

Instructions for Completing and Entering the
LTC Screening Document
and
Service Agreement
Into MMIS

Developed by the Aging and Adult Services Division
in the Continuing Care Administration
Department of Human Services
January, 2004

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Minnesota Department of Human Services Continuing Care Administration		Introduction
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The information in this manual focuses on the Long Term Care (LTC) Screening Documents of the Long Term Care Consultation (LTCC) Services Program, and the service agreements used by the Community Alternative Care (CAC), Community Alternatives for Disability Individuals (CADI), Elderly Waiver (EW), Traumatic Brain Injury (TBI), and the Alternative Care (AC) programs. Other subsystems are referenced.

This manual was designed to provide technical assistance for certain portions of the Prior Authorization Subsystem of the Medicaid Management Information System (MMIS) highlighted below. This complete subsystem consists of the following programs:

- ✓ **preadmission screening and assessment screening documents**
- ✓ **service agreements for the home and community based services programs**
- ✓ screening documents for the developmental disability programs
- ✓ authorizations for the Medical Assistance home care program
- ✓ prior authorizations for Medical Supply, Medical, Dental and Pharmacy
- ✓ the Minnesota Pregnancy Assessment Form
- ✓ Child and Teen Check Ups Program
- ✓ MN Children with Special Health Needs
- ✓ Chemical Dependency Program
- ✓ Insurance Extension Program

You may obtain additional copies of this manual through the DHS website at http://www.dhs.state.mn.us/infocenter/LTC_Screening_Document.pdf

<p>Minnesota Department of Human Services Continuing Care Administration</p> <p>Medicaid Management Information System (MMIS) January, 2004</p>		<p>Staff Contacts Health Care Help Desks</p>
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STAFF CONTACTS

Aging and Adult Services Division (EW, AC, LTCC Programs)

- Assistant Commissioner (651) 297-4155
- Director (651) 296-1531
- Supervisor (651) 297-3829

Disability Services Division (CAC, CADI, TBI, MR/RC, and Home Care Programs)

- Assistant Commissioner (651) 297-4155
- Director (651) 582-1805
- Supervisors
 - Consumer Directed Community Supports (651) 582-1759
(651) 582-1908
 - Options Initiatives (651) 582-1906
 - Division Operations (Resource Center) (651) 582-1930

POLICY CONTACTS

- Elderly Waiver (EW) Program, State Program Administrator (656) 297-1656
- Alternative Care (AC) Program, State Program Administrator (651) 296-2213
- Long Term Care Consultation (LTCC) Services, State Program Administrator (651) 297-3805
- Minnesota Seniors Health Options (MSHO), Project Coordinator (651) 215-1828
- Minnesota Disability Health Options (MnDHO) Program Coordinator (651) 296-0825
- CADI and TBI Program Waiver Coordinator (651) 582-1910
- MR/RC Program Coordinator (651) 582-1683
- CAC Waiver Program Coordinator (651) 582-1948

SUPPORTS AND RESOURCES

Electronic Data Interchange (EDI) Information Center (651) 282-5545
For electronic submission of claims and other documents

DHS HEALTH CARE HELP DESKS

MAXIS Help Desk

System help for county financial workers (651) 296-7987

MinnesotaCare

For enrollees and county workers (651) 297-3862 or
1-800-657-3672

MMIS User Services Help Desk

System help for Recipient Subsystem changes and system support (651) 282-3744
for MinnesotaCare Enrollment Operations

MHCP Provider Call Center

There is one central phone number for the Provider Help Desk, ITS/EDI Unit and Provider Enrollment. The Call Center phone number is (651) 282-5545 in the Twin Cities metro and 1-800-366-5411 outside of the metro. Option #1 is for Provider Help Desk, Option #5 is for Provider Enrollment.

MA/GAMC questions from recipients (651) 296-7675

Waiver, AC, PCA, Home Care and DT&H providers (651) 282-5545
Provider assistance in completing claim forms, questions with billing procedures, and claim denials.

Medical Assistance Information Line

For recipients and others. This is a one person help line. (651) 296-8517
Callers should first be directed to the help desk numbers above.

Disability Services Division Resource Center

For staff working with the MMIS, screening documents and service agreements

(651) 296-4488 (phone) or
CSMD.Programs@state.mn.us
or 651 282-3787 (fax)

The Disability Services Division Resource Center staff will provide the following MMIS assistance:

- ✓ Research questions regarding service agreements and screening documents
- ✓ Provide technical assistance in resolving edits and error messages
- ✓ Adjust approved service agreements to change the line item status rate, provider number or procedure code, and header begin date
- ✓ Process screening document deletions

Phone calls are taken Monday - Friday from 9:00 - 12:00 noon and Tuesday, Wednesday, and Thursday from 1:00 - 3:00.

Screening documents are deleted twice a month. If requests for screening document deletions are received by the 5th of the month, the deletion will occur on the 15th of the month. If the request is received by the 20th of the month, the document will be deleted on the 1st of the following month.

<p>Minnesota Department of Human Services Continuing Care Administration</p> <p>Medicaid Management Information System (MMIS) January, 2004</p>		<p>Terms and Definitions</p>
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Alternative Care Program (AC). A state-funded program that pays for home and community-based services for people aged 65 and older who require the level of care a nursing facility provides, and who, if they enter a nursing facility, will be eligible for Medical Assistance within 180 days of admission.

Applicant. A person who has submitted an application to participate in one of the publically funded health care programs including the waiver or Alternative Care programs.

Assessment. The process of identifying a person’s strengths, preferences, functional skills, natural supports, and need for support and services.

CAC. Community Alternative Care is a Medical Assistance home and community-based services program that pays for health care and other services for an individual who requires the level of care of a hospital.

CADI. Community Alternatives for Disabled Individuals is a Medical Assistance program that funds home and community-based services for people under age 65 who require the level of care provided in a nursing facility, and who choose to reside in the community.

Care Plan. The services or community support plan developed by the consumer with assistance from the services coordinator or case manager that outlines how identified needs will be met and strengths supported. For persons participating in Minnesota’s home and community-based programs, the plan must include outcomes, and includes information about the frequency, nature, duration, and scope of services, the provider(s) of these services, costs, and documentation of consumer participation and choice-making.

Case Manager. A case manager (also referred to as a Services Coordinator) is a social worker, a registered nurse or public health nurse employed by or under contract with the local county agency to provide case management. Other agencies are permitted to provide case management in some programs.

Case Mix Classification. A classification of a person for purposes of establishing payment levels that relies on the ability to complete certain Activities of Daily Living (ADL), the need for behavioral interventions, and clinical or nursing care required. Developed as a payment system for nursing facilities; used for establishing individuals community budgets under various public programs.

Claims Adjudication. The final decision by the Department regarding service payment.

CMS. The Center for Medicare and Medicaid Services is the federal agency formerly known as HCFA (Health Care Finance Administration) that oversees these programs.

Commissioner. The Commissioner of the Minnesota Department of Human Services.

Community-Based Care. Health and social services and supports provided to an individual or family in a non-institutional setting for the purpose of delaying or preventing institutionalization by promoting, maintaining, or restoring health and independence, or minimizing the effects of illness and disability.

Consumer Support Grant (CSG). A direct grant to a qualified consumer to assist the consumer in purchasing the supports needed to live as independently and productively as possible in the community.

Conversion. For purposes of coding program type “conversion” is a person who was a resident of a long term care facility at the time of the initial referral for an assessment.

For purposes of payment, people who were residents of a facility for at least thirty days may qualify for case mix rates higher than those available for diversions or conversions with less than a thirty day stay. Under the Minnesota Senior Health Options (MSHO) project, a six month facility stay is required for purposes of capitated rate payment.

Coordination of Benefits. The planning and coordination of services when more than one funding source is responsible for purchasing services.

Data Validity. The initial automatic editing by MMIS of submitted data to check that data fields are of the proper type and in the proper format.

Department. Minnesota Department of Human Services (DHS).

Diversion. An assessment was completed for a person which resulted in the prevention or delay of nursing home admission. Typically, community supports and services are arranged, and often purchased through the Elderly Waiver or Alternative Care programs. A “diversion” is a person who is not a resident of a long term care facility at the time of the initial referral for an assessment. A person will remain diversion until they are exited from the waiver or AC program.

DRG. Diagnosis-Relation Group is a classification of procedures used to sort hospital patients by discharge diagnosis into categories that are medically similar and have approximately equivalent lengths of stay. DRGs are utilized by MA, GAMC and CAC.

Durable Medical Equipment. Durable medical equipment is a device that can withstand repeated use, is provided to correct or accommodate a physiological disorder or physical condition, and is suitable for use in the person’s residence. If purchased through the Medical Assistance, Elderly Waiver or the Alternative Care programs, the equipment belongs to the person.

Elderly Waiver Program (EW). A Medical Assistance program that funds home and community-based services for people 65 and older who require the level of care provided in a nursing facility, and who choose to reside in the community.

Exceptions. Errors posting against a screening document or service agreement during editing in MMIS.

Excluded Time. Excluded time is the period of time a person spends in a hospital, sanitarium, nursing facility, shelter (other than an emergency shelter), boarding care facilities, halfway house, foster home, semi-independent living domicile or services program, regional treatment center, a facility stay based on an emergency hold, a placement in a training and habilitation program (including a rehabilitation facility or work or employment program), a day training and habilitation program, assisted living services, placement under an indeterminate commitment including independent living, supervised board and lodging facility or other institution for the hospitalization or care of human beings, in a maternity home, battered woman’s shelter, foster care, certified board and care, or correctional facility. These periods affect determination of county of financial responsibility.

Excluded Time Service. Excluded time service is the time the person participates in a rehabilitation facility which meets the definition of a long-term sheltered workshop or is receiving personal care services or is receiving services from a semi-independent living services (SILS) program.

Extended Services. Services covered under EW and other waiver programs that exceed the scope, amount, frequency, and duration of a comparable regular (state plan) Medical Assistance service, e.g. “extended personal care”, or “extended supplies and equipment”.

Fiscal Year. A period of time established for budgetary and accounting purposes. The state fiscal year is July 1st to June 30. The federal fiscal year is October 1st to September 30.

Formal Caregivers. Formal caregivers are persons or entities providing services who are employed by or under contract with a county agency or other agency or organization, public or private. Formal caregiver does not include the case manager.

HCFA. Health Care Finance Administration, renamed the Center for Medicare and Medicaid Services (CMS), is the federal agency that oversees the Medicare and Medicaid Programs.

HCPC. HCFA Common Procedure Coding System. A four digit number preceded by a zero that identifies the service to MMIS.

Home Care Provider. An individual, organization, association, corporation, unit of government or other entity that is regularly engaged in the delivery, indirectly or by contractual agreement, of home care services for a fee. At least one home care service must be provided directly, although additional home care services may be provided by contractual agreement.

Home Health Agency. A public or private agency or organization, or part of an agency or organization that holds a Class A home care license from the Minnesota Department of Health (MDH). In order to receive Elderly Waiver and Alternative Care funding, it must also be Medicare certified.

Hospice. A program which provides palliative and supportive care for terminally ill patients and their families either directly or on a consulting basis with the patient’s physician or other community agencies.

Hospital. An institution primarily engaged in providing, by or under the supervision of a physician, the diagnostic and therapeutic services for the medical diagnosis, treatment, and care of injured, disabled or sick inpatients. Hospitals may be classified by length of stay, as teaching or non-teaching, by major type of service (psychiatric, tuberculosis, general, etc.) or by type of ownership or control (federal, state, local government, for-profit or nonprofit).

Informal Caregivers. Informal or primary caregivers are family, friends, neighbors and others who provide services and assistance to persons without reimbursement for the services.

Information Transfer System (ITS). A PC computer-based system that allows forms such as screening documents, service agreements, prior authorizations, and claim forms to be “batched entered”. Documents are submitted to DHS via telephone or by diskette for data editing and further processing in MMIS.

Informed Choice. The decision a person participating in a home and community-based program makes about services, including the decision to receive services either in a community or facility setting, after receiving information about all available options and the right to choose from among these options,

including choices between services and providers.

Instrumental Activities for Daily Living (IADL). Activities necessary for independent functioning including shopping, cooking, doing housework, managing money, and using the telephone. Measurement of the functional capacity to perform these activities is frequently used to determine aspects of cognitive and social functioning.

Level of Care Determination. One outcome of assessment. The professional decision regarding a person's need for the level of care a facility provides. Facility level of care can be an acute or psychiatric hospital, a certified nursing (including a certified boarding care) facility, or an intermediate care facility for persons with mental retardation (ICF/MR). Long Term Care Consultants make determinations about the need for the level of care a nursing facility provides based on criteria provided by the Department and professional judgement. Determinations of other levels of care require the involvement of other qualified professionals.

Licensed Practical Nurse (LPN). A person licensed under and providing health services within the scope of Minnesota Statutes, section 148.211.

Long Term Care Consultation Services (LTCC) formally known as the Preadmission Screening and Community Assessment Program (PAS). LTCC provides assistance to people with long term or chronic care needs. Assessment and services planning are mandated in state statutes to be provided to all citizens. The process of screening and assessment of an individual applying for nursing home admission or home and community-based services is part of eligibility determination for publically funded long-term care. LTCC services includes preadmission screening as mandated by state and federal statute.

MA. Medical Assistance (also known as Medicaid or Title XIX of the Social Security Act).

MAXIS. The online computer system which records the data that determines a person's financial eligibility for various public programs.

Medicaid. The national program which funds health care services to low-income individuals authorized under Title XIX of the Social Security Act.

Medicaid Management Information System (MMIS). A complex, highly integrated claims payment, information management, and retrieval system implemented in June, 1994.

Medical Assistance (MA). Minnesota's state plan program which funds health care services under the provisions of Title XIX of the Social Security Act and Minnesota Statutes, Chapter 256B.

Medically Necessary. A term used to define criteria for approval of certain services or items. These criteria are listed in the MN Rule part 9505.0175 (Rule 47).

Medicare. The national program which funds health care services authorized under Title XVIII of the Social Security Act for certain Social Security beneficiaries (aged, disabled, certain dependents).

Minnesota Disability Health Options (MnDHO). Is a health care program offered to MA (including MA-EPD) eligible adults aged 18 through 64 with a physical disability. Currently this program is offered in Anoka, Dakota, Hennepin and Ramsey Counties. MnDHO provides the same benefit set (acute care, nursing home, home and community-based services, etc.) as regular MA as well a flexible alternative

services beyond the scope of MA and waiver services. Health coordination is provided by a disability specialist provider in a person centered service delivery model.

Minnesota Health Care Programs (MHCP). The collective term for Minnesota’s various health care programs: Senior Drug, Minnesota Senior Health Options, Medical Assistance, Prepaid Medical Assistance Program, General Assistance Medical Care, MnCare, and for purposes of this manual, the Alternative Care program.

Minnesota Health Care Programs Provider Manual. Sometimes referred to as the MA manual. Used by providers for claims and billing information. See Chapter 10 for more information on the contents of this manual.

Minnesota Senior Health Options (MSHO). A DHS program which combines Medicare and Medicaid financing and acute and long term care service delivery systems for persons over age 65 who are dually eligible for both Medicare and Medicaid. Formerly known as the Long Term Care Options Project.

Nursing Facility Resident. A person who has been admitted to a nursing facility.

OBRA Level I. The term used to describe one of the activities included in preadmission screening and required under state and federal law to occur prior to any admission to certified nursing or boarding care facility. See Chapter 2 of this manual for exceptions. A Long Term Care Consultant uses a series of questions to “screen” individuals for the presence or possible presence of mental illness or mental retardation, and makes referrals to other qualified professionals on the basis of the result of this screening. This screening and necessary referrals are also required as part of LTCC community assessments.

OBRA Level II. The activities carried out by other qualified mental health or developmental disabilities professionals at referral under OBRA Level I. These professionals further evaluate and make determinations about mental illness or mental retardation, including recommendations for specialized services and psychiatric or ICF/MR level of care.

Online. Using a personal computer to connect directly with MMIS to view or change data processed by MMIS.

PA. Prior Authorization. The method of authorizing Medical Assistance, extended waivers and Alternative Care funding of certain restricted health care services. This approval must be obtained in order to receive payment for services rendered or items purchased.

Person Master Index (PMI) Number. The number permanently assigned to an individual for identification in MMIS. Also may be called “Recipient ID” or “Client ID”.

Preadmission Screening. A federally mandated process for all persons entering a certified nursing or boarding care facility to screen for mental illness or mental retardation and determine the need for nursing facility level of care. See Chapter 2 of this manual for exceptions.

Primary Caregiver. The person designated by the individual as having the main role in providing informal care. A primary caregiver may be a family member, relative, friend, neighbor or other person who agrees to provide routine care and assistance to the individual without reimbursement for the services and who, with the case manager and other providers, assists in assuring that services specified in the individual’s care plan are provided.

Public Health Nurse. A nurse who is qualified as a public health nurse under the Minnesota Nurse Practice Act.

Quality Assurance and Review (QA&R) Number. The unique number contained on a form provided by the Department of Health and assigned by the county preadmission screener to a person at initial admission to a nursing facility.

Reassessment. The face-to-face reevaluation of an Elderly Waiver or Alternative Care client's eligibility for these programs, including a reassessment of health status and need for services. It must be completed at least once a year or whenever the person's health or needs change significantly.

Recipient. A person determined to be eligible for Medical Assistance or other Minnesota Health Care Program.

Registered Nurse (RN). A person licensed under Minnesota Statutes, section 148.211.

Relocation Services Coordination (RSC). A "state plan" service available to MA recipients of all ages for up 180 days to carry out activities such as planning for, locating, and arranging services and supports needed to permit a person to return to community settings after institutional admission.

Representative. A person appointed by the court as a guardian or conservator or a person designated to have power of attorney or a durable power of attorney, or a person authorized by the person under Minnesota rules part 9505.0015, subpart 8.

Residence. The person's established place of abode.

(LTC) Screening Document. The document that records in MMIS the outcome of a screening and assessment, or case management activity carried out under the Elderly Waiver or Alternative Care programs. This document is also used by other programs not described in this manual.

Service Agreement. The document that is entered on-line into MMIS which identifies services, providers, and payment information for a person receiving home care, waiver or AC services. The on-line service agreement allows providers to bill for approved services and allows DHS to audit usage and payment data.

Social Worker (SW). An individual who meets the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota and who is employed as a social worker by a county.

State Plan. The document which defines Medical Assistance services provided by the State of Minnesota under Title XIX of the Social Security Act for which the state receives federal financial participation (FFP). These services represent the "benefit set" for all persons with Medical Assistance.

Transaction Control Number (TCN). The unique 17-digit number assigned to each claim for identification purposes.

Visit. For purposes of MA home care, a visit is a unit of service.

Waiver Plan. The plan to offer waived services submitted by the state to, and approved by, the Center for Medicare/Medicaid Services (formerly known as HCFA) which allows the state to receive federal

financial participation for home and community-based services authorized under the Code of Federal Regulations, title 42, part 441, subpart G.

Waivered Services. Services defined and funded by the waiver programs such as respite, assisted living, or companion services, and extended MA home care services provided under the waiver service plan. Other waiver programs not described in this manual may differ in services that are covered in their respective plans. These services are available only to persons determined to be eligible for a waiver program.

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101.01 INTRODUCTION TO MMIS

MMIS means "Medicaid Management Information System". It is a complex, highly integrated claims payment, information management, and retrieval system implemented in June, 1994. Overall the system is designed to:

- ◆ process Minnesota's health care claims;
- ◆ control health care expenditures;
- ◆ detect and reduce fraud and abuse; and
- ◆ provide information that identifies trends for policy and administrative decisions.

This system allows claims to be received by paper or through an electronic claim transfer system called MN-ITS. Providers verify which programs a person is eligible for by using the Eligibility Verification Service (EVS) prior to billing. All coding systems and claim forms are recognized nationwide. Program policy and data editing occurs at an early stage to help ensure that claims are paid appropriately.

MMIS is made up of several subsystems. Each part performs its own functions but relies on information that is collected and maintained in the others. These subsystems are:

Recipient

Financial eligibility for public programs is determined through MAXIS and recorded here. Recipients screened through the Long Term Care Consultation (LTCC) Program are included in this subsystem. MinnesotaCare eligibility determination and financial obligation is included. Spenddown options and amounts are recorded.

Reference

Service rates, DRG amounts, procedure codes (HCPC), diagnosis codes, edit statuses control, and case mix limits are stored here and used for pricing.

SURS Summary Profile, SURS Treatment Analysis, SURS Claim Detail

Primary purpose is the development of exception reports regarding provider and recipient data which compare claims to determine if there are areas that need further review.

Claims Processing

Processing and payment or denial of all claims for services provided through public programs are completed here. All other subsystems support claims processing.

Quality Control

This subsystem can only be accessed by Department of Human Services' (DHS) staff. It was initially designed to meet the federal requirement to review a sample of all claims paid to determine under- or over-payments. This federal requirement was mandatory for a period of one year as a condition of system certification. Currently, this subsystem runs a monthly sample of claims to review for provider billing and/or claims examiner pricing errors. Generally, it provides an audit of MMIS.

Security Administration

This is the functional portion of the system which determines what access rights a user has to view or update records in MMIS. Only DHS/MMIS security administrators are allowed update access to this information. This function is comprised of two files: 1) User File: all users of MMIS must have a record in this file. Each user record contains a security group code as well as other information; and 2) Group File: this file contains the detailed access right information for each security group defined within MMIS.

Provider

Enrollment information is collected and processed for all providers enrolled in Minnesota who provide services to persons participating in public programs. Case manager information is identified here. It also supports the processing of claims with the correct provider data and allows reporting of provider activity.

MARS

Contains the reports required by the federal government. Only DHS staff have access to this subsystem.

Prior Authorization

The purpose of this subsystem is the processing and identification of those services which need to be authorized by case managers or DHS staff prior to payment to a provider. Programs that use prior authorization are: MA Home Care, Waivers (CAC, CADI, EW, TBIW, MR/RC), Alternative Care, MA Prior Authorization (Dental, Medical, Pharmacy, Supply), Child and Teen Check-Up, Children with Special Health Needs (MSSHN), Day Training and Habitation (DT&H) Non-waiver Pilot Program, and Insurance Extension programs.

Financial Control

The Financial Control subsystem gives staff the ability to create and update “obligations”, post receipt entries, post reimbursement requests and track financial obligation activity. Obligations include both payment and collection liabilities of DHS, the county, and individuals. Obligations can be created and changed by county workers or by DHS Central Office staff. This subsystem has interfaces with the MMIS Third Party Liability (TPL) Resource file, Recipient File, Provider File, Claims Processing File, Medical Assistance Reporting System (MARS), and a daily Recipient File.

Third Party Liability (TPL)

This subsystem has two selections: TPL Billing Application and TPL Resource File Application. The TPL Billing Application is used by Benefit Recovery to collect recovery payments on paid claims with possible third party liability. It is also used to maintain insurance carrier information for billing and reporting to providers.

The TPL Resource File Application is used to “cost avoid” and/or “pay and close” medical claims submitted by providers. It is also used to record third party liability information for Minnesota Health Care program participants. County financial workers can add or update the information.

Drug Rebate

This subsystem conducts a monthly download of utilization data for drugs reimbursed by Medicaid and the Senior Drug Program. MMIS also creates quarterly drug rebate invoices by combining the

utilization data with unit rebate amounts furnished by HCFA. These invoices are mailed to manufacturers by DHS Drug Rebate staff. Tracking of payments and resolution of disputes is not one of its functions.

Managed Care

This subsystem supports the processing of capitated claims submitted by the managed care health plans. Provider, contract, and rate information is identified here.

Recipient Miscellaneous Functions

How to Calculate MinnesotaCare Premiums

Request Managed Care Enrollment Forms

Generate a MAID Card

Request a Medical Service Questionnaire

101.02 MMIS INTERFACING WITH MAXIS

MMIS depends on MAXIS for recipient eligibility determination functions and maintenance of all recipient information. This interface is completed through the Recipient Subsystem. Some information entered into MAXIS by the financial worker is transferred to MMIS, while other information must be entered into both systems.

The Recipient Subsystem collects the information from MAXIS and controls recipient demographic or health care program eligibility determination for state supervised, county administrated programs.

Information Entered, Maintained, and Provided by MAXIS

- ◆ Data pertaining to a recipient's eligibility for Medical Assistance and other major programs such as GAMC, QMB, SLMB, etc. This assists counties in determining recipients' eligibility for these programs.
- ◆ Recipient records identifying the financial criteria used to determine eligibility.
- ◆ Assignment of the case number for MA households.
- ◆ Assignment of the recipient's ID number (also called Client ID number or PMI) to each recipient screened or applying for any program. It is a unique eight digit lifetime number that identifies the recipient in the system. (This number replaces the MAID, pseudo, private pay and MA using 180-day funds ID numbers used in MMIS-I. This ID number does not change when the person changes programs, loses eligibility, or moves to another county).

Data produced in MAXIS can only be changed in MAXIS. If a worker using MMIS notices incorrect information that was provided by MAXIS, the information must be corrected in MAXIS by the financial worker. The change is then transferred to MMIS.

The assignment of an ID number is also completed through the PMIN Function when there isn't a financial worker involved in the person's "case". Examples are those people screened through the preadmission screening program and not receiving services through a public program, or those people receiving services through the Alternative Care program who are not eligible for services through any other type of public program. (These people are "not known to MAXIS"). If an ID number is obtained through the PMIN Function, then any changes to the birth date, name, and marital status can be changed in MAXIS using the PMIN Function without the assistance of a financial worker. The information is automatically transferred to MMIS.

Each quarter, a file reconciliation process is performed between the MAXIS and MMIS files. Data concerning the recipient's current status, major program, basis of eligibility and other information on the MAXIS system is compared against the same information on MMIS files. All discrepancies are reported to the financial workers for correction in either system.

101.03 HOW TO USE MMIS TO VIEW DATA

ACCESS AND SECURITY FEATURES

County staff who need to either view, add or change information in MMIS are assigned to a security group as determined by their supervisor and the security officer in each county. Each security group controls which subsystem(s) may be entered and what type of action can be accomplished (inquiry, add, change, or delete data). If you are not able to access a specific subsystem or complete changes as needed, contact your supervisor and security officer to be moved to a different security group.

Each person will be assigned a logon ID number. For county staff, the number begins with "X1____". Positions 3 and 4 identify the county that the person is from. DHS staffs' ID number will start with "PW_____".

Security features include:

- ◆ the Main Menu screen restricts which subsystem(s) can be accessed.
- ◆ the Keypanel Screen restricts the type of action that can be completed
- ◆ the security group determines if specific screens will be blocked from your view and/or specific information blocked on those screens that you can view.

Follow these instructions to enter into MMIS:

1. At the State of Minnesota Screen type in either MNCICS1 or MDHS.
2. Press the transmit key. The "transmit" key is the Control key on the right side of the keyboard or the Enter key on the number pad. (Some keyboards are different and use the Enter key with the crooked arrow as the transmit key).
3. If you used MDHS, a screen appears to enter your logon ID and password. At this point, using any of the methods above, you are now on the Security Screen:

```
SYSTEM: A00DVG WELCOME TO CICS/ESA
          TO EXIT, CLEAR SCREEN AND ENTER "LOGOFF"
TERMINAL: A121
NODE: NMMAA121
DAY: TUESDAY
SYSTEM DATE: JANUARY 05, 1999
SYSTEM TIME: 02:17 PM

LOGONID: ====>
PASSWORD: ====>

NEW PASSWORD: ====>
(enter twice) ====>
ACFAE131 ACF2/CICS A121 Signoff has been completed
```

4. On the security screen, type in your logon ID number (starts with X1____) in the LOGONID field. Use the Tab key to move to the PASSWORD field and type your password.

Press the transmit key to move to the Main Menu Screen.

NOTE: Your password is valid for 30 days. When it has expired, you will receive a message to change it. To change it, type in the current password as normal, then tab to the NEW PASSWORD field and type in a new password using four to eight characters/numbers. Tab again to type it on the ENTER TWICE field. Press the transmit key. The password can be changed everyday if you wish. You should not share your logon ID number and password (such as when you go on an extended absence). The screening documents and service agreements record the logon ID number of the last person who made a change to the document.

If you type the password incorrectly three times in a row, your logon ID number will be suspended. You must then contact your county security officer and ask that it be “unsuspended”. To avoid suspending your logon ID number after typing in the password incorrectly twice, exit out of MMIS and then re-enter.

5. After the Security Screen, you are brought to this screen:

ACF01137 PWLMG30 LAST SYSTEM ACCESS 13.45-01/05/99 FROM A121 ACFAE139 ACF2/CICS A121 Signon OK: User=PW_____ NAME= DHS Staff

At the top of the screen type in “MW00”. Be sure you use the number zero and not the letter O. If you make an error, a message will appear at the bottom of the screen indicating that it does not recognize the command. NOTE: the cursor also moves one space to the left. Use your tab key to move the cursor over one space. Type in MW00 again. If successful, you are brought to the Main Menu screen.

6. The Main Menu screen shows you the subsystems you are able to access. Select a subsystem by moving the cursor using either the Tab or Enter (with the crooked arrow) keys so that the cursor is on the same line as the name of the subsystem. Type an “x” there. Use the Transmit Key. You are now on the first screen of the subsystem. This screen is called a Keypanel. Each one looks different for each subsystem but have the same purpose.

03/12/98 12:52:50

MMIS MAIN MENU - MAIN

PWMW000

*** MEDICAID MANAGEMENT INFORMATION SYSTEM ***

SEL	SEL
CLAIMS PROCESSING APPLICATION:	OTHER APPLICATIONS (CONT.):
BATCH CONTROL	TPL BILLING APPLICATION
EXAM ENTRY	ADMISSION CERTIFICATION
CORRECTION	MISCELLANEOUS FUNCTION
INQUIRY	SECURITY ADMINISTRATION
REFERENCE FILE APPLICATIONS:	FINANCIAL CONTROL
PROC, DRUG, DIAG, DRG, UPC	DRUG REBATE
RATES	QUALITY CONTROL
PREPAY U/R CRITERIA	TPL RESOURCE FILE
EXCEPTION CONTROL	SURS SUMMARY PROFILE
TEXT	SURS TREATMENT ANALYSIS
SYSTEM PARAMETERS/LIST PARAMETERS	SURS CLAIM DETAIL
PRIOR AUTHORIZATION APPLICATIONS	RECIPIENT MISCELLANEOUS
PRIOR AUTHORIZATION	DECISION SUPPORT
SCREENINGS	MN CARE FIN OBLIG ERROR CORRECTION
OTHER APPLICATIONS:	RATE SETTING
PROVIDER FILE APPLICATION	MANAGED CARE
RECIPIENT FILE APPLICATION	

ENTER---PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9--PF10--PF11--PF12
 S/EXT N/EXT OOPS

In this chapter are instructions for three of the subsystems that staff will use more often for viewing waiver and Alternative Care program information. Refer to that subsystem section for instructions on how to view its data. For information on entering data in the Prior Authorization subsystem, see either Chapter 2 for screening documents or Chapter 3 for service agreements.

When you are finished and wish to leave MMIS, use either the PF3 or PF6 (exit) keys to return to the Main Menu Screen (shown above). Use the exit keys once more to come to a screen with this sentence at the top:

MMIS SESSION TERMINATED

Type "logoff" over the above sentence and use the transmit key. You will return to the State of Minnesota Screen or the MDHS screen depending on how you entered MMIS.

NAVIGATION

Regardless of which subsystem you are viewing, there are keys that can be used to move the cursor or allow you to advance to another page. Please note that some keyboards may be set up differently, especially when using the Enter and Transmit instructions.

TAB

Moves the cursor across the page from one side to another stopping at each field. (This can only be used while you are in the Add or Change modes; it is not used for the Inquiry mode).

Shift and Tab

If the cursor has advanced too far on the screen, these two keys used together will back up the cursor. (This can only be used while you are in the Add or Change modes; it is not used for the Inquiry mode).

Enter

The Enter key with the crooked arrow will move the cursor from the top to the bottom of the page one line at a time. (This can only be used while you are in the Add or Change modes; it is not used for the Inquiry mode).

Home

This key will bring the cursor to the top of the page.

Delete

While in the Add or Change modes only, this key will delete a character in a field one at a time.

End

While in the Add or Change modes only, this key will delete all the characters in a field at the same time. The cursor needs to be at the beginning of the field.

Transmit

The Control key on the bottom right side of the keyboard or the Enter key on the number pad (used only when the NUM LOCK light is on) will bring you forward to the next screen.

Arrows

The arrow keys are used to move the cursor while in the Inquiry mode. The cursor is moved in the direction of the arrow.

PROGRAMMABLE FUNCTION KEYS

There are keys at the top of the keyboard called Programmable Function (PF or F) keys. At the bottom of each screen (except for screening document and service agreement screens) is a line with PF1 - PF12. If a specific PF key can be used on that screen, a word will be shown underneath. The purpose of these keys while in the screening document or service agreement are:

- PF1 While viewing screening document and service agreement screens, press this key and the PF line will show at the bottom of the screen. Press it again to hide the PF line. When the cursor is placed on the edit number at the edit line and this key is pressed, it will show the title of the edit.
- PF2 While in the Add or Change mode, use this key to copy the text from one Comment Screen to another in either screening documents or service agreements. When finished typing on the comment screen, press this key and the text will be copied to the next comment screen. Using the key more than once will copy the same text more than once.
- PF3 This key is used while in the Add or Change mode and will save changes to the screening document or service agreement.
- PF4 Allows you to leave the screening document or service agreement and transfer you to another subsystem to view information. Bring the cursor to one of the below fields and press the PF4 key.

Any place on the screen (except for the fields identified below): default to the Recipient Subsystem to view additional information about the recipient.

Diagnosis Code: to the Reference Subsystem to view information about the diagnosis.

Case Manager Number: to the Provider Subsystem to view information about the case manager and to view all provider screens.

Edit Number: to the Reference Subsystem to view a text file that explains why the edit posted.

The "Next" field on the service agreement screen to view the screening document file.

Procedure Code on the service agreement: to the Reference Subsystem to view additional information about that service.

Provider Number on the service agreement: to the Provider Subsystem to view additional information about that provider.

When you are finished viewing the information, use the PF3 or PF6 keys to return to your document.

- PF5 This key also allows you to travel to either the Recipient or Provider Subsystem from the screening document or service agreement. When you press the PF5 key, you will be brought to

a screen that asks for either the name of a recipient or the name of a provider. After typing the name, use the PF4 key to go to that file. This key allows you to view recipients or providers not associated with the document you were working on. When finished, use the PF3 or PF6 key to return to your document.

- PF6 This key will exit you from the screening document or service agreement but it will not save any changes you've just made. There is no last minute warning.
- PF7 While on a list of items that is too long to fit on the screen, this key allows you to scroll backwards on the list. This could be a list of recipients on the Recipient Subsystem, a list of providers on the Provider Subsystem, to move backward on the line items of a service agreement, or on a list of edits on the edit line of the screening document or service agreement (the cursor doesn't need to be on the edit line to use this key. For service agreements on the ASA3 screen, the cursor cannot be on the LINE NAV field. Use the Home key to bring the cursor to the top of the page in order to scroll on the edit line).
- PF8 See the description for the PF7 key. The PF8 key will allow you to move forward on the list.
- PF9 This key edits the information you typed on the screening document and service agreement. It is used while in the Add or Change mode. The editing determines if any mistakes were made or if the data is in conflict with information already in MMIS. This key can be used at any time (after each change, each screen, or when completely finished with data entering).
- PF10 This key is used in the Add or Change mode when information typed on a screen is incorrect and you want to erase all the information at once. This key has to be pressed before you use the transmit key or the PF9 key. It will erase all data just typed on the screen that wasn't previously saved. It will not erase data on other screens.
- PF11 This key is used only on service agreements while in the Add or Change mode. While on the line item screen (ASA3) press this key to show the next available blank line item for typing. The service agreement has 99 line items, but only two per screen can be shown.
- PF12 This key is not used.

MOVING BETWEEN SCREENS

There are two ways to move from one screen to another in a subsystem.

Transmit Key

Every time you use the Transmit key, you will be brought to the next screen. Eventually, you will come to the last screen in the subsystem and start all over again. Some subsystems have more than twenty screens.

Next Field

A feature to allow you to travel to a screen while bypassing all others is the “Next” field shown on the top left hand corner of the screen. This field has a four character name that identifies the name of the screen that will be shown after the screen you are currently viewing. By typing in the four character name of the screen you wish to go to and pressing the Transmit key, you will be brought directly to that screen. You can use the “Next” field whenever you move forward too far and need to back up to a previous screen. NOTE: The name of the screen you are currently viewing is shown at the top of the screen in the middle.

Following is a chart called MMIS Subsystems Screens that shows a few of the subsystems and the name of the screens in each. These screens are shown in the order that they will appear if you use the Transmit key to travel to each one. The four character name of the screen is also shown if you wish to use the “Next” field to navigate to other screens.

MMIS SUBSYSTEMS SCREENS

<p>Screenings ASCR - Keypanel ASEL - Selection List ALT1 - LTC Document ALT2 - LTC Document ALT3 - LTC Document ALT4 - LTC Document ALT5 - LTC Document ALT6 - AC & CSG Programs Only</p> <p>ADD1 - DD Document ADD2 - DD Document ADD3 - DD Document ADD4 - DD Document</p> <p>ADHS - DHS Comment ACMG - Case Manager Comment ARCP - Recipient Comment</p>	<p>Reference File Applications <u>For Procedure Codes/Drugs/DX/DRG/UPC</u> FKEY - Keypanel FPR1-7 - Procedure Codes FDR1 - Drug Codes FDI1 - Diagnosis Codes FDI2 - Diagnosis Codes FDRG - DRG Codes</p> <p><u>For Waiver/AC Service Rates</u> FRTK - Keypanel FPCA - Statewide Maximum Rates</p> <p><u>For Exception Control</u> FECK - Keypanel FPAC - Edit Titles FPA2 - Edit Routing Control FPA3 - Edit Statuses FPA4 - Notes</p> <p><u>For Edit Text</u> FTEK - Keypanel FPAT - Text File</p>
<p>Prior Authorization AKEY - Keypanel ASEL - Selection List ASA1 - Header Information ASA2 - Letter Indicators ASA3 - Line Items ADHS - DHS Comments APRV - Provider Comments ARCP - Recipient Comments</p>	<p>Third Party Liability Resource (TPL) TKEY - Keypanel TSEL - List Selection</p> <p><u>Policy Information</u> TPOL - Carrier, Coverage, Employer Group TPHO - Policyholder, Policy Indicators and CHAMPUS TPIN - Covered Individuals TPNT - Resource Case Notes TPCO - Cost Effective TPLE - Cost Effective History TPCE - TPL CE History TPEX - Pre-existing Conditions and Benefits Exhausted</p> <p><u>Employer Information</u> TESL - List Selection TEMP - Contract Dates and Basic Coverage Types TEPD - Policy Data</p>

Provider File Applications	Recipient File Applications
PKEY - Keypanel	RKEY - Keypanel
PINQ - List Selection	RSEL - List Selection
PSUM - Summary Screen	RSUM - Summary Screen
PADD - Master Screen #1 and Case Manager Information	RBEN - Benefit Limitations
PINF - Master Screen #2	RCAP - Annual Caps
PPGM - Master Screen #3	RSPL - Spenddown Search
PCOS - Catagory of Service	RSPD - Spenddown
PLIC - License Information	RSLG - Spenddown Log
PGRP - Provider Group Membership	RLVA - Living Arrangement
PMBR - Group Practice Membership	RLTC - Long Term Care and Case Mix
PPX1 - Associated PPHP Plans	RIMG - Immigration
PPX2 - Associated PPHP Plans	RELG - Eligibility
PBIL - Billing Agent	RIDS - Previous Recipient and Medicare ID
PFIN - Financial Information	RCAS - Previous Cases
PHSP - Hospital Information	RWVR -Waiver/CSG Spans
PSUR - SUR/Enhanced Services	RMCR - Medicare
PLAB - Lab Classification Data	RSVL - Medicare List
PXRF - Medicare Carrier	RSVC - Medicare Services
PPCS - Provider Claim Summary	RPCR - PCUR Information
PPWA - Provider Claim Summary	RHSP - Mental Health, Hospice, and Conservator
PPSP - Prior Year Claim Summary	RSPC - Special Processing, Transportation, DT&H
PARH - Claim Account Receivable History	RTRK - Managed Care Tracking
PBCK - Background Check	RPPH - Managed Care Enrollment and Exclusion Spans
<u>PPHP/Managed Care Files</u>	REFM - Managed Care Enrollment Data
PCON - PPHP Contracts	RPPR - Managed Care Rate
PPH1 - Contract	RMGR - Case Manager
PPH2 - Contract List	RPOL - TPL Information
	RPAR - Parent Information
	RCIP - Recipient Miscellaneous
	RHCI - Healthcare ID
	RVAR - Variable Recipient
	RBUY - Buy In Monthly Transaction
	RFED - Federal Reporting Category
	RFD2 -Federal Reporting Category
	RMSQ - Medical Service Questionnaire

<p>Claims Processing (Inquiry Only) CINQ - Keypanel CPPC - List Selection (for summary navigation)</p> <p><u>Types of Claims:</u> CHRP - MMIS History Profile CCAP - Capitation Claim History CARH - Credit & Recoupment Balance CHF1-3 - Outpatient and HCFA-1500 Claims (Waiver and AC) CUB 1-5 - Inpatient Hospital Claims (UB92) CUB6 - Outpatient Hospital Claims (UB92) CCT1 - Child and Teen Checkup Claims CDN1-3 - Dental CPH1-2 - Pharmacy CMS1-2 - Medical Supply</p>	<p>Recipient File Applications (continued) <u>Case Number Screens</u> RKEY - Keypanel RCAD - Recipients' Home and Medical Mailing Addresses, and Financial County of Service RREP - Authorization Representative RCIN - Associated Recipients and Financial Worker ID # RCHP - Selected Managed Care Health Plan</p> <p>Managed Care MCKY - Managed Care Menu</p> <p>Function A - County Programs and Enrollment Batch MKEY - Keypanel MCHP - Health Plan Policy</p> <p>Function B - Eligibility Specific Product and Rating Criteria Profile ESPK - Keypanel ESPL - Product List Screen ESPF - Product Eligibility Types, Living Arrangements, Age Ranges, Rate Cell Category Codes ESPC - Category of Service Codes ESPR - Procedure Codes ESPD - Covered Diagnosis Codes</p>
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101.04 PRIOR AUTHORIZATION SUBSYSTEM OVERVIEW

The Prior Authorization subsystem controls how services from specific programs are used. Processing involves:

- ◆ the entry, maintenance and approval of prior authorization requests for designated medical services, dental services, drugs, and supplies covered by Medical Assistance and GAMC programs.
- ◆ the entry, maintenance and approval of MA home care services;
- ◆ the entry and maintenance of screening documents used for eligibility determination by the CAC, CADI, EW, TBIW, AC, CSG, MSHO, MnDHO, and MR/RC programs, and the MA Home Care program.
- ◆ the entry, maintenance and approval of service agreements for recipients who are eligible for the above programs as well as the Day Training and Habilitation (DT&H) services (nonwaiver pilot program), Special Needs services (Rule 186 funding), the Insurance Extension Program, and Minnesota Children with Special Health Needs (MSSHN) programs.
- ◆ an inquiry only function to view the screening results from Child and Teen Checkup (C&TC) claims submitted to MMIS for payment.

101.05 RECIPIENT SUBSYSTEM OVERVIEW

The primary objective of this subsystem is to identify all persons eligible for Minnesota Health Care Programs, or who were screened or assessed through the Long Term Care Consultation Services Program (formally known as the Preadmission Screening and Community Assessment Program).

This subsystem is the source of all eligibility determination data for MMIS, whether generated by DHS public assistance programs, the Social Security Administration, the Department of Health, or MAXIS. The information contained in the MMIS eligibility files is used to support claims processing, management and administrative reporting, surveillance and utilization review reporting, and third party liability processing. It is also responsible for maintaining recipient benefit limits, controlling the buy-in process, and generating various reports.

Recipient eligibility, program, and demographic data is obtained from the Department of Health, screening documents, the Children's Health File, and MAXIS.

Updates to the Recipient Subsystem are provided on a daily basis from MAXIS. Information updated in the Recipient File is used for service agreement editing to ensure eligibility continues.

A single record is maintained on the Recipient Subsystem for each client. Waiver, Consumer Support Grant program and Alternative Care eligibility history is created and maintained by using information from the screening documents. The information that is obtained from the screening document is:

- **Waiver and CSG program eligibility.** Includes program type, eligibility begin and through dates, and last screening action date on the RWVR screen.
- **Case manager.** Includes case manager name, number, and begin and end dates on the RMGR screen.
- **Alternative Care program eligibility.** Includes the eligibility begin and end dates as well as the county of financial responsibility on the RELG screen.
- **Medicare program eligibility.** Includes the eligibility spans for Medicare Parts A and/or B on the RMCR screen.

In addition, the Alternative Care screening document updates the Recipient Subsystem with the client's mailing address on the RCAD screen. This screen shows the current home address, the last previous home address (if any) and any alternative mailing address. It can be accessed by using the case number (shown on the major program A span on the RELG screen) instead of the PMI number on the Keypanel screen.

The Recipient Subsystem maintains eligibility information for thirty-six months of active history for eligible persons. Some of these categories of eligibility are:

- ◆ Medically Needy Medical Assistance (MA)
- ◆ General Assistance Medical Care (GAMC)

- ◆ Children's Health Plan (CHP)
- ◆ Minnesota Services for Children with Special Health Needs (MSSHN)
(Treatment/Evaluation)
- ◆ Children's Health Plan/Minnesota Services for Children with Special Health Needs (MSSHN)
- ◆ Insurance Extension Program (HIV)
- ◆ Qualified Medicare Beneficiaries (QMB) premium plus some Medicare copays
- ◆ Qualified Working Disabled (QWD)
- ◆ Institute for Mental Disease (IMD)
- ◆ Pre-paid Health Plan (PPHP)
- ◆ Service Limited Medicare Beneficiary (SLMB) premium only; no Medicare co-payment or deductibles
- ◆ Refugee Medical Assistance (RMA)
- ◆ MinnesotaCare or MinnesotaCare/MSSHN Combination

How to Access the Recipient Subsystem

The Keypanel screen controls what actions you can use for this subsystem. Most people will have security to just view the information. You get to the Keypanel screen by choosing "Recipient File Application" on the Main Menu screen as shown below:

```
03/12/98 12:52:50  MMIS MAIN MENU - MAIN          PWMW000
***  MEDICAID MANAGEMENT INFORMATION SYSTEM  ***
SEL                      SEL
CLAIMS PROCESSING APPLICATIONS:  OTHER APPLICATIONS (CONT.):
  BATCH CONTROL                TPL BILLING APPLICATION
  EXAM ENTRY                   ADMISSION CERTIFICATION
  CORRECTION                   MISCELLANEOUS FUNCTION
  INQUIRY                      SECURITY ADMINISTRATION
REFERENCE FILE APPLICATIONS:    FINANCIAL CONTROL
  PROC, DRUG, DIAG, DRG, UPC   DRUG REBATE
  RATES                       QUALITY CONTROL
  PREPAY U/R CRITERIA         TPL RESOURCE FILE
  EXCEPTION CONTROL           SURS SUMMARY PROFILE
  TEXT                       SURS TREATMENT ANALYSIS
SYSTEM PARAMETERS/LIST PARAMETERS SURS CLAIM DETAIL
PRIOR AUTHORIZATION APPLICATIONS:  RECIPIENT MISCELLANEOUS
  PRIOR AUTHORIZATION         DECISION SUPPORT
  SCREENINGS                 MN CARE FIN OBLIG ERROR CORRECTION
OTHER APPLICATIONS:            RATE SETTING
  PROVIDER FILE APPLICATION   MANAGED CARE
X RECIPIENT FILE APPLICATION

ENTER---PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9--PF10--PF11--PF12
                S/EXT                N/EXT                OOPS
```

If you do not have the correct security to access the recipient subsystem, it will not be shown on this screen and you will need to contact your county's security officer to change the security group you are currently in.

