



MHD Intranet

RSN Inpatient Claims

INTRANET DISPUTE SYSTEM

Instructions

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Administered by the Department of Social and Health Services

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Overview

What is it?

The Mental Health Division RSN Dispute System is a Web-based system designed to assist the RSN in re-assigning claims to another RSN once a claim has been paid by the Medicaid Management Information System (MMIS) System. Use of the RSN Intranet Dispute System does not change the MMIS system information.

Prior to September 2006, Hospital Billing Instructions (MAA Numbered Memorandum 01-03, Inpatient Clarification Memorandum, Claims Assignment Guidelines, Hospital Appeals and RSN Reassignment Guideless were incorporated as an exhibit to the PIHP or SMHC.

Beginning August 2007, Hospital Billing Instructions included Psychiatric Inpatient Instructions incorporating MAA Numbered Memorandum 01-03, Inpatient Clarification Memorandum and Hospital Appeals. This information is now located on HRSA's website. Community Inpatient Psychiatric Authorization Information and RSN Reassignment Guidelines are located on the MHD Intranet and are incorporated into contract under PIHP Section 10.2.10 and SMHC Section 9.2.10

General Information

- 1) Inpatient hospital admissions are traced from the point of evaluation (of a person's need for such care) to the final cost for that admission
 - ◆ Refer to the RSN Community Inpatient Psychiatric Authorization Instructions.
- 2) Hospital Billing Process---dictated by WAC and Billing Instructions
 - ◆ Copy of the current hospital billing Instructions is available on the MHD web page.
- 3) MMIS Payment System—dictated by CMS, WAC and Billing Instructions
- 4) Mental Health intranet reporting (Began in 3/98);
 - ◆ the assignment by algorithm was corrected in 5/99
 - ◆ RSN Claims Reassignment Guidelines agreed upon in 5/01
- 5) Final reconciliation by MHD including resolved RSN to RSN disputed claims available in Community Hospital Reports. The following Community Hospital Utilization reports are available to assist in claims review:
 - ⇒ Community Hospital 18 Month Historical Utilization Report (month of service)
 - ⇒ Community Hospital 18-month Utilization Report (month of service)
 - ⇒ Community Hospital MOP Historical Utilization Report (month of payment)
 - ⇒ Community Hospital MOP Utilization Report (month of payment)

RSN Inpatient Claims Dispute System Instructions

Inpatient Claim Process

- ~ Please refer to the HRSA Hospital Billing Instructions or the Community Inpatient psychiatric Authorization Information.

Hospital Claim Billing

- ~ Hospital bills are submitted to HRSA (formerly Medical Assistance Administration) with supporting documentation.
 - ⇒ Hospitals must bill within 365 days.
 - ⇒ Hospitals may submit interim bills, depending upon their billing cycles.
 - ⇒ Claim adjustments can occur indefinitely.
 - ⇒ Hospital claims will be denied if they lack the required authorization and/or supporting documents
 - ⇒ RSNs do not have fiscal responsibility for hospital claims for persons determined not to be eligible for Medicaid or state support, irrespective of RSN certification of that person's need for hospitalization.

Hospital Claim Payment

- ~ MMIS adjudicates hospital claims based upon eligibility, proof of RSN authorization/certification and any supporting documents
- ~ MMIS does NOT cross match RSN authorization number with Recipient county or CSOR
- ~ Since MMIS processes and pays interim claims,
 - ⇒ the time between bills may potentially result in a change in the CSOR
- ~ MMIS has an indefinite claims adjustment period
 - ⇒ which may also result in a change in CSOR

MHD Claim Assignment to RSN

- ~ Each month MHD receives a download file that contains all claims process during the most recent 36 months.
 - ⇒ Billing lag factors affect the claim history available at any given time.
- ~ MHD IT staff import the tape into MHD's Client Information System (CIS). The import is restricted to the previous 30 months of billing data.
- ~ Beginning May 1999, the MHD has employed the following algorithm (**based upon RSN consensus**) to assign claims to an RSN.
 - ⇒ Recipient county
 - ⇒ RSN authorization number
 - ⇒ For claims assigned to a statewide CSO, the MHD assigns based upon the RSN authorization number.
 - ⇒ For claims assigned to a statewide CSO that do not have an RSN authorization number (Medicare crossover claims and ITA claims prior to 1/1/99), recipient zip code is utilized to assign the claim.
- ~ Medicare crossover claim costs (coduct payments) are the responsibility of the RSNs as of 7/1/01 per legislative action.
- ~ Assignment of a claim is based on the CSO of record on the first date of service.

RSN Review of Community Hospital Report

- ~ A 3-year history of eligibility periods by consumer is available on the MHD Intranet to assist in the determination of the RSN responsible for the hospital claim
- ~ The community utilization report is generated by CIS for each RSN.
 - ⇒ The utilization reports is a list of claims that have been paid through MMIS and assigned by MHD.
- ~ RSN reviews the community hospital utilization report against their known inpatient authorization activity and determines if claims are assigned correctly.
- ~ If the RSN thinks the claim is assigned incorrectly, the claim may be disputed to the appropriate RSN via MHD's Intranet Inpatient Dispute System.

