

**Illinois Department of Human Services /  
Division of Mental Health  
and  
Illinois Mental Health Collaborative  
Present**

**Introduction and Training: MIS Services  
with the Collaborative**

*June 2008*

# Agenda

- Introductions
- DHS-DMH Overview Introduction
- ProviderConnect Overview
  - ProviderConnect Overview
  - ProviderConnect Provider Website Registration
  - Information Look Up
- Provider Registration of Consumers
- Process and Work Flows
- Electronic Claims and Service Reporting Submission

## Introductions

Mary E. Smith, DHS-DMH

Kathy Melia, Vice President of Operations

Cathy Doran, Manager, EDI Help Desk

Michael Wagner, Manager, Illinois Claims Processing

Michael Mulvany, Director, Provider Relations

Cathy Gilbert, Director, National Provider Relations

## Questions

- Cards to submit questions
  - Pass cards to aisle and staff will collect
  - Please submit only one (1) question per card
- Will answer today as feasible
- Questions and answers will be posted on the Web site
- Questions at end of each section and at the end of today's session, as time permits

# DHS/DMH OVERVIEW OF MIS TRANSITION

## Operational Timeline

- Begin Submission of Consumer Registration to the Collaborative 7-1-08
- Claims submission/Service Reporting for dates of service through 6-30-08
  - Continue to submit to DMH/ROCS for dates of service through 6-30-08
  - Submit to the Collaborative for dates of service beginning 7-1-08 (837P formats)

# ProviderConnect Overview



## Online Services with the Collaborative

- ProviderConnect
  - Free, online, secure application
  - Portal into the Collaborative MIS System (CAS)
  - Access via the Collaborative website
- Today we will review:
  - Provider registration and login process
  - Tools currently available

## ProviderConnect

### What is available in ProviderConnect?

- Available today:
  - Submit updates to provider demographic information
  - Submit inquiries to customer service
  - View authorizations
  - View and print authorization letters
  - Access and print forms

## ProviderConnect (cont.)

Coming Soon – July 2008:

- Register a consumer
- View consumer registration status
- Request for Services for ACT/CST
- Submit single and batch claims
- View the details and status of claims

# ProviderConnect

## What are the benefits of ProviderConnect?

- Easily access routine information 24 hours a day, 7 days a week
- Easily submit requests for service-ACT/CST
- Use the same web address:  
[www.IllinoisMentalHealthCollaborative.com](http://www.IllinoisMentalHealthCollaborative.com)
- Complete multiple transactions in a single sitting
- View and print information
- Reduce calls for routine information

## How to Access ProviderConnect

- All Providers will be able to obtain one online registration per provider ID number via the Web site
- Letter with auto-registration emailed to providers 6/9/08
- To obtain additional logons for ProviderConnect – contact the ValueOptions® EDI Helpdesk at (888) 247-9311 and press option 3, Monday through Friday, 8 a.m. – 6 p.m. EST
  - The TAT for additional logons in 48 hours
- Forms are included in your packets

# Provider Registration

- Demonstration of Provider Registration Process

# ProviderConnect

## ProviderConnect Demonstration

Step 1: Go to [www.illinoismentalhealthcollaborative.com](http://www.illinoismentalhealthcollaborative.com)

Step 2: Click on “Providers”

Step 3: Click on “Demo”

# Questions and Answers



**Please pass your note cards with questions to the end of the row to be collected.**

# The Collaborative's MIS System Consumer Registration

*June 2008*

## Enrollment Database

- Consumer Registration Information
- Consumer Data from the Department of Healthcare and Family Services
  - RINs, names and key demographic information
  - Status of Medicaid (Title XIX) and All Kids (Title XXI)
  - Status for DHS Social Services Package A
  - Status for DHS Social Services Package B

## Provider Data

- Provider locations, and service sites
- Services offered by site
- DHS/DMH funding for community mental health program and services

# Consumer Registration

*June 2008*

# Consumer Registration Training Agenda

- Overview of policies and procedures for new consumers
- Conversion of ROCS data
- Registrations of new consumers and updating registration of existing consumers
- MIS System Overview

## Conversion of ROCS Registrations

- Consumers whose treatment ended on or before June 30, 2008-do nothing
- New Consumers need to register with the Collaborative

# Conversion of ROCS Registrations (cont.)

All registrations through June 30, 2008 will remain active through December 31, 2008, after which time the registrations must be updated.