After selecting "recipient file application", use the transmit key to bring you to the Keypanel screen.

```

NEXT: 03/13/98 11:22:26 MMIS RECIP KEY PANEL - RKEY PWMW101
ACTION CODE: (A=ADD/C=CHANGE/I=INQUIRY/R=MCRE REAPPLICATION)
----- RECIPIENT KEY PANEL -----
RECIPIENT ID:
SSN: MEDICARE ID:
RECIP LAST NAME: FIRST: INIT:
DOB(MM/DD/YYYY): - ALSO ENTER NAME
-----
CASE NUMBER: CLIENT OPTION NBR: CASE TYPE:
***** RECIPIENT SCREENS *****
RBEN - BEN LIMITATIONS RBUY - RECIP BUYIN RCAP - ANNUAL CAPS
RCIP - RECIPIENT INFO RCTY - CNTY RESIDENCE RELG - ELIGIBILITY
REMP - MCRE EMPLR RFED - FED RPT CAT RHIV - HIV PROGRAM
RHND - HANDICAP DIAG RHSP - MH/HSPC/CONS RIDS - PREVIOUS IDS
RIND - MCRE INDIV RLTC - LONG TERM CARE RLVA - LIVING ARRANGE
RMCR - RECIP MEDICARE RMGR - CASE MANAGER RPAR - PARENT INFO
RPCR - RECIP PCUR RPOL - RECIP POLICIES RTRK - TRACKING
***** CASE SCREENS *****
RCAD - CASE ADDRESS RCHP - CASE HLTH PLANS RCIN - CASE INFO
RINC - CASE INCOME RSLT - CASE RESULTS
*****
ENTER---PF1---PF2---PF3---PF4---PF5--PF6---PF7---PF8---PF9---PF1---PF11--PF12

```

The Keypanel screen will identify the person whose file you wish to review. Use an action code of "T", and one of the above identifying fields in the second section. If you use the birth date field, the person's name also needs to be entered. Press the transmit key. If you do not use the PMI number, you will be brought to the Selection Screen in order to choose the person you want.

How to View a Client's Address

The Case information fields are different from the Recipient fields. You are able to view case information on everyone connected to the case record as well as the recipient's home address and mailing address.

1. Finding the client's CASE-NUMBER.

A case number is different than a PMI. The PMI (Person Master Index) number is "person specific" -- meaning no two people share the same PMI. However, a "CASE NUMBER" is a different number that IS SHARED by all persons within a household -- it is what links individual PMI's together as being somehow related.

Steps to locating a client's case number:

- A. Go into the RECIPIENT subsystem using the PMI number to find the CASE NUMBER on the major program span of either the RSUM screen or the RELG screen.
- B. Write down the client's CASE NUMBER, then use the PF6 key.

2. Use of CASE information section of the RKEY panel.

- A. Again, use the INQUIRY action code, delete the PMI number in the first section of the RKEY screen. Now move your cursor to the CASE NUMBER field in the second section of RKEY, and enter the case number you wrote down. Press the TRANSMIT key.
- B. You should now be on the RCAD (Recipient Case Address) screen. This screen shows the residential address with the current address displayed on the left side. The previous address is on the right side. An optional address to send MMIS mailings to an alternative person is found in the Medical Mailing Address section.
- C. Use the PF3 or PF6 key to return to the Keypanel screen.

```

NEXT: 01/05/99 13:46:56 MMIS RECIP SELECTION- RSEL PWMW112
Name:
SSN:          MCARE:          DOB:
-----RECIPIENT SELECTION SCREEN-----
  RECIP S                                DOB    S
  ID   T ----- NAME ----- SSN   MCARE ID MMDDYYYY X

ENTER---PF1---PF2---PF3---PF4---PF5---PF6--PF7---PF8---PF9---PF10--PF11--PF12
PAGE          S/EXT          N/EXT PREV NEXT    OOPS

```

This is the Selection Screen that lists all of the recipients that closely match the selection criteria you typed on the Keypanel Screen. You can use the PF7 and PF8 keys to scroll back and forth on this screen. Place an “x” in front of the name you wish to view and then use the transmit key to move to the first detail screen.

RSUM The first detail screen you come to after using the transmit key. It shows the most recent data from a few of the other screens.

Program. The three most recent major program eligibility spans are shown. To be eligible for the any of the waiver programs, the person must also be eligible for Medical Assistance. The Alternative Care opening or reopening screening document will place the AC major program eligibility span here.

Spenddown. The three most recent monthly spenddown information are shown.

Waiver Type. The last waiver program and its begin and end date of the eligibility period. This information is taken from the screening document.

PPHP/Managed Care Health. The two most recent enrollment spans for the managed care (PMAP or MSHO) programs.

LA. The two most recent living arrangement spans.

PCUR Case Manager. This field is currently not used.

Mcare. If the person was eligible to receive Medical Parts A and/or B services, the last eligibility spans would be shown here.

RELG This screen shows a three year history of the major programs that the person participated in. Programs such as MA, GAMC, MinnesotaCare, QMB, SLMB, etc are displayed as well as the eligibility period(s) for the Alternative Care program. The case number is shown. Some of these programs can overlap. ***Screening edits 690 and 833 and service agreement edit 271.***

RWVR This screen shows the history of the waiver and CSG eligibility spans.

Waiver Type. Identifies the program.

Waiver Begin Date. The begin date that the program was opened or reopened.

Waiver Through Date. Shows the last day the person was eligible for the program. This date is extended if a reassessment screening document is approved or it is decreased if an exit screening document is completed and approved.

Last Screening Date. This is the last date that the person was screened or assessed.

Screening document edit 247 and Service agreement edit 253.

RMGR This screen shows the case manager assigned to the person. It is taken from the screening document. When the case manager changes on the screening document, a new span is added to this screen. You can view the case manager name, address, phone number and county of service by moving the cursor to one of the provider numbers and using the PF4 key. Then use the transmit key to get to the PADD screen in the provider file. When finished, use PF3 or PF6 to return to the RMGR screen. ***Screening document edits 114 and 260 and service agreement edits 112 and 114.***

RLVA This screen gives a history of the different living arrangements for the person. Elderly Waiver or Alternative Care services must not be provided during a period when the person was in an institution (except for AC conversion case management). By bringing the cursor to one of the provider numbers (if the person was in an institution), and using the PF4 key, you can view information about that provider. Then use the PF3 or PF6 key to return to the RLVA screen. ***Service agreement edit 375.***

RPPH This screen identifies which managed care benefit set a recipient is enrolled into. It includes the managed care enrollment begin and end dates, the contract number (which represents the health plan), and the product ID and description. The Product ID defines a managed care benefit set.

The first two digits of all of the managed care product ID's, are represented by the 2 digit major program that the recipient is eligible for at the time of enrollment into the health plan/product. The last 2 digits indicate the managed care benefit set for that major program.

For the Minnesota Disability Health Options (MnDHO) project, the product ID is "MA15." The first two digits of the product ID (MA) indicate the Medical Assistance major program, and the last two digits (15) indicate which managed care benefit (MnDHO) for the MA program that the recipient is enrolled in. A person enrolled in this program cannot be open to a waiver program at the same time. If a recipient is enrolled into the MA15 managed care product on the MMIS, this indicates that the health plan is responsible for the services, which excludes pharmacy.

If the person is enrolled in the Minnesota Seniors Health Options (MSHO) program, they may also receive services through the Alternative Care or Elderly Waiver programs, but the MA home care services will be provided and funded by the health plan. These services will need to be removed from the service agreement and a line item for x5609 representing the total cost of the home care services provided by the health plan is added instead. Please see Chapter 3, Section 301.19 for more information.

This screen lists two different types of data. At the top is the period that the person was excluded from the managed care program and the exclusion reason. The reasons are:

- AA Adoption Assistance
- BB Blind/Disabled Under 65 Years Old
- CC Child Protection Case
- DD Terminal Communicable Disease
- EE Severe Emotional Disturbance (SED) or Severe and Persistent Mental Illness (SPMI)
- FF Child in Foster Care
- GG Geographic Location
- HH Private HMO Coverage
- JJ GAMC Special Exclusions. Includes GAMC enrollees with Medicare, in a nursing facility, or receiving services at the Center for Victims of Torture.
- KK SIS/EW
- MM Native American Indian Living on Reservation
- QQ QMB, SLMB, or QWD only without major program M
- RR Refugee Eligibility. Undocumented Non-citizen on EMA or EGAMC
- SS Medical Spenddown
- TT Terminal Illness
- XX Unknown. Used for MMIS conversion
- YY Delayed or pending decision
- ZZ RTC/IMD/State Institution Resident

The next section shows the period when the person was enrolled in managed care, the provider number of the health plan, the last capitation payment made, and the rate cell that determines the rate paid to the health plan provider number. You can use the PF4 key on the health plan provider number to navigate to the contract file. ***Screening document edits 263, 264, and 687; and service agreement edits 257 and 265.***

RSPD This screen identifies the monthly spenddown amount and which provider, if any, is obligated to pay the spenddown. Each month is shown on one screen. The institutional spenddowns are shown first followed by the medical spenddowns. The + sign at the top right hand corner indicates that there are more screens to view. Use the PF8 key to view previous months. The spenddown types are: A - Automated monthly, M - Manual monthly, and S - Six month. The spenddown method is I - Institutional, M - Medical or W - SIS/EW. The covered population is either M - MA/GAMC/IMD (county administered) or S - Minnesota Children with Special Health Needs (state administered).

There are three options the client may choose for processing the spenddown: 1) the client

may prepay the spenddown. MMIS will bill the client monthly. Financial workers will receive computer generated worker messages if clients fail to make appropriate payments on time; 2) the client may designate up to five providers to collect the spenddown; or 3) use non-designated providers. This third option deducts the spenddown from the first bill or bills processed in the system for the month. The county case manager assists the client in choosing one of these options. The financial worker is then notified of the option. When the financial worker enters the client option information on MMIS spenddown screens, the invoice processing will be done automatically.

- RCIP Information includes the Medicare ID number, marital status, last education level, and the date of death.
- RMCR Displays the Medicare Part A and B spans. If the source code is an “L”, then the Medicare span was developed by the Alternative Care screening document. (See Bulletin #98-25-11 for more information on the Medicare data from the AC screening document). ***Screening document edit 389 and service agreement edits 274 and 388.***
- RVAR This screen identifies which screens have data and which are blank. If there is a “Y” next to the name of the screen, there is data there to view.

101.06 PROVIDER SUBSYSTEM OVERVIEW

This subsystem provides comprehensive provider related information on all providers enrolled in the Medical Assistance Program to support claims processing, management reporting, and surveillance and utilization review functions. It supports the processing of online provider enrollment applications and information changes.

This subsystem assigns, maintains and controls the nine-digit provider numbers so that duplicate numbers are not assigned. Changes are immediately available to the claims adjudication process and to other subsystems.

For Alternative Care and waiver providers, the original or a copy of the Provider Agreement and Waiver Application forms must be sent to the Provider Enrollment Unit at DHS for approval. When approved, the provider receives an approval letter. **Until this process is completed and the provider is in an active status, edits will post on any service agreement line item using this provider's number.**

A provider may receive the following types of letters from the Provider Enrollment Unit:

- 1) An approval letter when a new provider is added in an active status or a record is changed from pending to active, or when a new service is added to the record. Along with an approval letter the new provider will receive a packet which consists of a welcome letter, the provider manual, a supply of claim forms and the appropriate billing instructions.
- 2) A denial letter when a provider is determined to be ineligible, or when a providers' enrollment status is changed from pending to denied.
- 3) A reinstatement letter when an existing provider is changed from a terminated status to an active status.
- 4) A termination letter is generated when:
 - 1) a category of service (COS) code is deleted from the record or when a provider's status is changed from active to terminated;
 - 2) the record is changed to "terminated - no claims activity" status due to no claims activity in twelve months. Providers are not deleted from the Provider File and may request reinstatement; or
 - 3) the license of a Medical Assistance provider has been suspended. The Provider Enrollment Unit receives a list of license suspensions from HCFA and the Medical Review Board on a monthly basis.

County Case Manager Provider Number

Every case manager is also assigned a provider number that will be used for identification. This number is used on the screening document and on the ASA1 screen of the service agreement. It is not used on the line item for case management services. If a case manager contracts with several different counties, a provider number for each county needs to be assigned to that individual.

County staff with the appropriate security will enter information on the PADD screen to obtain a new case manager provider number. A new nine digit number is then assigned to the case manager. This online entry will be sent to the Provider Enrollment Unit at DHS for approval. The case manager number cannot be added to the screening document or service agreement until the status is changed from "pend" to "active - no pay" by the Provider Enrollment Unit. A report of pending providers is generated by the system. Providers whose status is pending will appear on this report. The Provider Enrollment Unit uses the report to update case manager status to "active - no pay". Staff may also call the Provider Enrollment Unit and request changes to their record.

If county staff changes information on the approved case manager record, the status is automatically changed to "pend". Staff must **call** the Provider Enrollment Unit at DHS so the status can be changed to "active - no pay".

If a case manager leaves county service entirely, the provider number is terminated by putting an end date on the PADD screen. If a new case manager replaces the one who left, that person will receive a new provider number.

If a case manager changes counties, they will keep the same provider number but the address, phone number, and county ID code is changed on the PADD screen. Again, this can be completed by the Provider Enrollment Unit so that the status is changed back to "active-no pay".

How to Obtain a New County Case Manager Provider Number

- 1) Select the Provider subsystem from the Main Menu screen
- 2) On the Provider Key Panel (PKEY) screen, type an "A" in the Action Code field and press the transmit key.
- 3) On the PADD screen, type the following information:
 - 23 in the Provider Type field
 - the county federal tax ID number (there is a dash after the first two digits)
 - case manager's name as it will be shown on the mailing label
 - case manager's business address as it will be shown on the mailing label
 - case manager's business phone number with area code (do not type any dashes between any of the numbers)
 - the county code number preceded by a zero
 - 01 in the Type Prac field
 - today's date in the App Date field
 - the case manager's name in the Sort Field as it will be used to sort in the Provider File (usually last name first).

- 4) Write down the nine digit provider ID number from the first field on this screen. This number is automatically assigned to the case manager.
- 5) Note that the status is listed as “pending”. The Provider Enrollment Unit will receive a daily report showing new provider entries. They will change the status to active- NPA. Until this is finished, the case manager number should not be used on the screening document or service agreement.
- 6) Save your entry by using the PF3 key.

Helpful Hint: When a case manager changes their name, the name field should be changed on this screen as well as the Sort field.

Any changes that are needed to the information on the provider record (including the case manager) must be called into the DHS Provider Enrollment Unit at 651 296-2160.

How to Access the Provider Subsystem

The Keypanel screen controls what kinds of actions that you will use for the provider file. Most people will have security to just view the information. You get to the Keypanel screen by choosing "Provider File Application" on the Main Menu screen as shown below:

03/12/98 12:52:50	MMIS MAIN MENU - MAIN	PWMW000
*** MEDICAID MANAGEMENT INFORMATION SYSTEM ***		
SEL		SEL
CLAIMS PROCESSING APPLICATIONS:		OTHER APPLICATIONS (CONT.):
BATCH CONTROL		TPL BILLING APPLICATION
EXAM ENTRY		ADMISSION CERTIFICATION
CORRECTION		MISCELLANEOUS FUNCTIONS
INQUIRY		SECURITY ADMINISTRATION
REFERENCE FILE APPLICATIONS:		FINANCIAL CONTROL
PROC, DRUG, DIAG, DRG, UPC		DRUG REBATE
RATES		QUALITY CONTROL
PREPAY U/R CRITERIA		TPL RESOURCE FILE APPLICATION
EXCEPTION CONTROL		SURS SUMMARY PROFILE
TEXT		SURS TREATMENT ANALYSIS
SYSTEM PARAMETERS/LIST PARAMETERS		SURS CLAIM DETAIL
PRIOR AUTHORIZATION APPLICATIONS:		RECIPIENT MISCELLANEOUS
PRIOR AUTHORIZATION		DECISION SUPPORT
SCREENINGS		MN CARE FIN OBLIG ERROR CORRECTION
OTHER APPLICATIONS:		RATE SETTING
X PROVIDER FILE APPLICATION		MANAGED CARE
RECIPIENT FILE APPLICATION		
ENTER---PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8--PF9---PF10---PF11--PF12		
S/EXT	N/EXT	OOPS

If you do not have the correct security to access the provider subsystem, it will not be shown on this screen and you will need to contact your county's security officer to change the security group you are currently in.

After selecting "provider file application", use the transmit key to bring you to the Keypanel screen.

```

NEXT:      03/13/98 12:43:43 MMIS PROV KEY PANEL - PKEY      PWMW200
ACTION CODE: (A=ADD/C=CHANGE/D=DELETE/I=INQUIRY)
----- PROVIDER MASTER FILE -----
PROV NBR:          UPIN:          PROV LICENSE:
PROV SSN:          PROV FEIN:      MINN TAX ID:
PROV COS/COUNTY:          PROVIDER COS:
MCARE NBR/CARRIER ID:      OLD PROV NBR:
PROVIDER NAME:
----- PPHP/MCP CONTRACT FILE -----
PROVIDER NUMBER:          EFF DATE:
CLONE:  ADD PROV NUMBER:  EFF DATE:
*****
PARH-ACCTS RECV HIST  PPCS-PROV CLAIMS SUMM  PPSP-PREV CLAIM
PADD-PROVIDER SCREEN PBIL-BILLING AGT PROVS  PCOS-CAT OF SVC
PFIN-PROV FIN. DATA   PGRP-GRPS/BILLING AGTS  PHSP-PROV HOSP
PINF-PROV INFOR.      PLAB-LABS CLS           PLIC- LICENSES
PMBR-INDIV IN GROUP   PPGM-PROV ADDRESS/PGMS  PPHC-RATE CELLS
PPH1-CONTRACT SCREEN PPH2-CONTRACT COS CVRG  PPH3-CONTRACT
PPX1-PPHP AFFIL 1     PPX2-PPHP AFFIL 2       PBCK- CRIMINAL CK
PSUM-PROV. SUMMARY   PSUR-SURS/ENHANCED SRV  PXRF- MCARE/CAR.
*****
ENTER---PF1--PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11--PF12
PAGE          S/EXT          N/EXT          OOPS

```

The Keypanel screen identifies the provider you wish to review. The first section identifies the action you wish to take. The second section has different criteria that can be entered (but enter only one criteria). If you do not use the provider number, a Selection Screen will appear when you use the transmit key. The PPHP/MCP Contract File is used to view the PPHP health plan contracts by entering the health plan provider number here.

NEXT: 03/31/98 8:16:04 MMIS PROVIDER LIST - PINQ PWMW201

SELECTION CRITERIA: LUEDERS

NAME AND ADDRESS	NUMBER	LICENSE	SSN/FEIN	TOP
LUEDERS M	Provider #	41-0000000	01	
	SPEC: SELF RESTRICT: PROV TYPE: 23			
Address	PHONE:	COUNTY: 050		
Address	STATUS: 3 ACTIVE NPA EFF DATE: 08/18/94			
LUEDKE M. J.	Provider # 37624	SS Number	01	
Address	SPEC: SELF RESTRICT:0 PROV TYPE:20			
Address	PHONE:	COUNTY: 093		
	STATUS: 2 ACTIVE REN EFF DATE: 01/25/98			
LUEDTKE K. DDS	Provider #	38-7385439	06	
	SPEC:62 SELF RESTRICT:0 PROV TYPE: 30			
Address	PHONE:	COUNTY: 093		
Address	STATUS:4 ACT ENC NTR EFF DATE 01/01/87			
LUEDTKE S.	Provider #	471-96-1607	01	
Address	SPEC: SELF RESTRICT: PROV TYPE: 23			
Address	PHONE:	COUNTY: 058		
Address	STATUS:3 ACTIVE NPA EFF DATE: 08/02/94			

ENTER---PF1---PF2---PF3---PF4---PF5---PF6---PF7--PF8---PF9---PF10---PF11--PF12

This Selection screen shows four providers on a page. Use the PF7 or PF8 keys to scroll.

Number: Provider's enrollment number.
License Number: Special licensing number, if any.
SSN/FEIN: Social security or federal tax ID number.
Spec: Indicates if the provider has a speciality service.
Self Restrict: Indicates if the provider is limiting the number of new Medical Assistance clients.
Provider Type: Even though each provider may be several types, they are assigned only one number to identify them as a specific type of provider.
Phone: Office phone number.
County: The county their office is located in.
Status: Providers can have one of these statuses: active, active no-pay (case managers), terminated, pending, active encounter, or denied. Only providers with an active status will be accepted on the screening document or service agreement.
Effective Date: The effective date of the status.

Select one of the providers by placing an "x" in front of the name. Use the transmit key.

PSUM This is the first detail screen. It contains the most recent information from other screens.

Provider Type: Indicates the classification that the provider was assigned. Only specific provider types can provide specific services. A listing of these numbers follows this section.

Specialties: This section identifies if the provider has a speciality. It is a two-digit code.

Major Programs: Identifies the major programs that the provider is acceptable. Edits on the waiver service agreement will post if there isn't an "MM" for Medical Assistance shown here. For Alternative Care service agreements, there must be an "AC" listed here.

Categories of Service: Each three digit code represents a service that the provider is approved to do. A list of these codes follows.

Service agreement edits 120, 125, 241, 275, 286 and 410.

PADD All of the case manager information can be found on this screen. This is also the screen where new case manager data is entered into MMIS to obtain a provider number. The county the provider is associated with, their phone number, address and the date they became active (or terminated) as a provider is shown on this screen. If a line item on the service agreement overlaps with a span for a status other than "active" edits will post on the line item and changes are not possible on the service agreement until the line item period is changed so it no longer overlaps.

Service agreement edits 300, 415, 416, 420, and 422.

PROVIDER TYPES

- 00 ... NURSING FACILITY
- 01 ... HOSPITAL
- 02 ... HOSPICE
- 03 ... INSTITUTION FOR MENTAL DISEASE
- 04 ... RENAL DIALYSIS FREE STANDING
- 05 ... ICF/MR - FACILITY
- 06 ... CHILDRENS RESIDENTIAL SERVICES
- 09 ... SCHOOL DISTRICT
- 10 ... COMMUNITY MENTAL HEALTH CENTER
- 11 ... REHABILITATION AGENCY
- 12 ... SERV FOR CHILDREN W/HAND CLIN
- 13 ... SERV FOR CHILDREN W/HAND PROV
- 14 ... SOCIAL WORKER-LICENSED IND
- 16 ... CHILD AND TEEN CHECKUP CLINIC
- 17 ... REGIONAL TREATMENT CENTER
- 18 ... HOME AND COMMUNITY SRV PROV.
- 19 ... DAY TRAINING & HABILITATN CTR
- 20 ... PHYSICIAN
- 22 ... AMBULATORY SURGERY CENTER
- 23 ... CASE MANAGER(WAIVER)
- 24 ... PRE-PAID HEALTH PLAN PROVIDER
- 25 ... MARRIAGE AND FAMILY THERAPIST
- 29 ... OCCUPATIONAL THERAPY
- 30 ... DENTIST
- 35 ... OPTOMETRIST
- 36 ... PODIATRIST
- 37 ... CHIROPRACTOR
- 38 ... PERSONAL CARE PROVIDER
- 39 ... REGISTERED PHYSICAL THERAPIST
- 40 ... SPEECH PATHOLOGIST
- 41 ... LIC PSYCHIATRIC PRACTITIONER
- 42 ... PSYCHOLOGIST
- 43 ... AUDIOLOGIST
- 44 ... COUNTY APPROVED CASE MNGR
- 45 ... COUNTY RESERVATIONS SRVC
- 46 ... APPROVED DAY TREATMENT CENTER
- 47 ... CNTY CNTRCT MNTL HLTH REHAB SV
- 48 ... REGIONAL SERVICES SPECIALIST
- 51 ... INDIAN HEALTH FACILITY PROV
- 52 ... FEDERALLY QUALIFIED HLTH CTR
- 53 ... RURAL HEALTH CLINIC
- 54 ... FAMILY PLANNING AGENCY
- 56 ... DENTAL LAB
- 57 ... PUBLIC HEALTH CLINIC
- 58 ... COMMUNITY HEALTH CLINIC

60 ... HOME HEALTH AGENCY
61 ... PUBLIC HEALTH NURSING ORG
62 ... CHEMICAL DEPEND FREE STANDING
64 ... PRIVATE DUTY NURSE
65 ... NURSE PRACTITIONER
66 ... NURSE MIDWIFE
67 ... CERT REGISTERED NURSE ANESTH
68 ... CLINICAL NURSE MENTAL HEALTH
69 ... PHYSICIAN ASSISTANT
70 ... PHARMACY
75 ... OPTICIAN
76 ... MEDICAL SUPPLIER
77 ... HEARING AID DISPENSER
78 ... OTHER NON-PHYSICIAN
79 ... OTHER NON-TRADITIONAL
80 ... LABORATORY, INDEPENDENT
81 ... X-RAY/DIAGNOSTIC
82 ... MEDICAL TRANSPORTATION PROV
83 ... LIEN HOLDER
84 ... STATE DEPARTMENT OF HEALTH
85 ... STATE DEPT OF HUMAN SERVICES
86 ... HEALTH CARE FINANCING ADMIN
87 ... CO-PAY PROVIDER
88 ... MCRE/MA ACCESS SERVICES
89 ... SPECIAL CONTRACT PROVIDER
90 ... INDIVIDUAL
91 ... EMPLOYER
92 ... GROUP PAYER
93 ... MANUFACTURER PHARM/MED SUPPLY
94 ... MEDICAL REVIEW AGENT
96 ... LICENSING AGENCY
97 ... INSURANCE COMPANY
98 ... BILLING INTERMEDIARY

Category of Service Table

001	.....	INPATIENT HOSPITAL GENERAL
003	.....	INPATIENT HOSP PSYCHIATRY
005	.....	CHILD WLFR TARGETED CASE MGMNT
006	.....	INPATIENT HOSP REHABILITATION
007	.....	OUTPATIENT HOSPITAL SERVICES
011	.....	NURSING FACILITY LEVEL I
013	.....	ICF-MR
014	.....	INPATIENT HOSPITAL IMD
015	.....	INPATIENT LONG TERM HOSPITAL
017	.....	NURSING FACILITY LEVEL II
019	.....	DAY TRAINING AND HABILITATION
020	.....	HOME HEALTH SERVICES
028	.....	RTC - DEV DISABILITIES
029	.....	RTC - MENTAL HEALTH
030	.....	PHARMACY SERVICES
032	.....	MEDICAL SUPPLY/DME
033	.....	MODIFICATIONS AND ADAPTATIONS
034	.....	FAMILY COUNSELING & TRAINING
035	.....	BEHAVIORAL PROGRAM SERVICES
036	.....	TRANSPORT, SPECIAL
037	.....	TRANSPORT, AMBULANCE
038	.....	PERSONAL CARE SERVICES
039	.....	CHILD & TEEN CHECKUP OUTREACH
040	.....	CHILD AND TEEN CHECKUP
041	.....	ANESTHESIA
042	.....	PRIM CARE UTILIZATION REVIEW
043	.....	PHYSICIAN SERVICES
044	.....	CASE MANAGEMENT WAIVER
045	.....	DENTAL
046	.....	MENTAL HEALTH
050	.....	COGNITIVE THERAPY
051	.....	PHYSICAL THERAPY
052	.....	IEP NURSING
053	.....	SPEECH THERAPY
054	.....	OCCUPATIONAL THERAPY
055	.....	PODIATRY
056	.....	AMBULATORY SURGERY
057	.....	CHIROPRACTIC
058	.....	AUDIOLOGY
062	.....	CHEMICAL DEPENDENCY
063	.....	CD EXTND CARE/HALFWAY HOUSE
071	.....	CASE MANAGEMENT SPMI/SED
072	.....	HOSPICE
073	.....	INPATIENT HOSP NEO-NATAL ICU
074	.....	INPATIENT HOSP RTC WAITING BED

075 EYEGASSES/CONTACT LENSES
076 PROSTHETICS AND ORTHOTICS
077 HEARING AIDS
078 VISION
079 RADIOLOGY, TECHNICAL COMPONENT
080 LABORATORY
082 FED QUALIFIED HEALTH CNTR SVC
083 RURAL HEALTH CLINIC SERVICES
084 SWING BED SERVICES
086 OUTPATIENT HOSP EMERGENCY SVC
087 END-STAGE RENAL DIALYSIS
088 PUBLIC HEALTH NURSING
089 PRIVATE DUTY NURSING
090 NURSE MIDWIFE SERVICES
091 NURSE PRACTITIONER SERVICES
092 NUTRITION SERVICES
093 CHORE
094 COMPANION SERVICES
095 HOME DELIVERED MEALS
096 HOMEMAKER SERVICES
097 CARE GIVER TRAINING
100 ACCESS SERVICES
101 ACCESS TO APPEAL
102 ADULT DAY CARE
103 FOSTER CARE
104 SUPPORTED EMPLOYMENT SERVICES
105 SUPPORTED LIVING SERVICES
106 STRUCTURED DAY PROGRAM SVC
107 RESPITE CARE
108 ASSISTED LIVING SERVICES
109 INDEPENDENT LIVING SKILLS
110 IN-HOME FAMILY SUPPORT
111 DEV DISABILITIES SCREENING
112 PASARR - DD
113 PASARR - MENTAL HEALTH
114 EXTENDED HOME HEALTH AIDE
116 EXTENDED MEDICAL SUPPLIES/DME
117 EXTENDED MENTAL HEALTH
118 EXTENDED OCCUPATIONAL THERAPY
119 EXTENDED PERSONAL CARE
120 EXTENDED PHARMACY
121 EXTENDED PHYSICAL THERAPY
122 EXTENDED PRIVATE DUTY NURSING
124 EXTENDED RESPIRATORY THERAPY
125 EXTENDED SPEECH THERAPY
126 EXTENDED TRANSPORTATION
127 PPHP - DPA

128 PPHP - GA
129 PPHP - MANDATORY
130 PPHP - SOCIAL HMO
131 PPHP - SUPPLEMENTAL HMO
132 PPHP - VOLUNTARY AFDC
133 PPHP - MSHO
134 COST EFFECTIVE HEALTH INS
135 CO PAY - MEDICAL SUPPLY/DME
136 CO PAY - MENTAL HEALTH
137 CO PAY - PHARMACY
138 CO PAY - PHYSICIAN
139 COLLECTIONS, MISCELLANEOUS
140 FINANCIAL TRANSACTION
141 SPENDDOWN COLLECTIONS
142 BUY-IN PART A
143 BUY-IN PART B
144 PREMIUM PAYMENTS/COLLECTIONS
999 UNABLE TO DEFINE

101.07 CLAIMS SUBSYSTEM OVERVIEW

Every other subsystem interacts in some way with this subsystem either by maintaining data necessary for claims processing, or by processing and/or reporting on the claims data which is created and maintained. Providers are encouraged to use the Eligibility Verification System (EVS) prior to submitting a claim. This telephone system identifies the person's eligibility for specific programs as of the time of the call.

This subsystem captures, controls, and processes claim invoice data from the time of initial receipt (on hard copy or electronic media) through final disposition, payment and application to the various claim files. Using the data contained in the most current recipient, provider, prior authorization and reference files, this subsystem edits, audits, and processes claims.

Initially, 36 months of claims history is maintained for auditing, online inquiry and reporting purposes. Claims that were adjudicated (processed) prior to the 36 month retention period are stored permanently on the archived claims file. Claims requiring a longer retention period to accommodate audit requirements or other needs are maintained on the lifetime claims file.

All claims entering the system are batched and assigned a 17 digit transaction control number (TCN). This TCN provides a method of uniquely identifying any claim in the system. Hard copy claims are either scanned or data entered by DHS staff. Electronic media claims (through MN-ITS) are entered directly into the system.

If the claim is not scanable or has edits it is sent to the suspended claims file where DHS claims staff attempt to resolve the claim exceptions or scanning errors. If the problems cannot be resolved, the claim is denied.

Once in the system, all claims are subject to a complete series of edits and audits to ensure that only valid claims for eligible persons and covered services are reimbursed to enrolled providers. Edits applied to each claim include data validity, recipient, provider, reference, duplicate checking and utilization review auditing.

Claims are adjudicated on a daily basis. A variety of pricing methodologies to accommodate the many claim types is used. To arrive at the final payment amount the system uses a fee schedule, DRG rate, or other method and subtracts applicable spenddown, co-payment, and third party payments.

Claim payment cycles typically occur on a bi-weekly basis. A remittance advice (RA) is created for every provider with claim activity in a payment cycle. The RA is organized primarily by claim type and lists all claims processed in the payment cycle for the provider including paid, denied, and suspended claims. Gross adjustments and summary information are also included.

Adjudicated claims and paid/denied claims on the current month claims file and paid/denied claims on the claims history file are available for review by counties using this subsystem. Claims may be displayed either in detail or in summary format with several claims per screen. Following are instructions in accessing claims for viewing.

How to Access the Claims Subsystem

The Keypanel screen controls what kinds of actions that you will use for the claims file. Most people will have security to just view the information. You get to the Keypanel screen by choosing "Inquiry" on the Main Menu screen as shown below:

```
03/12/98 12:52:50      MMIS MAIN MENU - MAIN      PWMW000
***  MEDICAID MANAGEMENT INFORMATION SYSTEM  ***

CLAIMS PROCESSING APPLICATIONS:      OTHER APPLICATIONS (CONT.):
BATCH CONTROL                        TPL BILLING APPLICATION
EXAM ENTRY                           ADMISSION CERTIFICATION
CORRECTION                           MISCELLANEOUS FUNCTIONS
X INQUIRY                             SECURITY ADMINISTRATION
REFERENCE FILE APPLICATIONS:         FINANCIAL CONTROL
PROC, DRUG, DIAG, DRG, UPC           DRUG REBATE
RATES                                QUALITY CONTROL
PREPAY U/R CRITERIA                 TPL RESOURCE FILE APPLICATION
EXCEPTION CONTROL                   SURS SUMMARY PROFILE
TEXT                                SURS TREATMENT ANALYSIS
SYSTEM PARAMETERS/LIST PARAMETERS    SURS CLAIM DETAIL
PRIOR AUTHORIZATION APPLICATIONS:    RECIPIENT MISCELLANEOUS
PRIOR AUTHORIZATION                  DECISION SUPPORT
SCREENINGS                           MN CARE FIN OBLIG ERROR CORRECTION
OTHER APPLICATIONS:                  RATE SETTING
PROVIDER FILE APPLICATION            MANAGED CARE
RECIPIENT FILE APPLICATION

ENTER---PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8--PF9---PF10---PF11--PF12
                                S/EXT      N/EXT      OOPS
```

If you do not have the correct security to access the claims subsystem, it will not be shown on this screen and you will need to contact your county's security officer to change the security group you are currently in.

After selecting "inquiry", use the transmit key to bring you to the Keypanel screen.

NEXT: 08/15/03 11:44:38 MMIS CLM INQ **KEY PNL-CINQ** PWMWC90

1. ENTER AN "X" BESIDE THE DESIRED SELECTION:

ALL CLAIMS	SUSPENDED CLAIMS
TO BE PAID/TO BE DENIED CLAIMS	CLAIMS HISTORY

2. ENTER ONE OF THE FOLLOWING KEY FORMATS TO BE USED FOR SEARCH:

A. TRANSACTION CONTROL NUMBER:

B. PROVIDER NUMBER: PAY-TO/SUBMIT: TREAT/CONTRACT:

C. RECIPIENT ID:

3. ADDITIONAL SEARCH CRITERIA FOR PROVIDER OR RECIPIENT SEARCH:

PROVIDER NBR:

RECIPIENT ID:

DATE OF SERV:

PROCEDURE CODE:

WARRANT DATE:

REVENUE CODE:

REIMB AMOUNT:

CLAIM TYPE: STATUS:

CATEGORY OF SERV:

MN SERV GROUP:

EXCEPTION CODE:

MDC:

4. ENTER THE LEVEL OF DETAIL INDICATOR:

D = DETAIL S = SUMMARY (DEFAULT) P = PROCEDURE SUMMARY

ENTER---PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11--PF12

PAGE

S/EXT

N/EXT

OOPS

The Keypanel screen lists the criteria you can use to identify a claim to view.

Section #1. Place an "x" in front of one of the choices.

Section #2. Putting the claim Transaction Control Number (a.k.a. the document control number) in this section will bring you directly to that claim. Otherwise, use the Provider Number or Recipient ID number (but not both).

Section #3. This section is not mandatory, but it will narrow the search for claims for the person or provider that was identified in section #2. You can use more than one selection criteria.

Section #4. The claims file will show you a list of claims that meet the selection criteria unless you put a "D" here. Then you will see each claim individually. The next claim will appear by using the PF3 key. Use the PF6 key to return to this Keypanel Screen.

NEXT: 08/15/03 11:55:08 MMIS PROV PD/DNY CLM-CPPC	PWMWC92																																								
PROV: 00000000 00 PROVIDER NAME: XXXXXXXX XXXX	TYPE:																																								
COS: MSG: PROC CD: REVENUE CD:																																									
MDC: EXC: BILLED AMOUNT:																																									
<table border="1"> <thead> <tr> <th>RECIP NBR</th> <th>FIRST ID</th> <th>LAST DOS</th> <th>WARRANT DATE</th> <th>REIMBURSE AMOUNT</th> <th>CLM STATUS</th> <th>CLM TYPE</th> <th>TRANSACTION CONTROL NUMBER</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>XXXXXXXX</td> <td>060103</td> <td>061503</td> <td>072303</td> <td>0.00</td> <td>N A</td> <td>00000200100000100</td> </tr> <tr> <td>02</td> <td>XXXXXXXX</td> <td>050103</td> <td>053003</td> <td>071803</td> <td>0.00</td> <td>N A</td> <td>00000800100000100</td> </tr> <tr> <td>03</td> <td>XXXXXXXX</td> <td>050103</td> <td>053003</td> <td>070803</td> <td>905.87</td> <td>N A</td> <td>00000200100000100</td> </tr> <tr> <td>04</td> <td>XXXXXXXX</td> <td>120102</td> <td>123102</td> <td>042203</td> <td>6.65</td> <td>N A</td> <td>20000700700000017</td> </tr> </tbody> </table>		RECIP NBR	FIRST ID	LAST DOS	WARRANT DATE	REIMBURSE AMOUNT	CLM STATUS	CLM TYPE	TRANSACTION CONTROL NUMBER	01	XXXXXXXX	060103	061503	072303	0.00	N A	00000200100000100	02	XXXXXXXX	050103	053003	071803	0.00	N A	00000800100000100	03	XXXXXXXX	050103	053003	070803	905.87	N A	00000200100000100	04	XXXXXXXX	120102	123102	042203	6.65	N A	20000700700000017
RECIP NBR	FIRST ID	LAST DOS	WARRANT DATE	REIMBURSE AMOUNT	CLM STATUS	CLM TYPE	TRANSACTION CONTROL NUMBER																																		
01	XXXXXXXX	060103	061503	072303	0.00	N A	00000200100000100																																		
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03	XXXXXXXX	050103	053003	070803	905.87	N A	00000200100000100																																		
04	XXXXXXXX	120102	123102	042203	6.65	N A	20000700700000017																																		
ENTER- - PF1- - PF2- - PF3- - PF4- - PF5- - PF6- - PF7- - PF8- - PF9- - PF10- - PF11- - PF12																																									
PAGE	S/EXT NAVIG N/EXT PREV NEXT OOPS																																								

This Selection Screen will automatically appear if you did not place a “D” in Section 4 of the Keypanel Screen. It lists all the claims that met the criteria of the Keypanel screen. To view individual claims, use the arrow keys to move the cursor to one of the lines. Press the PF4 key. You will be brought to the first detail screen of the claim.

NOTE: By using the Selection Screen to view claims, you will not be able to use the PF4 key again within the claim. To use the PF4 key within the claim itself, you need to have a “D” in Section 4.

NOTE: This example shows the screen when using the provider number in Section 2 of the Keypanel Screen. If the recipient number was used instead, the recipient would be identified at the top of the screen with the providers identified in the list.

By using the PF3 or PF6 key when finished viewing the detail screens, you will exit back to this Selection Screen.

- First DOS The first date of service.
- Last DOS The last date of service.
- Warrant Date The date that the claim was paid.
- Reimbursement Amount The total amount of money from all the paid line items on the claim.
- Claim Status The header status of the claim. Each claim line item needs to be reviewed to see the status of the individual line items. Even though the claim header status may be “paid”, some line items may have been denied or suspended. If the header status is “denied”, then all the line items will also be denied. Claims statuses are: N = paid, P = denied, S = suspend, I = to be paid at next warrant, K = to be denied at next warrant, B = in process, and X = verifying information.

Claim Type For waiver and Alternative Care claims, the type will be A = CMS HCFA-1500.

Transaction

Control # This is the same as the document control number. It is assigned to each claim by MMIS as a unique identifier.

```
NEXT: CHF2 08/15/03 12:34:28    HCFA-1500 - CHF1 PWAT255 06/30/03 PWMWC40
                                TCN: 0 00030 00 100 0001 00
ACCOUNTING CD: 0 NORM-PAY          CLAIM STATUS: N PAID
                                LAST CYCLE DT: 063003

PROVIDER NBR: 000000 00          TYPE: 45
                                LAST          FIRST      MI
RECIPIENT ID: 0000000 NAME: XXXXX          XXXX
DOB: 11111911 SEX: M    AGE: 091    MAJOR PROG: AC    LA: 80
PAT STATUS EMP:                OTHER INS INFO:
PAT CONDITION RELATED TO EMP:   ACCI:      OTHER ACCI:
NUMBER OF RIDERS: 0            CARRIER INFO:

OVR LOC:          OVR EOB/EXC:    ATTACH FOUND:  TPL BLNG IND:
WARRANT DATE: 070803  REPLACEMENT RSN:  TCN REPLCD:
OBLIG ID:          REPLCD BY TCN:
WARRANT NBR: 888888888 RA NBR: 000869409  TOT REIMB AMT:  905.87

LI ERR ST USER ID LI ERR ST USER ID LI ERR ST USER ID LI ERR ST USER ID
000 131 6    001 540 6
131 THE PROVIDER DID NOT SIGN THE INVOICE. CHECK FOR SCANNER ERRORS
IN THE SIGNATURE BOX. IF SIGNATURE IS PRESENT ENTER A "Y" IN THE
ENTER---PF1 -- PF2 -- PF3 -- PF 4-- PF5 -- PF6 -- PF7 -- PF8 -- PF 9-- PF1 0-- PF11 -- PF12
PAGE HELP          S/EXT NAVIG SLIST N/EXT PREV NEXT          OOPS
```

This is the first detail screen of the claim. Not all fields on this screen pertain to the waiver or AC claim. It identifies the header claim status, the person, the provider, living arrangement type and major program. The Warrant Date shows the date the claim was paid. If this claim was replaced by another claim, the reason and new claim number is shown. The total reimbursable amount is shown.

You can view the Recipient File by pressing the PF4 key when the cursor is on the Recipient ID field. You can also view additional information on the provider in the same manner by placing the cursor on the Provider Number field.

NEXT: CHF1 08/15/03 13:07:08 **HCFA-1500 - CHF3** PWAT255 06/30/03 PWMWC42

TCN: 0 00030 00 100 0001 00

ACCOUNTING CD: 0 NORM-PAY CLAIM STATUS: N PAID

PROVIDER NBR: 0000000 00 TYPE: 45 RECIP ID: 0000000

START LINE NBR: 001 MAX LINES: 1

SERVICE DATES PLC TYP --MODIFIER- SUBMITTED DAYS/ FAM

LI FROM TO SVC SVC PROC 1 2 3 4 -DIAG- CHARGES UNITS PLAN

001 050103 053003 99 X0000 2000.00 100

TREAT PROVIDER: 0000000 00 PA NBR: 000000000000

OVR EOB/EXC: BASE RATE/SRC: 2000.00 AA ALLOW UNITS: 100 MSG: 502

BASE RATE CHNG AMT/RSN: PROV TYPE/COS: 45 044

CALC ALLOW CHG: 2000.00 REIMB AMT/STAT: 905.87 B LA: 80 FUND CD: 299

002

TREAT PROVIDER: PA NBR:

OVR EOB/EXC: BASE RATE/SRC: ALLOW UNITS: MSG:

BASE RATE CHNG AMT/RSN: PROV TYPE/COS:

CALC ALLOW CHG: REIMB AMT/STAT: LA: FUND CD:

LI ERR ST USER ID LI ERR ST USER ID LI ERR ST USER ID LI ERR ST USER ID

000 131 6 001 540 6

131 THE PROVIDER DID NOT SIGN THE INVOICE. CHECK FOR SCANNER ERRORS

IN THE SIGNATURE BOX. IF SIGNATURE IS PRESENT ENTER A "Y" IN THE

ENTER- - PF1- - PF2 - - PF3 - - PF4 - - PF5 - - PF6 - - PF7 - - PF8 - - PF9 - - PF10 - - PF11 - - PF12

PAGE HELP S/EXT NAVIG SLIST N/EXT PREV NEXT OOPS

The last detail screen shows the individual line items. This screen can show two lines. Additional lines are obtained by moving the cursor to the line item section and using the PF8 key, or by typing in the number of the line in the Start Line NBR field, moving the cursor back to the field, and using the PF8 key. The Max Lines field indicates how many lines are in the claim. Each line item will have its own status, so there can be a combination of approved, pend, suspend or denied lines.

Service Dates: This is the period that the service was provided. The period cannot span different months.

Place of Service: Identifies the place where the service was provided. Value "12" is the most common - client's home.

Procedure: The HCPC or procedure code that identifies the service. By placing the cursor on this field and using the PF4 key, you can view additional information about the service.

MOD1/MOD2: Modifiers used to price the service.

Diagnosis: The number (1, 2, 3, 4 or combination) of the diagnosis(es) from the previous screen. It is not mandatory.

Charges: The amount of money that is being requested by the provider - their usual and customary charge.

Units: The amount of units that were provided during this period.

PA Number: Identifies the service agreement that the line item is paying from. If this field is left blank, the PA number from the CHF2 screen will be inserted.

Base Rate/Source: The rate that DHS will allow to be paid. The Source indicates how it was priced. Choices are: AA = priced by authorization; PP = priced by the procedure code; or RR = priced by the rate record.

Allowed Units: The amount of units that will be paid. This can be less than what was requested by the provider.

Based Rate Change
Amount/Reason: The rate was changed for one of these reasons. Waiver and AC claims would use one of the highlighted reasons.

