DIVISION OF BEHAVIORAL HEALTH AND RECOVERY
RESIDENTIAL BILLING INSTRUCTIONS

As a provider of DBHR funded residential services, you shall utilize the TARGET system to record patient information (e.g., assessment, admission date, discharge date, funding source, modality, etc.). The TARGET system must be used for all clients served, regardless of the origin of the payment.

Pursuant to the *Billing and Payment* and *RSVP Billing* sections of your contract, DBHR utilizes the RSVP (Residential Services Vendor Payment) system, a subsidiary payment system to the primary TARGET system. If you have Title XIX funding, you will also utilize the MMIS (Medicaid Management Information System) to bill for Title XIX services/clients. Each system/mode of payment is discussed in detail below.

The matrix below summarizes the billing/payment flow for DBHR services:

Type of Service	Source of Funding	Payment Documentation	Mode of Payment	Client Info Entered into TARGET?
All	Title XIX Note 1	HCFA-1500 Claim Form	MMIS System	Yes
Room & Board	State	HCFA-1500 Claim Form	MMIS System	Yes
All	State	RSVP Invoice	RSVP System	Yes
All	SAPT	RSVP Invoice	RSVP System	Yes
All	TANF	RSVP Invoice	RSVP System	Yes
Group Care Enhancement	State	A19 Invoice Voucher	DBHR Direct	Yes
Adult Care Enhancement	SAPT	A19 Invoice Voucher	DBHR Direct	Yes
Family Hardship	State	A19 Invoice Voucher	DBHR Direct	n/a
Special Projects	State	A19 Invoice Voucher	DBHR Direct	n/a
Set Rates	State	A19 Invoice Voucher	DBHR Direct	n/a
Physical Exams	State	A19 Invoice Voucher	DBHR Direct	n/a
Assessments	State	A19 Invoice Voucher	DBHR Direct	Yes

Note 1: See section below if MMIS claim is denied.

TARGET System

Before you can bill for residential services, you must first ensure that the patient information is entered into the TARGET system accurately.

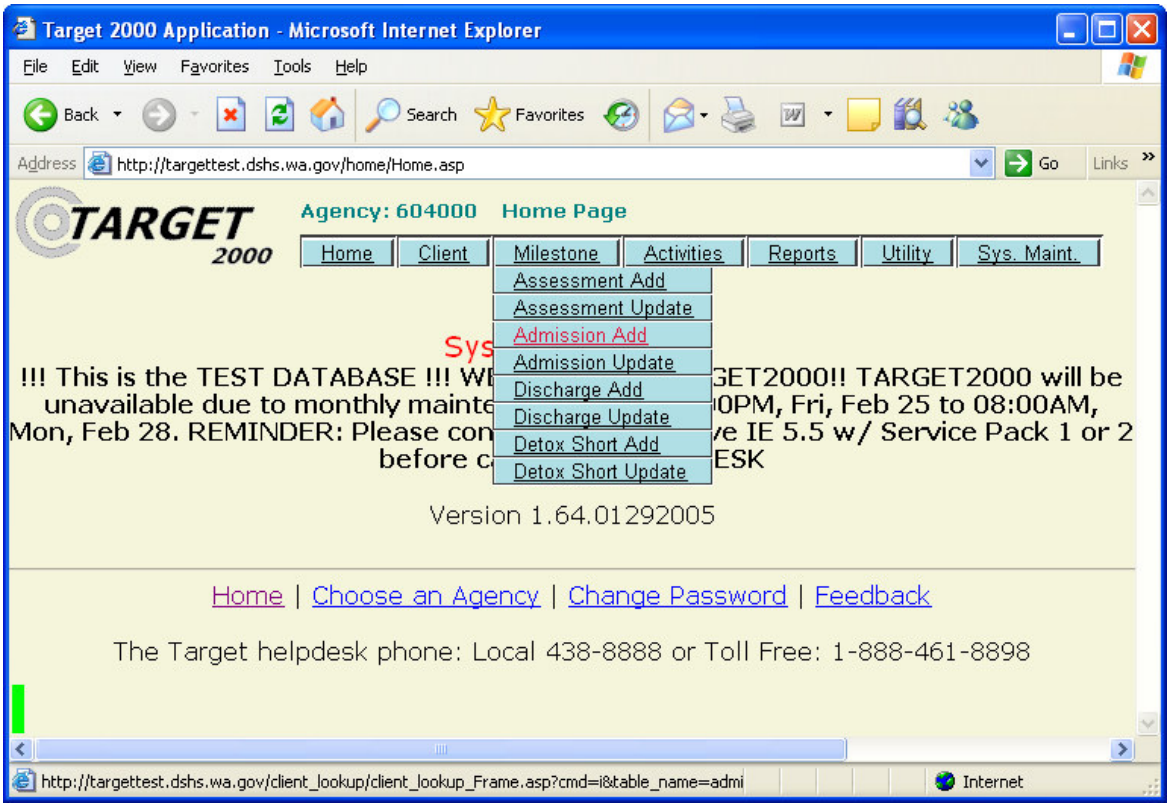
Entering a patient into TARGET

To enter a patient into TARGET, perform the following:

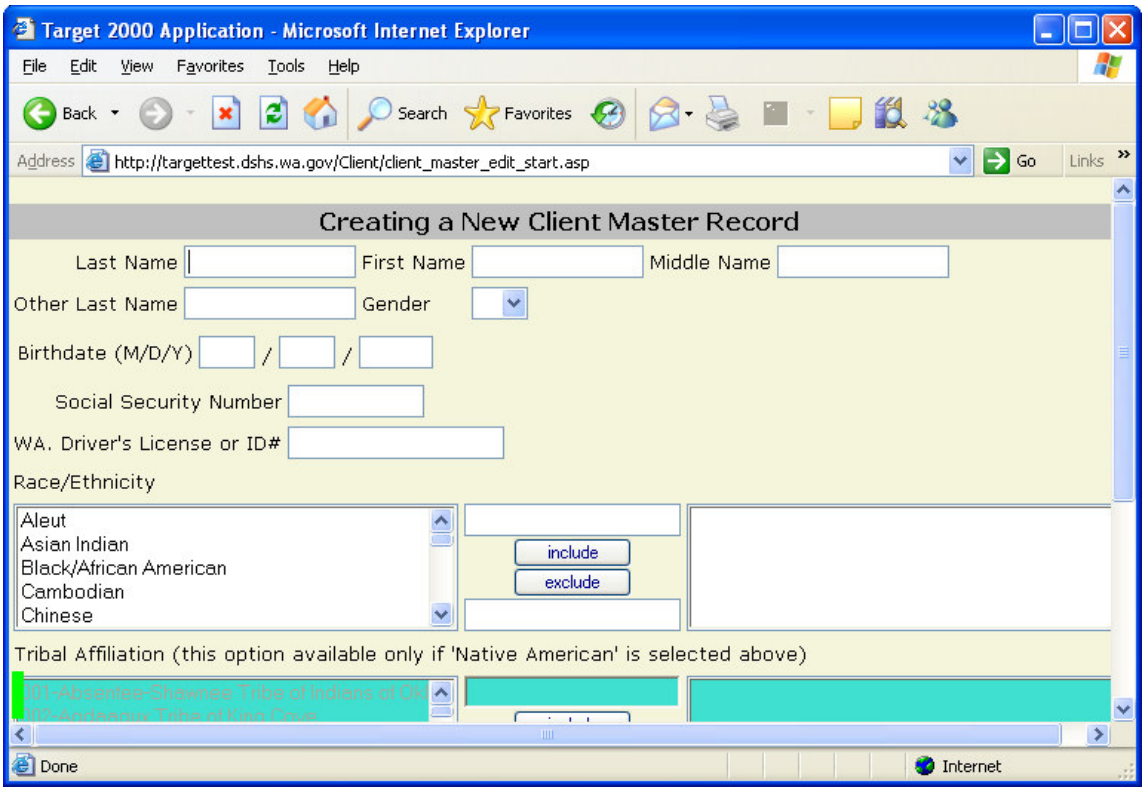
1. Log into TARGET (http://transact.wa.gov). Consult your residential contract or the TARGET Help Desk at 1.888.461.8898 for additional assistance logging into TARGET.

2. If your agency has multiple facilities, select the appropriate agency number from the list.

3. From the menu bar, click on Milestone and select Admission Add.



4. Click on the New Client button and enter the appropriate information or search for an existing patient.



5. Once you Save the record, you will see the Admission Setup screen. All fields are required. Note: If you forget to enter a field prior to clicking on the Next button, you will get an error message.

Additionally, the navigate window on the far left of the screen will show a red X on any sections of the admission setup that were not entered completely.

6. For billing purposes, the most important screen is the Admission Complete screen. The two critical fields are:

Public Assistance Type — Use this field to determine what type of patient you are treating. For example, if you are seeing an ADATSA client the Public Assistance Type for this patient would be ADATSA.

Use this field to determine what type of patient you are treating. For example, if you are treating a Treatment Expansion client that is General Assistance: Unemployable, the Public Assistance Type for this client would be General Assistance: Unemployable.

Modality/Contract/Fund Source

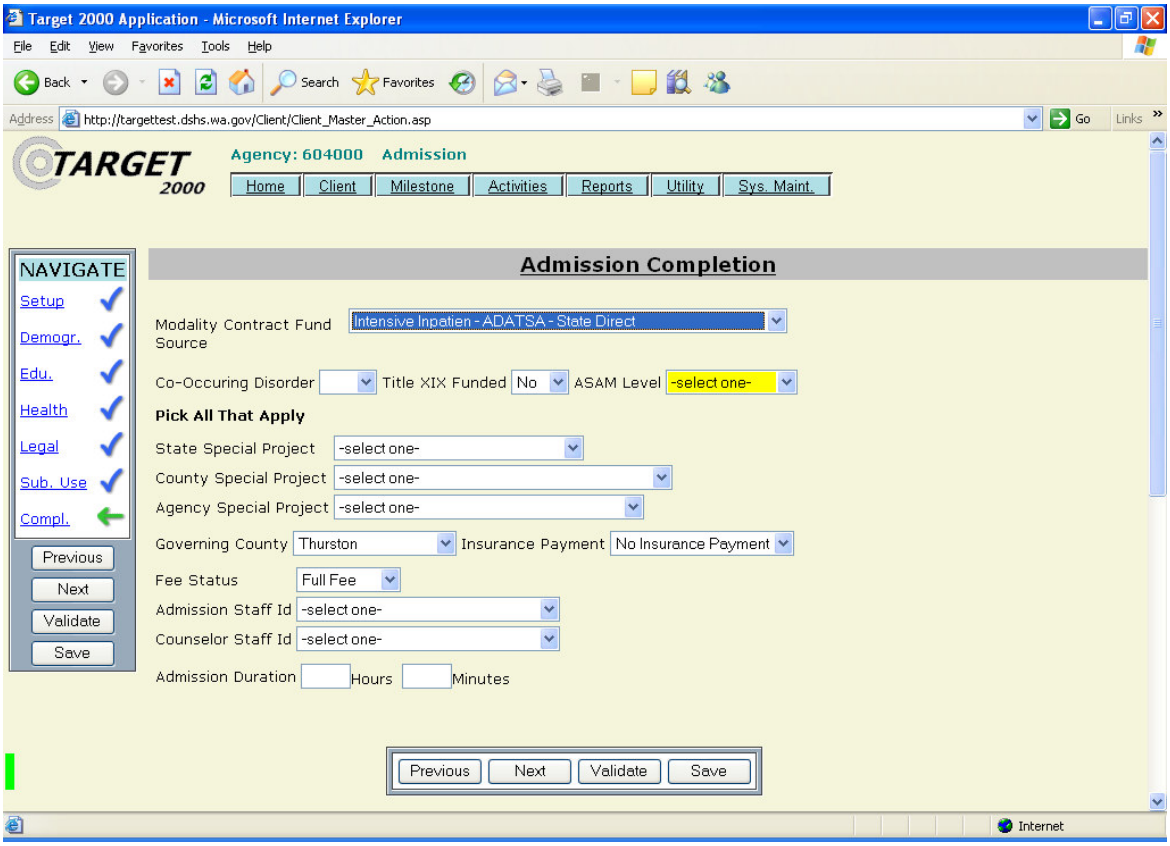
Use this field to determine these 3 separate components. For example, Intensive Inpatient/ADATSA/State Direct represents an intensive inpatient modality (as defined in your residential contract); the contract type (as defined in your residential contract); and the fund source (as defined in your contract).

