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## Rule 5 Healthcare Claiming in SSIS What You Need to Know

SSIS Fiscal Mentor Meeting – Rule 5 Healthcare Claiming

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### Overview

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

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### Overview

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

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### What is Rule 5 Claiming?

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

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### Client Eligibility Requirements

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

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### Supplemental Healthcare Eligibility in SSIS – Rule 5

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

MH rule 5 screening date:

MH rule 5 end date:

Client meets the needs for MH Rule 5 level of care and meets the legal criteria for SEMI or SED.  
 Yes  No

Workgroup:

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

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### Diagnosis Codes in SSIS

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

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

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

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### Diagnosis Codes in SSIS cont.

- ▣ A mental health diagnosis code is not billable if:
  - ▣ The effective end date in MMIS is before the Service Dates of the Healthcare Claim
  - ▣ The message "The diagnosis code is not specific enough for claiming." displays




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### Rule 5 Payment Information in SSIS

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

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### Healthcare Eligibility from MMIS

#### Eligibility Spans folder

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

#### Living Arrangements folder

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

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### Rule 5 Healthcare Claim

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### Rule 5 Claims Generation

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

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### Rule 5 Claim Proofing

**Don't forget to run Payment Proofing!!!**

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### Rule 5 Claiming Common Proofing Errors

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

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

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### Rule 5 Claiming Common Proofing Errors - #2007

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

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

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**Rule 5 Claiming  
Common Proofing Errors**

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

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

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**Rule 5 Claiming  
Common Proofing Errors**

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

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**Rule 5 Claiming  
Common Proofing Errors - #2015**

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

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

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**Rule 5 Claiming  
Common Proofing Errors - #2013**

#2013 – Living Arrangement is not valid for Rule 5

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

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**Rule 5 Claim Exception Code 381**

The description of exception code 381 is rate record not found

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

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**Rule 5 Claim Exception  
Codes 287 & 427**

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

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

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### Rule 5 Claim Exception Code 267

The description of exception code 267 is TPL resource available

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

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### Rule 5 Claim Exception Code 301

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

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

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### Rule 5 Payments in MMIS

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

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

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### Rule 5 Room and Board and the Child Foster Care Report

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

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

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### Rule 5 and the Child Foster Care Report

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

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

Rate Effective Date	Rate Expiration Date	Expiration Reason	Approved Per Diem Rate	Approved IV-E Rate %	Approved IV-E Rate / Per Diem	Approved IV-E Rate %	Approved MA %
04/01/2015	12/31/2015		\$211.92	43.70%	1.20%	0.00%	50.88%

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### Claim Batch Submission Reminders

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

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Questions?



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