RSN Inpatient Claims Dispute System Instructions

- ⇒ RSN analysis shall incorporate the above agreed upon algorithm;
- ⇒ In order for the claim to be transferred from one RSN to another the claim must be accepted.
 - If the claim is not accepted, the original MHD assignment of the claim is considered final
 - MHD does not reassign claims because of non-response
- ⇒ Claims with month of service (first date of service) prior to September 2006 must be finalized (disputed and accepted) prior to the 24th day of the end of the 18 month reconciliation period for that claim month of service.
- ⇒ Claims with month of service (first date of service) after to August 2006 will be reflected in the month that the claim is accepted.
- ⇒ Re-assigned claims shall be reflected in the preliminary Community Hospital Utilization report
 - as a "Removed *RSN ID*"
 - Medical X
 - Detox X
 - X RSN
- ⇒ For month of service (first date of service) prior to September 2006, billings which may result due to re-assignment of a disputed claims shall be the responsibility of the RSNs and will not be included in MHD's Intranet information.
- ⇒ MHD Intranet Resources for Assisting In Evaluating Inpatient Claims Responsibility:
 - ✓ Local MIS Service Records
 - ✓ TXIX Historical Eligibility Download File From MHD Intranet
 - ✓ Detailed MMIS Information Download From MHD Intranet
 - ✓ UB92

Hospital Appeals

- ~ Beginning 7/01/01 the MHD established a dispute resolution process to address unresolved disputes between a hospital provider and an RSN(s) regarding payment authorization for all or a portion of a hospital stay.
 - ⇒ The MHD resolution process will be conducted in accord with procedures published in the Hospital Billing Instructions and Community Inpatient Psychiatric Authorization Information on the MHD website.

RSN Inpatient Claims Reassignment Guidelines

- ~ Please refer to the Reassignment Guidelines located on the MHD website.



MHD Intranet

SYSTEM NAVIGATION



MHD Database

Obtaining Intranet Access

- Contact MHD Intranet Help, MHDIntranetHelp@dshs.wa.gov . Include the e-mail and phone number of the person requesting access...
- Description of the problem and include the problem page URL
- If is a request for data, include, a list of all the data elements being requested,
- Allow two working days for the MHD IT to assess the request and to estimate when/if your request can be fulfilled.

Or use the MHD Web Site



MHD Database

Logon

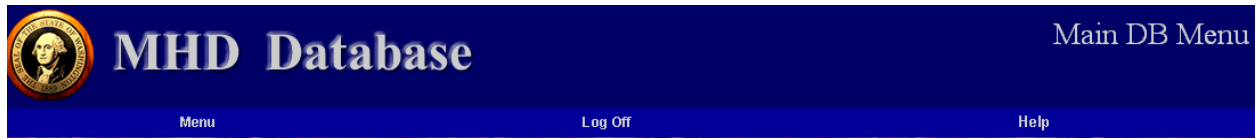
 Enter Login ID and Password

- ~ If you have forgotten your password, Contact MHD
 - o Intranet Help, MHDIntranetHelp@dshs.wa.gov .

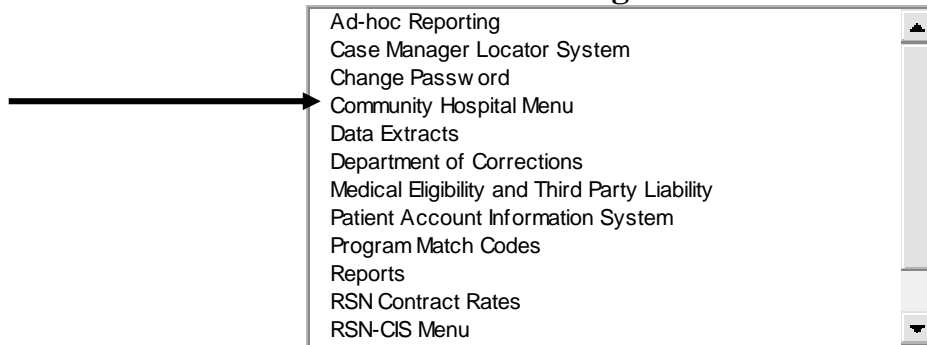
Community Hospital Navigation

MMIS Claim information is downloaded once per month. The download files contain all claims processed during the most recent 36 months. MHD IT staff import 30 months of the data into the Client Information System (CIS).

Agreed upon RSN changes to claims assignments are entered into the MHD Intranet Inpatient Dispute System. Review of changes/notes is available to view upon entry. Actual reassignment of the claim is available to review on the Utilization reports. Utilization reports are updated (refreshed) once per week with RSN dispute changes only.



**Your administrator has granted you access
to the following menu choices.**



 Select Community Hospital Menu to research claim information

Community Hospital Claims System Menu

Accept Community Hospital Claims option is used to

- Dispute/Accept a claim

- Enter explanation for decision

- Review list of claims redirected by your RSN (up to 18 months displayed)

- Review list claims accepted by your RSN (up to 18 months displayed)

- Review list of claims redirected to your (up to 18 months displayed)

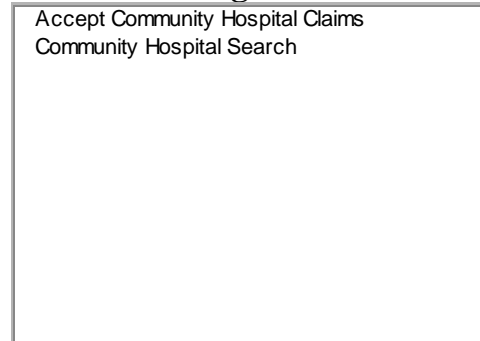
Community Hospital Search option is used to

- Search for client information (available up to 3 years)

- Review detailed claim information

- To obtain a PIC or date of service

Your administrator has granted you access to the following menu choices.



