DHS/DMH Provider Training
General Instructions for
Submitting Bills and Registering Consumers
With the Illinois Mental Health Collaborative System

1 PM Teleconference, Tuesday, August 19, 2008
2 PM Teleconference, Tuesday, September 2, 2008
2 PM Teleconference, Tuesday, September 3, 2008

Overview:

"Go Live" Date – The new MIS designed by the Collaborative will "go Live" on Tuesday September 2nd 2008. At this time providers will be able to submit batch registration and batch claims using third party proprietary software. Providers using the new system will also be able to submit on-line registration and direct data entry for claims/service processing directly through provider connect using a web-based system. The software for submission of claims using EDI Claims link in which software developed by the collaborative is downloaded on an agency's computer system is being enhanced and will be ready to use beginning Friday September 5th.

Registration Reporting Issues

1. a. Why are consumers registered in special programs?

DMH needs to be able to specifically identify consumers who are receiving services in specialized programs such as residential services, mental health juvenile justice, PATH and CILA. Only providers who are contracted with to provide these specialized services should be providing services to these consumers.

b. What are core programs?
Most of the core programs are essentially programs that most consumers can access.

2. What are the rules for reporting of diagnoses on Axis I, II and III?

Providers are expected to report diagnoses on Axes I, II and III following the same rules that were used under ROCS. That is, diagnoses are required for the first diagnosis on each axis. The Collaborative will be modifying the MIS to include these edits in a future software release.

3. Is reporting of CGAS, GAF and Functional Impairment criteria for target populations (e.g., SMI and SED) still required?

Providers are still expected to provide information on functional impairment using the CGAS for children/adolescents, the GAF for adults and to complete the additional functional impairment areas that are specific to adults and children. The label for the functional impairment levels are not currently displayed on the Collaborative registration screen, but this will be updated in a future release.

4. What is the source of consumers' addresses that are displayed on the registration?
The address field on the on-line registration software has been modified to reflect consumers' addresses from the HFS Eligibility File and from previous registrations on ROCS if the HFS information doesn't exist. Providers will also be able to update consumers' addresses in real time when using the on-line registration software.

5. What new fields have been added to the registration?

a. Consumer Third Party Payer – Simply indicate Yes or No with regard to whether a consumer has a third party payer.

b. Special Program Enrollments Programs and Dates– Dates?
See number 1 above for rationale for the use of special programs.
Special Program Open Date: Refers to the date that individual is enrolled in the special program; May not be the same as the registration date.
Special Program End Date: Refers closed out of the special program; not the same as closing date

c. LOCUS Scores – Currently required for individuals authorized for ACT and for individuals receiving CST.

d. Guardian Termination Date – Used to report the date that the guardianship was terminated. Please note that other Guardian fields are required for ICG only.

6. Registration Updates – Please remember to put into place a plan to begin updating your cases as soon as possible as all registrations must be updated by January 1, 2009.

CLAIMS/SERVICE REPORTING ISSUES

1. Use of Program Codes

a. DMH will use program code to assess the amount and type of services or activities occurring and paid for under each program.
b. This information can be used by community service agencies in calculating and reconciling costs for programs. It will be useful for providers to bill across capacity grants program codes because they won't have to reconcile those dollars back against expenses.
c. Such information can also be used by DHS/DMH in demonstrating accountability for state funding and managing the array of programs, services and activities provided in the state's public mental health system.

Legacy Program Codes from the DHS/DMH ROCS System

a. The majority of these codes will continue to be used in the billing system implemented by the Collaborative for DMH.

b. To minimize changes, these codes should be used in the same manner in FY09 in the as they were in FY08 in the DHS ROCS system.

Entering Program Codes When Using Software (e.g. EDI Claims Link or Direct Data Entry) developed by the Collaborative

a. Due to the different means of inputting bills in the system that the Collaborative has designed for DMH (e.g. EDI Claims Link or Direct Data Entry), when inputting multiple claims for a single consumer, please remember that you will need to be alert to ensure that the appropriate program code is applicable for the claim submitted. Note that each time the program changes, you will need to exit from the line claim screen to enter the appropriate program code. Please note that program codes are required.