Use this field to determine these 3 separate components. For example, Intensive Inpatient/Adult Residential/State Direct represents an intensive inpatient modality for a treatment expansion patient or a TANF patient (as defined in your residential contract); the contract type (as defined in your residential contract – **please note that the contract type for Treatment Expansion and TANF is Adult Residential)**; and the fund source (as defined in your contract and as defined by each patient).

Is Title XIX Funding the Service?

Use this field to determine whether a patient is Medicaid eligible, **and** their treatment services will be funded with Medicaid dollars. A **YES** in this field implies that the patient's services will be billed to the MMIS (Medicaid Management Information System). A **NO** in this field implies that the patient's services will be billed through the RSVP system or to DBHR directly. Note: A MCTFS of Inpatient/PPW/State Direct would still be used to identify a patient that will be paid from Title XIX through MMIS. In this case, the only distinguishing field between a patient that is state funded and one that is Title XIX funded is the Title XIX Funded field.

Once the admission record is complete, click on the Save button.



Editing an Existing Admission Record in TARGET

To edit an existing patient record in TARGET, perform the following:

1. From the menu bar, click on Milestone and select Admission Update.

2. Enter the patient's last name and first name (you must select at least 2 characters in the last name field).

From the query results, select the correct patient and click on the link on their name to get to the edit screen.

Target 2000 Application - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Address http://targettest.dshs.wa.gov/client_lookup/client_lookup_Frame.asp?cmd=u&table_name=admission

TARGET 2000 Agency: 604000 Admission

Home | Client | Milestone | Activities | Reports | Utility | Sys. Maint.

Search on Name Last: ww First: MI: Find Clear

Displaying Search Results

Name	Gender	Birthdate	SSN	Admission Date	Discharge Date
WWADMITO, LONGER NONE	F	06/22/1970	654-98-7321	12/31/1994 02:00 PM	Active
WWALLABY, CONGA DASA	F	05/08/1964	000-00-0000	01/21/2002 08:00 AM	Active
WWALLABY, CONGA DASA	F	05/08/1964	000-00-0000	10/31/2001 09:00 PM	01/15/2002 09:00 AM
WWALLABY, CONGA DASA	F	05/08/1964	000-00-0000	10/02/2001 10:00 AM	10/30/2001 10:00 AM
WWALLABY, CONGA DASA	F	05/08/1964	000-00-0000	01/01/1999 08:00 PM	02/01/1999 10:00 AM
WWARGLE, BARGLE	M	03/03/1933	000-00-0000	07/01/2002 08:00 AM	Active
WWARGLE, BARGLE	M	03/03/1933	000-00-0000	05/01/2002 08:00 AM	06/01/2002 08:00 AM
WWARGLE, BARGLE	M	03/03/1933	000-00-0000	01/15/2002 01:15 PM	03/29/2002 08:00 AM
WWASHY, WISHY SQUISHY	M	04/04/1944	000-00-0000	07/22/2002 09:00 AM	Active
WWCARRYOVERTEST, LJHFEADFA LKDSLKJFSD	M	04/04/1944	000-00-0000	06/01/2002 04:00 PM	Active
WWCARRYOVERTEST, LJHFEADFA LKDSLKJFSD	M	04/04/1944	000-00-0000	02/01/1999 09:00 AM	03/01/1999 08:00 AM
WWDATSATEST, MAGNUS	F	04/04/1914	000-00-0000	03/02/2002 08:00 AM	03/06/2002 04:00 PM
WWDATSATEST, MAGNUS	F	04/04/1914	000-00-0000	02/16/2002 08:00 AM	03/01/2002 09:00 AM
WWDATSATEST, MAGNUS	F	04/04/1914	000-00-0000	01/15/2002 04:00 PM	02/02/2002 08:00 AM
WWDELETE, WHOOSA FRAYED	F	03/03/1933	000-00-0000	12/02/2001 08:00 AM	12/17/2001 09:00 AM
WWEXCEPTION, TESTAMAY HUMBLE	F	03/03/1933	987-65-4321	02/15/2001 07:00 PM	03/01/2001 09:00 AM
WWEXCEPTION, TESTAMAY HUMBLE	F	03/03/1933	987-65-4321	01/30/2001 08:00 AM	02/15/2001 04:14 PM

Done Internet

Target 2000 Application - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Address http://targettest.dshs.wa.gov/admission/admission_setup_display.asp

TARGET 2000 Agency: 604000 Admission LONGER NONE WWADMITO

Home | Client | Milestone | Activities | Reports | Utility | Sys. Maint.

