



Rule 5 Healthcare Claiming in SSIS What You Need to Know

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Overview

- ▣ What is Rule 5 Claiming?
- ▣ Client eligibility requirements
- ▣ Information to enter in SSIS
- ▣ MMIS information needed

Overview

- SSIS Rule 5 healthcare claim batch generation and proofing
- When to submit Rule 5 claims
- Common Rule 5 denial reasons and resolution
- Rule 5 room and board and Child Foster Care Report

What is Rule 5 Claiming?

- Claiming of payments for clients meeting the Rule 5 criteria for Children's Residential Mental Health Treatment
 - Often referred to as:
 - Mental Health Rule 5
 - Rule 5

Client Eligibility Requirements

- Client must be Medical Assistance (MA) or MinnesotaCare (MNCare) eligible
- Client must be under age 21 as of the 1st of the month that you are claiming
- Client must meet MH Rule 5 level of care
- Client must be determined to have:
 - Severe Emotional Disturbance (SED) or
 - Serious and Persistent Mental Illness (SPMI)

Supplemental Healthcare Eligibility in SSIS – Rule 5

- Entered under client's Supplemental Healthcare Eligibility folder
- Confirms that client is eligible to receive MH Rule 5 services

Note: Selecting a workgroup on a Supplemental Healthcare Eligibility record assures that the Primary Worker displays on reports.



MH rule 5 screening date: *

MH rule 5 end date:

Client meets the needs for [MH Rule 5 level of care](#) and meets the legal criteria for [SPML](#) or [SED](#):
 Yes No *

Workgroup:

Diagnosis Codes in SSIS

Enter the mental health diagnosis code in client's Disability/Diagnosis/Substance folder

- A mental health diagnosis code is billable if:
 - ICD-9-CM codes with range
 - ≥ 290.0 and ≤ 302.9 or
 - ≥ 306.0 and ≤ 316.0
 - ICD-10-CM codes where Mental Health Indicator = "Y"

Note: SSIS assigns a "Y" Mental Health Billable Indicator to ICD-9 and ICD-10 codes that policy staff have designated as mental health diagnosis codes.

Diagnosis Codes in SSIS cont.

- A mental health diagnosis code is not billable if:
 - The effective end date in MMIS is before the Service Dates of the Healthcare Claim
 - A note that reads “The diagnosis code is not specific enough for claiming.” displays

Diagnosis Professionally Determined Disabilities Substance Involvement

Type: ICD-9-CM Code: 300.0 Diagnosis: ANXIETY STATES*

Diagnosis code effective dates: 01/01/1964 to 01/02/1964.

The diagnosis code is not specific enough for claiming.

Client's Diagnosis Information

Diagnosis Start Date: [] Diagnosis End Date: []

Primary Diagnosis: Yes No

Information from MMIS indicating Diagnosis code is not billable

Rule 5 Payment Information in SSIS

- ▣ Service start date and Service end date
- ▣ Client name
- ▣ Program: 420 – Children’s Mental Health
- ▣ Service: 483 – Children’s Residential Treatment
- ▣ HCPCS/modifier: H0019 – Children’s residential treatment
- ▣ Units
- ▣ Amount

Healthcare Eligibility from MMIS

Eligibility Spans folder

- ▣ Eligible Major Programs include:
 - EH – Federally Paid Emergency Medicaid
 - MA – Federally Paid Medical Assistance
 - MN – State Paid Medical Assistance
 - RM – Refugee

Living Arrangements folder

- ▣ “54 – Rehab option facility for children”
- ▣ National Provider Identifier Number (NPI) / Universal Minnesota Provider Identifier (UMPI) Number of Rule 5 facility

Rule 5 Healthcare Claim

Healthcare Claim				Time Records	Payments	Comments
Claim #:	Claim category:	Claim detail:	Generated date:			
210481856	Rule 5	From Payment Service dates.	06/15/2010 08:51:18 PM			
First service date:	Last service date:	Claim status:	Status date:			
08/01/2006	08/31/2006	Draft	06/15/2010 08:51:18 PM			
Bill type:	Original claim #:	Disposition:	Disposition date:			
Original claim	From Payment Units.	Open	06/15/2010 08:51:18 PM			
Units:	Amount:	From Payment Amount.	Billing county:			
30	\$10,681.50		Martin			
Allowed units:	Paid amount:	Client responsibility:				
Client name:	From Payment Client name.	SSIS person #:	PMI #:			
Car, Carla		111111111	22222222			
HCP/CS/modifiers:	From HCP/CS/modifier on Payment.					
H0019 - Children's residential treatment						
ICD-9 diagnosis:	From Billable MH Diagnosis entered in client's Disability/Diagnosis /Substance folder.					
316 - PSYCHIC FACTOR W OTH DIS						
Place of service:	From client's Living Arrangements folder.	Prior authorization number:	From client's Living Arrangements folder.			
Nursing facility						
Rule 5 facility name:		Rule 5 provider number:	Rule 5 NP/UMPI:			
GERARD OF MINNESOTA			A33333333			

