Instructions for Completing and Entering the
LTCC Screening Document and
Service Agreement
Into MMIS

Developed by the Aging and Adult Services Division
Of the Continuing Care Administration
Department of Human Services
October, 2020
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Introduction

The information in this manual focuses on the Long Term Care (LTC) Screening Documents used to support the Long Term Care Consultation (LTCC) Program, and the service agreements used by the waiver (EW), Alternative Care (AC), and Essential Community Supports (ECS) programs. Included are other subsystems that supports these programs.

While much of the MMIS processes for the LTC screening document and service agreements contained in this manual apply to the disability waiver programs (Brain Injury (BI), Community Alternative Care (CAC) and Community Alternative for Disability Inclusion (CADI)) as well as the EW, AC, and ECS programs, the online Community Based Services Manual (CBSM) contains additional policy, practice, and systems information related to these programs. Lead agency staff managing and administering those programs use the CBSM as a reference and guide.

See updates to this manual that have occurred since July 2020 in the table below and in italics in the text. An online version of this manual is on eDocs by searching for form DHS-4625.

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<thead>
<tr>
<th>Chapter</th>
<th>Section</th>
<th>Change</th>
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<td><strong>Staff Contacts</strong></td>
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<td>Updated contact information for the DSD Resource Center.</td>
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<tr>
<td>Two</td>
<td>201.08</td>
<td>Clarified that the cost authorized for AC conversion case management is not applied to the Total Cap Amount for non-CDCS AC service agreements.</td>
</tr>
<tr>
<td></td>
<td>201.09</td>
<td>Clarified that the cost authorized for AC conversion case management is not applied to the Total Cap Amount for CDCS AC service agreements.</td>
</tr>
<tr>
<td>Three</td>
<td>301.03</td>
<td>Added new instructions when edit 672 posts due to the Total Authorized Amount field exceeding the Total Cap Amount field on EW and AC CDCS service agreements.</td>
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**Staff Contacts**

Address questions regarding DSD program policies and procedures to (651) 431-4300 or 1 (866) 267-7655. Your Regional Resource Specialist will also provide technical assistance.

The [Community Based Services Manual](#) is a resource for lead agencies who administer home and community-based services that support older Minnesotans and people with disabilities. The Aging and Adult Services (AASD) and Disability Services (DSD) divisions publish guidance on and explanation of policy in the manual.

Address questions regarding the Long Term Care Consultation (LTCC), waivers, Alternative Care (AC), and Essential Community Supports (ECS) programs to the Disability and Aging PolicyQuest. Lead agencies (county, tribal, and managed care organization) have an administrator who may give you access to submit questions to PolicyQuest. All questions and answers are searchable by the public. For more details, please see the [PolicyQuest](#) page in the Community Based Services Manual.

**Health Care Help Desks**

MAXIS Help Desk aka Transition Supports Systems (TSS) Help Desk  
System help for county financial workers  
(651) 431-4100

DHS County Relations Resource Center (formally known as MMIS Help Desk)  
System help for Recipient Subsystem changes and system support  
(651) 431-3930

Health Care Program Member Help Desk  
Recipient questions for MA benefits and intake for health care  
(651) 431-2670 or 1-800-657-3739

**MnCHOICES** on DHS CountyLink  
[http://www.dhs.state.mn.us/main/dhs16_180264](http://www.dhs.state.mn.us/main/dhs16_180264)

**MHCP Provider Call Center**  
8:00 AM – 4:15 PM Monday through Friday  
Voice 651-431-2700 or 800-366-5411  
TTY 711 or 800-627-3529

