#06-14-03

Bulletin

April 17, 2006

Minnesota Department of Human Services □ 444 Lafayette Road □ St. Paul, MN 55155

OF INTEREST TO

- County Directors
- Social Services Supervisors and Staff
- County Financial Workers
- Community Organizations
- MCHP Mental Health Providers
- MAXIS and MMIS Users

ACTION/DUE DATE

Please review for information and updates as discussed in bulletin

Expiration Date

The policies in this bulletin are ineffective as of April 17, 2008

Overview and Amendments for the DHS HIV/AIDS Division Mental Health Program

TOPIC

On March 1, 2005, the DHS HIV/AIDS Division announced the addition of a limited mental health benefit to its list of programs. (See Bulletin #05-14-01) This bulletin provides an overview of the Mental Health Program and discusses amendments to the benefit that become effective on April 15, 2006.

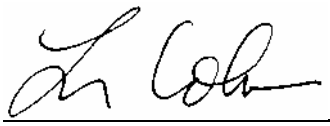
PURPOSE

This bulletin is to inform Minnesota Health Care Program (MHCP) mental health providers, community organizations and county workers of the existence of and recent revisions to the DHS HIV/AIDS Mental Health Program.

CONTACT

Dave Rompa, program director, at 651-431-2414 or toll-free in Minnesota at 1-800-657-3671

SIGNED



LOREN COLMAN
Assistant Commissioner
Continuing Care

Background

Mental health services have been available through the DHS HIV/AIDS Program (Program HH) since March 1, 2005. Since then, Program HH has experienced low utilization of its Mental Health Program. The program desires to increase the service activity of its mental health component. Accordingly, some benefits have been added and expanded upon to better serve client needs.

This bulletin serves as a reminder that Program HH has a limited mental health services benefit set that includes individual, group, family and couples therapy, and insurance co-payments. Group therapy guidelines and the procedures for mental health services access are detailed below.

Available Mental Health Services

The Program HH mental health benefit is a limited set of outpatient services which includes individual, group, family and couples therapy. *In addition, Program HH mental health dollars can pay the co-pays for mental health services that are covered by other insurance, including Medicare.* The enrolled client must participate in all sessions submitted for reimbursement. A complete list of covered services is posted at www.dhs.state.mn.us/hivaids.

Program HH encourages the use of group psychotherapy as indicated by a client's treatment goals. Guidelines for group therapy are as follows:

Group psychotherapy
Program HH covers two group sizes of group psychotherapy:

- Psychotherapy provided by one mental health professional for four to eight recipients
- Psychotherapy provided by two mental health professionals for nine to 12 recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting.

The group size applies regardless of the number of Program HH enrollees in the group. When a recipient participates in a group psychotherapy session conducted by two mental health professionals, the recipient's record must document that co-therapy is medically necessary.

When group psychotherapy is rendered by two professionals, the time billed can either be split between the professionals (i.e., an hour of group psychotherapy is rendered, each professional bills for 30 minutes) or the entire session can be billed under one therapist who will then reimburse the second professional.

Program HH covers a total of 78 hours per recipient per calendar year of group psychotherapy. Documentation must show how the group psychotherapy sessions applied to the recipient's treatment goals.

Group psychotherapy parameters:

- Psychotherapy groups can be conducted at or in collaboration with AIDS Service Organizations (ASO)
- A licensed mental health provider must conduct the group
- Faith-based programs meeting all other Program HH requirements are eligible to participate in this initiative
- If an agency's mental health provider is currently funded with any Ryan White CARE Act (RWCA) dollars, that staff person cannot be reimbursed under this program
- Current RWCA funding being used for Health Education/Risk Reduction cannot be combined with reimbursement for mental health therapy groups
- Therapy groups must adhere to current Program HH guidelines (i.e.: HIV status documentation, information needed to complete Prior Authorizations, etc.)
- A clear conflict resolution and grievance policy must be developed and shared with group members
- Therapy groups cannot be peer led
- A group psychotherapy session may be one hour, one and one-half hours or two hours in length.

Benefit Access

To meet the minimum requirements of the Program HH Mental Health Program, a person must:

- Be a resident of Minnesota
- Be HIV-positive
- Have an income under 300 percent of Federal Poverty Guidelines
- Have less than $25,000 in assets
- Be enrolled in Program HH and have selected the mental health benefit
- Have no mental health insurance, be able to document that current mental health coverage has been exhausted, or have mental health coverage that requires a co-payment.

