Mental Health Rule 5 Claiming

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Mental Health Rule 5 Overview and Introduction

Children’s Residential Mental Health Treatment, also referred to as Mental Health Rule 5 Claiming, is done for Payments with the HCPCS/modifier H0019 for eligible clients who meet the Rule 5 criteria. Mental Health Rule 5 potential claims can be validated or corrected, claim batches created, claims submitted to the MN-ITS mailbox and process responses from MMIS in a like manner with other Health Care Claiming.

Step-by-Step Navigation

Claim Batch Search

Search using as many filters as needed. Using several search filters together yields fewer search results than using a single search filter.
Claim Batch Search

1. Click the Healthcare Claiming button on the Task Panel, then select Claim Batch Search. Alternatively: Access Searches/Logs on the Windows toolbar, select Healthcare Claiming, then select Claim Batch Search.

2. Batch status: Select from the drop-down list if applicable.

3. Claim category: Select Rule 5 from the drop-down list.

4. Claiming county: This field only displays for counties that share a database. Select from the Claiming county drop-down list if applicable.

5. Date type defaults to Batch Dates. Select from the drop-down list if applicable.

6. Date range defaults to Custom. Select from the drop-down list if applicable.

7. From and To fields can either be left blank or entered with dates when the Date range is Custom.

8. Owner: Select a name from the field drop-down list, if applicable, or leave the field blank to search all batches.

9. Claim batch #: Enter a number if known and applicable.

10. Description: Enter a description if filtering by this field.

11. Click Search.
Create New Claim Batch

1. Highlight Claim Batch Search on the task panel.
2. Access the Action menu.
5. Included record types defaults to Payments only and is not editable.
6. Claim batch # is system generated.
7. Batch start date must be the first day of the month.
8. Batch end date must be the last day of the month.
9. Owner autofills with the logged on worker, but is editable.
10. Claiming county only displays for counties sharing a database.
11. Description: Enter if applicable.
12. Batch status defaults to Draft and is not editable.
13. Click the Generate button.
Healthcare Claim Search

Search using as many filters as needed. Using several search filters together yields fewer search results than using a single search filter.

**Healthcare Claim Search**

1. Click the **Healthcare Claiming** button on the Task Panel, then select **Healthcare Claim Searches**. Alternative: Access Searches/Logs on the Windows toolbar, select **Healthcare Claiming**, and select **Healthcare claim searches**.
2. **Claim #**: Enter a number if searching for a specific claim.
3. **Claim category**: Select Rule 5 from the drop-down menu, or leave blank to search all categories.
4. **Claim status**: Select a status from the drop-down list if applicable.
5. **Date type**: Defaults to **Generated Date**. Select from the drop-down list if applicable.
6. **Date range** defaults to **Custom**. Select from the drop-down list if applicable.
7. **From** and **To** fields can either be left blank or entered with dates when the **Date range** is **Custom**.
8. **Client first name**: Enter a Client’s first name if applicable.
9. **Client last name**: Enter a Client’s last name if applicable.
10. **County person #**: Enter a County person # if known and applicable.
11. **SSIS person #**: Enter a SSIS person # if known and applicable.
12. **PMI #**: Enter a PMI # if known and applicable.
13. **HCPCS/ modifiers**: Select from the drop-down list or use the type ahead feature, if applicable.
14. **Bill type**: Select from the drop-down list if applicable.
15. **TCN**: Enter a Transaction Control Number if applicable.
16. Click **Search**.
Complete Navigation

**Mental Health Rule 5 Claiming Requirements**

Children’s Residential Mental Health Treatment, also referred to as Mental Health Rule 5 Claiming, is done for Payments meeting Rule 5 criteria for eligible clients. Mental Health Rule 5 potential claims can be validated or corrected, claim batches created, claims submitted to the MN-ITS mailbox and process responses from MMIS in a like manner with other Health Care Claiming.