Search menu is used for detailed claims information for both Month of Service and Month of Payment

 Select Community Hospital Search

RSN Inpatient Claims Dispute System Instructions

~ Looking up a Claim.

- Enter all or part of Criteria (Last Name, SS#)
 - o Claims with Diagnosis codes outside of the approved range are not charged to the RSN and do not need to be disputed to MHD. Review Community Hospital Report, removed claims are marked as Medical X or Detox X.

Enter all or part of Criteria (Last Name, SS#)

Billing Records for

Name	Birth Date	Gender	SSN	Zip Code	Original Recipient ID (PIC)
Doe, Jonathan	XX/XX/XXXX	Male		99216	XXXXXXXXXXXXXX

Use Radio Button to select claim to review

Billing Detail

Status	Charged to SP-Spokane RSN
Transaction Control Number	30616555992004616
Dates Of Service	03/25/2006 - 03/29/2006
DRG Code	430
Program	M - PII (Psychiatric Inpatient Indigent)
Match	G - Regular Medical Care
Medical	0
Recipient County (CSO)	058 - CSO - SPOKANE/EAST VALLEY
CSO of Record (Current CSO)	058 - CSO - SPOKANE/EAST VALLEY
Prior Authorization	882048810
Initial RSN Assignment	SP - Spokane RSN
Proc Group Code	19
Provider Number	00003500022 - Sacred Heart Medical Center

RSN Inpatient Claims Dispute System Instructions

Total Claim Charge	6640.29
Total Allowed	1845.7
Third Party Liability Amount	0
Recipient Responsibility	0
Paid By Medicare	0
Reimbursement Amount	1790.33
Diag01	296.33 - RECUR MJR DEPRESSIVE SEVERE
Diag02	301.6 - DEPENDENT PERSONALITY
Diag03	493.90 - ASTHMA UNSPECIFIED
ITA Indicator	Voluntary
Provider Type	64
Claim Input Form Indicator	R
Provider Spec	86

Billing Detail Description

Following Fields are populated from CIS

Status

- ⇒ Charged to RSNID – RSN Full name
 - CIS assigned via algorithm (CSO)
 - ☐ appears on the Community Utilization report in the “status” field as blank or X-RSN Claim (if charged not charged to your RSN)
- ⇒ X-over - not charged to RSN
 - CIS discovers crossover claim, MHD assigns based on algorithm
 - ☐ appears on the Community Utilization report in the “status” field as blank
- ⇒ Accepted
 - CIS discovers crossover claim, MHD manually assigns
 - ☐ appears on the Community Utilization report in the “status” field as Accepted RSNID or Removed RSN ID

Initial RSN Assignment

- ⇒ Charged to RSNID – RSN Full name
 - MMIS Assignment

Following are populated from MMIS downloaded file:

Transaction Control Number,
 Dates of Service
 DRG Code
 Program, Match, Medical
 Recipient County (CSO)
 CSO of Record (current CSO)
 Prior Authorization
 Proc Group Code
 Provider Number
 Total Claim Charge

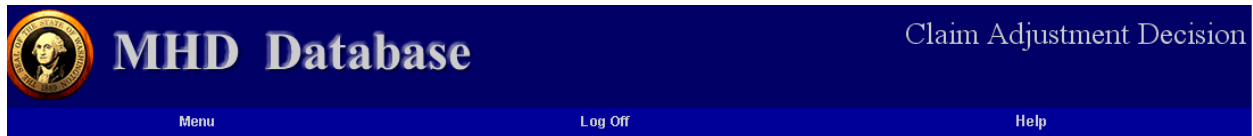
Total Allowed
 Third Party Liability Amount
 Recipient Responsibility
 Paid by Medicare
 Reimbursement Amount
 Diag01,Diag02,diag03
 ITA Indicator
 Provider Type
 Claim Input Form Indicator (Claim Type)
 Provider Spec (Provider Specialty)

:

Month of Service Dispute System

Use this system to dispute a claim with month of service prior to August 2006.

- Claim with disputes for month of service after August 2006 will appear on the Community Hospital MOP Utilization Report.
- Changes to the month of service system are made in real time. If you do not see the system change, exit your system and re-enter to refresh information



You have entered the Accept Community Hospital Claims System
Please indicate below whether you want to enter the MOS system or the MOP system




Community Hospital Claims System	
<input checked="" type="checkbox"/>	MOS System
<input type="checkbox"/>	MOP System

MOS and MOP information will appear on separate Community Hospital Utilization reports





Disputing a Month of Service Claim.

- ~ Dispute claims
 - o erroneously assigned to your RSN to the RSN that you feel is responsible
 - o Medical claims to MHD if Medical X does not appear in status field on Utilization report.
 - o Detox claims to MHD if Detox does not appear in status field on Utilization report
- ~ You may not dispute:
 - o Claims with secondary diagnosis code outside of Mental Health Diagnosis range. Claim payment is based on primary diagnosis code.
 - o Crossover claims. Medicare crossover claim costs (coduct payments) are the responsibility of the RSNs as of 7/1/01 per legislative action.
 - o Claims that may appear on your utilization report but do not appear in the dispute system
- ~ Non-Acceptance of Dispute
 - o Reply in note box,
 - o leave "Accept this claim?" check box as no
 - o redirect claim
 - Claim will not appear on Community Hospital 18-month Utilization

RSN Inpatient Claims Dispute System Instructions

-  To verify if claim has been accepted , you must review claims that have been redirected by you, Claim will appear as “pending” if the claim was not accepted.
-  Claim will not appear on Community Hospital report if it remains in pending status
-  radio button will remain “no”

Navigation to dispute/accept a Month of Service Claim

-  Select Accept Community Hospital Claim
-  Enter Client PIC and Month of Service
-  Enter reason for Dispute or non-Acceptance
-  Select RSN that you feel is responsible from drop down menu to redirect claim or enter notes



400 - Mental Health Division

Enter the PIC to identify the person of interest

Person ID (PIC):

Month of Service (YYYYMM):

Message: MOS must be 6 characters in length.

