



SSIS Software Specification

Healthcare Claiming - Requirements

Prepared By: Theresa Hill

Project Manager: Kate Stolpman

Last Updated: November 18, 2013

Change Sheet

Revision	Description	Date
Original	Sections 1-5	11/18/04
Rev 1	Changes per Product Team review of section 1-5.	11/20/04
Rev 2	Changes to section 2.1.3 "Claiming Policy and HealthCare Systems Requirements" Made updates based on VA/DD-TCM policy review. Added RSC Claiming	1/26/05
Rev 3	Updates based on Product Team review	2/16/05
Rev 4	Section 2 updates	9/08/06
Rev 5	Added section 8 and appendices	04/02/07
Rev 6	Added VA/DD-TCM proofing messages to section 8 Added MMIS Claim Status information to section 8 Added draft list of proofing messages for all remaining claim categories Added Paid Units to Claim record, screen and grids Removed Batch Owner default from Claim Batch search	05/31/07
Rev 6	Added Waiver proofing messages to section 8	07/02/07
Rev 7	DD Waiver name changes	07/27/07
Rev 8	Split document into 3 documents as follows: Requirements – Sections 1 – 7 Design – Section 8 Appendices	07/31/07
Rev 9	Waiver and AC: Moved T2030 from the Non-automated Claim Category to Waiver and AC Added Service 118 & 618 to T2032 TF for Waiver & AC LTCC Added 2 Activity Types to the list of valid values Added information on SSIS Supplemental LTC Screening	08/21/07
Rev 10	Waiver and AC: Ended T2003 UC effective 09/30/07	09/06/07
Rev 11	Minor corrections	10/16/07

Revision	Description	Date
Rev 12	<p>CW-TCM: Removed edit for clients in a MA Funded Facility. SSIS has requested MMIS do this edit rather than putting in SSIS Updated TEFRA Override requirement</p> <p>LTCC: Changed valid date range to 35 days before and 35 days after screening per policy area</p> <p>Waiver & AC Changes related to BRASS Service changes effective 01/01/08 in Waiver & AC and Non-automated sections Minor corrections to Waiver & AC HCPCS/Modifiers and Services</p> <p>Rule 5: Clarification to rules and claim record output</p> <p>MH-TCM: Removed references to the following HCPCS/Modifiers for services provided by state staff. The HCPCS/Modifiers ended 12/31/2007 and MMIS is no longer tracking state staff separately. SSIS will not submit claims with these modifiers T2023 HE HW U4 - MH-TCM, adult, telephone by state staff T2023 HE HW - MH-TCM, adult, face-to-face by state staff</p>	12/05/07
Rev 13	<p>CW-TCM: Added note that all HCPCS/Modifiers for CW-TCM have 2/29/08 end date</p> <p>Rule 5: Clarification to Living Arrangement rules Removed MNCare Major Programs from list of valid programs</p> <p>Waiver and AC: Removed references to HCPCS/Modifiers that ended prior to 01/01/07</p>	02/08/08
Rev 14	<p>RSC: Changed RSC to RSC-TCM Added Living Arrangement 52</p> <p>Non-automated: Ended all HCPCS/Modifiers with HW modifier, effective 12/31/07</p>	05/06/08
Rev 15	<p>RSC: Change the Procedure code, effective 9/1/8</p> <p>CW-TCM: Removed end date info</p>	07/02/08

Revision	Description	Date
Rev 16	v5.2 changes: <ul style="list-style-type: none"> • Added conversion for SSIS Location "Child's residence, (PR # 08-0801-1148-22) • Change MH-TCM claim date and age calculation to actual service date service instead of the 1st of the month (PR #08-0818-1444-26) • Change MH-TCM to add major programs for GAMC & MN-Care (PR #08-0902-1237-02) 	10/13/08
Rev 17	MH-TCM: Removed age edit for clients in an IMD facility	12/29/08
Rev 18	V5.2b changes: <ul style="list-style-type: none"> • Removed procedure codes with an end date of 12/31/07 or prior • Moved home health procedure codes from Waiver to Non-automated • Ended HCPCS G1056, replaced by T1004 	05/27/09
Rev 19	<ul style="list-style-type: none"> • V5.2b - Changed description of HCPCS/Modifier S5165 • Added notes to effected categories indicating major program DM ends on 09/30/09 • MH-TCM: Updated notes regarding age requirements for SED/SPMI. • LTCC: Removed note that indicated a LTCC Screening could not be claimed with 2 living arrangements 	05/21/09
Rev 20	v5.3 changes: <ul style="list-style-type: none"> • Added procedure code S5165 U3 for Waiver & AC • Changed the Diagnosis Required Indicator to Yes for several non-automated HCPCS/Modifiers (PR #09-0618-1346-30) • Added Non-automated HCPCS/Modifiers 90882 HK (PR #10-0324-0846-51) • Updates to non-automated S9484 HCPCS/Modifiers combination (PR #10-0223-0717-40) • Change T2001 UC to not-automated & end Service Associations (PR #10-0421-0904-13) • Added H0001 & H0002 not automated HCPCS (PR #09-0917-1450-44) • 2010 BRASS Service changes (PR #09-0723-0857-53) v5.4 changes: <ul style="list-style-type: none"> • DD Screening: Added as a new Claim Category 	07/13/10

Revision	Description	Date
Rev 21	v5.4 changes: <ul style="list-style-type: none"> • Update Waiver & AC "Units" information to include "Each time" for new HCPCS/Modifiers S5116 TF (PR #10-0714-1452-11) • Added S5160, S5161 & S5162 to Waiver & AC (PR #10-0326-0945-36) • Added S5116 TF to Waiver & AC (PR #10-0330-0713-00) • Additional code description changes for DD 	02/23/11
Rev 22	Updated Section 1 to add DD Screening claim category v11.4 changes: <ul style="list-style-type: none"> • Require a diagnosis on all claims for the new 5010 version of the EDI transactions (PR #11-0831-1303-10) • Proofing Message 2301 – Add "CADI" waiver for Service 622, Activity 29 (PR #10-1122-1318-32) 	11/21/11
Rev 23	v11.4 <ul style="list-style-type: none"> • Added 10/01/11 end date to T1020 (PR #11-1003-0836-06) v12.2 <ul style="list-style-type: none"> • Removed HCPCS S5181 UC from Waiver & AC. This HCPCS/Modifier has not ever been used and has new requirements that prevent it from being claimed through SSIS (PR #12-0308-1418-17) • Change references from TBI Waiver to BI Waiver (PR #12-0210-0956-20) 	04/13/12
Rev 24	v12.1 <ul style="list-style-type: none"> • Add Rock County to the Lincoln/Lyon/Murray (SWHHS) region using the new multi-county tables (PR # 12-0223-1834-46) v12.2 <ul style="list-style-type: none"> • Update HCPCS/Mod descriptions for BI Waiver (PR #10-1223-0802-06) V12.3 <ul style="list-style-type: none"> • Added end date of 4/30/09 to S5110 TF (PR #12-0510-1002-05) 	10/31/12

Revision	Description	Date
Rev 24 (cont.)	v12.4 <ul style="list-style-type: none"> • Removed references to Legacy Claim Date, which is no longer needed (PR # 12-0419-0839-21) • Rule 5 – Added a requirement that the provider on the Living Arrangement must have a NPI/UMPI (PR #09-0121-1646-11) • Rule 5 and Waiver & AC – Changes to I Living Arrangement provider information because of database changes for the MA Eligibility Expansion project • Moved HCPCS/Modifiers G0156 & T1004 from Waiver and AC to "Not-Automated" (PR #09-0324-1552-30) • Waiver & AC – HCPCS/Modifiers S5110 – associations with Activity "Family counseling (CAC)" ended 04/30/2009 – Renamed Activity "Family counseling/training (BI, CAC, CADI)" now covers CAC (PR #12-0719-0840-57) 	10/31/12
Rev 25	v12.4 <ul style="list-style-type: none"> • End S0215 UC – Transportation, mileage (commercial), effective 12/31/12 and rename S0215 UC – Transportation, mileage (non-commercial) to Transportation, mileage (PR # 12-1119-1002-32) • Removed references to HCPCS/Modifiers that ended prior to 01/01/2011 v13.2 <ul style="list-style-type: none"> • Major Program EH is no longer valid for CW-TCM, effective 01/01/12 (PR # 13-0219-1500-49) • Major Program EH is no longer valid for MH-TCM, effective 01/01/12 (PR #13-0214-1306-52) • Removed Major Programs EH and IM from RSC-TCM (PR #13-0219-1403-29) • Removed Major Programs EH and LL from VA/DD-TCM (PR #13-0219-1353-43) • End S5135 U9 (Behavioral Programming by Aide), effective 04/30/13 (PR #12-0514-1412-10) 	05/03/13
Rev 26	v13.3 <ul style="list-style-type: none"> • End S5116 and S5116 TF, effective 6/30/13 and add S5115 and S5115 TF, effective 7/1/13 (PR #13-0701-1110-06) 	08/19/13

Revision	Description	Date
Rev 27	v13.4 <ul style="list-style-type: none"> • DD and LTC Screenings are no longer claimable if the screening date is on or after 10/01/13 (PR# 13-0523-1521-05) • End E1399, effective 5/31/13. Add 3 new codes; E1399 NU, E1399 RR and E1399 RB, not-automated claim category, effective 6/1/13 (PR #13-0729-1311-12) • Add T2011 - PASRR Level II Screening, effective 9/1/12 to the not automated claim category (PR #13-0520-1503-46) • Delete X5574 & X5584, which have never been used n SSIS (PR #13-0909-1545-02) • BRASS code description changes for 2014-15, (PR #13-0729-1430-57) • Waiver Provider Standards – add end dates to many waiver codes that were billable for payments, change several descriptions and add one new code for staff time (PR #13-0925-1547-58) 	11/18/13

2.1.12.4	Non-automated HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers.....	96
2.1.12.5	Non-automated HCPCS/Modifiers Available on Payments – by Service	101
2.2	Use Cases	105
2.2.1	Create and Submit Claims.....	106
2.2.2	Resubmit a Claim.....	108
2.2.3	Search for Claims	109
2.2.4	Track Claims	110
2.3	File Input/Output	111
2.4	Reports.....	111
2.5	Security	111
SECTION THREE: NON-FUNCTIONAL REQUIREMENTS		113
3.0	Introduction	113
3.1	Performance.....	113
3.2	Reliability.....	113
3.3	Availability	113
3.4	Reuse	114
3.5	Industry Standards	114
SECTION FOUR: EXCEPTION CONDITIONS AND ERROR HANDLING		115
4.0	Introduction	115
4.1	Data Exchange Incomplete/Incorrect Data	115
4.2	File Read/Write	115
4.3	Network.....	115
4.4	Data Exchange Errors	115
4.5	Incorrect Data	115
SECTION FIVE: SUPPORTABILITY AND USABILITY		117
5.0	Introduction	117
5.1	Installability	117
SECTION SIX: DEVELOPMENT AND OPERATING ENVIRONMENTS		119
6.0	Introduction	119
SECTION SEVEN: SYSTEM INTERFACES		121
7.0	Introduction	121
RELATED DOCUMENTS.....		123
GLOSSARY		125

SECTION ONE: INTRODUCTION

1.0 Introduction

This document is the Software Specification for Healthcare Claiming. It describes the functional requirements and design of Healthcare Claiming.

Section One provides a project overview, Sections Two through Five describe requirements, Sections Six through Eight describe design.

1.1 System Requirements Statement

HIPAA standards and regulations require healthcare claims to be submitted using standard EDI transactions and file encryption. Each category of claim, such as VA/DD-TCM has a unique set of business rules, which the DHS policy group for the individual claim category defines. HealthCare Systems defines specific requirements and formats for data items submitted on the claims. Counties require the ability to automate the generation of healthcare claims based on Time records, Payments, Eligibility, and Client information that exists in the SSIS system. In addition, counties require proofing reports before they submit claims and reports showing submitted claims.

Figure 1-1 depicts the generic business process for all healthcare claims. The inputs may vary depending on the requirements for the category of claim. For example, VA/DD-TCM claims only use Time records, not Payments, Rule 5 only uses Payments, and Waiver claims can use both.

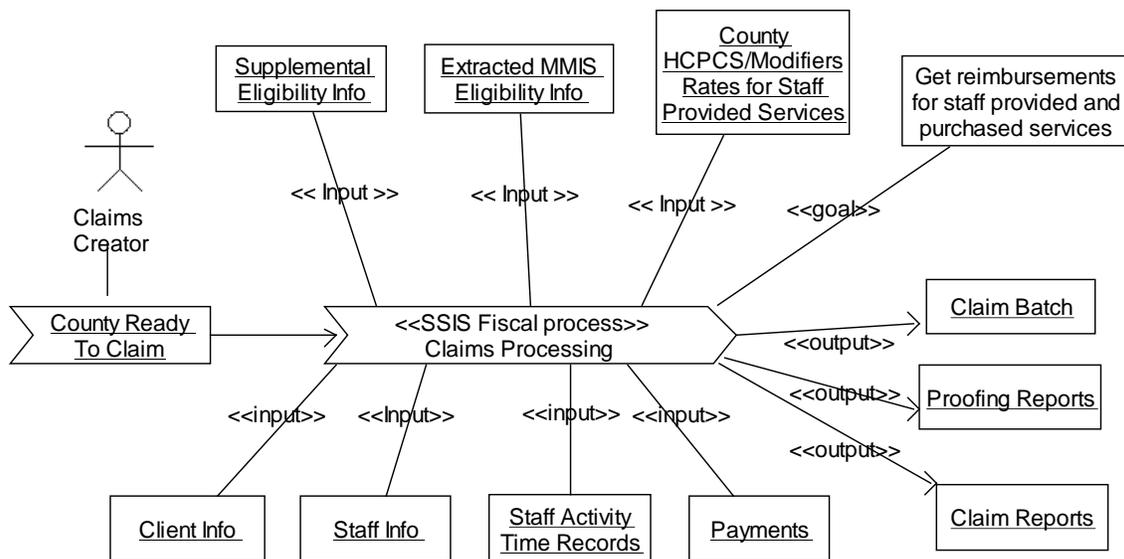


Figure 1-1 Healthcare Claiming Business Process

1.2 Overview

The purpose of the Healthcare Claiming module is to provide a means to validate and correct potential claims, create claims batches, submit the claims to the county's MN-ITS mailbox, and process responses from MMIS.

SSIS will use a phased approach to implement the different claim categories as well as some of the available functionality. Following is a list of the claim categories to be included in the order of implementation.

- 1) **RSC-TCM** (Relocation Services Coordination, Targeted Case Management)
- 2) **VA/DD-TCM** (Vulnerable Adult/Developmentally Disabled, Targeted Case Management)
- 3) **Waiver and AC Services**, which includes the following:
 - a) Community Alternative Care (CAC)
 - b) Community Alternative Care for Disabled Individuals (CADI)
 - c) Elderly Waiver (EW)
 - d) Developmental Disabilities (DD) Waiver
 - e) Brain Injury (BI)
 - f) Alternative Care (AC) AC is not a waiver, but follows the same rules as the waiver services and is claimed with waiver services.
- 4) **CW-TCM** (Child Welfare, Targeted Case Management)
- 5) **LTCC Screening** (Long Term Care Consultation Screening)
- 6) **MH-TCM** (Mental Health, Targeted Case Management)
- 7) **Rule 5** (a child residential treatment center for children with severe emotional disturbances)
- 8) **DD Screening** (Developmental Disabilities Screening)

The first phase of this document addresses RSC-TCM claiming. This phase includes the proofing and error reports, claims processing and submission, claims search and claim reports for RSC-TCM. Future phases will include additional claim categories, voiding and resubmitting claims, processing of the Remittance Advice EDI transaction from MN-ITS, and processing a claim status file from MMIS and additional claim reports.

The system sends claim batches to the county's MN-ITS mailbox using HIPAA compliant EDI transactions and secure FTP. For each claim received, MN-ITS will send an EDI acknowledgement response, which will be processed by SSIS.

Figure 1-2, "Healthcare Claiming Deployment Diagram", on the following page depicts the interfaces between SSIS and MMIS/MN-ITS. See SSIS/MMIS Data Interchange Specification for details on the exchange of information between SSIS and MMIS.

Figure 1-2 Healthcare Claiming Deployment Diagram

1.3 Project Objectives

The primary objectives of the Healthcare Claiming module are:

1. Automate the Healthcare claiming process in SSIS, in compliance with HIPAA requirements, DHS policy for healthcare claims and HealthCare Systems requirements
2. Automate the generation and submission of claims
3. Simplify the submission of void claims and resubmitted claims
4. Automate the claim's reconciliation process

1.4 Impact Statement

The Healthcare Claiming module impacts and is impacted by several modules, including Time records, Service Arrangements, Payments, Supplemental Eligibility, MMIS Eligibility and Programs & Services, and SSIS Admin. Appendix D and E contain the documentation of the changes required for impacted modules.

SECTION TWO: FUNCTIONAL REQUIREMENTS

2.0 Introduction

This Section describes the functional requirements for the Healthcare Claiming software.

2.1 Requirements

The sources of the requirements for the Healthcare Claiming application are Federal HIPAA standards and regulations, HealthCare policy group for each claim category, and county financial workers.

2.1.1 Federal HIPAA Requirements

The system must conform to HIPAA standards and regulations, which include the following:

Requirement
1. Healthcare claims submitted electronically to MMIS must conform to the ANSI X.12 standards for healthcare claims.
2. Electronic remittance advice (notification of Payment or rejection of claims) from MMIS must be in the format specified by ANSI X12 for remittance advice.
3. HCPCS/CPT codes specified by HIPAA data standards must be used (local HCPCS codes will not be supported).
4. HIPAA proposed security standards require the encryption of electronic transmissions containing data about healthcare services provided to clients. HIPAA does not dictate a particular encryption algorithm.
5. Provide the ability to enter a healthcare vendor's National Provider Identifier and use this to identify the provider in a claim.

Table 2-1: Federal HIPAA Requirements

2.1.2 County Requirements

The following requirements apply to the county business needs that require an electronic claims submission process.

Requirement
1. Provide the ability to create healthcare claims from Time records and Payments to vendors.
2. Provide the ability to record third party insurance Payments and reason (denial) codes for claims. Note: This requirement was not implemented due to the small number of claims submitted by counties with third party insurance and the significant amount of additional design, programming and testing that would be required.
3. Provide the ability to display proposed/potential healthcare claims on screen.
4. Provide the ability to display submitted healthcare claims on screen.
5. Provide the ability to customize the display of proposed and submitted claims, including sorting and filtering options. This allows the user to display the information by such things as Client or Service.
6. Provide a pre-edit process for potential healthcare claims and display errors and inconsistencies on-screen.
7. Provide access to screens where users can correct or edit the data for potential healthcare claims.
8. Provide the ability to mark a Time record, or Payment as 'Do Not Claim' to prevent a claim from being generated for that record.
9. Allow all on-screen reports to be printed.
10. Provide the ability to change information from a rejected claim.
11. Create a new claim when a user changes the data from a rejected claim. (Referred to as a 'resubmission')
12. Provide the ability to change information from a paid claim (fully or partially paid) in order to create a replacement claim (examples are included Time Payment records, Supplemental Eligibility or Worker Qualifications). Note: SSIS decided to create Void claims and allow users to resubmit a claim rather than creating replacement claims.
13. Create a replacement claim when a user changes the data from a paid claim (fully or partially paid). Note: SSIS decided to create Void claims and allow users to resubmit a claim rather than creating replacement claims.
14. Provide an interface with the healthcare claiming system (MMIS/MN-ITS) to support electronic submission of claims.
15. Provide an interface with MMIS/MN-ITS to import claim status and remittance advice information from MMIS/MN-ITS into SSIS.

Table 2-2: County Claiming Requirements

2.1.3 Claiming Policy and HealthCare Systems Requirements

The DHS policy group for the individual claim categories determines the specific billing rules for each claim category. The source of the requirements can be bulletins, provider manuals, memos, and e-mails. In addition, HealthCare Systems define requirements regarding the format of data contained on claims.

Below are the general requirements that apply to all claims, followed by general requirements for each claim category. Detailed information about the implementation of these requirements is included in Section 8.

In addition, HealthCare Systems has developed a 'cross-walk' defining their expected use of the 837 Claim Transaction, and the 835 Remittance Advice Transaction. Detailed information about the implementation of these requirements is included in Section 8 and the appendices.

MMIS Claiming Requirements
General
Counties must file all claims within one year of the date of service. MMIS will deny claims with service dates that are more than one year old.
Time records and Payments can only be paid by MMIS once. That is, counties cannot submit a claim for services provided under more than one claim category, or more than one HCPCS. If a claim for Time record or Payment is denied, the information in SSIS and/or MMIS can be corrected, and the claim can be resubmitted under the same claim category and HCPCS, or using a different claim category and HCPCS, which is determined by the changes that are made. SSIS uses cross reference tables from the claims table to Payments and Time records for the records that are included on a claim. These records are created when a claim is generated and are looked at when subsequent claims are generated to exclude those that have been claimed. In addition, for LTCC and DD Screenings, a cross reference to the screening document used on a claim prevents duplicate claims for a screening.
Required Client Information
Client Name
Client Address (If client does not have an address, use the county address) SSIS checks for a physical address, then a mailing address. If neither exists, SSIS uses the county address. The address records must be in effect when the claim is generated.
Gender
PMI # (Recipient ID)
Actual Date of Birth If the client has an estimated date of birth, no claims are generated for that client.
For all age calculations, if a client has a leap year birthday <ul style="list-style-type: none"> • Advance age on 2/29 in leap years • Advance age on 3/1 in non-leap years

MMIS Claiming Requirements		
Place of Service Code		
<p>Every claim must have a Place of Service code.</p> <p>The SSIS "Location" code is converted to a MMIS "Place of Service" code. The conversion table can be found in Section 2.1.3.3, "SSIS "Location" Conversion to MMIS "Place of Service" on page 16.</p>		
<p>In SSIS, all Payments with a HCPCS/Modifier must have a Location.</p> <p>Time records with one of the following activities require a Location:</p> <ul style="list-style-type: none"> • 7 Client contact • 8 Collateral contact • 15 CW-TCM eligible contact 60+ mi from cnty. border <p>On Time records with any other activity, the Location is optional.</p>		
<p>When Payments and/or Time records are combined into one claim the SSIS Location on the first record selected is used, all others are ignored.</p>		
Units / Claim Amount		
<p>The number of Units must be a whole number (no partial units are allowed).</p>		
<p>The number of Units must be greater than zero.</p>		
<p>Claim Amount must be greater than zero.</p>		
Payments		
<p>The Amount and Units on the Payment(s), after adjustment for Payment Modifications, must be greater than zero.</p>		
<p>The Payment Status must be "Paid"; it cannot be in a pending status.</p> <p>Payment Requests with the following Payment Statuses are excluded from claiming: Draft, Pending Approval, Approved, Submitted, Suspended, Denied</p> <p>The Payment Status on Posted Payments and Payment Modifications is always "Paid".</p>		
<p>The Payment cannot already have been claimed (with the exception of Void Claims and Resubmissions).</p> <p>This is determined by:</p> <ul style="list-style-type: none"> • The Payment has a cross reference to a claim record in SSIS. 		
<p>Negative claims cannot be submitted. Payment Modifications (partial Refunds and Recoveries) must be claimed with the original Payment. The net amount and units are submitted on the claim. If the original Payment has already been claimed, it must be voided by the county claims worker and resubmitted to include the Refund/Recovery.</p>		
<p>Cancellations, Adjustment Reversals and full Refunds and Recoveries are not claimed because the Payment nets to zero. If the original Payment has already been claimed, it must be voided by the county claims worker.</p>		
<p>The Payments Service Start Date and Service End Date must be completely within the dates of one Living Arrangement record. If not, the Payment is not claimed and is included on the proofing reports. The county must split the Payment into multiple records using the standard process for creating Payment Modifications. The county can also correct the service dates using the same process.</p>		

MMIS Claiming Requirements		
Counties set up as a region in SSIS (Faribault/Martin and SWHHS) only:		
Each county in the region submits separate claim batches. Payments are only included on claims in a batch if 'Paying County' is the 'Claiming County' on the batch. 'Paying County' is selected by the user when the Payment is created.		
The policy areas and bulletins define which Payments are eligible for each claim category.		
Staff Activity Time records		
Time recorded must be greater than zero.		
The Time record cannot already have been claimed (with the exception of Void Claims and Resubmissions). If the Time record has been claimed, a cross reference record will exist for the Time record and associated Claim in SSIS.		
Counties set up as a region in SSIS (Faribault/Martin and SWHHS) only:		
Each county in the region submits separate claim batches. Time records are only included on claims in a batch if 'County of Service' is the 'Claiming County' on the batch.		
The system sets the 'County of Service' to the Workgroup's 'County of Service' when the Time record is created.		
The policy areas and bulletins define which Time records are eligible for each claim category.		
Staff Worker Claiming Requirements		
Staff eligibility requirements for each claim category are defined by policy/bulletins. Staff claiming eligibility is determined by the county based on these requirements.		
SSIS requires the county to record which staff are eligible to claim for each claim category and the effective dates of eligibility. County staff creates Staff Claim Qualifications for each user in the SSIS Administration application.		
To claim a Time record, the Worker on the Time record must have Staff Claim Qualifications for the claim category for the date on the Time record.		
The requirements sections for the individual claim categories may include additional edits regarding staff requirements, such as state staff vs. county staff.		
HCPCS/Modifier Information		
The term "HCPCS/Modifiers" is used in SSIS and throughout this document, to refer to a valid procedure code, or HCPCS, with 0 to 4 Modifiers. Some HCPCS do not have any Modifiers, others have one, two, three, or four Modifiers.		
SSIS maintains tables of valid HCPCS and Modifiers along with the effective dates, a description of each HCPCS/Modifiers combination and the unit type.		
Each claim must have a "HCPCS/Modifier", which must be valid on the date of service.		

MMIS Claiming Requirements
HCPCS/Modifiers Rate Information
For claims based on Time records, SSIS calculates the county's cost of providing a service using HCPCS/Modifiers Staff-provided Rates stored in SSIS. Claims based on Payments use the actual rate and amount paid to the vendor.
DHS determines the maximum rate that MMIS will pay for some services. The rate may be set per county, as in the case of targeted case management services, or may be a maximum for all counties. DHS provides a reference file for other services.
The rate the county records on the HCPCS/Modifiers Rate table should be the county's actual cost for providing the services. MMIS may reduce the amount to pay according to their maximums.
SSIS requires the county to enter a rate and effective dates for each HCPCS/Modifier for claims based on Time records. <ul style="list-style-type: none"> • The county Staff Provided Rate for the HCPCS/Modifiers must be greater than zero. • The county Staff Provided Rate for the HCPCS/Modifiers must be effective on the Service Dates. Counties can enter a waiver type in the 'Claim Detail' field of the Staff Provided Rate record. If this field has a value, it must match the client's waiver type.
Supplemental Eligibility
Most claim categories require entry of some eligibility and/or miscellaneous information in SSIS. This information is in addition to the client's eligibility information in MMIS. Supplemental Eligibility requirements for each claim category are derived from policy/bulletins.
Counties have the option to set a 'Do Not Claim' indicator for a client for a particular claim category during a date range. SSIS excludes records for these clients during the claiming process.
MMIS Recipient Information
Each county receives a nightly update from the data warehouse containing Recipient Eligibility spans, Service Agreements, DD Screenings, and LTC Screenings for clients cleared to that county. The data warehouse receives updates from MMIS nightly. The recipient eligibility spans contain information about the major program, eligibility type, and waiver type for which the client is eligible. Each claim category uses specific information from recipient information in the SSIS claim edits to minimize the number of claims that MMIS rejects.

Table 2-3: Claiming Requirements

2.1.3.1 Claiming Terms

Following is a list of terms used in defining the requirements for individual claim categories. The remainder of this document denotes these terms with a bold, italic font (e.g. ***MA Funded Facility***).