SP	NO REASON INDICATED CUTBACK
AA	PA LIMIT EXCEEDED CUTBACK
AE	PROCEDURE NOT ALLOWED CUT
AN	BUNDLED OR PKGD PROC CUT
AV	VISIT NOT ALLOWED CUT
BB	BEN LIMIT EXCEEDED CUTBACK
CA	CAPITATION NF ADD-ON
CB	CAPITATION EW ADD-ON
CC	CAPITATION RISK ADJ ADD-ON
CD	CAPITATION OTHER ADD-ON
CE	CAPITATION MED ED RES CUTBACK
CR	HOSPITAL PAYMENT ADJUSTMENT
CW	IHS CWTCM ADMIN FEE CUT
DA	CRITICAL ACCESS DENTAL ADD-ON
DC	DENTAL COPAY
DD	PEDIATRICS ADD-ON
DP	DPA ADD-ON
EC	OXYGEN WITH QH MODIFIER ADD-ON
EE	CCDTF MEDICARE COVERED CUTBACK
FA	LTC 1ST 30 DAY ADD-ON
FB	LTC DAY 31-90 ADD-ON
FC	PAY PRIVATE ROOM
FF	COURAGE CENTER ADD-ON
GG	OBSTETRICS ADD-ON
HH	COMM/PUBLIC HEALTH ADD-ON
IA	INDIAN HEALTH SERVICE ADD-ON

IC	IMMUNIZATION CUTBACK
ID	INDIAN HEALTH SERVICE CUTBACK
IH	INDIAN HLTH ANCILLARY ADD-ON
II	OUTPATIENT AS OFFICE CUTBACK
JJ	DENTAL PREV HEALTH ADD-ON
JK	DENTAL NON-PREV HEALTH ADD-ON
KA	CORE HOSPITAL INCREASE
KK	SMALL HOSPITAL INCREASE
LB	CLINICAL CHEMISTRY CUTBACK
LL	COST OUTLIER ADD-ON
LM	DPA OUTLIER ADD-ON
LR	LEGISLATIVE RATABLE REDUCTION
MB	MCARE BLOOD DEDUCTIBLE ADD-ON
MC	MCARE COINSURANCE ADD-ON
MD	MCARE CASH DEDUCTIBLE ADD-ON
MJ	PAYER CODE J MCARE-B REIMB
MM	DAY OUTLIER ADD-ON
NA	INTERIM REBASING PAYMT ADJ
NB	INDIGENT CARE PAYMENT
NN	NEWBORN ADD-ON
NS	CLINICAL NURSE SPECIALIST CUT
PA	PHYSICIAN ASSIST CUTBACK
PP	SOLE COMMUNITY PROVIDER ADD-ON
QQ	PMT GREATER CHARGES OVER YR
RR	TRANS MULTI RIDER CUTBACK
SD	ESRD PROV TEACHS SELF DIAL ADD-ON
SS	ASC SEC SURGERY PROC ADD-ON
TT	ASC SEC SURGERY PROC CUTBACK
UU	PDDD MAX UNITS CUTBACK
VV	NURSE PRACTITIONER CUTBACK
XX	UNIT DOSE ADD-ON
YY	PHARM DISPENSING FEE ADD-ON
ZM	MINNESOTA CARE DENTAL ADD-ON
ZX	SED RATE ADD-ON
ZY	GAMC RATE CUTBACK
ZZ	MASTERS LEVEL PSYCH CUTBACK
01	SPENDDOWN CUTBACK
02	MINNESOTA CARE COPAYMENT
03	PROV-SUBMITTED TPL CUTBACK
04	DHS-COLLECTED TPL CUTBACK
05	AUTH LIMIT EXCEEDED CUTBACK
06	TPL DRUG COPAYMENT CUTBACK
07	OTHER LTC PROCESSING CUTBACK
08	C&TC OUTREACH LIMIT CUTBACK
09	SURS CUTBACK
10	SURS ADD-ON
11	REBASING AMOUNT ADD-ON
12	FINAL REBASING PAYMT ADJ

13	RECIPIENT CO-PAYMENT
14	CALC REIMB VS PAID AMT CUTBACK
15	SENIOR DRUG ADD-ON
16	SENIOR DRUG DEDUCTIBLE
17	AC CAP REDUCTION
18	EW SPECIAL INCOME STANDARD CUTBACK
19	CCDTF ADD-ON FOR SPENDDOWN
90	CONVERSION DHS TPL ADD-ON
91	CONVERSION BALANCING CUTBACK
92	CONVERSION BALANCING ADD-ON
93	INDIAN HLTH ENCOUNTER LIM CUT

When this field is indicated, the rate that was paid is the difference between what is allow and what was actually paid.

Calculated

Allowed

Charge: The amount that DHS would allow before any base rate changes.

Reimbursement

Amount/Status: The actual amount being reimbursed to the provider and how it was paid. B = billed amount, A = allowed amount. If the billed and allowed amounts are the same, it will use a "B". If there was a cutback 05 (base rate change amount) applied, this amount would represent the submitted change divided by the number of units. If the number of units were too much (such as billing for 30 rather than 1 for a monthly service), the provider would need to submit a replacement claim to correct this claim. If the cutback was 01 or 18 (spenddown, EW/SIS Waiver Obligation) then this field represents the total amount paid to the provider. The Base Rate Change Amount field would represent that portion of the payment that the recipient is responsible.

Claims History File

If claims older than 36 months are needed, staff must submit a MMIS II Recipient Claims History Profile Request form to DHS. If the request is for claims older than 1994, send the form to Steve Smothers at 3844. You will receive paper reports. Please note to include the recipient's name and a statement as to why the data is needed on the request form. You can receive a copy of this form by calling the Department at 651 215 1146.

This system is used for electronic submission of Medical Assistance claims and prior authorizations to MMIS for processing. MN-ITS will replace the Information Transfer System (ITS) in October, 2003. Users will submit individual claims through the Internet with an Internet Explorer browser of 5.9 or higher; or submit batch claims using the X12 format available at <http://mn-its.dhs.state.mn.us>

Providers submitting claims through MN-ITS instead of completing paper claims will have access to the MN-ITS mailbox feature which acts as a secure folder for client eligibility verification requests, remittance advices, and claims status information. MN-ITS complies with new HIPAA privacy standards.

101.09 ELIGIBILITY VERIFICATION SYSTEM (EVS)

EVS is a system designed to assist the provider in verifying eligibility for persons enrolled in Minnesota Health Care Programs, providing comprehensive recipient information and information regarding the last warrant issued by DHS. The system is accessed by using a push button phone with touchtone service. To access EVS call 1-800-657-3613 or (651) 282-5354. A provider will need the following information to better utilize the system:

- ◆ their nine digit provider number
- ◆ the person's eight digit ID number or date of birth and Social Security Number
- ◆ date of service

EVS is also accessible online at www.mnevs.state.mn.us Providers will need to have a PASCode and Authorization Code to access data online. If they don't have a pascode and auth code, they should contact the EDI help desk at 651-439-31 or 1/800-657-3651 or email acct.evs@state.mn.us

EVS will provide information from the following categories:

- ◆ Eligibility Information
Prepaid Health Plan, Waiver Services, Alternative Care, and Spenddown.
- ◆ Program Eligibility
Major Program Eligibility, MinnesotaCare, Alternative Care Program, Combined Program, and Medicare Care through GAMC.
- ◆ Benefit Limitations
Dental; Vision; Hearing Aids; Therapies: Physical, Occupational and Speech;
Chiropractic; Mental Health and Home Care.
- ◆ Third Party Liability
Medicare Coverage, HMO Coverage, Preferred Provider Coverage and Other Health Coverage.
- ◆ Last Check Information
Date, Amount and Warrant Number of last check issued

If a provider has any problems with the EVS system, they should call the Customer Services Help Desk at 1-800-366-5411 or (651) 282-5545. For TDD, Contact Minnesota Relay Service at (651) 215-0086 or 1-800-366-8930.

Minnesota Department of Human Services Continuing Care Administration Medicaid Management Information System (MMIS) January, 2004	Chapter 2	LTC Screening Document
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201.01 PURPOSE OF THE LTC SCREENING DOCUMENT FORM

Some form of the Long Term Care Screening (LTC) Document (DHS Form 3427) has been in use since 1984. This form is used to document preadmission screening and long term care consultation (LTCC) activities and public programs eligibility determination, as well as to collect information about people screened, assessed, or receiving services under home and community based services programs.

Long Term Care Consultation and Relocation Services Coordination

Each agency is responsible to perform certain activities under Minnesota Statutes 256B.0911 (Long Term Care Consultation). In addition, counties perform other activities related to Relocation Services Coordination and case management of home and community based services programs that are recorded on the Long Term Care Screening Document. This chapter provides instructions for the completion of this document.

Preadmission Screening and Recording Assessment/Program Eligibility

The LTC screening document records preadmission screening of all persons entering certified nursing or certified boarding care facilities as required under Minnesota Statutes, 256B.0911 (PAS) and under federal OBRA legislation (Public Law 101 and 103). The document is also used to record assessment and program eligibility determination information for persons served under the nursing facility level of care waiver programs, the Alternative Care (AC), and MnDHO programs. In addition, case managers use this form for certain program administration activities such as reassessment, closures, and program changes.

Services Authorization and Payment

The LTC screening document provides an important link between assessment and eligibility determination, recipient information, and services authorization and payment. It plays a vital role in the processing and acceptance of service agreements. A service agreement authorizes services planned for a person “opened” to the waiver or AC programs, and permits payment to providers of those services. A service agreement cannot be approved unless there is an eligibility span recorded. The approved screening document develops the eligibility span. Information from the LTC Screening Document is checked against eligibility information in the Recipient Subsystem that limits the length of services approved, the type of service agreement that can be entered, and the types and amounts of services that can be approved.

Payment of LTC and NF Services

Because this document plays a critical role in establishing payments for a variety of long term care services, including nursing facility services, each agency must ensure timely submission of the LTC screening document information into MMIS. It is strongly recommended that no more than fourteen (14) calendar days lapse between completion of any LTCC or case management activity and the submission of the data into MMIS.

Data Collection, Quality Assurance, and Management Reporting

Finally, information contained in the LTC screening document is used in combination with other data by the Department of Human Services for a variety of program evaluation purposes, including quality assurance and management reporting.

201.02 MAJOR ACTIVITIES UTILIZING THE LONG TERM CARE SCREENING DOCUMENT

Agencies use the LTC screening document to record:

1. Intake and referral activities undertaken by the LTCC team;
2. The completion of preadmission screening of all persons entering a certified nursing or certified boarding care facility, before admission, to determine the appropriateness of the institutional placement;
3. The completion of OBRA Level I screening for the presence of mental illness or mental retardation before admission as required under federal OBRA requirements mandates an OBRA Level II referrals for more thorough evaluations of persons identified under the Level I screening process;
4. Documents eligibility for home and community based waiver programs based on need for nursing facility level of care, AC, and the authorization of services;
5. Recommendations for services for persons screened or assessed, including institutional, formal, informal, or “quasi formal” services;
6. Public programs eligibility, and the person’s choice of institutional versus home and community based services (informed choice);
7. Case management activities including reassessment, termination from home and community based waiver programs, and program changes. A LTC Screening Document is used to terminate or “close” a waiver or AC eligibility “span” on the Recipient Subsystem. This does not affect Medical Assistance eligibility (only financial workers may open or close MA eligibility);
8. The extent of activity supported with the LTCC allocation provided to agencies; and
9. Relocation services coordination activities including assessment and the election of relocation services by the recipient.
10. Supports the Managed Care’s health plan rate cell request for the MnDHO Program.

LTCC Tools

DHS-2497 - Long Term Care Consultation Brochure
DHS-3361 - Nursing Facility Level of Care Brochure
DHS-2727 - Information and Signature Sheet for PAS/EW/AC/CADI/TBI
DHS-3428B - AC, EW, CADI, & TBI Waiver Case Mix Classification Worksheet
DHS-3428C - MN Long Term Care Consultation Services Form: Supplemental Form for Assessment of Children Under 18
DHS-3426 - Level 1: Screening for Mental Illness or Mental Retardation
DHS-3427 - LTC Screening Document: LTCC, CADI, CAC, AC, MSHO, MNDHO, EW, TBI, CSG
DHS-3427T - LTC Screening Document: Telephone Screening
DHS-3428 - MN LTC Consultation Services Form
DHS-3214B - MnDHO Rights Brochure
DHS-2925 - Community Support Plan

A supply of these forms, except for DHS-2727, 3426, and 3214B, can be ordered from the Department free of charge by calling (651) 296-9116. These forms can also be retrieved from the DHS website at <http://www.dhs.state.mn.us/infocenter/docs.htm#forms>.

With the Adobe Acrobat software you can view and print the forms.

The following instructions explain how to type data onto the MN LTC Consultation Services form (DHS-3428) and then merge the data onto the LTC Screening Document forms (DHS-3427 and 3427T).

What you need

The minimum browser requirement for eDocs is Internet Explorer 5.5. An **Adobe Acrobat Reader 5.1** is needed in order to download and read PDF documents. The Acrobat Reader is commonly bundled with popular graphics and publishing software, and is also available as a **free download (viewer only)** via the Adobe Web site. You may access the [Adobe Acrobat Reader download Web page](#).

Downloading the form

For access and completion of these forms, you must copy the form(s) onto your hard drive. Do not use the version on the web page for completing and merging.

1. Open one of the forms on the web page
2. Click on the “disc” icon found on the toolbar
3. Save document to your hard drive.

How to fill out a form

1. Open the form (saved on your hard drive) on the following page. Select the Hand tool.
2. Move the cursor inside the first field, and click. The I-beam pointer allows you to type text. The arrow pointer allows you to select a button, a check box, a radio button, or an item from a list. After entering text do one of the following:
 - Press Tab to go to the next form field to enter data.
 - Press Shift-Tab to go to the previous form field.
 - Press Enter (Windows) or Return (Macintosh) to travel down the page.
 - Use the Space Bar for fields that need a check mark.

How to save the data

Once you have filled in the appropriate fields, do one of the following:

- Choose File > Save As to save a copy of the form with the data. Type a filename from your C drive, and click Save. This saves the completed form. You may print this form. The next time you use this form you will be typing over the saved data.
- To save the data in order to keep a record and be able to return to the data for future changes, Choose File > Export > Form Data to save the form data in a separate FDF data file on your C drive. Type a filename (such Rogers01 [Rogers, activity type 01]) and click Save. When you open the “Form Data file” the form itself will automatically open too.

How to merge the data to another form

Open the LTC Screening Document form (DHS-3427 or 3427T) that is saved on your hard drive. Choose File > Import > Form Data. Double click on the Form Data file name that you wish to transfer the data to the screening document. The data should transfer to the form. You can print a copy of this form. To save the completed Screening Document form, or just the data itself, see instructions above.

How to clear all data from a form

Select the Reset Form button, if one exists on the form, or choose File > Revert.

How to print a form

Choose File > Print. If you have difficulty printing the form, or output does not look as expected, check the Print as Image option in the Print dialog box.

How to turn pages

Click the Previous Page or Next Page buttons on the toolbar at the top of the screen, or press the Right or Left Arrow keys on the keyboard.

How to enlarge or reduce the view of the page

Click on the page with the Magnifying Glass tool to enlarge the view of the page. Press Ctrl-0 (Windows) or Command-0 (Macintosh) to fit the page on the screen. Press Ctrl-2 (Windows) or Command-2 (Macintosh) to fit the width of the page on the screen.

201.03 SCREENING DOCUMENT FIELDS

The Long Term Screening Document is divided into eight sections. These are: Client Information, Screening/Assessment Information, General Function and History, Screening/Assessment Results, Professional Conclusions, Waiver/AC/MnDHO Eligibility Criteria, Service Plan Summary, and Alternative Care/Consumer Support Grant Information. This chart shows a field by field description and the edits, if any, that may post against the field.

Field #	Field Name	Description	Edits
1	Client Last Name	System Entered	167, 168
2	Client First Name	System Entered	167, 168
3	Middle Initial	System Entered	167, 168
4	PMI Number (Person Master Index)	System Entered	129
5	Reference Number	To identify the individual by the agency's unique numbering system.	None
6	Date Submitted	System Entered. The date the screening document is created on MMIS	None
7	Birth Date	This field must match the birthdate on the Recipient Subsystem.	248, 798
8	Sex	System Entered	None
9	Referral Date	The date of original referral for screening or assessment.	169
10	Activity Type	Identifies the activity: a face-to-face assessment, a telephone screening, or a case management activity. See section 201.04 for the definition of each type.	642, 643, 656, 685
10A	Reason	Field is used to indicate the reason for the Abbreviated Assessment Activity Type.	At time of manual update, the field was not ready for use.
11	Activity Type Date	The date the above activity occurred.	128, 137, 687, 782

Field #	Field Name	Description	Edits
12	COS, COR, CFR	County of Service, County of Residence and County of Financial Responsibility. Information entered is “written over” by MMIS if there is a financial worker involved with the case. COS refers to the county providing financial worker service for MA eligibility or redetermination. COR is where the person lives. For private pay, MSHO and all others without financial workers, assume the COS, COR and CFR are the same (i.e. where a person lives).	Fields turn red when left blank or contain an invalid value
13	PAS	County that completed the screening or assessment. For MSHO or MnDHO, it is the county of residence.	Field turns red when left blank or contain an invalid value
14	Legal Representative Status	Records guardianship or legal representative status as determined by a court.	139
15	Primary Diagnosis	The primary diagnosis that underlies the need for services and care. Use ICD-9 codes obtained from medical records.	205, 480 - 484
16	Secondary Diagnosis	The secondary diagnosis that may affect the need for care or services. Use ICD-9 codes obtained from medical records.	101, 102, 486, 489, 490
17	Is there a history of a MR/RC diagnosis?	Records if there is a history of a mental retardation or related condition diagnosis. (Y/N)	497
17A	If so, what is the diagnosis	Indicates the MR/RC diagnosis. Use ICD-9 codes obtained from medical records.	498 - 500, 652, 688, 689
18	Is there a history of a MI diagnosis?	Records if there is a history of a mental illness diagnosis (Y/N)	497
18A	If so, what is the diagnosis	Indicates the MI diagnosis. Use ICD-9 codes obtained from medical records.	498 - 500, 652, 688, 689
19	Is there a history of a TBI diagnosis?	Records if there is a history of a traumatic brain injury diagnosis (Y/N)	497
19A	If so, what is the diagnosis?	Indicates the TBI diagnosis. Uses ICD-9 codes obtained from medical records.	498 - 500, 652, 688, 689

Field #	Field Name	Description	Edits
20	Case Manager/Health Plan Name	System Entered	
21	Case Manager/Health Plan Number	For the MSHO and MnDHO program types, the health plan number (provider type 24) is entered. For all other waiver/AC program types, the case manager number is entered (provider type 23).	114, 260
22	Present at Screening/ Assessment	Identifies up to twelve different types of people who were present at the screening or assessment. NOTE: the County PAS Consult does not indicate that the second member of the team was physically present. It indicates that the consult occurred.	818, 819
23	Marital Status	Legal marital status.	809
24	Reason(s) for Referral	Why the person or family is requesting a screening or assessment. Use up to two different values.	820
25	Current Living Arrangement	Who the person lives with.	808
25A	Planned Living Arrangement	Who the person will live with.	808
26	Assessment Team	Who completed the assessment.	825
27	Hospital Transfer	Is the person being admitted to a long term care facility (nursing or certified boarding care facility) or leaving an acute care facility (hospital) to go to the community? (Y/N)	805
28	OBRA Screening Level 1	Was an OBRA Level 1 screening completed? (Y/N)	812
29	PAS 30 Day Exempt	A "Y" in this field indicates that an individual was excluded from a screening for the first 30 days of institution admission.	817

Field #	Field Name	Description	Edits
30	Current Housing Type	The setting where the person lives. NOTE: Assisted Living is not a housing type. It is a service that can be delivered in a variety of settings including licensed settings and the person's home. Do not use value 14 to indicate Assisted Living. Instead, indicate the type of license or the person's home.	650
30A	Planned Housing Type	The setting where the person will live.	651
31	OBRA Level 2 Referral	Indicate "y" if a referral was required and made as determined through Level 1 screening, or a Level 2 screening was completed prior to the Level 1 screening.	813, 649
32	TBI/CAC Referral	Indicates whether a referral was required and made according to TBI and CAC program requirements. For MnDHO this means if the person is opening to the MnDHO/TBI program then the Disability Services TBI paperwork must be completed and be on file at the healthcare system.	829
General Function and History Fields 33 - 64	ADLs Case Mix Disability Certification Self Evaluation Mental Status Evaluation IADLs Hospitalizations - 1 year Emergency Visits - 1 yr NF Stays - 3 years	Records information obtained during screening/assessment about the person's strengths and areas for support, and past health care utilization. The case mix letter will be evaluated by the system for accuracy based on the combination of ADL values.	180, 646, 653, 789 - 793, 795, 797, 799, 800, 804, 811, 816, 828, 831, 832, 834,
65A and 65B	Assessment Results and Exit Reasons	Field 65A: The outcome of the assessment activity; what happens to the person. Field 65B: When using an Exit Reason (values 19 - 26, 31, 33 or 34) in field 65A, an Assessment Result Code 02 -11, 14 - 18, 27, 30 or 98 must also be entered in field 65B to indicate what will happen to the person after leaving the program. Value 30 can only be used when the Exit Reason is 24 or 25.	504, 655, 780, 803

Field #	Field Name	Description	Edits
66	Assessment Results/Exit Date	Effective date of the outcome identified in field 65A. This date develops the eligibility span, extends the span, and closes the span on the RWVR (waiver) screen or the RELG (AC) screen.	109, 128, 213, 247, 263, 264, 502, 503, 677, 678, 690, 781, 786
67	Informed Choice	This field indicates that the person received information about and understands their rights regarding a choice between institution and community services, their right to a choice of available providers, and they signed the Community Support Plan, DHS Form 2925. Persons assessed for waivers and for other community assessments must be given this information, and this field must be a "Y".	141
68	Client Choice	The person's choice of services and setting.	823
69	Family Choice	The family's choice of services and setting for the person.	801
70	PAS/IDT Recommendation	The screening team's recommended services and setting for the person. Do not use "undecided".	830
71	Level of Care	The screening team's assessment of various levels of institutional need for care. For example, "NF Risk" indicates the person's need for the level of care a nursing facility provides.	179

Field #	Field Name	Description	Edits
72	NF Track Number	Since the case mix payment system was replaced by RUGS, the QAR forms are no longer used. The facility still needs to record that PAS was completed, and the Department suggests counties number the Level 1 form they forward to the facility in any way they choose as long as the initial numbers indicate the county code (e.g. Anoka = 02) so the facility can identify which county completed the PAS. You may choose to enter this number in this field on the screening document, but it is not required.	822
73	Case Mix/DRG Amount	The maximum monthly dollar limit that can be used for AC or waiver services. For the CAC and CSG programs, enter the monthly dollar amount in this field. For all other programs, it is system entered. See Bulletin 03-25-03 for information on requesting conversion rates.	793, 784, 794
74	Mn Diag Code (Shown on the MMIS screen as MnDC NUM)	Used for the CAC program, the field contains diagnostic code information obtained from DHS that is used to establish the rate cap for the person. Codes are provided by DHS. The final approved cap amount is entered by county staff in field # 73 with final approval by DHS staff.	645
75	Reason(s) for Continued or Long -Term Institution Stay	The reason(s) why the person remains in an institution after a relocation assessment is completed. Use up to two different values.	644
76 - 88	Professional Conclusions	Summary statements regarding the basis of "level of care" decisions as determined by assessors. Use Y or N.	647
89 - 91	Waiver/AC Eligibility Criteria	Verifies that waiver eligibility criteria have been reviewed and met. Use Y or N.	501

Field #	Field Name	Description	Edits
92	Program Type	<p>Indicates which program, if any, will fund planned services.</p> <p>Note: Program Type 22 (temporary AC) is used when a person's AC gross income and assets show that they are eligible for the MA program. The opening screening document is entered after the case manager has submitted the MA application and asset assessment for processing. Only 90 days of eligibility will be provided while the MA application is pending approval. The eligibility span cannot be extended or reopened after this initial eligibility period. A person cannot be opened to this program type if they were ever opened to the Elderly Waiver program in the past.</p>	243, 268, 269, 270, 272, 273, 648, 814, 815 821, 833, 879, 883
93	MnDHO RCC	The rate cell category used for this recipient on the MnDHO program.	692
94	Service Codes	Records informal care giving and/or quasi formal services. Mandatory for MSHO and MnDHO programs to provide information contained in the Service Plan (care plan). When selecting Relocation Service Coordination (Assessment Result 18), use value 38F in this section. May have up to eighteen different selections.	806

Field #	Field Name	Description	Edits
95	AC or CSG Recipient's Address	Always enter the first line of the address. The second line is optional. Information will transfer to the RCAD screen of the recipient file for the AC case record. Used to mail service agreement letters and other DHS correspondence to the person.	783
	CFR	The county of financial responsibility. Data entered will populate the CFR field on the first screen of the screening document and on the RELG screen for major program AC.	694
	*Gross Income	Enter the AC client's gross income as shown on the AC Financial Eligibility Worksheet in field II.A (DHS-2630) or II.D (DHS-2630A).	698, 833, 877, 878
	*Gross Assets	Enter the AC client's gross assets as shown on the AC Financial Eligibility Worksheet in field III.G (DHS-2630) or III.K (DHS-2630A).	698, 833, 877, 878
	*AC Adjusted Income	Enter the adjusted income used to determine whether the person will be required to pay a premium. Enter field II.C from DHS 2630 or enter II.G from DHS 2630A. Round to the nearest dollar.	694, 880
	*AC Adjusted Assets	Enter the adjusted asset amount used to determine whether the person will be required to pay a premium. Enter either field III.J from DHS 2630 or enter field III.O from DHS 2630A. Round to the nearest dollar.	694, 880
	Medicare ID Number	Verify this information by using the AC person's Medicare ID card or other documentation from Medicare.	389
	Medicare Part A Effective and Medicare Part B Effective	The begin date is the initial date of coverage and is the first day of the month. See Bulletin #98-25-11.	

Field #	Field Name	Description	Edits
96	AC Premium Waiver Reason	The reason that the person has no premium obligation because of one of these reasons. As of January 1, 2004, reasons 01 and 02 are no longer valid.	774, 775
97	AC Lien Referral	This field indicates if the AC Lien Referral was submitted by the case manager to DHS. Values are Y or N.	881
98	AC Premium Assessed	Indicates if the person will be paying an AC premium. Values are Y or N.	885
Section I	MSHO/MnDHO Only	Signatures of qualified professional	None

*Note: As of January 1, 2004 several new edits will assure that a person meets the Alternative Care program financial guidelines before an opening, reopening, or reassessment screening document can be approved.

Edit 877 “AC Minimum Limits” will post when the client’s Gross Income and Gross Assets fall below the financial guidelines to be on program type 09 or 10. Use program type 22 (temporary AC) but only if a completed, signed MA application has been received by the social services agency for processing. This program type will allow 90 days of AC eligibility while the MA application is pending. The eligibility span cannot be extended or reopened after 90 days. A person cannot be opened to AC Temporary if they were ever opened to the Elderly Waiver program in the past.

Edit 878 “Program Type 22 Invalid” will post when this program type is used and the client’s Gross Income and Gross Assets do not fall within the guidelines for temporary AC. Use program type 09 or 10 instead.

Edit 833 “Dual Access of AC/MA Not Allowed” will post when the Assessment Result Date falls within an eligibility span for MA and the client’s Gross Income and Gross Assets meet the financial guidelines for the MA program.

Edit 880 “AC Upper Limit Criteria Not Met” will post when the client’s combined AC Adjusted Income and Adjusted Assets exceed the maximum financial guidelines for the AC program.

The Gross Income, Gross Assets, Adjusted Income, Adjusted Asset, AC Waiver Reason, and AC Premium Assessed fields can be changed at any time using Activity Type 05 and Assessment Result 32.

Program Types: Diversions vs. Conversions

For purposes of coding program type, a diversion is a person who is not a resident of a long term care facility at the time of the initial referral for an assessment. A conversion is a person who was a resident of a long term care facility at the time of the initial referral for an assessment. A person who opens to a program under one of these types will remain that type until they exit the program.

If the person exits the program and later returns, it should be re-determined if they are now a diversion or a conversion. Exiting a program because of a funding change (such as exiting a program and opening to EW because of the EW expansion) does not constitute a change in the diversion or conversion type. See Bulletins #97-7-02 and #98-56-19 for more detailed information on the waiver programs supporting people with disabilities.

For purposes of payment, people who were residents of a facility for at least thirty days and enter the EW program may qualify for case mix rates higher than those available for diversions or conversions with less than a thirty day stay. See section 201.11 for more details.

201.04 USING ACTIVITY TYPES

An “Activity Type” indicates what task the LTCC staff or case manager completed.

Activity Type 01 - Telephone Screen

This activity type is used primarily for nursing facility admissions. Most admissions occur at discharge from an acute hospital. The LTCC statute limits this type of activity to admissions based on a decision regarding the need for facility care reached between the screener and another health care professional. This option assumes the screener can be provided with enough information to make the decision about the need for facility care. If not, a face-to-face assessment should be completed before admission is recommended. Completion of screening for mental illness or mental retardation are included in this activity (OBRA Level I) and nursing facility level of care.

Rules:

- ✓ only allowed when the screener has communication with another health care professional
- ✓ rarely dealing with admissions from the community
- ✓ usually used for admissions to a facility from the hospital
- ✓ program type is always 00
- ✓ screening for MI/MR (Level 1) and NF Level of Care Determination occur prior to admission (see Bulletin 97-67-01 for exemptions)
- ✓ admissions to a facility on a non-working day will result in the referral date, activity date, and assessment result date as the date of admission IF the agency was contacted on the first working day as required under law. If the agency is contacted later than the next business day, use the actual screening date for these fields.
- ✓ a telephone screening cannot be entered while the person is still on the waiver/AC program.

Activity Type 02 - Person to Person Assessment

This activity type represents the completion of a face-to-face assessment in the community. This activity type must always be completed for an initial opening to the waiver, AC or CSG programs from the community, as well as to indicate the provisions of waiver-like services and movement into certain rate cells under the MSHO or MnDHO program. This activity type will also permit the agency to document the election of ongoing Relocation Services Coordination by using Assessment Result 18.

NOTE: If an assessment is completed before a person is discharged from a facility, use Activity Type 04: Relocation/Transition.

Activity Type 03 - Visit/Early Intervention

This activity type represents a less-than-complete community visit. It is used for visits that result in providing information and referral or minimal assistance with services planning. For example, admission to institutions are not valid client outcomes for this level of assessment since the activity type neither indicates complete community assessment nor other health care professional involvement deemed necessary to determine need for admission.

Rules:

- ✓ indicates a face-to-face visit that was not fully completed
- ✓ use program type 00
- ✓ use assessment results 03 or 05

- ✓ does not indicate an opening to the waiver, AC or CSG programs

Activity Type 04 - Relocation/Transition Assessment

Use this activity type to indicate a face-to-face assessment before a person is discharged from an institution. It can be used to open the recipient to the AC, CSG or waiver programs. This activity type will also permit the agency to document the election of ongoing Relocation Services Coordination by using Assessment Result 18.

Activity Type 05 - Document Change Only

This activity type supports the need to make limited changes to an approved screening document. The changes are shown on a new screening document rather than the document that was entered in error. The waiver eligibility period on the RWVR screen is not increased. Only Assessment Result 32 or 98 can be used. It may be used in these circumstances:

- 1) when changes are needed to specific and limited fields to correct errors or update information. If a field is protected (i.e., it cannot be changed using this activity) it contains information that is intended to be changed only on the basis of a face-to-face assessment;
- 2) to enter and update a screening document with an activity type date of July 1 or after for purposes of increasing the case mix cap amount;
- 3) to change the Alternative Care or Consumer Support Grant recipient's address on the ALT6 screen; or the AC financial data.

Specific fields will be protected and not allowed to change while using this activity type. These fields are:
Section A: edit 754 will post if the PAS, Referral Date, Diagnosis and History fields are changed.

Section B: Fields 27 - 29, 31 and 32 are protected.

Sections C - F: All fields are protected.

If a protected field needs to be changed because of new information, a face-to-face visit is required rather than using Activity Type 05.

Activity Type 06 - Reassessment

This activity type is used to code face-to-face assessments provided at least annually during periods of continuous eligibility in the program.

Rules:

- ✓ the activity type date records the date of the actual reassessment. The assessment result date can be a later date.
- ✓ this activity type cannot occur before Activity Types 02 or 04.
- ✓ the assessment result date must fall within the waiver eligibility span (as shown on the RWVR screen in the recipient subsystem) or the AC eligibility span (as shown on the RELG screen in the recipient subsystem).
- ✓ the waiver or AC eligibility span will increase based on the assessment result date (see Section 201.08).

Activity Type 07 - Case Management/Administrative Activity

This activity type allows the performance of certain case management activities. It is to be used for specific tasks and does not replace a face-to-face assessment or case management visits. When used as an initial opening or when exiting the person from a program, the RWVR (waiver) or RELG (AC) eligibility span is changed.

Specific tasks performed with this activity type are:

- 1) Closing a program. Exit reasons 19 - 26, 31, 33 or 34 are entered into field 65A. The client outcome (values 02 - 11, 14 - 18, 27, 30 or 98) is entered into field 65B. When a person is entering a nursing facility at closing, the completion of any needed OBRA Level I screening is also documented.
- 2) Opening to EW because of the EW expansion (SIS/EW). Use this sequence:
To Exit AC Program Type 09 or 10 Exit Reason 19/10
To Open EW Program Type 03 or 04 Assessment Result 10 or 11
When using Exit Reason 19 to close the AC program, and Assessment Result 10 or 11 to open the EW program, it is not necessary to use Assessment Result 10 or 11 within 60 days of Assessment Result 19.
- 3) Recording an opening to a program within 60 days of a face-to-face assessment. Activity Type 07 with Assessment Result 01 is a valid combination only when immediately following Activity Type 02 or 04 with Program Type 00. The Activity Type Date of Activity Type 07 must be within 60 days of the Activity Type Date of Activity Type 02 or 04.

Activity Type 07 with Assessment Result 10 or 11 is valid when immediately following Assessment Result 19 - 26 only if the Assessment Result Date of Activity Type 07 is less than 61 days from the previous Activity Type 02, 04, 06, or 08.

- 4) Recording Relocation Service Coordination within six months of a face-to-face visit.
Many fields will be protected while using the activity type. These fields are:
Section A: edit 754 will post if the PAS, Referral Date, Diagnosis and History fields are changed.
Section B: fields 27, 31 and 32 are protected
Section C: all fields are protected except case mix
Section D: fields 71, 74 and 75 are protected. If program type is 04, the Case Mix/DRG Amount field is unprotected.
Section E: all fields are protected
Section F: fields 89 - 91 are protected
Sections G and H: no fields are protected

If a protected field needs to be changed because of new information, a face-to-face visit is required rather than using Activity Type 07.

Activity Type 08 - CAC/CADI/TBI/MnDHO Reassess 65th Birthday

This activity type is only used for the CADI, CAC, TBI, or MnDHO participant during the 65th birthday month. The person must be reassessed to determine whether EW could meet their needs. If so, the person is changed to the EW program. They may continue on the CADI, CAC, TBI or MnDHO program. This activity type cannot be used prior to Activity Types 02 or 04.

Activity Type	Assessment Result
08	22/10 (to leave CAC/CADI/TBI/MnDHO Program)
02	10 (to change to the EW or MSHO Program. Change the program type field also)
Or	
Activity Type	Assessment Result
08	13 (remain on CAC/CADI/TBI/MnDHO Program)

Activity Timelines

There are statutory timelines attached to the performance of certain LTCC or case management activities. Failure to perform these activities within timelines specified result in gaps in eligibility, discontinuance or denial of payments to providers, and non-compliance with state and federal program requirements. MMIS uses the Activity Type Date to determine whether timelines have been met. In addition, MMIS will edit for certain sequences of activities requiring or prohibiting certain sequences of tasks.

Timelines Associated with Activity Types

Activity Type 01 - Telephone Screening

There are several mandates associated with nursing facility admissions; the primary outcome of telephone screening. Timelines differ based on the expected length of stay in the facility and/or the age of the person being admitted.

- 2) Before Admission. All persons entering a certified nursing or boarding care facility must receive preadmission screening *before admission*, regardless of the payer source of NF services. This includes level of care determination, completion of Level I screening and any required Level II activity.
- 3) Persons Less than 21 Years of Age. Telephone screening is not permitted. Admission always requires a face-to-face assessment and Department approval.
- 4) 30-Day Exemption from Preadmission Screening. No preadmission screening is required for a person who is discharged from an acute hospital and enters a nursing facility for the same condition and whose physician documents the expected length of NF stay will be 30 days or less. However, if the stay exceeds 30 days:
 - a. and the person is under age 65, the LTCC staff in the county where the facility is located must complete a face-to-face assessment (see Activity Type 02 or 04) no later than the 40th day after admission AND any required OBRA Level II activity must be completed by the person's county of financial responsibility (CFR) no later than the 40th day after admission.
 - b. or the person is over the age of 65 the LTCC staff in the county where the facility is located must complete a telephone screening no later than the 40th day after admission regardless of the payer source for NF services or the person's eligibility for Minnesota Health Care programs AND any required OBRA Level II activity must be completed by the person's county of financial responsibility (CFR) no later than the 40th day after admission.

- 4) Impact on NF Claims. No Medical Assistance payment for NF services will be made for services provided prior to the Activity Type Date on the LTC Screening Document indicating the date the telephone screening occurred. In addition, for persons under age 65 who enter a facility with a telephone screening must complete tasks listed in 3a. For persons under age 65 a telephone screening is permitted for these admission as long as the county where the facility is located also completes a face-to-face assessment (see Activity Type 02 or 04) within 20 working days of admission. This face-to-face assessment may also occur before admission when feasible.
- 5) Emergency Admissions.
- 6) Admissions on Non Working Days.

Activity Type 02 - Face to Face Assessment

Completion of this comprehensive assessment is required to be completed within ten (10) working days of the request for recommendation for this visit. Use the “Referral Date” on the LTC Screening Document to enter the date of request or referral. This assessment is valid for 60 days from completion (the Activity Type Date) for purposes of opening to a waiver, Alternative Care (AC), MnDHO programs or nursing facility admission. Persons under age 65 entering a facility must be seen face-to-face again within twenty (20) working days of admission.

Note: Support or Care Plan Development: The “product” of assessment is the development of a community support plan. This is completed within twenty (20) working days of the visit.

Activity Type 03 - Early Intervention

This in-person visit with an individual did not include a comprehensive assessment. The visit must occur within ten (10) working days of the request or referral. The person may request assistance with community support planning which must be completed (to the extent possible given the information obtained during the Early Intervention) within twenty (20) working days of the visit.

Activity Type 04 - Face-to-Face Assessment

The requirements are the same as those outlined for Activity Type 02. Use this Activity Type to record comprehensive assessment and support plan development activities provided to a person who has not been discharged from an institution at the date of assessment.

Activity Type 05 - Document Change

This Activity Type is used on an as-needed basis, and whenever the person’s AC Gross Income or Asset, or AC Adjusted Income and Asset financial data changes. Also, when the AC Waiver Reason as well as the AC Premium Assessed fields are changed.

Activity Type 06 - Assessment Results

Used on an annual basis (within twelve months of last assessment) or whenever there is a change in case mix or a need for a face-to-face visit.

Activity Type 07 - Case Management/Administrative Activity

Primarily used for exiting or closing people who are no longer eligible for or who choose to leave the waiver, AC or MnDHO programs. This is the only activity type under which the Assessment Result Date can occur prior to the Activity Type Date when using an Exit Assessment Result.

Activity Type 08 - CAC/CADI/TBI/MnDHO 65th Birthday

This Activity Type is used during the 65th birthday month to indicate that the case manager made a decision to either keep the person on the same program, or close the program and open the person to the Elderly Waiver program (or MSHO for MnDHO persons) if the person chooses to change programs.

201.05 USING ASSESSMENT RESULTS

Action	Assessment Result Description/Use
Program Types 01 - 14, 22 Using Home & Community Based Services (HCBS) Programs	Initial Opening to Program - 01 Opening to a New Program - 10 Reopening to Same Program - 11 Reassessments - 13 Opening From a County Waiting List - 28 Updating AC Financial Data - 32 Exiting the Program - 19 - 26, 31, 33 or 34*
Program Type 00 Screened, Not Opening to HCBS Programs	Screened/Assessed and Staying in Community - 02 or 03 Screened/Assessed and Admitted to Institution - 04 - 09 Screened/Assessed and electing Relocation Service Coordination - 18 Screened and Person Placed on County Waiting List - 27
Program Types 15 - 19 MSHO Programs Program Type 20 (Home Care, NF and TBI) Program Type 21 (MnDHO - CADI)	Values 14 - 17 - Opening to MSHO Program Initial Open to Program can be 01 - 05, 07 - 09. Opening to New Program = 10 Reopening to Same Program = 11 Open from a waiting list = 28 Exiting the program = 19 - 24 and 26 Initial Open to New Program = 01 Opening to New Program = 10 Reopen to Same Program = 11 Open from a waiting list = 28 Exiting the Program = 19 - 24 and 26
Outcome of assessment is “undecided” Outcome of assessment is “other” Outcome of assessment is “Not Applicable; No Family”	Value 29 is used in fields 68 or 69 only Value 98 is used in fields 68 - 70 only unless Activity Type is 05 then value can be used in field 65A. Value 99 can be used in field 69 only

Field 65B

When using an Exit (19 - 26, 31, 33 or 34) an exit reason must be entered into field 65B. The Exit Date must be dated prior to or within the current month. Use values 02 - 11, 14 - 18, 27, 30 or 98 to indicate why the person left the program. Value 30 can only be used when the Exit is 24 or 25.

*Exit 25 is used when NO services were provided (including case management) and NO claims for program services will be submitted. The eligibility span will be deleted and the EW “slot” will be immediately withdrawn.

Assessment Result Date Rules

1. Except for Activity Type 07 using Assessment Result 19 - 26, 31, 32, or 34 the Assessment Result Date must have a date that is equal to or after the Activity Type Date. Edit 503.
2. The Assessment Result Date may be dated up to 40 days prior to the Activity Type Date when the Assessment Result = 04, 07 or 08, and the PAS 30 Day Exempt field = "y". Edit 503.
3. The Assessment Result Date cannot be more than 60 days after the Activity Type Date for Activity Types 01 - 04, 06 - 08. Edit 503.
4. If Program Type = 01 - 08, 11, 12 or 15 - 18, the Assessment Result Date must fall within a major program MA (Medical Assistance) span. If Program Type = 09 or 10 and the Activity Type = 06, or the Assessment Result = 19 - 26, 31, 33, or 34, the Assessment Result Date must fall within a major program Alternative Care (AC) span. If Program Type = 22 and the Assessment Result = 19 - 26, 31, 33, or 34, the Assessment Result Date must fall within a major program Alternative Care (AC) span. If the Program Type is 20 or 21, the Assessment Result date must fall within 30 days prior to capitation. Edit 690.
5. The Activity Type Date cannot be prior to the last approved Activity Type Date and/or the Assessment Result/Exit Date can not be prior to the last approved Assessment Result/Exit Date. Edit 128.
6. The exit date in the Assessment Result Date field must be dated prior to or within the current month. Edit 781.
7. Assessments: For MnDHO Assessment, a complete PAS and PASARR will be conducted for all new enrollees using the Minnesota Preadmission Screening and Assessment form.
8. Reassessment: For MnDHO Reassessments a complete PAS using the Minnesota Preadmission Screening and Assessment form will be conducted at least every 12 months and as needed if the enrollee's functioning, health condition, or living status changes.

Correct Assessment Result Values with Activity Type Values

These charts show which Assessment Results can be used with each Activity Type.

For Waiver, CSG, and Alternative Care Program Types (**Program Types 01 - 14, 22**)

Activity Types →	01 - Telephone Screening	02 - Face to Face	03 - Visit/Early Intervention	04 - Relocation/ Transition	05 - Document Change	06 - Reassessment	07 - Case Mgt./ Admint.	08 - 65 th B-Day Reassess.
Assessment Results ↘								
01 - In the community with CSG, AC, or waiver services		Y		Y			Y (only within 60 days of an Activity Type 02 or 04)	
10 - Change to new program		Y (only after an exit)		Y (only after an exit)			Y (only within 60 days of an Activity Type 02, 04, 06 or 08)	Y (only after an exit)
11 - Reopen to same program		Y (use if ever opened to same program)		Y (use if ever opened to same program)			Y (only within 60 days of an Activity Type 02, 04, 06, or 08)	
13 - Remain on same program						Y (not with program type 22)		Y
18 - Relocation Service Coordination		Y		Y				
19 - Exit, EW Expansion						Y (not with program type 22)	Y	Y
20 - Exit, needs not met						Y (not with program type 22)	Y	Y
21 - Exit, not at risk						Y (not with program type 22)	Y	Y
22 - Exit, not eligible						Y (not with program type 22)	Y	Y

23 - Exit, person choice						Y (not with program type 22)	Y	Y
24 - Exit, other reasons						Y (not with program type 22)	Y	Y
25 - Exit, no services ever used							Y	
26 - Exit, county change						Y (not with program type 22)	Y	Y
27 - On waiting list								
28 - Open from waiting list		Y (only following Assessment Result 27)		Y (only following Assessment Result 27)			Y (only following Assessment Result 27)	
31 - Exit, non payment of AC obligation						Y (only for program types 09 and 10)	Y (only for program types 09, 10, and 22)	
32 - Update AC financial					Y (only for program types 09, 10, and 22)			
33 - Exit, due to AC liens and estate claim recovery						Y (only for program types 09 and 10)	Y (only for program types 09, 10, and 22)	
34 - Exit, due to AC obligation change						Y (only for program types 09 and 10)	Y (only for program types 09, 10, and 22)	
98 - Other					Y			

For Community or Institutional Screenings and Assessments (**Program Types 00 or 19**)

Activity Types →	01 - Telephone Screening	02 - Face to Face	03 - Visit/Early Intervention	04 - Relocation/ Transition	05 - Document Change	06 - Reassessment	07 - Case Mgt./ Admint.	08 - 65 th B-Day Reassess.
Assessment Results ↘								
02 - In comm w/o AC, CSG, or waiver	Y	Y		Y				
03 - In community w/no service	Y	Y	Y	Y				
04 - In NF or Cert. B&C	Y (not under age 21)	Y		Y				
05 - In Noncertified B&C	Y (not under age 21)	Y	Y	Y				
06 - ICF/MR	Y	Y		Y				
07 - Hospital to Sort Term NF	Y (not under age 21)	Y		Y				
08 - Hospital to Long Term NF	Y (not under age 21)	Y		Y				
09 - Acute Care Hospital	Y	Y		Y				
18 - Relocation Service Coordination		Y		Y			Y	
27 - On waiting list		Y		Y				
98 - Other					Y			

For MSHO Program Types (**Program Types 15 - 19**)

Activity Types →	01 - Telephone Screening	02 - Face to Face	03 - Visit/Early Intervention	04 - Relocation/ Transition	05 - Document Change	06 - Reassessment	07 - Case Mgt./ Admint.	08 - 65 th B-Day Reassess
Assessment Results ↘								
01 - In community with CSG, AC or waiver services		Y						
02 - In comm w/oAC, CSG, WA		Y				Y		
03 - In community w/no service		Y				Y		
04 - In NF or Cert. B&C		Y**						
10 - Change to new program		Y						
11 - Reopen to same program		Y						
13 - Remain on same program						Y		
14 - MSHO-NHC short term	Y	Y				Y		
15 - MSHO - NHC long term	Y	Y				Y		

16 - MSHO - Non-NHC short	Y*	Y*						
17 - MSHO - Non-NHC long	Y*	Y*						
19 - Exit, EW Expansion							Y	
20 - Exit, person choice							Y	
21 - Exit, not at risk							Y	
22 - Exit, not eligible							Y	
23 - Exit, person choice							Y	
24 - Exit, other reasons							Y	
26 - Exit, county change							Y	

*Program Type 18 only

**Program Type 19 only

For MnDHO Program Type (**Program Type 20**)

Activity Types →	01 - Telephone Screening	02 - Face to Face	03 - Visit/Early Intervention	04 - Relocation/ Transition	05 - Document Change	06 - Reassessment	07 - Case Mgt./ Admint.	08 - 65 th B-Day Reassess.
Assessment Results ↘								
01 - In community with CSG, AC or waiver services		Y		Y				
02 - In community w/o AC, CSG, WA		Y		Y		Y	Y (only within 60 days of an Activity Type 02 or 04)	
03 - In community w/no service		Y		Y		Y	Y (only within 60 days of an Activity Type 02 or 04)	
04 - In NF or Cert. B&C		Y				Y	Y (only within 60 days of an Activity Type 02 or 04)	
05 - In Noncertified B&C		Y				Y	Y (only within 60 days of an Activity Type 02 or 04)	
07 - Hospital to Short Term NF		Y				Y	Y (only within 60 days of an Activity Type 02 or 04)	
08 - Hospital to Long Term NF		Y				Y	Y (only within 60 days of an Activity Type 02 or 04)	

Activity Types →	01 - Telephone Screening	02 - Face to Face	03 - Visit/Early Intervention	04 - Relocation/ Transition	05 - Document Change	06 - Reassessment	07 - Case Mgt./ Admint.	08 - 65 th B-Day Reassess.
Assessment Results ↘								
09 - Acute Care Hospital		Y				Y	Y (only within 60 days of an Activity Type 02 or 04)	
10 - Change to new program		Y				Y		
11 - Reopen to same program		Y				Y		
13 - Remain on same program						Y	Y	Y
18 - Relocation Service Coordination				Y				
19 - Exit, EW Expansion								Y
20 - Exit, person choice						Y	Y	Y
21 - Exit, not at risk				Y		Y	Y	
22 - Exit, not eligible						Y	Y	
23 - Exit, person choice						Y	Y	
24 - Exit, other reasons						Y	Y	
26 - Exit, county change						Y	Y	
27 - On waiting list		Y					Y	
28 - Open from waiting list		Y (used only after 27)		Y				

For MnDHO Program Type (**Program Type 21**)

Activity Types →	01 - Telephone Screening	02 - Face to Face	03 - Visit/Early Intervention	04 - Relocation/ Transition	05 - Document Change	06 - Reassessment	07 - Case Mgt./ Admint.	08 - 65 th B-Day Reassess.
Assessment Results ↘								
01 - In community with CSG, AC or waiver services		Y		Y			Y (only within 60 days of an Activity Type 02 or 04)	
02 - In comm w/oAC, CSG, WA							Y (only within 60 days of an Activity Type 02 or 04)	
03 - In community w/no service							Y (only within 60 days of an Activity Type 02 or 04)	
04 - In NF or Cert. B&C							Y	
05 - In Noncertified B&C							Y	
07 - Hospital to Short Term NF							Y	
09 - Acute Care Hospital							Y	
10 - Change to new program		Y (only after an exit)		Y (only after an exit)		Y	Y	
11 - Reopen to same program		Y (use if ever opened to same program)		Y (use if ever opened to same program)		Y	Y	

Activity Types →	01 - Telephone Screening	02 - Face to Face	03 - Visit/Early Intervention	04 - Relocation/ Transition	05 - Document Change	06 - Reassessment	07 - Case Mgt./ Admint.	08 - 65 th B-Day Reassess.
Assessment Results ↘								
13 - Remain on same program						Y	Y	Y
19 - Exit, EW Expansion						Y		Y
20 - Exit, person choice						Y		Y
21 - Exit, not at risk						Y		Y
22 - Exit, not eligible						Y		Y
23 - Exit, person choice						Y		Y
24 - Exit, other reasons						Y		Y
26 - Exit, county change						Y		Y
27 - On waiting list		Y						
28 - Open from waiting list		Y		Y				

Screening Scenarios: Activity Type/Assessment Result Combinations

<p>Preadmission screening related to NF admission is completed for person by telephone</p>	<p>Activity Type 01, Assessment Results 02 - 09</p>
<p>Person is visited face to face in the community but the full assessment is not completed</p>	<p>Activity Type 03, Assessment Results 03 or 05</p>
<p>Person is visited face-to-face in the community, assessment is completed and will:</p> <ul style="list-style-type: none"> - remain in community with HCBS or AC services - remain community without HCBS or AC services - move to institution - move to institution with Relocation Service Coordination (RSC) - in community with no HCBS or AC services and placed on county waiting list. 	<p>Activity Type 02, Assessment Results 01 Enter service agreement. Activity Type 02, Assessment Results 02 or 03</p> <p>Activity Type 02, Assessment Results 04 - 09</p> <p>Activity Type 02, Assessment Result 18</p> <p>Activity Type 02, Assessment Result 27</p>
<p>Person is visited face-to-face in an institution, assessment is completed and will:</p> <ul style="list-style-type: none"> - return to community with waiver or AC services - return to community with informal supports or services other than waiver and AC - remaining in institution - remain in institution with RSC. - remain in institution and placed on county waiting list. 	<p>Activity Type 04, Assessment Result 01 Enter service agreement. Activity Type 04, Assessment Results 02 and 03</p> <p>Activity Type 04, Assessment Results 04 - 09 Activity Type 04, Assessment Result 18 Activity Type 04, Assessment Result 27</p>
<p>Housekeeping. Screening documents can be entered at any time.</p> <p>Information on previous screening document needs updating or correcting. A new screening document is entered to show new information. This type of document can be added anywhere in the sequence of documents.</p> <p>The Gross Income, Gross Assets, Adjusted Income, and/or Adjusted Assets for the AC recipient has changed.</p>	<p>Activity Type 05, Assessment Result 98.</p> <p>Activity Type 05, Assessment Result 32.</p>

<p>Program Management Activity</p> <p>Person A. Initial opening to the waiver program.</p> <p>Person is reassessed (annually or at any time).</p> <p>Person is exited from program.</p> <p>Person reopens to the same program <i>within</i> 60 days of Activity Type 06; OR</p> <p>Person reopens to the same program <i>after</i> 60 days of Activity Type 06.</p> <p>Person is reassessed which results in exiting from the program.</p>	<p>Activity Type 02 or 04, Assessment Result 01. Enter new service agreement.</p> <p>Activity Type 06, Assessment Result 13. If this is an annual reassessment, enter new service agreement.</p> <p>Activity Type 07, Assessment Result 19 - 24, 26, 31, 33, or 34 with Assessment Results 02 - 09, 27, or 98 in Field 65B. Close service agreement.</p> <p>Activity Type 07 with Assessment Result 11. Add new service agreement.</p> <p>Activity Type 02 or 04, with Assessment Result 11. Add new service agreement.</p> <p>Activity Type 06 with Assessment Result 19 - 24 or 26 and value 02 - 11, 27, or 98 in field 65B. Close service agreement.</p>
<p>Person B. Person is screened face-to-face in the community resulting in no services.</p> <p>Person is opened to the waiver/AC program <i>within</i> 60 days of face-to-face screening.</p> <p>Person will enter an institution for <i>more than</i> 30 days without RSC.</p> <p>Person returns to community.</p>	<p>Activity Type 02 with Assessment Results 02 or 03.</p> <p>Activity Type 07 with Assessment Result 01. Add service agreement.</p> <p>Activity Type 07 with Assessment Results 23 or 24. Close all line items and header period on service agreement to date of admission.</p> <p>Activity Type 07 with Assessment Result 10 or 11 if within 60 days of last face-to-face visit. Otherwise, Activity Type 02 (community visit) or 04 (institution visit) with Assessment Result 10 or 11. Enter new service agreement.</p>

<p>Person C. Person is screened face-to-face in the institution resulting in no services.</p> <p>Person is opened to the waiver/AC program <i>more than</i> 60 days of face-to-face screening.</p> <p>Person is exited from the program. No services (even case management) was provided.</p>	<p>Activity Type 04 with Assessment Results 04 - 09.</p> <p>Activity Type 02 or 04 with Assessment Result 01.</p> <p>Activity Type 07 with Assessment Result 25.</p>
<p>Person D. Person has a face-to-face screening and is placed on county waiting list.</p> <p>Person is opened to the waiver/AC program and taken off the county waiting list.</p> <p>Person exits county of service</p> <p>Person is open to new county of service for the same program, OR Person is opened to new county of service for a different program.</p>	<p>Activity Type 02 or 04 with Assessment Result 27.</p> <p>Activity Type 02 or 04 with Assessment Result 28. Add service agreement.</p> <p>Activity Type 07 with Assessment Result 26. Close service agreement.</p> <p>Activity Type 02 with Assessment Result 11.</p> <p>Activity Type 02 with Assessment Result 10. New county adds new service agreement.</p>
<p>Person E. Person is opened to the CADI, CAC, or TBI program.</p> <p>Person turns age 65 and remains on program OR</p> <p>Person turns age 65 and exits program.</p> <p>Person opens to the EW program</p> <p>Person will enter an institution for <i>less than</i> 30 days without RSC..</p> <p>Person returns to community <i>within</i> 30 days.</p>	<p>Activity Type 02 or 04 with Assessment Result 01. Add new service agreement.</p> <p>Activity Type 08 with Assessment Result 13. Keep same service agreement.</p> <p>Activity Type 08 with Assessment Result 20, 22, or 23 and value 10 in field 65B. Close service agreement.</p> <p>Activity Type 08 with Assessment Result 10. Add new service agreement.</p> <p>Close all line items on service agreement to date of admission. Leave header period end date alone.</p> <p>Add new line items with new begin dates.</p>

<p>Person F. Person is opened to the waiver program.</p> <p>Person will enter an institution with RSC.</p> <p>Person returns to community.</p>	<p>Activity Type 02 or 04 with Assessment Result 01. Add service agreement.</p> <p>Activity Type 07 with Assessment Result 20, 23 or 24. Close all line items on service agreement to date of admission. Enter new screening document signifying that RSC will be used (see Section 201.07).</p> <p>Activity Type 07 with Assessment Result 10 or 11 if within 60 days of last face-to-face visit. Otherwise, Activity Type 02 (community visit) or 04 (institution visit) with Assessment Result 10 or 11. Enter new service agreement.</p>
<p>Person G. Person is opened to the Alternative Care program.</p> <p>Person will enter an institution for <i>less than 30</i> days without Conversion Case Management.</p> <p>Person returns to community <i>within 30</i> days.</p>	<p>Activity Type 02 or 04 with Assessment Result 01. Add service agreement.</p> <p>Close all line items on service agreement to date of admission. Leave header end date alone.</p> <p>Add new line items to service agreement starting with the new community date.</p>
<p>Person H. Person is opened to the Alternative Care program.</p> <p>Person will enter an institution for <i>more than 30</i> days without Conversion Case Management.</p> <p>Person returns to community.</p>	<p>Activity Type 02 or 04 with Assessment Result 01. Add service agreement.</p> <p>Activity Type 07 with Assessment Results 23 or 24. Informational edit 833 will post. Close all line items and header period on service agreement to date of admission.</p> <p>Activity Type 07 with Assessment Result 10 or 11 if within 60 days of last face-to-face visit. Otherwise, Activity Type 02 (community visit) or 04 (institution visit) with Assessment Result 10 or 11. Enter new service agreement.</p>

<p>Person I. Person is opened to the Alternative Care program.</p> <p>Person will enter an institution with AC Conversion Case Management.</p> <p>Person returns to community.</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, 11, or 28. Add service agreement.</p> <p>Close all line items on service agreement to date of admission. If service agreement type is a “diversion” keep the Case Management line item open. If service agreement type is a “conversion”, close the Case Management line item and enter a new line item for AC Conversion Case Management. AC Conversion Case Management may be provided up to 100 days. Edit 882 will post if the line item period exceeds this amount.</p> <p>If person is returning to the community within the SA header period, add new line items for services beginning with the new community period. End the Conversion Case Management line item.</p> <p>If person is returning to the community after the SA has ended, a reassessment visit is needed during the last month of eligibility. Enter AT 06 with AR 13. Add new service agreement.</p>
<p>Person J. Person is opened to the Alternative Care program and MA at the same time.</p> <p>Person will enter an institution with Conversion Case Management.</p> <p>Person returns to community.</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, 11 or 28. Add service agreement.</p> <p>Close the SA header period and all line items on service agreement to date of admission. Add exit SD with AT 07 and AR 20, 23 or 24. Informational edit 883 posts. Add screening document for RSC.</p> <p>Enter SD for Activity Type 07 with AR 11 (if opening within 60 days of the last face-to-face visit. If not, another visit is necessary. Then use AT 02 or 04 with AR 11). Add new service agreement.</p>

<p>Person K. Person is opened to the Alternative Care program temporary with program type 22 while waiting for approval of MA application.</p> <p>MA application is approved.</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, or 28. Informational edit 879 will post. Add service agreement.</p> <p>Enter exit SD with Activity Type 07 and Assessment Result 19. Informational edit 883 posts.</p> <p>Enter opening SD for the EW program with Activity Type 07 and Assessment Result 10. Add new service agreement.</p>
<p>Person L. Person is currently open to MA and a SD is entered to open to the AC program with program type 09 or 10 (regular AC) during the same period. The person's gross income and gross assets indicates the person should be open to the EW program instead.</p> <p>Person must be opened to the EW program possibly with a waiver obligation instead (SIS/EW).</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, 11 or 28. Edit 833 posts which denies the document.</p> <p>Activity Type 02 or 04 with Assessment Result 01, 10, 11 or 28 and program type 03 or 04. Add service agreement.</p>
<p>Person M. Person is attempting to open to the AC program with program type 09 or 10 (regular AC) with gross income and gross assets that indicate the person should apply for Medical Assistance.</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, 11, or 28. Edit 877 posts.</p> <p>Must use program type 22 (temporary AC) and the person must apply for MA. This program type will allow AC eligibility for 60 days while waiting for approval of the MA application. Informational edit 879 will post. Add service agreement.</p>
<p>Person N. Person is attempting to open to the AC program with program type 22 (temporary AC) with gross income and gross assets that indicate the person cannot be on temporary AC.</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, or 28. Edit 878 posts.</p> <p>Must use program type 09 or 10 (regular AC). Add service agreement.</p>

<p>Person O. Person is opened to the Alternative Care program temporary with program type 22 while waiting for approval of MA application.</p> <p>Person's application for MA is not approved at the end of the 60 day period.</p> <p>The MA application is approved and backdated.</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, or 28. Informational edit 879 will post. Add service agreement.</p> <p>AC eligibility period is 60 days and cannot be extended (Edit 780 posts) or reopened (Edit 803 posts). Services may continue at provider's risk of non payment.</p> <p>Add screening document to exit AC: Activity Type 07 with Assessment Result 19. Informational edit 883 posts.</p> <p>Add screening document to open to EW: Activity Type 07 with Assessment Result 10 for program type 03 or 04 (EW). The Assessment Result date will be the date following the last day of AC eligibility. Add service agreement.</p>
<p>Person P. Person is opened to the EW program.</p> <p>Person exits and attempts to open to the AC temporary program.</p>	<p>Activity Type 02 or 04 with Assessment Result 01 or 28 and program type 03 or 04.</p> <p>Activity Type 02, 04, or 07 with Assessment Result 10. Edit 780 posts. Person cannot be opened to temporary AC. Use Program Type 09 or 10.</p>
<p>Person Q. Person has a combined adjusted income and adjusted assets that is more than maximum financial guideline for the AC program.</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, 11, or 28 and program type 09 or 10; or Assessment Result 01, 10, or 28 with program type 22. Edit 880 posts. Document is denied. Person cannot be opened to the AC program.</p>

<p>Person R. Person is opened to temporary AC.</p> <p>Person's gross income/assets and/or adjusted income/assets increase.</p> <p>Person is now open to AC regular.</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, or 28 and program type 22.</p> <p>Activity Type 05 with Assessment Result 32. Edit 878 posts if person is no longer financially eligible for temporary AC. Exit person with Activity Type 07 with Assessment Result 19. Do not change the gross income/assets or adjusted income/assets. The Assessment Result date will be the last day the current financial data is effective. Close service agreement.</p> <p>Activity Type 07 with Assessment Result 10. The Assessment Result date is the first date the new financial data is effective. Change the program type to 09 or 10. Change the gross income/assets and/or adjusted income/assets. Add new service agreement and change the premium and effective date on the ASA2 screen.</p>
<p>Person S. Person is opened to regular AC.</p> <p>Person's gross income/assets and/or adjusted income/assets decrease.</p> <p>Person is now open to temporary AC.</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, or 28 and program type 09 or 10.</p> <p>Activity Type 05 with Assessment Result 32. Edit 833 posts if person is no longer financially eligible for regular AC. Exit person with Activity Type 07 with Assessment Result 19. Do not change the gross income/assets or adjusted income/assets. The assessment result date will be the last day the current financial data is effective. Close service agreement.</p> <p>Activity Type 07 with Assessment Result 10. The Assessment Result date is the first date the new financial data is effective. Change the program type to 22. Change the gross income/assets and/or adjusted income/assets. Edit 879 posts. Person must submit an application for MA. Add new service agreement and change the premium and effective date on the ASA2 screen.</p>

<p>Person T. Person is opened to the AC program.</p> <p>Person's gross income/assets and/or adjusted income/assets change. AC premium changes.</p> <p>Person exits AC because of a change in the AC premium. Informational edit 883 posts.</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, or 28 and program type 09, 10 or 22.</p> <p>Activity Type 05 with Assessment Result 32. Enter service agreement and change the premium and effective date on the ASA2 screen.</p> <p>Close service agreement. Enter a screening document with Activity Type 07 with Assessment Result 34.</p>
<p>Person U. Person is opened to the AC program.</p> <p>Person's gross income/assets and/or adjusted income/assets change.</p> <p>Person exits AC because of AC liens and estate claim recovery. Informational edit 883 posts.</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, or 28 and program type 09, 10 or 22.</p> <p>Activity Type 05 with AR 32.</p> <p>Close service agreement. Enter a screening document with Activity Type 07 with AR 33.</p>
<p>Person V. Person is opened to the AC program.</p> <p>Person does not pay their premium for more than 60 days.</p> <p>Person will not be able to reopen to the AC program for the next 30 days.</p>	<p>Activity Type 02 or 04 with Assessment Result 01, 10, or 28 and program type 09, 10, or 22.</p> <p>Enter exit screening document with Activity Type 07 with Assessment Result 31. Informational edit 883 posts. Close service agreement.</p>

Note: See Bulletin 03-25-04 for information on edit 883 - submitting the AC estate claim referral worksheet to the county's recovery unit; assessment result 31 (exit, non payment of monthly fee); and assessment result 33 (exit, due to AC liens and estate claim recovery).

201.06 MANDATORY FIELDS

This section shows which fields are mandatory for each program type. Please note some exceptions based on the Assessment Result or Activity Type.

Program Type Name	Program Type #	Program Type Name	Program Type #
None	00	TBI-NB	11, 12
TBI-NF	01, 02	CSG	13, 14
EW	03, 04	MSHO	15 - 18
CADI	05, 06	MA/MSHO NF	19
CAC	07, 08	MnDHO	20, 21
AC	09, 10	Temporary AC	22

Program Type 00 (Telephone Screens, Early Intervention, Relocation Activities)

All of Section A is to be completed except for:

Reference #
Referral Date (mandatory for Activity Types 01 - 04)
Legal Rep Status
Case Manager

All of Section B is to be completed except for:

Marital Status (mandatory for Activity Type 03)
Current Living Arrangement
Planned Living Arrangement
Hospital Transfer (mandatory for Assessment Result 07 or 08)
PAS 30 Day Exempt (mandatory for Activity Types 01 and 04)
Planned Housing Type
TBI/CAC Referral

Section C:

ADL Fields (mandatory for Activity Types 02 and 04)
IADL Fields (mandatory for Activity Types 02 and 04)

All of Section D is to be completed except for:

Client Choice
Family Choice
NF Track #
Case Mix/DRG Amount
Mn Diag Code
Reason(s) for Continued or Long Term Institution Stay (mandatory for Activity Type 04 with Assessment Results 04, 06 or 09)

All of Section E is to be completed

All of Section F is to be completed except for:

Questions 89, 90 and 91 (Waiver/AC Eligibility Criteria)
MnDHO RCC

Section G is to be completed for Relocation Service Coordination

Program Types 01 - 12, 22 (CAC, CADI, TBIW, EW, AC)

All of Section A is to be completed except for:

Reference #

Referral Date (mandatory for Activity Types 02 and 04)

Secondary Diagnosis (mandatory for Program Types 07 and 08)

All of Section B is to be completed except for:

Assessment Team (Mandatory for Program Types 01 - 06, 09 and 10)

Hospital Transfer (mandatory for Program Types 08 and 12 OR when the PAS 30 Day Exempt field is a "Y")

TBI/CAC Referral (mandatory for Program Types 01, 02, 07, 08, 11 or 12)

All of Section C is to be completed except for:

IADL Fields (mandatory for Program Types 01, 02, 05 and 06 only when the recipient age is 17 or older.

Mandatory for Program Types 02, 04, 09 and 10)

All of Section D is to be completed except for:

Case Mix/DRG Amount (mandatory for Program Types 07 and 08 OR when using the higher nursing facility case mix amount for EW and CADI Conversion)

MnDC Number (mandatory for Program Types 07 and 08)

Reason(s) for Continued or Long-Term Institution Stay

All of Section E is to be completed

All of Section F is to be completed except for:

MnDHO RCC

All of Section H is to be completed for Program Types 09, 10, and 22 except for:

Medicare ID Number (leave blank only if person is not eligible for this program)

Medicare Part A and Part B spans

Program Types 13 and 14 (Consumer Support Grant (CSG) Program)

All of Section A is to be completed except for:

Reference #
Referral Date (mandatory for Activity Type 02)
MR/RC, MI and TBI Diagnosis and History

All of Section B is to be completed expect for:

Present at Screening
Current Living Arrangement
Planned Living Arrangement
Hospital Transfer (Mandatory when the PAS 30 Day Exempt Field is a "Y")
OBRA Screening Level 1
PAS 30 Day Exempt (Mandatory for Activity Types 01 and 04)
Current Housing Type
OBRA Level 2 Referral
TBI/CAC Referral

All of Section D is to be completed except for:

Informed Choice
Client Choice
Family Choice
PAS/IDT Recommendation
Level of Care
NF Track #
Mn Diag Code
Reasons(s) for Continued or Long-Term Institution Stay

All of Section E is to be completed

All of Section F is to be completed except for:

MnDHO RCC

All of Section H is to be completed except for:

AC Monthly Income
AC Personal Assets
Medicare ID Number
Medicare Part A Span
Medicare Part B Span
AC Premium Waiver Reason
AC Premium Amount

Program Types 15 - 19 (MSHO Program)

All of Section A is to be completed except for:

Reference #

Referral Date (Mandatory for Program Type 19 with Activity Types 03 and 04; Program Type 15 - 19 with Activity Types 01 and 02)

Secondary Diagnosis

TBI Diagnosis History

Case Manager/Health Plan (Mandatory for Program Types 15- 18 OR Program Type 19 when Assessment Result is 14 - 17)

All of Section B is to be completed except for:

Planned Living Arrangement (Mandatory for Program Types 15 - 18 when Activity Type is 02, 04 or 06)

Assessment Team (Mandatory for Program Type 19)

Hospital Transfer (Mandatory for Assessment Results 14 and 17)

PAS 30 Day Exempt (Mandatory for Activity Type 01)

Planned Housing Type (Mandatory for Program Types 15 - 18 with Activity Types 02, 04 or 06)

TBI/CAC Referral

All of Section C is to be completed except for:

ADL Fields (Mandatory for Program Types 15 - 18 with Activity Types 02, 04 or 06)

Case Mix (Mandatory for Activity Type is 02 or 06)

Orientation (Mandatory for Program Types 15 - 17 when Activity Type is 02 or 06)

Self Preservation (Mandatory for Program Types 15 - 18 with Activity Types 02 or 06)

IADL Fields (Mandatory for Program Types 15 - 18 when Activity Type is 02, 04 or 06)

All of Section D is to be completed except for:

Informed Choice (Mandatory for Program Types 15 - 17 with Activity Type 02 or 07. Also mandatory for Assessment Results 01, 10 and 11)

Client Choice

Family Choice

PAS/IDT Recommendation

NF Track #

Reason(s) for Continued or Long Term Institution Stay (Mandatory for Program Type 19 with Activity Type 04 and Assessment Result 04, 06 or 09)

All of Section E is to be completed

All of Section F is to be completed except for:

Waiver/AC Eligibility Criteria (Mandatory for Program Types 15 - 17 with Assessment Result 01)

MnDHO RCC

Section G is to be completed when:

Program Types 15 - 18 with Activity Type 02 and Assessment Results 01, 02, 10 or 11

Program Types 20 - 21 (MnDHO Program)

All of Section A is to be completed except for:
Reference #

All of Section B is to be completed.

All of Section C is to be completed.

All of Section D is to be completed except for:
NF Track #
Case Mix DRG Amount
Mn Diagnosis Code

All of Section E is to be completed.

All of Section G is to be completed.

Section H does not apply to MnDHO.

All of Section I is to be completed
Fill out the nursing facility name and phone number only when requesting rate cell "T".

Section 201.07 RELOCATION SERVICE COORDINATION (RSC) AND NF ADMISSIONS

The 2001 legislation established targeted case management for persons eligible for MA who reside in institutions. The purpose was to provide transition assistance to persons wishing to move from institutions to the community where there is a lack of follow-up after admission or if the resident has no family or friends to advocate on their behalf. Relocation services should help the consumer make decisions about the support they will need outside the institution by providing information. RSC will provide payment for additional assessment and service planning to assist those who need help in planning and accessing supports to return to the community. Providers will be allowed to provide and receive payment for up to 180 consecutive days prior to a person's discharge. Please see Bulletin #02-56-08 dated June 10, 2002 (that replaces Bulletin #01-56-23 dated September 21, 2001) for more details.

A person may not be open to the waiver program while receiving RSC services. The waiver program must be closed by entering an exit screening document and closing the service agreement. If a person's health status has significantly changed since the last screening, it is recommended that another face-to-face assessment/screening is completed. If twelve months or more has passed from the last face-to-face assessment/screening and the person indicates they want to receive RSC, a new face-to-face assessment is required.

If less than twelve months have passed from the last face-to-face assessment/screening and a person requests RSC, another face-to-face assessment is not required. Instead, after closing the waiver program, enter a new screening document with the following information:

Field 10 - Activity Type	Value 07 Case Management/Administration Activity
Field 65A - Assessment Result	Value 18 Transition planning
Field 92 - Program Type	Value 00 (None)
Field 94 - Service Codes	Include value 38F Relocation Service Coordination

To authorize RSC services and receive payment during a face-to-face assessment a new screening document must be completed and these fields completed in the following manner:

Field 10 - Activity Type	Value 02 Face to Face Assessment or Value 04 Relocation/Transition Assessment
Field 22 - Present at Assessment	Include 04 social worker and/or Value 05 public health nurse
Field 24 - Reason(s) for Referral	Include 09 Request relocation to community from medical facility

Field 30 - Current Housing Type	Values 11 (NF/Certified boarding care), 14 (for hospital) or 15 (RTC)
Field 65A - Assessment Results	Value 18 Transition planning
Field 75 - Reason(s) for Continued or Long-Term Stay	Enter applicable codes
Field 92 - Program Type	Value 00 (None)
Field 94 - Service Plan Summary	Include 38F Relocation Service Coordination

Note: When RSC services end it is not necessary to enter an exit screening document.

The LTCC staff completing the face-to-face assessment may or may not be the provider of ongoing relocation services coordination. The person may return to community living with or without the support of waived services.

Opening to Waiver Programs After Provision of Relocation Services Coordination

If the person has received a complete assessment (Activity Type 02 or 04) within 60 days of opening to a waiver program, Activity Type 07 can be used with Assessment Result 01 to open a waiver program. If not, another face-to-face assessment will be required before a waiver program can be opened.

RSC Scenarios

Q I have a person open to the CADI waiver that is now entering a facility and would benefit from Relocation Service Coordination. How do I open RSC?

A Because RSC is not available for people open to a waiver, the person must be exited from the waiver prior to authorizing RSC. To exit the person from the waiver, the user should close out any applicable service agreements for the date the person became ineligible for the waiver. The user then should exit the person from the waiver using an Activity Type of 06, an Assessment Result of 22 and an exit reason of 04. The user then should add a new LTC Screening document with an Activity Type of 02, 04 or 07, an Assessment Result of 18, Program Type of 00 and Service of 38 “F” (RSC).

Q Can I use the same screening document to exit someone from the waiver and open RSC?

A No. The person must first be exited from the waiver and a new screening document must be added to authorize RSC.

Q I have a person who was on RSC and has now been discharged. How do I close RSC and reopen/open the waiver?

A Since RSC is not a waived service and the person can't be on a waiver and receive RSC, essentially opening the person to a waiver closes out RSC. A new screening document reopening the waiver will close out RSC.

Q Can I perform the Long-Term Care Consultation and open RSC at the same time?

A RSC can be authorized on the same screening document as LTCC as long as the Activity Type is 02, 04 or 07, the Assessment Result is 18, the Program Type is 00 and the service includes 38 (RSC).

Other edits may post based on the living arrangement, current housing etc and should be resolved based on individual criteria. In addition, if the person is under 21, the nursing home placement must be authorized by DHS and the ADL fields must be completed for LTCC.

Q I have some edits posting on my LTC Screening Document when I'm trying to authorize RSC. What do I do?

Edit 808- Since RSC is only for people in an institution, the living arrangement must be 04 (Congregate Setting) when authorizing RSC.

Edit 803-This edit has been changed to allow the Assessment Result of 18 with Program Type 00. If this edit is posting, make sure the program type is 00 if the Assessment Result is 18. See below with edit 643.

Edit 806- When authorizing RSC, the Service Code Indicator must be "F" (Formal). If either "I" or "Q" is used as the indicator for 38 (RSC), the edit will post.

Edit 650- For RSC, the Current Housing Type must be 02, 11, 14 or 15.

Edit 642- This edit has been changed to allow Activity Type 07 as a valid value with program type 00. If this edit is posting, make sure that the program type is 00 if the Activity Type is 07.

Edit 643- Since Conversion Case Management is no longer a valid service as of 11/1/01 for all programs except AC, the Assessment Result of 18 is not valid with any program type other than 00. If edit 643 posts when authorizing RSC, the program type must be changed to 00. If the person needs to be exited from the waiver, see instructions for exiting above.

Admissions to a Nursing Facility Without Relocation Service Coordination (RSC)

A person on the waiver program who enters a nursing facility but anticipates that they will return to the community with waiver services **within 30 days** does not need to be exited from the waiver program. All line items on the service agreement are closed to the last day the person was in the community. When they return to the waiver program **within 30 days**, new line items are added to the same service agreement beginning with the **new** period of community living.

If the person does not return to the community within thirty days, the service agreement is closed effective the day of admission. An exit screening document is entered with an assessment result date the same as the admission date.

NOTE: The service agreement may overlap the institution period on the date of admission and the date of discharge only.

Admissions to a Nursing Facility from the Alternative Care Program

When an AC recipient enters a nursing facility but anticipates that they will return to the community with AC services (regardless of the length of stay), it is not necessary to enter an exit screening document. End the AC service agreement line items effective the admission date. Case management conversion (x5477) and/or case management paraprofessional line items are added to the AC conversion service agreement with a begin date of the admission date. When the person returns to the community, case management conversion is closed and the community services are re-entered on the service agreement for the new period of community stay. Conversion case management services may be provided for a maximum of 100 days.

If the person is also eligible for MA, do not use AC Conversion Case Management. Instead use RSC services. Close the service agreement to the date of admission, enter an exit screening document with an assessment result date the same as the admission date, and enter another screening document for RSC.

If the service agreement is an AC diversion, use either ongoing case management (x5476) or case management paraprofessional (x5491) and end all other line items. When the person returns to the community, reenter the community services on the service agreement for the new period of community stay.

MnDHO Admissions to a Nursing Facility

Admission to a Nursing Facility or Hospital from the MnDHO Program

A person on the MnDHO program who enters a nursing facility must be screened on entry into a nursing facility. The LTCC document is completed and submitted to the Department. The health coordinator indicates on the cover sheet if this admission is a Medicare or non-Medicare-covered admission.

If the person has been institutionalized for 30 consecutive days, the health coordinator will submit to the Department documentation *showing the health plan has met the 180-day NF benefit*. On receipt of this document, DHS enables MMIS to allow Medical Assistance to pay nursing facility claims on a fee-for-service basis.

201.08 REASSESSMENTS AND ELIGIBILITY SPANS

The waiver and AC person or MnDHO enrollee must be reassessed at least once every twelve months. The case manager must arrange a face-to-face visit **within** this twelve month period.

The actual face-to-face date is recorded in the Activity Type Date field. The Assessment Result Date can be the same date as the Activity Type Date. The date in the Assessment Result Date field determines the begin date of the eligibility span on the RWVR screen (waiver) or RELG screen (AC). This field also increases the eligibility span at time of reassessment, or decreases the span when an exit is approved.

For the Alternative Care program, the Assessment Result Date must fall within the eligibility span on the RELG screen. The eligibility span will then expand to the same day in the following year.

Example of an AC span with an annual reassessment:

	<u>Activity Type</u>	<u>Assessment Result Date</u>	<u>RELG Screen</u>
Document #1	Initial Opening	4/24/01	4/24/01 - 4/24/02
Document #2	Reassessment:	3/10/02	4/24/01 - 3/10/03

Example of an AC span with two reassessments dated in the same month:

	<u>Activity Type</u>	<u>Assessment Result Date</u>	<u>RELG Screen</u>
Document #1	Initial Opening:	7/25/01	7/25/01 - 7/25/02
Document #2	Reassessment:	8/1/01	7/25/01 - 8/01/02
Document #3	Reassessment:	8/11/01	7/25/01 - 8/11/02

Example of an AC span with two reassessments dated in different months:

	<u>Activity Type</u>	<u>Assessment Result Date</u>	<u>RELG Screen</u>
Document #1	Initial Opening:	8/1/01	8/1/01 - 8/1/02
Document #2	Reassessment:	8/22/01	8/1/01 - 8/22/02
Document #3	Reassessment:	9/2/01	8/1/01 - 9/2/02

For the waiver programs, the Assessment Result Date dated within the month will expand the eligibility span on the RWVR screen to the last day of the previous month in the next year.

Example of an waiver span with an annual reassessment:

	<u>Activity Type</u>	<u>Assessment Result Date</u>	<u>RWVR Screen</u>
Document #1	Initial Opening	4/24/01	4/24/01 - 3/31/02
Document #2	Reassessment:	3/10/02	4/24/01 - 2/28/03

Example of a waiver span with two reassessments dated in the same month:

	<u>Activity Type</u>	<u>Assessment Result Date</u>	<u>RWVR Screen</u>
Document #1	Initial Opening:	7/25/01	7/25/01 - 6/30/02
Document #2	Reassessment:	8/1/01	7/25/01 - 7/31/02
Document #3	Reassessment:	8/11/01	No Change

Example of a waiver span with two reassessments dated in different months:

	<u>Activity Type</u>	<u>Assessment Result Date</u>	<u>RWVR Screen</u> (waiver)
Document #1	Initial Opening:	8/1/01	8/1/01 - 7/31/02
Document #2	Reassessment:	8/22/01	No Change
Document #3	Reassessment:	9/2/01	8/1/01 - 8/31/02

201.09 SUBMITTING THE LTC SCREENING DOCUMENT FORM

There are two methods available to agencies to submit screening documents to DHS to be processed by MMIS: online, by electronic batch, or by paper.

Submitting Online

Authorized users of MMIS have immediate online access to the most current information and may enter additions, changes, and corrections online.

A worker uses a PC-based computer to connect either directly or through a modem with MMIS. LTC screening documents are entered online. Each screening document is assigned a unique 11-digit number to identify it in the system. You can use this number to locate and view any screening document.

System exceptions and input errors are immediately shown on the screen for correction. Up to 25 exceptions/errors may be posted for each document. These exceptions and errors are corrected by staff with assistance from other staff such as the case manager, nursing staff, contract manager, etc. If the exceptions cannot be corrected right away, the document may be saved unfinished to be corrected and processed later. Monthly report 9200-R2455 Suspended LTC Screening Document Report shows those screening documents kept in suspense that need to be corrected or deleted. Once the document is entered correctly and any edits are corrected, it will be automatically approved. The exception to automatic approval online is when the higher nursing facility case mix rate for Elderly Waiver conversions is requested.

Submitting Paper Documents

For those agencies using paper documents, both sides of the form must be completed in ink or typewritten. After completion, the forms are mailed in the appropriate envelope (DHS-3138).

Since screening documents are not scannable, the Claims Processing Unit batches the documents, assigns an 11-digit number to each document, microfilms, and manually enters the information. Any document that has missing information or is not clear will be returned to the submitter with a cover letter for correction. After the documents are entered, staff may view the documents online using the client's ID number.

For MnDHO

The LTCC screening must be submitted on the LTCC paper document completed in ink or type written, signed by the qualified professional, and sent to DHS for processing.

If this is an initial enrollment, a complete and signed MnDHO application form must be submitted with the initial assessment.

201.10 ACCESSING THE PRIOR AUTHORIZATION SUBSYSTEM

Before you continue with the instructions below, read Chapter 1 to learn how to access MMIS, what security features will limit the data you can view or change, and how to navigate within and among the screens.

To access the Screening Document File on the Main Menu screen, place an “x” in front of “Screenings” and use the transmit key.

<i>*** MEDICAID MANAGEMENT INFORMATION SYSTEM ***</i>		
<i>SEL</i>		<i>SEL</i>
<i>CLAIMS PROCESSING APPLICATIONS:</i>		<i>OTHER APPLICATIONS (CONT.):</i>
<i>BATCH CONTROL</i>		<i>TPL BILLING APPLICATION</i>
<i>EXAM ENTRY</i>		<i>ADMISSION CERTIFICATION</i>
<i>CORRECTION</i>		<i>MISCELLANEOUS FUNCTIONS</i>
<i>INQUIRY</i>		<i>SECURITY ADMINISTRATION</i>
<i>REFERENCE FILE APPLICATIONS:</i>		<i>FINANCIAL CONTROL</i>
<i>PROC, DRUG, DIAG, DRG, UPC</i>		<i>DRUG REBATE</i>
<i>RATES</i>		<i>QUALITY CONTROL</i>
<i>PREPAY U/R CRITERIA</i>		<i>TPL RESOURCE FILE APPLICATION</i>
<i>EXCEPTION CONTROL</i>		<i>SURS SUMMARY PROFILE</i>
<i>TEXT</i>		<i>SURS TREATMENT ANALYSIS</i>
<i>SYSTEM PARAMETERS/LIST PARAMETERS</i>		<i>SURS CLAIM DETAIL</i>
<i>PRIOR AUTHORIZATION APPLICATIONS:</i>		<i>RECIPIENT MISCELLANEOUS FUNCTIONS</i>
<i>PRIOR AUTHORIZATION</i>		<i>DECISION SUPPORT</i>
<i>X SCREENINGS</i>		<i>MN CARE FIN OBLIG ERROR CORRECTION</i>
<i>OTHER APPLICATIONS:</i>		<i>RATE SETTING</i>
<i>PROVIDER FILE APPLICATION</i>		<i>MANAGED CARE</i>
<i>RECIPIENT FILE APPLICATION</i>		
<i>ENTER---PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11--PF12</i>		
<i>S/EXT</i>	<i>N/EXT</i>	<i>OOPS</i>

If you do not have the correct security to access the prior authorization subsystem, a message will appear here. Contact your agency’s security officer to change your security group.

Use the transmit key. The next screen to appear is the Keypanel screen. It looks like this:

```

NEXT:    03/12/98 12:54:34 MMIS SCRNG KEY PANEL-ASCR          PWMW901

ACTION CODE:                DOCUMENT TYPE:
A=ADD      C=CHANGE  I=INQUIRY      D=DD  L=LTC
B=BATCH ENTRY D=DELETE          P=PCI  C=C&TC

1. ENTER THE APPROPRIATE PRIMARY KEY FORMAT:
DOCUMENT NUMBER:
RECIPIENT ID:

CASE MGR/PROV NBR:          (INQUIRY ONLY)

2. ADDITIONAL SEARCH CRITERIA FOR RECIPIENT OR CASE MGR/PROV SEARCH:

START DATE:
END DATE:
STATUS:          (A=APPROVED D=DENIED S=SUSPENDED)
LOC:            USER ID:
*****
* ALT1 - LTC SCREEN 1  ALT2 - LTC SCREEN 2  ALT3 - LTC SCREEN 3  +  *
* ALT4 - LTC SCREEN 4  ADD1 - DD SCREEN 1  ADD2 - DD SCREEN 2  *
*****
ENTER---PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11--PF12
PAGE          S/EXT          N/EXT PREV NEXT          OOPS

```

Action Code. When adding an initial screening document, use the “A” action code. When adding additional screening documents use either the “A” or “C” action code. Use the “I” action code to view an existing document. The “D” code will delete specific documents (see Section 201.12 for detailed instructions).

Document Type. The document type must be “L” when you are using the A or C action codes. If this field is left blank while using the “I” action code, all document types will be retrieved, if available.

Selecting the Screening Document. To identify the screening document indicate either 1) PMI number; 2) the document number (document control number) of the screening document you want to retrieve; or 3) to select the screening documents for a particular case manager, use the Case Manager/Provider Number field.

Additional Search Criteria. Use this next section if you want to narrow the search for the screening document. By putting in the Start and End dates, only those documents with an Activity Date that falls within this period will be retrieved. By filling in the Status field with A=approved, S=suspended, or D=denied, only those screening documents with a matching status will be retrieved. The LOC field is

used to retrieve screening documents returned to the by DHS staff. This feature is explained in more detail in Section 201.13.

By using the “I” action code and the document number, you will be brought directly to that document for viewing. If you use the PMI number for selection instead, and the person has more than one screening document, you will be brought to the Selection screen. This is also true if selection is by the Case Manager/Provider Number field.

The Selection Screen looks like this:

<i>NEXT:</i>		<i>03/12/98 14:19:32 MMIS SCRNG SELECTION-ASEL</i>				<i>PWMW902</i>		
<i>RECIP ID: 00000000</i>		<i>PROV NBR:</i>						
<i>SEL</i>	<i>DOCUMENT</i>	<i>PROVIDER</i>	<i>PROVIDER</i>	<i>ACT</i>	<i>START</i>	<i>END</i>	<i>MAJ</i>	
<i>IND</i>	<i>TYPE</i>	<i>NUMBER</i>	<i>NUMBER</i>	<i>TYPE</i>	<i>NAME</i>	<i>ST DATE</i>	<i>DATE</i>	<i>PROG</i>
<i>L</i>	<i>00000000000</i>	<i>6666666 00</i>	<i>AMY K NELSON</i>	<i>13</i>	<i>A</i>	<i>121401</i>	<i>M</i>	
<i>L</i>	<i>00000000000</i>	<i>6666666 00</i>	<i>AMY K NELSON</i>	<i>10</i>	<i>A</i>	<i>060101</i>	<i>M</i>	
<i>L</i>	<i>00000000000</i>	<i>6666666 00</i>	<i>AMY K NELSON</i>	<i>23</i>	<i>A</i>	<i>032301</i>	<i>A</i>	
<i>L</i>	<i>00000000000</i>	<i>6666666 00</i>	<i>AMY K NELSON</i>	<i>13</i>	<i>A</i>	<i>110101</i>	<i>A</i>	
<i>L</i>	<i>00000000000</i>	<i>6666666 00</i>	<i>AMY K NELSON</i>	<i>13</i>	<i>A</i>	<i>110200</i>	<i>A</i>	
<i>L</i>	<i>00000000000</i>	<i>6666666 00</i>	<i>AMY K NELSON</i>	<i>01</i>	<i>A</i>	<i>101500</i>	<i>A</i>	
								<i>+</i>
<i>ENTER-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12</i>								
<i>PAGE</i>		<i>S/EXT NAVIG SLIST N/EXT PREV NEXT</i>				<i>OOPS</i>		

This screen is showing screening documents for the LTC programs. The document control number of each is listed. The number and name of the case manager is next, then the assessment result code, document status, assessment result date and major program type (M = Medical Assistance, A=Alternative Care and U= Unknown for screenings with no major program).

Document statuses will be A for approved, S for suspend, D for denied and R for replaced. A service agreement cannot be approved unless there is an opening, reopening or reassessment screening document with a status of A. Documents with a status of R can be ignored. They once were suspended, but then were replaced by the next entered document.

By pressing the PF4 key while on this selection screen, you are brought to the provider file of the case manager for the line where the cursor is located.

Viewing a Screening Document

To select a line to view a screening document move the cursor to the beginning of that line, type an "x" there, and press the transmit key. When finished viewing the screening document, use the exit key (PF3 or PF6) to come back to this screen; any lines above the one you selected will no longer be shown. Just use the PF7 key to show all the lines again. Use the PF8 key if there are more lines on the screen than can be shown (see the + sign on the bottom right hand corner of the screen).

Entering a Screening Document

If you chose action code A or C on the Keypanel Screen, you will be brought to the first screen of the screening document to enter the data. **When entering the initial screening document, the ALT1 - ALT6 screens will be blank. When entering additional screening documents, the ALT1 - ALT6 screens will contain a copy of the data from the last saved screening document.** NOTE: the ALT6 screen will only appear if the program type is AC or CSG.

Enter the information on the first screen (ALT1). You will not be able to move to the next screen if the PAS, Birthdate, Activity Type and Activity Type Date fields are left blank or the data is invalid. If the birthdate is incorrect, it will turn red when you use the PF9 key or try to move to the next screen. Use the PF4 key to view the birthdate on the Recipient File. Both must match. If the birthdate on the Recipient subsystem is incorrect, the county financial worker needs to correct it. If the PMI number was obtained through the PMIN Function, then it can be changed using the same PMIN process.

NEXT: ALT2 08/17/00 13:57:28 MMIS LTC SCREENING - ALT1 PWAT255 08/17/00 PWMW935							
DOCUMENT NBR: 0000 000 0 000							
DOC STAT:			CURR LOC/DT:			OVERRIDE	
			LOC:				
CLIENT NAME/ID:			00000000	REF NBR:			
DATE SUB:	DOB:	SEX:	REF DATE:	AGE:	LA:		
ACTIVITY TYPE:	ACT DT		COS:	COR:	CFR:	PAS:	
LEGAL REP STAT:			PRIMARY DIAG:		SECONDARY DIAG:		
MR/RC DIAGNOSIS HISTORY:			MR/RC DIAGNOSIS:				
MI DIAGNOSIS HISTORY:			MI DIAGNOSIS:				
TBI DIAGNOSIS HISTORY:			TBI DIAGNOSIS:				
CM/HP NAME:			CM/HP NBR:				
LI EXC ST USER ID	LI EXC ST USER ID	LI EXC ST USER ID	LI EXC ST USER ID				

When finished with the first screen, use the Transmit key to move to the remaining screens.

NEXT: ALT3 08/17/00 14:33:22 MMIS LTC SCREENING - ALT2 PWAT255 08/17/00 PWMW9

DOCUMENT NBR: 0000 000 0 000

DOC STAT: 000000000 AGE/LA:

PRESENT AT SCRNG:

MARITAL STATUS: REASONS FOR REF:

CURRENT LA: PLANNED LA: TEAM: HOSP TRNF:

OBRA LVL 1 SCR: PAS 30 DAY: CURR HOUSING: OTHER:

PLANNED HSNG: OTHER: OBRA LVL 2 REF: TBI/CAC REF:

LI EXC ST USER ID LI EXC ST USER ID LI EXC ST USER ID LI EXC ST USER ID

NEXT: ALT4 08/17/00 14:35:53 MMIS LTC SCREENING - ALT3 PWAT255 08/17/00 PWMW93

DOCUMENT NBR: 0230 900 0 009

DOC STAT: 00862719 AGE/LA:

DRESSING: GROOMING: BATHING: EATING: BED MOB:

TRANSFER: WALKING: BEHAVIOR: TOILET: SPC TRMT:

CL MONITOR: NEURO DX: CASE MIX: ORIENT: SLF PRES:

DIS CERT: SLF EVAL: MENT ST EV: TEL ANS: TEL CALL:

SHOPPING: PREP MLS: LT HOUSE: HY HOUSE: LAUNDRY:

MGMT MEDS: MONEY MT: TRANSP: FALLS: HOSP:

ER VISITS: NF STAYS:

LI EXC ST USER ID LI EXC ST USER ID LI EXC ST USER ID LI EXC ST USER ID

NEXT: ALT5 08/17/00 14:37:45 MMIS LTC SCREENING - ALT4 PWAT255 08/17/00 PWMW

DOCUMENT NBR: 0000 000 00 0

DOC STAT: 000000000 AGE/LA:

ASSESSMENT RESULTS/EXIT RSNS: ASSESSMENT DT:

INFORMED CHOICE: CLIENT CHOICE: FAMILY CHOICE:

PAS/IDT RECMND: RISK STATUS: QA/R NBR:

CASE MIX/DRG: CASE MIX APP (Y/N): MNDC:

REASONS FOR INSTITUTIONAL STAY:

ADL COND: IADL COND: COMP COND: COGNITION: BEHAVIOR:
HYG/SAFETY: NEG/ABUSE: FRAILITY: SENSORIAL: REST/REHAB:
UNSTABLE: SPEC TREAT: CMLPX CARE:

REQUIRES AC/WVR SVC: SAFE/COST EFFECTIVE: NO OTHER PAYOR IS RESP:
PROGRAM TYPE: MnDHO RCC

LI EXC ST USER ID LI EXC ST USER ID LI EXC ST USER ID LI EXC ST USER ID

NEXT: ADHS 08/17/00 14:39:21 MMIS LTC SCREENING - ALT5 PWAT255 08/17/00 PWMW93

DOCUMENT NBR: 0000 000 0 000

DOC STAT: 00000000 AGE/LA:

CODE IND DESCRIPTION CODE IND DESCRIPTION

LI EXC ST USER ID LI EXC ST USER ID LI EXC ST USER ID LI EXC ST USER ID

NEXT: ADHS 08/17/00 14:40:15 MMIS LTC SCREENING -ALT6 PWAT255 08/17/00 PWMW949

DOCUMENT NBR: 0000 000 0 00

DOC STAT: 00000000 AGE/LA: 075 80

STREET ADDRESS:

STREET ADDRESS:

CITY: DULUTH STATE: ZIP CODE: CFR:

GROSS INCOME: GROSS ASSETS:

AC ADJUSTED INCOME: AC ADJUSTED ASSETS:

MEDICARE ID NUMBER:

MEDICARE PART A BEGIN DT: END DT:

MEDICARE PART B BEGIN DT: END DT:

AC PREMIUM WAIVER REASON: AC LIEN REF: AC PREM ASSESSED:

LI EXC ST USER ID LI EXC ST USER ID LI EXC ST USER ID LI EXC ST USER ID

Comment Screens

A Case Manager Comment Screen is available for the case manager to add additional comments for DHS review. A Recipient Comment Screen collects comments about the person. A DHS Comment Screen is used to communicate back to the case manager.

NOTE: Any person with inquiry access to the screening file will be able to read your comments on each of these comment screens. Remember, when entering subsequent documents the notes on these screens for the new screening document should be deleted if the text does not pertain to the new document.

A copy feature is available for these comment screens that will copy text from the ADHS screen onto the ACMG screen OR from the ACMG screen to the ARCP screen. Nothing can be copied from the ARCP screen and you will receive a message indicating this. By pressing the PF2 key while on the screen that is to be copied from, the entire text will be copied to the following screen unless the new screen doesn't have enough room. A message will then appear asking you to view the new screen and delete text.

Edit Statuses

After entering all of the data that is required, use the PF9 key to edit the screening document. Using the PF9 key allows MMIS to check your entered data against all other applicable subsystems. It is checking that:

- 1) the mandatory fields are valued and the data entered is valid,
- 2) a Medical Assistance eligibility span (RELG screen) is active for the assessment result date of an opening, reopening, or reassessment waiver screening document, and
- 3) the assessment result type follows the proper sequence of any previously approved screening document.

If any of the circumstances in items 1 - 3 are not met, as well as other recipient, provider and reference cross editing, edits will show on the bottom of the screen explaining what the error is. These edits (with the exception of informational edits) must be corrected or forced.

```
LI  EXC  ST  USER  ID  LI  EXC  ST  USER  ID  LI  EXC  ST  USER  ID  LI  EXC  ST  +
00  798   4           00  139   4           00  128   4           00  803   4
798  DOB  GREATER  THAN  ACTIVITY  TYPE  AND/OR  ASSESSMENT  RESULT  DATES
```

By moving the cursor to the edit number and using the PF1 key, the title of the edit will be shown. If there is a "+" sign at the end of the edit line, this signifies that there are more edits. Use the PF8 and PF7 keys to scroll back and forth to view additional edits.

Every edit will have a status that determines the effect the edit will have on the screening document. It may deny the document, keep it in suspense, or merely give information.

3 - A status of "3" will cause the screening document to be denied.

Action Needed - The problem must be corrected before you use the PF3 key or the entire screening document is denied and a new document must be entered.

- 4 - This status causes the screening document to remain in suspense.
Action Needed - The problem must be corrected or the edit “forced” or the document will not be approved. You can save the document in a suspended status with the PF3 key and return to it later to finish correcting edits.

There are three edits that will keep the document in a suspended status and route the document to the Department for approval if all other edits with status 4 are resolved. These edits are: 784 (Case Mix Amount/TBIW/CADI Screening Requires Approval), 272 (CAC Screening Document Needs Approval), and 655 (Nursing Facility Admission Requires DHS Approval). If these are the remaining edits, when you save the document with the PF3 key, it will automatically route the document to another location in DHS for review and approval.

Action Needed - Edits that will route the document to DHS for approval do not need to be corrected and will route the document the following working day.

- 6 - This status may be used for those exceptions that are shown for information only. The system will display the exception, but will not delay processing the document or agreement.
Action Needed - These exceptions are to be reviewed for possible correction. These edits do not cause the screening document to remain in suspense or deny.

- F - When an exception is set to be forcible, it means that the system will ignore the exception as if it never occurred. This will be used very rarely. Forcing an edit means that you are not correcting the problem but rather telling MMIS to ignore the problem.

Action Needed - To force an edit, go down to the exception line, place a "F" over the green-colored "4" and press PF9. If the edit is not forcible, the "4" will turn red (see status C for correction). It is not necessary to force those edits with a status "6".

- C - If an exception status on the edit line is changed, it can revert back to what it was initially by placing a “C” over the edit status field and using the PF9 key. So if an exception was forced and then you discovered how to correct it instead, place a “C” over the "F" and it would default back to the initial setting so the edit can now be corrected. Or if the status field turns red, place the letter "C" over the invalid value to clear it.

Turn to Section 201.14 for a listing of the screening document edits, their meanings and how to correct the edits. Another method is to place your cursor on the edit number and use the PF4 key to view a text file that explains in detail why the edit posted and what action is needed to correct it. When finished, use the PF3 or PF6 key to return to the screening document.

Screening Document Statuses

Screening documents can have one of four statuses. The document’s status appears at the top left corner.

- S - suspend. The screening document was saved before it was finished, before all the edits were corrected, **or** edits 784, 272, or 655 was posting that will not allow the document to be approved but instead route to DHS for approval.

- R - replaced. This document used to be suspended but the status was changed to “replaced” when a newer document was entered and saved.
- D -denied. An edit with a status “3” was not corrected when the document was saved causing the screening document to be denied.
- A - approved. The screening document was finished, all edits were corrected, and the document did not need to route to DHS for approval.

Correcting Suspended Documents

You can save a screening document even if it isn’t finished or approved. It will be saved in a “suspended” status. To finish the document after you have saved it, use either A or C in the action code field on the Keypanel screen. Identify the screening document by using the PMI number. A *copy* of the last saved (suspended) document appears. You do not work off the suspended document. The fields that must be re-entered are: Birthdate, PAS, Activity Type, Activity Type Date, Assessment Result, Assessment Result Date, and CFR (on the ALT6 screen for Alternative Care or Consumer Support Grant recipients). Finish entering the data and correcting the edits. When the screening document’s header status changes to “A” for approved, save the document with the PF3 key. The previously suspended document will now have a status of “R” (replaced). MMIS ignores those documents with a replaced status.

201.11 ROUTING OF THE EW CONVERSION SCREENING DOCUMENT

There is one instance in which the Elderly Waiver screening document needs to be approved by DHS staff. If you are using the higher nursing home conversion dollar amount in the Case Mix/DRG Amount (ALT3 screen) instead of the normal A - K case mix rates, you will receive edit 784 - Case Mix Amount /TBIW/CADI Screening Requires Approval. This edit will cause the screening document to remain in suspense and route automatically to DHS staff for approval of the higher rate.

Note: EW documents are routing to the TBI/CAC/CADI queue #530. You need to manually enter "550" in the Override Location field at the top right side of screen ALT1 to route the EW screening document to the correct location for review.

The routing will occur overnight and the document will be available to department staff the next working day. You can use the inquiry mode the next day to check the Current Location and Date fields on the top right hand corner of the ALT1 screen to make sure it did route to the correct place. The Current Location field will have 550, and the Date field will have the date it was received at DHS. **Note:** Use the Inquiry code to view documents that were routed to DHS for approval. If you use the Change mode instead, the document will route from DHS back to the county queue before approval is given, and the DHS staff person will not see the document.

When approved, there will be a "y" in the Case Mix Approval field (located after the Case Mix/DRG Amount field on the ALT4 screen). Once a conversion rate has been approved, this amount is not affected by annual increases (or decreases) that may be approved by the legislature for nursing facility rates. If the EW recipient returns to a nursing facility and is reopened to Elderly Waiver as another conversion, the rate of the most recent nursing facility is then used to determine the dollar amount.

Please see Bulletin #03-25-03 for more information on requesting the NF conversion rate and for a copy of the new request form.

201.12 DELETING THE LTC SCREENING DOCUMENT

Counties may delete a screening document under these conditions and only starting with the most recent document:

- 1) a document may be deleted if the status is either suspended, replaced, or denied or
- 2) an approved document may be deleted if the assessment result is not 01, 10, 11, 19 - 26, 28, 31, 33, or 34.

Screening documents must be deleted starting with the most recent (the top) document on the Selection Screen. The Keypanel Screen is used to delete a screening document. Use a "D" in the Action Code field, an "L" in the Document Type field, identify both the screening document number and the PMI number. When the transmit key is used, a copy of the screening document is shown. Use the PF3 key to delete it. The document will no longer be shown on the Selection Screen nor can it be retrieved using the PMI number or document control number. Use the PF6 key to cancel the deletion.

Counties must contact the Disability Services Resource Center to delete a document under these circumstances:

- 2) when a wrong activity type date or assessment result date is used on an approved document, it cannot be corrected if the correct date is prior to the wrong date. An example is a date of May 6, 2003 was used and the document was approved. It was later discovered that the correct date was May 3, 2003.
- 3) Assessment Result is 01, 10, 11, 19 - 26, 28, 31, 33, or 34.
- 4) If the deleted document is with the MnDHO program, staff must contact the DHS MnDHO Coordinator so that the Coordinator can re-enter and rebuild the MnDHO screening document.

You must fax the Disability Services Resource Center for assistance in deleting the document. (See Bulletin #98-56-11).

201.13 VIEWING SUSPENDED SCREENING DOCUMENTS STORED IN QUEUES

Suspended screening documents are kept with the county of service listed on the ALT1 screen and can be retrieved by using the Screening Keypanel Screen (ASCR). These documents were saved incomplete and/or status 4 edits prevented the documents from being approved. These documents need to be retrieved and either the outstanding edits corrected/forced, or the documents need to be deleted.

At the Keypanel Screen, use an "I" in the Action Code field, an "L" in the Document Type field and your three digit county code in the LOC field located at the bottom of the screen. Press the transmit key. If there are no documents in the queue, a message will appear indicating that no documents were found. Otherwise, the first screening document that appears is the document held in suspense for the longest period. Use the PF3 key to view more documents. Use the PF6 key to leave the queue.

Newly suspended screening documents are transferred to the queue once per day. You can enter the queue using the Inquiry action code as many times each day as necessary. When using the Change action code, the screening documents can be retrieved only once per day. However, if you enter the queue through the "change" action code, any screening document viewed in this action code cannot be viewed again using the Change action code until the next day.

Another method to keep track of the suspended screening documents, is to use the monthly report 9200-R2455 Suspended LTC Screening Document. More details on the use of this report are explained in Chapter 4.

201.14 SCREENING DOCUMENT EDITS

Edit	Title	Description and Resolution
101	Second Diagnosis is Duplicate of First Diagnosis	Duplicates are not allowed. Edit Status = suspend, can not be forced
102	Second Diagnosis is Missing	The secondary diagnosis is missing. This field is mandatory if program type is 07 or 08 (CAC) or 20 and 21 (MnDHO). Edit Status = informational
109	Exit Date Before Header End Date	If Exit Reasons 19 - 26 or 31, 33 or 34 are valued, the Exit Date must not be prior to the service agreement header end date. The service agreement header end date must be changed first so that it does not exceed the screening document exit action date. Edit Status = suspend, can not be forced
114	Case Manager/Health Plan Number is Missing or Invalid	This field is mandatory for Program Types 01 - 18, 20 - 22, and for Program Type 19 if Assessment Result = 14 - 17. This edit will post in the following circumstances: <ul style="list-style-type: none"> ✓ field is left blank except for Activity Types 01 or 03 or for Program Type 00 ✓ the case manager or health plan number is not on the provider file ✓ if Program Type is 01 -14 or 22, the provider type must equal 23 ✓ if Program Type is 15 - 18, the provider type must be 24 ✓ if Program Type = 19, and the Assessment Result = 14 - 17, the provider type must be 24. ✓ if Program Type is 20 or 21 the Provider Type must be 24. Edit Status = suspend, can not be forced
128	Current Date is Prior to Previous Date	The Activity Type Date is prior to the last approved Activity Type Date and/or the Assessment Result/Exit Date is prior to the last approved Assessment Result/Exit Date. Check the last approved screening document and compare the Activity Type Date and Assessment Result Date fields to the new document. Edit Status = suspend, can not be forced
129	Recipient Number is Missing or Invalid	This edit will post if the data is scanned. Recheck the number for accuracy. Check the Recipient File to make sure the number is listed. Edit Status = suspend, can not be forced

137	Activity Type Date Not Within 65 th Birthday Month	When using Activity Type 08, the Activity Type Date must be within the 65 th birthday month. Edit Status = suspend, can not be forced.
139	Guardianship/Legal Representative is Missing or Invalid	This field is required for Program Types 01 - 22. <ul style="list-style-type: none"> ✓ The recipient's age must be 17 or younger to use values 05 - 10. ✓ Values 01 - 04 are not allowed for age 17 or younger. Edit Status = suspend, can not be forced
141	Informed Choice is Missing or Invalid	Valid values are "y" or "n". This field is mandatory for: <ul style="list-style-type: none"> ✓ Program Types 01 - 14, 22. It must be a "y". ✓ Program Type 00. It can be a "y" or "n". ✓ Program Types 15 - 17 with Activity Type 02 or 07 and Assessment Result 01, 10 or 11, the field can be a "y" or "n". ✓ If Activity Type is 02, 04 or 07 and Assessment Result is 01, 10, 11 or 28, the Informed Choice must be a "y". If Activity Type is 02, Program Type is 15 - 17, and Assessment Result is 01, 10 or 11, it can be a "y" or "n". Edit Status = suspend, can not be forced
167	Recipient First Name is Missing	MMIS will enter the name from the Recipient File into this field. This edit will post if the recipient number is missing or invalid. Edit Status = informational
168	Recipient Last Name is Missing	MMIS will enter the name from the Recipient File into this field. This edit will post if the recipient number is missing or invalid. Edit Status = informational
169	Referral Date is Missing or Invalid	This field is required when Activity Type is 01 - 04. <ul style="list-style-type: none"> ✓ The Referral Date must be prior or equal to the Activity Type Date. ✓ This date should be the same as the initial referral date for the screening or assessment. ✓ A new referral date is used if the case closes and then reopens for reasons other than changing funding sources. Edit status = suspend, can not be forced

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	<p>Level of Care is Missing or Invalid</p>	<p>This field is required for Program Types 00 - 12, 15 - 19 and 22.</p> <ul style="list-style-type: none"> ✓ If Program Type = 01 - 06, 09, 10, 15, 16, 17, 19 or 22 the Level of Care must be 02. ✓ If Program Type = 07 or 08, the Level of Care must be 04. ✓ If Program Type = 11 or 12, the Level of Care must be 05. ✓ If Program Type = 00, the Level of Care must be 01- 07. ✓ If Program Type = 18, the Level of Care must be 02 or 07. ✓ If Program Type = 20 and RCC = T, the Level of Care must be 02 or 06. ✓ If Program Type = 20 or 21 and RCC does not equal T, the Level of Care must be 02, 04 - 07. <p>If Program Type = 00, then:</p> <ul style="list-style-type: none"> ✓ If Assessment Result = 04, the Level of Care must be 02 ✓ If Assessment Result = 06, the Level of Care must be 01 ✓ If Assessment Result = 07, the Level of Care must be 02 ✓ If Assessment Result = 08, the Level of Care must be 02 ✓ If Assessment Result = 09, the Level of Care must be 04 <p>Edit status = suspend, can not be forced</p> <p>Note: The level of care for assessment result 18 can be any of these values since it is using program type 00.</p>
180	<p>Self Preservation is Missing or Invalid</p>	<p>The Self Preservation field is required when Program Type is 01 - 12 or 22. Also mandatory for Program Types 20 or 21 when the Activity Type is 02, 04, 06, or 08. Also mandatory for Program Type 00 when the Activity Type is 02 or 04, and the Assessment Result is 18 and the Service Plan Summary includes value 38F. Edit Status = suspend, can not be forced</p>
205	<p>Primary Diagnosis Code is Missing</p>	<p>The Primary Diagnosis Code field is required for Program Types 01 - 22. Edit Status = suspend, can not be forced</p>

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	TEFRA Open - Contract Financial Worker	<p>The eligibility type for the MA major program is “TEFRA” (BT or DT). It must be changed by the financial worker to resolve this edit. This edit will post when:</p> <ul style="list-style-type: none"> ✓ the Assessment Result is 01, 10, 11, 13 or 28 ✓ the Program type is 01, 02, 05 - 08, 11 or 12 ✓ the Assessment Result Date falls within an eligibility type of BT or DT for Major Program MA. <p>Edit Status = deny</p>
	Recipient Age Invalid for Program Type	<p>The person's program type is either 01, 02 (TBIW-NF); 05, 06 (CADI); 07, 08 (CAC); 11, 12 (TBI-NB); or 20, 21 (MnDHO) and the recipient's age is 65 as of the Assessment Result Date and there isn't a previous Activity Type 08. An Activity Type 08 needs to be entered first with an Activity Type Date within the 65th birthday month.</p> <p>The recipient's Program Type is either 03, 04 (EW), 09, 10 (AC), 15 - 18 (MSHO), 19 (MA/MSHO) or 22 (Temporary AC) and the age is less than 65. The recipient's Program Type = 19 with Assessment Result = 01, 14 - 17 when the recipient's age is less than 65.</p> <p>Edit Status = deny</p>
	Assessment Result Date Overlap with Waiver	<p>The person can only be opened to one waiver program at a time. The Assessment Result Date of Assessment Result 01, 10, 11, or 28 cannot overlap with an existing waiver span on the RWVR screen. If the person is currently opened on another waiver program and needs to be opened to a different program, the existing program must be closed prior to opening the new program.</p> <p>Edit Status = suspend, can not be forced</p>
	Recipient ID/Recipient Date of Birth Mismatch	<p>The date of birth does not match the date of birth listed on the Recipient File. The date should be checked for accuracy by using the PF4 key. If the Recipient File is incorrect, the Financial Worker must be notified to change the birthdate on the file in order to resolve this edit. If this is an Alternative Care client with no other major program eligibility on the RELG screen, the PMIN Function may be used to change the birthdate on the Recipient file.</p> <p>Edit Status = suspend, can not be forced</p>

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	Case Manager/Health Plan Number Does Not Match	<p>For Program Types 00 - 14, or 22 the case manager number does not match the case manager number on the RMGR screen as of the Assessment Result Date. If a new case manager was assigned to the recipient, no action is necessary and the edit may be forced. Otherwise, determine if the case manager number needs to match the current case manager number.</p> <p>For Program Types 15 - 21, the health plan number must equal the contract provider number on the RPPH screen as of the Activity Type Date. Recheck the number. Edit Status = suspend, forcible</p>
263	MSHO Eligibility Open	<p>Edit will post if Program Type is 00 - 14, 20 - 22 and the Assessment Result Date is within a MSHO/MnDHO eligibility span with a product ID number of M02 as shown on the RPPH screen. The recipient must be exited from the waiver/AC/CSG program prior to the start of the MSHO effective date. If the Program Type = 00 - 10 and the Assessment Result date falls within an MnDHO eligibility span (Product Type MA15 on the RPPH screen of the recipient subsystem) then post the edit.</p> <p>Edit Status = deny</p>
264	PPHP Eligibility Open	<p>A recipient must not be on the Consumer Support Grant (CSG) Program and eligible for PPHP at the same time. This edit will post when the Program Type is 13 or 14 and the Assessment Result Date is within a PPHP eligibility span. View the RPPH screen of the Recipient File to see when the PPHP span began.</p> <p>Edit Status = deny</p>
268	Person Reopened in the Same Waiver Year	<p>A new EW slot is not given. Person will keep their initial waiver slot. No action is necessary.</p> <p>Edit Status = informational</p>
269	Waiver Slot Available	<p>The EW program is open to new recipients. No action is necessary. Edit Status = informational</p>
270	Waiver Slot Not Available	<p>The EW program is closed. New recipients will be placed on a waiting list. Edit Status = deny</p>

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	CADI Program Closed	Ignore this edit if status is a "6". This edit was used in the past, and could be used in the future whenever the CADI program exhausts all of its waiver slots during a waiver year. It will post as a deny status when the Program Type is 05, 06 or 21 and the Assessment Result is 01, 10, 11 or 28 if the program is closed to new recipients. Edit Status = informational
	Medicare Data Not Updated	There is Medicare data on the RCIP and RMCR screens that will not be overlaid by the data on the ALT6 screen. Edit Status = informational. (See bulletin #98-25-11 dated December 28, 1998 for additional information on these Medicare fields.)
	First Primary Diagnosis Not on File	The first diagnosis is not listed on the Reference File. Recheck the number with the ICD-9 Codebook. Edit Status = suspend, can not be forced
	First Diagnosis Not Covered	(Currently edit is not being used for these programs).
	First Diagnosis Requires Review	(Currently edit is not being used for these programs).
	First Primary Diagnosis/Age Conflict	The person's age, as of the Assessment Result Date, does not fall within the minimum/maximum age limits for the first diagnosis. Recheck the birthdate and diagnostic code. Move the cursor to the diagnostic code and use the PF4 key to view the acceptable date range for this diagnosis. Edit Status = suspend, can not be forced
	First Primary Diagnosis/Sex Conflict	The person's gender is not acceptable for the primary diagnosis. Either the gender is incorrect on the Recipient File, the primary diagnostic code is incorrect, or the gender listed for the diagnosis is incorrect. You can view this by moving the cursor to the diagnostic code and using the PF4 key. Edit Status = suspend, can not be forced
	Second Diagnosis Not on File	The secondary diagnosis code is not on the Reference File. Recheck the number. Edit Status = suspend, can not force
	Second Diagnosis Not Covered	(Currently edit is not being used for these programs).
	Second Diagnosis Requires Review	(Currently edit is not being used for these programs).

489	Second Diagnosis/Age Conflict	The person's age, as of the Assessment Result Date, does not fall within the minimum/maximum age limits for the second diagnosis on the Reference File. Use PF4 key when the cursor is on the diagnosis code to view the age limits for this diagnosis. Edit Status = suspend, can not be forced
490	Second Diagnosis/Sex Conflict	The person's gender is not acceptable for the secondary diagnosis. Either the gender is incorrect on the Recipient File, the secondary diagnosis number is incorrect, or the gender listed for the diagnosis on the Reference File is incorrect. Edit Status = suspend, can not be forced
497	Diagnosis History Fields are Missing or Invalid	The MR/RC Dx History, MI Dx History and TBI Dx History fields are mandatory for Program Types 00 - 12 and 20 - 22. The MR/RC Dx History and MI Dx History fields are mandatory for Program Types 15 - 19. Edit Status = suspend, can not force
498	MR/RC, MI and/or TBI Diagnosis is Not on the Reference File	Either the MR/RC, MI or TBI diagnosis is not valid. For the MR/RC Dx field, the valid values are 317, 318, 318.1, 318.2, 319 and V79.8. Edit Status = suspend, can not force
499	MR/RC, MI and/or TBI Diagnosis is Not Covered	(Currently edit is not being used for these programs).
500	MR/RC, MI and/or TBI Diagnosis Requires Review	(Currently edit is not being used for these programs).
501	Waiver/AC Eligibility Criteria is Missing or Invalid	This field is mandatory for Program Types 01 -14, and 22. It is also mandatory for Program Types 15 - 17 if the Assessment Result is 01. If Program Type is 01 - 12, these fields must be a "y". Edit Status = suspend, can not force
502	Assessment Result Date is Missing or Invalid	This field is mandatory for all Program Types. Edit Status = suspend, can not force

503

	<p>Assessment Result Date/Activity Type Date Conflict</p>	<p>Except for Activity Type 07, the Assessment Result Date must have a date that is equal to, or after, the Activity Type Date.</p> <p>The Assessment Result Date may be dated up to 40 days prior to the Activity Type Date when the Assessment Result is 04,07 or 08 and the 30 Day Exempt field is a "y".</p> <p>The Assessment Result Date cannot be more than 60 days after the Activity Type Date of Activity Types 01 - 04, 06 - 08.</p> <p>When Program Types are 20 or 21, the Assessment Result Date cannot be more than 60 days after the Activity Type Date for Activity Types 02, 04, 06 or 08. Edit Status = suspend, can not force</p>
504	<p>Exit Reasons Need Assessment Results</p>	<p>If Exit Reason (field 65A) is 19 - 26 or 31, then field 65B must have 02 -11, 14 - 18, 27, 30 or 98. If field 65B is "30", then field 65A must be 24 or 25. Values 01 - 18, 27 and 28 in field 65A must not have a value in field 65B.</p> <p>Edit Status = suspend, can not force</p>
642	<p>Activity Type 07 Invalid</p>	<p>This edit will post in these circumstances when the Activity Type is 07:</p> <ul style="list-style-type: none"> ✓ The assessment result equals 98. ✓ The program type is 00 when assessment result is not 18 and the Service Plan Summary doesn't include 38F. ✓ The program type equals 01, 02, 05 - 08, 11, 12, 20 or 21 and the assessment result is 02 - 09, 13 - 18, 27. ✓ The program type equals 03, 04, 09, 10 or 22 and the assessment result is 02 - 09, 13 - 18, or 27. ✓ the program type equals 19 and the assessment result is 01 - 14, 16, 18 - 28. <p>Edit Status = suspend, can not force</p>

<p>Activity Type/Assessment Result is Invalid</p>	<p>If Activity Type = 01, and the Program Type is 00, the Assessment Results can be 02 - 09.</p> <p>If Activity Type = 01 and the Program Type is 15 - 17, the Assessment Results can be 14 and 15.</p> <p>If Activity Type = 01, and the Program Type is 18, the Assessment Result can be 16 and 17.</p> <p>If Activity Type = 01, and the Program Type = 20, the Assessment Results can be 03 - 05, 07, 08 and 09.</p> <p>If Activity Type = 02, and the Program Type = 01 -14, the Assessment Results can be 01, 10, 11, 28.</p> <p>If Activity Type = 02, and the Program Type = 00, the Assessment Results can be 02 - 09, 18, and 27.</p> <p>If Activity Type = 02, and the Program Type = 15 - 17, the Assessment Results can be 01, 02, 10, 11, 14 and 15.</p> <p>If Activity Type = 02, and the Program Type = 18, the Assessment Results can be 01 - 03, 16 and 17.</p> <p>If Activity Type = 02, and the Program Type = 19, the Assessment Results can be 01 - 04.</p> <p>If Activity Type = 02, and the Program Type = 20, the Assessment Results can be 01 - 05, 07 - 11, 27, and 28.</p> <p>If Activity Type = 02, and the Program Type = 21, the Assessment Results can be 01, 10, 11, 27 and 28.</p> <p>If Activity Type = 03, the Assessment Results can be 03 and 05.</p> <p>If Activity Type = 04, and the Program Type is 00, the Assessment Results can be 02 - 09, 18 and 27.</p> <p>If Activity Type = 04, and the Program Type = 01 - 19, or 21 the Assessment Results can be 01, 10, 11, and 28.</p>
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	Continued	<p>If Activity Type = 04, and the Program Type = 20, the Assessment Results can be 01 - 03, 10, 11, 18, and 28.</p> <p>If Activity Type = 04, and the Program Type = 20, the Assessment Results can be 01 - 03, 10, 11 and 28.</p> <p>If Activity Type = 04, and the Program Type = 21, the Assessment Results can be 01, 10, 11, and 28.</p> <p>If Activity type = 05, the Assessment Result must be 98 or 32.</p> <p>If Activity Type = 06, and the Program Type is 01 - 14, the Assessment Results can be 13, 19 - 26 and 31.</p> <p>If Activity Type = 06, and the Program Type is 15 - 17, the Assessment Results can be 02, 03, and 13 - 15.</p> <p>If Activity Type = 06 and the Program Type = 20, the Assessment Results can be 02 - 05, 07 - 11, 13 and 19 - 26.</p> <p>If Activity Type = 06, and the Program Type = 21, the Assessment Results can be 10, 11, 13, 19 - 26.</p> <p>If Activity Type = 08, the Assessment Results can be 10, 13, 19 - 24, and 26.</p> <p>If Activity Type = 08 and the Program Type is 20 or 21, the Assessment Results can be 13, or 19 - 26.</p> <p>Edit Status = Suspend, can not force.</p>
644	Reason(s) for Continued or Long Term Institution Stay is Missing, Invalid, or Duplicated	<p>This field is mandatory when the Activity Type is 04 and the Assessment Result is 04, 06, 09 or 18. At least one field must be valued and duplicates are not allowed.</p> <p>This field is mandatory for Program Type 20 when the Assessment Result is 04, 05, 07 - 09.</p> <p>Edit Status = suspend, can not force</p>
645	MnDC Number is Missing or Invalid	The MnDC Number field is mandatory for Program Types 07 or 08. Edit Status = suspend, can not force

646

IADLs/History Fields are Invalid or Missing

These fields are mandatory for:

- ✓ Activity Type 02 or 04 when the recipient age equals or is greater than 17 for program types 01 - 06, 09, 10 or 22.
- ✓ Program type 00 when the Activity type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F.
- ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06.
- ✓ Program Types 20 and 21 when the Activity Type is 02, 04, 06 or 08.

Edit Status = suspend, can not force

647

Professional Conclusion are Missing or Invalid

These fields are mandatory for all Program Types. If the Level of Care field is 02, 04 or 05, then one of these fields must be a "y".

Edit Status = suspend, can not force

648

Program Type/Age 15

Edit will post when the Program Type is 01, 02, 05, 06, 07, 08, 11 or 12 and the recipient's age is 15. This is a reminder that the case mix cap amount will decrease when the recipient age is 16.

Edit Status = informational

649

Level of Care/Risk Status and OBRA Level 2

If the Level of Care/Risk Status is 01, 03, or 06, then OBRA Level 2 Referral must be a "y".

Edit Status = suspend, can not force

650

Current Housing Type is Missing or Invalid

This field is mandatory for Program Types 00 - 12 and 15 - 22.

- ✓ When using Program Type 03, 04, 09, 10 or 22, values 01, 04 - 10, 12 and 13 cannot be used.
- ✓ If the Activity Type is 04, the Current Housing Type can only be 02, 03, 11, 14, or 15.
- ✓ If Program Type is 13 or 14, the only valid values are 09, 10, or 13.
- ✓ When the Assessment Result is 18, the Program Type is 00, and the Service Plan includes 38F, the only valid value is 02, 11, 14, or 15.

Edit Status = suspend, can not force

	<p>Planned Housing is Invalid or Missing</p>	<p>This field is mandatory for Program Types 01 - 12 and 22. It is also mandatory for Program Types 15 - 18 with Activity Types 02, 04, or 06, and for Program Types 20 - 21 when Activity Type is 02, 04, 06, or 08. Valid combinations are:</p> <p>Planned Housing is 01, the Program Types can be 00 or 15 - 18, and 20 - 21</p> <p>Planned Housing is 02, 03 or 15, the Program Types can be 00 or 19</p> <p>Planned Housing is 04 or 05, the Program Types can be 00 - 12 or 15 - 21</p> <p>Planned Housing is 06, the Program Types can be 00 - 12 or 15 - 18 and 20 - 21</p> <p>Planned Housing is 07 or 08, the Program Types can be 00 - 02, 05 - 08, 11, 12, and 20 - 21</p> <p>Planned Housing is 09 or 10, the Program Types can be 00 - 21</p> <p>Planned Housing is 11, the Program Types can be 00, 18 - 20</p> <p>Planned Housing is 12 or 13, the Program Types can be 00 - 12, 15 - 18, 20, or 21</p> <p>Planned Housing is 14, the Program Types can be 00 - 12</p> <p>Planned Housing is 14, the Program Types can be 15 - 18 when the Activity Type is 02, 04 or 06, or for Program Types 20 or 21 when the Activity Type is 02, 04, 06 or 08.</p> <p>If Assessment Result is 19 - 26 or 31 any value may be used with any program type.</p> <p>If value is 14, there must be text in the "Other" field that identifies the type or name of the housing.</p> <p>Edit Status = suspend, can not force</p>
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652	MR/RC, MI or TBI Diagnosis is Missing or Invalid	If the MR/RC Diagnosis History, MI Diagnosis History or TBI Diagnosis History fields have a “y”, there must be a valid diagnostic code in the corresponding MR/RC Dx, MI Dx, or TBI Dx fields. Edit Status = suspend, can not force
653	NF Stays or Hospitalization Field is Missing or Invalid	If Activity Type is 04, the NF Stays or Hospitalization field must have a value greater than zero. Edit Status = suspend, can not force
655	Nursing Facility Admission Requires DHS Approval	Assessment Result is 04, 05, 06, or 07 and age is 20 or younger. Document routes to DHS for approval. Edit Status = suspend, can not force
656	Phone Screening Invalid	If age is under 21 and the Assessment Result is 04, 05, 07 or 08, the Activity Type cannot be 01. Edit Status = Deny
677	Waiver or Alternative Care Eligibility Span Open	The CSG program cannot be opened at the same time the AC or waiver program is open. Close the other program first. The Assessment Result Date of Assessment Result 01, 10, 11, 13 or 28 for Program Types 13 or 14 must not fall within the waiver eligibility span on the RWVR screen or the AC eligibility span on the RELG screen. Edit Status = suspend, can not force
678	Waiver, AC or Home Care Service Agreement Open	The CSG program cannot overlap with a waiver, AC or home care service agreement. The Assessment Result Date for Assessment Result 01, 10, 11, 13 or 28 for Program Types 13 or 14 cannot fall within a waiver, AC, or Home Care service agreement header period. The service agreement must be closed prior to entering the CSG opening screening document. Edit Status = suspend, can not force

685

	Activity Type/Program Type is Invalid	<p>If Activity Type = 01, the Program Type can be 00, 15 - 21</p> <p>If Activity Type = 02, the Program Type can be 00 - 21</p> <p>If Activity Type = 03, the Program Type can be 00, 19</p> <p>If Activity Type = 04, the Program Type can be 00 - 21</p> <p>If Activity Type = 05, the Program Type can be 00 - 14, 19, 21, or 22</p> <p>If Activity Type = 06, the Program Type can be 01 - 17 or 20 - 21</p> <p>If Activity Type = 08, the Program Type can be 01, 02, 05, 06, 07, 08, 11, 12 ,or 20 - 21</p> <p>Edit Status = suspend, can not force</p>
687	MSHO/MnDHO Eligibility/Program Type Conflict	<p>The Activity Type Date for Program Types 15 - 19 must fall within an MSHO Eligibility span with a product code of M02 on the RPPH screen.</p> <p>The Activity Type Date for Program Type 20 and 21 may fall 30 days prior to the MnDHO eligibility span with Product ID of MA15.</p> <p>Edit Status = deny</p>
688	MR/RC, MI and/or TBI Diagnosis Conflict with Age	<p>Either the MR/RC, MI or TBI diagnosis is not valid for the person's age. Place cursor on each diagnostic code and use the PF4 key to view the valid age spans.</p> <p>Edit Status = suspend, can not force</p>
689	MR/RC, MI and/or TBI Diagnosis Conflict with Gender	<p>Either the MR/RC, MI or TBI diagnosis is not compatible with the person's gender. Place cursor on each diagnostic code and use the PF4 key to view the valid sex.</p> <p>Edit Status - suspend, can not force</p>

690	Assessment Result Date/Major Program Conflict	If the Program Type is 01 - 08, 11, 12, 15 - 18, 20 or 21 the Assessment Result Date must fall within a major program MA span. Go to the RLVA screen in the recipient subsystem and review the living arrangement spans. Contact the financial worker if the screen information is wrong. If the Program Type is 09 or 10 and the Activity Type is 06, or the Assessment Result is 19 - 26, 31, 33 or 34, the Assessment Result Date must fall within a major program AC span. If the Program Type is 22 and the Assessment Result is 19 - 26 or 31, 33 or 34, the Assessment Result Date must fall within a major program AC span. Edit Status = deny
691	Funding Level May Change	Edit will post for Program Types 13 or 14 when the recipient's age equals 21. Edit Status = informational
692	Invalid Values for MnDHO Program Types	If Program Type is 20, the Rate Cell Category (RCC) field can be A, E, F, G, H, I, J, N, O, P, Q, R, S, or T. If Program Type is 21, the Rate Cell Category (RCC) field can be B, C, D, K, L, or M. Edit Status = suspend, cannot be forced
694	AC Adjusted Asset/Income Field Invalid	Both the AC Adjusted Asset and AC Adjusted Income fields are blank, or one or both fields have a value of zero. An amount greater than zero is needed in one of the fields. If the number is unknown, use a "1" until the calculation is complete. Edit Status = suspend, can not be forced
696	Temporary Ineligible for AC Program	Person was exited from the AC Program for non payment of premium (fee) with exit reason 31. They are ineligible to reopen to the AC program for 30 days. Edit Status = deny
698	Gross Monthly Income/Assets is Missing or Invalid	Either the Gross Monthly Income and/or the Gross Assets field was left blank. Both fields are mandatory for Program Types 09, 10, or 22. Valid values are 1 - 99999. Edit Status = suspend, can not be forced.
754	Inappropriate Field Change	When using Activity Type 05 or 07, the following fields on the ALT1 screen cannot be changed: PAS, Referral Date, MR/RC Dx and History, MI Dx and History, TBI Dx and History. Change the field(s) back to the original value. Edit Status = suspend, can not be forced

	AC Premium Waiver Reason Code is Missing or Invalid	When the Program Type is 09, 10 or 22 the field indicates that the AC premium is waived. Do not use values 01 or 02. It is permissible to force the edit in those circumstances in which the premium is not collected nor is it being waived for one of the waiver reasons. Edit Status = suspend, can not be forced
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	<p>Assessment Result is Invalid</p>	<p>The Assessment Result does not follow the proper sequence. Check the history of the approved documents on file.</p> <p>If Assessment Result is 11 there must be an Exit 19 - 26, 31, 33 or 34 in the past.</p> <p>If Assessment Result is 01 there cannot be an Assessment Result 01 in the past.</p> <p>If Assessment Result is 28 there must be a Assessment Result 27 in the past.</p> <p>If Assessment Result is 02 - 11, 14 - 18 and Assessment Result 01, 10, 11, or 28 was used in the past, then Exit 19 - 26, 31, 33 or 34 must be used in between the two.</p> <p>If the previous Assessment Result is 01, 10, 11 or 28, the current Assessment Result can be 13 or Exit 19 - 26, 31, 33 or 34.</p> <p>If the previous Assessment Result is 13, the current Assessment Result can be 13, 14, or Exit 19 - 26, 31, 33, or 34.</p> <p>If the previous Assessment Result/Exit is 24/30 or 25/30, no other Assessment Result may follow.</p> <p>If the Assessment Result is 13 or Exit 19 - 26, 31, 33 or 34, there must be an Assessment Result 01, 10, 11 or 28 for the same Program Type.</p> <p>Exit 19 - 26, 31, 33 or 34 cannot immediately follow Assessment Results 02 - 09, 15 - 26, 31, 33 or 34.</p> <p>If Assessment Result = 10, Exits 19 - 26, 31, 33 or 34 must be used in the past and the previous exit cannot be the same waiver type as the current Assessment Result 10.</p> <p>Activity Type 07 with Assessment Result 01 is a valid combination only when immediately following Activity Type 02 or 04 with Program Type 00. The Activity Type Date of Activity Type 07 must be within 60 days of the Activity Type Date of Activity Type 02 or 04.</p>
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780

	Continued	<p>Activity Type 07 with Assessment Result 10 or 11 is a valid combination only when following a previous exit reason of 19 - 26 and the Assessment Result Date must be within 60 days of the Assessment Result Date of a previous Activity Type 02, 04, 06 or 08.</p> <p>For Program Types 03, 04, 09, 10, and 22, Assessment Result 10 and 11 does not need to be within 60 days of Activity Types 02, 04, 06 or 08 when following Assessment Result 19, 31, 33 or 34.</p> <p>Program Type 22 with Assessment Result 10 cannot follow a previous Program Type 03 or 04.</p> <p>Program Type 22 with Assessment Result 10 or 28 cannot follow a previous program type 22.</p> <p><u>For Program Types 20 and 21 (MnDHO)</u> If Assessment Result is 10 or 11 and Assessment Result 01 - 05, 07 - 11 or 28 was used in the past, then exit 19 or 26 must be used inbetween the two.</p> <p>If the Assessment Result is 13 or Exit 19 - 26, there must be an Assessment Result 01 - 05, 07 - 11 or 28 for the same program type.</p> <p>Exit 19 - 26 cannot immediately follow Assessment Result 19.</p> <p>If the previous Assessment Result is 01 - 05, 07 - 11 or 28, the current Assessment Result can be 13 or 19 - 26.</p> <p>Activity Type 07 with Assessment Result 01 - 05, or 07 - 09 are valid combinations only when immediately following Activity Type 02 or 04 with Program Type 00. The Activity Type Date of Activity Type 07 must be within 60 days of the Activity Type Date of Activity Type 02 or 04.</p> <p>Edit Status = suspend, can not be forced</p>
	Exit Reason Date is Greater than Current Month	<p>The Exit Reason Date (exit reasons 19 - 26, 31, 33 or 34) must be dated prior to, or within the current month.</p> <p>Edit Status = suspend, can not be forced</p>

781

782

	New Assessment is Required	<p>The purpose of this edit is to ensure that the client is not opened from a waiting list to a program with an effective date that is more than 60 days from a face-to-face screening. It will post if Activity Type 07 is used with Assessment Result 28 and the date is greater than 60 days from an approved Activity Type 02 or 04 with Assessment Result 27. If so, the case manager must conduct a new face-to-face assessment. Then, use Activity Type 02 or 04 with Assessment Result 28 for the new Activity Type Date.</p> <p>Edit will also post if the Assessment Result is 18, Program Type is 00 and Service Code Summary is 38, and the Activity Type Date is greater than 180 days from an approved Activity Type 02, 04 or 07. If so, use a new Activity Type 02 or 04 with Assessment Result 18.</p> <p>Edit Status = deny</p>
783	Fields Required for AC or CSG	<p>The AC or CSG person's home address is required on the ALT6 screen. Do not skip the first line. The second line is optional. The county of financial responsibility is also required.</p> <p>Edit Status = suspend, can not be forced</p>
784	Conversion Case Mix or TBI Screening Document Requires Approval	<p>This edit will route the screening document to DHS for approval when the Program Type is 04, the edit will post when the case mix amount entered in the Case Mix/DRG Amount field is greater than the case mix amount cap. All other edits with a status of "3" or "4" must be resolved in order for the screening document to route to DHS.</p> <p>Edit Status = suspend, can not be forced</p>
786	Assessment Result Date/Age Invalid	<p>This edit will post when the person's age is 65 or over as of the Assessment Result Date, the Assessment Result is 01, 10, 11 or 28 and the Program Type is 01, 02, 05 - 08, 11, 12, 20 and 21.</p> <p>If the recipient's age is over 65, they cannot be opened or reopened to the CAC, TBIW, CADI, or MnDHO programs.</p> <p>Edit Status = deny</p>

789

	Bathing Code is Missing or Invalid	<p>This field is required for:</p> <ul style="list-style-type: none"> ✓ Program Types 01 - 12 and 22 ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06 ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08 ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F. <p>Edit Status = suspend, can not be forced</p>
790	Bed Mobility is Missing or Invalid	<p>This field is required for:</p> <ul style="list-style-type: none"> ✓ Program Types 01 - 12 and 22 ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06 ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08 ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F. <p>Edit Status = suspend, can not be forced</p>
791	Behavior is Missing or Invalid	<p>This field is required for:</p> <ul style="list-style-type: none"> ✓ Program Types 01 - 12 and 22 ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06. ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08 ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F. <p>Edit Status = suspend, can not be forced</p>
792	Case Mix Code is Missing or Invalid	<p>This field is required for Program Types 01 -12, and 20 - 22. Also for Program Types 15 - 19 when the Activity Type is 02 or 06. Please review the Case Mix Classification Work-sheet (DHS-3428B) to determine the correct ADL combinations for each case mix letter.</p> <p>Edit Status = suspend, can not be forced</p>

793

Case Mix/DRG Amount is Missing or Invalid

The Case Mix/DRG Amount field is system entered for programs 03, 04, 09, and 10. When 13 or 14 are used, the CSG monthly grant dollar amount is entered. Not mandatory for Program Types 00, 15 - 21.

This field should also be completed when the Program Type is 04, **AND** the higher nursing facility payment rate is requested. You should erase the system generated rate that was placed in this field and add the actual monthly amount MA would pay the facility. This will cause the screening document to remain in suspense for DHS staff review and approval.
Edit Status = suspend, can not force

794

Case Mix/DRG Amount is Greater than Rate Price

This edit posts when the Program Type is 03, 09, 10, or 22 and the Case Mix/DRG Amount field was changed to an amount that was greater than the case mix limit for the A - K classifications. This field is automatically entered by the system and should not be manually entered for the above program types.
Edit Status = suspend, can not be forced

795

Clinical Monitoring is Missing or Invalid

This field is required for

- ✓ Program Types 01 - 12 and 22
- ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06.
- ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08
- ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F.

Edit Status = suspend, can not be forced

797

Disability Certification Source is Missing or Invalid

This field is required for

- ✓ Program Types 01 - 12, 15 - 17, and 20 - 22
- ✓ Program Type 00, Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F
- ✓ Program Type 01, 02, 05 - 08, 11, 12, 20 or 21 and the recipient is under the age of 65, then field must be 01 or 02. Otherwise it can be valued 01 - 03.
- ✓ Program Type 20 or 21 and the Recipient is under the age of 65 then field must be 01 or 02.