Claims redirected by your RSN

Claims accepted by your RSN

Claims redirected to your RSN

Claims redirected to another RSN over the past 24 months.

Person ID (PIC):

Month of Service (YYYYMM):

To dispute or accept a claim enter PIC and Month of Service

Requested PIC:

PIC	Name	MOS	Reimb Amount
XXXXXXXXXX	Client Name	06/2006	86.36

Dispute Comment:

Limit your text to 250 characters or less.

Crossover claim with Statewide CSO. Client zip code is 98122. MHD ass

To accept a claim make sure box is checked YES.

RSN Inpatient Claims Dispute System Instructions

This claim has been accepted by 411 - King RSN on 8/7/2006 1:58:35 PM

Accept this claim? No Yes

Redirect claim to:

Accepting a Month of Service Claim

- ~ only accept claims that have been disputed to you.
 - o it is not necessary to accept *all claims* in the utilization report.
- ~ Review list of claims redirected to you
 - Select claim using radio button, review reason for dispute
 - If you agree with the claim should be charged to your RSN, select the "Accept this claim? Check box as yes
 - Claim status will appear as "Accepted RSN ID" on the utilization report
 - View Status (accepted/pending) in *Claims redirected by/to your RSN*. Claim will appear as pending in the Intranet Inpatient System if the YES Tab has not been selected by the RSN that accepted the claim
 - radio button will remain "no" when reviewing claim detail from another RSN, radio button will change to "yes" when reviewing your detail
 - To verify if claim has been accepted, you must review claims that have been redirected by you, Claim will appear as "pending" if the claim was not accepted.

MHD Database
Accept Disputed Claims

Menu
Sub Menu
Log Off
Help

400 - Mental Health Division

Enter the PIC to identify the person of interest

Person ID (PIC):

Month of Service (YYYYMM):

Message: MOS must be 6 characters in length.

Claims redirected by your RSN

Claims redirected to another RSN over the past 24 months.

MOS	PIC	Name	Reimb Amount	Status	Redirected By	Last Activity Date
006/06	E [REDACTED]	E [REDACTED]	86.36	Accepted	ARMSTRONG, WENDY	8/7/2006 1:58:35 PM
006/06	L [REDACTED]	L [REDACTED]	952	Accepted	ARMSTRONG, WENDY	8/7/2006 2:19:12 PM
006/05	E [REDACTED]	E [REDACTED]	952	Accepted	ARMSTRONG, WENDY	8/7/2006 2:20:14 PM

Month of Payment Dispute System

Use this system to dispute a claim with month of service after August 2006.

- Claim with disputes for month of service after August 2006 will not appear on the Community Hospital 18 Month Utilization Reports.
- If you inadvertently accept a claim the claim, the claim will be transferred. **THERE IS NO REVERSAL OF THIS ACTION.**
 - Claims erroneously accepted by your RSN must be disputed (and accepted by another RSN) in order to be transferred.

You have entered the Accept Community Hospital Claims System
Please indicate below whether you want to enter the MOS system or the MOP system

Top of Form

Community Hospital Claims System	
<input type="checkbox"/>	MOS System
<input checked="" type="checkbox"/>	MOP System

Disputing/Accepting a Month of Payment Claim

- Select Accept Community Hospital Claim
- Enter Client PIC and Month/Day of Service
 - o Required date format includes day (YYYYMMDD)
for example 20061115 = November 15, 2006
- Select submit button to access claim

400 - Mental Health Division	GET SELECTED RSN
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Enter the PIC to identify the person of interest

Person ID (PIC):	PIC Number
First Date of Service (YYYYMMDD):	2006110

Note date message

Message: First Date of Service must be 8 characters in length.

Disputing a Month of Payment Claim

- ~ Read Message box above "Accept this Claim?" for claim status.
 - Enter reassignment reason in message box
 - Leave "accept this claim" check box as no.
 - If you inadvertently select "yes" in the "Accept this claim?" check box you will receive an error message
 - You may not forward a non-accepted claim to another RSN.
 - Select RSN in drop down menu box and select submit.
 - If you inadvertently select the wrong RSN (and the claim has not been accepted) you may resubmit the claim to the correct RSN.
- ~ Every unique claim must be disputed

RSN Inpatient Claims Dispute System Instructions

- Each claim is considered unique if the date of service is different. The following would be considered unique claims:
 - ~ Joe Smith
 - PIC 12345Z
 - First Date of Service Billed January 1, 200x
 - Last Date of Service Billed January 7, 200x
 - Activity Date: February 10, 200X
 - ~ Joe Smith
 - PIC 12345Z
 - First Date of Service Billed January 15, 200x
 - Last Date of Service Billed January 20, 200x
 - Activity Date: February 10, 200X
 -