## What is Changing?

- Register the Consumer with the Collaborative
- Consumers' Social Services Package A and B status is checked during the registration process
- DHS/DMH will allow a 30 day retro-registration

## What is Changing? (cont)

- Consumers will be registered into all core programs for which you are contracted
  - Core Programs
    - 131 – Child/Adolescent Flex Funds
    - 213 – Consumer Centered Recovery Support
    - 350 – Psychiatric Leadership
    - 572 – Adolescent Transition to Adult Services
    - 574 – Psychiatric Medications
    - 860 – Crisis Residential
    - ABC – Medicaid and non Medicaid FFS

## What is Changing? (cont)

- You can register a consumer in the special programs for which you are contracted
  - Special Programs
    - 121 – Juvenile Justice
    - 550 – Community Hospital Inpatient Psychiatric Services
    - 575 – PATH Grant
    - 620 – CILA
    - 820 – Supported Residential
    - 830 – Supervised Residential
    - ICG – Individual Care Grants

## What is the same?

- You obtain a RIN for new Consumers through eRIN
- You submit a request for Social Services Package B to DHS

# The Collaborative's Enrollment MIS System

- The collaborative will receive a daily HFS Eligibility file-
  - Consumers with Social Services Package B can be registered for all programs
  - Consumers eligible for SASS (Social Services Package A) can be registered for Juvenile Justice only; once SASS is no longer in effect, you may register the consumer for other programs

## When You Register a Consumer

- The Consumer must have a RIN and be authorized for DHS Social Services Package B
- The Consumer will be automatically registered for core program codes for which you are contracted
- You will have the opportunity to register the Consumer for additional special programs for which you are contracted

## Registration Updates

- Registration must be updated every 6 months

## Special Program End Date

There is a separate end date for special programs

- If you enter an end date for a special program that is less than 6 months from the registration start date, the consumer will be terminated for that special program only on that end date.
  - Example: Registration Start Date is 1/1/09 and special program PATH Grant is selected with an end date of 3/30/09, the consumer will be registered for core programs effective 1/1/09 with an end date of 7/1/09 but the PATH Grant program will be end dated 3/30/09

## Closing a Registration

If you enter a MH Closure Date on the registration that is less than 6 months from the registration start date, the consumer will be terminated from all programs with the MH Closure Date

## New Registration Data

- MH Cross Disabilities
- LOCUS
- Evidence-Based Practice
- Consumer in Residential Program funded by DMH and operated by registering Provider
- Special Programs – Juvenile Justice, PATH Grant and CHIPS
- Consumer's Third Party Payer
- Guardian termination Date

## Registration Data Eliminated

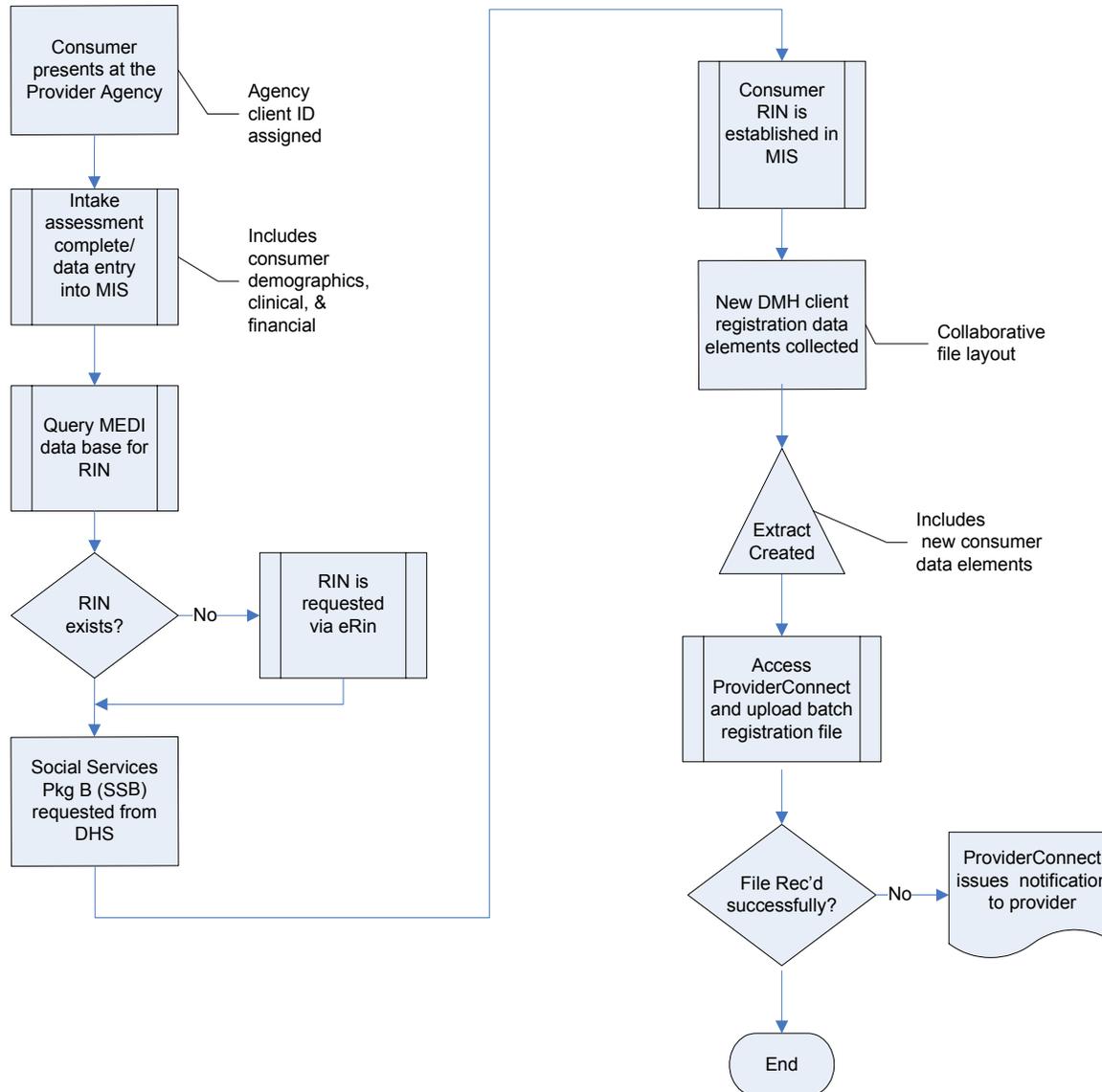
- Discharge – Linkage – AfterCare (DLA)/AfterCare (TLA) Meeting information at Discharge
- Discharge – Linkage – AfterCare (DLA)/AfterCare (TLA) agency Involvement in Discharge
- MCAS Functional Impairment – Adults
- CAFAS Functional Impairment – Child/Adolescent