Rules for reporting programs codes

a. When capacity grant services are reported, you may report any Medicaid or non-Medicaid services and any services associated with the specific capacity grant program as reflected on the service matrix.

b. You may not report any capacity grant services unless you are funded for the program.

c.. Program code ABC replaces program codes 110 and 120.

Program codes 515 and 510

These program codes should not be reported until DMH notifies providers.

2. "Roll-up" of Services

Among health care systems that pay for services on a fee-for-service basis, community mental health services are somewhat unique in that it is sometimes appropriate for the same service to be provided multiple times to the same individual on the same day. An example of this would be the administration of medication to an individual two or more times per day. Since delivery of the same service on the same day to the same individual is exceptional, standardized billing systems based on HIPAA standards handle such billings as duplicates, rejecting these multiple billings on the same day for the same service to the same individual after accepting the first one. The DMH currently provides a liberal means of reporting services that are provided multiple times during the day. Essentially services that are provided at least half of the amount of time associated with a unit are permitted to be "rolled" up to the full unit. DMH understands that many agencies utilizing third party proprietary software have designed their software to calculate units using this approach. DMH has therefore taken this information into consideration and will apply this methodology to services that are provided multiples time during the same day to the same individual. One way in which DMH will monitor the reporting of these services is to include them in sampling for post payment reviews.

How to Report Services That Are "Rolled Up"

Any time more than one service (8 minutes or more) is reported for the same consumer, on the same day, by the same staff level, at the same location, the provider will be required to

roll up these claims using the following methodology. Services that are billable in 15 minute increments: (1) Each service meeting the 8 minute specification would equal 1 unit. (2) The number of units would then be summed and entered into the unit field. (3) The actual number of minutes would however be entered in the duration field.

3. Reporting of Pseudo-RINS

As part of the Illinois public community mental health service system, DHS/DMH plans to continue to support certain services to individuals who cannot or should not be readily and reliably identified. Pseudo-RINS are being implemented to provide a level of accountability and means of monitoring these important services.

Pseudo-RINS are to be used only under certain conditions:

When the individual being served is either:

- **a.** Not known to the community service agency or the agency is unable to obtain sufficient information about the individual to register the individual in the Collaborative's System, **or**
- b. The individual is participating in a service or program in which it is a key component of the service or program that specific individual participation not be identified or is not necessary. These would include:
  - i. Stakeholder education service
  - ii. Drop-in centers for consumers

  Specific Pseudo-RINS are to be used for specific DHS/DMH programs and services, and are to reflect whether the individual is identified as being homeless. These codes are available on the DHS/DMH website at the address below. They will also be posted on the Illinois Mental Health Collaborative for Access and Choice website shortly.

http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/MentalHealth/DMH%20Service%20Matrix%20Final_063008xrrr.pdf

DHS/DMH and the Collaborative will monitor the utilization of pseudo-RINS to ensure appropriate usage and accountability.

4. SASS Exclusion

Note that due to the nature of SASS services, service billings to the Collaborative for consumer enrolled in SASS will be rejected EXCEPT if the consumer is enrolled in the Mental Health Juvenile Justice Program (Program 121); enrollment in this program is reflected in the consumer registration record (e.g., position 313 on the batch registration record, see page 12 of Batch Registration File Specifications).

5. Reporting of Payments

a. For each service claim the requirements for FY09 will not change from those for FY 08 for reporting:

i. The charges of the community service agency for the service (per Medicaid regulation) as well as
ii. Other payments the community service agency has received for the service (third party payment, per Medicaid regulation), and
iii. Payments received by the agency from consumers.

b. Community Service Agency Charges: Medicaid regulations require the reporting of the agency's charges for the service.

c. Other payments for the service:
   i. Medicaid regulations require the reporting of other third party payments for the service.
   ii. For non-HFS/Medicaid eligible consumers:
      a. DHS/DMH is still completing the analyses of the Coordination of Benefits impact for providers; this analysis is still expected to inform DMH of any additional action or adjustments that should be made.

d. Payments received by the agency from consumers
   i. As in FY08, DHS/DMH and the Collaborative will not require that community service agencies report amounts billed to or paid by consumers for their services, and any such payments reported will not impact the amount DHS/DMH or the Collaborative pays the agency for the service. (Note: Please remember that Medicaid regulations prohibit charging consumers for services paid for by Medicaid.)
   ii. However, consumer household income and size must still be reported as part of the consumer's registration information, and this information will be used in the future to adjust the rate DHS/DMH will pay for a service.