<p>Dispute Comment: <i>Limit your text to 250 characters or less.</i></p>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="text-align: center;">REVIEW MESSAGE FOR CLAIM STATUS.</p> </div> <p>This claim has not been accepted</p> <p>Accept this claim? <input type="button" value="No"/></p> <p>Redirect claim to: <input type="button" value="411 - King RSN"/> <input type="button" value="Reset"/> <input type="button" value="Submit"/></p>
<p>Other Comments</p>	<p>Reported by: ARMSTRONG, WENDY Telephone: (360) 902-0819 E-mail Address: armstws@dshs.wa.gov From: Mental Health Division Comment: Crossover Claim with Statewide CSO. Client zip code is 98001. MHD assigned to King. Redirected to: 411 - King RSN On: 5/10/2007 7:53:20 AM -----</p>

Accepting a Month of Payment Claim

- ~ only accept claims that have been disputed to you.
 - it is not necessary to accept *all claims* in the utilization report.
- ~ Review list of claims redirected to you
 - ☒ Select claim using radio button, review reason for dispute
 - ☒ If you agree the claim should be charged to your RSN, select the “*Accept this claim? Check*” box as yes
 - You may add a message in the message box prior to selecting submit button.
 - Do not change the *Redirect Claim to* box. Changes to this box will result in an error message.
 - ☒ Claim status will appear as “Accepted RSN ID” on the utilization report
 - ☒ View Status (accepted/pending) in *Claims redirected by/to your RSN*. Claim will appear as pending in the Intranet Inpatient System if the YES Tab has not been selected by the RSN that accepted the claim
 - ☒ If you inadvertently “yes” in the “*Accept this claim?*” check box the claim will be transferred. **THERE IS NO REVERSAL OF THIS ACTION.**
 - Claims erroneously accepted by your RSN must be disputed (and accepted) in order to be transferred back to the originating RSN.

Non-Acceptance of Disputed Month of Payment Claim

- ~ Denial of Claim
 - Read Message box above “Accept this Claim?” for claim status.
 - ☒ If you disagree with the claim reassignment, select the “*Accept this claim? Check*” box as no
 - Include message in message box prior to submitting submit button
 - leave “*Accept this claim?*” check box as no
 - ☒ Claim will not appear on Community Hospital Month of Service Report
 - ☒ Claim will appear as “denied” by your RSN in drop down menu
- ~ Pending Claims
 - Read Message box above “Accept this Claim?” for claim status.
 - Claims that are in pending status are not reflected on the Utilization report because the claim has not been transferred.
 - ☒ Claim will appear as “pending” by your RSN in drop down menu
 - ☒ You may not forward a non-accepted claim to another RSN.
 - ☒ Claim will not appear on Community Hospital Month of Service Report
 - ☒ If you inadvertently select “yes” in the “*Accept this claim?*” check box the claim will be transferred. **THERE IS NO REVERSAL OF THIS ACTION.**
 - Claims erroneously accepted by your RSN must be disputed and accepted to be transferred to another RSN or back to the originating RSN.

Verification of Month of Payment Accepted Claim (prior to monthly utilization report run)

- ☒ To verify if claim has been accepted, you must review claims that have been redirected by you. Claim will appear as “pending” or “denied”
- ☒ Claim will not appear on Community Hospital report if it remains in pending status
- ☒ Claim will appear on Month of Payment Community Hospital report as a negative value if the claim is accepted on the **next** Month of Payment Utilization report.
- For example a claim disputed anytime in the month of May will appear in the June utilization report.

Unusual Claims

Duplicate billings

- Contact the hospital.
 - ~ The hospital should submit claim information so that the claim is recouped through MMIS. It may take several months before the claim is removed.
- Notify MHD if the claim is not recouped in a reasonable amount of time and MHD will begin the recoupment process through MMIS.

ITA Clients on Q Program

- ITA clients on the Q program are clients that are ineligible for any Medicaid or State program; therefore, eligibility information is not available in ACES. An eligibility “segment” is prepared once the claim is submitted to MMIS for payment. Assignment of the claim is based on information submitted at the time the claim is paid.

Accepting “zero payment” claims

- \$0.00 claims do not affect the utilization report.

Combined claims

- Month of Service:
 - ~ Two claims enter the system for the same client for the same month. Both are correctly assigned to different RSNs.
 - ~ The correct assignment appears on the utilization report
 - ~ The claim is combined in the Intranet Dispute System because MHD retains client/claim information in a monthly table to ensure that recoupment is credited to the current claim assignment.
 - ~ If claim is disputed both claims are transferred
 - ~ Contact MHD by email if you encounter this problem
- Month of Payment:
 - ~ Contact MHD if you encounter a combined claim using the MOS system

Medicare Crossover claims

- Recipient zip code is used for claims assigned to a statewide CSO that does not have a valid RSN authorization number (Medicare crossover claims with authorization number of 00000000).
- Medicare crossover claim costs (conduct payments) are the responsibility of the RSNs as of 7/1/01 per legislative action.
- The broader ITA Diagnosis range applies to all Medicare crossover claims regardless of client legal status (ITA or Voluntary).
- RSN Authorization/Length of Stay is not required for dual eligible clients who have not exhausted their Medicare benefits.