# PROCESS / DATA FLOW

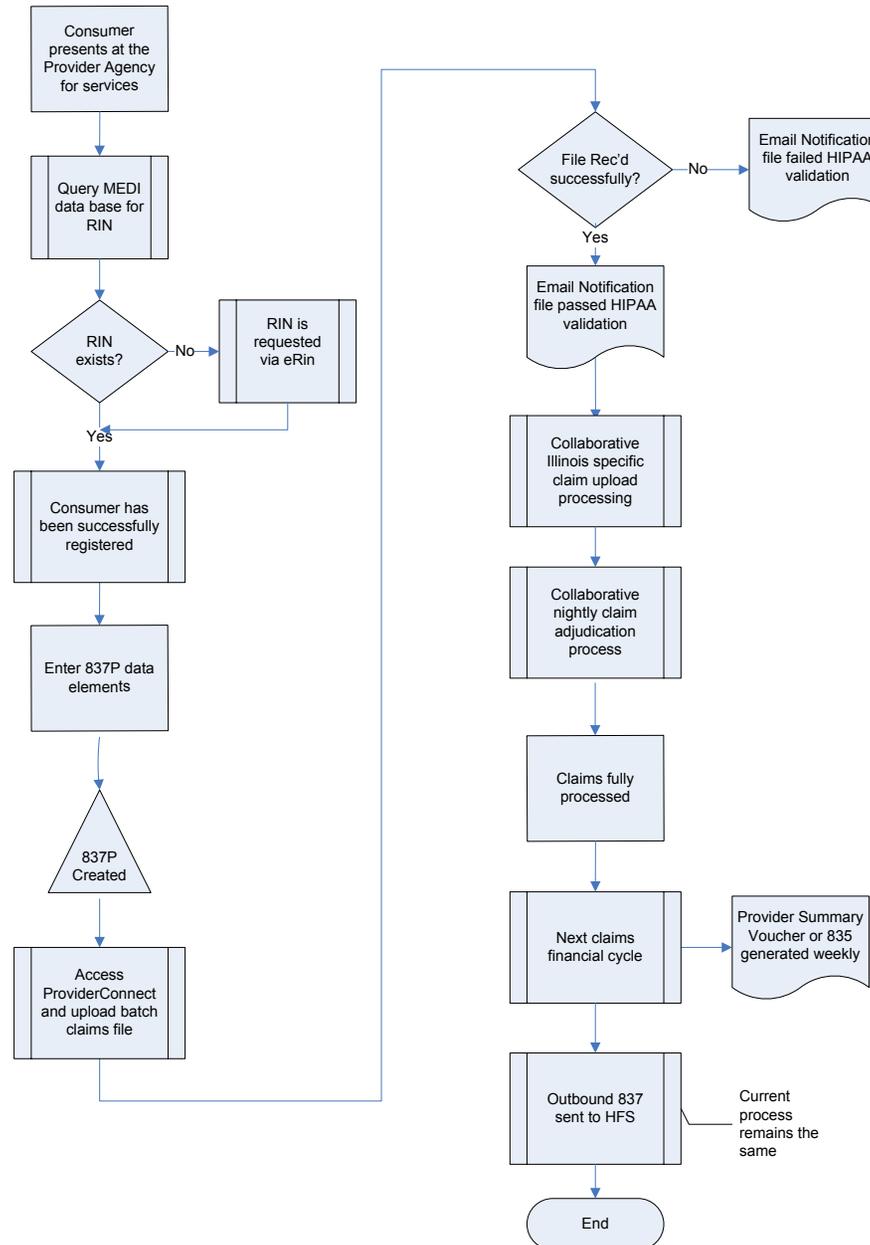
Registration and Claims