NAVIGATE
Setup
Demogr.
Edu.
Health
Legal
Sub. Use
Compl.
Previous
Next
Validate
Save

Admission Setup

ADMISSION DATE 12 / 31 / 1994 ADMISSION TIME 02 : 00 AM

IS THIS AN ADATSA ADMISSION? No

ENTRY REFERRAL

ADATSA Assessment Center
Court/Probation
DCFS/CPS
Dept of Corrections
Detoxification Facility

include
exclude

Dept of Licensing (DOL)
Self/Family

REFERRING AGENCY

REFERRING ASSESSMENT DATE / /

REFERRING CSO/HCS

CLIENT REGISTRY PARTICIPATION? Permitted STATUS DATE 12 / 1 / 2000

MILESTONE COPY Delete Print this admission

Done Internet

3. Edit the information as needed and click on the Save button. Note: You cannot edit the admission date and time. If an error is found in these fields, you must delete the incorrect record and establish a new record.

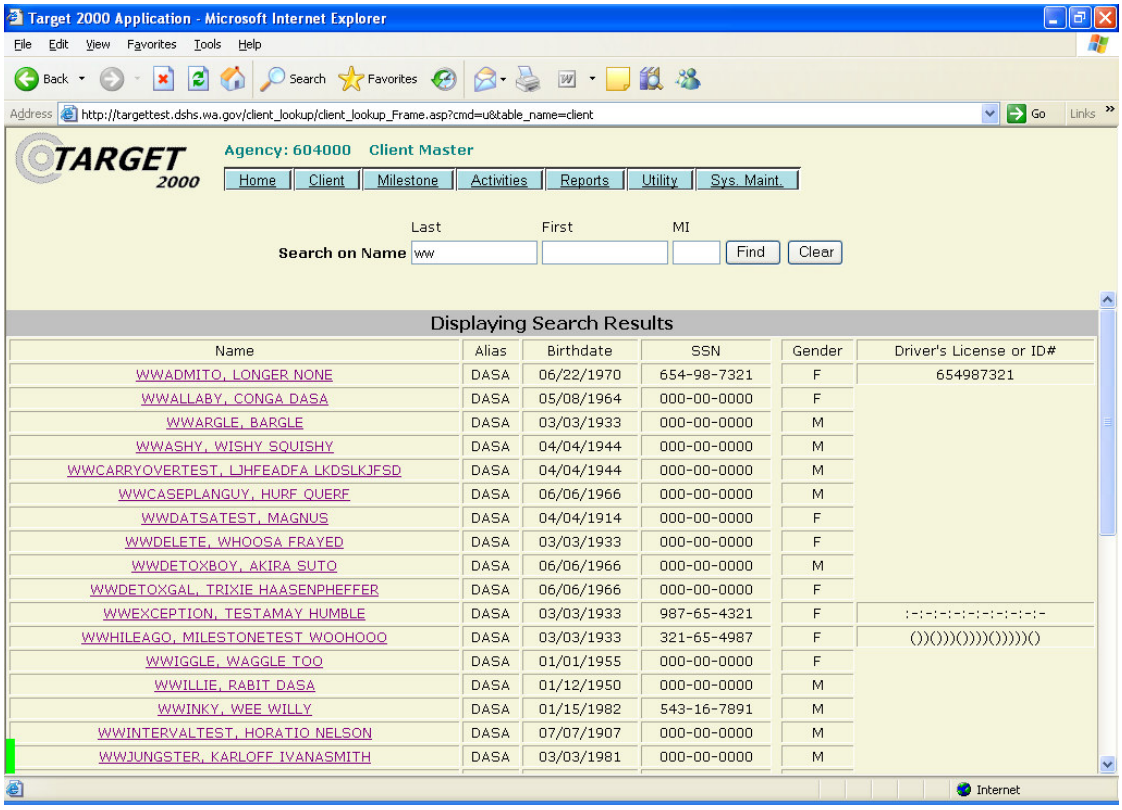
Editing Patient Information in TARGET

To edit an existing patient record in TARGET, perform the following:

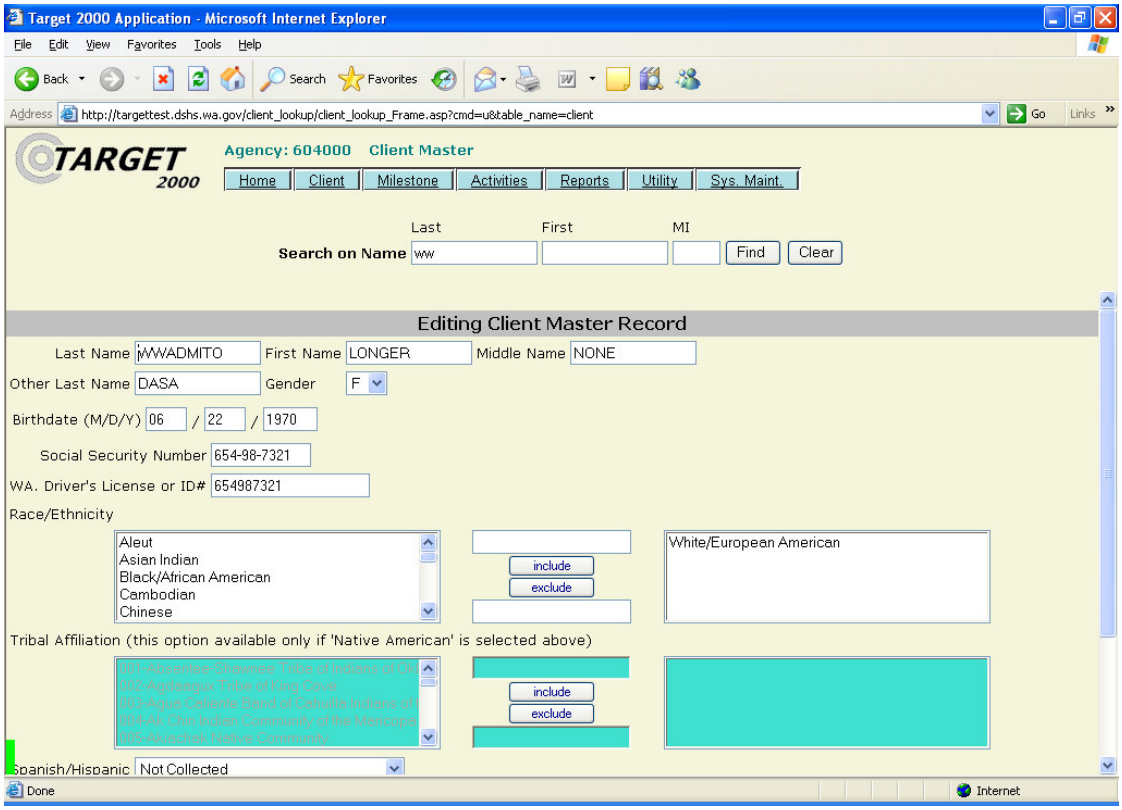
1. From the menu bar, click on Client and select Client Master Update.