Reports Menu Navigation

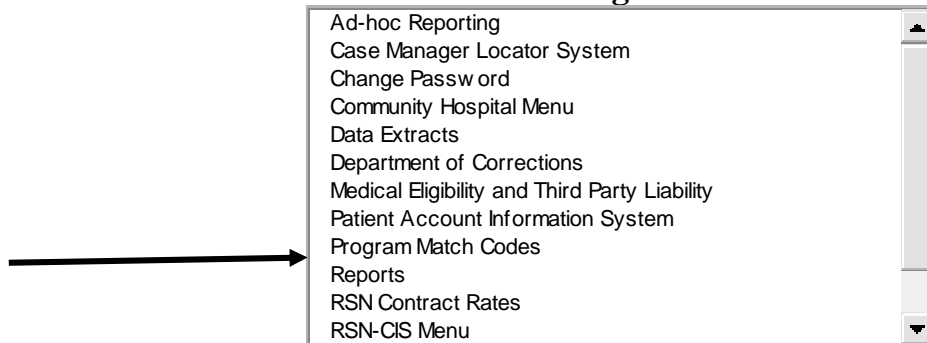
Community Hospital Utilization Report

The Utilization Report is a compiled list of claims that are paid by the Medicaid Management Information System (MMIS). Four reports are available to the RSN:

1. Community Hospital 18 Month Historical Utilization Report - compiled list of all hospital claims paid with all months of service and all month of payments. The report contains detail for claims prior to August 2006 for the most recent 18 months based on month of service.
2. Community Hospital 18-Month Utilization report – 18-month compiled list of all hospital claims paid for a particular month of service.
3. Community Hospital MOP Historical Utilization Month of Payment Report- compiled list of all hospital claims paid with all months of service and all month of payments. The report contains detail for claims after August 2006 for the most recent 18 months based on month of payment.
4. Community Hospital MOP Utilization Month of Payment Report - a one-month history of all claims activity for all months of service for a particular month of payment



Your administrator has granted you access to the following menu choices.



Portion of Utilization Report

Assigned RSN	Reciep CSO	Reciep RSN	Auth Number	Authorizing RSN	Name	Diag	Claim Type	Provider Type	Provider Specialty	DRG	Program	Match	ITA	MMIS Credit / Adjustment	Status	* Funding
MH	052	NS	883021853	MH	M	295.74	A	59	79	430	A	N	V	0	Medical NS	Title 19
MH	043	KI	640233143	MH	B R	291.1	A	59	80	750	U	U	V	0	No Auth	State Only
MH	065	NS	884434811	KI	S	305.51	R	59	79	745	U	U	V	1		State Only
MH	065	NS	884434811	KI	S	305.51	R	59	79	745	U	U	V	2		State Only
MH	065	NS	884434811	KI	S	305.51	R	59	79	745	U	U	V	3	Accepted NS	State Only
MH	130	MH	000000000	MH	W	295.74	V	64	86	000	P	C	V	3	Removed CD	Title 19
MH	131	MH	000000000	MH	R	295.70	V	65	86	000	P	A	V	3	Removed TM	State Only

RSN Inpatient Claims Dispute System Instructions

KI	051	PI	885033111	KI	H		296.90	S	65	86	430	H	M	V	0	X-RSN Claim	Title 19
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COLUMN HEADING DESCRIPTIONS

Assigned RSN.

Assignment of claim based on MHD algorithm using the following methodology

- ⇒ CSO of residence
- ⇒ CSO of residence is not available (claims for consumer with state-wide CSO) authorization number issued to assign
- ⇒ If authorization number is not available (Medicare crossover claims for consumer with state-wide CSO), consumer zip code on file at time of assignment is used

Reciep CSO (Recipient CSOR).

- ⇒ The CSO of residence where the recipient currently lives and is Medicaid eligible at the time the paid claim.
- ⇒ For some recipients, including foster children a statewide CSO is assigned. For these recipients, both the recipient county and the CSOR are denoted as "Mental Health Division.

Receip RSN (Recipient RSN) Type

- ⇒ RSN associated with Recipient CSOR

Auth Number (Authorization number)

- ⇒ Authorization number issued by RSN. Also called "prior Auth", length of stay auth. Refer to MHD Website, Inpatient Numbered Memorandum for Procedure regarding Authorization Numbers Admissions for Acute Psychiatric inpatient Care

Authorizing RSN

- ⇒ RSN associated with Authorization numbers RSN authorization numbers are comprised of 9 numerical digits. The RSN may not withhold an authorization for eligibility verification.
 - The **first two digits** of the number should be 88, indicating a psychiatric admission.
 - The **next five digits** identify a specific admission with a number from 00001 through 99999. Once the RSN has exhausted the above sequence, they start over with 00001.
 - The **last two digits** identify the RSN that authorized the admission. The two-digit code assigned to each RSN follows.
 - Spokane County RSN 10
 - King County RSN 11
 - North Sound RSN..... 12
 - Greater Columbia RSN..... 13
 - North Central RSN..... 14
 - North East RSN 15 (no longer used)
 - Peninsula RSN 16
 - Southwest RSN 17
 - Thurston/Mason RSN 18
 - Pierce County RSN 19
 - Grays Harbor County RSN 20
 - Clark County RSN 24
 - Chelan/Douglas RSN 25
 - Timberlands RSN 26
- ⇒ Authorization numbers with 00000000 (crossover with statewide CSO) is assigned to Mental Health and manually reassigned to RSN using zip code.
- ⇒ Authorization numbers ending with 400, 53, 64, 75, 86, 97 is assigned to the RSN and removed at final reconciliation.

RSN Inpatient Claims Dispute System Instructions

- ⇒ Authorization numbers 640233143 (alcohol) and 640233045 (drug) are for detoxification and are not the responsibility of the RSN

Diag (Diagnosis Code)

- ⇒ Refer to MHD Website, Inpatient Numbered Memorandum for current list of Psychiatric Diagnoses Categories.