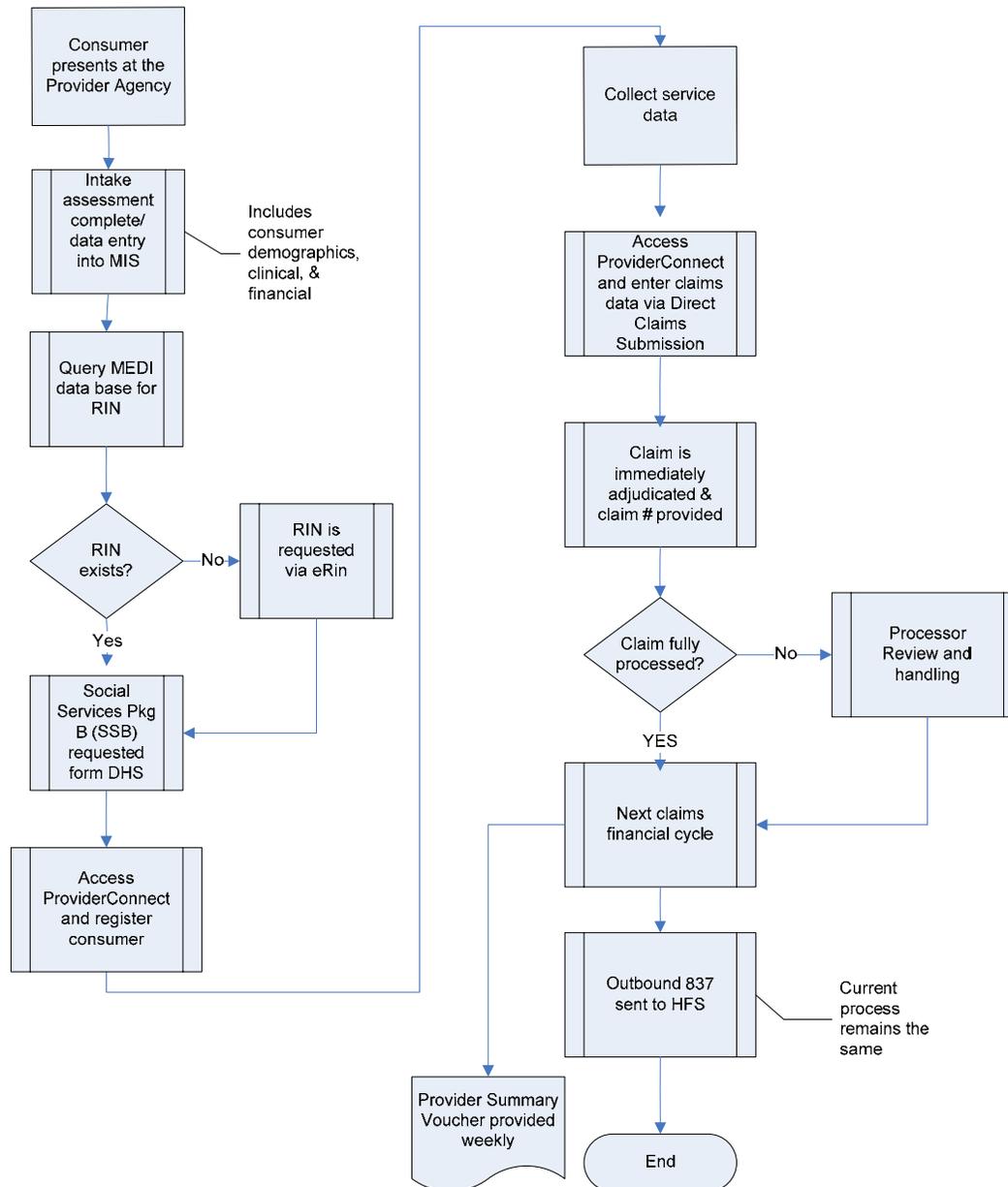
# Consumer Registration- Providers with Proprietary/Purchased Software



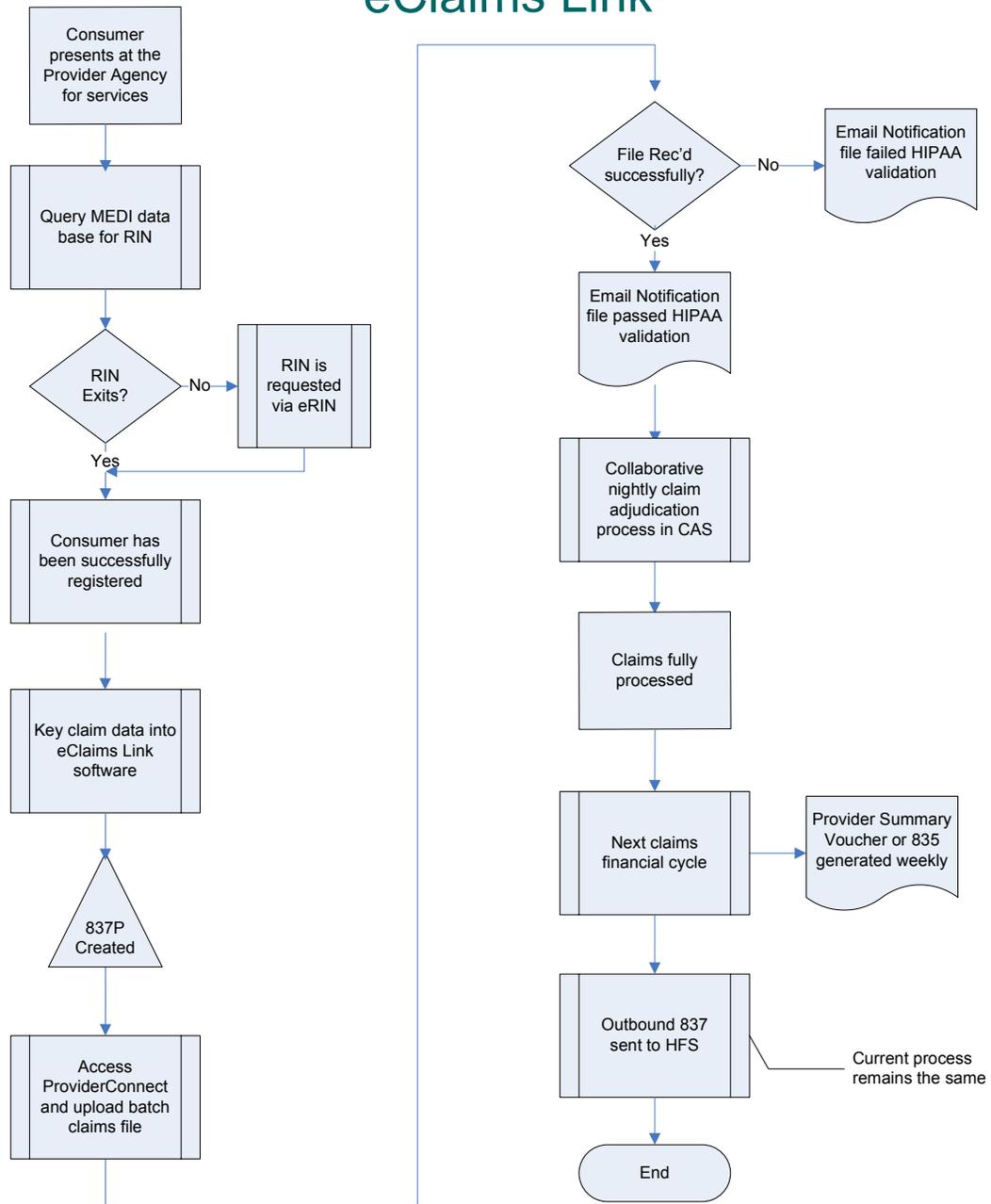
# Claims Submission – Providers with Proprietary/ Purchased Software



# Registration & Claims Collaborative Software – Claims Direct Submission



# Registration & Claims Collaborative Software – eClaims Link



# Claims Submission



## Claims and Service Reporting Training Agenda

- Billing and Service Reporting Guidelines
- HIPAA 837P Technical Information
- EDI Claims Set-up
- Claim Helpful Hints
- Billing with Psuedo-RINs
- Direct Claims Submission on ProviderConnect
- eClaims link on ProviderConnect

## Service Reporting

Under the Collaborative IT system, all service reports will be submitted as claims. This includes billable services (Medicaid and non-Medicaid) as well as what is currently known as "service reports only", which are typically associated with capacity grant programs.

## Claims Submission

Mental Health claims must be submitted electronically and meet all HIPAA compliance standards

- HIPAA standards govern both the file format and the codes used within the file
- Some claims require data elements for which there are no standard fields. The notes fields will be utilized for submission of these values

## Submission of Capacity Grant Claims

Capacity Grant claims will also be submitted electronically via the 837P file

- These claims are billed with non-standard codes
- To enable the submission of these claims within the same file format, we have additional guidelines for use of the notes on these claims
- Pseudo RINs can be used for some of these claims

## HIPAA 837P Software

The Illinois Collaborative will accept all HIPAA compliant 837P formatted files

Files must include all required DHS/DMH data elements

The Illinois Collaborative provides multiple ways for you to submit claims:

- Direct Claims Submission (web-based)
- Submission of any HIPAA compliant 837P file from proprietary or commercially available software, or
- eClaims Link (free software available through the Collaborative)

# Billing Guidelines

Required Claims Data



## Consumer Information

- Standardized claims transactions require certain consumer information to verify the individual's identity
- Some of this information matches what has been submitted in the registration process
- The Collaborative is working to minimize the consumer information necessary for a claim to be submitted while assuring that each service claim is correctly associated to the right consumer

# Claim Level Information

## Consumer Information Required

- RIN
- Consumer Name
- Date of Birth
- Gender
- All must match exactly to the registration information
- For claims for a non-identified consumer, each of these four data elements must be reported. The Collaborative will provide you necessary information.
- Consumer address is optional

## Claim Level Information

(cont.)

### Pseudo RIN

- Appropriate only for specific services when a specific consumer isn't identified, e.g. outreach and engagement or stakeholder education
- A list of these pseudo RIN numbers, name, and date of birth will be provided

## Claim Level Information

(cont.)

Provider Information you must submit for each claim

- Your 10 digit NPI number that matches a NPI we have on file
- Your Tax ID number
- The service location
- Taxonomy codes are optional
  - Service code and modifier combinations will identify staff level

## Claim Level Information

(cont.)

### Subcontractors

The Subcontractor's Federal Employer ID Number (FEIN) must be provided when subcontracting services to a different agency

## Claim Level Information (cont.)

### Program Codes

- Submit the Program Code under which you Provided the service
  - During claims adjudication, we will use the Service Codes, Modifiers, Place of Service, the Consumer's enrollment information, and your contract information to determine the program code for that service. There may therefore, be some circumstances when your billed program code may not match the program code under which the services are adjudicated

## Claim Line Level Information

### Claim lines

- Up to 99 service lines may be submitted per claim

### Service Codes

- Service codes must be valid HCPCS or CPT codes
- For Capacity Grant Services service code S9986 is billed as the service code
  - The specific “W” code that identifies the specific type of service will be entered in claim line notes (LOOP 2400)
- A separate list of Service Codes will be provided

## Claim Line Level Information (cont.)

### Modifiers

- Staff Level Modifiers drive the fee schedule applied to the claim
  - If no staff level modifier is submitted, the lowest fee schedule is assumed
- Modifier Position is very important
  - Staff Level Modifier should always be in the last modifier position when multiple modifiers are submitted

## Claim Line Level Information (cont.)

### Staff Level Modifiers

- AH – LCP - Licensed Clinical Psychologist
- HN – MHP - Mental Health Professional
- HO – QMHP - Qualified Mental Health Professional
- SA – APN -Advanced Practice Nurse
- HM – RSA - Rehabilitative Services Associate
- UA – MD, DO, DC

## Claim Line Level Information (cont.)

### Diagnosis Codes

- Must be ICD-9 and include 4<sup>th</sup> and 5<sup>th</sup> digit according to ICD-9 guidelines
- Only Mental Health diagnoses that are DMH/DHS defined will be accepted.

## Claim Line Level Information (cont.)

### Line Notes

For all services, the following are required:

- Delivery Method
- Service start time
- Service duration

### Situational Requirements:

- Activity code is required for Capacity Grant Services
- For group based services show the group id, # clients in group, and # of staff in the group

**DMH considers these data elements to be important and necessary components of billing and service reporting**

## Review Services Matrix

The Service Matrix provides the following information: Specific activities/services that are to be reported for Capacity Grant Programs, i.e., Section E services.

Information regarding the use of specific pseudo-RINS for consumers who are not identifiable (previously referred to as unregistered consumers).

This information will be posted on the Collaborative Website in an Excel Spreadsheet that you may download.

## Questions?



**Technical Information**  
**Third Party Software**  
**eClaims Link**



## Illinois Health Care Claim Companion Guide 837 Professional

HIPAA 4010 Version

The Companion Guide only applies to  
DHS/DMH specific services

- The same requirements apply for third party software as well as the Collaborative's free software
- The loops in this guide are in numerical order only to facilitate discussion

## Standard Implementation Guide

For complete technical information, please refer to the Standard Implementation Guide which contains the entire set of instructions for the EDI HIPAA 4010 version of the 837P. The Implementation Guide must be purchased.

- The sequencing of the loops should follow that specified within the Implementation Guide

## Consumer Information

- Loop 2000B- Consumer Information
  - DHS/DMH Program Code
- Loop 2010BA- Consumer Name
  - Name should be shown as it is in the enrollment system
  - RIN or Pseudo- RIN

## Billing/Pay to Provider Information

- Loop 2010AA- Billing Provider Name
  - Agency NPI (National Provider Identifier)
  - FEIN
- Loop 2010AB- Pay- to- Provider Name
  - Required if Pay-to is different than Billing Provider

## Purchased Service Provider/Service Facility Location

- Loop 2310C- Purchased Service Provider
  - FEIN is required when Subcontractor is used
- Loop 2310D- Service Facility Location
  - If not using a subcontractor, and the service location is different than Billing Provider location this must be completed
  - If Subcontractor is used, this field should be blank

# Questions?



## Claim Level Information

- Loop 2300- Claim Information
  - Individual ClientID | ClaimID
  - POS (Place of Service)
  - Assignment of Benefits
  - Diagnosis Codes
  - Claim Notes
    - Qualification Levels for staff
      - 01 = LPHA
      - 02 = QMHP
      - 03 = MHP
      - 04 = RSA

## Service Line

- Loop 2400- Service Line
  - Procedure code
    - For Section E (capacity grant services) services use S9986
      - Add appropriate W-code in note segment
  - Modifiers
    - Maximum of four modifiers, last modifier must be staff level modifier
  - Units
  - Date of Service
  - Line Control Number
    - up to 30 bytes