<table>
<thead>
<tr>
<th>Information needed</th>
<th>Option to select</th>
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<tbody>
<tr>
<td>To verify MHCP member eligibility (If the member is enrolled in a prepaid health plan, contact the appropriate managed care organization.)</td>
<td>Press 1</td>
</tr>
<tr>
<td>To get MHCP-related phone numbers, addresses, websites, and general information</td>
<td>Press 4</td>
</tr>
<tr>
<td>Information needed</td>
<td>Option to select</td>
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<tr>
<td>To reach a Call Center representative through your NPI or UMPI</td>
<td>Press 0, then one of the following:&lt;br&gt;• Press 1 to enter an NPI &lt;br&gt;• Press 2 to enter an UMPI &lt;br&gt;• Press 3 if you are not currently an enrolled provider</td>
</tr>
<tr>
<td>To reach a Call Center representative if you are not currently an enrolled provider or you entered an invalid NPI or UMPI</td>
<td>Select your provider type from the following:&lt;br&gt;• <strong>Option 1</strong>: Nursing facilities, dental, transportation, outpatient mental health, eyeglasses, contacts and eye exams &lt;br&gt;• <strong>Option 2</strong>: Pharmacy, medical supply, chiropractic and hearing aid dispensing (use NDC Search to verify drug coverage) &lt;br&gt;• <strong>Option 3</strong>: Rehab therapy, hospice, lab, physician, hospital, IEP, family planning services &lt;br&gt;• <strong>Option 4</strong>: Home care, waiver services, chemical dependency services</td>
</tr>
<tr>
<td>For questions about MN–ITS Registration, MN–ITS Administrator, and Password Resets</td>
<td>Press 6</td>
</tr>
<tr>
<td>For enrollment questions (get forms through the MHCP Provider Enrollment page)</td>
<td>Press 5</td>
</tr>
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**Office of Ombudsman for Long Term Care**<br>Investigates concerns relating to the rights, services, and benefits of long-term consumers. Voice: (651) 431-2555 or toll free 1-800-657-3591, or Fax: 651-431-7452

**SSIS Help Desk**<br>System help for county SSIS users and lead investigative agencies who receive vulnerable adult maltreatment reports electronically through SSIS. (651) 431-4801 dhs.ssishelp@state.mn.us
Resource Center

The DSD Resource Center is a help desk that provides technical assistance to lead agencies and DHS staff for the Medicaid Management Information System (MMIS) in the following areas:

- Alternative Care (AC) and Essential Community Supports (ECS) programs
- Home care services (type B service agreements) for personal care assistance (PCA), home health aide (HHA), skilled nursing visit (SNV), home care nursing (HCN), Consumer Support Grant (CSG) and Family Support Grant (FSG)
- Assessment and screening documents, including long-term care consultation (LTCC), preadmission screenings (PAS), DD screenings and Omnibus Budget Reconciliation Act (OBRA) screenings.

For more information, see the [Community Based Services Manual](#).

The Resource Center provides the following technical assistance:

- Adjusts service agreements as appropriate
- Helps staff to resolve edits and error messages on service agreements and screening documents
- Helps staff with the entry into MMIS of and technical issues related to service agreements and screening documents
- Processes and reviews home care service agreement requests
- Processes screening deletion requests

Lead agencies must send screening document deletion requests by fax only using Screening Deletion Request, [DHS-4689A](#) (PDF). The Resource Center will make every effort to process screening document deletion requests on a weekly basis.

Contact the Resource Center

For information on how to contact the Resource Center, see the [Community Based Services Manual](#). Resource Center staff is available Monday through Friday from 8:00 a.m. to 4:00 p.m.
Terms and Definitions

Activities of Daily Living (ADLs). “Activities of daily living” is a term used to refer to tasks associated with the person’s self-care and mobility. Common ADLs include feeding oneself, bathing, dressing, grooming, walking, using the bathroom, positioning, and transferring.

Alternative Care Program (AC). A program that pays for home and community-based services for people aged 65 and older who meet the nursing facility level of care criteria, and who, if they enter a nursing facility, will be eligible for Medical Assistance within 180 days of admission. Previously state-funded, the AC program now receives federal financial participation.

Applicant. A person who has submitted an application to participate in one of the publicly funded health care programs including the waiver, Alternative Care or Essential Community Supports programs.