Claim Type, MMIS designation of Claim Type

- ⇒ A is a Diagnosis related Code - Outlier
- ⇒ R is a Diagnosis Related Code (DRG) paid claim
- ⇒ S is a Inpatient Claim type
- ⇒ V is a Medicare Inpatient cross-over claim type

Provider Type, MMIS designation of Provider Type. (MHD does not maintain a list of provider names)

- ⇒ 59 is General Hospital-in state
- ⇒ 64 is Psychiatric Hospital
- ⇒ 65 is a Free Standing Psyche Facility
- ⇒ 36 is a detoxification specific provider number

Provider Specialty

- ⇒ MMIS designation to assist in claims adjudication used to assist processing for ITA Claims only.

DRG (Diagnosis Related Group)

- ⇒ Diagnosis Related groupings to assist in claims adjudication and per diem payment.
- ⇒

Program .

- ⇒ HRSA program information. For a complete listing of Program/ Match codes, refer to the MHD Website

Match

- ⇒ HRSA program information. For a complete listing of Program/ Match codes, refer to the MHD Website

ITA (Involuntary Treatment Act) Indicator.

- ⇒ MMIS code to identify whether claim is processed as voluntary or involuntary.
- ⇒ MMIS does process some claims where the ITA indicator is blank

MMIS Credit/Adjustment or MHD indicator to identify the following:

- ⇒ 0 is the original claim from MMIS
- ⇒ 1 is a credit to the original claim
- ⇒ 2 is an adjustment to the original claim
- ⇒ 3 is an RSN dispute reassignment

Status is an MHD assigned code to identify changes to the original claim assignment. If status is blank, the claim was assigned used the MHD assigned algorithm.

- ⇒ Detox is designated as the status when the *provider type* is Hospital Full Care (Out-of-sate and Detox) and the *provider specialty code* is either Detox – Hospital or Detox – Freestanding
 - ▣ Claim will not appear on Community Hospital 18-month Utilization or Month of Payment Final reports.
 - ▣ Claim will appear on Community Hospital Historical report as DETOX
- ⇒ X-Over is used for hospital claims where the *first date of service* is before July 1, 2001 and the Claim Type is V - Medicare Crossover. These claims are now assigned through algorithm.
- ⇒ Removed "RSN ID" – is used to identify a claim that was moved from the original CIS assignment to the accepting RSNs utilization report. MMIS records are not changed.

RSN Inpatient Claims Dispute System Instructions

- ▣ Claim will not appear on Community Hospital 18-month Utilization or Month of Payment Final reports.
- ▣ Claim will appear on Community Hospital Historical report and Month of Payment Historical Report as Removed (claim sent to) RSN ID
- ⇒ Accepted "RSNID" – is used to identify the RSN that accepted reassignment of a disputed claim
 - ▣ Claim will appear on all utilization reports as Accepted (claim from) RSN ID
- ⇒ X-RSN Claim – Claims between RSNs. When the Assigned RSN is not equal to the authorizing RSN, This status is used for billings that are assigned to an authorizing RSN
- ⇒ Medical MH – is used for billings where
 - the first two digits of the *prior authorization code* are 88 and the last three digits are 400, or
 - RSN ID (RSN name) is not Mental Health and the first two digits of the *prior authorization code* are 88 and the last two digits are in the following list: '53', '64', '75', '86', '97'
 - ▣ Claim will not appear on Community Hospital 18-month Utilization or Month of Payment Final reports.
 - ▣ Claim will appear on Community Hospital report as MEDICAL
- ⇒ No Auth is used for billings where
 - the *prior authorization code* is 000000000 and the *claim type* is not Medicare Inpatient Crossover and the Status is empty, or
 - the *claim type* is not V (Medicare Inpatient Crossover) and the Status is empty and the first two digits of the *prior authorization code* are not 88
- ⇒ Funding is an MHD indicator to identify the following:
 - T-19 is a payment using Medicaid fund source
 - State Only is a payment using a state fund source
- ⇒ First Date of Service is used to identify month service was provided.
- ⇒ Date of Payment is used to identify month payment of claim was processed in MMIS.

Disputing Western/Eastern State Hospital Client Assignment

Please refer to the Community Inpatient Psychiatric Authorization Information located on MHD's website for procedures related to the disputing a client incorrectly assigned at Western State or Eastern State Hospital.

Disputing Unauthorized Length of Stay

For any claims paid for month of service after August 2007, if the number of days billed exceeds the number of days authorized by the RSN, MHD will assist with the recovery of unauthorized days paid.

- RSN must track the number of days authorized and compare that number to the total number of days that were billed by the hospital and subsequently paid by the Division (using the Community Hospital Month of Payment Utilization report)
- By the 5th of each month, the RSN must notify the MHD fiscal staff of any discrepancies between the number of days authorized and the number of days billed/paid for the previous month's claims in an excel spreadsheet format.
- MHD fiscal staff will forward the list of claims that need to be adjusted to the HRSA Dental and Institutional Resolutions and Adjustment Unit. This will occur in block fashion on a no less than quarterly basis for any admissions for date of service prior to the implementation date of the Provider One Prior-Authorization Program.
- The HRSA Dental and Institutional Resolutions and Adjustment Unit will then recoup the funds paid to the hospitals for the unauthorized days.