## Service Line (cont.)

- Line Notes
  - This field is used for various data needs. Please be sure to include the pipe (|) between the identifiers. If pipe does not work in your software you can use a semi colon (;).
    - W- code (non-standard codes for capacity grant services/Section E)
  - Delivery Method
    - Face to face
    - Telephone
    - Video

## Service Line (cont.)

- Time
  - Service begin date
  - Duration in minutes
- Group based services
  - Group ID
  - # clients in group
  - # staff in group

## Coordination of benefit information

- Loop 2320- Other Consumer Information
  - Other insurance information
    - Insurance Code
    - Carrier allowed amount
    - Carrier paid amount
- Loop 2330B- Claims adjudication date
  - Date of other insurance payment

# Submitting Corrected/Replacement Claims

LOOP 2300 – CLAIM INFORMATION

- When an original claim was denied or incorrectly billed, send a corrected or replacement claim by indicating the Claim Frequency Type Code
  - 6=Corrected
  - 7=Replacement
- Enter the Collaborative’s original Claim Number prefixed with “RC” in the Reference Identification

# Questions?



# Claims Helpful Hints



## Helpful Hints to Faster Claim Processing

- Submit the Consumer's RIN in the Patient ID field
  - if the RIN doesn't match the DHS assigned number, the claim will be uploaded to our claims processing system identifying the Consumer as "UNKNOWN" please submit the correct RIN

## Helpful Hints to Faster Claim Processing (cont.)

- To be in compliance with HIPAA Regulations, the National Provider Identifier (NPI) must be submitted on all claims. The Agency NPI should be entered into the NPI field
  - If the NPI is not on the claim, the file will be rejected
  - If the NPI submitted does not match the NPI we have on file for your agency, the claim will be delayed for resolution of the NPI discrepancy

## Helpful Hints to Faster Claim Processing (cont.)

### Examples

Agency has multiple sub-NPIs for various service locations in addition to the Agency NPI:

- Submit the Agency NPI in Billing Pay-to loop, enter the Service Location NPI in Service location loop
- All NPIs used on the 837P must be on file with the Collaborative

Agency has multiple sub-NPIs by Program.

- Enter Agency NPI in Billing Pay-to loop, Program NPI in Service location loop

## Helpful Hints to Faster Claim Processing (cont.)

When billing for specific services that allow or require a “pseudo- RIN” enter the pseudo RIN exactly as provided to you.

Also enter the pseudo-name and date of birth associated to the pseudo- RIN exactly as shown.

## Helpful Hints to Faster Claim Processing (cont.)

- A separate claim must be submitted for every different staff level rendering services (except for multiple disciplinary groups).
- ACT and CST services require an authorization. Please ensure the authorization is in place prior to submitting the claim, otherwise the claim will be denied.

## Most Common Reasons for Claim Denial

### Consumer Information:

- RIN doesn't match the RIN assigned by DHS or registration
- Service code on the claim is not on the list of covered service
- Service code billed is not one the provider is contracted to render (the service is not on the provider's fee schedule).
- Consumer's date of service is outside of the registration date in our system.

## Most Common Reasons for Claim Denial (cont.)

### Codes/Modifiers

- Service code is not a covered code
- Place of service code on the claim is not a valid place of service code for the service rendered
- Modifier code billed on the claim is not valid with the CPT or HCPCS code
- Staff level modifier is not billed on the claim
- Diagnosis code is not current ICD-9 standard
- Diagnosis code does not contain a required 4th or 5th digit

## Most Common Reasons for Claim Denial (cont.)

### Authorization

- There is not an authorization in the system for the date of service billed or for the provider
- There is an authorization on the system but the dates of service on the claim are either before the effective date or after the expiration date of the authorization

## Timely Filing of Claims

- Claims for all services must be received by the Collaborative within 365 days of the date of service
- Claims Involving Third Party Liability (TPL) must be received by the Collaborative within 365 days of the date of the other carrier's Explanation of Benefits (EOB), or notification of payment / denial.
- Timely filing limit applies to replacement claims as well as original claims; claims must be received by the Collaborative within 365 days from date of service.

# Billing with Pseudo-RIN



## Reason for Pseudo-RINS

The database has entries for pseudo consumers to be used for reporting services to consumers known in the current system as un-registered consumers. This helps to identify what populations (children/adolescents, adults, homeless persons) are served under capacity grants