Edit Status = suspend, can not be forced

798

DOB is Greater Than Activity Type and/or Assessment Result Dates

The person's date of birth cannot be greater than the Activity Type or Assessment Result Date.
Edit Status = suspend, can not be forced

799

	Dressing is Missing or Invalid	<p>This field is required for:</p> <ul style="list-style-type: none"> ✓ Program Types 01 - 12 and 22 ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06. ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08 ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F. <p>Edit Status = suspend, can not be forced</p>
800	Eating is Missing or Invalid	<p>This field is required for:</p> <ul style="list-style-type: none"> ✓ Program Types 01 - 12 and 22 ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06. ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08 ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F. <p>Edit Status = suspend, can not be forced</p>
801	Family Choice is Missing or Invalid	<p>This field is required for Program Types 01 - 12 and 22. Edit Status = suspend, can not be forced</p>

<p>Assessment Results/Exit Reasons Invalid with Program Type</p>	<p>This field is mandatory for all program types. Valid combinations are:</p> <p>Assessment results 01 can be used with program types 01 - 21</p> <p>Assessment results 02 can be used with program types 00 - 20</p> <p>Assessment results 03 can be used with program type 00 and 15 - 20</p> <p>Assessment results 04 can be used with program types 00 and 19 - 20</p> <p>Assessment results 05 can be used with program types 00 and 19 - 20</p> <p>Assessment results 06 can be used with program types 00 and 15 - 17, 19</p> <p>Assessment results 07 and 08 can be used with program type 00 and 19 - 20</p> <p>Assessment results 09 can be used with program type 00, 19, and 20</p> <p>Assessment result 10 can be used with program types 01 - 17, 20 - 22</p> <p>Assessment result 11 can be used with program types 01 - 17, 20 and 21.</p> <p>Assessment result 13 can be used with program types 01 - 17, 20 and 21</p> <p>Assessment result 14 can be used with program types 15 - 17</p> <p>Assessment result 15 can be used with program type 19</p> <p>Assessment result 16 can be used with program type 18</p> <p>Assessment result 17 can be used with program type 19</p> <p>Assessment result 18 can be used with program type 00</p> <p>Exit 19 can be used with program types 03, 04, 09, 10, 15 - 22</p> <p>Exit 20 - 24 can be used with program types 01 - 21</p> <p>Exit 25 can be used with program types 01 - 08, 11, 12, 20 and 21</p> <p>Exit 26 can be used with program types 01 - 21</p> <p>Other reason 27 can be used with program types 00 and 19 - 21</p> <p>Other reason 28 can be used with program types 01 - 14, 20 - 22</p> <p>Other reason 29 can only be used for fields 68 and 69</p> <p>Other reason 30 cannot be used in field 65A</p> <p>Exit reasons 31, 33 or 34 can be used with program types 09, 10, or 22</p> <p>Other reason 32 can be used with program types 09, 10, or 22</p> <p>Other reason 99 can only be used for field 69</p>
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804

Grooming is Missing or Invalid

This field is required for Program Types 01 - 12 and 22

- ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06.
- ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08
- ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F.

Edit Status = suspend, can not be forced

805

Hospital Transfer is Missing or Invalid

This field is required for

- ✓ Program Types 08 and 12
- ✓ Assessment Results 14 - 17 (can be a “y” or “n”)
- ✓ When Assessment Result is 07 or 08 the Hospital Transfer must be a “Y”
- ✓ When the PAS 30 Day Exempt field is a “Y” then the Hospital Transfer field must be a “Y”.

Edit Status = suspend, can not force

806

Service Codes are Missing or Invalid

This field is required for Program Types 15 - 18 when the Activity Type is 02 and the Assessment Result is 01, 02, 10 or 11. It is also mandatory if the Assessment Result is 18. If more than one code is entered, there may not be duplicates. (A duplicate is a match on all characters). Each number must be followed by either I, F or Q. If value is 38, the indicator must be “F” and Assessment Result must be 18.

Edit Status = suspend, can not be forced

808

Current or Planned Living Arrangement is Missing or Invalid

The Current Living Arrangement Field is mandatory for Program Types 01 -12, 15 - 19 and 22. When the Assessment Result is 18 and the Service Plan Summary includes 38F, the value must be 04.

The Planned Living Arrangement field is mandatory for Program Types 01 - 12 and 15 - 22. It is mandatory for Program Types 15 - 18 when Activity Type field is 02, 04, or 06, and for Program Types 20 and 21 when the Activity Type is 02, 04, 06, or 08.

Edit Status = suspend, can not be forced

809

Marital Status is Missing or Invalid

This field is mandatory for Program Types 01 - 19, or 22 and also for Activity Type 03.

Edit Status = suspend, cannot be forced

811	Neuromuscular Diagnosis is Missing or Invalid	<p>This field is required for</p> <ul style="list-style-type: none"> ✓ Program Types 01 - 12 and 22 ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06. ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08 ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F. <p>Edit Status = suspend, can not be forced</p>
812	OBRA Screening Level 1 is Missing or Invalid	<p>This field is mandatory for Program Types 00 - 14 or 22.</p> <ul style="list-style-type: none"> ✓ When the Program Type is 00 - 14 or 22 and the Assessment Result is 03, 05 or 98, then this field can be a “y” or “n”. ✓ For Program Types 15 -19 and the Assessment Result is 14 - 17, the value must be a “y”. ✓ For Program Types 20 or 21, this field must be a “y” when Assessment Results is 01 - 05, 07 - 11 or 28. ✓ For Program Types 00 - 14 or 22 and the Assessment Result is 01, 02, 04, 06 - 26, 28 or 31, the value must be a “y”. <p>Edit Status = suspend, can not be forced</p>
813	OBRA Level 2 Referral is Missing or Invalid	<p>This field is mandatory for Program Types 00 - 12 and 15 - 19. When the MR/RC Diagnosis History is a “y” and the Assessment Result field is 04, 06 - 08 then this field must be a “y”. If the TBI Diagnosis History or MI Diagnosis History fields are a “y” and the Assessment Result field is 04, 06 - 08 then this field can be a “y” or “n”.</p> <p>Edit Status = suspend, can not be forced</p>
814	CAC, CADI, TBI, or MnDHO 65 th Birthday	<p>Edit will post if the Program Type is 01, 02, 05 - 08, 11, 12, 20 or 21 and the recipient’s age is 65 years, and the Activity Type is not 08 and there isn’t a previous approved Activity Type 08.</p> <p>Edit Status = deny</p>
815	Program Type Change Invalid	<p>If Assessment Result = 13, the Program Type must not change from the last approved 01, 10, 11, 13 or 28.</p> <p>Edit Status = suspend, can not be forced</p>

816	Orientation is Missing or Invalid	<p>This field is required for</p> <ul style="list-style-type: none"> ✓ Program Types 01 - 12 and 22 ✓ Program Types 15 - 17 when the Activity Type is 02 or 06. ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08 ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F. <p>Edit Status = suspend, can not be forced</p>
817	PAS 30 Day Exempt is Missing or Invalid	<p>This edit will post when:</p> <ul style="list-style-type: none"> ✓ the field is blank ✓ the value is not valid ✓ if the value is a “y” and the Hospital Transfer field is a “n”. <p>Edit Status = suspend, can not force</p>
818	Present at Screening or Assessment Duplicate	<p>There are duplicate codes.</p> <p>Edit Status = suspend, can not be forced</p>
819	Present at Screening/Assessment is Missing or Invalid	<p>This field is required for Program Types 00 - 12 and 15 - 19.</p> <p>Edit Status = suspend, can not be forced</p>
820	Reason(s) for Referral Missing or Invalid	<p>This field is mandatory for all program types. At least one of the two fields must be valued and duplicates are not allowed.</p> <p>Edit Status = suspend, can not be forced</p>
821	Program Type is Missing or Invalid	<p>This field is always required.</p> <p>Edit Status = suspend, can not be forced</p>
822	NF Track # is Missing or Invalid	<p>This field is no longer required since the case mix payment system was replaced by RUGS, the QAR forms are no longer used. The facility still needs a record that PAS was completed, and the department suggest counties number the Level 1 form they forward to the facility in any way they choose as long as the initial numbers indicate the county code (e.g. Anoka = 002) so the facility can identify which county completed the PAS. You may choose to enter this number in this field on the screening document, but it is not required. Edit Status = informational</p>
823	Recipient Choice is Missing or Invalid	<p>This field is required for Program Types 01 - 12 and 22. Edit Status = suspend, can not be forced</p>

825	Assessment Team is Missing or Invalid	<p>This field is mandatory for Program Types 00 - 06, 09, 10, 13, 14 and 19. Valid combinations are: Value 01 is valid for Program Types 00 - 06, 09, 10, 13, 14 or 19 Value 01 - 03 is valid for Program Types 15 - 19 Value 04 is valid for Program Types 00 - 19 When the Program Type is 07, 08, 11 or 12, the value must be 04. Edit Status = suspend, can not be forced</p>
828	Special Treatments is Missing or Invalid	<p>This field is required for</p> <ul style="list-style-type: none"> ✓ Program Types 01 - 12 and 22 ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06. ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08 ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F. <p>Edit Status = suspend, can not be forced</p>
829	TBI/CAC Referral is Missing or Invalid	<p>This field is mandatory for Program Types 01, 02, 07, 08, 11 or 12 and must be a "y". For Program Type 20 and RCC = L, J, R or S, this field must be a "y". Edit Status = suspend, can not be forced</p>
830	PAS/IDT Recommendation is Missing or Invalid	<p>This field is mandatory for Program Types 00 - 12 and 15 - 21. Value 29 is not valid. Edit Status = suspend, can not be forced</p>
831	Toileting is Missing or Invalid	<p>This field is required for</p> <ul style="list-style-type: none"> ✓ Program Types 01 - 12 and 22 ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06. ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08 ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F. <p>Edit Status = suspend, can not be forced</p>

832

	Transferring is Missing or Invalid	<p>This field is required for</p> <ul style="list-style-type: none"> ✓ Program Types 01 - 12 and 22 ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06. ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08 ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F. <p>Edit Status = suspend, can not be forced</p>
833	Program AC/MA Eligible	<p>The person is opening or currently on the Alternative Care program and is eligible for Medical Assistance. This edit will post for Program Type 09, 10 or 22 and the Assessment Result Type is 01, 10, 11, 13 or 28, and the Assessment Result Date is within a major program MA span on the RELG screen. Person must be open to the Elderly Waiver program instead.</p> <p>Edit Status = suspend, can not be forced</p>
834	Walking is Missing or Invalid	<p>This field is required for</p> <ul style="list-style-type: none"> ✓ Program Types 01 - 12 and 22 ✓ Program Types 15 - 18 when the Activity Type is 02, 04 or 06. ✓ Program Type 20 or 21 when Activity Type is 02, 04, 06 or 08 ✓ Program Type 00 when the Activity Type is 02 or 04, the Assessment Result is 18 and the Service Plan Summary includes 38F. <p>Edit Status = suspend, can not be forced</p>
877	AC Minimum Limits	<p>The Gross Income and Gross Assets do not fall within the financial guidelines for the AC program. The Program Type must be 22 (temporary AC) and a completed, signed MA application must be submitted.</p> <p>Edit Status = deny</p>
878	Program Type 22 Invalid	<p>The Gross Income and Gross Assets do not fall within the financial guidelines to be on temporary AC. The Program Type must be 09 or 10.</p> <p>Edit Status = deny</p>
879	MA Application/Asset Assessment Required	<p>When the Program Type is 22, the case manager must forward a completed and signed MA application and Asset Assessment Form DHS-3340 for married applicants. These forms are required for processing prior to the approval of opening to temporary AC.</p> <p>Edit Status = informational</p>

880	AC Upper Limit Criteria Not Met	The combined AC Adjusted Assets and AC Adjusted Income exceed the upper financial limits for the AC program. Edit Status = deny
881	AC Lien Referral Required	The AC Lien Referral field was left blank or the value is not a Y or N. Edit Status = suspend, can not be forced
883	AC Estate Claim Referral Required	For exit reassessment values, the case manager must submit an AC Estate Claim Recovery to the county of financial responsibility. Edit Status = informational
885	AC Fee Assessment Required	The AC Premium Assessed field cannot be left blank. The value must be a Y or N. Edit Status = suspend, can not be forced
899	More Than 25 Exceptions	This edit will occur when there are more than 25 edits are posting to the screening document. The system can only show 25 edits at one time. As other edits are corrected, this edit will disappear when the total count is below 25. Edit Status = suspend, can not be forced

Minnesota Department of Human Services Continuing Care Administration Medicaid Management Information System (MMIS) January, 2004	Chapter 3	Service Agreement
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301.01 PURPOSE OF THE SERVICE AGREEMENT FORM

All Home Care (with some exceptions), waiver and Alternative Care services must be prior authorized by the case manager prior to providing the service. The service agreement is used by the case manager to control the service costs by identifying the services that the client will be provided, the time period, number of units, the provider, and the rate that will be paid. Claims submitted by the provider are matched against the service agreement information to determine if the claim can be paid.

The service agreement form, DHS-3070, can be ordered from the Department free of charge by calling (651) 296-9116. This form can also be retrieved from the DHS website at <http://www.dhs.state.mn.us/infocenter/docs.htm#forms>. With the Adobe Acrobat software you can view and print the form.

301.02 SERVICE AGREEMENT FORM FIELDS

The service agreement is divided into three parts: General Information, SCH Data, and Line Items.

The General Information section provides information about the client, the case manager, the beginning and ending dates of the service agreement period, the total cost of the services, and the cap amount.

SCH Data is used for the Minnesota Children with Special Health Needs Program (MSSHN). County staff will not be completing service agreements for this program and these fields should be left blank.

The Line Item section identifies those services authorized by the case manager for the person. Each line item identifies the provider, the service, maximum number of units or dollars, and the period that the service may be provided.

The following chart is a field by field description of the service agreement form, MMIS screens, and which edits are assigned to each field.

Field Number and Name	Description	Edits
ASA1 Screen 1 - Document Control #	An eleven digit number assigned to the agreement when initially entered into MMIS Format is YDDDBBBRNNN Y = last digit of the current year DDD = julian day BBB = batch number R = microfilm roll number NNN = document number within the batch	None
2 - Agreement Type	Identifies the type of program. F = CADI Conversion G = CADI Diversion H = CAC Conversion I = CAC Diversion J = EW Conversion K = EW Diversion L = TBIW-NF Conversion M = TBIW-NF Diversion N = AC Conversion O = AC Diversion P = TBIW-NB Conversion Q = TBIW-NB Diversion	253, 254
3 - Agreement Start Date	The beginning date of the service agreement.	271, 608
4 - Agreement End Date	The last date of the service agreement. If left blank, a date of 366 days from the begin date will be plugged in here.	None
5 - Provider Number	The nine digit number that identifies the provider. Use this field only when one provider will be providing all the services on all the line items. If this field is entered, then by leaving the provider field on the line item(s) blank, the provider number in this field will be used for the line item(s).	None
6 - Referring Provider	This field identifies the physician who referred a client to another provider. <u>Do not use this field.</u>	None
7 - Total Authorized Amount	This amount is automatically calculated by MMIS and <u>does not need to be entered.</u> It is the sum of all the approved, suspended and pended line items.	672

8 - Client Last Name	<u>Leave blank.</u> MMIS will insert the name from the client file.	168
9 - Client First Name	<u>Leave blank.</u> MMIS will insert the name from the client file.	167
10 - Client Middle Initial	<u>Leave blank.</u> MMIS will insert the name from the client file.	None
11 - Recipient ID Number (a.k.a. Client or PMI Number)	The identifying number assigned to the person.	129, 251
12 - Birth date	The format is MMDDYYYY. This field turns red and not allow you to move to the next screen if it doesn't exactly match the birth date listed on the Recipient File. Use the PF4 key to view the birth date on the Recipient File. If that birth date is incorrect, the financial worker must change it. If the PMI number was obtained through the PMIN Function, then that method can be used to change the birth date.	248
13 - Disc. Fund	<u>Do not use this field.</u> It was used for MR/RC service agreements only.	None
14 - Case Manager Number	The provider number assigned to the case manager. Placing the cursor on this field and pressing the PF4 key will bring you to the Provider Subsystem. Go to the PADD screen to view the case manager information.	112, 114
15 - Authorization Date	The date that the service agreement form was completed and ready to be data entered.	None
16 - Authorizing Signature	Identifies that the person completing the service agreement form has signed off. Use a "Y" in MMIS.	None
17 to 24 - MSSHN Fields	These fields are completed for MN Children with Special Health Needs (MSSHN) clients <u>They all should be left blank.</u>	None

Field Number and Name	Description	Edits
ASA2 Screen These fields are not on the paper form. Reason Codes	There are spaces for four reason codes. These codes represent text that will be automatically place on all service agreement letters. It is used to explain an action or the reason why the letter was produced. Remember to delete the reason codes the next time you make changes to the service agreement so the text is not again added to future letters. (See the reason code list in Section 301.13).	835, 838 839
Send Recipient Letter	This field must be completed and signifies that a letter from DHS will be sent to the client that identifies all the services they will be receiving, the provider, the payment amount and the period of time the service will be provided. If you place an “N” in this field, the letter will be suppressed and you will need to send a replacement notice from your agency.	181
Attachment	This field indicates if an attachment was scanned along with the initial form. It would be a “Y” if the service agreement was sent by paper form for processing. For online users, this field should always have a “N” entered.	695
Send Provider Letter	This field will default to “Y” indicating that a letter from DHS will always be sent to the provider(s).	182
SACTAD Number	<u>This field should be left blank.</u> It is used only for MA Home Care agreements.	None
Override Location	<u>This field does not need to be completed for EW or AC service agreements.</u> It is used to transfer suspended or partially suspended service agreements online from county to DHS staff and visa versa.	None
AC Premium Amount	To record the amount of monthly premium the AC recipient is obligated to pay. If none, place 0. See Bulletin #01-32-14 for more information on billing and collecting AC premiums.	699

Field Number and Name	Description	Edits
Premium Effective Date	The effective date of the AC premium amount. It is a format of MM/YY. The month must be the month following the current month (example: if you are entering the service agreement in May, this field will show 06/02). See Bulletin #01-32-14 for more information on changing prior effective dates.	734
Claims Last Date Update	This is the last date that a claim was paid against the service agreement. An old date on a current service agreement could be an indicator of billing problems.	None
Input Media	An indicator identifies if the data was submitted by paper or exam entry (online).	None
DHS Comment Screen Recipient Comment Screen Provider Comment Screen	These fields will have a “Y” shown here if there is text on any of these screens.	None

Field Number and Name	Description	Edits
ASA3 Screen 25 - Service Comments	There is a blank line to enter additional text about the service. Otherwise, there is no need to type in the name of the service as MMIS will plug in the name of the service based on the procedure code.	157
26 - Procedure Code	The code assigned to the service. Also known as HCPC. It begins with an "x". Moving your cursor to this field and using the PF4 key will bring you to the Reference Subsystem to view additional information about the service.	275, 276, 323, 375, 376, 430, 431, 433, 434, 435, 437, 438, 439
27 - Mod 1	This is the first modifier used for MA authorizations. <u>Leave this field blank except for Shared PDN. See Section 301.21.</u>	117, 324, 333, 334, 363, 505
28 - Mod 2	This is the second modifier used for MA authorizations. <u>Leave this field blank.</u>	121, 324, 371, 505
30 - Delete	This field is used to signify to MMIS that the line item should be ignored. It is used only when submitting paper documents to MMIS for processing. Unwanted line items are not crossed out, but rather have an "x" placed in this field.	None
32 - Start Date	The begin date of the service shown in field 25. If you leave this field blank, the date from field 3 will be plugged in here.	124, 126
33 - End Date	The last day that the service will be provided. If you leave this field blank, the date from field 4 will be plugged in here.	155

Field Number and Name	Description	Edits
34 - Requested Rate Per Unit	This is the dollar amount that was contracted with the provider. When using this field, the Total Units field must also have a value. The rate is checked against the statewide maximum cap.	196, 321 381, 763
35 - Requested Total Units	This is the total number of units that will be provided during the period identified in fields 32 and 33. If this field is valued, then field 34 must have a value.	196, 393 763
36 - Requested Total Amount	<p>If fields 34 and 35 are valued, then MMIS will calculate the total amount of money. The following services may have fields 34 and 35 valued, or just field 36:</p> <ul style="list-style-type: none"> x5416 - MR adult supported living services x5398 - MR adult supported living services x5399 - MR child supported living services x5668 and x5669 - 24 hour emergency services x5674 - specialist services x5415 - supported living services x5666 - housing access coordinator x5671 - assistive technology x5419 - modifications and adaptations x5362 - assisted living plus x5502 - consumer education and training x5526 - ac cash grant x5673 and x5672 - personal support x5527 - ac discretionary service x5467 - extended supplies and equipment x5363 - corporate foster care x5417 and x5418 - in-home family support x5651 - ac supplies and equipment x5492 - ac telehomecare device x5503, x5504 and x5506 - consumer directed services 	763

37 - Provider Number	The nine digit number assigned to the provider. If this field is left blank, then the provider shown in field 5 will be used by MMIS. Putting your cursor on this field and using the PF4 key will bring you to the Provider Subsystem to view all the screens related to this provider.	120, 125, 241, 286, 300, 366, 410, 415, 416, 420, 422
38 - Provider Name	<u>Leave blank.</u> MMIS will automatically plug in the name of the provider based on the provider number.	None
39 - Shared Care	This field is used to identify that the Personal Care Assistant or Private Duty Nurse will provide services to more than one client at the same time in the same setting. Valid value is a “y”. See Sections 301.21 and 301.22 for more information on using this field.	869
40 - Frequency	This field will place text on the service agreement letter indicating how many times the service may be provided. Values are: 1 - daily 2 - weekly 3 - monthly 5 - entire length of the line item period It is not a mandatory field.	

301.03 USE OF THE COMMENT SCREENS

The comment screens are used to record information or to write text to explain a change on the service agreement or why another service agreement letter is being produced. The screens can only be accessed via online. Remember, that any county or DHS staff with inquiry access to the service agreement file may view your comments on all three screens.

The PF2 key will copy text from the ADHS screen to the APRV screen. Text on the APRV screen can be copied onto the ARCP screen. Text on the ARCP screen cannot be copied. After typing the text, press the PF2 key and the text will be copied onto the next screen. If the text does not fit onto the next screen, a message will appear to delete text on the copied screen.

DHS Comment Screen

- ✓ Identify each medical supply and equipment item(s), the cost, and explain how the items are needed to avoid institution. AC and waiver programs do not pay for separate installation charges nor shipping and handling charges for supplies and equipment. These charges must be included in the cost of the product or item. Do not add a separate line item for these charges. If a provider is authorized for more than one item, do not place each item on its own line unless the line covers different periods of time and these periods do not overlap. If the items will be provided during the same period of time determine the total cost of all items and use one line item with a total amount (no requested rate and no units).
- ✓ All modifications will be placed on a different line item from the medical supplies and equipment. The AC and waiver programs do not pay for ramp insurance, inspections, estimates, and design fees. The justification for the modification must be shown on this screen.
- ✓ When using the *pseudo* procedure code x5609 for the services that the PMAP provider is responsible, indicate on this screen what those services are and the estimated number of units for each.
- ✓ When the person will be receiving hospice services, document that the case manager is working with the hospice case manager to coordinate services.
- ✓ Indicate what services will be funded with the AC Cash Grant or AC Discretionary Services.

Provider Comment Screen

The Provider Comment screen is used to add text that will be shown on all provider letters. It can be a message that all providers need to know. Remember to delete the text the next time a change is made to the service agreement or the text will show on future letters.

Recipient Comment Screen

The Recipient Comment Screen is used to add text that will be shown on the client and case manager letter. Remember to delete the text the next time a change is made to the service agreement or the text will show on future letters.

301.04 SUBMITTING THE SERVICE AGREEMENT

There are two ways to submit the service agreement form to MMIS for processing: online or by paper.

Submitting Online

Staff uses a PC-based computer to submit documents. Each document is assigned an 11-digit number by the system for identification and to avoid duplication. The ASA3 screen can be scrolled to reveal up to 99 line item lines.

Any system exceptions or user errors are listed immediately for correction. The service agreement can be saved even when partially completed. Future changes can be made to the service agreement.

There are two copy features. One feature copies the ASA1 screen from an existing agreement to create a new agreement with the same ASA1 information but blank line items. Another feature allows the user to copy line items for repeating on the same service agreement.

Submitting Paper Documents

If the agency uses paper service agreements, the form must be typed. These forms are sent to DHS using envelope number DHS-3137. The Claims Processing Unit batches, assigns a batch number and an individual document control number, microfilms, and scans each document.

If more than one form is used for a client because there are more than four line items, the additional forms are treated as attachments only when the "5s" in the top right hand corner are blocked out by marker. The attachment(s) are assigned the same 11-digit control number as the initial form. While the initial form is scannable, these attachments must be manually entered by the Claims Processing Unit.

Minimal data edits are performed. Those documents passing these edits are saved to the Prior Authorization subsystem. The Claims Processing Unit then obtains the documents, checks for scanning errors and enters the additional information from the attachments. Additional changes and corrections must be made online by the staff who submitted the document.

If the form is not scannable, an attempt will be made to enter it manually. If the service agreement contains errors or it cannot be entered into the system, the Claims Processing Unit returns the document to the submitter with a cover letter for correction. The submitter corrects the errors and submits a new document.

301.05 ELIGIBILITY REQUIREMENTS

This section explains how the screening document supports the service agreement and what happens if there are problems.

No Eligibility Span

Before a service agreement can be approved in MMIS, there must be a waiver or Alternative Care eligibility period created by an opening, reopening, or reassessment screening document for the same program type. If there isn't this eligibility period, or the service agreement starts prior to, or after this period ends, edits* will not allow the service agreement to be approved. (You can save it and return later to correct the edits). You can check the RWVR screen (for waiver) or the RELG screen (for AC) in the Recipient Subsystem for these dates of eligibility. If there are more than one period of eligibility, the service agreement cannot overlap both periods. **Edits 253 and 254 and will post.*

Service Agreement Type Does Not Match Screening Document Program Type

The service agreement will not match the screening document if the screening document is a "diversion" and the service agreement is a "conversion" (or visa versa). If the service agreement is incorrect, use the PF6 key to delete the service agreement instead of saving it. If it was already saved with PF3, change the header status to a "D". Remove any line items or delete the provider number on each line item. Make sure that the Send Recipient Letter field on the ASA2 screen is "N". This will ensure that the client will not receive a denial service agreement letter. Place a message on the comment screen or use Reason Code 834 on the ASA2 screen. If the screening document is incorrect, the DSD Resource Center will need to be notified to delete the screening document so the corrected document can be entered. See the Health Care Help Desks section in the beginning of the manual for instructions in contacting the DSD Resource Center. *Edit 253 will post.*

The waiver service agreement must also fall within the MA eligibility period as shown on the RELG screen in the Recipient Subsystem. If MA is not open, or the service agreement dates on the ASA1 screen start prior to, or end after, the MA eligibility span, edits* will prevent the service agreement from becoming approved. If the MA eligibility span is not present, or the dates are incorrect, the financial worker must make the corrections. **Edit 271 will post.*

Recipient Not on File

Using the wrong PMI number on the ASA1 screen will produce edits* that won't allow the service agreement to be approved. Correct the field. **Edits 129 and/or 251 will post.*

Living Arrangement is Not Correct

The line item dates cannot overlap with an institution living arrangement period except for the date of admission and the date of discharge. See the RLVA screen in the Recipient Subsystem for the living arrangement periods and types. If the data on the RLVA screen is incorrect, the financial worker must be notified to correct it.

The AC Case Management, Paraprofessional Case Management, and AC Conversion Case Management services on the Alternative Care service agreement may overlap with a nursing facility institution period but only for the purpose of providing conversion case management.

301.06 ACCESSING THE PRIOR AUTHORIZATION SUBSYSTEM

The service agreement file is in the Prior Authorization Subsystem. On the Main Menu screen, move the cursor to this line and place an "x" there. Use the transmit key. You will be brought to the Keypanel Screen.

```
03/12/98 12:52:50 MMIS MAIN MENU - MAIN          PWMW000
*** MEDICAID MANAGEMENT INFORMATION SYSTEM ***
SEL
CLAIMS PROCESSING APPLICATION:
  BATCH CONTROL
  EXAM ENTRY
  CORRECTION
  INQUIRY
REFERENCE FILE APPLICATIONS:
  PROC, DRUG, DIAG, DRG, UPC
  RATES
  PREPAY U/R CRITERIA
  EXCEPTION CONTROL
  TEXT
SYSTEM PARAMETERS/LIST PARAMETERS
PRIOR AUTHORIZATION APPLICATIONS
X PRIOR AUTHORIZATION
  SCREENINGS
OTHER APPLICATIONS:
  PROVIDER FILE APPLICATION
  RECIPIENT FILE APPLICATION

SEL
OTHER APPLICATIONS (CONT.):
  TPL BILLING APPLICATION
  ADMISSION CERTIFICATION
  MISCELLANEOUS FUNCTION
  SECURITY ADMINISTRATION
  FINANCIAL CONTROL
  DRUG REBATE
  QUALITY CONTROL
  TPL RESOURCE FILE
  SURS SUMMARY PROFILE
  SURS TREATMENT ANALYSIS
  SURS CLAIM DETAIL
  RECIPIENT MISCELLANEOUS
  DECISION SUPPORT
  MN CARE FIN OBLIG ERROR CORRECTION
  RATE SETTING
  MANAGED CARE

ENTER---PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9--PF10--PF11--PF12
                                     S/EXT          N/EXT          OOPS
```

This is the Keypanel Screen. It is used to identify the service agreement you wish to view or change, or if you want to add a new service agreement.

```

NEXT:    03/12/98 10:12:59 MMIS PA KEY PANEL - AKEY          PWMW900
ACTION CODE:                AUTHORIZATION TYPE:
A=ADD      C=CHANGE    I=INQUIRY    D=DENTAL    P=PHARMACY
B=BATCH ENTRY D=DELETE          M=MEDICAL    S=SUPPLY
                                T =SVC AGMT      AGMT TYPE:

1. ENTER ONE OF THE FOLLOWING KEY FORMATS:
    AUTHORIZATION NUMBER:        COPY FROM:
    RECIPIENT ID:
    PROVIDER NUMBER:

2. ADDITIONAL SEARCH CRITERIA FOR RECIPIENT OR PROVIDER SEARCH:
    START DATE:
    END DATE:
    STATUS:
    (FOR SUSPENSE RESOLUTION) LOC:        USER ID:
*****
AMD1 - MEDICAL PA 1   AMD2 - MEDICAL PA 2   AMD3 - MEDICAL PA 3
APH1 - PHARMACY PA 1  APH2 - PHARMACY PA 2  APH3 - PHARMACY PA 3
*****
ENTER---PF1---PF2--PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11--PF12
PAGE           S/EXT       N/EXT  PREV NEXT    OOPS
  
```

Action Code. When adding a new service agreement, use the “A” action code. When changing an existing service agreement, use the “C” action code. Use the “I” action code to view an existing service agreement. The Batch Entry and Delete action codes are not allowed with service agreements.

Authorization Type. The MA program also uses this screen for their authorizations. When using the “A” action type, place a “T” in this authorization type field.

Agreement Type. When adding a new service agreement, you need to indicate what type it is. Use codes F (CADI Conversion) or G (CADI Diversion); H (CAC Conversion) or I (CAC Diversion); J (EW Conversion) or K (EW Diversion); L (TBI-NF Conversion) or M (TBI-NF Diversion); or N (AC Conversion) or O (AC Diversion); P (TBI-NB Conversion) or Q (TBI-NB Diversion).

NOTE: The Authorization Type and Agreement Type fields are not necessary for the Change or Inquiry modes unless you want to narrow the search to a specific service agreement type.

SECTION 1: Identifying the Recipient. This first section is NOT used with the “A” action code. For the “C” or “I” action codes, indicate either 1) the authorization number (document control number) of the agreement you want to retrieve; or 2) the Recipient ID (PMI) number. The Provider Number field

is not used as this is the header provider which is normally not used on the service agreement (an exception would be home care agreements). The Copy From field can be used to copy the ASA1 screen from an existing agreement to a new agreement. When using this feature, use the "A" action code, the authorization and agreement type fields and put the document control number of the existing agreement in this field that you wish to copy and press the transmit key. A new service agreement will appear with the ASA1 screen information completed. The ASA2 and ASA3 screens will need to be entered.

SECTION 2: Additional Search Criteria. Use this next section if you want to narrow the search for the service agreement. By putting in the Start and End dates, only those agreements with a header period that falls within this period will be retrieved. By filling in the Status field with A=approved, S=suspended, P= Pend, T=partially suspended or D=denied, only those service agreements with a matching header status will be retrieved.

LOC Field. Suspended or partially suspended service agreements for the county of service can be retrieved by using this field. To do so, place an "T" in the Action Code field, a "T" in the Authorization Type field, one of the service agreement types in the Agreement Type field, and your three-digit county code in the LOC field. If there are service agreements in the queue, the first one will appear. Use the PF3 key to view any additional service agreements. Use the PF6 key to exit the queue.

These service agreements were saved incomplete, status 4 edits prevented the service agreements from being approved, and/or one line item was kept in suspense. These service agreements need to be retrieved and one of these actions taken:

- ▶ outstanding edits corrected/forced and the header status changed;
- ▶ the suspended line item(s) changed to a different status and the header status changed; and/or
- ▶ if the service agreement was saved by mistake, the header status needs to be changed to a "D". This will automatically deny all the line items. Go to the ASA2 screen and put a "N" in the Sent Recipient Letter field. Add reason code 834 or another appropriate code to the ASA2 Reason code field. Delete the line item provider numbers.

New service agreements are transferred to the queue just once per day. You can enter the queue using the Inquiry action code as many times each day as necessary. But, when using the Change action code, the service agreements can be retrieved only once per day.

If you used the PMI number to view or change a service agreement, and there was more than one service agreement for the client, you will be brought to the Selection Screen to pick the service agreement you need.

<i>NEXT:</i>		<i>03/12/98 10:35:58</i>		<i>MMIS PA SELECTION - ASEL</i>		<i>PWMW90</i>	
<i>RECIP ID: 00000000</i>		<i>PROV NBR:</i>		<i>START DT:</i>		<i>END DT:</i>	
<i>AUTH TYPE:</i>				<i>STAT:</i>			
<i>SEL</i>	<i>AUTH</i>	<i>PROVIDER</i>	<i>PROVIDER</i>		<i>START</i>	<i>END</i>	
<i>IND TYPE</i>	<i>NUMBER</i>	<i>NUMBER</i>	<i>TYPE</i>	<i>NAME</i>	<i>ST</i>	<i>DATE</i>	<i>DATE</i>
<i>M</i>	<i>00000000000</i>	<i>933208100</i>	<i>20</i>	<i>THOMAS J DIEM MD</i>	<i>A</i>	<i>101792</i>	<i>101792</i>
<i>M</i>	<i>00000000000</i>	<i>933208100</i>	<i>20</i>	<i>THOMAS J DIEM MD</i>	<i>A</i>	<i>092892</i>	<i>092893</i>
<i>D</i>	<i>00000000000</i>	<i>807818100</i>	<i>30</i>	<i>THOMAS L BOE DDS</i>		<i>041195</i>	<i>041096</i>
<i>T-K</i>	<i>00000000000</i>				<i>T</i>	<i>090197</i>	<i>083198</i>
<i>T-K</i>	<i>00000000000</i>	<i>400355100</i>	<i>61</i>	<i>RICE CNTY PUBLIC</i>	<i>S</i>	<i>062697</i>	<i>08019</i>
<i>T-K</i>	<i>00000000000</i>	<i>400355100</i>	<i>61</i>	<i>RICE CNTY PUBLIC</i>	<i>A</i>	<i>81296</i>	<i>062597</i>
<i>T-K</i>	<i>00000000000</i>				<i>A</i>	<i>030196</i>	<i>080896</i>
<i>T-K</i>	<i>00000000000</i>				<i>A</i>	<i>091895</i>	<i>022996</i>
 <i>ENTER-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12</i>							

This screen shows two Medical authorizations (M) and one Dental authorization (D) as well as several Elderly Waiver service agreements. The document control number of each is shown. The number and name of the header provider is listed, the status of the authorization (D= denied, S= suspend, A= approved, P=Pend, and T=Partially Suspended), the period the authorization covers and the program (MA= Medical Assistance and AC= Alternative Care).

For service agreements, the provider name and number may be blank as this information is not normally entered on the ASA1 screen.

Some of the authorization types you may see on this screen are: M = medical, D = dental, P = pharmacy, S = supplies/equipment, T = service agreement, and B = home care agreement.

Move the cursor to the line of the authorization or service agreement you want to view or change. Type an "X" on the line and press the transmit key. You will be brought to that document. When finished, use the exit key (PF3 or PF6) to come back to this screen, any lines above the one you selected will no longer be shown. Just use the PF7 key to show all the lines again. By pressing the PF4 key while the cursor is on a line you are brought to the Provider File.

Use the PF8 key if there are more lines on the screen than can be shown (there will be a + sign on the bottom right hand corner).

The ASA1 Screen. These fields are represented by the General Information Section on the service agreement form. See the field by field description in Section 301.02 for an explanation of these fields.

NEXT: ASA2 09/18/03				MMIS SERVICE AGMT - ASA1 PWLMG30 09/18/03 PWMW925			
AUTHORIZATION NBR: 3261 900 0 000							
AGMT STAT: S SUSPENDED				CURR LOC/DT:			
AGMT TYPE: J EW CONVRSN				AGMT START/END DT:			
PROV NBR/NAME:							
REF PROV NBR:		TOT AUTH AMT:		CAP AMT:			
LAST		FIRST MI					
RECIP NAME:				RECIP ID:		SEX:	
DOB(MMDDYYYY):		AGE:		LA:		MAJ PROG:	
CM NBR/NAME:							
CO OF SVC:		CO OF RES:		CO OF FIN RESP:			
DISC FUND(Y/N):		AUTH DATE:		AUTH SIG(Y/N):			
SCH EVAL/TRMT:		MSG 1 2 3					
DIAG RANGE 1 FR:		DIAG RANGE 1 THRU:					
DIAG RANGE 2 FR:		DIAG RANGE 2 THRU:					
AVG MO AUTH AMT:		AVG DAILY AUTH AMT:					
TOT USED UNITS:		TOT USED AMT:					
LI EXC ST USER ID							

Some fields are shown on this screen that are not on the paper form. This is because MMIS will add the data to the fields from other subsystems and you are not required to data enter the fields. These are: Sex, Age, Living Arrangement (LA), Major Program, Agreement Status, Case Manager Name, Total Authorized Amount, and Cap Amount.

The fields on the ASA2 Screen are not on the paper form. See Section 301.02 for an explanation of these fields.

NEXT: ASA3 09/18/03 MMIS SERVICE AGMT - ASA2 PWLMG30 09/18/03 PWMW926
AUTHORIZATION NBR: 3261 900 0 000

AGMT TYPE/STAT: J S SUSPENDED

PROV NBR/TYPE:

RECIP NAME/ID:

SEX: AGE/LA:

STAT RSN:

SEND RECIP LTR(Y/N):

ATTACH(Y/N):

SEND PROV LTR(Y/N): Y

SACTAD NBR:

OVR LOC:

AC PREMIUM AMOUNT:

PREMIUM EFFECTIVE DATE (MM/YY):

CLAIMS UPDT DT:

PROV COMMENTS: N

INPUT MEDIA: 0 EXAM ENTRY

RECIP COMMENTS: N

DHS COMMENTS: N

LI EXC ST USER ID LI EXC ST USER ID LI EXC ST USER ID LI EXC ST USER ID

The ASA3 Screen contains 99 line items. See the field descriptions listed in Section 301.02.

NEXT: ADHS 09/18/03 MMIS SERVICE AGMT - ASA3 PWLMG30 09/18/03 PWMW927			
AUTHORIZATION NBR: 3261 900 0 000			
AGMT TYPE/STAT: J S SUSPENDED	PROV NBR/TYPE:		
RECIP NAME/ID:	SEX: AGE/LA:		
LINENAV: 00			
		FEE	
LI COMMENTS/PROCEDURE DESCRIPTION	PROC	MOD1	REV CD (Y/N) CLIENT FEE
01			
		START/END DT:	
REQ RATE/UNIT:		REQ TOT UNITS/AMT:	
PROV NBR/NAME:			SHR/FREQ:
APP RATE/UNIT: SRC:		TOT USED UNITS/AMT:	
STAT CD/DATE:		RSN CD:	REPEAT:
02			
		START/END DT:	
REQ RATE/UNIT:		REQ TOT UNITS/AMT:	
PROV NBR/NAME:			SHR/FREQ:
APP RATE/UNIT: SRC:		TOT USED UNITS/AMT:	
STAT CD/DATE:		RSN CD:	REPEAT:
LI EXC ST USER ID	LI EXC ST USER ID	LI EXC ST USER ID	LI EXC ST USER ID

Some of these fields shown on this screen are not on the paper form. These are:

Line Nav. You can quickly go to a specific line item by placing the number in this field and using the transmit key. To view the last line item, place a high number in this field (such as 99). To return to the beginning of the line items, place 01 in this field.

REV CD, Fee (Y/N), Client Fee. These fields are not used with waiver or AC service agreement types. You will not be allowed to enter data in these fields.

APP RATE/UNIT and SRC. The rate that is entered in the Requested Rate field is compared to the rate file on the Reference Subsystem. If the rate does not exceed the statewide maximum rate for that service, the Approved Rate per Unit field will match the requested rate and the Source field will show RQ. If the Requested Rate field is higher than the statewide maximum rate, the Approved Rate/Unit field will show what the statewide maximum rate is, and the Source field will be RR. If the service is priced from the PDDD file instead of the Rate file in the Reference Subsystem, the Source field will be PP. If the rate is manually priced (Assisted Living, Residential Care, Foster Care, PMAP pseudo code, or Respite in a Certified Facility) the worker changes this field to MM.

STAT CD/Date. The Status Code field shows the status of the line item. The user must choose a status for each line. Choices are: A = approved, P = pend, D = deny, or S = suspend. The Date field is the effective date of the status.

RSN CD. Each line item may have up to four reason codes added here. Each reason code have a message associated with it. By placing that reason code on the line item, the message will appear on the service agreement letters for that line item. See Section 301.13 for a listing of these reason codes. If you use a reason code on a line item, remember to delete it the next time you make changes to the service agreement, or the new letter will be produced with the same message again.

Repeat. This field allows the line item to be repeated as many times as indicated in the field. The new line items will show at the end of the current line items. Possible reasons to use this field are:

- ▶ The service is Residential Care or Assisted Living Services. Each month is placed on its own line item.
- ▶ The provider uses up all of the units prior to the line item ending date instead of properly allocating units over the entire period. The line item can be limited to one month per line item and the units allocated to each month.
- ▶ The rate or provider number on the approved line item needs to change. The old line is ended, repeated once, and the new line allows changes for the new period.
- ▶ The client entered a NF for less than 30 days. The current line items are closed to the date of admission. When they return to the community, the line items are repeated once so the new line items start with the new period.
- ▶ More than one provider will be providing the same service but at different periods or rates. Copy the line and change the provider number, and the rate and/or period on the new line.

301.07 EDITING THE SERVICE AGREEMENT

Before entering the line items on the ASA3 screen I recommend using the PF9 key to edit the service agreement. Using the PF9 key allows MMIS to check your entered data against all other applicable subsystems. It is checking to make sure that:

- 1) the mandatory fields are valued and the data entered is valid,
- 2) an opening, reopening, or reassessment screening document was approved establishing the period of eligibility, and
- 3) that the program type listed in field 2 matches the same program of the last approved screening document.

If any of the circumstances in items 1 - 3 are not met, as well as other client, provider and reference cross editing, edits will show on the bottom of the screen explaining what the error is. Edit 140 (Header is Suspended) will always post and will remain until you later change the header status to another type, and edit 157 (Line Item Count is Zero) reminds you that there are no line items. If any other edit is posting, you will need to correct or force it.

See Section 301.05 of the problems that could occur with the data you entered on the ASA1 screen. It is desirable, but not necessary, to use the edit key (PF9) after entering each line item. This makes it easier to correct edits since the ones that appear will relate to the line you just entered. Notice a 00 or other number in front of the three-digit edit number. The 00 indicates that the edit is posting because of an error on the ASA1 or ASA2 screens. Any other number identifies that the edit is posting against that numbered line item.

Edit Statuses

Every edit will have a status that determines the affect the edit will have on the service agreement. It may deny the service agreement or line item, keep it in suspense, or act as an informational edit. These are the types of edit statuses and the action you must take in each case.

- 3 - A status of "3" will cause the line item or the header status to be denied.
Action Needed: Correct the problem if the line item or service agreement needs to be approved.
- 4 - This status causes the service agreement and/or line item to remain in suspense.
Action Needed: Correct or force the edit. **Note:** Edit 140 (Header/Line Item Status is Suspended) will always post until the header status and line item status is changed from suspense to a different status.
- 6 - This status is used to give you additional information about the data you entered. The system will display the exception, but will not delay processing the service agreement.
Action Needed: These exceptions are to be reviewed for possible correction.
- F - When an exception is forcible, it means that the system will ignore the exception as if it never occurred. This will be used very rarely.

Action Needed: To force an edit, move the cursor to the exception line, place a "F" over the green-colored "4" and press PF9. If the edit is not forcible, the "4" will turn red (see status C for correction). It is not necessary to force those edits with a status of "6".

- C - If an exception status on the edit line is changed, it can revert back to what it was initially by placing a "C" over the edit status field and using the PF9 key. So if an exception was forced and then you discovered how to correct it instead, place a "C" over the "F" and it would default back to the initial setting so the edit can now be corrected. Or, if an invalid value was placed in the status field causing it to turn red, use the "C" to clear it.

By moving the cursor to the edit number and using the PF1 key, the title of the edit will be shown. If there is a "+" sign at the end of the edit line, this signifies that there are more edits. Use the PF7 and PF8 keys to scroll back and forth to view additional edits. **Note:** the cursor does not need to be on the edit line to use the PF7 and PF8 keys. But, it *cannot* be in the line item section.

By moving your cursor on the edit number and using the PF4 key, you can view a text file that explains in detail why the edit posted and what action is needed to correct it. When finished, use the PF3 or PF6 key to return to the service agreement.

Line Item Statuses

After all the line items are entered and the edits are either corrected or forced, the user may use one of the following statuses for each line item:

- 1) **A - Approve.** The line item is approved. Payments may now be made against the line item. Some fields are protected from further changes.
- 2) **D - Deny.** The line item is denied. Any edits posting against the line item is ignored by the system.
- 3) **P - Pend.** More information is needed before a decision can be made. Line items with this status will show on the service agreement letters.
- 4) **S - Suspend.** No action has been taken by the user. No payments may be made against the line item. The line item will not show on the service agreement letters.

In order to change a line item status, move the cursor to the STAT CD field.

Header Statuses

The header service agreement status field on the ASA1 screen is based on the line item decisions. To change the header status, move the cursor to the DOC STAT field on the ASA1 screen. These header statuses are:

- 1) **Approve.** A combination of approved, denied and pending line items.
- 2) **Deny.** When the header status is set to denied the system will automatically change each line item status to denied. Approved service agreements cannot later be changed to denied.

- 3) **Pend.** At least one line item status is pend.
- 4) **Ssuspend.** At least one line item is suspended.
- 5) **T Partially Suspend** One or more line items are suspended and others are approved.

You may add text to the Provider and/or Recipient Comment Screens to further explain the services and decisions to the provider(s) and client. When finished, use the PF3 key to save your service agreement.

301.08 NAVIGATION ON THE SERVICE AGREEMENT

Line Item Navigation

There are 99 line items on the service agreement. Only two per page are viewable. To view additional line items, you need to use the PF8 key to go forward on the list of line items. Use the PF7 key to go back to the beginning.

To quickly move to a specific line item, use the NAV IND field located above the line items. By placing a two-digit number in this field and using the transmit key, you are brought to that line item. If there are no line items matching the number you entered, you are brought to the end of the line items.

Navigation to the Screening Document File

You can view the screening document(s) from the service agreement by moving the cursor to the “Next” field at the top of the screen (use the Home key to get there quickly). Once on this field, use the arrow key to move the cursor so it is under the word “Next”. Press the PF4 key. You can now view the screening document (if there is only one) or the Selection Screen (if there are more than one) to choose a screening document. The PF4 key is not available to use again. Use one of the exit keys to return to the service agreement.

PF4 Key

ASA1 - ASA3 Screens

By pressing the PF4 key when it is anywhere on the screen, you will be brought to the Recipient Subsystem. By moving the cursor to the edit number, you will be brought to the edit text file.

ASA3 Screen

The Procedure Code field: navigate to the Reference Subsystem for information about the service.
The Provider Number field: navigate to the Provider Subsystem.

PF5 Key

Use this key on any screen and you will be brought to a screen that allows you to view the Provider or Recipient Subsystem for any provider or recipient you identify on the screen. See Section 101.03 in Chapter 1 for the use of this field.

301.09 DELETING LINE ITEMS

Line items can only be deleted if the header status is “S” - suspend and the line item status is “S” or “P”. Move the cursor to the first field of the line item and put in four periods “. . . .”. Use the PF9 key. That line will be deleted. Any lines that followed it will move up.

301.10 REPEATING OR COPYING LINE ITEMS

There are five circumstances where you may want to copy a line item:

- 1) The service is provided monthly and each month will be placed on its own line item (Assisted Living or Residential Care Services).
- 2) The provider used up all the units before the end of the line item period. To restrict the use of units by day, week, or month, a new line item is added for each day, week or month of service with enough units to cover that period.
- 3) More than one provider will be providing the same service but at different periods or rates. Copy the line and change the provider number, and the rate and/or period on the new line.
- 4) A line item will be closed and a new line item entered to show a change in the rate and/or provider.
- 5) The client entered a NF for less than 30 days. The current line items are closed to the date of admission. When they return to the community, the line items are repeated once so the new line items start with the new period.

After entering the line item you wish to repeat, use the PF9 key to make sure no edits post. Then go to the Repeat field at the end of the line item and add a number that represents how many times the line should be repeated. Use the PF9 key again. Edit 876 (Line Item Duplicate) now posts. Each line must be unduplicated by changing either the periods so they do not overlap, the provider number or the rate. When corrected, approve the line items.

301.11 CHANGES TO AN APPROVED SERVICE AGREEMENT

On the Keypanel screen, you will need to use an Action Code of “C” and the PMI number or the service agreement authorization number.

If the service agreement has a header status or any line item status of pend or suspend, all fields are updateable (signified by a green color). If the service agreement header or line item status is approved, some fields will be protected as signified by their white color. Furthermore, all denied service agreements or line items cannot be changed. If the service agreement header is partially suspended (T), only those line items that are not approved will have all their fields updateable.

On the ASA1 screen when the status is approved or partially suspended, just the header period end date, the birth date and the case manager number are updateable.

On the ASA2 screen, the Send Recipient Letter and the Reason Code fields can be changed.

On the ASA3 screen, if the line item is approved, you may change the start and end dates, the units and the total amount fields.

Changing the Unit Field

Units can be increased or decreased. To do so, go to the unit field and use your "end" key to delete what is shown. Enter the new amount. Use the PF9 key to recalculate the total amount based on the new unit amount. You will receive an edit if the increased units puts the service agreement over the total cap amount. (compare the Total Authorized Amount field to the Total Cap Amount field on the ASA1 screen). You will then need to reduce this or another line item. You will not be able to decrease the number of units to a number that is lower than the number that has already been used. See the Total Units Used line. You will not be able to increase the units to more than what can fit within the period. Such as a daily service with ten units needs ten days in the period.

Changing the Total Amount Field

See the field explanation in Section 301.02 for the services that can be priced with a total amount instead of a rate and unit. If the line item is priced by a total amount instead of using a rate and unit, the same procedure as above is used for the total amount field when it needs to be increased or decreased.

Changing Begin/End Dates

The header begin date cannot be changed on an approved service agreement. The header end date or a line item period may be changed if services need to be continued beyond the initial period. The periods may also be decreased if the client leaves the program for any reason. The header period cannot exceed 365 days nor fall outside of the waiver eligibility period (on RWVR screen), or Medical Assistance eligibility period on the RELG Screen. The AC service agreement header period must fall within the AC eligibility period (on RELG screen).

Adding a Line Item

A new line item can be added regardless of the status of the service agreement (except for denied, of course). While on the ASA3 screen, use the PF11 key to bring you to the next blank line item. If you keep the line item in suspense, the header status field on the ASA1 screen needs to be changed from an "A" to a "T".

Closing **Approved** Line Items with No Payments

If you do not want claims to pay against a line item (perhaps because the service will no longer be provided or was never provided; or the rate and/or provider number is incorrect), you need to change the line so future claims will not pay off the line item.

If the line was priced by a rate and unit, and no units were used or money paid, delete the units and total amount fields. Change the end date so that it is the same as the begin date.

If the line item was priced by a total amount of money, and no money was paid, delete the total amount field. Change the end date so it is the same as the begin date.

Closing **Approved** Line Items When Claims Have Been Paid

When you do not want additional claims to be paid from an approved line item, and if the line was priced by a rate and unit, decrease the units to match the Total Units Paid field. If the line item was priced by a total amount of money, decrease the total amount field to match what was paid as indicated in the Total Amount Paid field. Change the end date so it matches the last service date that was paid. You should check the last claim that was paid from the line item to make sure the line item period covers the month the claim covers. This can be found in the Claims Subsystem using the PMI number, provider number and procedure code on the Keypanel Screen.

If the closing is due to the person leaving the program for a different program (or leaving one county of service for another), use the last day the person received services as the line item end date. Sometimes, a provider may bill under the old program for a period that is covered under the new program if the worker did not close the line item first. If this happens, the provider must complete a credit claim prior to closing the line item. They will then re-bill under the new program. See Section 301.16 on Credit and Replacement Claims.

Closing **Approved** Line Items Because of a Rate or Provider Change

A rate on an approved line item may have been increased during the period of the line item, or a new provider will now provide the service. Since the rate and provider fields are protected, a new line item is needed. Close the existing line item to the last date the rate or provider will be used. Adjust the units. Use the Repeat field to copy the line once. The new line will be at the end of the existing line items. Change the rate or provider on this new line item and the begin date will be the first date that the new provider or rate will be used. Adjust the units. Use the PF9 key and correct any edits. Approve the line item.

301.12 CLOSING A SERVICE AGREEMENT

A service agreement must be closed for the following reasons:

- ◆ the person is moving to a different program (including MA Home Care)
- ◆ the person dies
- ◆ the person no longer needs or wants services
- ◆ the waiver person is admitted to the nursing facility for more than 30 days
- ◆ the person loses AC or MA financial eligibility
- ◆ a different county of service will now manage the case
- ◆ Relocation Service Coordination (RSC) will be used during the period of institution for the waiver recipient

In all of these cases, an exit screening document is entered showing the last date that the person will be receiving services. The service agreement header and line item end dates are changed to this date. If you try to enter an exit screening document and the exit date is beyond the service agreement header end date, edit 109 will post requiring you to close the service agreement first.

Closing the service agreement does not close the screening file and visa versa. If the closing is due to death, the Alternative Care exit screening document will not allow payments beyond the date of death. But, the service agreement needs to be closed for payment and encumbrance reports to be correct. For the waiver programs, when the financial worker closes Medical Assistance due to death, claims submitted against the service agreement will not be payable beyond the date of death. But, it is also necessary to close the service agreement.

Closing a *Waiver* Service Agreement Due to Institutional Admission

Note: No action is taken if the client is in an institution for respite.

If the waiver client enters a nursing facility or other institution on a short term basis (30 days or less) -

- ◆ a closing screening document does not need to be entered;
- ◆ the service agreement header period may remain open for the next thirty days; and
- ◆ all line item end dates must be changed to the last date the client was in the community and the units adjusted for the new period.

When the client returns to the community within the 30 day period, new line items are added to the existing service agreement (use the Repeat field) with new begin dates.

If the client enters a nursing facility or other institution on a long term basis (more than thirty days):

- ◆ an exit screening document must be entered as of the date they were admitted;
- ◆ the service agreement header end date is changed to the last day of community placement; and
- ◆ all line item end dates must be changed to the last date the client was in the community.

NOTE: the service agreement may overlap the institution period only on the date of admission and the date of discharge.

Relocation Service Coordination (RSC)

Relocation targeted case management is now a Medical Assistance benefit for persons eligible for MA who in reside in institutions. Called "Relocation Service Coordination" it provides transition

assistance to persons wishing to move from institutions (hospital, RTC, NF, ICFs/MR) to the community. Relocation services coordinators help the consumer to make decisions about the supports they will need outside the institution by providing information. The relocation service coordinator also assists the individual to access the services and supports needed. RSC provides payment for additional assessment and service planning and build ups, not duplicates, discharge planning resources already available and in place. Due to the intensive nature of RSC, providers assisting persons in relocating from institutions are allowed to provide and receive payment for up to 180 consecutive days prior to the person's discharge.

This service is not available to Alternative Care recipients. Instead, they will receive AC conversion case management while in the institution.

A person may not be open to the waiver program while receiving RSC services. The waiver program must be closed by entering an exit screening document and closing the service agreement. If twelve months or more has passed from the last face-to-face assessment, and the person indicates they want to receive RSC, a new face-to-face assessment is required. However, if a person's health status has significantly changed since the last assessment, the Department recommends doing another assessment to account for, and reflect, those changes.

To authorize RSC services, and receive payment during a face-to-face assessment, a new screening document must be completed and these fields completed in the following manner:

Activity Type = 02 (assessment in community) or 04 (assessment in institution)

Present at Assessment = 04 and/or 05

Reasons for Referral = 09

Current Housing Type = 11, 14 (for hospitals), or 15

Assessment Results = 18

Program Type = 00

Service Plan Summary = 38F

If less than twelve months has passed from the last face-to-face assessment, another face-to-face assessment is not required. To authorize RSC under this scenario, enter a new screening document with this information: Activity Type = 07, Assessment Results = 18, and Service Codes = 38F.

For more detailed information on this service, see Bulletin #02-56-08 dated June 10, 2002 (Note: this bulletin replaces Bulletin #01-56-23 dated September 21, 2001).

Institutional Admissions for *Alternative Care* Recipients

If the client enters a nursing facility or other institution on a short or long term basis with the anticipation that they will return to the community:

- ◆ an exit screening document does not need to be entered;
- ◆ all line item end dates must be changed to the last date the client was in the community and the units adjusted to fit within the new period; and
- ◆ a new line item is added for conversion case management (for conversion program types) or ongoing case management or paraprofessional (for diversion program types) beginning with the first day of admission.

When the client returns to the community, new line items are added to the existing service agreement (use the Repeat field) with new begin dates. The conversion case management line item is now closed.

Note: If the service agreement is an AC Conversion, use x5477 - conversion case management. If the service agreement is an AC Diversion, use x5476 - case management ongoing, or x5491 - Paraprofessional Case Management.

If the client enters a nursing facility or other institution with no anticipation that they will return to the community -

- ◆ an exit screening document must be entered;
- ◆ the service agreement header end date is changed to the last day of community placement; and
- ◆ all line item end dates must be changed to the last date the client was in the community.

MA Application Pending for AC Recipients

A client may be open to the Alternative Care program while the MA application is pending. When it is approved the AC service agreement is closed effective the date the case manager is notified or becomes aware that the client is now eligible for MA.

- ◆ an exit screening document for AC is entered as of this notification date
- ◆ the AC service agreement header and line items are closed as of this date
- ◆ the Elderly Waiver opening screening document is opened the following day
- ◆ the EW service agreement is entered with an effective date to match the screening document.

Overlapping Service Agreements with MA Home Care and Other Programs

If a home care agreement header period overlaps the waiver or AC service agreement header period, edit 874 - Duplicate Service Agreement will post. This will happen if the agreements are in a suspended, pend, or approved status. You can view the MA home care agreement by using the "T" in the action code field on the Keypanel screen and using agreement type "B".

The waiver service agreement needs to be sent to the Home Care Unit in a suspended status using the code 580PWLMW64 in the override location field on the ASA2 screen. At this point, the agreement should have edits 140, 874, and any status "6" edits that were not corrected. The Home Care unit will close their agreement so that it does not overlap. You can then re-enter the waiver service agreement in the change mode and use the PF9 key to remove the 874 edit.

If the Alternative Care service agreement overlaps with the MA home care agreement, county staff must call the Service Agreement Specialist instead of sending the AC service agreement online. Their number is (651) 282-5382. Leave the service agreement authorization number, the header start and end dates, your name and phone number. They will then close the MA home care agreement. When finished, you can re-enter the AC service agreement in the change mode, use the PF9 key and edit 874 will be deleted.

If an Alternative Care or waiver suspended/approved/pend service agreement overlaps with another service agreement, edit 874 will also post. County staff must decide which header periods need to be changed, or if one or more agreements in suspense need to be denied (a denied service agreement can overlap with others).

If you enter an agreement by mistake you can use the PF6 key to delete it instead of saving it with the PF3 key. If you have already saved it in suspense, you must change the header status to “D” to deny. This automatically denies all line items and the system will now ignore it. Go to the ASA2 screen and change the “Send Recipient Letter” field to “N”. Delete the provider number fields or use reason code 834 on the ASA2 screen which explains to the providers that the agreement was entered by mistake or has errors that cannot be corrected.

301.13 SERVICE AGREEMENT LETTERS

The client's mailing address is shown on the RCAD screen in the Case File of the Recipient Subsystem. If there is an alternative address on file, that will be used rather than the client's home address. The address for the Alternative Care clients is shown on the ALT6 screen of the screening document.

Letters are printed nightly during batch processing. The ASA2 screen determines if a letter generated by DHS will be mailed. If the "Send Recipient Letter" field is marked "N", letters are not generated for the client and the county will be responsible to notify the client of the status of the services.

The letter generated for each provider contains only the service(s) provided by that provider. Counties may receive two letters: one is the case manager letter which lists all pend, approved or denied line items; and the other is the provider letter which lists only those services provided by the county.

The letter produced for the client or guardian always contains a complete list of the services defined on the service agreement except for those services with a suspended status. The case manager letter is the same as the client letter.

Letters are produced when:

- ◆ the header status is initially changed from suspend to another status,
- ◆ there is a change in a field of the line item, or
- ◆ a new line item is added and changed from suspense.

Each letter that is mailed is a duplicate of the initial letter with any header or line item changes or line item additions. The Provider and Recipient Comment Screens may be used to explain why a new letter was mailed. This would assist the client and provider in understanding what changes were made since the previous letter. Comments on the Recipient Comment Screen are added to the client/guardian and case manager letters. Comments on the Provider Comment Screen are printed on all provider letters at the end of the letter. Comments on the DHS Comment Screen are not printed on the letters.

If a reason code is entered on the ASA2 screen or on the line items, the text will also appear on the letters. For the Reason Codes listed on the ASA2 screen, the text is shown at the beginning of the letter. For the line item text, it is listed with that line item on the letter. If a provider requests another copy of their service agreement letter, use reason code #488 on one of their line items. Check the PADD screen of the Provider Subsystem to verify that the address is correct for that provider number. If it isn't the provider must contact the DHS Provider Enrollment Unit to change it.

Reasons why a provider, recipient or case manager may not receive a letter are:

- ◆ the service agreement header status = S
- ◆ the PADD address is incorrect for the case manager and/or provider
- ◆ the RCAD address is incorrect for the recipient
- ◆ the case manager field on the ASA1 screen was left blank and edit 114 was forced

Below is a chart of the reason codes and their meanings. New reason codes can be developed by calling (651) 282-5509.

Code	Message
488	You requested another copy of the original authorization notice. No changes were made from the original notice.
499	This service agreement has been changed due to a rate adjustment. For billing purposes, please make sure you save this copy.
823	The units and total amount was deleted on this line item because the rate was incorrect.
824	This line item was added to replace a duplicate line item that was priced with an incorrect rate.
825	This line item was closed because the provider is no longer active under this provider number beyond the end date.
826	This line item replaces a duplicate line item that was closed because the provider was no longer active.
827	This is a new line item that authorizes a new service.
828	The units or total amount on this line item was reduced.
829	The units or total amount on this line item was increased.
830	The date span on this line item was reduced. The service may only be provided for this new time period.
831	The date span on this line item was increased. The service may be provided for a longer period.
832	The total units/amount and date span was reduced for this line item. The client is no longer participating in the program as of the service agreement end date.
833	The client is no longer participating in the program as of the new service agreement end date. Any line item that began after this date, and was previously approved, is no longer valid.
834	This service agreement is denied because it was entered by mistake or has errors that cannot be corrected.
835	NOTE TO PROVIDERS: Refer to the client’s “Individual Service Plan” (DD) or “Individual Care Plan (LTC) approved by the county case manager for details regarding the type, amount, frequency and duration of services to be provided.
836	This line item was closed because the provider was changed or previously incorrect.
837	This line item replaces a duplicate line item that was closed because the provider was changed or incorrect.

838	If this letter does not contain line items, it was generated in error. Please ignore.
839	The line item is being closed as of the new service agreement end date.
840	The units and total amount were deleted on this line item because the service agreement was closed.
841	This line item is no longer needed.
842	This service agreement is being closed due to client entering the nursing facility.
843	The date span has been extended and the amount increased on this line item.
844	This service agreement is being closed as of the new service agreement closure date.
845	This service agreement is being extended.
984	This line has been ended effective 12/31/03 due to a HIPAA requirement to replace local procedure codes with national codes. Use this procedure code to bill for services provided before 01/01/04.
985	This line has been added effective 01/01/04 due to a HIPAA requirement to replace local procedure codes with national codes. Use this new procedure code to bill for services provided on or after 01/01/04.

301.14 CLAIMS PROCESSING AGAINST THE SERVICE AGREEMENT

Waiver and Alternative Care claims are paid against those agreements that are approved or partially suspended with at least one line item approved. Claims will not be paid against any line items with a status of suspend, pend, or deny. A claim checks the following information on the service agreement to determine if it can be paid.

1. Does the authorization number on the claim form match a service agreement authorization number? If no, deny. If yes, continue.
2. Does the claim line item match a service agreement line item's provider number, procedure code, and dates? If no, deny. If yes, continue.
3. Does the line item have a status of approved? If no, deny. If yes, continue.
4. Does the rate on the claim exceed the rate on the service agreement line item? If yes, the claim will use the rate on the line item and continue. If no it will use the rate on the claim and continue.
5. Does the service agreement line item have enough units or total amount to cover the claim? For all waivers and AC program: If no, pay as much of the claim as possible. If yes, pay the entire claim amount. For the MR/RC program: If no, deny the claim. If yes, pay the entire claim amount.

Claims must be in a status of "to-be-paid" or "paid" within 365 days of the service date. A provider must accept reimbursement as payment in full for covered services provided to a client. This means that a provider may not request or accept payment from a client, the client's relatives, the local human service agency or any other source in addition to the amount allowed under the programs except in the case of a spenddown. An additional exception is made when the client has received an insurance payment designated for the service. In this case, the provider is allowed to bill the client directly to recover an insurance payment that the client has received.

Providers are encouraged to contact the Eligibility Verification System (EVS) to verify eligibility once per month per client. EVS is a touch-tone automated telephone service providing eligibility information for each client. See Chapter 1, Section 101.09 for more information on EVS.

Leave Days

Providers who are providing Foster Care for a person who is not receiving the service each day of the month shall not submit a claim for those days the person was on "leave". Leave days may be those times the person is living temporary with family or friends; or are admitted to a hospital, nursing facility or other institution. If the provider's contract with the county agency allows overhead expenses to be paid for these leave days, then a claim for the overhead expenses for those days may be submitted. Overhead expenses are the cost of utilities, rent, and staff time for the person.

If the provider's contract does not allow overhead expenses for leave days, then no claim may be submitted for these leave days. Providers will determine their daily amount multiplied by the number of days in the month the person was not on leave days and indicate the total amount with one unit on

their claim form.

Providers who are providing Assisted Living, Assisted Living Plus, or Residential Care Services are not able to submit a claim for leave days. Providers will determine their daily amount multiplied by the number of days in the month the person was not on leave days and indicate the total amount with one unit on their claim form.

Below are two examples to indicate the period of time that the person was on leave days

Example #1

January 1 - January 14 the person is receiving Assisted Living Services.

January 15 - January 31 the person is in the hospital.

The paper claim form or MN-ITS will show a period of January 1 - January 14 with one unit.

Example #2

January 1 - January 5 the person was living at the daughter's home out-of-state.

January 6 - January 20 the person was receiving Foster Care services.

January 20 - January 25 the person was in the hospital.

January 25 - January 31 the person was receiving Foster Care services.

Billing on a paper claim will show one line item for January 6 - January 20 with one unit and a total amount determined by the daily amount multiplied by 22 days. Another line item will be for the period January 25 - January 31 and a total amount and units of zero.

Billing on MN-ITS will show a line item for either January 6 - 20 OR January 25 - 31 with a total amount determined by the daily amount multiplied by 22 days. The number of units will be one.

See Bulletin #00-56-30 for more information.

301.15 BILLING OPTIONS FOR COUNTIES AND PROVIDERS

While providers submit claims directly to the Department for processing and receive direct reimbursement, county agencies may act as a "billing agent" for smaller or one-time vendors by submitting the vendor's claims to the Department. Reimbursement is then paid directly to the provider. Counties may charge a fee for their service as a billing agent and these costs may be factored into the unit rate for the service, but the costs may not be charged to the waiver or AC program as a separate unit of service.

Payment may be made to a business agent, such as a billing service or an accounting firm that furnishes statements and receives payments in the name of the provider, if the agent's compensation for this service is:

- 1) related to the cost of processing the billing;
- 2) not related on a percentage or other basis to the amount that is billed or collected; and
- 3) not dependent upon the collection of the payment.

The costs of using a billing agent may be factored into the unit rate for the service but may not be charged to the waiver program as a separate unit of service.

Counties will also need to submit claims for those waiver or AC services they provide. If the claim is for case management, the county provider number, and not the individual case manager number, is used on the line item and claim form. In all cases, the HCFA-1500 claim form is used.

Counties may choose to subcontract with individuals providing services. In situations where individuals providing services are not employing others and are not employees of an agency under contract to provide the services:

- a) the county may offer the choice to the vendor of being enrolled directly as a MA home and community-based service provider **or** work under subcontract with the county where the county is the enrolled provider, **and**
- b) the provider, when offered the choice, decides whether to enroll directly as a MA home and community-based service provider **or** provide the service as a subcontractor of the county agency which is enrolled as a provider.

301.16 CLAIM AND SERVICE AGREEMENT CORRECTIONS

There are two methods to correct a claim because of an error on the service agreement or a billing error on the part of the provider.

Credit Claims

A provider will need to submit a **credit** when the wrong rate is approved on the line item, or the wrong provider number was used (when the agency has more than one provider number). It is necessary to do a credit in this situation in order to delete the paid units/amount on the line item so a new line item with the corrected information can be added and approved.

- 1) The provider submits a credit request to the Benefit Recovery unit. Processing the request allows the paid units and money on the line item to be removed.
- 2) The line item is then “shut down” by deleting the units and total amount fields and changing the end date so it matches the begin date.
- 3) A new line item for the correct rate (or provider) is added and approved. If edit 876 (Line Item Duplicate) posts because both lines are now overlapping, the edit may be forced for the EW and AC programs. For other programs, you will need to call the DSD Resource Center for assistance.
- 4) The provider may now re-bill for the rate that is needed (not the difference).

To submit a credit:

- 1) do not submit a paper claim form or MN-ITS.
- 2) the DHS Benefit Recovery Section is notified of the TCN (claim ID number) listed on the Remittance Advice form that needs to be credited.
- 3) monies can be returned by check or withheld from a future warrant.

A check with a copy of the RA that highlights the paid claims(s) and an explanation for the refund should be sent to: DHS Benefit Recovery, P.O. Box 64836, St. Paul, MN 55164-0836. Or, to send just a copy of the RA for a credit adjustment, mail to DHS Benefit Recovery, 444 Lafayette Road, St. Paul, MN 55155-3850. The fax number for the DHS Benefit Recovery Section (BRS) is (651) 296-9438. Their phone number is 800-657-3963 or (651) 296-9938.

Replacement Claims

A provider will need to submit a **replacement claim** in both of these situations:

- 1) When they mistakenly bill at a lower rate than what is shown on the line item. Provider then bills for the rate they need (not the difference).
- 2) When the provider bills for more units or money than what is on the line item.

When this happens, the provider will have his claim cut back to as many units or money that is left unused on the line item. Additional units or money needs to be added to the line item. The provider can then submit a replacement claim for the entire amount that is needed (not the difference).

The replacement claim includes all the line items on the initial claim including the line items that were paid correctly.

To submit the replacement claim:

- 1) on the paper or MN-ITS document, list the TCN of the paid claim that had errors and is to be replaced. Use replacement reason code "406".
- 2) The DHS claims processing division takes back the previously paid claim and re-processes the replacement claim. Monies may or may not change hands depending on this result.

301.17 SERVICE AGREEMENT EDITS

Edit

Number

Edit Title

Description and Resolution

Edit Number	Edit Title	Description and Resolution
112	Case Manager Check Digit Invalid	<p>The case manager number is incorrect. Recheck the number. It must match the number on the Provider File. The last two digits must be 00.</p> <p>Edit Status = suspend, no forcing.</p>
114	Case Manager Number is Missing or Invalid	<p>This field must be completed. Recheck the number for accuracy. Place the cursor on the field and use the PF4 key to check the PADD screen to make sure that the number is active and that the provider type is 23.</p> <p>This edit will post when:</p> <ol style="list-style-type: none"> 1) field is left blank; 2) the last two digits are not 00 3) there is more than one case manager number on the RMCR screen of the Recipient File overlapping with the service agreement header period. By forcing the edit, the system will accept the number you typed; or 4) the case manager number is different from the screening document. If correct, force the edit. <p>Edit Status = suspend, forcible in two circumstances only.</p>
117	Modifier 1 Field is Invalid	<p>Modifiers are only used for Shared Care. See edit 363.</p> <p>Edit Status = informational.</p>
120	Provider is Missing or Invalid	<p>The provider number is missing or invalid for the line item. Recheck the number. Place the cursor on the number and use the PF4 key to review the PSUM screen to make sure it is a valid number.</p> <p>Edit Status = suspend, no forcing.</p>
124	FDOS is Missing or Invalid	<p>The line item start date is either 1) missing; 2) invalid; or 3) beyond the header level or line item end dates, or prior to the header level start date. Compare the date to the header period.</p> <p>Edit Status = suspend, no forcing.</p>

125	Provider Check Digit is Invalid	<p>The provider number is invalid. The last two remaining digits should be "00".</p> <p>Edit Status = suspend, no forcing.</p>
129	Recipient ID is Missing or Invalid	<p>If the screening document was submitted by paper, the scanner will default this field to zeros when there is a scanning error. Recheck the number for accuracy. Compare the number to the Recipient File.</p> <p>Edit Status = suspend, no forcing.</p>
130	Line Item Amount Exceeds Allocation	<p>The total amount on one or more line items will exceed the county's AC allocation cap. If the line item amount is approved and not reduced, the provider's claim may reject. You can view the allocation caps and total amount paid on the PFIN screen of the provider file. Use the provider number of the CFR shown on the first screen of the service agreement. The provider number will be provider type 45. The case manager needs to be informed of this situation and a request for targeted funds may need to be submitted to DHS.</p> <p>Edit Status = informational</p>
140	Header/Line Item Status Suspended	<p>The header status and/or line item status(es) are suspended. This edit will no longer post when both statuses are changed to a status other than "S".</p> <p>Edit Status = suspend, no forcing.</p>
155	LDOS is Missing or Invalid	<p>The line item end date is missing, invalid, or beyond the header level end date. Compare the date with the header period.</p> <p>Edit Status = suspend, no forcing.</p>
157	Line Item Count is Zero	<p>The service agreement contains no line items. There must be at least one line item.</p> <p>Edit Status = suspend, no forcing.</p>

166	Reason Code Duplicate	<p>If more than one Reason Code is entered on the ALT2 screen or on a line item, there can be no duplicates.</p> <p>Edit Status = suspend, no forcing.</p>
167	Recipient First Name is Missing	<p>The client's first name was missing when the screening document was entered via paper or the PMI number is missing/incorrect.</p> <p>Edit status = informational.</p>
168	Recipient Last Name is Missing	<p>The client's last name was missing when the screening document was submitted via paper or the PMI number is missing/invalid.</p> <p>Edit status = informational.</p>
175	Override Location Code Invalid	<p>The override location code is not correct. Change the code.</p>
181	Send Recipient Letter is Invalid	<p>The field on the ASA2 screen is not valid or missing. It must be a "y" or "n".</p> <p>Edit Status = suspend, no forcing.</p>
189	Requested Units Field is Missing or Invalid	<p>If the Requested Rate field is valued, the Requested Units field must also be valued. Or, the field does not contain numeric values.</p>
190	Requested Rate/Units/Amount is Inconsistent	<p>If pricing the line item by total units, you must also indicate the rate per unit.</p> <p>Edit Status = suspend, no forcing.</p>
196	Service Needs a Rate and Unit	<p>This procedure code must have the rate and unit fields completed.</p> <p>Edit Status = suspend, no force</p>

233	Hospice Client Ineligible for Service	<p>The waiver and AC service agreement can only be issued in certain situations for a client receiving hospice services. If the requested EW or AC services are for the terminal illness or related condition, cancel the service agreement or end the approved line items as of the first date the person began hospice.</p> <p>Edit Status = suspend, forcible only if the service plan as been reviewed with the hospice plan of care and the requested services are for a condition unrelated to the terminal condition and do not duplicate or supplant the hospice benefit. You must indicate on the Comment Screen that this coordination took place.</p>
241	Provider Type and Service are in Conflict	<p>The provider type is not authorized to provide the line item service. Check the procedure code for the acceptable provider types by moving the cursor to the procedure code and use the PF4 key.</p> <p>Check the acceptable provider types on the first screen. Next, check the provider's type by moving the cursor to the provider number and using the PF4 key. The provider type number is at the top of the screen.</p> <p>Edit Status = suspend, no forcing.</p>
248	Recipient ID and Date of Birth are a Mismatch	<p>The date of birth does not match the date of birth listed on the Recipient File. The date should be checked for accuracy by moving the cursor to the PMI number and using the PF4 key.</p> <p>If the Recipient File is incorrect, the financial worker must be notified to change the birth date. If this is an Alternative Care service agreement and the PMI number was obtained using the PMIN Function, staff may use the PMIN Function again to change the birth date on the Recipient File.</p> <p>The date of birth cannot be after the activity type date.</p> <p>Edit Status = suspend, no forcing.</p>

251	Recipient is not on File	<p>The Recipient ID number is not located on the Recipient File. Recheck the number.</p> <p>Edit Status = suspend, no forcing.</p>
253	Recipient and Waiver Type is in Conflict	<p>The client is not covered by the waiver program. This edit will post when the Waiver Type on the RWVR screen of the Recipient File does not match the service agreement type on the ASA1 screen for the header period. If the Recipient File is correct you must use the PF6 key to cancel the service agreement and start over with a new agreement.</p> <p>If you have already saved the service agreement, the header status must be changed to denied. Check the ASA2 screen to make sure that the Send Recipient Letter indicator is a "N". A reason code on the ASA2 screen should be added, or a message on the Provider Screen to tell the provider(s) that a new service agreement will replace this denied one.</p> <p>If the Recipient File is incorrect, this means that field 92 of the screening document was coded incorrectly. An exit screening document is needed (which can have the same activity type date as the opening activity type date) to close the incorrect span. Then, add a new screening document opening to the correct waiver type.</p> <p>This edit will also post when the service agreement header start and/or end dates are outside the client waiver eligibility start and/or end dates. Check the RWVR screen to make sure the header period is covered entirely by one line of eligibility.</p> <p>Edit Status = suspend, no forcing.</p>

254	Screening Document is not on File	<p>An approved opening, reopening, or reassessment document must be approved before the corresponding service agreement can be approved.</p> <p>The service agreement header start date is before the opening, reopening or reassessment date.</p> <p>The screening document type is different from the service agreement type. (See edit 253).</p> <p>This edit will also post if the PMI number is incorrect.</p> <p>Edit Status = suspend, no forcing.</p>
257	Recipient is Enrolled in PPHP	<p>Home care services cannot be authorized for clients enrolled with PPHP. The home care line item period is overlapping with the PPHP period.</p> <p>1) Compare the eligibility spans on the RPPH screen of the Recipient File with the line item period. Change the line item period so the dates do not overlap. If this is not possible because the PPHP begin date is before the approved line item begin date, call the DSD Resource Center to resuspend the line item and deny it.</p> <p>2) Contact the PMAP provider for the total amount of units being provided for these MA home care services - nursing, home health aid, or PCA - and multiply the units by the total maximum rate amount for the service. Add the total to a new line item with procedure code x5609. (More than one service can be represented by this pseudo code). This is needed to determine that the cap is not exceeded. Use your counties' provider number on the line item (payments will not be made from this line item). List out the individual services on the DHS Comment Screen.</p> <p>Edit Status = suspend, not forcible</p>

262	Bath Not Allowed with PPHP	<p>This edit will post when procedure code x5293 (bath) has a line item period that overlaps with the PPHP eligibility span. Check the RPPH screen of the Recipient Subsystem for the PPHP span. Adjust the line item period so it no longer overlaps.</p> <p>Edit Status = suspend, not forcible</p>
265	MSHO/MnDHO Eligibility Open	<p>This edit posts if the waiver or Alternative Care service agreement header period overlaps with a MSHO or MnDHO eligibility span and the header status is A, S, T, or P. The header period must be adjusted so it no longer overlaps. To view the MSHO or MnDHO eligibility span, go to the RPPH screen of the Recipient File. If the Product ID field is M02, that is a MSHO span. If the Product ID field is M15, that is a MnDHO span.</p> <p>Edit Status = denied</p>
271	Recipient is Ineligible for Service	<p>The service agreement header start and/or end date is not within the MA or AC eligibility period on the Recipient File. Check the RELG screen on the Recipient File for the start/end dates of the MA or AC eligibility period. Adjust the header period.</p> <p>Edit Status = suspend, no forcing.</p>
274	Medicare is Present	<p>The client is eligible for Medicare. One of the line items is personal care attendant (PCA), public duty nursing (PDN) or home health aide (HHA). The case manager must determine if skilled nursing or home health services should be used instead. Using PCA, HHA, PDN, or one of the following extended services on the service agreement implies that Medicare payment was first submitted and denied. Waiver codes: x5650, x5467, x5581, x5441, x5266, x5433, x5436 or Alternative Care codes: x5660, x5661, x5651, x5289, x5653, x5662, x5663.</p> <p>Edit Status = informational.</p>

275	Major Program and Service is in Conflict	<p>The procedure code is not covered by the client's major program as of the header start date. Place the cursor on the procedure code field and use the PF4 key to view the acceptable major programs on the FPR3 screen. If "AC" is not listed, the service cannot be used on an Alternative Care service agreement. If "MA" is not listed, the service cannot be used on a waiver service agreement.</p> <p>Edit Status = suspend, no forcing.</p>
276	Waiver Program and Service is in Conflict	<p>The procedure code is not covered by the waiver or AC program as of the header start date. Place the cursor on the procedure code field and use the PF4 key to view the acceptable programs on the FPR3 screen. If N or O is not listed, the service cannot be used on an Alternative Care service agreement. If J or K is not listed, the service cannot be used on an Elderly Waiver service agreement. CADI is F and G, CAC is H and I, TBI is L, M, P and Q.</p> <p>The line item period must not overlap two different periods shown on this screen. If it does, use two different line item lines.</p> <p>Do not use MA funded therapy procedure codes on the service agreement.</p> <p>Edit Status = suspend, no forcing.</p>
286	Provider is Not Authorized for Program Type	<p>The provider is not authorized to provide Medical Assistance and/or AC services.. Check the PSUM screen on the Provider Subsystem by using the PF4 key when the cursor is on the provider number. to determine if an "MA" and/or an "AC" is listed in the Major Program section. If not, these major programs must be added by the Provider Enrollment Unit.</p> <p>This edit will also post when the line item period starts prior to, or exceeds, the major program dates on the RELG screen of the Recipient Subsystem.</p> <p>Edit Status = suspend, no forcing.</p>

300	Provider is Not on File	<p>The line item provider is not on the Provider File. Recheck the number. If correct, determine if the provider is in an active status and the effective date by moving the cursor to the provider number and pressing the PF4 key to view the PADD screen. The provider cannot be used on the service agreement until they are in an active status on the Provider Subsystem.</p> <p>This edit will also post when the last two digits of the provider number are not "00".</p> <p>Edit Status = deny.</p>
321	Manual Price is Greater than Allowed	<p>The requested rate per unit on the line item is greater than the amount Medicaid would pay for the service (the statewide maximum rate). You must reduce the requested rate prior to approving the line item.</p> <p>Edit Status = suspend, not forcible.</p>
323	Procedure Code is Invalid for Service Agreement	<p>The procedure code is not allowed on the service agreement.</p> <p>Edit Status = deny.</p>
334	Modifier 1 Requires Manual Review	<p>Unless the service is Shared PDN, do not put a value in this field.</p> <p>Edit Status = informational.</p>
363	Procedure Code and Modifier 1 is in Conflict	<p>Only modifier 52 can be added to the modifier 1 field and only with procedure codes x5662 and x5663 (AC) or x5266 and x5267 (waiver) when requesting SHARED PDN. Delete the modifier or change the procedure code and add a "y" in the Shared Care field.</p> <p>Edit Status = informational.</p>
366	Procedure Code and Provider Specialty is a Mismatch	<p>Recheck the provider number. The provider specialty indicator on the procedure record is in conflict with the provider specialty on the Provider File. Call the MMIS Provider Help Desk for assistance.</p> <p>Edit Status = deny.</p>

375	Procedure Code and Living Arrangement is in Conflict	<p>The procedure code may only be performed in specific places and the client's living arrangement is not one of them. Place the cursor on the procedure code field and use the PF4 key to view the first screen of acceptable or excluded living arrangement types. Then place the cursor on the PMI number and go to the RLVA screen to view the living arrangement types and periods. Either reduce the line item period to fit within the acceptable living arrangement, or contact the financial worker if the living arrangement type or span is not correct.</p> <p>Edit Status = suspend, not forcible.</p>
376	Procedure Requires Modifier	<p>When the procedure code is x5662, x5663 (AC PDN), x5266 or x5267 (waiver PDN) and the Shared Care field equals a "Y", modifier 52 must be in the modifier 1 field.</p> <p>Edit Status: suspend, not forcible.</p>
379	Missing System Parm for Date of Service (DOS)	<p>The date span for the service cannot be found on the system parameter record. Recheck your start and end dates.</p> <p>Edit Status = suspend, not forcible.</p>
380	Auto Rate Increase Suspend	<p>This edit will post upon running the Provider Rate adjustment program. Pressing PF9 and saving the document will remove this edit. Approve the new line item and header if needed.</p> <p>Edit Status = suspend, not forcible</p>

381	Rate Record Not Found	<p>A rate for this procedure code is not on the Reference Subsystem. There are four possible causes for this edit: 1) the opening screening document for the service agreement is not approved or is for the wrong waiver/AC type. Recheck the last approved document to match the program type with the service agreement type on the ASA1 screen; 2) the line item begin date is before the service agreement header begin date on the ASA1 screen or waiver eligibility period (see the RWVR screen of the Recipient Subsystem for the waiver eligibility periods), or the line item end date is after the service agreement header end date or waiver eligibility period; 3) the line item period overlaps two different rate spans. If there was a rate change on July 1, the line item needs to be adjusted so it ends on June 30 and a new line item added to begin on July 1; or 4) the service is AC Discretionary (x5527) or AC Cash Grant (x5526) and the CFR did not receive approval from DHS to provide these services. For item #4 only, call the AC Program Coordinator to request AC Cash Grant or AC Discretionary Services (651) 296-2213.</p> <p>Edit Status = suspend, not forcible.</p>
388	Medicare is Present	<p>The client is eligible for Medicare Part B as of the effective date of the service agreement and the procedure code is a Medicare covered service. These HCPCs are: X5280, X5281, X5282, X5283, X5284 and X5285. The waiver program can pay for this service only if Medicare was denied.</p> <p>Edit Status = informational.</p>

393	Procedure Code and Maximum Units are in Conflict	<p>The line item exceeds the maximum number of units listed on the Reference File for the procedure code or for the period of time on the line item. Reduce the number of units.</p> <p>Place the cursor on the HCPC and press PF4 to view the FPR4 screen to see the maximum number of units allowable. Reduce the Home Care line item to this maximum and place the rest of the units on a different line item as extended waiver services.</p> <p>Edit Status = suspend, not forcible.</p>
408	Provider Under Review - SURS	<p>The line item start date falls within a hold/review period for the provider.</p>
411	Provider is Under Review	<p>The line item start date falls within a hold/review period for the provider. This is a "General Review".</p>
412	Category of Service is Invalid	<p>This edit will post when the provider type is acceptable for the procedure code, but the provider is not authorized for the category of service. The provider must contact the Provider Enrollment Unit at DHS for assistance in changing their provider file.</p> <p>Edits Status = suspend, forcible</p>
415	Provider Enrollment Status is "Pend"	<p>The enrollment status for this line item provider is listed as "pending" on the Provider File as of the line item start date. Until the status is changed to "active" by the Provider Enrollment Unit, this provider may not be used on the service agreement.</p> <p>Edit Status = deny.</p>

416	Provider Enrollment Status is "Terminated"	<p>The enrollment status is listed as "terminated" for this provider on the Provider File. For new line items, this provider may not be used until the status is changed by the Provider Enrollment Unit to "active". Contact the Provider Enrollment Unit for additional information regarding this status.</p> <p>For approved line items, move the cursor to the provider number and use the PF4 key to view the PADD screen to check the date of the termination against the period listed on the line item. Adjust the period on the line item so that it does not overlap the termination date. If this is not possible, contact the DSD Resource Center to resuspend and deny the line item.</p> <p>Edit Status = deny.</p>
420	Provider is Enrolled as "No-Pay"	<p>The Provider status is listed as "no-pay". This means that the provider will not be paid for the service on the line item. When authorizing case management services, the provider number of the <u>agency</u> providing the case management is listed on the line item and not the case manager assigned to the client.</p> <p>Edit Status = suspend, not forcible.</p>
422	Provider is Ineligible for the Effective Date	<p>The provider on the line item is not active on the Provider Subsystem as of the line item start date. Recheck the provider number and the line item start date. Compare it to the status and start dates on the PADD screen of the Provider File. If the service's category of service (COS) code is not shown on this screen, contact the Provider Enrollment Unit at DHS for assistance.</p> <p>Edit Status = deny.</p>
430	Procedure Code is Not on File	<p>The procedure code is not listed on the Reference Subsystem. Recheck the number. The HCPC must have an "x" followed by four digits.</p> <p>Edit Status = suspend, not forcible.</p>

431	Procedure Code is Not Covered	<p>The procedure code is not active as of the line item start date. Recheck the start date. Place the cursor on the procedure code and use the PF4 key to start date. Adjust the date.</p> <p>Edit Status = deny.</p>
433	Procedure Code Requires Review	<p>The procedure code is suspended on the Reference Subsystem. Recheck the number.</p> <p>Edit Status = deny.</p>
434	Procedure Code and Age is in Conflict	<p>The client's age does not fall within the minimum and maximum ages for the procedure code as shown on the FPR2 screen of the Reference Subsystem. Place the cursor on the procedure code and use the PF4 key to navigate to this screen.</p> <p>Edit Status = deny.</p>
435	Procedure Code and Sex is in Conflict	<p>The client's gender is not acceptable for this service. Move your cursor under the procedure code field. Use the PF4 key to review the FPR2 screen of the Reference Subsystem which will show which gender is acceptable for this service. F = female, M = male and B = both.</p> <p>Status Edit = informational</p>
437	Procedure Code is Not Covered for the Effective Date	<p>The line item period for the procedure code overlaps with two or more date spans on the FPR3 screen. Place the cursor on the procedure code and use the PF4 key to view the date spans. This edit also occurs if you have a modifier on the line item. If so, delete the modifier.</p> <p>Edit Status = deny.</p>

438	Procedure Code Requires Manual Pricing	<p>The procedure code is listed on the Reference Subsystem as needing manual pricing. Retype the unit rate or the total amount (whatever was used to price) on the "Approved Rate" field and type "MM" on the "Source" field of the line item. Multiply the rate by the total units and place the result in the "Total Amount" field. Press PF9 to edit. Assisted Living Services, Assisted Living Plus, Respite Care in a Certified Facility, PPHP Pseudo code x5609, Foster Care, and Residential Care Services will need manual pricing.</p> <p>Edit Status = suspend, not forcible.</p>
439	Procedure Code is Not Allowed for Effective Date	<p>The procedure code has a pricing segment on the Reference Subsystem of "Procedure Not Allowed for Effective Date". Contact the DSD Resource Center for assistance.</p> <p>Edit Status = deny.</p>
505	Modifiers Require Manual Review	<p>The modifier is set to require a manual review by DHS staff.</p> <p>Edit Status = informational.</p>
608	Service Agreement Date Span is Invalid	<p>The header period exceeds 365 days. You must change the header dates on the ASA1 screen.</p> <p>Edit Status = suspend, not forcible.</p>
609	Service Agreement End Date is Invalid	<p>The header end date on the ASA1 screen is invalid or cannot be prior to the header start date. Recheck the dates.</p> <p>Edit Status = suspend, not forcible.</p>
639	Extended PCA Without MA PCA	<p>A line item for extended PCA (x5581) is suspended, pended or approved without another approved line item for MA PCA (x5645) or PPHP Home Care Services (x5609). Add another approved line item for x5645 or x5609.</p> <p>Edit Status = suspend, not forcible.</p>

641	Bath/Adult Daycare/Respite Only	<p>When procedure code x5293 (bath) is listed on the service agreement, another line item for x5486, x5487, x5485 or x5484 must also be approved for the same or overlapping time period.</p> <p>Edit Status = deny</p>
672	Total Authorized Amount is Excessive	<p>The total authorized amount field on the ASA1 screen cannot be greater than the total cap amount field. Services need to be reduced or eliminated.</p> <p>Edit Status = suspend, not forcible.</p>
675	Residential Care and/or Assisted Living Limits are Exceeded	<p>The monthly dollar limit for Residential Care Services or Assisted Living Services is exceeded. Recheck the maximum limit for these services.</p> <p>If the service will be provided for less than one month, pro rate the amount and use the total amount field rather than a rate and number of units fields.</p> <p>Edit Status = suspend, not forcible.</p>
676	Client is Opened to CSG	<p>Edit will post when the line item proc code is 'X5643', 'X5644', 'X5645', 'X4037', or 'X5285' and a screening document opening to CSG was entered that overlaps with the MA Home Care Agreement.</p> <p>Edit Status = suspend, not forcible.</p>
686	Service Invalid with Planned Housing Type	<p>Edit will post if on the screening document the Planned Housing Type = 01, 02, 03, 11, 14, or 15 and the Assessment Result Date overlaps with an approved, suspended or pend line item period for procedure codes x5272, x5292, x5604, x5291, x5605, x5450, or x5449. These services cannot be provided in this housing type.</p> <p>Move the cursor to the "NEXT" field at the top of the service agreement screen. Use the PF4 key. You can now view the screening documents. Check the ALT2 screen for the housing type.</p> <p>Edit Status = Suspend, not forcible</p>

694	AC Adjusted Income or Adjusted Asset Field Invalid	Both the AC Adjusted Income and Adjusted Asset fields were left blank or contain zeros. Edit Status = Suspend, forcible
695	Attachment Indicator is Invalid	The Attachment Indicator field on the ASA2 screen does not have a valid code of "N". For service agreements entered online, this field must always have a "N". Edit Status = suspend, not forcible.
699	AC Premium Amount is Invalid	The AC Premium Amount field was valued for a service agreement other than N and O (AC). Erase the value. Edit Status = suspend, not forcible
734	AC Premium Date is Invalid	The AC Premium Date was left blank for an AC service agreement (types N and O) or the field was valued for a service agreement other than types N and O. Edit Status = suspend, not forcible
739	Medicare ID # is Missing or Invalid	When the Medicare spans are valued, this field must be completed. Or, the number entered is invalid. Edit Status = suspend, not forcible
763	Fee/Requested Amount/Requested Unit is Missing	When the line item has a requested rate per unit, then the requested total units field must also be completed. If neither is completed, the requested total amount field must be completed. Edit Status = suspend, not forcible.
835	Reason Code 1 is Invalid	The first reason code on the ASA2 screen or line item is not valid or is a duplicate. Edit Status = suspend, not forcible.
838	Reason Code 2 is Invalid	The second reason code on the ASA2 screen or line item is not valid or is a duplicate. Edit status = suspend, not forcible.

839	Reason Code 3 is Invalid	<p>The third reason code on the ASA2 screen or the line item is not valid or is a duplicate.</p> <p>Edit Status = suspend, not forcible.</p>
858	Frequency Period Field is Missing	<p>The frequency field on the line item is missing or invalid. The values are: 1 = daily, 2 = weekly, 3 = monthly, and 5 = entire line item period. By completing the frequency field, a sentence is added to the service agreement letter which explains how frequently the service may be provided for the line item. This field is not mandatory.</p> <p>Edit Status = informational</p>
869	Shared Care is Missing or Invalid	<p>A “Y” is the acceptable value to use in this field for shared PCA or shared PDN services. Do not complete this field for any other service. See Bulletins #99-56-8 and 00-56-18 for detailed information on the use of this field.</p> <p>Edit Status = deny</p>

874	Duplicate Service Agreement on File	<p>An approved and/or suspended LTC/DD/Home Care service agreement is on file for the same client with overlapping agreement start and end dates. When changing from one program to another, the current service agreement must be closed and a closing screening document completed (in this order). A new screening document and service agreement is then completed for the new program.</p> <p>If the new service agreement was entered in error and it was not saved, use the PF6 key to cancel it. If it was already saved in a suspended status, change the status to a “D” on the ASA1 screen. Leave a message on the Provider Comment Screen that another service agreement will replace it, or place reason code 834 on the ASA2 screen, or delete the provider number fields. Change the Send Recipient Letter field on the ASA2 screen to a “N”.</p> <p>If the duplicate agreement is a Home Care service agreement, the WAIVER agreement needs to be saved and sent to the Home Care Unit by Adding 580PWLMW64 to the override location field on the ASA2 screen. The Home Care unit will close their agreement and you can re-enter the waiver service agreement in the change mode.</p> <p>If the duplicate agreement is a Home Care service agreement, the saved ALTERNATIVE CARE agreement cannot be sent to the Home Care Unit. Instead, call the Home Care unit at (651) 282-5382. Leave the AC agreement authorization number, your name, and phone number. They will close down the Home Care agreement and you can then re-enter the Alternative Care agreement in the change mode.</p> <p>Edit Status = suspend, not forcible.</p>
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876	Line Item Duplicated	<p>The fields that are compared for duplication are: overlapping periods, same provider number and same procedure code. One or more of the above needs to be changed. A line item that was denied may be duplicated.</p> <p>1) When using the repeat function, and the same procedure code and/or provider number will be used for each line item remember to change the start and end dates on each line item so there is no overlapping.</p> <p>2) When closing future line items to a current or past date (because the person left the program earlier than the service agreement end date) the line item periods may overlap since all lines must not exceed the new service agreement end date. For the EW and AC program, you can force this edit. For all other programs, call the DSD Resource Center for assistance.</p> <p>3) When an incorrect rate was used on an approved line item, the total units or total amount (whatever was used for pricing) needs to be zero out and the line item end date changed to match the begin date. If there are future line items, the end date is changed to match the begin date. Add a new line item with the correct information. Force the edit for the EW or AC programs. Call the DSD Resource Center for assistance for all other programs.</p> <p>Edit Status = suspend, forcible in circumstances #2 and 3 only.</p>
882	AC Conversion Case Management Exceeds 100 Days	<p>AC Conversion Case Management (x5477) may only be provided for a maximum of 100 days. Edit Status = suspend, can not be forced</p>
884	AC Conversion Case Management Not Available	<p>AC Conversion Case Management is not available when the line item period overlaps with a MA eligibility span. Exit the recipient and close the service agreement, Enter a new screening document for Relocation Service Coordination (RSC).</p>

899	More than 25 Exceptions	<p>This exception will occur when there are more than 25 edits posting for the agreement. The system can show only 25 edits at one time. Further editing will not occur unless the edits are corrected.</p> <p>It may be necessary to contact the DSD Resource Center to delete line items if the edit is posting due to the large number of line items</p> <p>Edit Status = suspend, not forcible.</p>
936	Homemaker/Respite/AC Cash Grant Not Allowed	<p>Homemaker, Respite, and AC Cash Grant services are not allowed during the same period as Assisted Living, Assisted Living Plus, or Residential Care Services. AC Cash Payment and Respite Services are not allowed during the same period as Foster Care Services.</p> <p>You must change one or more line item periods so these services do not overlap the same period of time.</p> <p>Edit Status = suspend, not forcible.</p>

301.18 SERVICES FUNDED BY MEDICARE PARTS A AND B

Edit 274 (Medicare Present) will post on service agreements to alert county staff that the person is also eligible for Medicare Part A and/or Part B. The Recipient File shows the most recent eligibility span for Medicare Parts A and B on the RSUM screen. The RMCR screen will show all of the spans.

This edit will post if the line item period overlaps with a Medicare span when the following services are used:

- ◆ MA funded home care services - PCA, PDN and HHA
- ◆ EW funded services- extended PCA, extended PDN, extended HHA, and extended medical supplies/equipment
- ◆ AC funded services - HHA, medical supplies/equipment, PCA, PDN, and RN Supervision of PCA.

Even though the edit is informational, approving these line items on the service agreement implies that Medicare payment was first pursued for these services and was denied. When using PCA or PDN, the case manager should determine if skilled nursing or HHA services (which are funded by Medicare) will meet the client's needs just as well.

Edit 388 (MNCare Is Present) posts for those MA home care funded home health aide and skilled nursing services on the Elderly Waiver service agreement when the line item overlaps with a Medicare Part B span.

For more information, refer to bulletin #96-57-6 dated July 1, 1996 titled "Legislature Initiates Effort to Maximize Medicare Payment for Home Care Services".

301.19 DUAL ELIGIBLE RECIPIENTS FOR PMAP AND ELDERLY WAIVER PROGRAMS

Under the Prepaid Medical Assistance Program (PMAP), DHS contracts with prepaid health plans to provide services to medical assistance (MA) participants. The participating health plans are responsible for providing the full array of MA covered services to their enrollees in return for a fixed payment rate per month. These covered services include all of the home care services provided by MA.

The MA populations required to participate in PMAP are composed of the Minnesota Family Investment Program (MFIP), the MA/needy children, and the institutionalized and non-institutionalized aged population groups. **Currently, persons whose basis of MA eligibility is “disabled” and who are under age 65 are not being enrolled in PMAP.** All MA participants in the mandatory populations who live in a managed care county are required to enroll in PMAP unless they are a part of an excluded group.

The financial worker enters the data on the RPPH screen in the Recipient Subsystem to show if a person covered by the statements above is either enrolled or excluded.

Persons aged 65 and older participating in PMAP may also be eligible for waived services such as foster care or homemaker services. These individuals must be assessed and must meet all of the eligibility criteria for the EW program.

If an EW client who is also participating in PMAP needs home care services which exceed the amount, scope, and duration of the MA-covered services, these additional services are provided under EW. However, the PMAP must provide all of the services available under MA home care before using extended services under the waiver.

Extended Home Health Aide

MA can pay for one home health aide visit in a day. For persons who need more than one home health aide visit per day, extended hours of home health aide care may be covered as personal care services (PCA) through the PMAP. These services must be used prior to using extended services under the waiver.

Extended Personal Care Services

The amount of personal care authorized for a client and reimbursable by MA is based on the person's case mix classification and documented as medically necessary. If the person needs more personal care services than authorized under MA, the additional personal care services are then considered an extended service under the waiver. If a line item is added for extended personal care, an edit will post if there isn't another approved line item for MA home care PCA or for x5609.

Extended Skilled Nursing

MA can pay for one skilled nurse visit in a day. For clients who need more than one visit daily, private duty nursing may be provided by the PMAP. A skilled nurse visit and/or private duty nursing may be done by an RN or LPN. These services must be used before using extended services under the waiver.

Extended Supplies and Equipment

MA covers most supplies and equipment that the client needs. However, if the client needs an item not covered by MA, then those items are to be considered as extended supplies and equipment under the waiver.

PMAP Enrollment

Some agencies have specialized managed care units to determine eligibility and present the client with enrollment choices and materials. In other county agencies, it is the financial workers.

Each fall during open enrollment, health plans may choose to do a mass mailing (marketing) to all PMAP eligible individuals in a county. DHS approves the materials and provides the names and addresses of potential members.

Additional information on PMAP enrollment practices can be found in the Health Care Program Manual in section 0914.03.05.

Case Manager's Responsibilities

The EW case manager must work very closely with the PMAP health plan case manager in developing a care plan which must protect the health and safety of the clients. Case managers must be aware of the client's payers and understand order of payers.

Service Agreement Changes and Implementation

PMAP

For EW clients who are also eligible for PMAP, the care plan developed by the case manager must include home care services provided by Medicare and PMAP. The home care services provided by PMAP must be counted in the client's case mix cap and identified by using the *pseudo* procedure code x5609 on a line item, using a total amount instead of a rate and unit, and using the county's provider number.

When developing the EW service agreement, edit 257 will post (Recipient Enrolled in PPHP) if the MA home care line item period overlaps with the PMAP eligibility span on the RPPH screen. This is a non-forcible edit that will not allow the MA home care line item(s) to be added to the service agreement if the line item period overlaps with the PMAP eligibility span.

Instead, use a line item with *pseudo* procedure code x5609 for these MA services that the health plan will be providing. All MA home care services that the PMAP health plan will be providing (except for therapies) must be lumped together under this procedure code. If there is more than one type of service on this line item, the total cost of all the services should be shown on the total amount line instead of using the rate and unit fields. On the Case Manager Comment Screen, list the different services and units represented on this line. NOTE: the line item for x5609 will not show on the service agreement letter, nor does it produce a new letter when added to an existing service agreement. Claims are not paid from this line item.

If there is just one MA home care service on this line item, you may indicate on the line above the service name what the line item represents and use the rate and unit fields. The units for each service should be obtained from the PMAP provider. Use the MA maximum rate listed for that home care service. Or, you can still use the total amount field instead of the rate and unit fields.

Even though services listed on this *pseudo* procedure code will not be payable from the service agreement, the line item must have an active provider type 00, 01, 02, 05, 11, 20, 38, 45, 57, 60, 61, or 64 in order to be approved. To prevent confusion for the provider, use your provider number (type 45). The line item is added to the agreement in order to determine that the case mix dollar cap is not exceeded. If it is exceeded, one or more of the waiver services must be reduced to bring the total cost of the service agreement within the case mix cap amount.

MSHO

Services MA participants age 65 or older who have Medicare Parts A and B or no Medicare coverage. Recipients may voluntarily enroll in Minnesota Senior Health Options (MSHO), a demonstration project which combines Medicare and Medicaid funding and service delivery in Anoka, Carver, Dakota, Hennepin, Mille Lacs, Ramsey, Scott, Sherburne, Washington, and Wright counties. MSHO includes all Medicare and Medicaid-covered services, including Elderly Waiver services. Therefore, coordination of all services including “MA-covered” and “extended” home care services, is the responsibility of the MSHO health plan. Persons choosing this program cannot be enrolled in a waiver or AC program at the same time.

MnDHO

Individuals who are eligible for Medical Assistance (MA) or MA-EPD, under the age of 65 and have a physical disability may voluntarily enroll in Minnesota Disability Health Options. This program will provide all home and community-based services through a managed care health plan. Currently, this program is offered in Hennepin, Ramsey, Anoka and Dakota counties. People who receive home and community-based services through Community Alternatives for Disabled Individuals (CADI) waiver or the Traumatic Brain Injury (TBI) waiver are eligible to enroll in MnDHO. CADI and TBI participants who choose to enroll in MnDHO will receive case management services from the health plan’s health coordinator disability specialist instead of a county case manager.

301.20 HOSPICE SERVICES FOR ELDERLY WAIVER OR ALTERNATIVE CARE CLIENTS

Procedures described in this update apply only to MA recipients who receive their care through the Fee-For-Service delivery system. Procedures described in this update apply to all Fee-For-Service recipients, including those receiving other MA covered services such as Home and Community Based Services such as: Community Alternative Care (CAC) Waiver, Community Alternatives for Disabled Individuals (CADI) Waiver, Traumatic Brain Injury (TBIW) Waiver, Elderly Waiver (EW), the Mental Retardation or Related Conditions (MR/RC) Waiver, and the Alternative Care Program.

Hospice Benefit under Minnesota Medical Assistance and MinnesotaCare

The Hospice Benefit is a comprehensive package of services offering palliative care support to terminally ill individuals and their family. Hospice care is palliative, with a focus on holistic support and relieving pain and other symptoms of the terminal illness. Individuals electing the Hospice Benefit agree to receive only palliative care for their terminal illness or condition. When a recipient voluntarily elects the Hospice Benefit, they agree to forego curative care for their terminal diagnosis. In exchange, the recipient receives the hospice package of services.

The Hospice Benefit is available to recipients who have been certified by a physician as terminally ill. An individual is considered to be terminally ill if he or she has a medical prognosis with life expectancy of six months or less. Individuals who meet these requirements may elect the Hospice Benefit. Dually eligible recipients who elect the Medicare Hospice Benefit must also elect the MA Hospice Benefit. Recipients with a terminal illness must be informed of all MA service and support options including the Hospice Benefit. Hospice care is entirely optional and the recipient may revoke their election at any time.

In order for MA to cover hospice services, hospice providers must be Medicare-certified and have a current state hospice license, which requires certain standards of care. In order for hospice services to be covered, a plan of care must be established.

The MA Hospice Benefit is fashioned after the Medicare Hospice Benefit, which was designed to supplement the care provided by primary care givers such as family (as the patient defines family), friends and neighbors. The Hospice Benefit is not intended to replace the supportive role of the client's informal support network of primary care givers. As such MA-covered services that replace the duties of primary care givers, do not duplicate the hospice team's services. Examples of supportive functions that are provided by primary care givers include coordinating the patient's cares, performing personal cares, assisting with activities of daily living, assisting with incidental activities of daily living, providing nutrition, and assisting with medications. Examples of services which may resemble the supportive role provided by primary care givers include Adult Foster Care services, Personal Care Assistant services, Home Delivered Meals, Lifeline, CAC, CADI, TBI, EW, and MR/RC Waiver services, and the Alternative Care Program.

The Hospice Benefit includes coverage for the following services, when provided directly in response to the terminal illness:

- physician services
- nursing care
- medical social services

- counseling
- medical equipment and supplies
- outpatient drugs for symptom and pain control
- dietary and other counseling
- short-term inpatient care
- respite care
- home health aide and homemaker services
- speech, physical and occupational therapy
- other items and services included in the plan of care that are otherwise covered medical services

Hospice Care Provided In Conjunction with Other MA Covered Services

The department understands that recipients facing death may have a complex set of health care needs.

These needs often stem from their terminal condition. These needs may also stem from other medical conditions that either (a) pre-existed their terminal condition, or (b) arise during the course of their terminal condition but are unrelated to their terminal condition. A recipient should never be asked to make an “either/or” choice between an otherwise MA-covered, medically necessary service which *is not* related to the terminal condition, and covered, medically necessary Hospice Benefit service that *is* related to the terminal condition.

Pre-existing health care needs

Some MA-covered services may already be needed and/or in place before the client seeks hospice, due to the client’s pre-existing medical conditions or disability. The hospice benefit is not intended to duplicate health services or supports that relate to a pre-existing condition. Examples include continuing care services such as home care related to a previous stroke, waiver services related to a disability, or adult foster care related to a disability such as elderly dementia. Examples of preexisting medical care include services for conditions such as diabetes, ALS, arthritis, cardiac conditions, AIDS, or high blood pressure.

Preexisting continuing care services may need to be adjusted during the period that the client is receiving the Hospice Benefit. Clients with pre-existing needs, such as quadriplegia or stroke, may have more intensive physical needs due to the terminal illness than persons without such pre-existing conditions. The resulting higher needs are an interaction of the two conditions together, some of which may need to be addressed through increased continuing care services.

Medical needs that arise during the period of the Hospice Benefit but which are unrelated to the terminal illness

Sometimes recipients need new health care services in addition to the services that are offered as part of the Hospice Benefit. MA-covered services may be provided in response to conditions not related to the terminal condition. Examples of this include treatment for a hip fracture unrelated to the terminal diagnosis, or the development of a new condition or symptom unrelated to the terminal diagnosis.

How to Determine When a MA-Covered Service Duplicates a Hospice Benefit Service

Generally, the determination about whether a service duplicates a Hospice Benefit service will be made as part of the hospice provider's general responsibility to provide care coordination. The hospice care coordinator must assume the lead responsibility for collaborating with the county case manager, home care agency, physician, or other provider providing the services which are outside of the Hospice Benefit.

Because some Hospice Benefit services and MA-covered services may be similar, this determination process should focus on the *purpose*, rather than the *type* of service -- that is, what recipient *need* is the service addressing?

The following considerations may be helpful in approaching the determination:

- ▶ Is the purpose of a service to address a pre-existing condition or a pre-existing need?
- ▶ Is the purpose of a service to address a health care problem that would have existed even without the terminal diagnosis?
- ▶ Is the purpose of a service to facilitate the client's ability to live in the community setting rather than an institution, and would that need have been present with or without the terminal diagnosis?

Documentation Requirements When A Case Manager is Involved

When the MA-covered care is the type that includes county-based Home and Community Based Services (HCBS) case management, the hospice must notify the case manager in writing of the recipient's election of hospice and the anticipated start date. Written notification via FAX, mail, or hand delivery must be given to the case manager within two business days using the AHCA Form 5000-25, Notice of Hospice Election.

The hospice agency staff must assume lead responsibility for collaboration *and documentation of that collaboration* with the case manager. The hospice staff must forward the documentation within eight (8) calendar days of the effective date of hospice services. Collaboration may be completed via telephone, FAX, email, or face-to-face visit. Documentation such as this should be included in the recipient's hospice record. The case manager will be invited to participate in the hospice interdisciplinary care team meetings for a patient receiving home and community based services.

The case manager will keep a copy of the Cooperative Agreement in the recipient's record. When the client is receiving "regular MA" home care and no case manager is involved, the hospice must coordinate care and communicate with the Home Care Agency involved with the client, rather than through a county case manager.

Seeking HCBS After Hospice Election

When a recipient is receiving concurrent Home and Community Based Services (HCBS) and hospice services, the HCBS is usually in place before the hospice services began. There may be situations where a recipient seeks case-managed HCBS, or an increase in HCBS, after electing the Hospice Benefit. Example: An adult with a disability is living with an aging mother, who is the primary care giver. The aging mother experiences a decline in health status, and has to cut back on the amount of primary care she is able to provide the recipient. The recipient therefore applies for HCBS to access available services and supports that the primary care giver no longer provide. In situations where the initial HCBS is added or increased after the Hospice Benefit is elected, county case management documentation must justify the addition/increase of the HCBS services.

Case Manager Approval of Services that are Concurrent with the Hospice Benefit

A forcible edit (233 - Hospice Recipient Ineligible for Services) will appear on the service agreement to indicate that the client has elected the hospice benefit. Following coordination with the hospice provider agency, case managers must add comments on the county DHS Comment Screen of the service agreement documenting the coordination of services. The notes must indicate why continuing care services are necessary. (Either they are pre-existing, or they are new but treat a condition not related to the terminal condition.) The MMIS Service Agreement line items must be adjusted as needed to reflect the type and amount of services required. Changes to services continue to require a ten-day notice to clients to allow for continuity of care, client rights, and transitional needs.

When waiver or Alternative Care provider claims are received by the Department, a claim edit suspends the claim when the date of service overlaps with the hospice benefit period. Because the hospice provider becomes the primary payer of services, DHS will manually review HCBS provider claims to determine if payment is appropriate. Case management notes on the DHS Comment Screen will be reviewed at that time to ensure hospice provider coordination with the case manager has occurred. If it appears that the coordination by the hospice provider has not occurred, the claim will remain in suspense until the coordination process is completed. If it appears that the coordination process has occurred, then the claim will be paid. When payment appears appropriate, the claim will be paid as requested. The edit and manual review of claims will remain in place temporarily to encourage consistent coordination between the provider areas.

Hospice Services for Residents of Long Term Care Facilities

MA eligible residents of Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) and Nursing Facilities (NFs) who also meet hospice service eligibility may elect to receive hospice services where they live. The hospice provider becomes the primary provider of the service, and authorizes and funds the hospice benefits. Medicare and Medicaid payments are made to the hospice provider for both the hospice services it provides, and for the residential services provided by the facility. Current law requires a payment, to the hospice provider, of at least 95% of the rate that would have been paid for facility services for the individual. Effective July 1, 2001, payments to be made by DHS are indicated in column (E):

Facility Type (A)	DHS Payment Rate (B)	Percentage of Rate (C)	Private Room (D)	Hospice Payment For Room & Board (E)
ICF/MR	ICF/MR	100%		95% * ((B)*(C))
NF	NF Case Mix	100%		95% * ((B)*(C))
NF	NF Case Mix	100%	115%	95% * (((B)*(D))* (C))
NF First 30 Days ❶	NF Case Mix	120%		95% * ((B)*(C))
NF Days 31 - 90 ❶	NF Case Mix	110%		95% * ((B)*(C))
NF First 30 Days ❶	NF Case Mix	120%	115%	95% * (((B)*(D))* (C))
NF Days 31 – 90 ❶	NF Case Mix	110%	115%	95% * (((B)*(D))* (C))
Out-of-State NF	NF Rate	100%		95% * ((B)*(C))

❶ Begins with date of NF admission on or after July 1, 2001, (not MA eligibility date).

The hospice provider and residential provider negotiate the payment of the room and board per diem to the facility.

Residents of ICFs/MR and NFs may receive end-of-life care from their residential provider without making the hospice election. Facilities may be able to arrange for the specific care needs of persons with terminal illness by making internal staffing adjustments, or by also purchasing the specialized services, or making staff additions ICFs/MR facilities may apply through their host counties for a variable rate adjustment in order to accommodate the increased needs of a person with terminal illness. Bulletin 00-56-23 describes the variable rate process.

Submitting the Hospice Transaction Form

DHS must be notified of recipients who are enrolled in hospice (regardless of whether MA is the primary payer).

The Medicare approved transaction form is to be submitted to DHS immediately upon enrolling with Medicare Hospice. This election form must contain signatures with dates, MA number, election dates, terminal illness, date of death, recertification dates and revoked dates.

Dual eligible Medicare and Medicaid recipients may submit the Medicare approved hospice election form to DHS in place of the DHS hospice transaction form DHS-2868, 9/97.

The election form must also be sent to the financial worker when a spenddown is involved.

For recipients enrolled in a health plan, only submit their hospice election forms to DHS if they are residing in a nursing facility.

DHS must also be notified when the recipient is no longer receiving hospice care.

Mail or fax the Medicare Election Form and the Notification of Hospice termination to:

Minnesota Department of Human Services
Attention: Hospice Notification
444 Lafayette Road
St. Paul, MN 55155-3849
FAX (651) 282-6744

Hospice overpayments for spenddowns may be sent back to the following address. A copy of the original RA must be included for correct claim credit.

Minnesota Department of Human Services
Attention: Benefit Recovery/Hospice
444 Lafayette Road
St. Paul, MN 55155-385

Billing for Consulting Physician Services when billing for the services of a Consulting Physician for a MA-only client (no Medicare or other third party payer involved), break out the technical portion and bill MHCP for the physician portion only. In this circumstance you must bill on a HCFA-1500.

Future Communications

- The MHCP Provider Manual (see dhs.state.mn.us/provider) will be updated to reflect the information in this update.
- Counties will receive a Bulletin which reflects the information in this update.

- DHS will convene quarterly hospice focus groups beginning in the spring of 2002, to maintain ongoing communication with the hospice provider community.
- DHS is working with the Minnesota Hospice Organization to present two future workshops, one on billing, and one on coordination between hospice and home and community based waivers.

301.21 SHARED PERSONAL CARE ASSISTANT (PCA) SERVICES

The shared care option is available to two or three PCA recipients who choose to share services in the same setting at the same time from the same PCA worker. For this arrangement, the Department can pay a personal care provider organization under new payment rates. The shared care payment rates do not apply when a PCA is caring for more than one recipient in more than one location. Please see Bulletin #99-56-8 dated April 1, 1999 for more detailed information on using this option.

When showing the shared care option on the waiver service agreement, use HCPC x5645 (PCA Services) or x5581 (Extended PCA) on the line item. Place a “y” in the Shared Care field. Use x5645 to the fullest extent before using the extended procedure code.

When showing the shared care option on the Alternative Care service agreement, use x5653 (PCA Services) on the line item with a “y” in the Shared Care field. Shared PCA services are not available to AC recipients if the PCA is a relative with a Relative Hardship Waiver and not an employee of a personal care provider organization. This restriction only applies to AC recipients.

In either case, the provider will now follow the billing instructions shown in Bulletin #99-56-8.

301.22 SHARED PRIVATE DUTY NURSING (PDN) SERVICES

See Bulletin 00-56-18 dated July 27, 2000 for a complete explanation on the use of this service. The role of the service agreement is described here.

Instructions for completing the service agreement:

1. On a separate line item, enter the procedure code, rate, and total number of units for 1:1 PDN services.
2. On a separate line item, enter the procedure code, rate, and total number of units for shared 1:2 PDN services.

Both 1:1 and 1:2 PDN services use the same procedure codes. To authorize 1:2 services, a modifier and shared care indicator must be used. For the shared PDN line item, enter the line item:

- “52” in the Modifier 1 (MOD1) field.
- “Y” in the Shared Care (SHR) indicator
- “5” in the Frequency (FREQ) field
-

The following edits will post if the information entered is not complete or correct:

- Edit 363 will post if the incorrect modifier number is used for shared PDN.
- Edit 376 will post if an invalid modifier number is used, or if there isn't a “52” in the MOD1 field and there is a “Y” in the shared field.
- Edit 869 will post if a “Y” is not placed on the share care indicator field.

Use MA home care procedure codes for PDN services to the *fullest extent* possible (for all medically necessary nursing services) before using extended PDN codes on waiver service agreements.

Minnesota Department of Human Services Continuing Care Administration Medicaid Management Information System (MMIS) January, 2004	Chapter 4	Program Management
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Alternative Care Allocations	401.01
Elderly Waiver Allocation Process	401.02
Program Management Reports	401.03
9200-R2208 AC Cumulative Service Encumbrance and Payments (By Date of Payment)	
9061-R2216 EW Waiver Slot Allocation Master List	
9200-R2453 Screening Documents Approved	
9200-R2455 Suspended LTC Screening Documents	
9200-R2457 LTC Cumulative Service Encumbrance and Payments (By Date of Service)	
9200-R2460 LTC Cumulative Encumbrance and Payments (By Date of Service)	
9200-R2488 AC Cumulative Service Encumbrance and Payments By Provider (By Date of Payment)	

401.01 ALTERNATIVE CARE ALLOCATIONS

Local AC lead agencies are allocated a portion of the state funds appropriated for the AC program to spend on AC services. AC funds are retained by the state in separate lead agency program accounts and are utilized to support payment for authorized AC covered services delivered to eligible persons. Therefore, funds for AC services are accessed from lead agency accounts through the state's Medicaid Management Information System (MMIS) and distributed in the form of payments to AC service providers contracted under those lead agencies.

Technical Resources for Administrators of Lead Agencies

Information is available to assist administrators in tracking and monitoring AC activity. Data such as the total amount of local AC services authorized for payment and the status of the lead agency's AC base allocation are readily available through the MMIS InfoPac reports (listed below) and provider file. Local administrators can submit report questions, request access to local agency-specific reports, or reference the MMIS payment and claim calendar through the local agency's MMIS liaison. The MMIS provider file, on the PFIN screen, provides each lead agency with a current status of its AC allocation USED amount to routinely monitor the rate of program expenditures, level of provider payment, and status of the lead agency's allocation amount. The AC allocation USED amount is updated every two weeks following the MMIS warrant payment. The PFIN screen of the Provider Subsystem contains the current year and previous years' amounts. Use the county's provider number associated with provider type 45 (social services) on the Provider Keypanel screen to view this information.

The following reports are available through the state's MMIS InfoPac:

MMIS InfoPac Report No. & Title	Data Available
R2208 AC Cumulative Service Encumbrance And Payment (Using Date of Payment)	Data by county; by procedure code, unduplicated recipient, total units encumbered, total units used, total amount encumbered, total amount used, total days SA, total days eligible, county average cost per recipient, county average cost per unit, county average units per recipient.
R2457 AC Cumulative Service Encumbrance And Payments (Using Date of Service)	Data by county; by procedure code, unduplicated recipient, total units encumbered, total units used, total amount encumbered, total amount used, total days SA, total days eligible, county average cost per recipient, county average cost per unit, county average units per recipient.
R2460 AC Cumulative Service Encumbrance And Payments (Using Date of Service)	Data by county; per person amount encumbered, amount paid, remaining balance, total days on SA, average monthly encumbered, average monthly paid.

Edits

Service agreement edit 130 (AC Allocation Exceeded) will post if one or more line items exceeds the AC cap. Counties may request targeted funds to increase their AC allocation cap in order to continue to pay claims.

Claims will reject with cutback reason 17 if the county of financial responsibility has exhausted their allocation. The provider may re-bill after the allocation amount is increased (due to targeted funds), or they may wait until July 1 when the county receives a new allocation amount.

Local Programs Providing AC “Other” Services Option

Lead agencies that have already been approved to administer AC “other” services, which include discretionary services and cash grants, need to complete *Part D: AC “Other” Services* of the budget worksheet. Under this service category, lead agencies are limited to designating no greater than 25% of their total base allocation amount. The 25% figure represents the fiscal year cap amount for that agency. From this 25% figure, agency’s must designate the portion of those funds that will be dedicated to either the AC cash grant option (X5526) or AC discretionary services (X5527), or each service for counties administering both options. The designation of funds for AC “other” services creates an upper payment limit within the MMIS for payment of lead agency service claims, but does not remove funds from the total allocation amount supporting payments for all AC services the agency provides.

401.02 ELDERLY WAIVER ALLOCATION PROCESS

Federal law limits the number of participants who may be served on the Elderly Waiver program. The Department has developed a method to remain in federal compliance for not exceeding the maximum number of program participants during each waiver year.

Tracking Automation

MMIS supports the tracking and management of Elderly Waiver clients. This is accomplished by:

Screening Document Edits

- ◆ informational edit 269 (Open to EW) assigned to new clients.

- ◆ informational edit 268 (Reopened in Same Waiver Year as Closed) assigned to clients who reopen in the same waiver year that they exited.

Daily Report

MW2216 - Waiver Utilization Master List

Screening Document Edits

New screening document edits were developed to assist in the accurate processing of counting participants.

Edit 269 - Open to Elderly Waiver (Informational status = 6)

New screening documents which have an opening assessment type (or reopening if the assessment date is in a different waiver year from the exit date) will post this informational edit during the time that the program is accepting new recipients. Recipients will be counted from either the past waiver year or the current waiver year based on the assessment type and date fields on the screening document. The assessment date will determine which waiver year the client will be counted, and the assessment type will determine if it is a screening document that needs to be counted (assessment types 01, 10, 11, or 28). The process does not take into consideration diversions and conversions, so that a client is not counted again if they should later change from one type to another.

Screening documents that request a higher conversion case mix level will continue to first post edit 784 (Case Mix/TBIW Screening Document Requires Approval), remain in suspense and route to DHS staff for approval. When approved, edit 269 will post if the program is open.

Edit 268 - Reopened in Same Waiver Year as Closed (Informational status = 6)

This edit will post on those screening documents when the reopening assessment date is in the same waiver year as the exit assessment date. This assures that the client will not be counted again for that waiver year.

There are two ways that the program can accept additional recipients:

- 1) any approved screening document with an exit type 25 (waiver services will not be used) will allow that waiver slot to be re-used immediately, and

- 2) petitioning the federal auditors to serve additional persons. (All recipients that exited from the program

in the previous waiver year and did not reopen again before the end of the waiver year will lose their slots when the new waiver year begins. These slots will be reassigned in the new waiver year).

There are several factors that are controllable by staff that will cause this process to be inaccurate. These are:

- 1) Exit screening documents are not entered and/or approved in a timely manner.
- 2) Reassessment 25 (exit, waiver services will not be used) is not used in those cases where the opening reassessment screening document was entered by mistake or the client did not use any services. This will not allow that slot to be reused immediately.
- 3) The approved opening or reopening screening document has the wrong county of financial responsibility. The CFR on the major program MA span on the Recipient File is carried over to the screening document. If the wrong CFR is used, that client will not be shown on the correct county's reports. You can check the CFR on the ALT1 screen of the opening or reopening screening document. If incorrect, the financial worker needs to make the correction to the RELG screen. The opening or reopening screening document would need to be deleted and a new document entered after the CFR correction in order for the client to show on the correct county's report.

Daily Report

It should be noted that even though this report is sorted by county, each county is not allocated a maximum number of people that they may serve. The program remains open until the Department determines that it is closed to additional clients.

Report PWMW9061-R2216 Elderly Waiver Utilization Master List

This report is sorted by program for each county of financial responsibility. It identifies the name of the client, their waiver type, reassessment type, reassessment date and process date for each recipient on the program for the current waiver year. Whenever the person is exited from the program a "Y" will be shown in the DEL IND column that signifies that they will be dropped from the program at the end of the waiver year because the person has exited from the program.

Staff should use this report to check for two things:

- 1) for each recipient to make sure that they are currently on the program and receiving services. People who are on this report by mistake because they are no longer participating on the program should have an exit screening document entered and approved.
- 2) for recipients who are missing from the report or are not the financial responsibility of the county. The wrong CFR may be listed on the ALT1 screen of their opening or reopening screening document. Check this screen in MMIS. If incorrect, the financial worker will need to make changes to the RELG screen. In order to record the correct CFR on the opening or reopening screening document and allow the recipient to show on the correct county report, the document would need to be deleted and a new document entered after the CFR correction is made.

Case Examples

Below are examples of different cases and the edits and reports that will be affected.

Client #1 has an opening or reopening screening document. The program is open. Screening document will post edit 269. Client is added to report 2216.

Client #2 exits from the program. They will remain on report 2216. A “Y” indicator shows that the person will be removed from the report at the end of the waiver year if they do not reopen to the program prior to the end of the waiver year.

Client #3 is reopening during the same waiver year that they exited. Screening document will post edit 268. Client remains on report 2216 and the “Y” indicator is removed.

Client #4 is reopening to the same waiver program that they exited from in a previous waiver year. Screening document will post edit 269. Person is added to report 2216.

401.03 PROGRAM MANAGEMENT REPORTS

Except for report 9061-R2216 the following reports are produced by MMIS on a monthly basis.

9200-R2208	AC Cumulative Service Encumbrance and Payments (By Date of Payment)
9061-R2216	EW Waiver Slot Allocation Master List
9200-R2453	Screening Documents Approved
9200-R2455	Suspended LTC Screening Documents
9200-R2457	LTC Cumulative Service Encumbrance and Payments (By Date of Service)
9200-R2460	LTC Cumulative Encumbrance and Payments (By Date of Service)
9200-R2486	AC Cumulative Service Encumbrance and Payments (By Date of Payment and By Provider)

These reports are available for viewing online using Infopac. Most agencies can also print the reports at their offices. Infopac holds a history of past report versions and allows the printing of the entire report, selected pages, or a custom design of pages. The user is not allowed to change the data or the date parameters.

The ability to print at each agency is dependent on the availability of a suitable printer. If you are interested in viewing or having the reports print directly at your agency, contact your county Infopac MMIS Liaison. An Infopac user manual is available by calling the Department at (651) 772-3754.

This report is run on a monthly basis. It is sorted by county of financial responsibility. It should be used by the Alternative Care program administrator to determine if the county will exceed their AC allocation limit for the current year. It also compares the usage among services for the CFR.

Column Definitions

- 1) The reporting period.
All AC clients with an approved or partially approved service agreement in which some or all of the header period falls within this period are on this report. For line items that partially cover this period, only those units or amount that falls within the reporting period are shown. The header status must be approved or partially approved prior to the report processing date.
- 2) Recipient Name
- 3) Recipient ID or PMI Number
- 4) Encumbered Amount.
This is a calculated amount based on approved line items during the reporting period. Computations are not rounded up. If a service agreement exceeded twelve months, the column may be a lesser amount because it will be prorated by more than twelve months.
- 5) Amount Paid.
This is the total amount paid for the client based upon claims with a status of “paid” and “to be paid”. These claims must have a “as of last cycle date” (shown on the claim form) that does not exceed the reporting period. The payment date must fall within the reporting period. Computations are not rounded up.
- 6) Balance Remaining.
This is the difference between the calculated encumbered amount and the amount paid.
- 7) Total Days Service Agreement.
The number of days of all the service agreements represented in this reporting period. The formula is the difference between the service agreement begin date and the ending date of the reporting period. If a closing screening document is entered, but the service agreement was not closed down to the same date, the service agreement days will exceed the Total Days Eligibility column.

Total Days Eligibility.

The number of days based on the eligibility period from the AC major program (see the RELG screen of the Recipient subsystem) that the person was eligible for services within the reporting period. If there is a zero in the total days eligibility field and a number higher than zero in the total service agreement field, there was a screening document deletion and the eligibility period was not rebuilt.

- 8)** Average Monthly Encumbered.
The calculated encumbered amount is divided by the number of total service agreement column and the sum is multiplied by 30.
- 9)** Average Monthly Paid.
The amount paid divided by the number of total days service agreement column and the sum is multiplied by 30.
- 10)** This section represents the total amounts of all columns.

This report is run on a daily basis. It is sorted by county of financial responsibility. It should be used by the Elderly Waiver case managers to check that each of their clients are listed on this report, and clients who have left the program no longer show on the report. Each person on the report has a waiver “slot”. Those with a “Y” in the Delete Column are people who will keep their slot until the beginning of the new waiver year. Then, their slot is removed to be re-used.

Column Definitions

- 1) The reporting period.
- 2) County. County of Financial Responsibility that is listed on the last opening or reopening assessment result.
- 3) Recipient ID or PMI Number
- 4) Recipient Name
- 5) Waiver Type. Diversion or Conversion
- 6) Assessment Result. The last opening or reopening assessment result code.
- 7) Assessment Result Date. The date of the last opening or reopening assessment result code.
- 8) Process Date. The date the screening document was approved in MMIS.
- 9) DEL IND. A “y” listed here indicates that the person has exited the program and will be deleted from the report at the end of the waiver year if they do not reopen to the program prior to June 30.

Report 9200-R2453 Screening Documents Approved

This monthly report is sectioned by the case manager name. Screening documents approved within the reporting period are shown for the case manager listed on the screening document. It is not a cumulative report. This report can be used to track when screening documents were data entered and approved, and if a service agreement was entered to cover the period of eligibility.

Column Definitions

- 1) Recipient Name.
- 2) Recipient ID or PMI Number.
- 3) The reporting period and name of program.
- 4) Program Eligibility Date.
The beginning date of the most recent waiver eligibility span listed on the RWVR screen of the Recipient subsystem. This column will be left blank for Alternative Care clients.
- 5) Screening Document Number.
The number assigned to the screening document that was approved during the reporting period.
- 6) Assessment Result Code/Date.
The reassessment type and date as shown on the screening document.
- 7) SC ST
The status of the screening document. A = approved.
- 8) DD Reassessment Type/Date
- 9) DD Waiver Thru Date
This column is used only for the Developmental Disabilities programs. It shows the end date of the most recent waiver eligibility span.
- 10) SA TP
The most recent service agreement. The types are:
F = CADI Conversion
G = CADI Diversion
H = CAC Conversion
I = CAC Diversion
J = EW Conversion
K = EW Diversion
L = TBIW-NF Conversion
M = TBIW-NF Diversion
N = AC Conversion
O = AC Diversion
P = TBIW-NB Conversion
Q = TBIW-NB Diversion

11) Service Agreement Start and End Dates

This column will be valued if the screening document reassessment date falls within a service agreement header period and the service agreement was entered during the reporting period. If the service agreement header begin date does not match the screening document reassessment date, it will not be shown here. This column can be used to make sure that if the screening document is an opening or reassessment type, then this column should also have a service agreement of the same period. If the screening document is an exit, then the service agreement end date should match.

12) SA ST

The service agreement header status. A = approved, S = suspend, T = partially suspend.

13) Last Claim Payment Date.

The last time a payment was made against the service agreement. If this column is blank or the claim date is very old it could indicate that providers are having difficulty in submitting and approving claims or the client is no longer receiving services.

Report 9200-R2455 Suspended LTC Screening Document

This is a monthly report for the county of service. It identifies the screening documents that are in suspense and the number of days since they were data entered. The screening document needs to be either deleted or a new document entered that corrects the problem that is keeping the document in suspense. This is a cumulative report.

Column Definitions

- 1) Reporting Period.
- 2) Program Type.
- 3) Recipient Name.
- 4) Recipient ID or PMI Number
- 5) Document Number.
The number assigned to the screening document.
- 6) Number of Days Since Entry.
- 7) Total County ___ Screening Documents.
The total number of screening documents listed on the report.

County Average Days.

The average number of days that the documents have been suspended.

This is a monthly report for the county of financial responsibility. It lists the cumulative encumbrance and payments of each procedure code as of the service date. One report is for each of the waiver programs and another report is for the Alternative Care program. Each program has a section for the current year and a section for the past year. It may be used to determine the total encumbered and/or paid amounts for each service during the reporting period, and to compare your county average with the state average amounts.

Column Definitions

- 1) **Reporting Period and Program Type.**
All approved or partially approved service agreements in which some or all of the header period that falls within the reporting period will be shown.

- 2) **PROC CODE**
The procedure code (HCPC) that identifies the service. The name of the service is listed on the next line.

- 3) **UNDUP RECIP ENCUMB and USED**
The number of unduplicated clients with an approved line item within the reporting period. The second number represents the number of people who have at least one unit or dollar amount of the service paid.

- 4) **TOTAL UNITS ENCUMB and USED**
The number of units with an approved line item within the reporting period. The second number represents the number of units that have been paid. Those line items that were priced by a total amount rather than a unit (such as supplies and equipment or modifications) would not be shown here.

The encumbered amount is spread out over the entire reporting period. If the line item was paid in a short period of time (such as modifications or supplies and equipment in a one lump sum, or monthly services such as Residential Care) the encumbered amount and units will be lesser than the amount used columns.

If the line item spans over more than one year, the total units used may be more in one year than the other.

- 5) **TOTAL AMOUNT ENCUMBERED**
This is a calculated amount based on approved line items during the reporting period. Computations do not round up. If the service agreement header period exceeded twelve months, this column may be a lesser amount because it will be prorated by more than twelve months.

TOTAL AMOUNT USED

This is the amount that was paid for the units of service. Only claims with a status of "paid" or "to be paid" are used. Computations do not round up.

- 6) TOTAL DAYS SVC AGMT
The number of service agreement days within the reporting period.

TOTAL DAYS SCRNG DOC

The number of days in the reporting period that the clients were eligible and who had an approved or partially approved service agreement.

- 7) COUNTY AVERAGES
Cost Per Recipient
Cost Per Unit
Units Per Recipient

These columns would not include line items that were priced by a total amount rather than a rate and unit (such as supplies and equipment, or modifications).

- 8) STATE AVERAGES
Cost Per Unit
Units Per Recipient

- 9) This section represents the total amount of all sections.

This report is provided on a monthly basis. It is by the county of financial responsibility and shows data by date of service. It can be used to check the clients that are assigned to that county of financial responsibility and compare the usage of services among the clients.

Column Definitions

- 1) The reporting period.
All clients with an approved or partially approved service agreement in which some or all of the header period falls within this period are on this report. For line items that partially cover this period, only those units or amount that falls within the reporting period are shown. The header status must be approved or partially approved prior to the report processing date.
- 2) Recipient Name
- 3) Recipient ID or PMI Number
- 4) Encumbered Amount.
This is a calculated amount based on approved line items during the reporting period. Computations are not rounded up. If a service agreement exceeded twelve months, the column may be a lesser amount because it will be prorated by more than twelve months.
- 5) Amount Paid.
This is the total amount paid for the client based upon claims with a status of “paid” and “to be paid”. These claims must have a “as of last cycle date” (shown on the claim form) that does not exceed the reporting period. The payment date must fall within the reporting period. Computations are not rounded up.
- 6) Balance Remaining.
This is the difference between the calculated encumbered amount and the amount paid.
- 7) Total Days Service Agreement.
The number of days of all the service agreements represented in this reporting period. The formula is the difference between the service agreement begin date and the ending date of the reporting period. If a closing screening document is entered, but the service agreement was not closed down to the same date, the service agreement days will exceed the Total Days Eligibility column.

Total Days Eligibility.

The number of days based on the eligibility period from the AC major program (see the RELG screen of the Recipient subsystem) or the waiver eligibility period (from the RWVR screen of the Recipient subsystem) that the person was eligible for services within the reporting period. If there is a zero in the total days eligibility field and a number higher than zero in the total service agreement field, there was a screening document deletion and the eligibility period was not rebuilt.

- 8)** Average Monthly Encumbered.
The calculated encumbered amount is divided by the number of total service agreement column and the sum is multiplied by 30.
- 9)** Average Monthly Paid.
The amount paid divided by the number of total days service agreement column and the sum is multiplied by 30.
- 10)** This section represents the total amounts of all columns.

This report is run on a monthly basis. It is sorted by county of financial responsibility. It should be used by the Alternative Care program administrator to determine if providers are submitting claims on a timely basis. Providers may submit claims up to 365 days from the date of service. AC allocations are decremented by claims submitted within that AC year regardless of what year the service was provided.

Column Definitions

- 1) The reporting period.
All AC clients with an approved or partially approved service agreement in which some or all of the header period falls within this period are on this report. For line items that partially cover this period, only those units or amount that falls within the reporting period are shown. The header status must be approved or partially approved prior to the report processing date.
- 2) Recipient Name
- 3) Recipient ID or PMI Number
- 4) Encumbered Amount.
This is a calculated amount based on approved line items during the reporting period. Computations are not rounded up. If a service agreement exceeded twelve months, the column may be a lesser amount because it will be prorated by more than twelve months.
- 5) Amount Paid.
This is the total amount paid for the client based upon claims with a status of “paid” and “to be paid”. These claims must have a “as of last cycle date” (shown on the claim form) that does not exceed the reporting period. The payment date must fall within the reporting period. Computations are not rounded up.
- 6) Balance Remaining.
This is the difference between the calculated encumbered amount and the amount paid.
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- 9)** Average Monthly Paid.
The amount paid divided by the number of total days service agreement column and the sum is multiplied by 30.
- 10)** This section represents the total amounts of all columns.