6. Section E Services (W Codes) for Capacity Grants

Purpose of W Codes

a. The transition to fee-for-service identifies the specific services that an individual receives, but there remains a parallel need to demonstrate more specifically what activities, services and supports are being secured through the DHS/DMH funding for capacity grants. The W Codes are part of DHS/DMH's effort in this regard. The use of these W codes will permit electronic reporting of services and activities supported by capacity grants (rather than the paper reporting to Regional Offices currently in place for some capacity grants), and the integration of this reporting with fee-for-service billings.

b. These codes are still in development, with the codes presented for FY09 as the product of discussions with providers and DMH staff that have been able to be conducted to date.
   i. Over the next several months, additional codes and modifications of W Codes should be anticipated.
   ii. More detailed definitions are currently being drafted for the W Codes.

c. Each of these services is presently valued at $1 to simply allow integration and utilization of the Collaborative's billing and reporting system, which requires that a fee be associated with

all reported services. Establishment of differential rates for these services may be considered in the future.

When should community service agencies begin using/reporting the W Codes?

a. i. They are **required immediately--**As was the case last fiscal year, DHS/DMH expects providers of residential services to report consumers in their residential settings. Under the ROCS system, this was reported as "nights of care." In the FY09 Collaborative's billing and reporting system these "nights of care" are to reported as "Residential Service: per diem service", or codes W00R1 (CILA), W00R2 (supported residential), W00R4 (supervised residential), W00R5 (crisis residential). Reporting should be based on the current program number assigned to the residential setting (e.g., 820, 830).

ii Last two digits of W codes correspond to old DMH activity codes, so reporting for service previously defined may continue as previously.

iii. Providers will not be expected to report using the new W Codes that have not been defined until DHS/DMH has provided specific definitions for these codes and instructions to begin reporting (as noted in the FY09 Provider Contract).

b. It should be noted that the same functionality for the provider and for DMH described for Program Codes earlier also is applicable to the use of W Codes. That is, the use of W Codes could be helpful to community service agencies in calculating and reconciling costs for programs, and to DHS/DMH in demonstrating accountability for funding. It will also help track staff time or other resources in providing services and thus in reconciling expenses for capacity grant programs.

7. Group Numbers, Number of Consumers and Number of Staff Participating in Groups

These fields are required for all group procedure codes reported by providers. DMH needs a methodology to monitor information regarding these services that are provided to consumers. DMH understands that this information will be "rolled up" into one claim for the same procedure code (services reported for the same consumer, on the same date by the same staff level of provider).

8. Staff ID

Staff ID has been added to the Direct Data Claims Entry Software and to the EDI claims software at the request of providers attending the MIS training provided in June 2008.

Additional Questions Posed by Providers During the 8/19 Call

Registration Questions

Q: How should we set up our software to ensure that we update registrations every six months?
A: every 180 days would work.

Q: What are the fields on the registration that must be updated?
A: DMH and the Collaborative will provide a list in the next several weeks. The updated fields will be related to outcomes such as employment.

Q: Can we pull up a client registration and just enter a change of address?
A: You should be able to modify a field without submitting an entire registration for new registrations submitted to the system designed by the Collaborative beginning in October. DMH will confirm the date.

Q: It is our experience that we have to hold registrations for at least a week before the Collaborative has the client and the appropriate RIN loaded on their system. Will this be the standard?
A: As you may know, we have requested that providers not submit registrations to ProviderConnect until September 2. The Collaborative has suggested that providers can review the various screens and become familiar with the entry of information, but registrations should not be loaded until September 2, 2008. The Collaborative downloads an eligibility file from HFS daily so their RINs and client information should be timely.