<b>PSEUDO RIN</b>			<b>Not Homeless</b>		<b>Homeless</b>	
			<b>Child/ Adolescent</b>	<b>Adult</b>	<b>Child/ Adolescent</b>	<b>Adult</b>
<b>DMH Legacy Program / Fund Codes</b>		<b>Any / All Groups</b>				
<b>Mental Health Juvenile Justice</b>	<b>121</b>	<b>121000</b>	<b>121001</b>			
<b>Child and Adolescent Flex</b>	<b>131</b>	<b>131000</b>	<b>131001</b>			
<b>Urban Systems of Care</b>	<b>140</b>	<b>140000</b>	<b>140001</b>	<b>140002</b>		
<b>Consumer Centered Recovery Support</b>	<b>213</b>	<b>213000</b>	<b>213001</b>	<b>213002</b>		
<b>Psychiatric Leadership</b>	<b>350</b>	<b>350000</b>	<b>350001</b>	<b>350002</b>		
<b>Geropsychiatric Services</b>	<b>540</b>	<b>540000</b>		<b>540002</b>		
<b>Client Transitional Subsidies</b>	<b>572</b>	<b>572000</b>	<b>572001</b>	<b>572002</b>		
<b>Adolescent Transition to Adult Services</b>	<b>573</b>	<b>573000</b>	<b>573001</b>	<b>573002</b>		
<b>Psychiatric Medications</b>	<b>574</b>	<b>574000</b>	<b>574001</b>	<b>574002</b>		
<b>PATH Grants</b>	<b>575</b>	<b>575000</b>	<b>575001</b>	<b>575002</b>	<b>575011</b>	<b>575012</b>
<b>Co-location Project</b>	<b>576</b>	<b>576000</b>	<b>576001</b>	<b>576002</b>		
<b>Crisis Staffing Services</b>	<b>580</b>	<b>580000</b>	<b>580001</b>	<b>580002</b>		
<b>Crisis Residential</b>	<b>860</b>	<b>860000</b>	<b>860001</b>	<b>860002</b>		
<b>Specific Billable Activities</b>	<b>AB</b>	<b>C ABC000</b>	<b>ABC001</b>	<b>ABC002</b>	<b>ABC011</b>	<b>ABC012</b>

## Pseudo-RIN

- Example: if a provider is billing for Urban Systems of Care (Program Code 140):
- for a child or adolescent use Pseudo-RIN 140001
  - for an adult use Pseudo-RIN 140002
  - for a group of consumers, or not consumer related use Pseudo-RIN 140000

## Pseudo-RIN cont.

- Certain client information is required for all claims to help identify the claim for reporting purposes:  
Each Pseudo-RIN has a specific Pseudo-consumer name, date of birth (DOB), and gender:
- DOB used for Any/All Groups Pseudo – 01-01-1980
  - DOB used for Child/adolescent- 01-01-2000
  - DOB used for Adult – 01-01-1970
  - Gender is always U

## Pseudo-RIN (cont.)

- The provider should always use the most definitive Pseudo-RIN available for the program. For example, there is a different Pseudo-RIN for a child or adult who is homeless or not, under the PATH Grant program.
- The following programs will always be associated to a Pseudo-RIN. There will never be a consumer attached to these funds.
  - Urban Systems of Care 140
  - Geropsychiatric Services 540
  - Co-Location Project 576
  - Crisis Staffing Service 580

## Pseudo-RIN (cont.)

The following programs will never be associated to a Pseudo-RIN. Provider can only bill with true RINs for services in these programs:

CHIPS	550
ICG	ICG
CILA	620
Supported Res	820
Permanent Supported Housing	821
Supervised Res	830
Crisis Residential	860

# EDI Claim Submission DEMO

For all providers



## EDI Claims Set-up

Submit via <http://www.illinoismentalhealthcollaborative.com>

The same guidelines apply for all submitters regardless of the software used to submit a file

- All submitters must submit a completed Account Request Form
- Billing agents must also submit an Intermediary Form
  - Fax forms to 866-698-6032
  - Allow 2 days for your submitter account to be set up
  - You will receive an email with your ID and Password
  - You will be set up in test mode
  - After submitting a successful file, call to be taken out of test mode

## EDI Claims Set-up cont.

### Submit file

- 1<sup>st</sup> email from eSupport confirms receipt of file
- 2<sup>nd</sup> email from eSupport confirms pass/failure of file
  - If file fails email will give you the reason for failure

### EDI Helpdesk

- 888-247-9311
- M-F 8-6 EST

## Collaborative's Website for Claims Activities

- Access the Collaborative web site at [www.illinoismentalhealthcollaborative.com](http://www.illinoismentalhealthcollaborative.com)
- Select “For Providers” on the left hand side of the screen
- Access Handbooks – Administration- Online Services.
- Required Forms referenced in Online Services are available by accessing the forms menu on the left side of the screen
- EDI help is available from eSupport Services at 1.888.247.9311 (*Mon-Fri. 8am – 6pm Eastern*)

# Questions and Answers



**Please pass your note cards with questions to the end of the row to be collected.**

## Posting of the Presentation

Today's presentation will be available online

[http://www.IllinoisMentalHealthCollaborative.com/providers/Training/Training\\_Workshops\\_Archives.htm](http://www.IllinoisMentalHealthCollaborative.com/providers/Training/Training_Workshops_Archives.htm)

Be sure to share this information with your staff!

Thank you!

*Illinois Mental Health Collaborative for  
Access and Choice*