Rule 5 Claims Generation

- Generate healthcare claim batch from Claim Batch Search
- Select Claim category - Rule 5
- Enter Batch start date and Batch end date

The screenshot shows a web-based form for generating a Rule 5 claim batch. The form is titled "Rule 5 (Draft) 07/01/2005 - 09/30/2005 Martin" and has two tabs: "Claims" and "Payment Proofing". The form contains several fields and a "Generate" button.

Claim category:	Included record types:	Claim batch #:
Rule 5	Payments only	212005619
Batch start date:	Batch end date:	Claiming county:
07/01/2005	09/30/2005	Martin
Owner: Alsdurf, Stacey		
Description: 		
Batch status:	Generated date:	Submitted date:
Draft	04/28/2015 09:58:02 AM	
Claims total:	# of claims:	
\$10,681.50	1	

Generate

Rule 5 Claim Proofing

Don't forget to run Payment Proofing!!!

Rule 5 (Draft) 09/01/2005 - 09/30/2005 Martin

Claims | **Payment Proofing**

Claim category: Rule 5
Included record types: Payments only
Claim batch #: 208811794

Batch start date: 09/01/2005
Batch end date: 09/30/2005
Claiming county: Martin

Owner: Alsdurf, Stacey

Description:

Batch status: Draft
Generated date: 04/09/2015 07:41:50 AM
Submitted date:

Claims total: \$10,681.50
of claims: 1

[Generate](#)



Rule 5 Claiming Common Proofing Errors

#2007 – “No HCPCS/Modifiers” for a Rule 5 claimable “Service”

- A HCPCS/Modifier is required to claim
- Create Adjustment Reversal and Correcting Entry Adjustment on the Payment to add HCPCS/modifier H0019, if applicable

The screenshot displays a software interface with two main sections. On the left, an 'Error Help' window is open, showing a 'Help Description' for message #2007: 'The "Service" is claimable and no "HCPCS/Modifiers" was selected on the Payment. (Message #2007)'. On the right, a form titled 'Programs and services' contains several dropdown menus. The 'Program' dropdown is set to '420 - Children's Mental Health', the 'Service' dropdown is set to '483 - Children's Residential Treatment', and the 'Location' dropdown is set to 'Residential treatment facility'. The 'County sub-service' and 'HCPCS/modifier' dropdowns are currently empty.

Rule 5 Claiming

Common Proofing Errors

#2007 – “No HCPCS/Modifiers” for a Rule 5 claimable “Service”

- The Payment has no HCPCS/modifier and Special cost code 17 – Rule 5 Room and Board is on the Payment

The screenshot displays a software interface with an 'Error Help' panel on the left and a main form on the right. The 'Error Help' panel contains a 'Help Description' section with a downward arrow icon, stating: 'The "Service" is claimable and no "HCPCS/Modifiers" was selected on the Payment. (Message #2007)'. The main form is divided into two sections: 'Programs and services' and 'Fiscal details'. Under 'Programs and services', there are five dropdown menus: 'Program' (420 - Children's Mental Health), 'Service' (483 - Children's Residential Treatment), 'County sub-service' (empty), 'HCPCS/modifier' (empty), and 'Location' (Residential treatment facility). Under 'Fiscal details', there is a 'Special cost code' dropdown menu set to '17 - Rule 5 Room and Board'.

Programs and services	
Program:	420 - Children's Mental Health
Service:	483 - Children's Residential Treatment
County sub-service:	
HCPCS/modifier:	
Location:	Residential treatment facility

Fiscal details	
Special cost code:	17 - Rule 5 Room and Board

Rule 5 Claiming Common Proofing Errors

Compare the Approved Per Diem on the Title IV-E Group Provider Search to the Rate on the Payment

- If the Rate on the Payment is less than the Approved Per Diem, the Payment is most likely for Rule 5 room and board for Title IV-E claims only
 - Example: The agency does not reimburse the facility when the facility bills the Managed Care Organization (MCO) directly
 - If Payment is determined to be a Rule 5 room and board Payment for IV-E claims only, create a Do Not Claim Determination record or Exclusion to stop Payment from displaying this proofing message in Healthcare Claiming