2. Enter the patient's last name and first name (you must select at least 2 characters in the last name field).

3. From the query results, select the correct patient and click on the link on their name to get to the edit screen.



Name	Alias	Birthdate	SSN	Gender	Driver's License or ID#
WWADMITO, LONGER NONE	DASA	06/22/1970	654-98-7321	F	654987321
WWALLABY, CONGA DASA	DASA	05/08/1964	000-00-0000	F	
WWARGLE, BARGLE	DASA	03/03/1933	000-00-0000	M	
WWASHY, WISHY SQUISHY	DASA	04/04/1944	000-00-0000	M	
WWCARRYOVERTEST, LJHFEADFA LKDSLKJFSD	DASA	04/04/1944	000-00-0000	M	
WWCASEPLANGUY, HURF QUERF	DASA	06/06/1966	000-00-0000	M	
WWDATSATEST, MAGNUS	DASA	04/04/1914	000-00-0000	F	
WWDELETE, WHOOSA FRAYED	DASA	03/03/1933	000-00-0000	F	
WWDETOXBOY, AKIRA SUTO	DASA	06/06/1966	000-00-0000	M	
WWDETOXGAL, TRIXIE HAASENPHEFFER	DASA	06/06/1966	000-00-0000	F	
WWEXCEPTION, TESTAMAY HUMBLE	DASA	03/03/1933	987-65-4321	F	:-:-:-:-:-:-:-:-:-:-
WWHILEAGO, MILESTONETEST WOOHOOO	DASA	03/03/1933	321-65-4987	F	()()()()()()()()()()
WWIGGLE, WAGGLE TOO	DASA	01/01/1955	000-00-0000	F	
WWILLIE, RABIT DASA	DASA	01/12/1950	000-00-0000	M	
WWINKY, WEE WILLY	DASA	01/15/1982	543-16-7891	M	
WWINTERVALTEST, HORATIO NELSON	DASA	07/07/1907	000-00-0000	M	
WWJUNGSTER, KARLOFF IVANASMITH	DASA	03/03/1981	000-00-0000	M	



4. Edit the information as needed and click on the Save button.

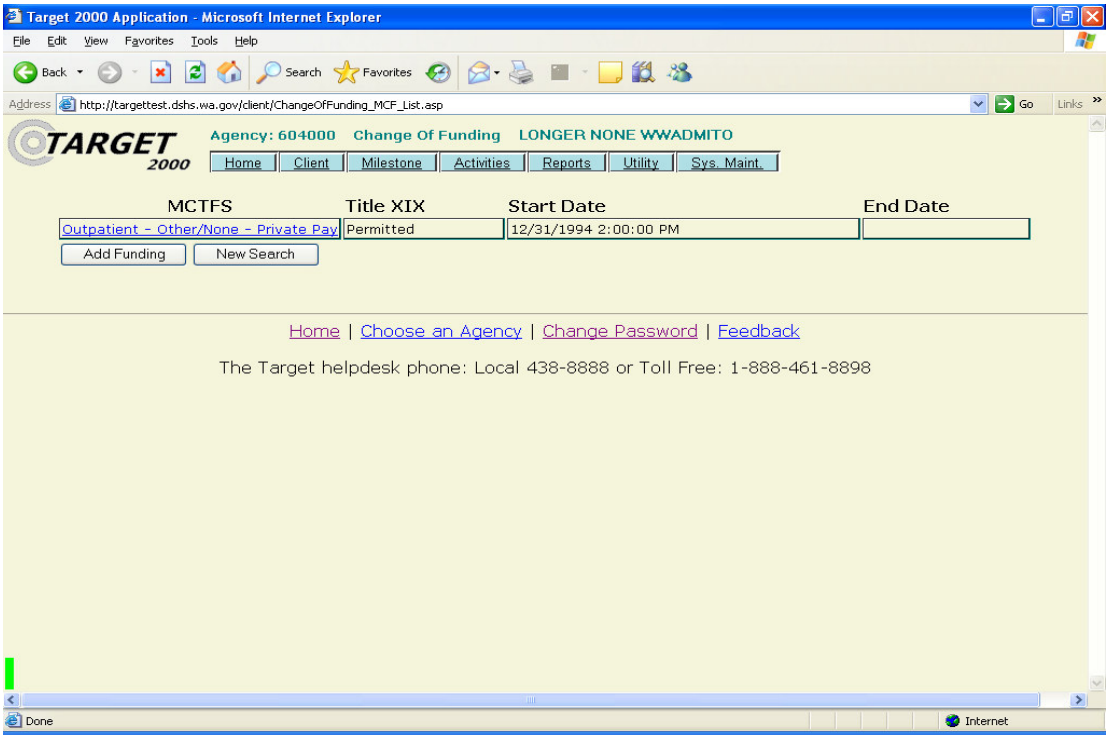
Editing Patient Funding in TARGET

To edit an existing patient funding record in TARGET, perform the following:

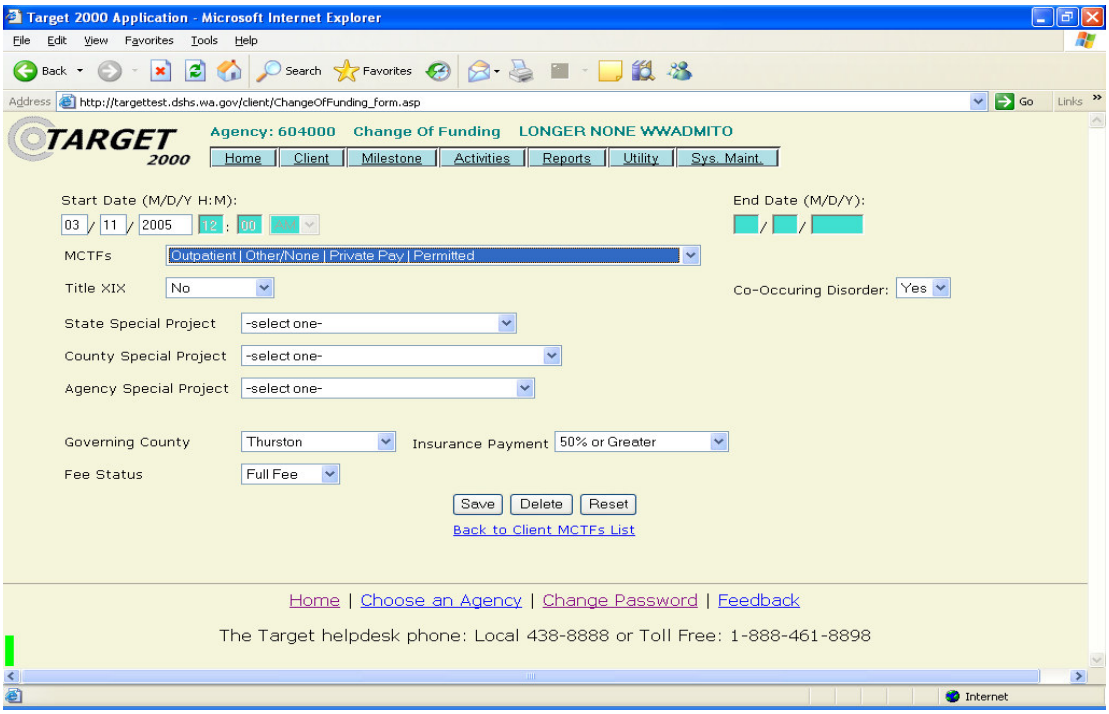
1. From the menu bar, click on Client and select Change of Funding.

2. Enter the patient's last name and first name (you must select at least 2 characters in the last name field).

3. From the query results, select the correct patient and click on the link on their name to get to the funding screen.



4. Click on the MCTFS (Modality/Contract/Fund Source) stream to edit the existing funding or click on the Add Funding button to create additional funding streams. Note: Funding streams cannot overlap. If you create another funding stream, the system will automatically end the existing stream prior to the start date of the new funding stream.



5. Click on the Save button to enter the new record.

MMIS System

If your residential contract specifies compensation to be paid by Title XIX funds (CFDA 93.778) or for room and board, you must first bill the MMIS (Medicaid Management Information System). Even though you will receive payment from the MMIS system for Medicaid-eligible services, you must enter the patient information into TARGET.

See the TARGET System section for information on how to enter or edit a client using this system.

MMIS Billing

In order to bill to MMIS, you must be issued a MMIS provider number. The DBHR Office of Financial Services will provide this number to you. Once the provider number is activated, you can begin billing MMIS for authorized services. MMIS billing can be done through the Internet or through a paper HCFA-1500 (Health Insurance Claim Form) form.

MMIS billing instructions can be found at http://fortress.wa.gov/dshs/maa/download/BillingInstructions/Chemical%20Dependency%201003%20Update.pdf. Refer to your contract for the correct billing rates.

When billing the MMIS, it is important you use the correct billing/procedure code for the service being billed. Incorrect billing will result in additional workload to subtract the incorrect procedure code and to bill the correct procedure code.

The correct Title XIX billing/procedure codes and rates can be found in your residential contract.

REMINDER: When billing MMIS, you cannot include the discharge date as a payment day. You are not eligible for payment on the day of discharge. The accuracy of the days billed is subject to verification during a contract monitoring and compliance review.

Therapeutic Childcare

Therapeutic childcare is limited to five billing days per week.

Title XIX Claims Denied by MMIS

If a Title XIX claim, which was billed through the HCFA-1500 Claim Form, is subsequently denied by the MMIS because the patient was not Medicaid-eligible, it should be billed to DBHR as a state funded item on a separate Form A19 Invoice Voucher. The Invoice Voucher will be emailed to you at the time your contract is executed. Contact the DBHR Office of Financial Services for assistance or for additional information.

The A19 must contain the following information:

- ✓ Client(s) Names
- ✓ Start/End Date
- ✓ Procedure Code Billed
- ✓ Amount Denied
- ✓ Copy of the MMIS Remittance Advice showing the denial and the applicable reason code.

You will not be reimbursed by DBHR for Title XIX charges that are denied due to late filing.

MMIS Billing Errors

If you discover that a billing error has been made (e.g., you used the wrong procedure code), you must correct the error via an Adjustment Request form.

For additional information about MMIS, contact the DSHS Medical Assistance Administration's Provider Relations Unit at 1.800.562.3022 or http://fortress.wa.gov/dshs/maa/contact/prucontact.asp.

RSVP System

As specified in the matrix above, the RSVP system is used to pay for all state, SAPT, Treatment Expansion (includes SSI, GAU, GAX, medical assistance only, or TANF), or TANF funded residential services, excluding family hardship, physical exams, non-ADATSA assessments, group care enhancement, adult care enhancement, special projects, and set rates.

The patient information must be entered into TARGET by the 10th calendar day (or the next business day if the 10th falls on a weekend or holiday) of the subsequent month. For example, to be paid for February services, you must enter all the patient information into TARGET by the 10th of March. This is because on the 11th day of the month (or the next business day if the 11th falls on a weekend or holiday), DBHR exports the data from TARGET and imports it to RSVP in order to create the RSVP invoices.

Note: For providers with multiple TARGET provider numbers, it is very important you use the correct provider number. If you need to verify which provider number to use, please contact the TARGET Help Desk at 1.888.461.8898.

The RSVP invoices contain a high-level summary of the TARGET information as follows:

Note: The contract type for TANF, Treatment Expansion and SSI is now Adult Residential.

Field on RSVP Invoice	Content		
Client Name	Clients Name (Last, First, Middle) as entered into TARGET.		
Modality	Type of Service being provided.		
Total Service	The total number of days the person has been in treatment since the date of admission.		
Service Period	The beginning and ending dates service was provided for the month (will include the discharge date).		
Amount Authorized	The total month's payment based on the days in treatment multiplied by the daily rate.		
Contract Type (CT)	A	=	ADATSA
	B	=	Adult Residential
	P	=	Pregnant/Parenting Women
	Y	=	Youth
Public Assistance Type (PAT) (mandatory field)	A	=	ADATSA
	I	=	Applicant
	M	=	Medical Assistance Only
	N	=	None
	P	=	Supplemental Security

			Income (SSI)
	R	=	Refugee
	T	=	Temporary Assistance for Needy Families (TANF)
	U	=	General Assistance-Unemployable
	X	=	General Assistance-Presumptive Disability
	A	=	Agency Funded
	C	=	County Community Services
	F	=	Federal Direct
Funding Source (FS)	O	=	Other
	P	=	Private Pay
	S	=	State Direct
	Identifies the payment type to which the services will be charged (e.g., Youth, PPW, ADATSA, etc).		
	This is a unique, TARGET-generated field composed of the patient's last name, first name, and middle initial.		
	The rate authorized in your contract for that modality/service.		
Payment Type	Payment to the provider is based on this number, which is the numeric calculation of the service period during the month less the discharge date if the patient was discharged during the month. **The date of discharge is not a paid day.**		
Client Identifier	The provider uses this field to certify that the number of reported days is accurate and agrees to the patient's folder or other supporting documentation.		
Rate	This field should be used to indicate the total amount of monies received by third parties (e.g., the patient's primary insurance) if less than the amount paid by or owed by DBHR. DBHR will calculate equivalent patient days based on the rate in order to adjust the amount owed. If the amount		

	of monies received from third parties exceeds the amount paid by or owed by DBHR, the provider is authorized to retain the excess.
Reported Days	
Actual Days	
Insurance Amount	

Upon receipt of the RSVP invoice, each agency should certify that the data is correct and accurate. Adjustments to the data are allowed as follows:

Number of Reported Days

Changes to the number of reported days shown on the report should be indicated in the Actual Days field. If no changes are needed, you can leave the Actual Days field blank. Any changes to the number of days must be adjusted for in TARGET as well.

Reminder: Pursuant to your residential billing contract, you are not paid for the discharge day. If a patient is discharged during the month, RSVP will automatically calculate the correct number of paid days.

Insurance Payments or Other Third Party Payments

Use the Insurance Days field to enter the total amount that was provided by third parties. Pursuant to the Billing and Payment section of the contract, third party payments are to be netted against the amount owed by DBHR. The amount shown in the Insurance Days field will be used to deduct an equivalent number of days served. This amount may be subject to verification during a contract monitoring and compliance review.

For example, let's assume that Patient A was treated for 12 days during the month at an intensive inpatient rate of $67.64/day. Before consideration of third party payments, the amount that would be paid to the provider is $811.68 ($67.64 * 12).

If, after receiving the full payment from DBHR, the patient's insurance company paid $400.00 towards the care of Patient A, the provider will indicate $400.00 in the Insurance Days field on the RSVP invoice.

DBHR will adjust the amount owed for this patient as a credit of $400.00 or 5.91 patient days ($400.00 ÷ $67.64).

Changes to Start/End Dates

If you increase or decrease the start or end date, a corresponding increase or decrease should be reflected in the Actual Days field.

PPW State Funded Treatment through RSVP With Children vs. Without Children

A State Special Project code has been created for all PPW contracts to differentiate between patients with children and those without children. Use the state special project code (PPW with children) to flag any patients that have children. If the patient's status changes during their treatment, you must edit the Client Change of Funding screen in TARGET to remove the special code, indicating that they are now without children, or adding the special code, indicating that they are now with children. Correct usage of the agency special project code will ensure the correct rate is used on the payment.

Certification of the RSVP Invoice

Once the adjustments, if any, have been made to the RSVP invoice, a representative from your agency must sign and date each page of the detail certifying that the charges are correct, all services billed have been provided by the agency, and that the services billed were not paid by a secondary source of funding. Each page must be signed individually.

WRITE-INS

Write-ins may be necessary because the TARGET system compiles and exports to RSVP only the details for the month that has just ended. Only client information entered into TARGET by the 11th of the following month will appear on the RSVP Invoice. For example, February information entered on March 12th would not be picked up in TARGET in time for the February RSVP reporting. Likewise, client information entered into TARGET for any month prior to the month being processed would not appear on the RSVP Invoice. For example, January information entered during the month of February would not be picked up in TARGET.

For both of these examples an A19 Invoice Voucher would need to be prepared as follows:

- Prepare the A19 Invoice Voucher and list each write-in entry with the name, modality, period of service, rate, actual number of days being claimed, and the total amount authorized.
- Include a reason for the write-in.
- Include the Target C3 (last day of the month report) and D6 (the whole month period for which reimbursement is being requested) reports.
- Send the A19 Invoice Voucher for write-ins to your DBHR Treatment Manager. The treatment manager will verify, approve, and then forward the A19 and attachments to DBHR Finance for payment.

Questions regarding the write-in process should be directed to your DBHR Treatment Manager. If an A19 is needed, contact DBHR Finance at (360) 725-3766.

REMINDER: When billing a write-in to RSVP, you cannot include the discharge date as a payment day. The accuracy of the days billed is subject to verification during a contract monitoring and compliance review.

ON-TIME PAYMENTS THROUGH RSVP

DBHR will process an on-time payment around the 25th of the month, representing 75% of your primary non-Medicaid funding source assuming full utilization of the patient days as specified in your contract. This on-time payment represents payment on charges that have already been incurred during the month. It is not based on the future costs not already incurred.

The on-time payment is optional but is not offered on any Title XIX services. DBHR will subtract the on-time payment from the month's certified RSVP invoice and process a payment for the difference. Any on-time payments that exceed the amount of the RSVP invoice (and results in a net credit) will be treated as a reduction on the next payment due.

Any net credits resulting from under-utilization of your primary funding source will result in a reduction or elimination of your pre-payment.

THIRD PARTY RECOVERIES

Third Party Recovery (through RSVP)

Third party recoveries, usually payments from the patient's insurance company, must be netted against the total amount owed/received if the amount received is less than the amount paid by or owed by DBHR. If the amount received is more than the amount paid by or owed by DBHR, the excess amount can be retained.

As an example, let's assume that Patient A was admitted on July 10 and discharged July 29. Through the RSVP system, you billed/received payment of $1,285.16. In August you received $500.00 from the patient's insurance company.

The correct way to reflect this is to show a write-in on the August RSVP invoice for a reduction of 7.39 patients days ($500.00 ÷ $67.64 (the modality's rate). Do not show a rate reduction (e.g., $1,285.16 - $500.00 ÷ 19 (the number of days served) = $41.32) as the RSVP system is not designed to accept alternate rates.

If you received $1,500.00 from the patient's insurance company, you would show a write-in for a reduction of 19.0 patient days and a total of $1,285.16 (19 * $67.64 = $1,285.16). The excess amount of $214.84 ($1,500.00 - $1,285.16 = $214.84) is to be retained.

Third Party Recovery (through MMIS)

Follow the DSHS Medical Assistance Administration billing instructions regarding adjustment of claims for third party reimbursement.

CONTRACT MONITORING AND COMPLIANCE REVIEWS

During the course of the contract period, a contract monitoring and compliance review will be performed by DBHR staff. This review is designed to verify whether the provider is in compliance with the terms of their residential contract and billing requirements.

You will be notified by letter 30 days before the review.

Non-ADATSA Assessments

DBHR will pay Adult Residential providers for a non-ADATSA assessment for patients upon admission who meet the following criteria:

1. The person is a treatment expansion clients (includes SSI, GAU, GAX, Medical Assistance only, or TANF).

2. An assessment has not been performed on the client in the last 30 days.

When billing DBHR for non-ADATSA assessments, the provider must submit the following with the Form A19 Invoice Voucher:

1. The attached *Non-ADATSA Assessment Form* which identifies the client, where the client was referred from, has the client received a prior assessment and why it is necessary to conduct another assessment, and

2. The *TARGET M-2 Report*.

Payments for non-ADATSA Assessments <u>are</u> included in the maximum consideration of your residential contract.

NON-ADATSA ASSESSMENT FORM

Client Name	For Each Client define Referral Source*	Did Client Receive Assessment from a different agency? If yes, please explain.

PHYSICAL EXAMS

DBHR will pay for physical examinations for patients upon admission who meet the following criteria:

1. The person is dependent on barbiturates or benzodiazepines, or

2. The person used intravenous drugs in the thirty days before admission.

The physical exam must be conducted by a licensed health care practitioner functioning within his/her scope of practice under state law.

When billing DBHR for physical exams, the provider must submit the following with the Form A19 Invoice Voucher:

3. The attached *Referral and Payment for Physical Examination* form which identifies the client, the referral source for the physical examination, and the criteria met by the client, and

4. The medical documentation from the medical care practitioner who provided the physical examination.

Payments for physical examinations <u>are</u> included in the maximum consideration of your residential contract.

Referral and Payment for Physical Examination

Client Name: _____

Date of Referral:_____

Contact Name & Phone No: _____

Date of Admission: _____

Who made the referral:

- θ The Assessment Center (Referral Source for ADATSA Clients)
- θ Residential Treatment Provider
- θ Outpatient Treatment Provider
- θ Other (Identify):_____

Criteria met for the referral:

- θ Dependent on Barbiturates or Benzodiazepines
- θ Used Intravenous Drugs in the Thirty Days Before Admissions

		Who pays and how
θ	Title XIX	Medical card pays for physical
θ	GAU/W	Medical card pays for needed services
θ	Third party	Whenever possible
θ	DBHR	**Only** when above is not possible (limited to IDU clients)

DBHR only pays for a physical examination when (1) it is performed by a medical practitioner and (2) it is for a person who is dependent on barbiturates or benzodiazepines or who used intravenous drugs in the 30 days prior to admission.

DBHR Maximum Rates:	Physical Exam Only	$71.69
	Physical Exam with Lab Tests	$136.56

For DBHR payments attach medical documentation.