**Required Data Entry Information**

Eligible Payments include:

**Services:**
- Rule 5 Child Residential Treatment MH

**HCPCS/Modifiers:**
- H0019 Children’s residential treatment

**Supplemental Eligibility Record:**

Client must have a Rule 5 Supplemental Eligibility record in effect on the Service Dates as indicated as the following:

- MH Rule 5 Screening Date must be on or prior to the Payment Service Start Date.
- MH Rule 5 End Date blank or if the MH Rule 5 has an end date then the end date must be on or after the service end date of payment.

Client meets needs for MH Rule 5 Level of Care indicator must be yes. Workgroup is optional.
Rule 5 Eligibility

MMIS Recipient Information

MMIS recipient information includes:
Client must be MA Eligible MNCare on the Service Dates. The MA or MNCare Eligible program codes include:

MA Eligible
- DM (Demonstration to Maintain Indep. & Employment - DMIE)
- EH (Federally paid Emergency Medicaid)
- MA (Federally paid Medical Assistance)
- NM (State-Paid Medical Assistance)
- RM Refugee.

MNCare Eligible (Submit through MN-ITS)
- KK (Minnesota Care Noncitizen Kids/PWS)
- LL (MinnesotaCare Citizen Kids/PWS).

Eligibility Status includes:
- Active
- Closed.

The Service Dates are within the Eligibility Start Date and the Eligibility End Date. Client’s Living Arrangement on the Service Dates must be
- SED – Residential Treatment
Living Arrangement is based on the following:
- The Living Arrangement must be in effect for the Service Start Date through the Service End Date.
- If a Living Arrangement ends and another Living Arrangement exists with the same date, the Living Arrangement with the Start Date is used.

**Client Information**

Client information includes:
- Client Age
- Client Age must be under 21 as of the 1st of the month
- Diagnosis Codes include (Only MH Diagnosis codes are included on the claim)
  - Diagnosis Codes greater than or equal to 290.0 and less than or equal to 302.99
  - Diagnosis Codes greater than or equal to 306.0 and less than or equal to 316.0.

**Additional Requirements**

Additional requirements include:
- One claim is submitted for each eligible Payment. (Payment Modifications, such as a partial Refund, are combined with the original Payment.)
- Maximum of one Rule 5 claim can be submitted for a given date range per client.

**Information Displayed on Rule 5 Claim Records**

- HCPCS/Modifiers include:
  - H0019 Children’s residential treatment
- Units are the total number of Units on all selected Payments.
- Amount is the total Amount on all selected Payments
- First Service Date is the Payment Service Start Date.
- Last Service Date is the Payment Service End Date.
- Diagnosis Code is from the SSIS MH Diagnosis entered for the client.
• Rule 5 Facility Name is the name of the Facility where the child is residing.
• Rule 5 Provider Number is the Provider Number of the Facility.
• Rule 5 NPI is the NPI or UMPI Number of the Facility.

Additional Program Requirements and Policy Information that is not included in SSIS Processing includes:

• Client must have been screened for MH Rule 5 and found to meet the Rule 5 placement criteria.
• Services must be on or after the screening date.
• The MH Rule 5 screening serves to establish medical necessity for Children’s Mental Health Residential Treatment Services.
• Children’s Mental Health Residential Treatment facilities must be enrolled as providers under the Minnesota Health Care Program.
• Eligible providers must be licensed by the State of Minnesota and must be under contract with a lead county.
• Children’s Mental Health Residential Treatment payment rates are set at the end of a quarter and must be submitted after the end of the quarter.