Claiming Terms	
<i>Billable Contact Date</i>	The "Date" on the Time record that triggered the claim, which is one of the following: <ul style="list-style-type: none"> • The date of the earliest valid face-to-face contact for the month • Or the date of the earliest valid phone contact for the month if no face-to-face contacts exist for the month
<i>Billable Diagnosis Code</i>	An ICD-9 diagnosis code that MMIS will accept on a claim. MMIS maintains a table of valid diagnosis codes, which identifies the diagnoses that can be included on a claim. SSIS has a similar table and receives updates from MMIS as changes are made.
<i>MA Funded Facility</i>	Some claim categories have edits that apply only when the client is in a MA Funded Facility. The following Living Arrangements from MMIS indicate MA funded facilities (DI_ELIG_LIVE_ARR.LIVE_ARR_CD). <ul style="list-style-type: none"> • 41 Nursing Facility I - Medicare certified • 42 Nursing Facility II - Non-Medicare certified • 43 ICF/DD - Public or private • 44 NF I - Short term stay <30 days • 45 NF II - Short term stay <30 days • 46 ICF/DD - Short term stay <30 days • 48 Medical hospital >30 days • 53 Private psychiatric inpatient hospital – IMD • 58 RTC - CD psychiatric inpatient hospital - IMD
<i>Screening Diagnosis Code</i>	Indicates the diagnosis code for a claim comes from a DD Screening or a LTC Screening as defined in section 2.1.3.2.1, "Screening Diagnosis Codes" on page 13. Screening Diagnosis Codes are received from MMIS on DD Screenings and LTC Screenings.
<i>Service Dates</i>	Service Date on a Time record is the "Date" on the Time record (TIME_RECORD.ACTIVITY_DT). Service Dates on a Payment are the "Service Start Date" (PAYMENT.PYMT_SVC_START_DT) through the "Service End Date" (PAYMENT.PYMT_SVC_END_DT).
<i>SSIS Diagnosis Code</i>	Indicates the diagnoses for a claim come from SSIS values as defined in section 2.1.3.2.2, "SSIS Diagnosis Codes" on page 15. <i>SSIS Diagnosis Codes</i> are entered for a client by a worker in SSIS, not received from MMIS.

Claiming Terms	
<i>Waiver/AC Recipient</i>	<p>Some claim categories exclude clients who are Waiver or AC recipients.</p> <p>The following conditions must be met for a client to be considered a Waiver Recipient:</p> <ol style="list-style-type: none"> 1. Client has a Waiver span 2. The <i>Service Dates</i> are within the Waiver Start Date (DI_ELIG_WAIVER.WAIVER_START_DT) and the Waiver End Date (DI_ELIG_WAIVER.WAIVER_THRU_DT). <p>AC clients are also excluded from these claim categories based on the list of valid Major Programs for those categories, which does not include AC.</p>

Table 2-4: Claiming Terms

2.1.3.2 Diagnosis Codes

A diagnosis code is required on all claims. MMIS requires only one diagnosis code. The EDI claim transaction allows up to four diagnosis codes, SSIS sends only one.

A diagnosis code can come from a DD Screening, a LTC Screening, from values entered in SSIS, or from a generic default defined by the policy area. The source of the diagnosis code is dependent on the claim category. The following table defines the source for each claim category and indicates the default if one is used.

Claim Category	Source, in order of precedence	Default if no <i>Billable Diagnosis Code</i>
CW-TCM	N/A	V68.9
DD Screening	Screening Document SSIS Diagnosis Code	None
LTCC	Screening Document SSIS Diagnosis Code	None
MH-TCM	SSIS Diagnosis Code	None
RSC-TCM	Screening Document SSIS Diagnosis Code	V68.9
Rule 5	SSIS Diagnosis Code	None
VA/DD-TCM	Screening Document SSIS Diagnosis Code	V68.9
Waiver and AC	Screening Document SSIS Diagnosis Code	None

Table 2-5: Claim Categories Requiring a Diagnosis Code

In the table above, when both 'Screening Document' and 'SSIS Diagnosis Code' appear for a claim category, the system first checks for a Screening Document with a ***Billable Diagnosis Code***. If the Screening Document does not have a ***Billable Diagnosis Code***, the system checks for a ***SSIS Diagnosis Code***.

The following subsections describe how the system selects diagnosis codes from a screening document and from SSIS values.

2.1.3.2.1 Screening Diagnosis Codes

This section describes the criteria for selecting a diagnosis code from a screening document.

A client may have a DD Screening, a LTC Screening, both types of screenings, or may not have either. The diagnosis codes on the screening can be used for a claim even if the effective date of the screening is after the service dates on the claim. If a client has both a DD Screening and a LTC Screening with the same effective date, the DD Screening has precedence.

All 'Approved' screening documents have at least one diagnosis code. A DD Screening can have up to four diagnoses; an LTC Screening can have up to two. It is possible for a screening document to have a diagnosis code that is no longer billable or is no longer effective.

The system checks all of the available diagnosis codes to find a ***Billable Diagnosis Code***. The most recent screening is always checked first.

Following are the steps used to select a **Billable Diagnosis Code** from a screening document. Once a **Billable Diagnosis Code** is found, all other diagnoses are ignored.

1. Get the most recent screening:
 - a. Select the screening with the most recent effective date and with an 'Approved' Screening Status as defined below.

DD Screenings **Table Name: DI_ELIG_DD_SCRNG**

Display Label	Field Name	Comments
Screening Status	PA_SCRNG_STATUS_CD	Must be 'A' (Approved)
Action Date	ACTION_DT	The screening's effective date.

Table 2-6: Valid DD Screenings

LTC Screenings **Table Name: DI_ELIG_LTC_SCRNG**

Display Label	Field Name	Comments
Screening Status	PA_SCRNG_STATUS_CD	Must be 'A' (Approved)
Activity Type Date	SCRNG_ACT_TYPE_DT	The screening's effective date.

Table 2-7: Valid LTC Screenings

- b. If the client has both a DD Screening and an LTC Screening with the same effective date, the system first checks the DD Screening's diagnosis code for a **Billable Diagnosis Code** and only checks the LTC Screening's diagnosis code if the DD Screening does not have a **Billable Diagnosis Code**.
2. Get the first **Billable Diagnosis Code**:
 - a. Compare the diagnosis codes, in the order they appear on the screening, with the SSIS Diagnosis Code Master table. A diagnosis code must be a **Billable Diagnosis Code** on the 'First Service Date' and the 'Last Service Date' of the claim. The diagnosis code is billable if it meets the following conditions:

Table Name: DIAGNOSIS_CODE

Field Name	Comments
DIAG_TYPE_CD	Must be '2' (ICD-9-CM)
DIAG_CD_START_DT	Must be <= 'First Service Date' on the claim
DIAG_CD_END_DT	Must be blank or >= 'Last Service Date' on the claim
NONSPECIFIC_IND	Must be 'N'

Table 2-8: Billable Diagnosis Codes

- b. If the diagnosis code is billable, the process is complete. If not, the system continues checking each diagnosis code on all available DD and LTC Screening documents until a **Billable Diagnosis Code** is found. If the client has both a DD Screening and a LTC Screening on the same date, and no **Billable Diagnosis Code** is found on the DD Screening, the diagnosis codes on the LTC Screening are checked.

2.1.3.2.2 SSIS Diagnosis Codes

This section describes the criteria for selecting a diagnosis code to include on a claim for claim categories that use SSIS entries as the source of diagnosis codes.

SSIS allows each client to have no more than one 'primary' diagnosis code, though the user is not required to designate a primary diagnosis. A 'primary' diagnosis takes precedence over other diagnoses.

Users can optionally specify effective dates for a client's diagnoses. A client can have any number of diagnoses in effect at any given time. The SSIS Diagnosis does not need to be effective on the Service Dates on the Claim.

The system uses the following selection criteria for SSIS Diagnoses.

1. SSIS Diagnoses must be a **Billable Diagnosis Code** during the Service Dates on the Claim.

Note: If the code is a DSM-IV code (DIAGNOSIS_CODE.DIAG_TYPE_CD = '3'), the ICD-9 version of the same code is used to determine if the code is billable.

Table Name: DIAGNOSIS_CODE

Field Name	Comments
DIAG_TYPE_CD	Must be '2' (ICD-9-CM)
DIAG_CD_START_DT	Must be <= 'First Service Date' on the claim
DIAG_CD_END_DT	Must be blank or >= 'Last Service Date' on the claim
NONSPECIFIC_IND	Must be 'N'

Table 2-9: Billable Diagnosis Codes

2. For MH-TCM and Rule-5 claims, the diagnoses must be in the following range:
DIAGNOSIS_CODE >= 290.0 and <=302.99 or >= 306.0 and <=316.0
3. If the Primary Diagnosis is billable, that code is used on the claim.
Primary Diagnosis: PERSON_DIAG.PRIMARY_DIAG_IND = 'Y'
4. If the client does not have a Primary Diagnosis or it is not billable, all other diagnoses codes are checked as follows:
 - a) The system selects all billable SSIS Diagnoses.
 - b) The diagnosis codes are sorted in descending order by PERSON_DIAG.PERSON_DIAG_ID to get the most recent entries.
 - c) The system uses the first **Billable Diagnosis Code** on the claim.

2.1.3.3 SSIS "Location" Conversion to MMIS "Place of Service"

Each claim requires a "Place of Service". The SSIS "Location" is converted to a MMIS "Place of Service" for Time records and Payments as defined in the table below.

SSIS Location Code		MMIS Place of Service Code	
0	Nursing facility	32	Nursing facility
1	Field/home	12	Home
2	Office	99	Other unlisted facility
4	School	03	School
5	Law enforcement	99	Other Unlisted Facility
7	Board and care facility	33	Custodial Care Facility
8	Other	99	Other Unlisted Facility
9	Residential treatment facility	99	Other Unlisted Facility
A	Clinic	11	Office
B	Inpatient Hospital	21	Inpatient Hospital
C	Outpatient Hospital	22	Outpatient Hospital
D	Child's residence	12	Home
Blank	Can occur only on Time records	99	Other Unlisted Facility

Table 2-10: SSIS "Location" Conversion to MMIS "Place of Service"

2.1.3.4 MMIS "Waiver Type" Translation to SSIS "Claim Detail"

The 'Claim Detail' field is used for Waiver & AC to store the Waiver Type or the 'AC' Program type. When applicable, the MMIS Waiver Type is converted to the more generic SSIS waiver type.

Staff-provided Rates for a HCPCS/Modifier can vary based on the waiver type. The user can enter a 'Claim Detail' code on the rate, which can be AC or a Waiver. If the 'Claim Detail' field contains a value, it must match the client's waiver type when selecting a rate to use on a claim.

The table below lists the translations of the 'Waiver Type' to the SSIS 'Claim Detail'.

Except where noted, translation is based on the client's waiver type (DI_ELIG_WAIVER.WAIVER_TYPE_CD)

MMIS Waiver Type	SSIS 'Claim Detail' (CLAIM_CAT_DETAIL_CD)
F LTC - CADI Conversion	4 CADI
G LTC - CADI Diversion	4 CADI
H LTC - CAC Conversion	3 CAC
I LTC - CAC Diversion	3 CAC
J LTC - EW Conversion	1 EW
K LTC - EW Diversion	1 EW
L LTC - BI NF Conversion	5 BI
M LTC - BI NF Diversion	5 BI
P LTC - BI Hosp Conversion	5 BI
Q LTC - BI Hosp Diversion	5 BI
R DD - DD Conversion	6 DD
S DD - DD Diversion	6 DD
Major Program = 'AC' (DI_ELIG_RECIPIENT.MAJOR_PROG_CD = 'AC')	2 AC

Table 2-11: MMIS "Waiver Type" Translation to SSIS "Claim Detail"

2.1.4 CW-TCM Claiming

The table below summarizes the requirements for CW-TCM claiming.

CW-TCM Claiming	
Child Welfare – Targeted Case Management (CW-TCM) claiming is done for Time records meeting the CW-TCM criteria for eligible clients.	
Inputs	
Eligible Staff Activity Time records	
Services	<ul style="list-style-type: none"> • 104 Child protection investigation • 107 Child welfare assessment • 108 Family assessment response • 109 Concurrent planning assessment • 192 Family assessment case management • 193 General case management • 492 Child general case management • 592 Child (<21) DD non-waiver case management
Activities	<ul style="list-style-type: none"> • 7 Client contact • 8 Collateral contact • 15 CW-TCM eligible contact 60+ mi from cnty. border
Contact Status	<ul style="list-style-type: none"> • 2 Completed
Contact Method	<ul style="list-style-type: none"> • 1 Face to face • 2 Phone <p>Phone is only valid if Activity is 15 (CW-TCM eligible contact 60+ mi from cnty border)</p>
Supplemental Eligibility	
<p>Client must have a CW-TCM Supplemental Eligibility record in effect on the Billable Contact Date as indicated by the following:</p> <ul style="list-style-type: none"> • The Billable Contact Date must be between the CW-TCM Effective “Start Date” and “End Date” <ul style="list-style-type: none"> TIME_RECORD.ACTIVITY_DT between ELIG_CWTCM.DET_FACT_START_DT and ELIG_CWTCM.DET_FACT_END_DT or (TIME_RECORD.ACTIVITY_DT >= ELIG_CWTCM.DET_FACT_START_DT and ELIG_CWTCM.DET_FACT_END_DT IS NULL) 	

CW-TCM Claiming

If the **Billable Contact Date** is more than 1 year after the CW-TCM Effective "Start Date", an associated Annual Review record must exist and the **Billable Contact Date** must be within 1 year of the Annual Review Date

If $\text{TIME_RECORD.ACTIVITY_DT} \geq \text{ELIG_CWTCM.DET_FACT_START_DT} + 1 \text{ year}$

Record exists where $\text{TIME_RECORD.ACTIVITY_DT} \geq$
 $\text{ELIG_CWTCM_REVIEW.CWTCM_REVIEW_DT}$ and $<$
 $(\text{ELIG_CWTCM_REVIEW.CWTCM_REVIEW_DT} + 1 \text{ year})$

Example:

CW-TCM Start Date 3/15/06

Time records on 3/15/07 and after require an Annual Review

Annual Review 5/1/07

Time records between 3/15/07 and 4/30/07 cannot be claimed

MMIS Recipient Information

Client must be MA Eligible or MNCare Eligible on the **Billable Contact Date** as indicated by the following:

1. Major Program (DI_ELIG_RECIPIENT.MAJOR_PROG_CD) must be one of the following:

MA Eligible

- DM Demonstration to Maintain Indep. & Employment (DMIE)
- MA Federally Paid Medical Assistance

The following is no longer valid effective 01/01/12 (PR #13-0219-1500-49)

- EH Federally-Paid Emergency Medicaid

MNCare Eligible

- LL MinnesotaCare Citizen Kids/PWS

2. Eligibility Status must be 'Active' or 'Closed'
(DI_ELIG_RECIPIENT.RCP_ELIG_STATUS_CD = 'A' or 'C')
3. The **Billable Contact Date** is within the Eligibility Start Date
(DI_ELIG_RECIPIENT.ELIG_START_DT) and the Eligibility End Date
(DI_ELIG_RECIPIENT.ELIG_END_DT).

Client

Client Age calculation:

Client Age is determined as of the first day of the month in which the service was provided.

Client Age must be < 21

Diagnosis Codes

A diagnosis code is required.

The default diagnosis code "V68.9" (ADMINISTRATIVE ENCOUNTER NOS) is used on all CW-TCM claims.

CW-TCM Claiming

Additional Rules

Maximum of one CW-TCM claim can be submitted for a given month per client.

All eligible Time records in a month are linked to the claim.

A separate claim is created for each CW-TCM eligible client listed in the Regarding section of the Time record.

For a month in which both 'Phone' and 'Face-to-face' contacts occur, the 'Face-to-face' contact is claimed even though it may occur after the 'Phone' contact.

A telephone claim is created for a month in which only 'Phone' contacts occur.

A 'Face-to-face' contact must occur at least once every 3 months. There can be no more than two consecutive monthly 'Phone' claims. If a 'Face-to-face' Claim does not exist in one of the previous two months, the 'Phone' contact is not claimed. (This edit ignores 'Face-to-face' Claims that are 'Denied' or 'To be denied'.)

The Contact Method of the first claimable contact must be 'Face to face'.

If a TEFRA Eligibility record exists any time during the month of service, the current CW-TCM Supplemental Eligibility record must have a TEFRA Override in effect for the month of service:

- Check for TEFRA Eligibility during the month of service:
This edit is implemented by using the first of the month for the TEFRA Eligibility Start Date and the last day of the month for the TEFRA Eligibility End Date:

record exists where

DI_ELIG_RECIPIENT.ELIG_TYPE_CD in ('BT', 'DT')

and DI_ELIG_RECIPIENT.RCP_ELIG_STATUS_CD = 'A' or 'C'

and (TIME_RECORD.ACTIVITY_DT

between trunc(DI_ELIG_RECIPIENT.ELIG_START_DT, 'MONTH')

and last_day(DI_ELIG_RECIPIENT.ELIG_END_DT)

or (TIME_RECORD.ACTIVITY_DT

>= trunc(DI_ELIG_RECIPIENT.ELIG_START_DT, 'MONTH')

and DI_ELIG_RECIPIENT.ELIG_END_DT is null))

Below is an example:

Activity Date 8/23/07

TEFRA Eligibility 10/04/05 – 8/16/07 Translated to 10/1/05 – 8/31/07

The 8/23/07 Activity Date is between the 10/1/05 – 8/31/07 TEFRA dates

- Check for TEFRA Override on the current CW-TCM Supplement Eligibility record:

(TIME_RECORD.ACTIVITY_DT between ELIG_CWTCM.DET_FACT_START_DT
and ELIG_CWTCM.DET_FACT_END_DT

or TIME_RECORD.ACTIVITY_DT >= ELIG_CWTCM.DET_FACT_START_DT
and ELIG_CWTCM.DET_FACT_END_DT IS NULL))

and (TIME_RECORD.ACTIVITY_DT between

ELIG_CWTCM.TEFRA_OVER_START_DT and

ELIG_CWTCM.TEFRA_OVER_END_DT

or (TIME_RECORD.ACTIVITY_DT >=

ELIG_CWTCM.TEFRA_OVER_START_DT and

ELIG_CWTCM.TEFRA_OVER_END_DT is null))

CW-TCM Claiming	
Claim Record Outputs	
HCPCS/Modifiers	If Contact Method = Face to face: T2023 U3 CW-TCM, face-to-face If Contact Method = Phone: T2023 U3 U4 CW-TCM, telephone
Units	1
Amount	Staff-provided Rate for HCPCS/Modifiers
First Service Date	Billable Contact Date
Last Service Date	Billable Contact Date
Diagnosis Codes	V68.9
Additional Program Requirements and Policy Information NOT included in SSIS processing	
Eligibility	
Using the CW-TCM Supplemental Eligibility screen, the worker must record the basis for providing CW-TCM (child is at risk of or is experiencing child maltreatment, placement, or is in need of child protection or services).	
The worker must record the date and type of service plan that specifies CW-TCM related services.	
When reviewing the continuing need for CW-TCM services, the worker must record the type of plan and plan date that specifies the continued CW-TCM services.	
Worker Eligibility	
To trigger a claim, the worker on the Time record must be qualified to claim CW-TCM as defined in statute. The county must create a CW-TCM Staff Qualification record for each worker qualified to claim CW-TCM.	
County Practice	
Worker must ensure that the role of each "relevant" collateral is documented in the case record.	
If the service plan used to establish CW-TCM eligibility is for the entire family, the worker must ensure that it specifically identifies the services to be provided to each child who will receive CW-TCM.	

CW-TCM Claiming
<p>Contacts must be documented in the case record, either electronically or written, and must be easily identifiable in an audit.</p> <p>The following must be included in the documentation:</p> <ul style="list-style-type: none"> • Location of contact (e.g. home, office, school) • Type of contact (face-to-face, telephone) • Identification of the client • Name of contact • Kind of service provided (BRASS Service) • Date of contact <p>In addition, a description of the service provided must be documented in the case record.</p>
<p>Claims for clients in a MA Funded Facility are limited to one claim in the last 30 days in the facility. The 30 day allowed claims period starts over each time a client is admitted to a MA Funded Facility. A maximum of 2 CW-TCM claims for a client in a MA Funded Facility is allowed in a calendar year.</p>
Notes
<p>A CW-TCM telephone contact is only claimable for MN recipients placed outside the county of financial responsibility in an excluded time facility or through the Interstate compact and the placement is more than 60 miles beyond the county boundary.</p>
<p>CW-TCM may be provided concurrently with an investigation of child maltreatment.</p>
<p>CW TCM expenses are included as a part of a person's spenddown for MA eligibility.</p>
<p>Place of Service is converted from the SSIS Location. This is a change from the CSIS processing per CW-TCM policy group</p>
References
<p>DHS Instructional Bulletin # 93-16L August 31, 1993, Child Welfare – Targeted Case Management</p>
<p>MHCP Provider Manual, Chapter 30, CW-TCM</p>
<p>"CW-TCM Rules.doc" summarizing the CSIS CW-TCM claim processing, written by Jack Kinzer and Mary Klinghagen.</p>

Table 2-12: CW-TCM Claiming

2.1.5 DD Screening Claiming

The table below summarizes the requirements for DD Screening claiming.

Effective 10/01/2013, DD Screenings are no longer claimable in MMIS (PR# 13-0523-1521-05):

- DD screenings that occur on or before September 30, 2013 can be claimed for up to one year after the date of the screening. Related time records and payments can only be included in the claim if the date on the time record or the service start and end dates on the payment are before October 1, 2013. Time records and payments on or after October 1, 2013 cannot be included in the claim.
- If the screening occurs on or after October 1, 2013, all related time and payments will be reimbursed as an administrative expense. This includes the preparation work that occurs prior to October 1, 2013.

DD Screening Claiming	
DD Screening claiming is done for Time records and Payments meeting the DD Screening criteria for clients with eligible DD Screenings.	
Inputs	
Eligible Staff Activity Time records	
Services	• 505 Assessment for Long-term Services and Supports
Activities	• 28 Screening
Eligible Payments	
Services	• 505 Assessment for Long-term Services and Supports
HCPCS/Modifiers	• T2024 DD Screening (15 minutes)
Supplemental Eligibility	
The "Screening date" on the SSIS Supplemental DD Screening record must match the "Action Date" on a valid MMIS DD Screening ELIG_DD_SCRNG.DD_SCREENING_DT = DI_ELIG_DD_SCRNG.ACTION_DT	
The "Ready to claim" field on the SSIS Supplemental DD Screening must be Yes ELIG_DD_SCRNG.READY_TO_CLAIM_IND = 'Y'	
Note: The business rules for entering a Supplemental DD Screening record require the screening dates be more than 70 days apart. If counties wish to claim DD Screening for screenings that are less than 70 days apart, one of the claims must be submitted using MN-ITS.	
MMIS Recipient Information	
The "Screening Status" on the MMIS DD Screening must be Approved (DI_ELIG_DD_SCRNG.PA_SCRNG_STATUS_CD = 'A')	
The "Action Type " on the MMIS DD Screening must be 01 - Full team screening (DI_ELIG_DD_SCRNG.ACTION_TYPE_CD = '01')	

DD Screening Claiming	
Client	
No additional requirements	
Diagnosis Codes	
A diagnosis code is required.	
Screening Diagnosis Codes , then SSIS Diagnosis Codes are checked for a Billable Diagnosis Code .	
Additional Rules	
Record selection process for DD Screening is based on the "Screening date" of the Supplemental DD Screening records under Supplemental Healthcare Eligibility for a person. All eligible Time records and Payments for that DD Screening are then selected.	
The "Screening date" must be in the date range entered by the claims creator on the claim batch.	
The Service Dates of all Time records and all Payments can be up to 35 days prior and 35 days after the "Screening date" on the Supplemental DD Screening. Service Dates >= ELIG_DD_SCRNG. DD_SCREENING_DT – 35 days and Service Dates <= ELIG_DD_SCRNG. DD_SCREENING_DT + 35 days	
At least one billable Time record or Payment must include the "Screening date" on the SSIS Supplemental DD Screening: <ul style="list-style-type: none"> • Time record Service Date must be = "Screening date" or <ul style="list-style-type: none"> • Payment Service Start Date <= "Screening date" and Payment Service End Date >= "Screening date" 	
All eligible Time records and Payments are combined into one claim per DD Screening.	
Claim Record Outputs	
HCPCS/Modifiers	<ul style="list-style-type: none"> • T2024 DD Screening (15 minutes)
Units	Total of: <ul style="list-style-type: none"> • The total time (ON_BEHALF_OF.DURATION) on all selected Time records for the screening / 15 Units are rounded up if 8 or more minutes remain. If less than 8 minutes remain, the remainder is ignored. The total time on all selected Time records must be at least 8 minutes (half a unit) to be included in the claim. Plus <ul style="list-style-type: none"> • The total number of Units on all selected Payments.

DD Screening Claiming	
Amount	Total of: <ul style="list-style-type: none"> • Calculated Units on Time records multiplied by the county's rate for HCPCS/Modifiers on the Screening Date Plus <ul style="list-style-type: none"> • The total Amount on all selected Payments.
First Service Date	"Screening date" on the SSIS Supplemental DD Screening (ELIG_DD_SCRNG.DD_SCREENING_DT)
Last Service Date	"Screening date" on the SSIS Supplemental DD Screening (ELIG_DD_SCRNG.DD_SCREENING_DT)
Place of Service	The first selected Time record or Payment that includes the "Screening date" on the SSIS Supplemental DD Screening is used for this conversion, all others are ignored.
Diagnosis Codes	Screening Diagnosis Code or SSIS Diagnosis Code
Additional Program Requirements and Policy Information	
NOT included in SSIS processing	
Eligibility	
The client does not have to be eligible for MA for DD Screening services to be claimable.	
County Practice	
Counties must submit a Case Manager's Cost Report for DD Full Team Screening or similar form	
Notes	
<p>For a person with a developmental disability diagnosis or a related condition, screening teams are convened to evaluate the level of care needed by the person when the assessment indicates that the person is at risk of placement in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD), nursing facility or is requesting services in the areas of residential, training and habilitation, nursing facility or family support.</p> <p>The evaluation addresses whether home and community-based services are appropriate for persons who are at risk of placement in an ICF/DD or for whom there is reasonable indication that they might require this level of care.</p>	
Maximum of 96 units per DD Screening will be paid.	
References	
Disability Services Program Manual (DSPM), DD Screening section, 10/30/07 on the DHS web site	
MHCP Provider Manual on the DHS web site	

Table 2-13: DD Screening Claiming

2.1.6 LTCC Claiming

The table below summarizes the requirements for LTCC claiming.

Effective 10/01/2013, LTC Screenings are no longer claimable in MMIS (PR# 13-0523-1521-05):

- LTC screenings that occur on or before September 30, 2013 can be claimed for up to one year after the date of the screening. Related time records and payments can only be included in the claim if the date on the time record or the service start and end dates on the payment are before October 1, 2013. Time records and payments on or after October 1, 2013 cannot be included in the claim.
- If the screening occurs on or after October 1, 2013, all related time and payments will be reimbursed as an administrative expense. This includes the preparation work that occurs prior to October 1, 2013.

LTCC Claiming	
Long Term Care Consultation (LTCC) claiming is done for Time records and Payments meeting the LTCC criteria for clients with eligible LTC Screenings.	
Inputs	
Eligible Staff Activity Time records	
Services	<ul style="list-style-type: none"> • 105 Assessment for Long-term Services and Supports • 605 Assessment for Long-term Services and Supports
Activities	<ul style="list-style-type: none"> • 28 Screening
Eligible Payments	
Services	<ul style="list-style-type: none"> • 105 Long Term Care Consultation (LTCC) • 605 Long Term Care Consultation (LTCC)
HCPCS/Modifiers	<ul style="list-style-type: none"> • T1023 Life/disability evaluation: Face-to-face LTCC assessment under age 65
Supplemental Eligibility	
The "Screening date" on the SSIS Supplemental LTC Screening must match the "Activity Type Date" on a valid MMIS LTC Screening ELIG_LTC_SCRNG.LTC_SCREENING_DT = DI_ELIG_LTC_SCRNG.SCRNG_ACT_TYPE_DT	
The "Ready to claim" field on the SSIS Supplemental LTC Screening must be Yes ELIG_LTC_SCRNG.READY_TO_CLAIM_IND = 'Y'	
Note: The business rules for entering a Supplemental LTC Screening record require the screening dates be more than 70 days apart. If counties wish to claim LTCC for screenings that are less than 70 days apart, one of the claims must be submitted using MN-ITS.	

LTCC Claiming
MMIS Recipient Information
The "Screening Status" on the MMIS LTC Screening must be Approved (DI_ELIG_LTC_SCRNG.PA_SCRNG_STATUS_CD = 'A')
The "Activity Type" on the MMIS LTC Screening must be one of the following <ul style="list-style-type: none"> • 02 Person to person assessment • 04 Relocation/transition assessment • 06 Reassessment • 08 CAC/CADI/BI reassessment 65th birthday (DI_ELIG_LTC_SCRNG.SCRNG_ACT_TYPE_CD = '02', '04', '06' or '08')
Client
Client Age must be < 65 on the "Screening date" on the SSIS Supplemental LTC Screening.
Diagnosis Codes
A diagnosis code is required.
Screening Diagnosis Codes , then SSIS Diagnosis Codes are checked for a Billable Diagnosis Code .
Additional Rules
Record selection process for LTCC is based on the "Screening date" of the Supplemental LTC Screening records under Supplemental Healthcare Eligibility for a person. All eligible Time records and Payments for that LTC Screening are then selected.
The "Screening date" must be in the user entered date range for the claim batch.
The Service Dates of all Time records and all Payments can be up to 35 days prior and 35 days after the "Screening date" on the Supplemental LTC Screening. Service Dates >= ELIG_LTC_SCRNG. LTC_SCREENING_DT – 35 days and Service Dates <= ELIG_LTC_SCRNG. LTC_SCREENING_DT + 35 days
At least one billable Time record or Payment must include the "Screening date" on the SSIS Supplemental LTC Screening: <ul style="list-style-type: none"> • Time record Service Date must be = "Screening date" or <ul style="list-style-type: none"> • Payment Service Start Date <= "Screening date" and Payment Service End Date >= "Screening date"
All eligible Time records and Payments are combined into one claim per LTC Screening.

LTCC Claiming	
Claim Record Outputs	
HCPCS/Modifiers	<ul style="list-style-type: none"> T1023 Life/disability evaluation: Face-to-face LTCC assessment under age 65
Units	<p>Total of:</p> <ul style="list-style-type: none"> The total time (ON_BEHALF_OF.DURATION) on all selected Time records for the screening / 15 Units are rounded up if 8 or more minutes remain. If less than 8 minutes remain, the remainder is ignored. The total time on all selected Time records must be at least 8 minutes (half a unit) to be included in the claim. <p>Plus</p> <ul style="list-style-type: none"> The total number of Units on all selected Payments.
Amount	<p>Total of:</p> <ul style="list-style-type: none"> Calculated Units on Time records multiplied by the county's rate for HCPCS/Modifiers on the Screening Date <p>Plus</p> <ul style="list-style-type: none"> The total Amount on all selected Payments.
First Service Date	"Screening date" on the SSIS Supplemental LTC Screening (ELIG_LTC_SCRNG.LTC_SCREENING_DT)
Last Service Date	"Screening date" on the SSIS Supplemental LTC Screening (ELIG_LTC_SCRNG.LTC_SCREENING_DT)
Place of Service	The first selected Time record or Payment that includes the "Screening date" on the SSIS Supplemental LTC Screening is used for this conversion, all others are ignored.
Diagnosis Codes	Screening Diagnosis Code or SSIS Diagnosis Code
Additional Program Requirements and Policy Information	
NOT included in SSIS processing	
Eligibility	
The client does not have to be eligible for MA for LTCC services to be claimable.	
County Practice	
CBP counties bill LTCC the same as non-CBP counties.	
Notes	
The purpose of LTCC services is to assist persons with long term or chronic care needs in making decisions and selecting options that meet their needs and reflect their preferences. The intent is to prevent or delay nursing facility placements and to provide relocation assistance after admission.	
Maximum of 96 units (24 hours) per LTC Screening will be paid.	

LTCC Claiming
References
DHS Bulletin # 01-25-05, July 27, 2001 Preadmission Screening Program (PAS) Changed to Long Term Care Consultation Services (LTCC), Additional Funding Made Available
DHS Bulletin # 01-56-20, August 31, 2001 Options Series: Face-to-face LTCC Assessments For Persons Under Age 65
DHS Bulletin # 01-56-20, Attachments D & E
DHS Bulletin # 03-25-10, November 7, 2003 Long Term Care Consultation – Legislative Update and Policy Clarifications
“LTCC Rules.doc” summarizing the CSIS LTCC claims processing, written by Jack Kinzer and Mary Klinghagen.
DSD Listserv Announcement, August 14, 2007 LTCC Assessment

Table 2-14: LTCC Claiming

2.1.7 Mental Health Rule 5 Claiming

The table below summarizes the requirements for Rule 5 claiming.

Mental Health Rule 5 Claiming	
Children’s Residential Mental Health Treatment, also referred to as Mental Health Rule 5 Claiming (Rule 5), is done for Payments meeting the Rule 5 criteria for eligible clients.	
Inputs	
Eligible Payments	
Services	<ul style="list-style-type: none"> • 483 Children’s residential treatment
HCCPS/Modifiers	<ul style="list-style-type: none"> • H0019 Children's residential treatment
Supplemental Eligibility	
<p>Client must have a Rule 5 Supplemental Eligibility record in effect on the Service Dates as indicated by the following:</p> <ul style="list-style-type: none"> • MH Rule 5 Screening Date (ELIG_RULE5.MH_RULE5_SCRNG_DT) must be <= Service Dates • MH Rule 5 End Date (ELIG_RULE5.MH_RULE5_END_DT) must be >= Service Dates or blank • Client meets needs for MH Rule 5 Level of Care indicator must be Yes (ELIG_RULE5.MH_RULE5_CARE_IND = 'Y') 	
MMIS Recipient Information	
<p>Client must be MA Eligible or MNCare Eligible on the Service Dates as indicated by the following:</p> <ol style="list-style-type: none"> 1. Major Program (DI_ELIG_RECIPIENT.MAJOR_PROG_CD) must be one of the following: MA Eligible <ul style="list-style-type: none"> • DM Demonstration to Maintain Indep. & Employment (DMIE) • EH Federally-Paid Emergency Medicaid • MA Federally Paid Medical Assistance • NM State-Paid Medical Assistance • RM Refugee 2. Eligibility Status must be 'Active' or 'Closed' (DI_ELIG_RECIPIENT.RCP_ELIG_STATUS_CD = 'A' or 'C') 3. The Service Dates are within the Eligibility Start Date (DI_ELIG_RECIPIENT.ELIG_START_DT) and the Eligibility End Date (DI_ELIG_RECIPIENT.ELIG_END_DT) 	
<p>Client’s Living Arrangement on the Service Dates must be (DI_ELIG_LIVE_ARR.LIVE_ARR_CD):</p> <ul style="list-style-type: none"> • 54 SED - Residential treatment <p>Living Arrangement selection is based on the following criteria:</p> <ul style="list-style-type: none"> • The Living Arrangement must be in effect for the Service Start Date through the Service End Date. • The provider on the Living Arrangement must have a NPI/UMPI 	

Mental Health Rule 5 Claiming	
Client	
Client Age must be < 21 as of the 1st of the month	
Diagnosis Codes	
A diagnosis code is required.	
SSIS Diagnosis Code is used.	
Only MH Diagnosis codes are included on the claim (diagnosis code >= 290.0 and <=302.99 or >= 306.0 and <=316.0).	
Additional Rules	
One claim is submitted for each eligible Payment. (Payment Modifications, such as a partial Refund, are combined with the original Payment.)	
Maximum of one Rule 5 claim can be submitted for a given date range per client.	
Claim Record Outputs	
HPCS/Modifiers	H0019 Children's residential treatment
Units	The total number of Units on all selected Payments
Amount	The total Amount on all selected Payments
First Service Date	Payment Service Start Date
Last Service Date	Payment Service End Date
Diagnosis Codes	SSIS Diagnosis Code
Rule 5 Facility Name	"Facility name" of the provider on the Living Arrangement DI_ELIG_PROVIDER.ELIG_PROV_NAME where DI_ELIG_LIVE_ARR.DI_ELIG_PROVIDER_ID = DI_ELIG_PROVIDER.DI_ELIG_PROVIDER_ID
Provider Number	"Provider number" of the provider on the Living Arrangement DI_ELIG_PROVIDER.PROV_NUM where DI_ELIG_LIVE_ARR.DI_ELIG_PROVIDER_ID = DI_ELIG_PROVIDER.DI_ELIG_PROVIDER_ID
NPI/UMPI	"NPI/UMPI" of the provider on the Living Arrangement DI_ELIG_PROVIDER.NPI where DI_ELIG_LIVE_ARR.DI_ELIG_PROVIDER_ID = DI_ELIG_PROVIDER.DI_ELIG_PROVIDER_ID
Additional Program Requirements and Policy Information	
NOT included in SSIS processing	
Eligibility	
Client must have been screened for MH Rule 5 and found to meet the rule 5 placement criteria. Services must be on or after the screening date.	
The MH Rule 5 screening serves to establish medical necessity for children's mental health residential treatment services.	

Mental Health Rule 5 Claiming
Major program DM ends 09/30/09 because the funding was not extended per e-mail from Margaret Wright on 04/22/09.
County Practice
Claims for clients on MinnesotaCare must be submitted using MN-ITS. These clients will have a Living Arrangement of 80 (Community). SSIS does not receive information about the facility providing the Rule 5 services to the client on these Living Arrangement records from MMIS, which is needed to create a claim.
Notes
Children's mental health residential treatment facilities must be enrolled as providers under the Minnesota Health Care Program (MHCP). Eligible providers must be licensed by the state of Minnesota and must be under contract with a lead county.
Children's mental health residential treatment Payment rates are set at the end of a quarter. Claims must be submitted after the end of the quarter per DHS Bulletin 01-73-01.
References
DHS Bulletin #01-73-01, June 21, 2001, Children's Residential Mental Health Treatment Added to Medical Assistance and MinnesotaCare Benefit Set.
"MH R5 Rules.doc" summarizing the CSIS Mental Health Rule 5 claims processing, written by Jack Kinzer and Mary Klinghagen.

Table 2-15: Rule 5 Claiming

2.1.8 MH-TCM Claiming

The table below summarizes the requirements for MH-TCM claiming.

MH-TCM Claiming	
Mental Health – Targeted Case Management (MH-TCM) claiming is done for Time records meeting the MH-TCM criteria for eligible clients.	
Inputs	
Eligible Staff Activity Time records	
Services	<ul style="list-style-type: none"> • 490 Child Rule 79 Case Management • 491 Adult Rule 79 Case Management
Activities	<ul style="list-style-type: none"> • 7 Client contact
Contact Status	<ul style="list-style-type: none"> • 2 Completed
Contact Method	<ul style="list-style-type: none"> • 1 Face to face • 2 Phone <p style="text-align: center;">(Phone is valid only if the client is 18 or over)</p>
Supplemental Eligibility	
Client must have a MH-TCM Supplemental Eligibility record in effect on the Billable Contact Date .	
<ul style="list-style-type: none"> • The Billable Contact Date must be between the MH-TCM Effective “Start Date” and “End Date” <ul style="list-style-type: none"> TIME_RECORD.ACTIVITY_DT between ELIG_MHTCM.MHTCM_START_DT and ELIG_MHTCM.MHTCM_END_DT or (TIME_RECORD.ACTIVITY_DT >= ELIG_MHTCM.MHTCM_START_DT and ELIG_MHTCM.MHTCM_END_DT IS NULL) 	

MH-TCM Claiming		
MMIS Recipient Information		
<p>Client must be MA Eligible or MNCare Eligible on the Billable Contact Date as indicated by the following:</p> <ol style="list-style-type: none"> Major Program (DI_ELIG_RECIPIENT.MAJOR_PROG_CD) must be one of the following: <ul style="list-style-type: none"> MA Eligible <ul style="list-style-type: none"> DM Demonstration to Maintain Indep. & Employment (DMIE) MA Federally Paid Medical Assistance GM General Assistance Medical Care (GAMC) IM IMD - Inst. for Mental Disease NM State-Paid Medical Assistance RM Refugee <p>The following is no longer valid effective 01/01/12 (PR #13-0214-1306-52)</p> <ul style="list-style-type: none"> EH Federally-Paid Emergency Medicaid MNCare Eligible <ul style="list-style-type: none"> LL MinnesotaCare Citizen Kids/PWS BB MinnesotaCare Adults = <175% FPG FF MinnesotaCare Parents = <275% FPG JJ MinnesotaCare Noncitizen Parents = <275% FPG KK MinnesotaCare Noncitizen Kids/PWS Eligibility Status must be 'Active' or 'Closed' (DI_ELIG_RECIPIENT.RCP_ELIG_STATUS_CD = 'A' or 'C') The Billable Contact Date is within the Eligibility Start Date (DI_ELIG_RECIPIENT.ELIG_START_DT) and the Eligibility End Date (DI_ELIG_RECIPIENT.ELIG_END_DT). 		
Client		
<p>Client Age calculation:</p> <ul style="list-style-type: none"> Client Age is determined as of the Billable Contact Date. If Contact Method is Phone, Client Age must be >= 18 on the Billable Contact Date. 		
Diagnosis Codes		
A diagnosis code is required.		
SSIS Diagnosis Codes are used.		
Only MH Diagnosis codes are included on the claim (diagnosis code >= 290.0 and <=302.99 or >= 306.0 and <=316.0).		
Additional Rules		
Maximum of one MH-TCM claim can be submitted for a given month per client.		
All eligible Time records in a month are linked to the claim.		
A separate claim is created for each MH-TCM eligible client listed in the Regarding section of the Time record.		

MH-TCM Claiming	
<p>For a month in which both 'Phone' and 'Face-to-face' contacts occur, the 'Face-to-face' contact is claimed even though it may occur after the 'Phone' contact.</p> <p>A telephone claim is created for a month in which only 'Phone' contacts occur.</p> <p>A 'Face-to-face' contact must occur at least once every 3 month. There can be no more than two consecutive monthly 'Phone' claims. If a 'Face-to-face' Claim does not exist in one of the previous two months, the 'Phone' contact is not claimed. (This edit ignores 'Face-to-face' Claims that are 'Denied' or 'To be denied'.)</p> <p>The Contact Method of the first claimable contact must be 'Face to face'.</p>	
Claim Record Outputs	
HCPCS/Modifiers	<p>For Client Age < 18 (Contact Method must = Face to face) T2023 HA HE (MH-TCM, child, face-to-face)</p> <p>For Client Age >= 18 For Contact Method = Face to face T2023 HE (MH-TCM, adult, face-to-face)</p> <p>For Contact Method = Phone: T2023 HE U4 (MH-TCM, adult, telephone)</p>
Units	1
Amount	Staff-provided Rate for HCPCS/ Modifiers
First Service Date	Billable Contact Date
Last Service Date	Billable Contact Date
Diagnosis Codes	SSIS Diagnosis Code
Additional Program Requirements and Policy Information NOT included in SSIS processing	
Eligibility	
<p>Based on the client's age, the client must be eligible for SPMI or SED on the Service Date.</p> <ul style="list-style-type: none"> • If the client's age is under 18, the client must be SED eligible • If the client is between 18 and 21 and has received continuous MH-TCM services since before turning 18, the client can remain SED eligible or can be SPMI eligible • Otherwise, if the client is 18 or over, the client must be SPMI eligible 	
Client must have a written service plan prior to claiming.	
Major program DM ends 09/30/09 because the funding was not extended per e-mail from Margaret Wright on 04/22/09.	
County Practice	
<p>Services provided to a client under age 18, should be recorded as:</p> <ul style="list-style-type: none"> • 490 Child Rule 79 Case Management <p>Services provided to a client age 18 or over, should be recorded as:</p> <ul style="list-style-type: none"> • 491 Adult Rule 79 Case Management 	

MH-TCM Claiming
Notes
MH TCM expenses are included as a part of a person's spenddown for MA eligibility. MMIS does this edit.
Claims for clients in a MA Funded Facility are limited to 180 days for VA/DD-TCM, MH-TCM and RSC-TCM combined. The beginning of the 180 days is the Service Date of the first paid claim for VA/DD-TCM, MH-TCM, or RSC-TCM. MMIS enforces this rule.
References
DHS Bulletin #99-53-4; June 7, 1999; MH Case Management Payment Update; this bulletin replaces bulletin 99-53-2.
Minnesota Health Care Programs (MHCP) Provider Manual, June 2000, Chapter 16 pages 25-31 (printed version). The current MHCP manual is online at www.dhs.state.mn.us/provider .
"MH-TCM Rules.doc" summarizing the CSIS MH-TCM claim processing, written by Jack Kinzer and Mary Klinghagen.
DHS Bulletin #09-68-01; April 22, 2009; Adolescent Services Provides Guidance on Transition Planning and Requirements for Older Youth in Care.

Table 2-16: MH-TCM Claiming

2.1.9 RSC-TCM Claiming

The table below summarizes the requirements for RSC-TCM claiming.

RSC-TCM Claiming	
Relocation Service Coordination – Targeted Case Management (RSC-TCM) claiming is done for Time records and Payments meeting the RSC-TCM criteria for eligible clients.	
Inputs	
Eligible Staff Activity Time records	
Services	<ul style="list-style-type: none"> • 194 Relocation Service Coordination (RSC-TCM) • 694 Relocation Service Coordination (RSC-TCM)
Activities	<ul style="list-style-type: none"> • 7 Client contact • 8 Collateral contact • 9 Consultation • 10 Coordination • 16 Documentation • 34 Transportation • 35 Travel in county • 36 Travel out of county
Contact Status	<ul style="list-style-type: none"> • 2 Completed <p>This edit only applies to the following activities:</p> <ul style="list-style-type: none"> • 7 Client contact • 8 Collateral contact
Eligible Payments	
Services	<ul style="list-style-type: none"> • 194 Relocation Service Coordination (RSC-TCM) • 694 Relocation Service Coordination (RSC-TCM)
HCPCS/Modifiers	<ul style="list-style-type: none"> • T1017 Relocation Service Coordination (RSC-TCM)
Supplemental Eligibility	
None	

RSC-TCM Claiming

MMIS Recipient Information

Client must be MA eligible on the **Service Dates** as indicated by the following:

1. Major Program (DI_ELIG_RECIPIENT.MAJOR_PROG_CD) must be one of the following:
 - MA Federally Paid Medical Assistance
 - NM State-Paid Medical Assistance
 - RM Refugee

Note: Removed Major Programs EH and IM, which are not valid for RSC-TCM (PR #13-0219-1403-29)
2. Eligibility Status must be 'Active' or 'Closed'
(DI_ELIG_RECIPIENT.RCP_ELIG_STATUS_CD = 'A' or 'C')
3. The **Service Dates** are within the Eligibility Start Date
(DI_ELIG_RECIPIENT.ELIG_START_DT) and the Eligibility End Date
(DI_ELIG_RECIPIENT.ELIG_END_DT)

Client cannot be a **Waiver/AC Recipient** on the **Service Dates**.

Client's Living Arrangement on the **Service Dates** must be one of the following (DI_ELIG_LIVE_ARR.LIVE_ARR_CD):

- 41 Nursing Facility I - Medicare certified
- 42 Nursing Facility II - Non-Medicare certified
- 43 ICF/DD - Public or private
- 44 NF I - Short term stay <30 days
- 45 NF II - Short term stay <30 days
- 46 ICF/DD - Short term stay <30 days
- 47 RTC/ICF-DD - Not IMD
- 48 Medical hospital >30 days
- 50 RTC - MI psychiatric inpatient hospital – IMD
- 52 Rule 36 MI - IMD
- 53 Private psychiatric inpatient hospital – IMD
- 58 RTC - CD psychiatric inpatient hospital - IMD
- 80 Community

Living Arrangement selection is based on the following criteria:

Time records

- If a Living Arrangement ends on the Time record date, and another Living Arrangement exists (which would start on the same date), a claim is generated if either Living Arrangement has one of the Living Arrangement codes listed above.

Payments

- If the Service Start Date and Service End Date are the SAME:
 - If a Living Arrangement ends on the Service Dates, and another Living Arrangement starts on the same date, a claim is generated if either Living Arrangement has one of the Living Arrangement codes listed above.
- Otherwise:
 - Select the Living Arrangement in effect for the entire Service Date range (Service Start Date through Service End Date).

RSC-TCM Claiming	
Client	
No additional requirements	
Diagnosis Codes	
A diagnosis code is required.	
Screening Diagnosis Codes , then SSIS Diagnosis Codes are checked for a Billable Diagnosis Code .	
If there is not a Billable Diagnosis Code , the default diagnosis code "V68.9" (ADMINISTRATIVE ENCOUNTER NOS) is used.	
Additional Rules	
If the client's Living Arrangement is 'Community' (DI_ELIG_LIVE_ARR.LIVE_ARR_CD = 80):	
<ul style="list-style-type: none"> • The SSIS Location on the Time record or Payment must be 'Inpatient Hospital' (CONTACT_LOC_CD = B), which is translated to MMIS Place of Service 'Inpatient Hospital' (MMIS_PLACE_SVC_CD = 21) on the claim. 	
Time records and Payments for the same client, covering the same date range, are combined into one claim.	
<ol style="list-style-type: none"> 1. A Time record with a date that is within the date range of a Payment is combined into one claim using the Payment's Service Dates. 2. Two or more Time records with the same date are combined into one claim. 3. Two Time records with contiguous dates are submitted as separate claims. 4. Two or more Time records that do not meet any of the above conditions are submitted as separate claims. 5. Two or more Payments with the same date range or overlapping date ranges are combined into one claim. 6. Two or more Payments that do not meet any of the above conditions are submitted as separate claims. 	
Claim Record Outputs	
HCPCS/Modifiers	<ul style="list-style-type: none"> • T1017 Relocation Service Coordination (RSC-TCM)

RSC-TCM Claiming	
Units	<p>Total of:</p> <ul style="list-style-type: none"> • The number of Units on selected Time records are calculated PER DAY, then totaled for all days included <p>Following is the per day calculation:</p> <ul style="list-style-type: none"> • The total time (ON_BEHALF_OF.DURATION) on all selected Time records / 15 (for a day) <ul style="list-style-type: none"> ○ Units are rounded up if 8 or more minutes remain. If less than 8 minutes remain, the remainder is ignored. ○ The total time on all selected Time records for a day must be at least 8 minutes (half a unit) to be included in the claim. <p>Plus</p> <ul style="list-style-type: none"> • The total number of Units on all selected Payments
Amount	<p>Total of:</p> <ul style="list-style-type: none"> • Calculated Units on Time records multiplied by the Staff-provided Rate for the HCPCS/Modifier • Amount is calculated PER DAY, then totaled for all days included <p>Plus</p> <ul style="list-style-type: none"> • The total Amount on all selected Payments
First Service Date	<p>If the claim is based on Payment(s) or both Time record(s) and Payment(s):</p> <p style="padding-left: 40px;">Earliest Service Start Date of the Payment(s)</p> <p>If the claim is based only on Time record(s):</p> <p style="padding-left: 40px;">Date on the Time record</p>
Last Service Date	<p>If the claim is based on Payment(s) or both Time record(s) and Payment(s):</p> <p style="padding-left: 40px;">Latest Service End Date of the Payment(s)</p> <p>If the claim is based only on Time record(s):</p> <p style="padding-left: 40px;">Date on the Time record</p>
Diagnosis Codes	Screening Diagnosis Code, SSIS Diagnosis Code, or V68.9
Additional Program Requirements and Policy Information	
NOT included in SSIS processing	
Eligibility	
RSC-TCM services are authorized via the LTC screening document or the DD screening document. Editing for this authorization takes place in MMIS.	
Claims for clients in a MA Funded Facility are limited to 180 days for VA/DD-TCM, MH-TCM and RSC-TCM combined. The beginning of the 180 days is the Service Date of the first paid claim for VA/DD-TCM, MH-TCM, or RSC-TCM. MMIS enforces this rule.	

RSC-TCM Claiming
RSC-TCM services may be provided to persons of all ages for up to 180 consecutive days per episode. The 180 days starts with the service dates on first paid claim. MMIS does these edits.
Counties cannot claim RSC-TCM costs if a person is moving from one institution to another.
County Practice
Counties cannot claim services provided by case aides under RSC-TCM. Counties can choose not to enter a Staff Claim Qualification for RSC-TCM for case aides or can set the value of the "Qualified" field to No.
Client cannot be receiving CW-TCM, MH-TCM, or VA/DD-TCM in the same calendar month as RSC-TCM services. The county needs to decide which they will provide and bill for only that one.
Notes
While RSC-TCM cannot be claimed if the client is on a waiver on the day the service was provided, both waiver case management and RSC-TCM can be provided in the same month, per e-mail from Mark Skrivanek on 9/25/08.
RSC-TCM was designed to help the consumer make decisions about the supports he or she will need outside of an institution by providing information so that the client can make an informed decision. The coordinator should also assist the individual to access the services and supports needed.
RSC-TCM claims do not require a date of current illness.
Counties Social Services can bill via SSIS and PHN (Public Health Nursing) can bill via MMIS separately and the claims will not be denied as duplicates.
References
DHS Bulletin #01-56-23 September 21, 2001 Options Series: Implementation of Relocation Service Coordination
DHS Bulletin #02-56-08 June 10, 2002 Relocation Service Coordination (RSC) Policy Update
MHCP Provider Update 166 October 22, 2003 Relocation Service Coordination (RSC) Benefit
"RSC Rules.doc" summarizing the CSIS RSC claim processing, written by Jack Kinzer and Mary Klinghagen.
DSD Listserv Announcement April 16, 2006: "Billing for Relocation Service from an Eligible Institution"
DHS Bulletin #07-56-01 March 28, 2007 "DHS Updates Relocation Service Coordination Targeted Case Management Implementation". This bulletin replaces all previous RSC-TCM bulletins

Table 2-17: RSC-TCM Claiming

2.1.10 VA/DD-TCM Claiming

The table below summarizes the requirements for VA/DD-TCM claiming.

VA/DD-TCM Claiming	
Vulnerable Adult / Developmentally Disabled – Targeted Case Management (VA/DD-TCM) claiming is done for Time records meeting the VA/DD-TCM criteria for eligible clients.	
Inputs	
Eligible Staff Activity Time records	
Services	<ul style="list-style-type: none"> • 592 Child (<21) DD non-waiver case management • 593 Adult (21+) DD non-waiver case management • 604 Adult protection assessment • 607 General Assessment • 693 General Case Management
Activities	<ul style="list-style-type: none"> • 7 Client contact • 8 Collateral contact
Contact Status	<ul style="list-style-type: none"> • 2 Completed
Contact Method	<ul style="list-style-type: none"> • 1 Face to face • 2 Phone
Supplemental Eligibility	
Client must have a VA/DD-TCM Supplemental Eligibility record in effect on the Billable Contact Date .	
MMIS Recipient Information	
Client must be MA Eligible or MNCare Eligible on the Billable Contact Date as indicated by the following:	
<ol style="list-style-type: none"> 1. Major Program (DI_ELIG_RECIPIENT.MAJOR_PROG_CD) must be one of the following: <ul style="list-style-type: none"> MA Eligible <ul style="list-style-type: none"> • DM Demonstration to Maintain Indep. & Employment (DMIE) • MA Federally Paid Medical Assistance Note: Removed Major Programs EH and LL, which are not valid for VA/DD-TCM (PR # 13-0219-1353-43) 2. Eligibility Status must be 'Active' or 'Closed' (DI_ELIG_RECIPIENT.RCP_ELIG_STATUS_CD = 'A' or 'C') 3. The Billable Contact Date is within the Eligibility Start Date (DI_ELIG_RECIPIENT.ELIG_START_DT) and the Eligibility End Date (DI_ELIG_RECIPIENT.ELIG_END_DT) 	
Client cannot be a Waiver/AC Recipient on the Billable Contact Date .	
Client	
Client Age calculation: Client Age is determined as of the Billable Contact Date .	

