Rule 5 Healthcare Claiming in SSIS
What You Need to Know

06/25/2015  Presented by: Stacey Alsdurf – SSIS Fiscal
Overview

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

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

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

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

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

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

MH rule 5 screening date: [ ]
MH rule 5 end date: [ ]
Client meets the needs for MH Rule 5 level of care and meets the legal criteria for SPML or SED: [ ] Yes [ ] No
Workgroup: [ ]
Diagnosis Codes in SSIS

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

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

Note: SSIS assigns a “Y” Mental Health Billable Indicator to ICD-9 and ICD-10 codes that policy staff have designated as mental health diagnosis codes.
A mental health diagnosis code is not billable if:
- The effective end date in MMIS is before the Service Dates of the Healthcare Claim
- A note that reads “The diagnosis code is not specific enough for claiming.” displays
Rule 5 Payment Information in SSIS

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

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

Living Arrangements folder

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

### Healthcare Claim Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim #</td>
<td>210481856</td>
</tr>
<tr>
<td>Claim category</td>
<td>Rule 5</td>
</tr>
<tr>
<td>Claim detail</td>
<td>From Payment Service dates.</td>
</tr>
<tr>
<td>Generated date</td>
<td>06/15/2010 08:51:18 PM</td>
</tr>
<tr>
<td>First service date</td>
<td>08/01/2006</td>
</tr>
<tr>
<td>Last service date</td>
<td>08/31/2006</td>
</tr>
<tr>
<td>Bill type</td>
<td>From Payment Units.</td>
</tr>
<tr>
<td>Units</td>
<td>30</td>
</tr>
<tr>
<td>Amount</td>
<td>$10,681.50</td>
</tr>
<tr>
<td>Client name</td>
<td>Carla</td>
</tr>
<tr>
<td>HCPCS/modifiers</td>
<td>H0019 - Children's residential treatment</td>
</tr>
<tr>
<td>ICD-9 diagnosis</td>
<td>316 - PSYCHIC FACTOR W OTH DIS</td>
</tr>
<tr>
<td>Place of service</td>
<td>Nursing facility</td>
</tr>
<tr>
<td>Rule 5 facility name</td>
<td>GERARD OF MINNESOTA</td>
</tr>
<tr>
<td>Rule 5 provider num</td>
<td>A3333333333</td>
</tr>
</tbody>
</table>

### Notes
- From Payment Service dates: 06/15/2010 08:51:18 PM
- From Payment Units: 30
- From Payment Amount: $10,681.50
- From Payment Client name: Carla
- From HCPCS/modifier on Payment: H0019 - Children's residential treatment
- From Billable MH Diagnosis entered in client's Disability/Diagnosis /Substance folder: 316 - PSYCHIC FACTOR W OTH DIS
- From client's Living Arrangements folder: GERARD OF MINNESOTA
- From client's Living Arrangements folder: GERARD OF MINNESOTA
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
Rule 5 Claim Proofing

Don’t forget to run Payment Proofing!!!
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
#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
Rule 5 Claiming
Common Proofing Errors

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

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

If Payment is determined to be Rule 5 treatment and room and board, create an Adjustment Reversal and Correcting Entry Adjustment on the Payment to add HCPCS/modifier H0019 to claim for both a Healthcare Claim and a Title IV-E claim.
# 2015 – No Rule 5 Supplemental Eligibility exists for the service dates

- Enter Rule 5 Supplemental Healthcare Eligibility if the client is eligible for Rule 5 services

- If the client is not eligible for Rule 5 services, create a Do Not Claim Determination record
Rule 5 Claiming
Common Proofing Errors

#2013 – Living Arrangement is not valid for Rule 5

- The MMIS Living Arrangement must be “54 – Rehab option facility for children” to claim for Rule 5 in SSIS
- When the client is on MinnesotaCare, the Living Arrangement is “80 – Community.”
  - Submit Healthcare Claims through MN-ITS Direct Data Entry (DDE) or another method for clients on MinnesotaCare
  - Create Rule 5 Do Not Claim Determination records for clients on MinnesotaCare
Rule 5 Claim Exception Code 381

The description of exception code 381 is rate record not found

- If claims are submitted before the rates have been entered in MMIS, claims will deny with this code.
  - Submit Rule 5 Healthcare Claims after the Approved Per Diem for the service dates you are claiming display in SSIS in the Title IV-E Group Provider Search and display in MMIS
  - Rates are entered in MMIS after they display in the Title IV-E Group Provider Search
Rule 5 Claim Exception
Codes 287 & 427

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

- Rule 5 Healthcare Claims for the Woodland Hills facility require submission of a taxonomy code on the claim
  - Submission of taxonomy codes is not available in SSIS
  - Submit Healthcare Claims for Woodland Hills through MN-ITS DDE or another method
  - Create a Do Not Claim Determination record
Rule 5 Claim Exception Code 267

The description of exception code 267 is TPL resource available

- Client has other third party insurance that is primary to Medicaid
  - Submission of third party insurance information is not available in SSIS
  - Submit Healthcare Claims with third party insurance information through MN-ITS DDE or another method
- Create a Do Not Claim Determination record
Rule 5 Claim Exception Code 301

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

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

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

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

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

- Payments must include:
  - Service Code 483 – Children’s Residential Treatment
  - Special cost code 17 – Rule 5 Room and Board
Rule 5 and the Child Foster Care Report

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

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

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

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