Q: Do you require the first field for each diagnosis?
A: Follow the same rules that were required for ROCS. The Collaborative screens will be revised in the near future.

Q: What do we put in the Social Security field that is one space wide?
A: Put Y or leave blank.

Q: Do we have to complete the guardianship information for all ICG clients?
A: No, it is optional.

Q: In the 302-303 position, there appears to be some words missing in the 6/27/08 version.
A: Yes, #11 should be adult parole.

Claims Questions

Q: Is staff ID required for claim reporting?
A: No, it is optional. The staff ID was added at the request of providers.

Q: When is the start date for submitting bills?
A: September 2, 2008

Q: What is the process for registering and submitting bills for ICG clients?
A: You should register ICG clients in both ROCS and ProviderConnect. Services should be billed through ROCS until DMH notifies you with different instructions. **This applies only to ICG clients.**

Q: How do we report nights of care?
A: Nights of care should be reported as "Residential Service: per diem service", or codes W00R1 (CILA), W00R2 (supported residential), W00R4 (supervised residential), W00R5 (crisis residential). Reporting should be based on the current program number assigned to the residential setting (e.g., 820, 830).

Q: Should we use Program 110 or 120 rather than ABC?
A: ABC should be used (see above).

Q: Do we use the program code when we bill for services under those programs, e.g., services in supported (820) or supervised residential settings (830)?
A: Yes.

Q: If we have the same service, same client, same level of staff, same day, and same location code if the provider has two different NPI numbers?
A: No, you submit separate claims.

Q: Do we roll up services that provided in the event mode differently from the 15 minute units?
A: You add the number of events in a day.

Q: Do we report face-to-face services for consumers only or does it apply to all face-to-face interactions?
A: All face-to-face services. .

Q: Should we report 120 services in addition to SASS services?
A: You should continue to bill services for SASS clients directly to HFS.

Q: If parents are in a two hour therapy group at the same time that their child is in a two therapy group, do we roll up those services to four hours of service, realizing that they are occurring at the same time?
A; Yes, if it is appropriate to bill for the services. There is an indicator on the file that shows that the claim was rolled up, and DMH will confirm that procedure.

Additional Questions from the September 2 and September 3 Teleconferences

1. If an individual who is **Medicaid eligible (has a Medicaid card)** presents for treatment, what steps should be taken to assure that he/she can be registered in the MIS that the Collaborative has implemented for DMH?

A. The first step should be to access the MEDI system to determine if the individual has been assigned a RIN and to determine if DHS Social Services Package B has been requested for the individual.

If the individual has a RIN, but DHS Social Services Package B as not been activated, the agency should submit a request through ERIN by entering "Activate DHS Social Services Package B in the note field.

2. If an individual is **not Medicaid** eligible what steps should be taken to assure that he/she can be registered in the MIS that the Collaborative has implemented for DMH

A. The first step should be to access the MEDI system to determine if the individual has been assigned a RIN and to determine if Social Services Package B has been requested for the individual.

If the individual does not have a RIN, the agency should submit an ERIN request for a RIN and a request to "Activate DHS Social Services Package B". The request to "Activate DHS Social Services Package B should be entered in the note field.

3. If we have not yet begun collecting information for the Cross-Disabilities Database, how should I complete the registration form?

A. DMH is required by legislation to collect information for the Cross-Disabilities Database. DMH understands that some agencies have not begun to collect this information systematically, however, there is an expectation that all community mental health agencies will begin collecting this information as of October 1, 2008. Agencies that currently collect the information should enter the appropriate values into the registration.

Agencies that will not begin collecting the information until October 1, 2008 should enter the following information until that time:

Cross Disabilities Data Form Completion Date: **01/01/1990**
Primary Age of Caregiver: Enter **99** Unknown
Type of Services Needed 1, 2 and 3: Enter **99** Unknown
Type of Services Needed Other: (Conditional—**leave blank**)
Type of Services Sought: 1, 2 and 3: Enter **99 Unknown**
Type of Services Needed Other (Conditional—**leave blank**)