VA/DD-TCM Claiming	
Client's age must be ≥ 18 on the Billable Contact Date	
Diagnosis Codes	
A diagnosis code is required.	
Screening Diagnosis Codes , then SSIS Diagnosis Codes are checked for a Billable Diagnosis Code .	
If there is not a Billable Diagnosis Code , the default diagnosis code "V68.9" (ADMINISTRATIVE ENCOUNTER NOS) is used.	
Additional Rules	
Maximum of one VA/DD-TCM claim can be submitted for a given month per client.	
All eligible Time records in a month are linked to the claim.	
A separate claim is created for each VA/DD-TCM eligible client listed in the Regarding section of the Time record.	
For a month in which both 'Phone' and 'Face-to-face' contacts occur, the 'Face-to-face' contact is claimed even though it may occur after the 'Phone' contact. A telephone claim is created for a month in which only 'Phone' contacts occur. A 'Face-to-face' contact must occur at least once every 3 months. There can be no more than two consecutive monthly 'Phone' claims. If a 'Face-to-face' Claim does not exist in one of the previous two months, the 'Phone' contact is not claimed. (This edit ignores 'Face-to-face' Claims that are 'Denied' or 'To be denied'.) The Contact Method of the first claimable contact must be 'Face to face'.	
Claim Record Outputs	
HCPSC/Modifiers	If Contact Method = Face to face: T2023 U1 VA/DD-TCM, face-to-face If Contact Method = Phone: T2023 U1 U4 VA/DD-TCM, telephone
Units	1
Amount	Staff-provided Rate for HCPSC/Modifiers
First Service Date	Billable Contact Date
Last Service Date	Billable Contact Date
Diagnosis Codes	Screening Diagnosis Code, SSIS Diagnosis Code, or V68.9
Additional Program Requirements and Policy Information NOT included in SSIS processing	
Eligibility	
Client must be in need of service coordination to attain or maintain living in an integrated community setting and must be a vulnerable adult in need of adult protection as defined in statute.	

VA/DD-TCM Claiming		
Major program DM ends 09/30/09 because the funding was not extended per e-mail from Margaret Wright on 04/22/09.		
County Practice		
Counties develop criteria for identifying who is in need of case management/service coordination and keep a copy of those criteria on file in case of appeal.		
Counties can develop a tool to determine/document eligibility. A sample is attached to the bulletin, which counties can change for local use as long as everything included in the bulletin is a part of the edited document.		
Notes		
Claims for clients in a MA Funded Facility are limited to 180 days for VA/DD-TCM, MH-TCM and RSC-TCM combined. The beginning of the 180 days is the Service Date of the first paid claim for VA/DD-TCM, MH-TCM, or RSC-TCM. MMIS enforces this rule.		
VA/DD-TCM may be provided concurrently with an investigation of maltreatment of a vulnerable adult. Documentation for both must be completed.		
VA/DD-TCM cannot be provided to a person in an institution unless it is for the purposes of transitioning/relocating from the institution to the community. Institutions are defined as hospitals, nursing facilities (including Certified Boarding Care Facilities), and Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD).		
VA/DD TCM expenses are included as a part of a person's spenddown for MA eligibility. MMIS does this edit.		
Contact during the month can be with the adult, the adult's legal representative, family member, or primary caregiver or other relevant person identified as necessary to the development/implementation of the service plan.		
References		
DHS Bulletin # 02-56-17, September 18, 2002, Targeted Case Management Implementation for Vulnerable Adults and Adults with Developmental Disabilities		
MHCP Provider Update 166, October 22, 2003		
"VADD Rules.doc" summarizing the CSIS VA/DD-TCM claim processing, written by Jack Kinzer and Mary Klinghagen.		
DSD Listserv Announcement April 16, 2006: "Billing for Relocation Service from an Eligible Institution"		

Table 2-18: VA/DD-TCM Claiming

2.1.11 Waiver and AC Claiming

The table below summarizes the requirements for Waiver and Alternative Care (AC) claiming.

Waiver and AC Claiming	
<p>Waiver and AC claiming is done for Time records and Payment meeting the criteria for eligible clients.</p> <p>Waiver Types:</p> <ul style="list-style-type: none"> • CAC Community Alternative Care • CADI Community Alternatives for Disabled Individuals • EW Elderly Waiver • DD Developmental Disabilities Waiver • BI Brain Injury <p>Alternative Care</p> <ul style="list-style-type: none"> • AC Alternative Care <p>AC is not actually a MA waiver, but the claiming rules and requirements are the same as for the Elderly Waiver, so it is claimed with waivers.</p> <p>In the remainder of this section, the term 'waiver' includes all of the waiver types listed above as well as AC.</p>	
<p>Section 2.1.11.1, "Waivers and AC HCPCS/Modifiers", starting on page 53 contains a list of all HCPCS/Modifiers that can be claimed thru SSIS for Waiver and AC. This list indicates whether the HCPCS/Modifiers is valid for Time records and/or Payments and the Unit Type.</p>	
Inputs	
Eligible Staff Activity Time records	
The valid Services and Activities vary by waiver type and HCPCS/Modifiers.	
Service and Activity combined determine which HCPCS/Modifiers the system assigns.	
SSIS limits available Services by Program (SSIS Sub-Program) and Activities by Program and Service. The Claiming module does not have any edits for the SSIS Sub-Program selected on the record	
See Section 2.1.11.2, "Waivers and AC HCPCS/Modifiers for Time records - by HCPCS/Modifiers", starting on page 58 for a list of the HCPCS/Modifiers assigned to each Service/Activity combination.	
See Section 2.1.11.3, "Waivers and AC HCPCS/Modifiers for Time records - by Service and Activity", starting on page 62 for a list by Services and Activities of HCPCS/Modifiers assigned to time records.	
Waiver Type	Some Services/Activity combinations are valid only for certain waivers. These requirements are listed in Section 2.1.11.2 and Section 2.1.11.3 with the HCPCS/Modifiers and Service/Activity combinations.

Waiver and AC Claiming	
Contact Status	<ul style="list-style-type: none"> • 2 Completed <p>This edit only applies to the following activities:</p> <ul style="list-style-type: none"> • 7 Client contact • 8 Collateral contact • 107 Service delivery, in home • 108 Service delivery, out of home
Eligible Payments	
Valid Services and HCPCS/Modifiers vary by waiver type.	
SSIS limits available HCPCS/Modifiers by Service.	
See Section 2.1.11.4, "Waivers and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers", starting on page 67 for a list of HCPCS/Modifiers and the Services on which they are available.	
See Section 2.1.11.5, "Waivers and AC HCPCS/Modifiers Available on Payments – by Service", starting on page 77 for a list of Services and the HCPCS/Modifiers available for each on Payments.	
Supplemental Eligibility	
None	
MMIS Recipient Information	
<p>Client must be MA eligible or AC eligible on the Service Dates as indicated by the following:</p> <ol style="list-style-type: none"> 1. Major Program (DI_ELIG_RECIPIENT.MAJOR_PROG_CD) must be one of the following: <ul style="list-style-type: none"> MA Eligible: <ul style="list-style-type: none"> • MA Federally Paid Medical Assistance • NM State-Paid Medical Assistance • RM Refugee AC Eligible: <ul style="list-style-type: none"> • AC Alternative Care 2. Eligibility Status must be 'Active' or 'Closed' DI_ELIG_RECIPIENT.RCP_ELIG_STATUS_CD = 'A' or 'C') 3. The Service Dates are within the Eligibility Start Date and the Eligibility End Date Service Dates between DI_ELIG_RECIPIENT.ELIG_START_DT and ELIG_END_DT 	

Waiver and AC Claiming

MA Eligible clients (Major Program = MA, NM, or RM) must have a valid Waiver span on the **Service Dates** as defined below:

- Client has a Waiver span with one of the following Waiver Types (DI_ELIG_WAIVER.WAIVER_TYPE_CD):

MMIS Waiver Type	
F	LTC - CADI Conversion
G	LTC - CADI Diversion
H	LTC - CAC Conversion
I	LTC - CAC Diversion
J	LTC - EW Conversion
K	LTC - EW Diversion
L	LTC - BI NF Conversion
M	LTC - BI NF Diversion
P	LTC - BI Hosp Conversion
Q	LTC - BI Hosp Diversion
R	DD - DD Conversion
S	DD - DD Diversion

- The **Service Dates** must be within the Waiver Start Date and the Waiver End Date

Service Dates between WAIVER_START_DT and WAIVER_THRU_DT

Waiver and AC Claiming

Client must have an Approved MMIS Service Agreement on the **Service Dates** for the service provided as defined below:

1. Service Agreement Header Status is Approved or Partially Suspended
`DI_ELIG_SA.SA_HEADER_STATUS_CD = 'A' or 'T'`
2. Service Agreement Line Item Status is Approved
`DI_ELIG_SA_LN_ITM.SA_LINE_STATUS_CD = 'A'`
3. **Service Dates** are within the Service Agreement Line Item Start Date and Line Item End Date
Service Dates between `PA_LINE_START_DT` and `PA_LINE_END_DT`
4. The HCPCS and Modifiers on the Service Agreement Line Item matches the Payment or Time record:
 - Payments
`DI_ELIG_SA_LN_ITM.HCPCS_CD, MOD_1, MOD_2, MOD_3 & MOD_4 = HCPCS_MOD.HCPCS_CD, MOD_1, MOD_2, MOD_3 & MOD_4`
 for the `PAYMENT.HCPCS_MOD_ID`
 - Time records - the HCPCS/Modifiers assigned to the Service and Activity on the Time record matches
`DI_ELIG_SA_LN_ITM.HCPCS_CD, MOD_1, MOD_2, MOD_3 & MOD_4 = HCPCS_MOD.HCPCS_CD, MOD_1, MOD_2, MOD_3 & MOD_4`
 for the `HCPCS_MOD_SVC_ACT.HCPCS_MOD_ID`
 for the `TIME.SERVICE_ID` and `TIME.ACTIVITY_ID`
5. The Line Item Provider Number is the county's
`CNTY_CLM_CONTROL.MMIS_PROV_NUM = DI_ELIG_PROVIDER.PROV_NUM`
 where `DI_ELIG_SA_LN_ITM.DI_ELIG_PROVIDER_ID = DI_ELIG_PROVIDER.DI_ELIG_PROVIDER_ID`
 For regions only: "Claiming county" on the selected County Claim Control record must match the "Claiming county" on the Claim Batch
`CNTY_CLM_CONTROL.CNTY_CD = CLM_BATCH.CNTY_CD`

Client

No additional requirements

Diagnosis Code

A diagnosis code is required.

Screening Diagnosis Codes, then **SSIS Diagnosis Codes** are checked for a **Billable Diagnosis Code**.

Waiver and AC Claiming

Additional Rules

Time records and Payments for the same client and the same HCPCS/Modifiers, covering the same date range are combined into one claim.

1. A Time record with a date that is within the date range of a Payment is combined into one claim using the Payment's **Service Dates**.
2. Two or more Time records with the same date are combined into one claim.
3. Two Time records with contiguous dates are submitted as separate claims.
4. Two or more Time records that do not meet any of the above conditions are submitted as separate claims.
5. Two or more Payments with the same date range or overlapping date ranges are combined into one claim.
6. Two or more Payments that do not meet any of the above conditions are submitted as separate claims.

Claim Record Outputs

HCPCS/Modifiers

From Time records:

- Assigned based on the Service & Activity

From Payments:

- The HCPCS/Modifiers on the Payment

Waiver and AC Claiming

Units	<p>Total of:</p> <ul style="list-style-type: none"> The total number of Units on all selected Time records, calculated as follows: <ul style="list-style-type: none"> If the Unit Type for the HCPCS/Modifiers is a unit of time <ul style="list-style-type: none"> The number of Units on selected Time records are calculated PER DAY, then totaled for all days included To calculate the per day units, the Duration (ON_BEHALF_OF.DURATION) is totaled on all selected Time records for the day The following calculation is applied to the total Duration based on the unit type <p>The number of Units is rounded up when the remainder of the calculation is a half unit or more. A partial unit less than half is not claimed.</p> <table border="1" style="margin-left: 40px;"> <thead> <tr> <th>Code</th> <th>Description</th> <th>Calculation</th> <th>Half Unit Minimum</th> </tr> </thead> <tbody> <tr> <td>11</td> <td>Hour</td> <td>Duration / 60</td> <td>30</td> </tr> <tr> <td>15</td> <td>Minute</td> <td>Duration</td> <td>n/a</td> </tr> <tr> <td>16</td> <td>15 Minutes</td> <td>Duration / 15</td> <td>8</td> </tr> <tr> <td>17</td> <td>30 Minutes</td> <td>Duration / 30</td> <td>15</td> </tr> </tbody> </table> <ul style="list-style-type: none"> For other Unit Types, Units is set as follows: <ul style="list-style-type: none"> Visit – 1 unit per day, per client Trip, one way – 1 unit per time record Session – 1 unit per worker per day Each time – 1 unit per time record <p>Plus</p> <ul style="list-style-type: none"> The total number of Units on all selected Payments 	Code	Description	Calculation	Half Unit Minimum	11	Hour	Duration / 60	30	15	Minute	Duration	n/a	16	15 Minutes	Duration / 15	8	17	30 Minutes	Duration / 30	15
Code	Description	Calculation	Half Unit Minimum																		
11	Hour	Duration / 60	30																		
15	Minute	Duration	n/a																		
16	15 Minutes	Duration / 15	8																		
17	30 Minutes	Duration / 30	15																		
Amount	<p>Total of:</p> <ul style="list-style-type: none"> Calculated Units on Time records multiplied by the Staff-provided Rate for the HCPCS/Modifier and Waiver Type or AC Major Program (referred to below as Waiver) <p>The "Claim Detail" field on Staff-provided Rates is used for Waiver and AC to specify rates by Waiver</p> <ul style="list-style-type: none"> If valued, the client's Waiver must match If blank, the rate is valid for all Waivers where there is not another rate record during the time period for that Waiver Amount is calculated PER DAY, then totaled for all days included <p>Plus</p> <ul style="list-style-type: none"> The total Amount on all selected Payments. 																				

Waiver and AC Claiming	
First Service Date	If the claim is based on Payment(s) or both Time record(s) and Payment(s): Earliest Service Start Date of the Payment(s) If the claim is based only on Time record(s): Date on the Time record
Last Service Date	If the claim is based on Payment(s) or both Time record(s) and Payment(s): Latest Service End Date of the Payment(s) If the claim is based only on Time record(s): Date on the Time record
Diagnosis Codes	Screening Diagnosis Code or SSIS Diagnosis Code
Prior Auth #	DI_ELIG_SA.PRIOR_AUTH_NUM of the effective MMIS Service Agreement
Additional Program Requirements and Policy Information NOT included in SSIS processing	
Eligibility	
<p>The following HCBS waiver programs currently available under MA are for individuals who are under age 65 at the time of enrollment and who have a disability:</p> <ul style="list-style-type: none"> • Community Alternative Care (CAC) Waiver • Community Alternatives for Disabled Individuals (CADI) Waiver • Brain Injury Waiver (BI) <p>The following HCBS programs are for people aged 65 and over whose care needs would otherwise require the level of services provided by a nursing facility:</p> <ul style="list-style-type: none"> • Elderly Waiver (EW) • Alternative Care (AC) <p>The following waiver program does not have any age edits:</p> <ul style="list-style-type: none"> • Developmental Disabilities (DD) Waiver <p>Recipients who are on CAC, CADI, and BI and turn 65 are allowed to continue services if all other eligibility factors are met.</p> <p>Client waiver eligibility age edits are performed in MMIS.</p>	
Clients are eligible for only one waiver at a time.	
Waiver services are authorized via MMIS Service Agreements/Prior Authorizations.	
County Practice	
Counties have the option to pay waiver providers directly or have the waiver provider bill MMIS.	

Waiver and AC Claiming	
Notes	
<p>Elderly Waiver and extended state plan services are authorized and billed on a service agreement entered into MMIS for those recipients enrolled with South Country Alliance, Blue Plus, and UCare Minnesota* health plans using Minnesota Senior Health Options (MSHO) or Minnesota Senior Care Plus (MSC+) products. Service rates are negotiated with the providers and the statewide maximum rate will apply. The state plan services will continue to be billed through the health plan using their billing forms and procedures.</p> <p>Elderly Waiver, extended state plan, and state plan services are through the health plan using their forms and billing system for all other health plan organizations regardless of the product.</p> <p>Elderly Waiver and extended state plan services are authorized and billed on a service agreement entered into MMIS for those recipients enrolled with any health plan using PMAP. The state plan services are through the health plan using their forms and procedures.</p> <p>*Note: this statement is not true for all UCare EW recipients as it depends on the county of residence.</p>	
References	
<p>Disability Service Program Manual Note: For CAC, CADI, DD, and BI this document contains the most up to date program information and takes precedence of information in other documents listed below</p>	
<p>DHS Instructional Bulletin # 85-75, August 5, 1985, Billing Procedures to Receive Reimbursement for Screening MA and 180-Day Eligible Clients Under Age 65 Entering SNF, ICF-I or II Facilities</p>	
<p>DHS Instructional Bulletin # 85-110, October 22, 1985, Revised Screening Document for Persons With Mental Retardation</p>	
<p>DHS Instructional Bulletin # 87-58A, November 12, 1987, Home and Community Based Services Waiver for Disabled Individuals Under 65 (Pre-Admission Screening/Community Alternatives for Disabled Individuals - PAS/CADI)</p>	
<p>DHS Instructional Bulletin # 92-57B, May 19, 1992, Implementation of the Brain Injury (BI) Home and Community Based Services Waiver</p>	
<p>MHCP Provider Manual, Chapter 26, HCBS Waivered Services</p>	
<p>DHS Bulletin #05-24-01, May 27, 2005, Changes to the County Based Purchasing Model of Managed Care for Minnesota Seniors</p>	
<p>MHCP Provider Update WAV-05-01, June 2, 2005, Minnesota Senior Care Plus, EW Services and SNF Changes for CBP Enrollees</p>	
<p>"Waiver Rules.doc" summarizing the CSIS Waivered Services claims processing, written by Jack Kinzer and Mary Klinghagen.</p>	

Table 2-19: Waiver Claiming

2.1.11.1 Waivers and AC HCPCS/Modifiers

Following is a list of the HCPCS/Modifiers that are claimable through SSIS for Waivers and AC.

Waivers and AC HCPCS/Modifiers						
HCPCS / Modifiers	Description	Start Date	End Date	Unit Type	Time	Pay-ments
H0025	Behavioral Support, by analyst	10-01-06		15 Minutes	N	Y
H0025 TF	Behavioral Support, by specialist	10-01-06		15 Minutes	N	Y
H0025 TG	Behavior Support, by professional	10-01-06		15 Minutes	N	Y
H0045	Respite care services, not in home	11-01-04		Day	N	Y
H2032	Independent living skills, maintenance	10-01-06	12-31-13	15 Minutes	Y	Y
H2032 HQ	Independent living skills, group therapy	10-01-06		15 Minutes	Y	Y
H2032 TF	Independent living skills, counseling	10-01-06		15 Minutes	Y	Y
H2032 TG	Independent living skills, individual therapy	10-01-06		15 Minutes	Y	Y
S0215 UC	Transportation, mileage (commercial vehicle)	10-01-06	12-31-12	Mile	N	Y
S0215 UC	Transportation, mileage	10-01-06		Mile	N	Y
S5100	Day care services, adult (15 minutes)	11-01-04		15 Minutes	N	Y
S5100 TF	Adult day care bath	11-01-04		15 Minutes	N	Y
S5100 U7	Family adult day services (FADS) (15 minutes)	11-01-08		15 Minutes	N	Y
S5102	Day care services, adult (day)	11-01-04		Day	N	Y
S5102 U7	Family adult day services (FADS) (day)	11-01-08		Day	N	Y
S5109	Consumer training and education	10-01-06		Session	N	Y
S5110	Family training	11-01-04		15 Minutes	Y	Y
S5115	Caregiver training/education	07-01-13		15 Minutes	Y	Y
S5115 TF	Caregiver Coaching and Counseling/Caregiver Assessment	07-01-13		15 Minutes	N	Y
S5116	Caregiver training/education	11-01-04	06-30-13	Session	Y	Y
S5116 TF	Caregiver Assessment	04-01-10	06-30-13	Each Time	Y	Y
S5120	Chore services	11-01-04		15 Minutes	Y	Y
S5125	DD, in home family support (15 minutes)	11-01-04		15 Minutes	Y	Y
S5126	Caregiver living expenses	11-01-04		Day	N	Y

Waivers and AC HCPCS/Modifiers						
HCPCS / Modifiers	Description	Start Date	End Date	Unit Type	Time	Payments
S5126 TG	DD, in home family support (day)	11-01-04	12-31-13	Day	N	Y
S5130	Homemaker services – cleaning only (15 minutes)	11-01-04		15 Minutes	Y	Y
S5131	Homemaker services (day)	11-01-04		Day	N	Y
S5135	Companion care, adult/Personal support	11-01-04		15 Minutes	Y	Y
S5135 U9	Behavioral programming by aide	11-01-04	04-30-13	15 Minutes	N	Y
S5135 UA	BI night supervision	11-01-04		15 Minutes	N	Y
S5135 UB	24 hour emergency assistance (15 minutes)	11-01-04	12-31-13	15 Minutes	N	Y
S5136	Personal support	11-01-04	12-31-13	Day	N	Y
S5136 UB	24 hour emergency assistance (day)	11-01-04	12-31-13	Day	N	Y
S5140	Foster care, adult (day)	11-01-04		Day	N	Y
S5140 U9	Foster care, adult, corporate (day)	11-01-04		Day	N	Y
S5141	Foster care, adult (month)	11-01-04	12-31-13	Month	N	Y
S5141 HQ	Foster care, adult (month)	10-01-06		Month	N	Y
S5141 U9	Foster care, adult, corporate (month)	11-01-04	12-31-13	Month	N	Y
S5145	Foster care, child (day)	11-01-04		Day	N	Y
S5146	Foster care, child (month)	11-01-04	12-31-13	Month	N	Y
S5150	Respite care, in home (15 minutes)	11-01-04	12-31-13	15 Minutes	Y	Y
S5150	Respite care, in home (15 minutes)	01-01-14		15 Minutes	Y	N
S5150 UB	Respite care, out of home	10-01-06		15 Minutes	Y	Y
S5151	Respite care, in home (day)	11-01-04		Day	N	Y
S5160	Emergency response system-installation and testing	05-01-10		Item	N	Y
S5161	Emergency response system-service fee, per month	05-01-10		Item	N	Y
S5162	Emergency response system-purchase	05-01-10		Item	N	Y
S5165	Environmental accessibility adaptations, Home Modifications/Install and Expenses	11-01-04		Item	N	Y
S5165 U3	Environmental accessibility adaptations, square footage	08-01-09		Item	N	Y
S5170	Home delivered meals	11-01-04		Meal	N	Y

Waivers and AC HCPCS/Modifiers						
HCPCS / Modifiers	Description	Start Date	End Date	Unit Type	Time	Payments
S9125	Crisis respite (day)	11-01-04		Day	N	Y
S9470	Nutritional counseling, diet	11-01-04		Visit	N	Y
T1005	Crisis respite (15 minutes)	11-01-04		15 Minutes	N	Y
T1005 TG	Crisis respite, specialized	11-01-04		15 Minutes	N	Y
T1016	AC Conversion	07-01-01		15 Minutes	Y	Y
T1016 TF UC	Waiver case management by paraprofessional	10-01-06		15 Minutes	Y	Y
T1016 UC	Waiver case management	10-01-06		15 Minutes	Y	Y
T1019	Personal care services (PCA) 1:1	11-01-04		15 Minutes	Y	Y
T1019 HQ	Personal care services (PCA) 1:3	11-01-04		15 Minutes	N	Y
T1019 HQ UC	Extended shared personal care services 1:3	11-01-04		15 Minutes	N	Y
T1019 TT	Personal care services (PCA) 1:2	11-01-04		15 Minutes	N	Y
T1019 TT UC	Extended shared personal care services 1:2	11-01-04		15 Minutes	N	Y
T1019 UA	Supervision of PCA	10-01-06		15 Minutes	N	Y
T1019 UC	Extended personal care 1:1	11-01-04		15 Minutes	Y	Y
T2002	DT&H, non-pilot, transportation	10-01-06	12-31-13	Day	N	Y
T2003	Non-emergency transportation; encounter/trip (one way)	10-01-06		Trip, one way	N	Y
T2003 UC	Non-emergency transportation; encounter/trip (one way)	10-01-06		Trip, one way	N	Y
T2013	Specialist service	10-01-06		Hour	N	Y
T2014	Prevocational services (day)	10-01-06		Day	N	Y
T2015	Prevocational services (hour)	10-01-06		Hour	N	Y
T2016	Supported living services, adult (day)	10-01-06		Day	N	Y
T2016 HA	Supported living services, child	10-01-06		Day	N	Y
T2016 U9	Supported living services, adult, corporate AFC (day)	10-01-06		Day	N	Y
T2017	Supported living services, adult (15 minutes)	10-01-06		15 Minutes	N	Y
T2017 HA	Supported living services, child	10-01-06		15 Minutes	N	Y
T2017 U9	Supported living services, adult, corporate AFC (15 minutes)	10-01-06		15 Minutes	N	Y
T2018	Supported employment (day)	10-01-06	12-31-13	Day	N	Y
T2018 U5	Supported employment (partial day)	10-01-06	12-31-13	Day, partial	N	Y

Waivers and AC HCPCS/Modifiers						
HCPCS / Modifiers	Description	Start Date	End Date	Unit Type	Time	Payments
T2019	Supported employment (15 minutes)	10-01-06		15 Minutes	N	Y
T2020	DT&H, non-pilot/Structured day program	10-01-06		Day	N	Y
T2020 U5	DT&H, non-pilot	10-01-06	12-31-13	Day, partial	N	Y
T2021	DT&H pilot, Rate D/Structured day program	10-01-06		15 Minutes	N	Y
T2021 TF	DT&H pilot, Rate B	10-01-06	12-31-13	15 Minutes	N	Y
T2021 TG	DT&H pilot, Rate A	10-01-06	12-31-13	15 Minutes	N	Y
T2021 UB	DT&H pilot, Rate C	10-01-06	12-31-13	15 Minutes	N	Y
T2028 U1	CDCS - Personal assistance	10-01-04		Dollar amount	N	Y
T2028 U2	CDCS - Treatment and training	10-01-04		Dollar amount	N	Y
T2028 U3	CDCS - Environmental modifications and provisions	10-01-04		Dollar amount	N	Y
T2028 U4	CDCS - Self direction support activities	10-01-04		Dollar amount	N	Y
T2028 U8	CDCS - Flexible case management	10-01-04		Dollar amount	N	Y
T2030	Customized living services (monthly)	10-01-06	12-31-13	Month	N	Y
T2030 TG	24-hour customized living (monthly)	10-01-06	12-31-13	Month	N	Y
T2030 TG U9	24-hour customized living (corporate)	10-01-06	12-31-13	Month	N	Y
T2031	Customized living services (daily)	10-01-06		Day	N	Y
T2032	Residential care services	10-01-06	12-31-13	Month	N	Y
T2032	Supported living services, adult (month)	10-01-06	12-31-13	Month	N	Y
T2032	Supported living services, adult (semi-monthly)	10-01-06	12-31-13	Bimonthly (2 X month)	N	Y
T2032 HA	Supported living services, child (semi-monthly)	10-01-06	12-31-13	Bimonthly (2 X month)	N	Y
T2032 HA	Supported living services, child (month)	10-01-06	12-31-13	Month	N	Y
T2032 U9	Supported living services, adult, corporate AFC (month)	10-01-06	12-31-13	Month	N	Y

Waivers and AC HCPCS/Modifiers						
HCPCS / Modifiers	Description	Start Date	End Date	Unit Type	Time	Pay-ments
T2032 U9	Supported living services, adult, corporate AFC (semi-monthly)	10-01-06	12-31-13	Bimonthly (2 X month)	N	Y
T2033	Residential care services	10-01-06		Day	N	Y
T2038	Transitional services	11-01-04		Dollar amount	N	Y
T2038 TF	Housing access coordination	10-01-06	12-31-13	Each time	N	Y
T2038 U1	Transitional services, furniture	11-01-04		Dollar amount	N	Y
T2038 U2	Transitional services, supplies	11-01-04		Dollar amount	N	Y
T2040	CDCS - Background check	10-01-04		15 Minutes	N	Y
T2041	CDCS - Mandatory case management	10-01-04		15 Minutes	Y	Y
X5527	AC Discretionary service	07-01-99		Dollar amount	N	Y

Table 2-20: Valid HCPCS/Modifiers for Waivers and AC

2.1.11.2 Waivers and AC HCPCS/Modifiers for Time records - by HCPCS/Modifiers

Following is a list of the HCPCS/Modifiers for Waiver and AC assigned to a claim for Time records based on the Time record's Service and Activity listed by HCPCS/Modifiers.

Note: Start and End Dates are defined as follows:

- HCPCS/Modifiers The date range that the HCPCS/Modifiers code is valid
- Service The date range that the Service with the HCPCS/Modifiers is valid
- Activity The date range that the Activity with the Service is valid for the HCPCS/Modifiers

Waiver and AC HCPCS/Modifiers for Time records - by HCPCS/Modifiers					
HCPCS / Modifiers	Service	Activity	Description	Start Date	End Date
H2032 - Independent living skills, maintenance				10/01/06	12/31/13
	147 – Independent living skills			01/01/08	12/31/13
	45	Maintenance		01/01/08	12/31/13
	647 – Independent living skills			01/01/08	12/31/13
	45	Maintenance		01/01/08	12/31/13
H2032 HQ - Independent living skills, group therapy				10/01/06	
	147 – Independent living skills			01/01/08	12/31/13
	44	Group therapy		01/01/08	12/31/13
	647 – Independent living skills			01/01/08	12/31/13
	44	Group therapy		01/01/08	12/31/13
H2032 TF - Independent living skills, counseling				10/01/06	
	147 – Independent living skills			01/01/08	12/31/13
	11	Counseling		01/01/08	12/31/13
	647 – Independent living skills			01/01/08	12/31/13
	11	Counseling		01/01/08	12/31/13
H2032 TG - Independent living skills, individual therapy				10/01/06	
	147 – Independent living skills			01/01/08	12/31/13
	43	Individual therapy		01/01/08	12/31/13
	647 – Independent living skills			01/01/08	12/31/13
	43	Individual therapy		01/01/08	12/31/13
S5110 - Family training				11/01/04	
	156 - Group counseling			11/01/04	
	39	Family counseling/training (BI, CAC, CADI)		11/01/04	
	656 - Group counseling			11/01/04	
	39	Family counseling/training (BI, CAC, CADI)		11/01/04	

Waiver and AC HCPCS/Modifiers for Time records - by HCPCS/Modifiers					
HCPCS / Modifiers	Service	Activity	Description	Start Date	End Date
S5115 - Caregiver training/education				07/01/13	
	624 - Home-based support services			07/01/13	
	33	Training - family/individual		07/01/13	
S5116 - Caregiver training/education				11/01/04	06/30/13
	502 - Community education and prevention			11/01/04	06/30/13
	33	Training - family/individual		11/01/04	06/30/13
	531 - In-home family support services			11/01/04	06/30/13
	33	Training - family/individual		11/01/04	06/30/13
	624 - Home-based support services			11/01/04	06/30/13
	33	Training - family/individual		11/01/04	06/30/13
S5116 TF – Caregiver Assessment				04/01/10	06/30/13
	607 - General Assessment			04/01/10	06/30/13
	91530000	Caregiver Assessment		04/01/10	06/30/13
S5120 - Chore services				11/01/04	
	623 - Chore services			11/01/04	
	29	Service delivery		11/01/04	
S5125 - DD, in home family support (15 minutes)				11/01/04	
	531 - In-home family support services			11/01/04	12/31/13
	29	Service delivery		11/01/04	12/31/13
S5130 - Homemaker services – cleaning only (15 minutes)				11/01/04	
	125 - Homemaking services			11/01/04	
	29	Service delivery		11/01/04	
	525 - Homemaking services			11/01/04	
	29	Service delivery		11/01/04	
	625 - Homemaking services			11/01/04	
	29	Service delivery		11/01/04	
S5135 - Companion care, adult/Personal support				11/01/04	
	145 - Social and recreational			11/01/04	12/31/13
	20	Personal support	DD only	11/01/04	12/31/13
	622 - Companion services			11/01/04	12/31/13
	29	Service delivery	AC, EW, CADI, BI only	11/01/04	12/31/13
	645 - Social and recreational service			11/01/04	12/31/13
	20	Personal support	DD only	11/01/04	12/31/13
S5150 - Respite care, in home (15 minutes)				11/01/04	12/31/13
	689 - Respite care			11/01/04	12/31/13
	107	Service delivery, in home		07/01/07	12/31/13

Waiver and AC HCPCS/Modifiers for Time records - by HCPCS/Modifiers					
HCPCS / Modifiers	Service	Activity	Description	Start Date	End Date
S5150 - Respite care, in home (15 minutes)				01/01/14	
	689 - Respite care			01/01/14	
	107		Service delivery, in home	01/01/14	
S5150 UB - Respite care, out of home				10/01/06	
	689 - Respite care			10/01/06	06/30/14
	108		Service delivery, out of home	07/01/07	06/30/14
T1016 - AC Conversion				07/01/01	
	691 - AC/EW/CAC/CADI/BI case management			07/01/01	
	5		Case conversion – AC	07/01/01	
T1016 TF UC - Waiver case management by paraprofessional				10/01/06	
	191 - CAC/CADI/BI case management			10/01/06	
	19		Paraprofessional case management	10/01/06	
	691 - AC/EW/CAC/CADI/BI case management			10/01/06	
	19		Paraprofessional case management	10/01/06	
T1016 UC - Waiver case management				10/01/06	
	191 - CAC/CADI/BI case management			10/01/06	
	7		Client contact	10/01/06	
	8		Collateral contact	10/01/06	
	9		Consultation	10/01/06	
	10		Coordination	10/01/06	
	16		Documentation	10/01/06	
	34		Transportation DD & BI only	10/01/06	
	35		Travel in county DD & BI only	10/01/06	
	36		Travel out of county DD & BI only	10/01/06	
	591 - DD waiver case management			10/01/06	
	7		Client contact	10/01/06	
	8		Collateral contact	10/01/06	
	9		Consultation	10/01/06	
	10		Coordination	10/01/06	
	16		Documentation	10/01/06	
	31		Service planning DD only	10/01/06	
	34		Transportation DD & BI only	10/01/06	
	35		Travel in county DD & BI only	10/01/06	
	36		Travel out of county DD & BI only	10/01/06	
	691 - AC/EW/CAC/CADI/BI case management			10/01/06	
	7		Client contact	10/01/06	
	8		Collateral contact	10/01/06	
	9		Consultation	10/01/06	
	10		Coordination	10/01/06	

Waiver and AC HCPCS/Modifiers for Time records - by HCPCS/Modifiers					
HCPCS / Modifiers	Service	Activity	Description	Start Date	End Date
		16	Documentation	10/01/06	
		34	Transportation DD & BI only	10/01/06	
		35	Travel in county DD & BI only	10/01/06	
		36	Travel out of county DD & BI only	10/01/06	
T1019 - Personal care services (PCA) 1:1				11/01/04	
		624 - Home-based support services		11/01/04	
		42	Service delivery - personal care assistance	11/01/04	
T1019 UC - Extended personal care 1:1				11/01/04	
		124 - Home-based support services		11/01/04	
		38	Service delivery - extended personal care	11/01/04	
		624 - Home-based support services		11/01/04	
		38	Service delivery - extended personal care	11/01/04	
T2041 - CDCS - Mandatory case management				10/01/04	
		658 - Approved pilot projects		10/01/04	
		105	CDCS - Mandatory case management	10/01/04	

Table 2-21: Waivers and AC HCPCS/Modifiers for Time records - by HCPCS/Modifiers

2.1.11.3 Waivers and AC HCPCS/Modifiers for Time records - by Service and Activity

Following is a list of the HCPCS/Modifiers for Waiver and AC assigned to a claim for Time records based on the Time record's Service and Activity listed by Service and Activity.

Note: Start and End Dates are the date range that the Service and Activity are valid with the HCPCS/Modifiers.

Waiver and AC HCPCS/Modifiers for Time records - by Service and Activity					
Svc	Act	HCPCS / Modifiers	Description	Start Date	End Date
124 - Home-based support services					
	38 - Service delivery - extended personal care				
		T1019 UC	Extended personal care 1:1	11/01/04	
125 - Homemaking services					
	29 - Service delivery				
		S5130	Homemaker services – cleaning only (15 minutes)	11/01/04	
145 - Social and recreational					
	20 - Personal support				
			DD only		
		S5135	Companion care, adult/Personal support	11/01/04	12/31/13
147 – Independent living skills					
	11 – Counseling				12/31/13
		H2032 TF	Independent living skills, counseling	01/01/08	12/31/13
	43 - Individual therapy				12/31/13
		H2032 TG	Independent living skills, individual therapy	01/01/08	12/31/13
	44 - Group therapy				12/31/13
		H2032 HQ	Independent living skills, group therapy	01/01/08	12/31/13
	45 – Maintenance				12/31/13
		H2032	Independent living skills, maintenance	01/01/08	12/31/13
156 - Group counseling					
	39 - Family counseling/training (BI, CAC, CADI)				
		S5110	Family training	11/01/04	

Waiver and AC HCPCS/Modifiers for Time records - by Service and Activity					
Svc	Act	HCPCS / Modifiers	Description	Start Date	End Date
191 - CAC/CADI/BI case management					
			7 - Client contact		
		T1016 UC	Waiver case management	10/01/06	
			8 - Collateral contact		
		T1016 UC	Waiver case management	10/01/06	
			9 - Consultation		
		T1016 UC	Waiver case management	10/01/06	
			10 - Coordination		
		T1016 UC	Waiver case management	10/01/06	
			16 – Documentation		
		T1016 UC	Waiver case management	10/01/06	
			19 - Paraprofessional case management		
		T1016 TF UC	Waiver case management by paraprofessional	10/01/06	
			34 - Transportation		
			DD & BI only		
		T1016 UC	Waiver case management	10/01/06	
			35 - Travel in county		
			DD & BI only		
		T1016 UC	Waiver case management	10/01/06	
			36 - Travel out of county		
			DD & BI only		
		T1016 UC	Waiver case management	10/01/06	
502 - Community education and prevention					
			33 - Training - family/individual		
		S5116	Caregiver training/education	11/01/04	06/30/13
525 - Homemaking services					
			29 - Service delivery		
		S5130	Homemaker services – cleaning only (15 minutes)	11/01/04	
531 - In-home family support services					
			29 - Service delivery		
		S5125	DD, in home family support (15 minutes)	11/01/04	12/31/13
			33 - Training - family/individual		
		S5116	Caregiver training/education	11/01/04	06/30/13

Waiver and AC HCPCS/Modifiers for Time records - by Service and Activity					
Svc	Act	HCPCS / Modifiers	Description	Start Date	End Date
591 - DD waiver case management					
			7 - Client contact		
		T1016 UC	Waiver case management	10/01/06	
			8 - Collateral contact		
		T1016 UC	Waiver case management	10/01/06	
			9 - Consultation		
		T1016 UC	Waiver case management	10/01/06	
			10 - Coordination		
		T1016 UC	Waiver case management	10/01/06	
			16 - Documentation		
		T1016 UC	Waiver case management	10/01/06	
			31 - Service planning		
			DD only		
		T1016 UC	Waiver case management	10/01/06	
			34 - Transportation		
			DD & BI only		
		T1016 UC	Waiver case management	10/01/06	
			35 - Travel in county		
			DD & BI only		
		T1016 UC	Waiver case management	10/01/06	
			36 - Travel out of county		
			DD & BI only		
		T1016 UC	Waiver case management	10/01/06	
607 - General Assessment					
			91530000 - Caregiver Assessment		
		S5116 TF	Caregiver Assessment	04/01/10	06/30/13
622 - Companion services					
			29 - Service delivery		
			AC, EW, CADI, BI only		
		S5135	Companion care, adult/Personal support	11/01/04	12/31/13
623 - Chore services					
			29 - Service delivery		
		S5120	Chore services	11/01/04	

Waiver and AC HCPCS/Modifiers for Time records - by Service and Activity					
Svc	Act	HCPCS / Modifiers	Description	Start Date	End Date
624 – Home-based support services					
			33 - Training - family/individual		
		S5115	Caregiver training/education	07/01/13	
		S5116	Caregiver training/education	11/01/04	06/30/13
			38 - Service delivery - extended personal care		
		T1019 UC	Extended personal care 1:1	11/01/04	06/30/13
			42 - Service delivery - personal care assistance		
		T1019	Personal care services (PCA) 1:1	11/01/04	06/30/13
625 - Homemaking services					
			29 - Service delivery		
		S5130	Homemaker services – cleaning only (15 minutes)	11/01/04	
645 - Social and recreational service					
			20 - Personal support		
			DD only		
		S5135	Companion care, adult/Personal support	11/01/04	12/31/13
647 – Independent living skills					
			11 - Counseling		
		H2032 TF	Independent living skills, counseling	01/01/08	12/31/13
			43 - Individual therapy		
		H2032 TG	Independent living skills, individual therapy	01/01/08	12/31/13
			44 - Group therapy		
		H2032 HQ	Independent living skills, group therapy	01/01/08	12/31/13
			45 - Maintenance		
		H2032	Independent living skills, maintenance	01/01/08	12/31/13
656 - Group counseling					
			39 - Family counseling/training (CADI, BI)		
			CADI & BI only		
		S5110	Family training	11/01/04	
			41 - Family counseling (CAC)		
			CAC only		
		S5110	Family training	11/01/04	
658 - Approved pilot projects					
			105 - CDCS - Mandatory case management		
		T2041	CDCS - Mandatory case management	10/01/04	

Waiver and AC HCPCS/Modifiers for Time records - by Service and Activity					
Svc	Act	HCPCS / Modifiers	Description	Start Date	End Date
689 - Respite care					
	107 – Service delivery, in home				
		S5150	Respite care, in home (15 minutes)	07/01/07	12/31/13
		S5150	Respite care, in home (15 minutes)	01/01/14	
	108 – Service delivery, out of home				
		S5150 UB	Respite care, out of home	07/01/07	06/30/14
691 - AC/EW/CAC/CADI/BI case management					
	5 - Case conversion - AC				
		T1016	AC Conversion	07/01/01	
	7 - Client contact				
		T1016 UC	Waiver case management	10/01/06	
	8 - Collateral contact				
		T1016 UC	Waiver case management	10/01/06	
	9 - Consultation				
		T1016 UC	Waiver case management	10/01/06	
	10 - Coordination				
		T1016 UC	Waiver case management	10/01/06	
	16 - Documentation				
		T1016 UC	Waiver case management	10/01/06	
	19 - Paraprofessional case management				
		T1016 TF UC	Waiver case management by paraprofessional	10/01/06	
	34 - Transportation				
			DD & BI only		
		T1016 UC	Waiver case management	10/01/06	
	35 - Travel in county				
			DD & BI only		
		T1016 UC	Waiver case management	10/01/06	
	36 - Travel out of county				
			DD & BI only		
		T1016 UC	Waiver case management	10/01/06	

Table 2-22: Waivers and AC HCPCS/Modifiers for Time records - by Service and Activity

2.1.11.4 Waivers and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers

Following is a list of Services on Payments that are valid for HCPCS/Modifiers claimable in SSIS for Waivers and AC listed by HCPCS/Modifiers.

Note: Start and End Dates are defined as follows:

- HCPCS/Modifiers The date range that the HCPCS/Modifiers code is valid
- Service The date range that the Service with the HCPCS/Modifiers is valid

Waiver and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
H0025 - Behavioral Support, by analyst			10/01/06	
	118	Health-related services	10/01/06	12/31/13
	618	Health-related services	10/01/06	12/31/13
H0025 TF - Behavioral Support, by specialist			10/01/06	
	118	Health-related services	10/01/06	12/31/13
	618	Health-related services	10/01/06	12/31/13
H0025 TG - Behavior Support, by professional			10/01/06	
	118	Health-related services	10/01/06	12/31/13
	618	Health-related services	10/01/06	12/31/13
H0045 - Respite care services, not in home			11/01/04	
	189	Respite care	11/01/04	06/30/14
	489	Child respite care	11/01/04	06/30/14
	589	Respite care	11/01/04	06/30/14
	689	Respite care	11/01/04	06/30/14
H2032 - Independent living skills, maintenance			10/01/06	12/31/13
	147	Independent living skills	01/01/08	12/31/13
	647	Independent living skills	01/01/08	12/31/13
H2032 HQ - Independent living skills, group therapy			10/01/06	
	147	Independent living skills	01/01/08	12/31/13
	647	Independent living skills	01/01/08	12/31/13
H2032 TF - Independent living skills, counseling			10/01/06	
	147	Independent living skills	01/01/08	12/31/13
	647	Independent living skills	01/01/08	12/31/13
H2032 TG - Independent living skills, individual therapy			10/01/06	
	147	Independent living skills	01/01/08	12/31/13
	647	Independent living skills	01/01/08	12/31/13
S0215 UC - Transportation, mileage (commercial vehicle)			10/01/06	12/31/12
	116	Transportation	10/01/06	12/31/12
	516	Transportation	10/01/06	12/31/12
	616	Transportation	10/01/06	12/31/12

Waiver and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
S0215 UC - Transportation, mileage			10/01/06	
	116	Transportation	10/01/06	
	516	Transportation	10/01/06	
	616	Transportation	10/01/06	
S5100 - Day care services, adult (15 minutes)			11/01/04	
	649	Adult day care	11/01/04	12/31/13
S5100 TF - Adult day care bath			11/01/04	
	649	Adult day care	11/01/04	12/31/13
S5100 U7 - Family adult day services (FADS) (15 minutes)			11/01/08	
	649	Adult day care	11/01/08	12/31/13
S5102 - Day care services, adult (day)			11/01/04	
	649	Adult day care	11/01/04	12/31/13
S5102 U7 - Family adult day services (FADS) (Day)			11/01/08	
	649	Adult day care	11/01/08	12/31/13
S5109 - Consumer training and education			10/01/06	
	145	Social and recreational	10/01/06	
	502	Community education and prevention	10/01/06	
	645	Social and recreational service	10/01/06	
S5110 - Family training			11/01/04	
	156	Group counseling	11/01/04	
	656	Group counseling	11/01/04	
S5115 - Caregiver training/education			07/01/13	
	624	Home-based support services	07/01/13	
S5115 TF - Caregiver Coaching and Counseling/Caregiver Assessment			07/01/13	
	607	General Assessment	07/01/13	
S5116 - Caregiver training/education			11/01/04	06/30/13
	502	Community education and prevention	11/01/04	06/30/13
	531	In-home family support services	11/01/04	06/30/13
	624	Home-based support services	11/01/04	06/30/13
S5116 TF - Caregiver Assessment			04/01/10	06/30/13
	607	General Assessment	04/01/10	06/30/13
S5120 - Chore services			11/01/04	
	623	Chore services	11/01/04	
S5125 - DD, in home family support (15 minutes)			11/01/04	
	531	In-home family support services	11/01/04	12/31/13
S5126 - Caregiver living expenses			11/01/04	
	564	Adult supported living services	11/01/04	

Waiver and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
S5126 TG - DD, in home family support (day)			11/01/04	12/31/13
	531	In-home family support services	11/01/04	12/31/13
S5130 Homemaker services – cleaning only (15 minutes)			11/01/04	
	125	Homemaking services	11/01/04	
	525	Homemaking services	11/01/04	
	625	Homemaking services	11/01/04	
S5131 - Homemaker services (day)			11/01/04	
	625	Homemaking services	11/01/04	12/31/13
S5135 - Companion care, adult/Personal support			11/01/04	
	145	Social and recreational	11/01/04	12/31/13
	564	Adult supported living services	11/01/04	12/31/13
	565	Child supported living services	11/01/04	12/31/13
	618	Health-related services	11/01/04	12/31/13
	622	Companion services	11/01/04	12/31/13
	627	Customized Living/Residential Care	11/01/04	12/31/13
	645	Social and recreational service	11/01/04	12/31/13
S5135 U9 - Behavioral programming by aide			11/01/04	04/30/13
	118	Health-related services	11/01/04	04/30/13
	145	Social and recreational	11/01/04	04/30/13
	564	Adult supported living services	11/01/04	04/30/13
	565	Child supported living services	11/01/04	04/30/13
	618	Health-related services	11/01/04	04/30/13
	622	Companion services	11/01/04	04/30/13
	627	Customized Living/Residential Care	11/01/04	04/30/13
	645	Social and recreational service	11/01/04	04/30/13
S5135 UA - BI night supervision			11/01/04	
	118	Health-related services	11/01/04	12/31/13
	145	Social and recreational	11/01/04	12/31/13
	564	Adult supported living services	11/01/04	12/31/13
	565	Child supported living services	11/01/04	12/31/13
	618	Health-related services	11/01/04	12/31/13
	622	Companion services	11/01/04	12/31/13
	627	Customized Living/Residential Care	11/01/04	12/31/13
	645	Social and recreational service	11/01/04	12/31/13

Waiver and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
S5135 UB - 24 hour emergency assistance (15 minutes)			11/01/04	12/31/13
	118	Health-related services	11/01/04	12/31/13
	145	Social and recreational	11/01/04	12/31/13
	564	Adult supported living services	11/01/04	12/31/13
	565	Child supported living services	11/01/04	12/31/13
	618	Health-related services	11/01/04	12/31/13
	622	Companion services	11/01/04	12/31/13
	627	Customized Living/Residential Care	11/01/04	12/31/13
	645	Social and recreational service	11/01/04	12/31/13
S5136 - Personal support			11/01/04	12/31/13
	145	Social and recreational	11/01/04	12/31/13
	564	Adult supported living services	11/01/04	12/31/13
	565	Child supported living services	11/01/04	12/31/13
	622	Companion services	11/01/04	12/31/13
	645	Social and recreational service	11/01/04	12/31/13
S5136 UB - 24 hour emergency assistance (day)			11/01/04	12/31/13
	145	Social and recreational	11/01/04	12/31/13
	564	Adult supported living services	11/01/04	12/31/13
	565	Child supported living services	11/01/04	12/31/13
	645	Social and recreational service	11/01/04	12/31/13
S5140 - Foster care, adult (day)			11/01/04	
	681	Adult foster care	11/01/04	12/31/13
S5140 U9 - Foster care, adult, corporate (day)			11/01/04	
	681	Adult foster care	11/01/04	12/31/13
S5141 - Foster care, adult (month)			11/01/04	12/31/13
	681	Adult foster care	11/01/04	12/31/13
S5141 HQ - Foster care, adult (month)			10/01/06	
	681	Adult foster care	10/01/06	12/31/13
S5141 U9 - Foster care, adult, corporate (month)			11/01/04	12/31/13
	681	Adult foster care	11/01/04	12/31/13
S5145 - Foster care, child (day)			11/01/04	
	181	Child family foster care	11/01/04	12/31/13
S5146 - Foster care, child (month)			11/01/04	12/31/13
	181	Child family foster care	11/01/04	12/31/13
S5150 - Respite care, in home (15 minutes)			11/01/04	12/31/13
	118	Health-related services	11/01/04	12/31/13
	189	Respite care	11/01/04	12/31/13
	589	Respite care	11/01/04	12/31/13
	689	Respite care	11/01/04	12/31/13

Waiver and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
S5150 UB - Respite care, out of home			10/01/06	
	189	Respite care	10/01/06	06/30/14
	589	Respite care	10/01/06	06/30/14
	689	Respite care	10/01/06	06/30/14
S5151 - Respite care, in home (day)			11/01/04	
	189	Respite care	11/01/04	06/30/14
	589	Respite care	11/01/04	06/30/14
	689	Respite care	11/01/04	06/30/14
S5160 - Emergency response system- installation and testing			05/01/10	
	141	Env. accessibility adaptations, spec. supplies & equip.	05/01/10	
	641	Env. accessibility adaptations, spec. supplies & equip.	05/01/10	
S5161 - Emergency response system- service fee, per month			05/01/10	
	141	Env. accessibility adaptations, spec. supplies & equip.	05/01/10	
	641	Env. accessibility adaptations, spec. supplies & equip.	05/01/10	
S5162 -Emergency response system- purchase			05/01/10	
	141	Env. accessibility adaptations, spec. supplies & equip.	05/01/10	
	641	Env. accessibility adaptations, spec. supplies & equip.	05/01/10	
S5165 - Environmental accessibility adaptations, Home Modifications/Install and Expenses			11/01/04	
	141	Env. accessibility adaptations, spec. supplies & equip.	11/01/04	
	541	Env. accessibility adaptations, spec. supplies & equip.	11/01/04	
	641	Env. accessibility adaptations, spec. supplies & equip.	11/01/04	
S5165 U3 - Environmental accessibility adaptations, square footage			11/01/04	
	141	Env. accessibility adaptations, spec. supplies & equip.	08/01/09	
	541	Env. accessibility adaptations, spec. supplies & equip.	08/01/09	
	641	Env. accessibility adaptations, spec. supplies & equip.	08/01/09	

Waiver and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
S5170 - Home delivered meals			11/01/04	
	628	Home delivered meals	11/01/04	12/31/13
S9125 - Crisis respite (day)			11/01/04	
	589	Respite care	11/01/04	12/31/13
S9470 - Nutritional counseling, diet			11/01/04	
	118	Health-related services	11/01/04	12/31/13
	618	Health-related services	11/01/04	12/31/13
T1005 - Crisis respite (15 minutes)			11/01/04	
	589	Respite care	11/01/04	12/31/13
T1005 TG - Crisis respite, specialized			11/01/04	
	589	Respite care	11/01/04	12/31/13
T1016 - AC Conversion			07/01/01	
	691	AC/EW/CAC/CADI/BI case management	07/01/01	
T1016 TF UC - Waiver case management by paraprofessional			10/01/06	
	191	CAC/CADI/BI case management	10/01/06	
	691	AC/EW/CAC/CADI/BI case management	10/01/06	
T1016 UC - Waiver case management			10/01/06	
	191	CAC/CADI/BI case management	10/01/06	
	591	DD waiver case management	10/01/06	
	691	AC/EW/CAC/CADI/BI case management	10/01/06	
T1019 - Personal care services (PCA) 1:1			11/01/04	
	624	Home-based support services	11/01/04	
T1019 HQ - Personal care services (PCA) 1:3			11/01/04	
	124	Home-based support services	11/01/04	
	624	Home-based support services	11/01/04	
T1019 HQ UC - Extended shared personal care services 1:3			11/01/04	
	124	Home-based support services	11/01/04	
	624	Home-based support services	11/01/04	
T1019 TT - Personal care services (PCA) 1:2			11/01/04	
	124	Home-based support services	11/01/04	
	624	Home-based support services	11/01/04	
T1019 TT UC - Extended shared personal care services 1:2			11/01/04	
	124	Home-based support services	11/01/04	
	624	Home-based support services	11/01/04	
T1019 UA - Supervision of PCA			10/01/06	
	624	Home-based support services	10/01/06	

Waiver and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
T1019 UC - Extended personal care 1:1			11/01/04	
	124	Home-based support services	11/01/04	
	624	Home-based support services	11/01/04	
T2002 - DT&H, non-pilot, transportation			10/01/06	12/31/13
	566	Day Training and Habilitation	10/01/06	12/31/13
T2003 - Non-emergency transportation; encounter/trip (one way)			10/01/06	
	616	Transportation	10/01/06	
T2003 UC - Non-emergency transportation; encounter/trip (one way)			10/01/06	
	116	Transportation	10/01/06	
	516	Transportation	10/01/07	
	616	Transportation	10/01/06	
T2013 - Specialist service			10/01/06	
	564	Adult supported living services	10/01/06	12/31/13
	565	Child supported living services	10/01/06	12/31/13
T2014 - Prevocational services (day)			10/01/06	
	649	Adult day care	10/01/06	12/31/13
T2015 - Prevocational services (hour)			10/01/06	
	649	Adult day care	10/01/06	12/31/13
T2016 - Supported living services, adult (day)			10/01/06	
	564	Adult supported living services	10/01/06	12/31/13
T2016 HA - Supported living services, child			10/01/06	
	565	Child supported living services	10/01/06	12/31/13
T2016 U9 - Supported living services, adult, corporate AFC (day)			10/01/06	
	564	Adult supported living services	10/01/06	12/31/13
T2017 - Supported living services, adult (15 minutes)			10/01/06	
	564	Adult supported living services	10/01/06	12/31/13
T2017 HA - Supported living services, child			10/01/06	
	565	Child supported living services	10/01/06	12/31/13
T2017 U9 -Supported living services, adult, corporate AFC (15 minutes)			10/01/06	
	564	Adult supported living services	10/01/06	12/31/13
T2018 - Supported employment (day)			10/01/06	12/31/13
	538	Extended and supported employment	10/01/06	12/31/13
	638	Extended employment	10/01/06	12/31/13
T2018 U5 - Supported employment (partial day)			10/01/06	12/31/13
	538	Extended and supported employment	10/01/06	12/31/13

Waiver and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
T2019 - Supported employment (15 minutes)			10/01/06	
	538	Extended and supported employment	10/01/06	12/31/13
	638	Extended employment	10/01/06	12/31/13
T2020 - DT&H, non-pilot/Structured day program			10/01/06	
	566	Day Training and Habilitation	10/01/06	12/31/13
	618	Health-related services	10/01/06	12/31/13
T2020 U5 - DT&H, non-pilot			10/01/06	12/31/13
	566	Day Training and Habilitation	10/01/06	12/31/13
T2021 - DT&H pilot, Rate D/Structured day program			10/01/06	
	566	Day Training and Habilitation	10/01/06	12/31/13
	618	Health-related services	10/01/06	12/31/13
T2021 TF - DT&H pilot, Rate B			10/01/06	12/31/13
	566	Day Training and Habilitation	10/01/06	12/31/13
T2021 TG - DT&H pilot, Rate A			10/01/06	12/31/13
	566	Day Training and Habilitation	10/01/06	12/31/13
T2021 UB - DT&H pilot, Rate C			10/01/06	12/31/13
	566	Day Training and Habilitation	10/01/06	12/31/13
T2028 U1 - CDCS - Personal assistance			10/01/04	
	158	Approved pilot projects	10/01/04	12/31/13
	558	Approved pilot projects	10/01/04	12/31/13
	658	Approved pilot projects	10/01/04	12/31/13
T2028 U2 - CDCS - Treatment and training			10/01/04	
	158	Approved pilot projects	10/01/04	12/31/13
	558	Approved pilot projects	10/01/04	12/31/13
	658	Approved pilot projects	10/01/04	12/31/13
T2028 U3 - CDCS - Environmental modifications and provisions			10/01/04	
	158	Approved pilot projects	10/01/04	12/31/13
	558	Approved pilot projects	10/01/04	12/31/13
	658	Approved pilot projects	10/01/04	12/31/13
T2028 U4 - CDCS - Self direction support activities			10/01/04	
	158	Approved pilot projects	10/01/04	12/31/13
	558	Approved pilot projects	10/01/04	12/31/13
	658	Approved pilot projects	10/01/04	12/31/13
T2028 U8 - CDCS - Flexible case management			10/01/04	
	158	Approved pilot projects	10/01/04	12/31/13
	558	Approved pilot projects	10/01/04	12/31/13
	658	Approved pilot projects	10/01/04	12/31/13

Waiver and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
T2030 – Customized living services (monthly)			10-01-06	12/31/13
	627	Customized Living/Residential Care	10-01-06	12/31/13
T2030 TG - 24-hour customized living (monthly)			10/01/06	12/31/13
	627	Customized Living/Residential Care	10/01/06	12/31/13
T2030 TG U9 - 24-hour customized living (corporate)			10/01/06	12/31/13
	627	Customized Living/Residential Care	10/01/06	12/31/13
T2031 - Customized living services (daily)			10/01/06	
	627	Customized Living/Residential Care	10/01/06	12/31/13
T2032 – Residential care services			10/01/06	12/31/13
	627	Customized Living/Residential Care	10/01/06	12/31/13
T2032 - Supported living services, adult (month)			10/01/06	12/31/13
	564	Adult supported living services	10/01/06	12/31/13
T2032 - Supported living services, adult (semi-monthly)			10/01/06	12/31/13
	564	Adult supported living services	10/01/06	12/31/13
T2032 HA - Supported living services, child (monthly)			10/01/06	12/31/13
	565	Child supported living services	10/01/06	12/31/13
T2032 HA - Supported living services, child (semi-monthly)			10/01/06	12/31/13
	565	Child supported living services	10/01/06	12/31/13
T2032 U9 - Supported living services, adult, corporate AFC (month)			10/01/06	12/31/13
	564	Adult supported living services	10/01/06	12/31/13
T2032 U9 - Supported living services, adult, corporate AFC (semi-month)			10/01/06	12/31/13
	564	Adult supported living services	10/01/06	12/31/13
T2033 - Residential care services			10/01/06	
	627	Customized Living/Residential Care	10/01/06	12/31/13
T2038 - Transitional services			11/01/04	
	644	Housing Access Services	10/01/05	
T2038 TF - Housing access coordination			10/01/06	12/31/13
	564	Adult supported living services	10/01/06	12/31/13
	565	Child supported living services	10/01/06	12/31/13
T2038 U1 - Transitional services, furniture			11/01/04	
	644	Housing Access Services	10/01/05	
T2038 U2 - Transitional services, supplies			11/01/04	
	644	Housing Access Services	10/01/05	
T2040 - CDCS - Background check			10/01/04	
	158	Approved pilot projects	10/01/04	12/31/13
	558	Approved pilot projects	10/01/04	12/31/13
	658	Approved pilot projects	10/01/04	12/31/13

Waiver and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
T2041 - CDCS - Mandatory case management			10/01/04	
	658	Approved pilot projects	10/01/04	
X5527 - AC Discretionary service			07/01/99	
	618	Health-related services	07/01/99	

Table 2-23: Waivers and AC HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers

2.1.11.5 Waivers and AC HCPCS/Modifiers Available on Payments – by Service

Following is a list of HCPCS/Modifiers available on Services on Payments that are claimable in SSIS for Waivers and AC listed by Service.

Note: Start and End Dates are the date range that the Service with the HCPCS/Modifiers is valid

Waiver and AC HCPCS/Modifiers Available on Payments – by Service				
Service	HCPCS / Modifiers	Description	Start Date	End Date
116 - Transportation				
	S0215 UC	Transportation, mileage (commercial vehicle)	10/01/06	12/31/12
	S0215 UC	Transportation, mileage	10/01/06	
	T2003 UC	Non-emergency transportation; encounter/trip (one way)	10/01/06	
118 - Health-related services				
	H0025	Behavioral Support, by analyst	10/01/06	12/31/13
	H0025 TF	Behavioral Support, by specialist	10/01/06	12/31/13
	H0025 TG	Behavior Support, by professional	10/01/06	12/31/13
	S5135 U9	Behavioral programming by aide	11/01/04	04/30/13
	S5135 UA	BI night supervision	11/01/04	12/31/13
	S5135 UB	24 hour emergency assistance (15 minutes)	11/01/04	12/31/13
	S5150	Respite care, in home (15 minutes)	11/01/04	12/31/13
	S9470	Nutritional counseling, diet	11/01/04	12/31/13
124 - Home-based support services				
	T1019 HQ	Personal care services (PCA) 1:3	11/01/04	
	T1019 HQ UC	Extended shared personal care services 1:3	11/01/04	
	T1019 TT	Personal care services (PCA) 1:2	11/01/04	
	T1019 TT UC	Extended shared personal care services 1:2	11/01/04	
	T1019 UC	Extended personal care 1:1	11/01/04	
125 - Homemaking services				
	S5130	Homemaker services – cleaning only (15 minutes)	11/01/04	

Waiver and AC HCPCS/Modifiers Available on Payments – by Service				
Service	HCPCS / Modifiers	Description	Start Date	End Date
141 - Env. accessibility adaptations, spec. supplies & equip.				
	S5160	Emergency response system- installation and testing	05/01/10	
	S5161	Emergency response system- service fee, per month	05/01/10	
	S5162	Emergency response system- purchase	05/01/10	
	S5165	Environmental accessibility adaptations, Home Modifications/Install and Expenses	11/01/04	
	S5165 U3	Environmental accessibility adaptations, square footage	08/01/09	
145 - Social and recreational				
	S5109	Consumer training and education	10/01/06	
	S5135	Companion care, adult/Personal support	11/01/04	12/31/13
	S5135 U9	Behavioral programming by aide	11/01/04	04/30/13
	S5135 UA	BI night supervision	11/01/04	12/31/13
	S5135 UB	24 hour emergency assistance (15 minutes)	11/01/04	12/31/13
	S5136	Personal support	11/01/04	12/31/13
	S5136 UB	24 hour emergency assistance (day)	11/01/04	12/31/13
147 – Independent living skills				
	H2032	Independent living skills, maintenance	01/01/08	12/31/13
	H2032 HQ	Independent living skills, group therapy	01/01/08	12/31/13
	H2032 TF	Independent living skills, counseling	01/01/08	12/31/13
	H2032 TG	Independent living skills, individual therapy	01/01/08	12/31/13
156 - Group counseling				
	S5110	Family training	11/01/04	
158 - Approved pilot projects				
	T2028 U1	CDCS - Personal assistance	10/01/04	12/31/13
	T2028 U2	CDCS - Treatment and training	10/01/04	12/31/13
	T2028 U3	CDCS - Environmental modifications and provisions	10/01/04	12/31/13
	T2028 U4	CDCS - Self direction support activities	10/01/04	12/31/13
	T2028 U8	CDCS - Flexible case management	10/01/04	12/31/13
	T2040	CDCS - Background check	10/01/04	12/31/13
181 - Child family foster care				
	S5145	Foster care, child (day)	11/01/04	12/31/13
	S5146	Foster care, child (month)	11/01/04	12/31/13

Waiver and AC HCPCS/Modifiers Available on Payments – by Service				
Service	HCPCS / Modifiers	Description	Start Date	End Date
189 - Respite care				
	H0045	Respite care services, not in home	11/01/04	06/30/14
	S5150	Respite care, in home (15 minutes)	11/01/04	12/31/13
	S5150 UB	Respite care, out of home	10/01/06	06/30/14
	S5151	Respite care, in home (day)	11/01/04	06/30/14
191 - CAC/CADI/BI case management				
	T1016 TF UC	Waiver case management by paraprofessional	10/01/06	
	T1016 UC	Waiver case management	10/01/06	
489 - Child respite care				
	H0045	Respite care services, not in home	11/01/04	06/30/14
502 - Community education and prevention				
	S5109	Consumer training and education	10/01/06	
	S5116	Caregiver training/education	11/01/04	06/30/13
516 - Transportation				
	S0215 UC	Transportation, mileage (commercial vehicle)	10/01/06	12/31/12
	S0215 UC	Transportation, mileage	10/01/06	
	T2003 UC	Non-emergency transportation; encounter/trip (one way)	10/01/07	
525 - Homemaking services				
	S5130	Homemaker services – cleaning only (15 minutes)	11/01/04	
531 - In-home family support services				
	S5116	Caregiver training/education	11/01/04	06/30/13
	S5125	DD, in home family support (15 minutes)	11/01/04	12/31/13
	S5126 TG	DD, in home family support (day)	11/01/04	12/31/13
538 - Extended and supported employment				
	T2018	Supported employment (day)	10/01/06	12/31/13
	T2018 U5	Supported employment (partial day)	10/01/06	12/31/13
	T2019	Supported employment (15 minutes)	10/01/06	12/31/13

Waiver and AC HCPCS/Modifiers Available on Payments – by Service				
Service	HCPCS / Modifiers	Description	Start Date	End Date
541 - Env. accessibility adaptations, spec. supplies & equip.				
	S5165	Environmental accessibility adaptations, Home Modifications/Install and Expenses	11/01/04	
	S5165 U3	Environmental accessibility adaptations, square footage	08/01/09	
558 - Approved pilot projects				
	T2028 U1	CDCS - Personal assistance	10/01/04	12/31/13
	T2028 U2	CDCS - Treatment and training	10/01/04	12/31/13
	T2028 U3	CDCS - Environmental modifications and provisions	10/01/04	12/31/13
	T2028 U4	CDCS - Self direction support activities	10/01/04	12/31/13
	T2028 U8	CDCS - Flexible case management	10/01/04	12/31/13
	T2040	CDCS - Background check	10/01/04	12/31/13
564 - Adult supported living services				
	S5126	Caregiver living expenses	11/01/04	
	S5135	Companion care, adult/Personal support	11/01/04	12/31/13
	S5135 U9	Behavioral programming by aide	11/01/04	04/30/13
	S5135 UA	BI night supervision	11/01/04	12/31/13
	S5135 UB	24 hour emergency assistance (15 minutes)	11/01/04	12/31/13
	S5136	Personal support	11/01/04	12/31/13
	S5136 UB	24 hour emergency assistance (day)	11/01/04	12/31/13
	T2013	Specialist service	10/01/06	12/31/13
	T2016	Supported living services, adult (day)	10/01/06	12/31/13
	T2016 U9	Supported living services, adult, corporate AFC (day)	10/01/06	12/31/13
	T2017	Supported living services, adult (15 minutes)	10/01/06	12/31/13
	T2017 U9	Supported living services, adult, corporate AFC (15 minutes)	10/01/06	12/31/13
	T2032	Supported living services, adult (month)	10/01/06	12/31/13
	T2032	Supported living services, adult (semi-monthly)	10/01/06	12/31/13
	T2032 U9	Supported living services, adult, corporate AFC (month)	10/01/06	12/31/13
	T2032 U9	Supported living services, adult, corporate AFC (semi-monthly)	10/01/06	12/31/13
	T2038 TF	Housing access coordination	10/01/06	12/31/13
565 - Child supported living services				
	S5135	Companion care, adult/Personal support	11/01/04	12/31/13
	S5135 U9	Behavioral programming by aide	11/01/04	04/30/13
	S5135 UA	BI night supervision	11/01/04	12/31/13
	S5135 UB	24 hour emergency assistance (15 minutes)	11/01/04	12/31/13
	S5136	Personal support	11/01/04	12/31/13

Waiver and AC HCPCS/Modifiers Available on Payments – by Service

Service	HCPCS / Modifiers	Description	Start Date	End Date
	S5136 UB	24 hour emergency assistance (day)	11/01/04	12/31/13
	T2013	Specialist service	10/01/06	12/31/13
	T2016 HA	Supported living services, child	10/01/06	12/31/13
	T2017 HA	Supported living services, child	10/01/06	12/31/13
	T2032 HA	Supported living services, child (month)	10/01/06	12/31/13
	T2032 HA	Supported living services, child (semi-monthly)	10/01/06	12/31/13
	T2038 TF	Housing access coordination	10/01/06	12/31/13
566 - Day Training and Habilitation				
	T2002	DT&H, non-pilot, transportation	10/01/06	12/31/13
	T2020	DT&H, non-pilot/Structured day program	10/01/06	12/31/13
	T2020 U5	DT&H, non-pilot	10/01/06	12/31/13
	T2021	DT&H pilot, Rate D/Structured day program	10/01/06	12/31/13
	T2021 TF	DT&H pilot, Rate B	10/01/06	12/31/13
	T2021 TG	DT&H pilot, Rate A	10/01/06	12/31/13
	T2021 UB	DT&H pilot, Rate C	10/01/06	12/31/13
589 - Respite care				
	H0045	Respite care services, not in home	11/01/04	06/30/14
	S5150	Respite care, in home (15 minutes)	11/01/04	12/31/13
	S5150 UB	Respite care, out of home	10/01/06	06/30/14
	S5151	Respite care, in home (day)	11/01/04	06/30/14
	S9125	Crisis respite (day)	11/01/04	12/31/13
	T1005	Crisis respite (15 minutes)	11/01/04	12/31/13
	T1005 TG	Crisis respite, specialized	11/01/04	12/31/13
591 - DD waiver case management				
	T1016 UC	Waiver case management	10/01/06	
607 – General Assessment				
	S5115 TF	Caregiver Coaching and Counseling/Caregiver Assessment	07/01/13	
	S5116 TF	Caregiver Assessment	04/01/10	06/30/13
616 - Transportation				
	S0215 UC	Transportation, mileage (commercial vehicle)	10/01/06	12/31/12
	S0215 UC	Transportation, mileage	10/01/06	
	T2003	Non-emergency transportation; encounter/trip (one way)	10/01/06	
	T2003 UC	Non-emergency transportation; encounter/trip (one way)	10/01/06	

Waiver and AC HCPCS/Modifiers Available on Payments – by Service

Service	HCPCS / Modifiers	Description	Start Date	End Date
618 - Health-related services				
	H0025	Behavioral Support, by analyst	10/01/06	12/31/13
	H0025 TF	Behavioral Support, by specialist	10/01/06	12/31/13
	H0025 TG	Behavior Support, by professional	10/01/06	12/31/13
	S5135	Companion care, adult/Personal support	11/01/04	12/31/13
	S5135 U9	Behavioral programming by aide	11/01/04	04/30/13
	S5135 UA	BI night supervision	11/01/04	12/31/13
	S5135 UB	24 hour emergency assistance (15 minutes)	11/01/04	12/31/13
	S9470	Nutritional counseling, diet	11/01/04	12/31/13
	T2020	DT&H, non-pilot/Structured day program	10/01/06	12/31/13
	T2021	DT&H pilot, Rate D/Structured day program	10/01/06	12/31/13
	X5527	AC Discretionary service	07/01/99	
622 - Companion services				
	S5135	Companion care, adult/Personal support	11/01/04	12/31/13
	S5135 U9	Behavioral programming by aide	11/01/04	04/30/13
	S5135 UA	BI night supervision	11/01/04	12/31/13
	S5135 UB	24 hour emergency assistance (15 minutes)	11/01/04	12/31/13
	S5136	Personal support	11/01/04	12/31/13
623 - Chore services				
	S5120	Chore services	11/01/04	
624 - Home-based support services				
	S5115	Caregiver training/education	07/01/13	
	S5116	Caregiver training/education	11/01/04	06/30/13
	T1019	Personal care services (PCA) 1:1	11/01/04	12/31/13
	T1019 HQ	Personal care services (PCA) 1:3	11/01/04	12/31/13
	T1019 HQ UC	Extended shared personal care services 1:3	11/01/04	12/31/13
	T1019 TT	Personal care services (PCA) 1:2	11/01/04	12/31/13
	T1019 TT UC	Extended shared personal care services 1:2	11/01/04	12/31/13
	T1019 UA	Supervision of PCA	10/01/06	12/31/13
	T1019 UC	Extended personal care 1:1	11/01/04	12/31/13
625 - Homemaking services				
	S5130	Homemaker services – cleaning only (15 minutes)	11/01/04	
	S5131	Homemaker services (day)	11/01/04	12/31/13

Waiver and AC HCPCS/Modifiers Available on Payments – by Service

Service	HCPCS / Modifiers	Description	Start Date	End Date
627 - Customized Living/Residential Care				
	S5135	Companion care, adult/Personal support	11/01/04	12/31/13
	S5135 U9	Behavioral programming by aide	11/01/04	04/30/13
	S5135 UA	BI night supervision	11/01/04	12/31/13
	S5135 UB	24 hour emergency assistance (15 minutes)	11/01/04	12/31/13
	T2030	Customized living	10/01/06	12/31/13
	T2030 TG	24-hour customized living (monthly)	10/01/06	12/31/13
	T2030 TG U9	24-hour customized living (monthly)	10/01/06	12/31/13
	T2031	Customized living services (daily)	10/01/06	12/31/13
	T2032	Residential care services	10/01/06	12/31/13
	T2033	Residential care services	10/01/06	12/31/13
628 - Home delivered meals				
	S5170	Home delivered meals	11/01/04	12/31/13
638 - Extended employment				
	T2018	Supported employment (day)	10/01/06	12/31/13
	T2019	Supported employment (15 minutes)	10/01/06	12/31/13
641 - Env. accessibility adaptations, spec. supplies & equip.				
	S5160	Emergency response system- installation and testing	05/01/10	
	S5161	Emergency response system- service fee, per month	05/01/10	
	S5162	Emergency response system- purchase	05/01/10	
	S5165	Environmental accessibility adaptations, Home Modifications/Install and Expenses	11/01/04	
	S5165 U3	Environmental accessibility adaptations, square footage	08/01/09	
644 - Housing Access Services				
	T2038	Transitional services	10/01/05	
	T2038 U1	Transitional services, furniture	10/01/05	
	T2038 U2	Transitional services, supplies	10/01/05	
645 - Social and recreational service				
	S5109	Consumer training and education	10/01/06	
	S5135	Companion care, adult/Personal support	11/01/04	12/31/13
	S5135 U9	Behavioral programming by aide	11/01/04	04/30/13
	S5135 UA	BI night supervision	11/01/04	12/31/13
	S5135 UB	24 hour emergency assistance (15 minutes)	11/01/04	12/31/13
	S5136	Personal support	11/01/04	12/31/13
	S5136 UB	24 hour emergency assistance (day)	11/01/04	12/31/13
647 – Independent living skills				
	H2032	Independent living skills, maintenance	01/01/08	12/31/13
	H2032 HQ	Independent living skills, group therapy	01/01/08	12/31/13

Waiver and AC HCPCS/Modifiers Available on Payments – by Service

Service	HCPCS / Modifiers	Description	Start Date	End Date
	H2032 TF	Independent living skills, counseling	01/01/08	12/31/13
	H2032 TG	Independent living skills, individual therapy	01/01/08	12/31/13
649 - Adult day care				
	S5100	Day care services, adult (15 minutes)	11/01/04	12/31/13
	S5100 U7	Family adult day services (FADS) (15 minutes)	11/01/08	12/31/13
	S5100 TF	Adult day care bath	11/01/04	12/31/13
	S5102	Day care services, adult (day)	11/01/04	12/31/13
	S5102 U7	Family adult day services (FADS) (day)	11/01/08	12/31/13
	T2014	Prevocational services (day)	10/01/06	12/31/13
	T2015	Prevocational services (hour)	10/01/06	12/31/13
656 - Group counseling				
	S5110	Family training	11/01/04	
658 - Approved pilot projects				
	T2028 U1	CDCS - Personal assistance	10/01/04	12/31/13
	T2028 U2	CDCS - Treatment and training	10/01/04	12/31/13
	T2028 U3	CDCS - Environmental modifications and provisions	10/01/04	12/31/13
	T2028 U4	CDCS - Self direction support activities	10/01/04	12/31/13
	T2028 U8	CDCS - Flexible case management	10/01/04	12/31/13
	T2040	CDCS - Background check	10/01/04	12/31/13
	T2041	CDCS - Mandatory case management	10/01/04	
681 - Adult foster care				
	S5140	Foster care, adult (day)	11/01/04	12/31/13
	S5140 U9	Foster care, adult, corporate (day)	11/01/04	12/31/13
	S5141	Foster care, adult (month)	11/01/04	12/31/13
	S5141 HQ	Foster care, adult (month)	10/01/06	12/31/13
	S5141 U9	Foster care, adult, corporate (month)	11/01/04	12/31/13
689 - Respite care				
	H0045	Respite care services, not in home	11/01/04	06/30/14
	S5150	Respite care, in home (15 minutes)	11/01/04	12/31/13
	S5150 UB	Respite care, out of home	10/01/06	06/30/14
	S5151	Respite care, in home (day)	11/01/04	06/30/14

Waiver and AC HCPCS/Modifiers Available on Payments – by Service				
Service	HCPCS / Modifiers	Description	Start Date	End Date
691 - AC/EW/CAC/CADI/BI case management				
	T1016	AC Conversion	07/01/01	
	T1016 TF UC	Waiver case management by paraprofessional	10/01/06	
	T1016 UC	Waiver case management	10/01/06	

Table 2-24: Waivers and AC HCPCS/Modifiers Available on Payments – by Service

2.1.12 Non-automated Claim Category

Some HCPCS/Modifiers used by counties cannot be claimed using SSIS, either because the system is not structured to collect the needed data or because SSIS and the policy group has not met to define the claiming requirements in SSIS. Non-automated HCPCS/Modifiers can be claimed using MN-ITS.

2.1.12.1 Non-automated HCPCS/Modifiers

Following is a list of the HCPCS/Modifiers that cannot be claimed through SSIS.

Payments with these HCPCS/Modifiers and Time records with a Service and Activity listed for the HCPCS/Modifiers are displayed on the non-automated claiming reports.

Counties can claim these Payments and Time records through MN-ITS if the record is billable based on the claiming criteria for the HCPCS/Modifier.

Non-automated HCPCS/Modifiers						
HCPCS / Modifiers	Description	Start Date	End Date	Unit Type	Time	Pay-ments
90882	Community intervention, indiv.	01-01-02		Session	N	Y
90882 HK	Community intervention, crisis response	01-01-10		Session	N	Y
90882 HM	Community intervention, indiv. by rehab worker	01-01-02		Session	N	Y
90882 HM UD	Community intervention, indiv., transitional by rehab worker	01-01-02		Session	N	Y
90882 UD	Community intervention, indiv., transitional	01-01-02		Session	N	Y
E1399	Durable medical equipment	11-01-04	05/31/13	Item	N	Y
E1399 NU	Durable medical equipment, new	06-01-13		Item	N	Y
E1399 RR	Durable medical equipment, rental	06-01-13		Item	N	Y
E1399 RB	Durable medical equipment, repair	06-01-13		Item	N	Y
G0154	Direct skilled nursing services - LPN or RN - home	11-01-04		15 Minutes	N	Y
H0001	Alcohol and/or Drug Assessment	07-01-09		Screening	Y	N
H0002	Behavioral Health Eligibility Screening	07-01-09		Screening	Y	N
H0018	Crisis stabilization, residential	01-01-04		Day	N	Y
H0019	Intensive Residential Rehab. Treatment (IRT)	07-01-04		Day	N	Y
H0035	Partial hospitalization	01-01-04		Day	N	Y
H0040	Assertive Community Treatment (ACT)	07-01-04		Day	Y	N
H2017	Psychosocial rehab., indiv.	01-01-04		15 Minutes	N	Y

Non-automated HCPCS/Modifiers						
HCPCS / Modifiers	Description	Start Date	End Date	Unit Type	Time	Payments
H2017 HM	Psychosocial rehab., indiv. by rehab worker	01-01-04		15 Minutes	N	Y
H2017 HM HQ	Psychosocial rehab., group by rehab worker	01-01-04		15 Minutes	N	Y
H2017 HM HQ UD	Psychosocial rehab., group, transitional by rehab worker	01-01-04		15 Minutes	N	Y
H2017 HM UD	Psychosocial rehab., indiv., transitional by rehab worker	01-01-04		15 Minutes	N	Y
H2017 HQ	Psychosocial rehab., group	01-01-04		15 Minutes	N	Y
H2017 HQ UD	Psychosocial rehab., group, transitional	01-01-04		15 Minutes	N	Y
H2017 UD	Psychosocial rehab., indiv., transitional	01-01-04		15 Minutes	N	Y
H2019 HE UA	Therapeutic behavioral services, direction of MHBA	07-01-04		15 Minutes	N	Y
H2019 HM UA	Therapeutic behavioral services, Level II MHBA	07-01-04		15 Minutes	N	Y
H2019 UA	Therapeutic behavioral services - Level I MHBA	07-01-04		15 Minutes	N	Y
S9128 UC	Extended speech therapy	11-01-04		Visit	N	Y
S9129 TF UC	Extended occupational therapy assistant	11-01-04		Visit	N	Y
S9129 UC	Extended occupational therapy	11-01-04		Visit	N	Y
S9131 TF UC	Extended physical therapy assistant	11-01-04		Visit	N	Y
S9131 UC	Extended physical therapy	11-01-04		Visit	N	Y
S9484	Crisis assessment, intervention and stabilization, non-residential, ind. by professional	01-01-04		Hour	Y	Y
S9484 HM	Crisis assessment, intervention and stabilization, non-residential, ind. by rehab. worker	01-01-04		Hour	Y	Y
S9484 HN	Crisis assessment, intervention and stabilization, non-residential, ind. by practitioner	01-01-10		Hour	Y	Y
S9484 HQ	Crisis assessment, intervention and stabilization, non-residential, group	01-01-04		Hour	Y	Y
T1002	RN, regular	11-01-04		15 Minutes	N	Y
T1002 TG	RN, complex	11-01-04		15 Minutes	N	Y

Non-automated HCPCS/Modifiers						
HCPCS / Modifiers	Description	Start Date	End Date	Unit Type	Time	Pay-ments
T1002 TG UC	RN, complex, extended	11-01-04		15 Minutes	N	Y
T1002 TT	RN, regular 1:2	11-01-04		15 Minutes	N	Y
T1002 TT UC	RN, regular, extended 1:2	11-01-04		15 Minutes	N	Y
T1002 UC	RN, regular, extended 1:1	11-01-04		15 Minutes	N	Y
T1003	LPN, regular	11-01-04		15 Minutes	N	Y
T1003 TG	LPN, complex	11-01-04		15 Minutes	N	Y
T1003 TG UC	LPN, complex, extended	11-01-04		15 Minutes	N	Y
T1003 TT	LPN, regular 1:2	11-01-04		15 Minutes	N	Y
T1003 TT UC	LPN, regular, extended 1:2	11-01-04		15 Minutes	N	Y
T1003 UC	LPN, regular, extended 1:1	11-01-04		15 Minutes	N	Y
T1004	Home health aide/extended home health aide	07-01-09		15 Minutes	Y	Y
T1021	Home health aide visit	11-01-04		Visit	Y	Y
T1030	Home health skilled nurse	11-01-04		Visit	N	Y
T1030 GT	Home health telehomecare	11-01-04		Dollar amount	N	Y
T2001 UC	Transportation, extra attendant	10-01-06		Trip, client	N	Y
T2011	PASRR Level II Screening	09-01-12		Screening	N	Y
T2025	Consumer Support Grant (CSG)	06-01-06		Dollar amount	Y	Y
T2025 UD	Family Support Grant (FSG) with CSG	06-01-06		Dollar amount	Y	Y
T2029	Assistive technology/Supplies and equip., extended	10-01-06		Item	N	Y
X5632	MH preadmission screening	01-01-99		15 Minutes	N	Y
X5639	PAS/ARR MH diag asses Masters	01-01-99		30 Minutes	N	Y
X5640	PAS/ARR MH diag asses PhD	01-01-99		30 Minutes	N	Y

Table 2-25: Non-automated HCPCS/Modifiers

2.1.12.2 Non-automated HCPCS/Modifiers for Time records - by HCPCS/Modifiers

Following is a list of the non-automated HCPCS/Modifiers that can be assigned to a claim for Time records based on the Time record's Service and Activity listed by HCPCS/Modifiers.

Note: Start and End Dates are defined as follows:

- HCPCS/Modifiers The date range that the HCPCS/Modifiers code is valid
- Service The date range that the Service with the HCPCS/Modifiers is valid
- Activity The date range that the Activity with the Service is valid for the HCPCS/Modifiers

Non-automated HCPCS/Modifiers for Time records - by HCPCS/Modifiers					
HCPCS / Modifiers	Service	Activity	Description	Start Date	End Date
H0001 - Alcohol and/or Drug Assessment				07/01/09	
	305 – Rule 215 Assessments			07/01/09	
		7	Client Contact	07/01/09	
H0002 - Behavioral Health Eligibility Screening				07/01/09	
	490 - Child Rule 79 case management			07/01/09	
		17	Eligibility/Financial Fee Assessment	07/01/09	
	491 – Adult Rule 79 case management			07/01/09	
		17	Eligibility/Financial Fee Assessment	07/01/09	
H0040 - Assertive Community Treatment (ACT)				07-01-04	
	438 - Assertive Community Treatment (ACT)			01-01-05	
		7	Client contact	01-01-05	
		8	Collateral contact	01-01-05	
		9	Consultation	01-01-05	
		10	Coordination	01-01-05	
		16	Documentation	01-01-05	
		19	Paraprofessional case management	01-01-05	
		29	Service delivery	01-01-05	
		31	Service planning	01-01-05	
		34	Transportation	01-01-05	
	91308885		Group time - .5 hours	01-01-08	
	91308887		Group time - 1 hour	01-01-08	
	91308889		Group time - 1.5 hours	01-01-08	
	91308891		Group time - 2 hours	01-01-08	
	91308893		Group time - 4 hours	01-01-08	

Non-automated HCPCS/Modifiers for Time records - by HCPCS/Modifiers					
HCPCS / Modifiers	Service	Activity	Description	Start Date	End Date
S9484 - Crisis assessment, intervention and stabilization, non-residential, ind. by professional				01/01/04	
	431		Adult mobile crisis services	01/01/10	
	7		Client contact	01/01/10	
	9		Consultation	01/01/10	
	10		Coordination	01/01/10	
	16		Documentation	01/01/10	
S9484 HM - Crisis assessment, intervention and stabilization, non-residential, ind. by rehab. worker				01/01/04	
	431		Adult mobile crisis services	01/01/10	
	7		Client contact	01/01/10	
	9		Consultation	01/01/10	
	10		Coordination	01/01/10	
	16		Documentation	01/01/10	
S9484 HN - Crisis assessment, intervention and stabilization, non-residential, ind. by practitioner				01/01/10	
	431		Adult mobile crisis services	01/01/10	
	7		Client contact	01/01/10	
	9		Consultation	01/01/10	
	10		Coordination	01/01/10	
	16		Documentation	01/01/10	
S9484 HQ - Crisis assessment, intervention and stabilization, non-residential, group				01/01/04	
	431		Adult mobile crisis services	01/01/10	
	7		Client contact	01/01/10	
	9		Consultation	01/01/10	
	10		Coordination	01/01/10	
	16		Documentation	01/01/10	
T1004 - Home health aide/extended home health aide				07/01/09	
	124		Home-based support services	07/01/09	
	30		Service delivery - extended home health aide CAC, CADI, BI only	07/01/09	
	624		Home-based support services	07/01/09	
	29		Service delivery AC only	07/01/09	
	30		Service delivery - extended home health aide	07/01/09	
T1021 - Home health aide visit				11/01/04	
	624		Home-based support services	11/01/04	
	48		Service delivery - visit	11/01/04	

Non-automated HCPCS/Modifiers for Time records - by HCPCS/Modifiers					
HCPCS / Modifiers	Service	Activity	Description	Start Date	End Date
T2025 - Consumer Support Grant (CSG)				06-01-06	
	136		Consumer Support Grant	06-01-06	
	9		Consultation	06-01-06	
	10		Coordination	06-01-06	
	16		Documentation	06-01-06	
	636		Consumer Support Grant	06-01-06	
	9		Consultation	06-01-06	
	10		Coordination	06-01-06	
	16		Documentation	06-01-06	
T2025 UD - Family Support Grant (FSG) with CSG				06-01-06	
	136		Consumer Support Grant	06-01-06	
	9		Consultation	06-01-06	
	10		Coordination	06-01-06	
	16		Documentation	06-01-06	
	636		Consumer Support Grant	06-01-06	
	9		Consultation	06-01-06	
	10		Coordination	06-01-06	
	16		Documentation	06-01-06	

Table 2-26: Non-automated HCPCS/Modifiers for Time records - by HCPCS/Modifiers

2.1.12.3 Non-automated HCPCS/Modifiers for Time records - by Service and Activity

Following is a list of the non-automated HCPCS/Modifiers that can be assigned to a claim for Time records based on the Time record's Service and Activity listed by Service and Activity.

Note: Start and End Dates are the date range that the Service and Activity are valid with the HCPCS/Modifiers.

Non-automated HCPCS/Modifiers for Time records - by Service and Activity					
Svc	Act	HCPCS / Modifiers	Description	Start Date	End Date
124 - Home-based support services					
	30 - Service delivery - extended home health aide CAC, CADI, BI only				
	T1004		Home health aide/extended home health aide	07/01/09	
136 - Consumer Support Grant					
	9 - Consultation				
	T2025		Consumer Support Grant (CSG)	06-01-06	
	T2025 UD		Family Support Grant (FSG) with CSG	06-01-06	
	10 - Coordination				
	T2025		Consumer Support Grant (CSG)	06-01-06	
	T2025 UD		Family Support Grant (FSG) with CSG	06-01-06	
	16 - Documentation				
	T2025		Consumer Support Grant (CSG)	06-01-06	
	T2025 UD		Family Support Grant (FSG) with CSG	06-01-06	
305 - Rule 215 Assessments				07/01/09	
	7 - Client Contact			07/01/09	
	H0001		Alcohol and/or Drug Assessment	07/01/09	
431 - Adult mobile crisis services					
	7 - Client contact				
	S9484		Crisis assessment, intervention and stabilization, non-residential, ind. by professional	01-01-10	
	S9484 HM		Crisis assessment, intervention and stabilization, non-residential, ind. by rehab. worker	01-01-10	
	S9484 HN		Crisis assessment, intervention and stabilization, non-residential, ind. by practitioner	01-01-10	
	S9484 HQ		Crisis assessment, intervention and stabilization, non-residential, group	01-01-10	
	9 -Consultation				

Non-automated HCPCS/Modifiers for Time records - by Service and Activity						
Svc	Act	HCPCS / Modifiers	Description	Start Date	End Date	
		S9484	Crisis assessment, intervention and stabilization, non-residential, ind. by professional	01-01-10		
		S9484 HM	Crisis assessment, intervention and stabilization, non-residential, ind. by rehab. worker	01-01-10		
		S9484 HN	Crisis assessment, intervention and stabilization, non-residential, ind. by practitioner	01-01-10		
		S9484 HQ	Crisis assessment, intervention and stabilization, non-residential, group	01-01-10		
		10 -Coordination				
		S9484	Crisis assessment, intervention and stabilization, non-residential, ind. by professional	01-01-10		
		S9484 HM	Crisis assessment, intervention and stabilization, non-residential, ind. by rehab. worker	01-01-10		
		S9484 HN	Crisis assessment, intervention and stabilization, non-residential, ind. by practitioner	01-01-10		
		S9484 HQ	Crisis assessment, intervention and stabilization, non-residential, group	01-01-10		
		16 - Documentation				
		S9484	Crisis assessment, intervention and stabilization, non-residential, ind. by professional	01-01-10		
		S9484 HM	Crisis assessment, intervention and stabilization, non-residential, ind. by rehab. worker	01-01-10		
		S9484 HN	Crisis assessment, intervention and stabilization, non-residential, ind. by practitioner	01-01-10		
		S9484 HQ	Crisis assessment, intervention and stabilization, non-residential, group	01-01-10		

Non-automated HCPCS/Modifiers for Time records - by Service and Activity					
Svc	Act	HCPCS / Modifiers	Description	Start Date	End Date
438 - Assertive Community Treatment (ACT)					
			7 - Client contact		
		H0040	Assertive Community Treatment (ACT)	01-01-05	
			8 -Collateral contact		
		H0040	Assertive Community Treatment (ACT)	01-01-05	
			9 -Consultation		
		H0040	Assertive Community Treatment (ACT)	01-01-05	
			10 -Coordination		
		H0040	Assertive Community Treatment (ACT)	01-01-05	
			16 - Documentation		
		H0040	Assertive Community Treatment (ACT)	01-01-05	
			19 -Paraprofessional case management		
		H0040	Assertive Community Treatment (ACT)	01-01-05	
			29 -Service delivery		
		H0040	Assertive Community Treatment (ACT)	01-01-05	
			31 -Service planning		
		H0040	Assertive Community Treatment (ACT)	01-01-05	
			34 -Transportation		
		H0040	Assertive Community Treatment (ACT)	01-01-08	
			91308885 - Group time - .5 hours		
		H0040	Assertive Community Treatment (ACT)	01-01-08	
			91308887 - Group time - 1 hour		
		H0040	Assertive Community Treatment (ACT)	01-01-08	
			91308889 - Group time - 1.5 hours		
		H0040	Assertive Community Treatment (ACT)	01-01-08	
			91308891 - Group time - 2 hours		
		H0040	Assertive Community Treatment (ACT)	01-01-08	
			91308893 - Group time - 4 hours		
		H0040	Assertive Community Treatment (ACT)	01-01-08	
490 – Child Rule 79 case management				07/01/09	
			17 - Eligibility/Financial Fee Assessment	07/01/09	
		H0002	Behavioral Health Eligibility Screening	07/01/09	
491 – Adult Rule 79 case management				07/01/09	
			17 - Eligibility/Financial Fee Assessment	07/01/09	
		H0002	Behavioral Health Eligibility Screening	07/01/09	

Non-automated HCPCS/Modifiers for Time records - by Service and Activity					
Svc	Act	HCPCS / Modifiers	Description	Start Date	End Date
624 - Home-based support services					
			29 - Service delivery AC only		
		T1004	Home health aide/extended home health aide	07/01/09	
			30 - Service delivery - extended home health aide AC, EW, CAC, CADI, BI only		
		T1004	Home health aide/extended home health aide	07/01/09	
			48 - Service delivery - visit		
		T1021	Home health aide visit	11/01/04	
636 - Consumer Support Grant					
			9 - Consultation		
		T2025	Consumer Support Grant (CSG)	06-01-06	
		T2025 UD	Family Support Grant (FSG) with CSG	06-01-06	
			10 - Coordination		
		T2025	Consumer Support Grant (CSG)	06-01-06	
		T2025 UD	Family Support Grant (FSG) with CSG	06-01-06	
			16 - Documentation		
		T2025	Consumer Support Grant (CSG)	06-01-06	
		T2025 UD	Family Support Grant (FSG) with CSG	06-01-06	

Table 2-27: Non-automated HCPCS/Modifiers for Time records - by Service and Activity

2.1.12.4 Non-automated HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers

Following is a list of Services on Payments that are valid for non-automated HCPCS/Modifiers listed by HCPCS/Modifiers.

Note: Start and End Dates are defined as follows:

- HCPCS/Modifiers The date range that the HCPCS/Modifiers code is valid
- Service The date range that the Service with the HCPCS/Modifiers is valid

Non-automated HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
90882 - Community intervention, indiv.			01-01-02	
	446	Basic living/social skills and community intervention	01-01-06	
90882 HK - Community intervention, crisis response			01-01-10	
	431	Adult mobile crisis services	01-01-10	
90882 HM - Community intervention, indiv. by rehab worker			01-01-02	
	446	Basic living/social skills and community intervention	01-01-06	
90882 HM UD - Community intervention, indiv., transitional by rehab worker			01-01-02	
	446	Basic living/social skills and community intervention	01-01-06	
90882 UD - Community intervention, indiv., transitional			01-01-02	
	446	Basic living/social skills and community intervention	01-01-06	
E1399 - Durable medical equipment			11-01-04	05-31-13
	641	Env. accessibility adaptations, spec. supplies & equip.	11-01-04	05-31-13
E1399 NU- Durable medical equipment, new			06-01-13	
	141	Env. accessibility adaptations, spec. supplies & equip.	06-01-13	
	541	Env. accessibility adaptations, spec. supplies & equip.	06-01-13	
	641	Env. accessibility adaptations, spec. supplies & equip.	06-01-13	
E1399 RR- Durable medical equipment, rental			06-01-13	
	141	Env. accessibility adaptations, spec. supplies & equip.	06-01-13	
	541	Env. accessibility adaptations, spec. supplies & equip.	06-01-13	
	641	Env. accessibility adaptations, spec. supplies & equip.	06-01-13	
E1399 RB- Durable medical equipment, repair			06-01-13	

Non-automated HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
	141	Env. accessibility adaptations, spec. supplies & equip.	06-01-13	
	541	Env. accessibility adaptations, spec. supplies & equip.	06-01-13	
	641	Env. accessibility adaptations, spec. supplies & equip.	06-01-13	
G0154 - Direct skilled nursing services - LPN or RN - home			11/01/04	
	618	Health-related services	11/01/04	
H0018 - Crisis stabilization, residential			01-01-04	
	436	Adult residential crisis stabilization	01-01-04	
H0019 - Intensive Residential Rehab. Treatment (IRT)			07-01-04	
	474	Adult residential treatment	07-01-04	
H0035 - Partial hospitalization			01-01-04	
	469	Partial hospitalization	01-01-04	
H2017 - Psychosocial rehab., indiv.			01-01-04	
	446	Basic living/social skills and community intervention	01-01-06	
H2017 HM - Psychosocial rehab., indiv. by rehab worker			01-01-04	
	446	Basic living/social skills and community intervention	01-01-06	
H2017 HM HQ - Psychosocial rehab., group by rehab worker			01-01-04	
	446	Basic living/social skills and community intervention	01-01-06	
H2017 HM HQ UD - Psychosocial rehab., group, transitional by rehab worker			01-01-04	
	446	Basic living/social skills and community intervention	01-01-06	
H2017 HM UD - Psychosocial rehab., indiv., transitional by rehab worker			01-01-04	
	446	Basic living/social skills and community intervention	01-01-06	
H2017 HQ - Psychosocial rehab., group			01-01-04	
	446	Basic living/social skills and community intervention	01-01-06	
H2017 HQ UD - Psychosocial rehab., group, transitional			01-01-04	
	446	Basic living/social skills and community intervention	01-01-06	
H2017 UD - Psychosocial rehab., indiv., transitional			01-01-04	
	446	Basic living/social skills and community intervention	01-01-06	

Non-automated HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
S9128 UC - Extended speech therapy			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
S9129 TF UC - Extended occupational therapy assistant			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
S9129 UC - Extended occupational therapy			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
S9131 TF UC - Extended physical therapy assistant			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
S9131 UC - Extended physical therapy			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
S9484 - Crisis assessment, intervention and stabilization, non-residential, ind. by professional			01-01-04	
	431	Adult mobile crisis services	01-01-10	
S9484 HN - Crisis assessment, intervention and stabilization, non-residential, ind. by practitioner			01-01-10	
	431	Adult mobile crisis services	01-01-10	
S9484 HM - Crisis assessment, intervention and stabilization, non-residential, ind. by rehab. worker			01-01-04	
	431	Adult mobile crisis services	01-01-10	
S9484 HQ - Crisis assessment, intervention and stabilization, non-residential, group			01-01-04	
	431	Adult mobile crisis services	01-01-10	
H2019 HE UA - Therapeutic behavioral services, direction of MHBA			07-01-04	
	440	Direction of child mental health behavioral aides	01-01-08	
H2019 HM UA - Therapeutic behavioral services, Level II MHBA			07-01-04	
	439	Child mental health behavioral aide services	01-01-08	
H2019 UA - Therapeutic behavioral services - Level I MHBA			07-01-04	
	439	Child mental health behavioral aide services	01-01-08	
T1002 - RN, regular			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	

Non-automated HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
T1002 TG - RN, complex			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
T1002 TG UC - RN, complex, extended			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
T1002 TT - RN, regular 1:2			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
T1002 TT UC - RN, regular, extended 1:2			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
T1002 UC - RN, regular, extended 1:1			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
T1003 - LPN, regular			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
T1003 TG - LPN, complex			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
T1003 TG UC - LPN, complex, extended			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
T1003 TT - LPN, regular 1:2			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
T1003 TT UC - LPN, regular, extended 1:2			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
T1003 UC - LPN, regular, extended 1:1			11/01/04	
	118	Health-related services	11/01/04	
	618	Health-related services	11/01/04	
T1004 -Home health aide/extended home health aide			07/01/09	
	124	Home-based support services	07/01/09	
	624	Home-based support services	07/01/09	
T1021 - Home health aide visit			11/01/04	
	624	Home-based support services	11/01/04	

Non-automated HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers				
HCPCS / Modifiers	Service	Description	Start Date	End Date
T1030 - Home health skilled nurse			11/01/04	
	618	Health-related services	10/01/06	
T1030 GT - Home health telehomecare			11/01/04	
	618	Health-related services	11/01/04	
T2011 - PASRR Level II Screening			09/01/12	
	408	Adult Outpatient Diagnostic Assessment/Psychological Testing	09/01/12	
T2025 - Consumer Support Grant (CSG)			06-01-06	
	136	Consumer Support Grant	06-01-06	
	636	Consumer Support Grant	06-01-06	
T2025 UD - Family Support Grant (FSG) with CSG			06-01-06	
	136	Consumer Support Grant	06-01-06	
	636	Consumer Support Grant	06-01-06	
T2029 - Assistive technology/Supplies and equip., extended			10/01/06	
	141	Env. accessibility adaptations, spec. supplies & equip.	10/01/06	
	541	Env. accessibility adaptations, spec. supplies & equip.	10/01/06	
	641	Env. accessibility adaptations, spec. supplies & equip.	10/01/06	
X5632 - MH preadmission screening			01-01-99	
	408	Adult outpatient diagnostic assessment/psychological testing	01-01-00	
X5639 - PAS/ARR MH diag asses Masters			01-01-99	
	408	Adult outpatient diagnostic assessment/psychological testing	01-01-00	
X5640 - PAS/ARR MH diag asses PhD			01-01-99	
	408	Adult outpatient diagnostic assessment/psychological testing	01-01-00	

Table 2-28: Non-automated HCPCS/Modifiers Available on Payments – by HCPCS/Modifiers

2.1.12.5 Non-automated HCPCS/Modifiers Available on Payments – by Service

Following is a list of Services on Payments that are valid for non-automated HCPCS/Modifiers listed by Service.

Note: Start and End Dates are the date range that the Service with the HCPCS/Modifiers is valid

Non-automated HCPCS/Modifiers Available on Payments – by Service				
Service	HCPCS / Modifiers	Description	Start Date	End Date
118 - Health-related services				
	S9128 UC	Extended speech therapy	11/01/04	
	S9129 TF UC	Extended occupational therapy assistant	11/01/04	
	S9129 UC	Extended occupational therapy	11/01/04	
	S9131 TF UC	Extended physical therapy assistant	11/01/04	
	S9131 UC	Extended physical therapy	11/01/04	
	T1002	RN, regular	11/01/04	
	T1002 TG	RN, complex	11/01/04	
	T1002 TG UC	RN, complex, extended	11/01/04	
	T1002 TT	RN, regular 1:2	11/01/04	
	T1002 TT UC	RN, regular, extended 1:2	11/01/04	
	T1002 UC	RN, regular, extended 1:1	11/01/04	
	T1003	LPN, regular	11/01/04	
	T1003 TG	LPN, complex	11/01/04	
	T1003 TG UC	LPN, complex, extended	11/01/04	
	T1003 TT	LPN, regular 1:2	11/01/04	
	T1003 TT UC	LPN, regular, extended 1:2	11/01/04	
	T1003 UC	LPN, regular, extended 1:1	11/01/04	
124 - Home-based support services				
	T1004	Home health aide/extended home health aide	07/01/09	
136 - Consumer Support Grant				
	T2025	Consumer Support Grant (CSG)	06-01-06	
	T2025 UD	Family Support Grant (FSG) with CSG	06-01-06	
141 - Env. accessibility adaptations, spec. supplies & equip.				
	E1399 NU	Durable medical equipment, new	06-01-13	
	E1399 RR	Durable medical equipment, rental	06-01-13	
	E1399 RB	Durable medical equipment, repair	06-01-13	
	T2029	Assistive technology/Supplies and equip., extended	10-01-06	

Non-automated HCPCS/Modifiers Available on Payments – by Service				
Service	HCPCS / Modifiers	Description	Start Date	End Date
408 - Adult outpatient diagnostic assessment/psychological testing				
	T2011	PASRR Level II Screening	09-01-12	
	X5632	MH preadmission screening	01-01-00	
	X5639	PAS/ARR MH diag asses Masters	01-01-00	
	X5640	PAS/ARR MH diag asses PhD	01-01-00	
431 - Adult mobile crisis services			01-01-10	
	90882 HK	Community intervention, crisis response	01-01-10	
	S9484	Crisis assessment, intervention and stabilization, non-residential, ind. by professional	01-01-10	
	S9484 HN	Crisis assessment, intervention and stabilization, non-residential, ind. by practitioner	01-01-10	
	S9484 HM	Crisis assessment, intervention and stabilization, non-residential, ind. by rehab. worker	01-01-10	
	S9484 HQ	Crisis assessment, intervention and stabilization, non-residential, group	01-01-10	
436 - Adult residential crisis stabilization				
	H0018	Crisis stabilization, residential	01-01-04	
446 - Basic living/social skills and community intervention				
	90882	Community intervention, indiv.	01-01-06	
	90882 HM	Community intervention, indiv. by rehab worker	01-01-06	
	90882 HM UD	Community intervention, indiv., transitional by rehab worker	01-01-06	
	90882 UD	Community intervention, indiv., transitional	01-01-06	
	H2017	Psychosocial rehab., indiv.	01-01-06	
	H2017 HM	Psychosocial rehab., indiv. by rehab worker	01-01-06	
	H2017 HM HQ	Psychosocial rehab., group by rehab worker	01-01-06	
	H2017 HM HQ UD	Psychosocial rehab., group, transitional by rehab worker	01-01-06	
	H2017 HM UD	Psychosocial rehab., indiv., transitional by rehab worker	01-01-06	
	H2017 HQ	Psychosocial rehab., group	01-01-06	

Non-automated HCPCS/Modifiers Available on Payments – by Service				
Service	HCPCS / Modifiers	Description	Start Date	End Date
	H2017 HQ UD	Psychosocial rehab., group, transitional	01-01-06	
	H2017 UD	Psychosocial rehab., indiv., transitional	01-01-06	
469 - Partial hospitalization				
	H0035	Partial hospitalization	01-01-04	
474 - Adult residential treatment				
	H0019	Intensive Residential Rehab. Treatment (IRT)	07-01-04	
541 - Env. accessibility adaptations, spec. supplies & equip.				
	E1399 NU	Durable medical equipment, new	06-01-13	
	E1399 RR	Durable medical equipment, rental	06-01-13	
	E1399 RB	Durable medical equipment, repair	06-01-13	
	T2029	Assistive technology/Supplies and equip., extended	10/01/06	
618 - Health-related services				
	G0154	Direct skilled nursing services - LPN or RN - home	11/01/04	
	S9128 UC	Extended speech therapy	11/01/04	
	S9129 TF UC	Extended occupational therapy assistant	11/01/04	
	S9129 UC	Extended occupational therapy	11/01/04	
	S9131 TF UC	Extended physical therapy assistant	11/01/04	
	S9131 UC	Extended physical therapy	11/01/04	
	T1002	RN, regular	11/01/04	
	T1002 TG	RN, complex	11/01/04	
	T1002 TG UC	RN, complex, extended	11/01/04	
	T1002 TT	RN, regular 1:2	11/01/04	
	T1002 TT UC	RN, regular, extended 1:2	11/01/04	
	T1002 UC	RN, regular, extended 1:1	11/01/04	
	T1003	LPN, regular	11/01/04	
	T1003 TG	LPN, complex	11/01/04	
	T1003 TG UC	LPN, complex, extended	11/01/04	
	T1003 TT	LPN, regular 1:2	11/01/04	
	T1003 TT UC	LPN, regular, extended 1:2	11/01/04	
	T1003 UC	LPN, regular, extended 1:1	11/01/04	
	T1030	Home health skilled nurse	10/01/06	
	T1030 GT	Home health telehomecare	11/01/04	

Non-automated HCPCS/Modifiers Available on Payments – by Service				
Service	HCPCS / Modifiers	Description	Start Date	End Date
624 - Home-based support services				
	T1004	Home health aide-extended home health aide	07-01-09	
	T1021	Home health aide visit	11-01-04	
636 - Consumer Support Grant				
	T2025	Consumer Support Grant (CSG)	06-01-06	
	T2025 UD	Family Support Grant (FSG) with CSG	06-01-06	
641 - Env. accessibility adaptations, spec. supplies & equip.				
	E1399	Durable medical equipment	11-01-04	05-31-13
	E1399 NU	Durable medical equipment, new	06-01-13	
	E1399 RR	Durable medical equipment, rental	06-01-13	
	E1399 RB	Durable medical equipment, repair	06-01-13	
	T2029	Assistive technology-Supplies and equip., extended	10-01-06	

Table 2-29: Non-automated HCPCS/Modifiers Available on Payments – by Service

2.2 Use Cases

Figure 2-1 shows the use cases identified for Healthcare Claiming.