Resources

Links

Hospital Billing Instructions

http://fortress.wa.gov/dshs/maa/download/BillingInstructions/Inpatient_Hospital_BI.pdf

Certification/Authorization Forms (DSSH Form 13-821 and 13-822)

<http://www1.dshs.wa.gov/msa/forms/eforms.html>

Rate Information (including per diem, DRG, RCC, CUP, and bariatric for Medicaid and State Administered programs.)

<http://fortress.wa.gov/dshs/maa/hrates/rccDrgIndexAug07on.html>

Downloadable Reports

Website: (select Facilities tab, RSN tab, RSN Contract Info tab,)

Community Inpatient Psychiatric Authorization

Inpatient Assignment Guidelines

Program/Match

Zip Codes

Intranet Ad-hoc Reports

Community Hospital Utilization Report

Community Hospital 18 Month Utilization Report

Community Hospital Month of Payment Utilization Report

Mental Health Contacts

Inpatient Intranet Dispute Questions:

Wendy Armstrong, 360-902-0819, armstw@dshs.wa.gov

Inpatient Program Questions:

CPI-UMMAILBOX@dshs.wa.gov

IT System Assistance

MHDIntranetHelp@dshs.wa.gov

RSN Inpatient Claims Dispute System Instructions

Definitions

Community Hospital Month of Payment Utilization Report. Report used to verify the amount billed for a particular month that hospital claims were paid through MMIS.

Community Hospital 18-Month Utilization Report. Report used to verify the amount billed for a particular month of service that hospital claims were paid through MMIS.

Community Hospital Utilization Report. A compiled list of claims that are paid by the Medicaid Management Information System (MMIS)

CSOR: The CSO of residence where the recipient currently lives and is Medicaid eligible at the time the paid claim is extracted to the Consultec report sent to the MHD by MAA. The CSOR may differ from the Recipient County if the person has moved to another county since the time of that inpatient service, thus transferring their eligibility to another CSO.

DRG. Diagnosis Related Group. Form of payment based on grouping of diagnosis codes.

MMIS. Medicaid Management Information System. Payment system used by HRSA to pay claims.

Primary RSN: The RSN of residence at the time the consumer was hospitalized. The RSN of residence is determined by the Recipient County. The primary RSN has full responsibility for the recipient (fiscal, resource management, outpatient service provision) regardless of which RSN authorized the inpatient admission. Exception: When eligibility is newly determined or changed solely as a direct result of inpatient hospitalization outside of the consumer's known county of residence, that inpatient admission shall be presumed to be the responsibility of the RSN where the consumer actually lived prior to the hospitalization.

Recipient County: The Community Service Office (or local CSO office) in the county where the person was eligible for Medicaid at the time of inpatient service.

Secondary RSN: RSN that authorized admission for a recipient from another RSN.

Statewide CSO: Assigned CSO for some recipients, including foster children. For these recipients, both the recipient county and the CSOR are denoted as "Mental Health Division."

Utilization. Compiled information regarding claims that have been paid by the MMIS.

Psychiatric Diagnoses Codes
PSYCHIATRIC DIAGNOSES CATEGORIES REQUIRING APPROVAL FOR
INPATIENT PSYCHIATRIC CARE

Organic Psychotic Conditions (290-294)

- 290- Senile and pre-senile organic psychotic conditions
- 291- Alcoholic psychoses
- 292- Drug Psychoses
- 293- Transient organic psychotic conditions
- 294- Other organic psychotic conditions (chronic)

Other Psychoses (295-299)

- 295- Schizophrenic Psychoses
- 296- Affective Psychoses
- 297- Paranoid Psychoses
- 298- Other non organic psychoses
- 299- Psychoses with origin specific to childhood

Neurotic Disorders, personality disorders and other non psychotic mental disorders (300-314)

- 300- Neurotic disorders
- 301- Personality Disorders
- 306- Physiological malfunction arising from mental factors
- 307- Special symptoms or syndromes not elsewhere classified
- 308- Acute reaction to stress
- 309- Adjustment reaction
- 310- Specific non psychotic mental disorders due to organic brain damage
- 311- Depressive disorder, not elsewhere classified
- 312- Disturbance of conduct not elsewhere classified
- 313- Disturbance of emotions specific to childhood and adolescence
- 314- Hyperkinetic syndrome of childhood

PSYCHIATRIC DIAGNOSES CATEGORIES WHICH CANNOT BE APPROVED FOR
VOLUNTARY INPATIENT PSYCHIATRIC CARE

Non-psychotic Mental Disorders (302-316)

- 302- Sexual deviations/disorders
- 303- Alcohol dependence syndrome (1)
- 304- Drug Dependence (1)
- 305- Non dependent abuse of drugs (1)
- 315- Specific delays in development

- 316- Psychiatric factors associated with diseases classified elsewhere

Mental Retardation (317-319)

- 317- Mild Retardation
- 318- Other specified mental retardation
- 319- Unspecified mental retardation

1. The requirements in this memorandum do not apply to admissions to 3 and 5 day detoxification programs associated with the Division of Alcohol and Substance Abuse. Please reference MAA *Billing Instructions for Hospital-Based Inpatient Detoxification*.
2. For persons admitted involuntarily in accordance with RCW 71.34 or 71.05, the exclusion of diagnoses codes 302-319 does not apply
3. For persons with Medicare and Medicaid dual eligibility, the exclusion of diagnoses codes 302-319 does not apply until the lifetime Medicare benefit has been exhausted
4. For medical inpatient detoxification (MID) see Hospital Billing Instructions, Utilization Review section.

Inpatient Claims Dispute System

NOTES: