized instead of actual units provided to the individual

The MESAV report shows an individual was authorized 46 units for June 2006. A claim for DAHS shows the provider was paid for the entire 46 units in June. When the claim was matched with a hospital claim, the individual was found to have been in the hospital for the

dates of 6/2/06 – 6/7/06. This provider indicated billing was submitted according to units authorized on the individual's service authorization and not for actual services provided. The provider's daily attendance records also showed the individual to be at the facility and these records were incorrect.

Providers must immediately adjust all claims that were inappropriately billed for services not provided. The provider should bill **only** for those days and units of service when the individual actually received DAHS.

Providers may bill for services the day the individual was admitted to the hospital or was discharged from the hospital **if** services were actually provided to the individual on that date and for a minimum of three hours (one unit).

Providers must maintain accurate service delivery documentation. Both the Daily Transportation Record (Form 3682) and the Daily Attendance Record (Form 3683) are to be completed with actual pick up or facility entry times and actual drop off or facility exit times. These forms cannot be pre-filled to reflect authorized units of service.

Providers may continue to bill (without a gap) for services delivered to individuals who remain in the community and receive DAHS throughout the entire billing period.

RULE §98.207 - Suspension of Day Activity and Health Services

- a) The DAHS facility must suspend services before the end of the prior approval period if one or more of the circumstances specified in paragraphs (1) - (10) of this subsection occur:
1. the client leaves the state or moves outside the geographic area served by the DAHS facility;
 2. the client dies;
 3. the client is admitted to a hospital, nursing home, state school, or state hospital;
 4. the client requests that services end;
 5. the physician requests that services end;
 6. the Health and Human Services Commission (HHSC) denies the client's Medicaid/Title XX eligibility;
 7. DADS enforces sanctions against the DAHS facility by terminating the contract;
 8. the client threatens the health and safety of himself or others;
 9. the client is absent from the DAHS facility for 15 consecutive days;
 10. the client becomes ineligible for Medicaid. Each month the DAHS facility must verify that a client has a current HHSC Medical Care Identification Card.

State and federal rules and laws do not allow reimbursement for services not provided. This is prohibited both by the provider's contract with DADS and by Texas Administrative Code rules. DADS will continue to monitor DAHS providers to ensure billing is for services actually provided to the individual.

Please contact your regional contract manager with questions regarding this information letter.

Sincerely,

[signature on file]

Gordon Taylor
DADS Chief Financial Officer

GT:mgm