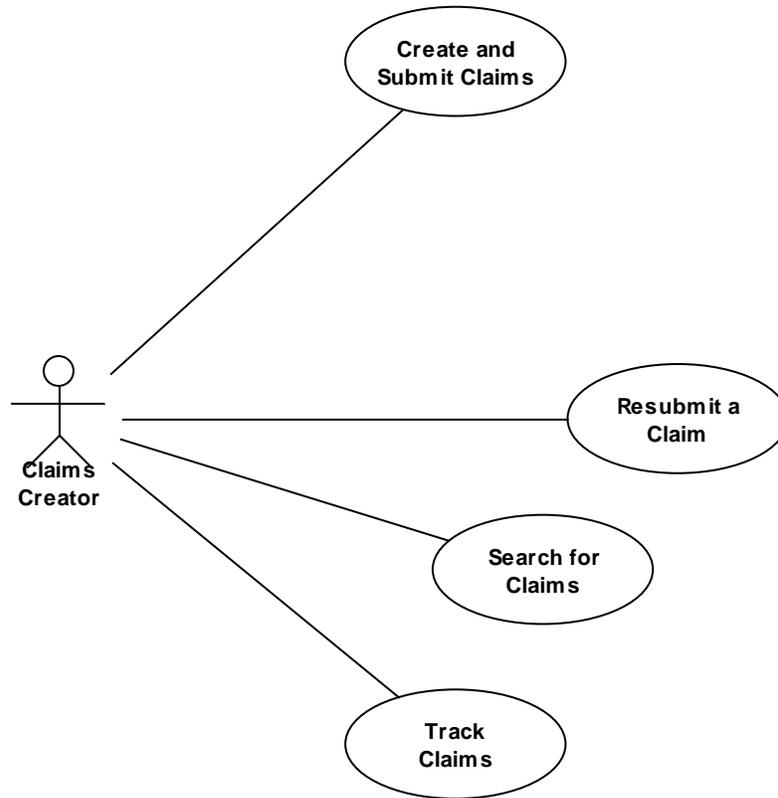


Figure 2-1 Healthcare Claiming Use Cases

2.2.1 Create and Submit Claims

Healthcare Claiming	
Use Case	Create and Submit Claims
Use Case #	1
Purpose	Create claims for one or more types of claimable services.
Description	<p>Precondition:</p> <p>Post-condition:</p> <ul style="list-style-type: none"> Applicable Time records and Payments have been updated with a link to the claim record. Claim records have been submitted to MMIS/MN-ITS.
Related Use Cases	
Actors & Type(primary/secondary)	
Claims Creator (Primary), SSIS Worker User (secondary)	
Actor Actions	System Response
1. Select Claiming Proofing and Error Reports.	1. Display claim categories selection screen.
2. Select one or more types of claim categories to include on the report.	2. Display list of available reports for selected claim categories and filtering and sorting options. Default date selection to include unclaimed items from the 12 calendar months prior to the claim date.
3. Enter filtering and sorting options.	3.
4. Run Report	4. Display reports based on selection criteria.
5. Correct errors based on report. (If correcting Time records or eligibility records, actor may be social worker or case aide. Corrections may be required in MMIS rather than SSIS.)	5.
6. If there are records that will not be changed and should not be displayed on future error reports: Select the Record and select 'Remove from report'.	6. Update record so that future reports do not display the same error.
7. Repeat steps 3 through 6 until errors are corrected	7.
8. Select Create and Submit Claims.	8. Create Claim Records for those records that meet the criteria and do not have errors using the same criteria used in the error reports. Update Time records and Payments with ID of the claim record. Create EDI transaction file and send to the county's MN-ITS mailbox.

Alternative Courses
5a. Select Print. System sends report to the printer.
5b. Export to a file rather than the printer.
Exception Conditions
Notes
6. Marking the record only removes it from the error report. If the record or criteria causing the error changes, and the record becomes claimable, system will include on the proofing report and create a claim for that record.
8. Actor may choose to submit the claims at a later time. If this is the case, the actor does not need to rerun the reports.

2.2.2 Resubmit a Claim

Healthcare Claiming	
Use Case	Resubmit a Claim
Use Case #	3
Purpose	Re-submit a claim that was totally denied after resolving the issues around the denial.
Description	Precondition: Claim has been denied. Post-condition: Applicable Time records and Payment records will be updated with a link to the claim record that is created. A new claim is created and submitted.
Related Use Cases	Search for Claims
Actors & Type(primary/secondary)	
Claims Creator (Primary), SSIS Worker User (secondary)	
Actor Actions	System Response
1. Select original denied claim to be resubmitted.	1. Display Claim information
2. Select Resubmit Claim – Proofing & Potential Errors Report	2. Poll Time records, eligibility, and Payments for new and changed information pertinent to the claim. (Includes records previously claimed as well as new records). Display report results.
3. Correct errors based on report. (If correcting Time records or eligibility records, actor may be social worker or case aide.)	3.
4. If there are records that will not be changed and should not be displayed on future error reports: Select the Record and select 'Remove from report'.	4. Update record so that future reports do not display the same error.
5. Repeat steps 2 through 5 until errors are corrected	5.
6. Select Create Claim Resubmission	6. Generate new claim record based on above data. Create EDI transaction file and send to the county's MN-ITS mailbox.
Alternative Courses	
1. Select multiple claims to be replaced.	
Exception Conditions	
Notes	
3. Claims that have been denied may require corrections not only to the claim, but to the eligibility information or MMIS	

2.2.3 Search for Claims

Healthcare Claiming	
Use Case	Search for Claims
Use Case #	4
Purpose	Search submitted claims for a particular claim or claims.
Description	Precondition: Post-condition:
Related Use Cases	
Actors & Type(primary/secondary)	
Claims Creator (Primary)	
Actor Actions	System Response
1. Select Claim Search.	1. Display search criteria screen.
2. Select parameters, filters, and sort order	2.
3. Select Start Search	3. Display Claim records based on search criteria.
4. Select a Claim record.	4. Display Claim detail record.
Alternative Courses	
2-3. Change parameters/options and rerun the search.	
Exception Conditions	
Notes	

2.2.4 Track Claims

Healthcare Claiming	
Use Case	Track Claims
Use Case #	5
Purpose	Monitor claims, reconcile Remittance Advice
Description	Precondition: Post-condition:
Related Use Cases	Search for Claims
Actors & Type(primary/secondary)	
Claims Creator (Primary)	
Actor Actions	System Response
1. Select parameters, filters and sort options.	1. Display Claims information based on selection
2. Select print report.	2. Send list to printer
Alternative Courses	
2-3. Change parameters/options and rerun the search.	
Exception Conditions	
Notes	
To be determined during the design process whether these are Tools – General Reports or detailed e-grids with sub-reports, etc., or a combination of these.	

2.3 File Input/Output

The Healthcare Claiming module exchanges files with MN-ITS. The SSIS/MMIS Data Interchange Specification describes these files. A summary of the files are listed below.

The claims generation process creates HIPAA compliant EDI claims transaction files. These files are submitted using secure FTP to transfer the files to the county's MN-ITS mailbox. The MN-ITS system then translates the claims and transfers them to the MMIS system for processing.

The MN-ITS system responds to claims transaction files with acknowledgement response files. The files identify the claims that were received and could be translated and sent on to MMIS. If MN-ITS cannot read a claim, that is indicated in the acknowledgement response.

MN-ITS sends the county's Remittance Advice to the county's MN-ITS mailbox using a HIPAA compliant transaction. Remittance Advice files are sent to the county every 2 weeks as part of the MMIS warrant cycle. The Remittance Advice indicates which claims have been paid as part of the warrant and the amount paid on each claim.

MMIS sends claims status files to the county's MN-ITS mailbox using an ASCII flat file. These files are not EDI transactions, but are accessed using secure FTP. The claim status file is created nightly for claims that have been processed since the last cycle. Depending on the frequency of the individual county's claiming cycle, this file will only have data a few days per month.

2.4 Reports

Each claim category requires proofing reports to identify possible errors in data before a claim is submitted. Once submitted, information about the claims must be available in a report format. Wherever possible, the Healthcare Claiming module uses grid style reports that can be customized by the user and viewed online or printed.

2.5 Security

A new security function, 'Create Health Care Claims', is required to limit the ability to create and submit healthcare claims.

The 'Manage Claims' security function is used to change the 'Batch Owner' on a Claim Batch.

SECTION THREE: NON-FUNCTIONAL REQUIREMENTS

3.0 Introduction

This section describes the non-functional requirements for Healthcare Claiming. Non-functional requirements refer to product requirements for aspects other than functionality, for example, adherence to standards.

Refer to the SSIS Fiscal System Specification for non-functional requirements that affect the entire application.

3.1 Performance

Proofing, claims submission, and generation of reports must be available on demand. Performance of these functions must be weighed against the impact to other workers, so as not to negatively affect other workers and still allow these functions to be completed during regular business hours.

3.2 Reliability

The Healthcare Claiming module must accurately generate claim records in the ANSI X.12 EDI format. This includes the assignment of HCPCS codes and modifiers to claim records for Time records. The system must also accurately link Time records and Payments to claim records.

The Healthcare Claiming module must provide the ability to recover and resend claim batches. In addition, the system must process all EDI acknowledgement transactions (transaction 999), and reconcile each submitted claim with the acknowledgement record.

Errors that occur transmitting and reconciling claims must be detected and logged. A mechanism to automatically report these errors to the SSIS Help Desk must be implemented.

3.3 Availability

The ability to run claim proofing reports to prepare for claims submission and to submit claims to the county's MN-ITS mailbox must be available during normal business hours.

Healthcare claims must be sent to the county's MN-ITS mailbox at the time the user requests the submission. Claim batches are processed by the MN-ITS as that system has available resources, giving preference to its interactive system. Immediate submission of a claim batch allows the county and SSIS support staff to respond to connectivity and transmission errors in a timely manner.

The inability to transmit claims for more than 1 day would significantly affect county workflow. Errors that occur during transmission must be detected and logged. A mechanism to automatically report these errors to the SSIS Help Desk must be implemented.

3.4 Reuse

Each claim category has its unique set of claiming requirements and business rules. However, there are many similarities between claim categories. In addition, each category uses similar proofing reports. A claiming and reporting engine that can be utilized by all claim categories and that provides a simple method of adding claim categories, and changing business rules is required. However, business rules for each type of claim can be unique and additional programming may be required to implement new claim category or new business rules

3.5 Industry Standards

The Healthcare Claiming module uses the following standards: secure FTP (File Transfer Protocol), ANSI X.12, and HIPAA compliant EDI transactions for Claims Submission (EDI transaction 837), and Remittance Advice (EDI transaction 835)

SECTION FOUR: EXCEPTION CONDITIONS AND ERROR HANDLING

4.0 Introduction

This section describes requirements for detecting, handling, and logging of exceptions and errors for Healthcare Claiming.

Refer to the SSIS Fiscal System Specification for details about exception handling that affect the entire application.

4.1 Data Exchange Incomplete/Incorrect Data

Error handling during the interchange of data between SSIS and the County's MN-ITS mailbox must log errors and provide a mechanism to notify county staff of the problem to take corrective action or to notify SSIS Fiscal Staff or Operations.

This will be documented in detail in the SSIS/MMIS Data Interchange Specification.

4.2 File Read/Write

Errors that occur translating or submitting EDI files or Claim Status ASCII files must be detected and logged. This will be documented in detail in the SSIS/MMIS Data Interchange Specification.

4.3 Network

Network errors, such as connectivity issues, must be logged. This will be documented in detail in the SSIS/MMIS Data Interchange Specification.

4.4 Data Exchange Errors

Data exchange errors and invalid data received must be detected and logged. This will be documented in detail in the SSIS/MMIS Data Interchange Specification.

4.5 Incorrect Data

Incorrect data on individual claims sent to MMIS is handled in MMIS by denial of the claim. Denied claim information is processed in the Claim Status file. Denial status and reason codes must be posted with claim. County staff must determine if data was incorrectly entered into SSIS and/or MMIS. If either is the case, county staff require the ability to resubmit a claim after correcting the information. This process is covered in Section 2.2.2, "Resubmit a Claim", on page 108.

SECTION FIVE: SUPPORTABILITY AND USABILITY

5.0 Introduction

This Section describes the supportability, usability, and installability requirements for the Healthcare Claiming module.

Refer to the SSIS Fiscal System Specification for supportability, usability, and installability requirements that affect the entire application. Additional requirements for the Healthcare Claiming module are listed below.

5.1 Installability

Updates to the claiming business rules must be possible without a new release of the application.

SECTION SIX: DEVELOPMENT AND OPERATING ENVIRONMENTS

6.0 Introduction

This section describes the development and operations environments, and executable software packaging for the Healthcare Claiming module.

See the System Specification for the SSIS Fiscal Application for detailed information about the development and operating environments.

SECTION SEVEN: SYSTEM INTERFACES

7.0 Introduction

This section describes the external and internal interfaces for Healthcare Claiming. Healthcare claims are submitted to MMIS as part of an EDI transactions containing one Claim Batch. MMIS processes the EDI transaction and sends a confirmation of receipt for each claim processed in the batch. MMIS processes the claims and sends a nightly Claim Status file to each county's MN-ITS mailbox. MMIS also sends a bi-weekly Remittance Advice in EDI format to the same mailbox. The receipt confirmation, claim status and remittance advice are processed by A SSIS DEX processes, which update the claim in SSIS with the information received from MMIS. See the "SSIS/MMIS Data Interchange Specification" for details on these interfaces.

RELATED DOCUMENTS

The following documents are related to this software specification:

- SSIS Fiscal System Specification
- MA & Waivered Program Eligibility Software Specification
- SSIS/MMIS Data Interchange Specification
- CW-TCM CLAIMING BUSINESS RULES
("M:\Everyone\SSIS Fiscal\Claiming\Claiming Rules\CW-TCM Rules.doc")
- LTCC CLAIMING BUSINESS RULES
("M:\Everyone\SSIS Fiscal\Claiming\Claiming Rules\LTCC Rules.doc")
- MH-TCM CLAIMING BUSINESS RULES
("M:\Everyone\SSIS Fiscal\Claiming\Claiming Rules\MH-TCM Rules.doc")
- MENTAL HEALTH RULE 5 CLAIMING BUSINESS RULES
("M:\Everyone\SSIS Fiscal\Claiming\Claiming Rules\MH R5 Rules.doc")
- RSC-TCM CLAIMING BUSINESS RULES
("M:\Everyone\SSIS Fiscal\Claiming\Claiming Rules\RSC rules.doc")
- VA/DD-TCM CLAIMING BUSINESS RULES
("M:\Everyone\SSIS Fiscal\Claiming\Claiming Rules\VADD rules.doc")
- WAIVER CLAIMING BUSINESS RULES
("M:\Everyone\SSIS Fiscal\Claiming\Claiming Rules\Waiver rules.doc")

GLOSSARY

Term	Definition
AC	Alternative Care. The program is for people aged 65 and over whose care needs would otherwise require the level of services provided by a nursing facility. Similar to Elderly Waiver, but with a different funding source.
ACCUMULATED CLAIM	Time records and Payments with the same client, same service, same date, and the same provider number are accumulated into one claim line.
ACTIVITY	Used in time reporting when a Sub-Program and BRASS Service are selected. The selection of a service activity more fully defines the services provided to the client.
Batch Owner	The Claims Creator currently assigned to the batch.
Billable Contact Date	The "Date" on the Time record that triggered the claim, which is one of the following: <ul style="list-style-type: none"> • The date of the earliest valid face-to-face contact for the month • Or the date of the earliest valid phone contact for the month if no face-to-face contacts exist for the month
Billable Diagnosis Code	An ICD-9 diagnosis code that MMIS will accept on a claim. MMIS maintains a table of valid diagnosis codes, which identifies the diagnoses that can be included on a claim. SSIS has a similar table and receives updates from MMIS as changes are made.
BI Waiver	<u>B</u> rain <u>I</u> njury Waiver (formerly Traumatic Brain Injury Waiver). The program is currently available under MA are for individuals who are under age 65 at the time of enrollment and who have a diagnosed disability and/or acquired brain injury who would otherwise need nursing facility or neurobehavioral hospital level of care.
BRASS SERVICE	See Service.
CAC WAIVER	<u>C</u> ommunity <u>A</u> lternative <u>C</u> are Waiver. Home and community-based services necessary as an alternative to institutionalization that promote the optimal health, independence, safety and integration of a person (under age 65) who is chronically ill or medically fragile and who would otherwise require the level of care provided in a hospital.
CADI WAIVER	<u>C</u> ommunity <u>A</u> lternatives for <u>D</u> isabled <u>I</u> ndividuals Waiver. Home and community-based services necessary as an alternative to institutionalization that promote optimal health, independence, safety and integration of a person (under age 65) who would otherwise require the level of care provided in a nursing facility.

Term	Definition
CBP	County Based Purchasing – refers to a group of counties who are operating as a managed care organization
CLAIM	Healthcare claim. The detailed itemization of services submitted for reimbursement through Medical Assistance (Medicaid; MA).
CLAIM BATCH	A SSIS Claim Batch contains a group of claims that the user proofs and submits to MMIS as a group. Each batch is for one claim category. A claim batch is identified by a Claim Batch # (unique ID number).
<i>Claim Category</i>	A claim program area that is part of the SSIS Healthcare Claiming module. Current Claim Categories are listed below: <ul style="list-style-type: none"> • CW-TCM • MH-TCM • LTCC • RSC-TCM • Rule 5 • VA/DD-TCM • Waiver and AC
<i>Claims Creator</i>	A user with the 'Create Health Care Claims' security function.
<i>Claiming Manager</i>	A user with the 'Manage Claims' security function.
CLAIM REBILL (aka Resubmit)	An original claim to MMIS II has been denied and it is necessary to create a new "original" claim for Payment. This claim has no identifiers that directly connect or relate it to the original claim.
CLIENT	Person receiving social services from the county.
CMS-1500 (HCFA-1500)	A standard Health Insurance Claim Form used to claim MA reimbursement through MMIS. Previously known as HCFA-1500.
CPT	Current Procedural Terminology code is a nationally standardized procedure code as determined by the Department of Health and Human Services (DHHS) implementing HIPAA standards. Also see HCPCS; Procedure Code.
CSIS	Community Services Information System. County social services computer system maintained by DHS and used by 77 Minnesota counties before implementation of SSIS.
CW-TCM	Child Welfare Targeted Case Management. Counties and individual county providers can receive Medical Assistance reimbursement (MA) for providing Child Welfare Targeted Case Management services to children who are receiving MA.
DD SCREENING	Developmental Disabilities screening document.

Term	Definition
DD WAIVER	Developmental Disabilities Waiver. This waiver program is currently available under MA for individuals who are under age 65 at the time of enrollment and who have a diagnosed disability of mental retardation or a related condition.
DIAGNOSIS CODE	Clinical diagnosis of a medical condition according to the International Classification of Diseases Code Manual 9th Edition (ICD-9-CM).
DISABILITY	Physical, mental or emotional characteristics which may require treatment and which may impair a person's functioning or may require special equipment or adaptations to permit full function and/or development.
DSM-IV	<u>D</u> iagnostic and <u>S</u> tatistical <u>M</u> anual of Mental Disorders, 4 th Edition. American Psychiatric Association's official manual of mental disorders. Manual contains a glossary of descriptions of the diagnosis categories.
DT&H	Day Training & Habilitation.
EDI	<u>E</u> lectronic <u>D</u> ata <u>I</u> nterchange. Electronic transfer of data. Specific formats are required by HIPAA for claim transactions.
EW	Elderly Waiver. The program is for people aged 65 and over, living in the community, whose care needs would otherwise require the level of services provided by a nursing facility.
Exclusion	An Exclusion is a record linked to a Time record or Payment that is used to exclude the record from the proofing and generate processes. Healthcare Claiming only considers Exclusions where the "Exclude From" (EXCL_MODULE_CD) is "Healthcare Claiming."
EXTRACTED MMIS II ELIGIBILITY INFORMATION	County client eligibility information extracted nightly from the Data Warehouse, which gets its data from MMIS. This includes Recipient Eligibility spans, Service Agreements, DD Screenings, and LTC Screenings. The recipient eligibility spans contain information about the major program, eligibility type, waiver type, living arrangement, PPHP & DT&H.
HCPCS	Healthcare Common Procedure Coding System. This is a 5-character code which identifies Medical Assistance (MA) reimbursable services. The 5-character code is made up of one alphabetic character followed by four numeric digits. Also see Procedure Code.

Term	Definition
HIPAA	Health Insurance Portability and Accountability Act of 1996. Law passed by congress in 1996 to improve the portability and continuity of health insurance coverage, enhance the quality and efficiency of health insurance by standardizing electronic data interchanges between healthcare organizations, protect the security, privacy and availability of individual health information and combat waste, fraud and abuse in health insurance and healthcare delivery.
ICD	International Classification of Diseases. A recognized manual of diagnoses of diseases. Also see Diagnosis Code.
ICF	Intermediate Care Facility. A facility certified by the State Department of Health to provide, on a regular basis, health-related services to individuals who do not require hospital or skilled nursing facility care, but whose mental or physical condition require services above the level of room and board.
ICD-9	The ninth edition of the International Classification of Diseases manual. Also shown as ICD-9-CM.
ICF/DD	Intermediate Care Facility for Persons with Developmental Disabilities. A facility certified by the State Department of Health to provide health and rehabilitative services for mentally retarded individuals or persons with related conditions who require active treatment.
IMD	Institution for Mental Disease. A hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. This definition includes chemical dependency treatment facilities with more than 16 beds.
LTC SCREENING	Long Term Care screening document.
LTCC	Long-Term Care Consultation Services (formerly Preadmission Screening) includes a variety of services designed to help people make decisions about long-term care.
MA ELIGIBILITY	Client eligibility for services provided through the Medical Assistance program.

Term	Definition
MA Funded Facility	<p>Some claim categories have edits that apply only when the client is in a MA Funded Facility.</p> <p>The following Living Arrangements are MA funded facilities</p> <ul style="list-style-type: none"> • 41 Nursing Facility I - Medicare certified • 42 Nursing Facility II - Non-Medicare certified • 43 ICF/DD - Public or private • 44 NF I - Short term stay <30 days • 45 NF II - Short term stay <30 days • 46 ICF/DD - Short term stay <30 days • 48 Medical hospital >30 days • 53 Private psychiatric inpatient hospital – IMD • 58 RTC - CD psychiatric inpatient hospital - IMD
MEDICAL ASSISTANCE	<p>Also know as MA or Medicaid. The Title XIX program that assists clients who receive healthcare services, based on client income and assets. Not to be confused with Medicare (Title XVIII) which is based on client age.</p>
MH-TCM	<p>Mental Health Targeted Case Management.</p>
MMIS	<p>Medicaid Management Information System. The DHS system that processes MA claims for reimbursement. Also known as MMIS II.</p>
MMIS PROVIDER NUMBER	<p>Service provider number assigned by MMIS. It identifies the county or other entity that provides healthcare services and submits reimbursement claims to MMIS. Sometimes called Pay-to Provider Number.</p>
MN-ITS	<p>The MMIS processing system that allows manual entry of MA reimbursement claims information and submission of that information to MMIS for claims processing. Counties can use MN-ITS to enter and submit claims that are not automatically created in SSIS.</p>
MODIFIER	<p>Certain HCPCS codes require one or more two-digit modifiers entered after the procedure code. These modifiers more fully describe the services performed so that accurate Payment can be determined.</p>
NPI	<p>National Provider Identifier - a ten digit number</p>
NPI / UMPI	<p>The provider's NPI or UMPI, whichever is assigned to them. Refer to: NPI; UMPI.</p>
PATIENT ACCOUNT NUMBER	<p>A county agency's reference number for a client. Previously used in claims to allow sorting of the MMIS Remittance Advice.</p> <p>In SSIS Fiscal this field is used to store the system assigned Claim ID in order to return claim status and Payment information back to the claim.</p>

Term	Definition
PAY-TO PROVIDER	The service provider who receives MA claim reimbursement from MMIS.
PAYMENT	Reimbursement from county social services to a vendor who has provided contracted services to clients.
PLACE OF SERVICE	An item in a reimbursement claim that indicates where the services were provided. Place of Service is derived from the SSIS Location in Time records and Payments.
PMI	Person Master Index. System assigned unique identifier assigned to a person within the MAXIS system. Within the MMIS system this is referred to as Recipient ID (RID).
PRIOR AUTHORIZATION NUMBER	Same as the service agreement number assigned by MMIS for a client. This number is the unique identifier for providing authorization for a service, prior to the service being delivered.
PROCEDURE CODE	Also called HCPCS code or CPT code. Five- character code that identifies services reimbursed by Medical Assistance (MA).
PROVIDER	Internal or external giver of a service.
REBILL CLAIM	See Claim Rebill. Also called Claim Resubmission.
RECIPIENT ID (RID)	The unique system assigned client identifier used by MMIS. Also known as PMI.
REMITTANCE ADVICE	A MMIS report that is sent to the county every 2 weeks as part of the MMIS warrant cycle. The Remittance Advice indicates which claims have been paid as part of the warrant and the amount paid on each claim.
RSC-TCM	Relocation Service Coordination – Targeted Case Management. An MA benefit designed to assist recipients with transition from institutions to the community.
RTC	Regional Treatment Center. State institution as defined in Minnesota Statutes, section 245.0312. A state operated institutional facility providing 24-hour a day care and treatment for persons diagnosed as mentally retarded, mentally ill, or chemically dependent.
RULE 5	Child Residential Treatment Facility. A residential treatment program for children with severe emotional disturbance.
RULE 36	Residential Facilities for Adult Persons with Mental Illness. Licensed facility for the treatment of mental health providing residential treatment and rehabilitation services to adults with mental illness on a 24-hour per day basis.
Screening Diagnosis Code	Indicates the diagnosis code for a claim comes from a DD Screening or a LTC Screening
SED	Serious Emotional Disturbance (Child).

Term	Definition
SERVICE	Refers to the BRASS Service. The classification structure for social services which relates to the functions of planning, budgeting, reporting and accounting for social services. Also known as Service Code. A BRASS Service Code is a 3 digit number assigned by the BRASS committee. The first position of the BRASS Service is always the BRASS Program Number.
Service Dates	Service Date on a Time record is the "Date" on the Time record. Service Dates on a Payment are the "Service Start Date" through the "Service End Date".
SPAN	<u>Inclusive</u> period of time used to reference a person's period of eligibility for certain MA programs. (Inclusive means that both the start date and the end date are considered eligible dates.)
SPMI	Serious and Persistent Mental Illness (Adult).
SSIS Diagnosis Code	Indicates the diagnoses for a claim come from values entered in SSIS
SUPPLEMENTAL ELIGIBILITY	Client eligibility information entered directly into SSIS and used in claims processing. This is eligibility information in addition to what is in MMIS.
TBI WAIVER	See BI Waiver
TCM	<u>T</u> argeted <u>C</u> ase <u>M</u> anagement. Billable case management services provided to a client to better meet their needs. The services are available within specific target populations.
TCN	Transaction Control Number (17 digits) assigned by MMIS to a claim. Also called Payer Claim Number.
TEFRA	<u>T</u> ax <u>E</u> quity and <u>F</u> iscal <u>R</u> esponsibility <u>A</u> ct of 1982. The TEFRA option provides MA eligibility to some disabled children who live with their families. Unlike the waived services described in this chapter, TEFRA does not provide any additional MA covered services. It provides for the waiver of parental deeming requirements. Excludes certain parental income and assets from being considered available for the child's treatment and care. TEFRA eligibility is a determining factor in claiming CW-TCM.
THIRD PARTY LIABILITY (TPL)	Payment resources available from both private and public health insurance and other liable third parties that can be applied toward a recipient's/enrollee's healthcare expenses. MMIS requires that a claim be submitted for reimbursement to this third party prior to submitting a claim to MMIS for MA reimbursement.
TIME RECORD	A record of county staff time for specific service and activity provided by a worker.

Term	Definition
UMPI	Unique Minnesota Provider Identifier - atypical provider number assigned by MMIS to counties in lieu of an NPI. A 10 character value starting with a letter, followed by 9 digits.
VA/DD-TCM	Vulnerable Adults/Developmental Disabilities-Targeted Case Management. Case management services provided to vulnerable adults and developmentally disabled persons to assist MA eligible persons gain access to needed medical, social, educational and other services.
VENDOR	Provider of service to which Payment will be made. Contracted provider of purchased services.
<i>Waiver/AC Recipient</i>	<p>Some claim categories exclude clients who are Waiver or AC recipients.</p> <p>The following conditions must be met for a client to be considered a Waiver Recipient:</p> <ol style="list-style-type: none"> 1. Client has a Waiver span 2. The <i>Service Dates</i> are within the Waiver Start Date (DI_ELIG_WAIVER.WAIVER_START_DT) and the Waiver End Date (DI_ELIG_WAIVER.WAIVER_THRU_DT). <p>AC clients are also excluded from these claim categories based on the list of valid Major Programs for those categories, which does not include AC.</p>
WAIVERED SERVICES	Services, equipment, and various other items not covered by regular MA that can be covered based on the person's disability or related condition, typically for the purpose of assisting the person to remain in a non-institutional setting. Waiver refers to waiving of MA rules to allow MA reimbursement for the services.
WAIVER TYPE	A MMIS data item that identifies the waiver service program for which a client is eligible. Waiver type is also broadly used to refer to any of the waiver eligibility programs. Waiver Types include: CAC, CADI, EW, DD, & BI.

End of Healthcare Claiming – Requirements Software Specification