All mental health services, including co-payments, must be granted Prior Authorization (PA) by Program HH prior to utilization. Providers must contact Jeff Buckles (651-431-2398) at Program HH to verify eligibility and to process the PA. Services are billable when provided through an enrolled Fee-for-Service Minnesota Health Care Program mental health provider only. A fact sheet on completing Prior Authorization forms and billing for mental health services is included with this bulletin. It can also be found on the program Web site at www.dhs.state.mn.us/hivaids.

The eligibility type in MMIS indicates the client's approved benefits through Program HH. A recipient may be on one or more of our five programs (Drug, Nutrition, Insurance, Dental or Mental Health). Mental Health does not have its own eligibility type, but is a MHCP Fee-for-Service program. To protect client confidentiality, "HIV" does not appear on any MMIS screen.

County workers, clinic staff and providers are urged to avoid using the term "HIV" when referring to these programs.

If you are a mental health provider not currently enrolled as a Fee-for-Service Minnesota Health Care Program provider, and you would like to provide services to Program HH clients, contact the Provider Enrollment Help Line at 651-431-2700 or 1-800-366-5411.

The DHS HIV/AIDS Program receives both federal and state funds. This program is administered, and eligibility is determined, on the state level by the personnel of the Department of Human Services HIV/AIDS Division only. The county financial worker's role in the operation of this program is solely to ensure coordination with other Minnesota Health Care Programs.

Training Opportunity

Program HH is hosting a provider training on Mental Health Program utilization. This training will cover topics ranging from mental health treatment referral strategies and identifying billable services to methods for working with mental health providers to address client needs and the establishment of psychotherapy groups. The training is designed for AIDS Service Organization staff, HIV support group managers and mental health providers. The training will be held on May 16, 2006 from 9 to 10:30 in Room 2370 of the Elmer L. Andersen Building in downtown St. Paul. (540 Cedar Street). To register, call Mary Dwyer at 651-431-2849 .

Additional Information

For more information on the completion of PA's and/or the billing of mental health services, visit the web site at www.dhs.state.mn.us/hivaids or contact Jeff Buckles at Program HH at 651-431-2398.

To enroll as a Fee-for-Service Minnesota Health Care Program provider in order to provide services to Program HH clients, contact the Provider Enrollment Help Line at 651-431-2700 or toll-free 1-800-366-5411.

Applications for Program HH are available at www.dhs.state.mn.us/hivaids and through many community and clinic-based programs throughout Minnesota. Applications are also available through the Program HH office at:

HIV/AIDS Programs
Minnesota Department of Human Services
PO Box 64972
St. Paul, MN 55164-0972
Metro (651) 431-2414
Statewide (800) 657-3761
Fax (651) 431-7448

For additional information about the Program HH Mental Health Program, or other programs administered by the DHS HIV/AIDS Division, contact Program HH at 651-431-2414 or 1-800-657-3761.

Special Needs
This information is available in other forms to people with disabilities by contacting us at 651-431-2414 (voice), toll free at 1-800-657-3761 or through the Minnesota Relay Service at 1-800-627-3529 (TDD), 7-1-1 or 1-877-627-3848 (speech to speech relay service).

Prior Authorization for Program HH Mental Health Services

Program HH will provide for limited outpatient mental health services for qualifying individuals. These services must be prior authorized by the Department of Human Services (DHS) Program HH. This program does not include coverage of mental health medication(s). This is not an entitlement program, rather it is operating on limited funds. Program availability may be limited or eliminated, dependent on the availability of resources. The mental health provider will be notified of the PA results, and instructed as to the number of sessions that have been prior authorized within 3 working days of receipt of the completed PA form.

To Be Completed by Mental Health Provider:

1 CLIENT INFO

CLIENT'S SOCIAL SECURITY #	DATE OF BIRTH	PMI #
1a	1b	1c

FIRST NAME	M.I.	LAST NAME
1d	1e	1f

ADDRESS
1g

CITY	STATE	ZIP	PHONE #
1h	1i	1j	( )1k

2 PROVIDER INFO

MENTAL HEALTH PROVIDER NAME (PRINT)	PROVIDER'S SIGNATURE / DATE
2a	2b

LIC#	ADDRESS / LOCATION
2c	2d

MINN. HEALTH CARE PROVIDER # (MA#)	PHONE	FAX
2e	( )2f	( )2g

3 DIAGNOSTIC & TREATMENT INFO

DIAGNOSTIC CODE(S): 3a 3b

☐ Initial PA
☐ Addl Req.

SERVICES	PROCEDURE CODE	# OF SESSIONS REQUESTED
INDIVIDUAL THERAPY	3c	3d
GROUP THERAPY / SUPPORT GROUP	3c	3d
FAMILY / COUPLES THERAPY	3c	3d
ADDITIONAL ASSESSMENT	3c	3d
	3c	3d

Fax completed form to: Jeff Buckles, Prior Authorization at 651-431-7448. If you have questions or need more information, please call 651-431-2414 or email Jeff at: jeff.buckles@state.mn.us

FOR DHS USE ONLY

☐ Approved notes: _____

☐ Denied _____

signature_____ date_____

How to complete the Program HH Mental Health Prior Authorization form

The form is divided into 3 parts. The first part is for client information, the second for Provider information, and the third for treatment information. All sections need to be as complete as possible; missing information will cause delays in processing.

SECTION 1 – Client Information
1a – Client's Social Security Number
1b – Client's date of birth
1c – Client's Minnesota Health Care Program ID, otherwise known as their MA number
1d,e,f – Client's first, middle and last name
1g – Client's street address including apartment or unit number
1h,I,j – Client's city, state and zip code
1k – Client's primary phone number – can be cell phone or home phone

SECTION 2 – Provider Information
2a – Provider(Therapist) name
2b – Provider's signature and date
2c – Provider's Minnesota License number – the license number from your professional licensure
2d – Provider's address – the address of the clinic or office where you will be seeing the patient
2e – Provider's Health Care Provider number (also known as MA number) THIS MUST BE INCLUDED!
2f. g Provider's phone and fax numbers that we can reach you at

SECTION 3 – Treatment info
3a – Diagnostic code – DSM-IV diagnostic code(s) for this patient
3b – Is this the first request for treatment (initial) or a request for additional treatment?
3c – Procedure code for treatment desired
3d number of sessions requested (each PA can be for up to 10 sessions; further sessions require a subsequent PA)

This form can then be faxed to Program HH at 651-431-7448 or 651-431-7414 or mailed to:

Department of Human Services
ATTN: Jeff Buckles
P.O. Box 67972
St. Paul, MN 55164-0972

Responses to requests are usually processed within 3 working days if all information requested is supplied. Missing information will slow the process. Questions can be addressed to Jeff Buckles, at 651-431-2398 or by email at jeff.buckles@state.mn.us

Submit requests for payment on DHS form 1863 , including the Prior Authorization number, to:

	P.O. Box 64166 St. Paul, MN 55164

Objective: ***Complete a MN–ITS Interactive 837P claim without third party liability (TPL) for Outpatient Mental Health***

Performed by: MN–ITS Users

Background: The process outlined below covers the required fields for the 837P (Professional) claim for individuals who do not have other insurance (third party liability, or TPL) in addition to MHCP coverage.

Using MN–ITS Interactive

- Complete all **bolded** (required) fields.
- Complete other (non-bolded, situational) fields as appropriate for your claim.
- Underlined items are linked to definitions and additional information about that item, including information about completing a field, code definitions for fields, or instructional information.
- Some fields are grouped together in “boxes” of associated information. Field titles with an asterisk (*) indicate that the information is “situational.” If you complete one asterisked field within a boxed section of a screen, you must complete all asterisked fields in that section of the screen.

Entering an Online Claim

1. Login to MN–ITS to reach the MN–ITS Welcome page. (Refer to the Login process, if necessary.)

2. Select **MN–ITS Interactive** from the left-hand menu to reach the MN–ITS Interactive Welcome page.

3. Hover over **New Claim** on the left-hand menu with your mouse to display the claim options menu.

4. Select **Professional (837P)** from the shaded menu to reach the online claim entry screens.

There are five online tabs on the MN–ITS Interactive Professional claim:

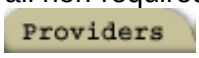
1. Subscriber
2. Providers
3. COB
4. Claim Information
5. Services

Completing the Subscriber Tab

Enter information relating to the subscriber (or recipient) on this tab.

1. Enter the 8-digit Subscriber ID from the recipient's MHCP identification card in the **Subscriber ID** field.
2. Enter the recipient's birth date in the **Birth Date** field. The birth date must match the birth date on the MHCP file. The format for entering the birth date is 2-digit month, 2-digit day, and 4-digit year (MMDDYYYY).
3. Enter the recipient's last name in the **Last Name** field.
4. Enter the recipient's first name in the **First Name** field.
5. Click the down-arrow in the **Gender** field to select appropriate option.
6. Enter the recipient's street address in the **Address** field.
7. Enter the city/town where the recipient lives in the **City** field.
8. Enter the state where the recipient resides in the **State** field. This should be **MN**.
9. Enter the recipient's zip code in the **Zip Code** field.

> ***Note:*** *The Address, City, State and Zip Code fields can be the recipient's current address, last known address or Post Office box.*

You may complete any and all non-required fields, as needed. After you complete the required fields for this tab, select the 

tab.

Completing the Providers Tab

This tab contains your organization's provider information in two main sections:

- BILLING PROVIDER: (Corresponds to Box 33 on the CMS-1500.) MN–ITS Interactive will auto-populate the required fields in this section of this screen with data entered during the MN–ITS registration process.
- OTHER PROVIDER TYPES: (Corresponds to Box 24K on the CMS-1500.) Complete this section based on your provider type and the service provided. Click the OTHER PROVIDER TYPES title to determine which fields you are required to complete. Information entered in the OTHER PROVIDER TYPES section of the Providers tab will be used to populate fields on both the Claim Information and Services tabs.

Most outpatient mental health providers must enter *rendering provider* information on all claims. To do this:

1. Scroll down to the OTHER PROVIDER TYPES section of the Providers tab.

2. Select **1D** (Medicaid Provider Number) from the drop-down menu in the **Provider Number Type** field.

3. Enter the 9-digit MHCP Provider ID of the rendering provider in the **Provider ID** field.

4. Enter the last name of the treating or supervising Mental Health Professional in the **Last or Organization Name** field.

5. Select **Rendering** from the drop-down options in the **Provider Type** field.

6. Enter the first name of the treating or supervising Mental Health Professional in the **First Name** field.

7. Enter the rendering provider's federal or state tax ID number or social security number in the **Primary ID** field.

8. Click the Save button located at the top of the OTHER PROVIDER TYPES section to save the rendering provider information. Saved title information will appear immediately under the OTHER PROVIDER TYPES heading. If you do not save this information, it will be lost.

A blue dot indicates the line of information on display in the OTHER PROVIDER TYPES fields. If you add more than one other provider type, a letter-number indicator of P1, P2, etc. would be used to indicate each other provider type added.

- ***To add additional entries***, click the New button to clear the fields and add your additional information. When you save a second entry, a second line of information would appear under the first line of information. The blue dot would then be located at the second line of information, and there would be an underlined P1 next to the first line of information where the blue dot currently exists.
- ***To delete an entry***, click on the number of the line you want deleted. The blue dot should move to that line. Click the Delete button.

Skip the COB tab for claims without TPL and select the 

tab to continue.

Completing the Claim Information Tab

The Claim Information tab contains claim level information. Many of the required fields on this tab are defaulted to the most common responses. The **Total Submitted Charges** field is displayed but cannot be altered. That field will populate after you enter the line information on the Services tab.

1. The **Place of Service** field is defaulted to 11 (office) and can be changed as needed to reflect the appropriate Place of Service code to apply to the entire claim.

2. Enter the **Patient Account Number** in the field of the same name. The Patient Account Number is a unique alphanumeric code you assign, which can be 1-38 characters in length. This number will appear on your Remittance Advice.

3. The following are required fields with generally accepted defaults. Review each defaulted section for accuracy and adjust as needed.

    a. The **Medicare Assignment** field indicates whether or not you accept assignment. Because MHCP requires you to accept assignment, Option A is the default.

    b. The **Submission Code** indicates if you are filing an original (1) or replacement (7) claim. You may only replace a paid claim, even if the claim pays at zero. If a previous claim denies, re-submit the claims as an original claim. The default value is 1 - Original.

    c. The **Benefits Assignment** field uses a yes/no response to indicate that a third party payer authorization is on file in your office allowing you to bill for the recipient. Yes is the default selection.

    d. The **Release of Information** field indicates whether or not you have a release of information on file from the recipient. The default response is A for appropriate release of information.

    e. The **Provider Signature on File** field requires a yes/no response to indicate that you have a signature on file acknowledging the performance of the service and authorizing you to bill for those services. Yes is the default response.

4. Enter the appropriate ICD-CM-9 diagnosis code in the **Diagnosis Code** field.

5. Click the A button to add the diagnosis code. Codes will not be visible unless you click the down-arrow in the second diagnosis code field to see your entry.

6. Add any additional diagnosis codes in order of importance to a maximum of eight.

7. When appropriate, enter the prior authorization number in the **Authorization Number** field.

8. Click the down-arrow in the **Additional Dates field** to select **Onset of the Current Illness**.

    a. Enter the date of the original mental health diagnosis or the date of the completion of the most recent diagnostic assessment in the **Date** field.

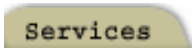
    b. Click the A button to add the date. The date and code will populate in the box directly below.

9. If a psychological test was performed, enter the name of the test from Buros' Mental Assessments Handbook in the **Additional Notes** field.

10. Scroll down to the CLAIM LEVEL PROVIDERS section to add rendering provider information for the entire claim.

11. When appropriate, select the down-arrow in the **Rendering** field to view the list of rendering providers that you entered on the Provider tab.

12. Click the appropriate name from the list. (If there are several rendering providers, you will enter that information at the line level on the Services tab.)

Select the  tab to continue.

Completing the Services Tab

The Services tab contains the line item information.

1. Enter the actual date that services were provided in the **From Date** field in MMDDYYYY format. You do not need to complete the **To Date** field because Mental Health Services are billed as single Dates of Service. You may only bill for services provided within the same calendar month.

2. Complete the **Place of Service** field on the service line to indicate a different place of service than indicated on the Claim Information tab.

3. Enter the appropriate code in the **Procedure** field.

4. Enter modifiers when necessary in the **Modifiers** field. If you have a Prior Authorization, the modifiers on the service line must match your Prior Authorization.

5. Complete the **Diagnosis Pointers** field by relating the diagnosis to the procedure code with a Diagnosis Pointer when appropriate. This enables MN–ITS to read the diagnosis code that was entered on the Claim Information tab. The Diagnosis pointer reflects the order of the diagnosis codes on the Claim Information tab. If you had entered multiple codes, you would have to remember the order of the diagnosis code entry, and then select the appropriate pointer here. You may have more than one Diagnosis Pointer per entry. Enter the most relevant diagnosis first in the Diagnosis Pointers field.

    a. Click the down-arrow in the Diagnosis Pointers field.

    b. Select the appropriate pointer number (1-8).

    c. Click the A button to add the pointer number. (The pointer number is not visible unless you select the down arrow in the second Diagnosis Pointer field.)

6. Enter the total dollar amount you are billing for the line item in the **Charge** field. Multiply your usual and customary charge by the number of units you are billing for to get the total dollar amount for the line item. The decimal point will right-justify if not entered, so if you want to enter $10.00, you could enter one followed by zero (10). Entering a one and three zeroes would result in a $1,000 charge.

7. Enter the number of units charged in the first **Units** field. This field has two parts: the number of units and the unit type. The first field located just below the field title contains the number of units you are billing for. The second field located below the number of units is the field type. The default response is UN for units.

8. When appropriate, scroll down to the SERVICE LEVEL PROVIDERS section, which is completed when you are billing for multiple services and are required to enter a different individual rendering provider for each line item billed.

a. Select the down-arrow in the **Rendering** field to view the list of rendering providers that you entered on the Provider tab.

b. Click the appropriate name from the list.

c. Save the line item.

Note: If your rendering provider is the same for all services being billed, select the rendering provider on the Claim Information tab and skip the SERVICE LEVEL PROVIDERS section.

9. Move to the top of the screen and review this tab to ensure that you have completed all required fields.

10. Click the Save button to save the line item. Saved line information is visible next to the blue dot (P1). You may enter a maximum of 50 lines of service per professional claim transaction.

- ***To add additional lines***, click the New button to add an additional line (P2) and clear the fields on the screen.

- ***To delete a line***, click the Delete button to delete the line item next to the blue dot.

11. Repeat Steps 1 – 10 until all line items are entered.

Validating and Submitting Your Claim

Validate your claim after completing the necessary tabs to:

- Ensure that you have completed all required HIPAA-compliant fields; and
- Verify with DHS that your claim information will be submitted and returned to you with the appropriate edits.

To validate your claim:

1. Click the Validate button.

2. Review the validate response to ensure the claim information is correct. Check the Claim Status Category Codes and Claim Status Codes for edits, which will determine if any corrections may be needed.

3. Close the validate response and make any necessary changes based upon your validation response.

4. Click the Validate button for your new validate response.

To submit your claim to DHS:

1. Close the validate response.

2. Click the Submit button. Within seconds, you will receive a Claim Response similar to the Validate Response in appearance.

Your claim is now complete. You have the option of copying the claim, beginning a new claim or logging out of MN–ITS.

Copying a Claim

After you have submitted a claim, you may choose to copy a portion or an entire claim. This can save you time if you have multiple claims for the same individual or the same exact claim for multiple recipients.

1. Click the Copy Claim button from the Claim Detail or Claim Response screen.

2. Select the appropriate button to select which screens you want to copy. You may choose all tab screens or individual tab screens to copy.

3. Click the Submit button at the bottom of the Copy Claim Options screen to return to the Subscriber tab to begin your next claim.