Additional county requirements:

• The Rule 5 facility must bill the county.
• The county submits the MH Rule 5 claim to MMIS and is reimbursed by MMIS.
• Claims for clients with third party liability (TPL) must be submitted using MN-ITS.
• Counties must submit invoices three times to a non-responding TPL before submitting a reimbursement claim to DHS for MHCP reimbursement.
• Claims for clients with MNCare KK or LL major programs eligibility will need to submit claims through MN-ITS.
• Prior Authorization when clients have TPL should be received prior to admission.
Mental Health Rule 5 Proofing Reports

MH Rule 5 Proofing

<table>
<thead>
<tr>
<th>Error Category</th>
<th>Error Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment</td>
<td>No HCPCS/Modifier on Payment-</td>
</tr>
<tr>
<td></td>
<td>Payment must have HCPC H0019 entered</td>
</tr>
<tr>
<td></td>
<td>Original Payment for a Modification already claimed-</td>
</tr>
<tr>
<td></td>
<td>Claims for a negative amount cannot be submitted. The claim for the original payment must be replaced or voided.</td>
</tr>
<tr>
<td></td>
<td>Client Age must be under 21-</td>
</tr>
<tr>
<td></td>
<td>The client must be under 21 as of the first of the month for the month of service to claim Mental Health Rule 5 services</td>
</tr>
<tr>
<td></td>
<td>Client’s TPL indicator = ‘Y’ (Warning)</td>
</tr>
<tr>
<td></td>
<td>Claims for client’s with third party liability (TPL) must be submitted using MN-ITS. Counties must submit invoices three times to a non-responding TPL before submitting a reimbursement claim to DHS for MHCP reimbursement.</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>MH Diagnosis is required</td>
</tr>
<tr>
<td></td>
<td>The Diagnosis code must be between 290.0 and 302.99 or between 306.0 and 316.0</td>
</tr>
<tr>
<td>Error Category</td>
<td>Error Description</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Duplicate Claim</td>
<td>Claim would be duplicate.</td>
</tr>
<tr>
<td></td>
<td>Only one claim can be submitted for a HCPCS/modifier for a given date range.</td>
</tr>
<tr>
<td>MA Eligibility</td>
<td>Service Dates not within a single Living Arrangement</td>
</tr>
<tr>
<td></td>
<td>The Service Start Date through the Service End date must be completely within the Living Arrangement effective dates.</td>
</tr>
<tr>
<td></td>
<td>Service Dates not within a single Recipient Eligibility Span</td>
</tr>
<tr>
<td></td>
<td>The Service Start Date through the Service End Date must be completely within the dates of a single Eligibility span.</td>
</tr>
<tr>
<td></td>
<td>Client must be on MA/MN Care Eligible to claim</td>
</tr>
<tr>
<td></td>
<td>Client must have an MMIS eligibility span in effect from the Service Start Date through the Service End Date.</td>
</tr>
<tr>
<td>Invalid Major Program</td>
<td>The Major Program on the Recipient Eligibility Span in effect during the Service Dates must be valid for the Claim Category.</td>
</tr>
<tr>
<td>Invalid Living Arrangement</td>
<td>The Client’s MMIS Living Arrangement must be 54 SED Residential Treatment to Claim.</td>
</tr>
<tr>
<td>No MMIS Eligibility Information</td>
<td>The client must have MMIS Eligibility information in SSIS to verify eligibility. No eligibility information has been received from MMIS.</td>
</tr>
<tr>
<td>No Living Arrangement</td>
<td>Client must have a living arrangement record on the service dates.</td>
</tr>
<tr>
<td>Error Category</td>
<td>Error Description</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Supplemental Eligibility | No Supplemental Eligibility  
Client must have a Supplemental Eligibility in effect from the Service Start Date through the Service End Date.  
MH Rule 5 Level of Care = No  
The “Client meets the need for MH Rule 5 level of care and meets the legal criteria for SPMI or SED” on the Rule 5 Supplemental Eligibility in effect on the service dates must be “Yes” to claim. |
| Client              | Estimated Date of Birth (DOB)  
Client has an estimated DOB rather than an actual DOB to claim.  
Missing PMI #  
Client must have a PMI # to claim. |
| Do Not Claim         | Client Marked ‘Do Not Claim’  
Client has a Do Not Claim record in effect during the service dates of the Payment. |