Rule 5 Claiming Common Proofing Errors

- If the Rate on the Payment is the same as the Approved Per Diem, the Payment is most likely for Rule 5 treatment and room and board for Rule 5 healthcare claims and Title IV-E claims
 - If Payment is determined to be Rule 5 treatment and room and board, create an Adjustment Reversal and Correcting Entry Adjustment on the Payment to add HCPCS/modifier H0019 to claim for both a Healthcare Claim and a Title IV-E claim

Rule 5 Claiming Common Proofing Errors

#2015 – No Rule 5 Supplemental Eligibility exists for the service dates

- ❑ Enter Rule 5 Supplemental Healthcare Eligibility if the client is eligible for Rule 5 services
- ❑ If the client is not eligible for Rule 5 services, create a Do Not Claim Determination record

Rule 5 Claiming Common Proofing Errors

#2013 – Living Arrangement is not valid for Rule 5

- The MMIS Living Arrangement must be “54 – Rehab option facility for children” to claim for Rule 5 in SSIS
- When the client is on MinnesotaCare, the Living Arrangement is “80 – Community.”
 - Submit Healthcare Claims through MN-ITS Direct Data Entry (DDE) or another method for clients on MinnesotaCare
 - Create Rule 5 Do Not Claim Determination records for clients on MinnesotaCare

Rule 5 Claim Exception Code 381

The description of exception code 381 is rate record not found

- If claims are submitted before the rates have been entered in MMIS, claims will deny with this code.
 - Submit Rule 5 Healthcare Claims after the Approved Per Diem for the service dates you are claiming display in SSIS in the Title IV-E Group Provider Search and display in MMIS
 - Rates are entered in MMIS after they display in the Title IV-E Group Provider Search

Rule 5 Claim Exception Codes 287 & 427

The descriptions of exception codes 287 and 427 points to a problem with the treating provider number in MMIS

- Rule 5 Healthcare Claims for the Woodland Hills facility require submission of a taxonomy code on the claim
 - Submission of taxonomy codes is not available in SSIS
 - Submit Healthcare Claims for Woodland Hills through MN-ITS DDE or another method
 - Create a Do Not Claim Determination record

Rule 5 Claim Exception Code 267

The description of exception code 267 is TPL resource available

- Client has other third party insurance that is primary to Medicaid
 - Submission of third party insurance information is not available in SSIS
 - Submit Healthcare Claims with third party insurance information through MN-ITS DDE or another method
 - Create a Do Not Claim Determination record

Rule 5 Claim Exception Code 301

The description of this exception code is treating provider/category of service conflict

- Rule 5 facility requires contract renewal with provider enrollment
 - Contact MHCP Call Center to verify that this is the reason for the denial
 - Contact Rule 5 facility to indicate they need to complete the contract renewal process
 - Create a Payment Exclusion

Rule 5 Payments in MMIS

Rule 5 Healthcare Claiming payments are reduced by the non-federal share amount with a provider level adjustment on the Remittance Advice

- The adjustment information that displays at the end of the Remittance Advice includes:
 - MMIS adjustment reason code 519 - Rule 5 Services Cutback
 - A TCN number that begins with a "4"
 - A dollar amount that sums all of the non-federal share cutback amounts for all of the Rule 5 claims on the Remittance Advice

Rule 5 and the Child Foster Care Report

Room and board payments are included as Title IV-E Claims on the Child Foster Care Report if the client is IV-E eligible and the IV-E Reimbursable indicator on the Payment is "Yes"

- ▣ Payments must include:
 - Service Code 483 – Children’s Residential Treatment
 - Special cost code 17 – Rule 5 Room and Board

Rule 5 and the Child Foster Care Report

- ▣ Rule 5 payments for IV-E eligible clients with HCPCS/modifier H0019 and no Special cost code create Title IV-E claims on the Child Foster Care Report
- ▣ Rule 5 payments for IV-E eligible clients with no HCPCS/modifier and Special cost code 17 create Title IV-E claims on the Child Foster Care Report for room and board only

Note: Payments for Rule 5 room and board use an adjusted Approved IV-E Maintenance % because the treatment portion of the cost is not included in the Payment.

☰ Rate Effective Date	Rate Expiration Date	Expiration Reason	Approved Per Diem	Approved IV-E Mtn %	Approved IV-E Intake / Plan %	Approved IV-E Trng %	Approved MA %
▶ 04/01/2015	12/31/2015		\$211.93	43.78%	1.35%	0.00%	50.88%

Claim Batch Submission Reminders

- Remember to check periodically for claim batches in Draft Batch Status
- Always regenerate Healthcare Claim batches before submission
- Submit Healthcare Claim batches within one year from the Service Dates
 - MMIS denies claims more than 1 year from the Service date of the claims

Questions?