Assessment. The process of identifying a person’s: strengths, preferences, functional skills, natural supports, and need for support and services in order to develop a plan for services and supports.

Brain Injury (BI) Waiver. BI is a Medical Assistance program that funds home and community-based services (HCBS) for people under age 65 who meet the level of care criteria for nursing facility or neuro-behavioral hospital, and who choose to reside in the community. This program provides funding for children and adults who have an acquired or traumatic brain injury. BI Waiver services may be provided in a person’s own home, in his/her biological or adoptive family’s home, in a relative’s home (e.g. sibling, aunt, grandparent etc.), in a family foster care home, in a corporate foster care home, in a board and lodging facility or in an assisted living facility. If married, a person may receive BI waiver services while living at home with his or her spouse.

Community Access for Disability Inclusion (CADI). Community Access for Disability Inclusion is a Medical Assistance program that funds home and community-based services for people first opening to the program while under age 65 who require the level of care provided in a nursing facility, and who choose to reside in the community. The name of this program changed from Community Alternatives for Disabled Individuals to Community Access for Disability Inclusion effective August 1, 2016.

Community Alternative Care (CAC). Community Alternative Care is a Medical Assistance home and community-based services program that pays for health care and other services for an individual who requires the level of care of a hospital.

Care Coordinator/Care Management for MSHO/MSC+ Members. An individual who coordinates the provision of all Medicare and Medicaid health and long-term care
services for MSHO or MSC+ members among different health and social service professionals and across settings of care. This individual must be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician.

**Care Management for SNBC.** The assignment of an individual who coordinates Medicare and Medicaid health services for a member.

**Case Manager.** A county or tribal case manager (also referred to as a Services Coordinator) is a social worker, a registered nurse or public health nurse employed by or under contract with the local lead agency to provide case management service.

**Case Manager for MSC+ Members.** An individual who coordinates Medicaid health and long-term care services for an MSC+ members receiving Elderly Waiver Services among different health and social service professionals and across settings of care.

**Case Mix Classification.** A classification of a person for purposes of establishing budget and service rate limits that relies on the ability to complete certain Activities of Daily Living (ADL), the need for behavioral interventions, and clinical monitoring of treatments. Developed as a payment system for nursing facilities; used for establishing individuals community budgets under various public programs.

**Claims Adjudication.** Final decision by the Department regarding service payment to a provider.

**CMS.** The Center for Medicare and Medicaid Services is the federal agency that oversees health care and waiver programs.

**Collaborative or Comprehensive Care Plan (CCP).** For managed care enrollees, the document developed in consultation with the member, the member’s treating physician, health care or support professional, or other appropriate individuals, and where appropriate, the member’s family, caregiver, or representative that, taking into account the extent of and need for any family or other supports for the member, identifies the necessary health and Home and Community-Based services to be furnished to the member.

**Commissioner.** The Commissioner of the Minnesota Department of Human Services.

**Community Support Plan (CSP).** A plan that outlines the community supports identified following a Long Term Care Consultation assessment. All individuals participating in the assessment receive a CSP, regardless of eligibility for publicly-funded home and community-based services.

**Consumer Directed Community Supports (CDCS).** CDCS is a service option within the home and community-based services programs that gives individuals more flexibility
and responsibility for directing their services and supports, including hiring and managing direct care staff. CDSCS may include traditional goods and services, as well as additional allowable services that provide needed support to participants.

**Conversion.** “Conversion” refers to the use of home and community-based services to return a person to the community from an institutional setting.

For purposes of coding a home and community-based services program type, “conversion” means the program opened for a person who was a resident of a long term care facility at the time of the initial referral for an assessment and who will open to the program at discharge.

For purposes of budgeting and payment, people who were residents of a facility for at least thirty days may qualify for case mix budgets and service rate limits at discharge that are higher than those available for diversions or conversions with less than a thirty day stay. Request conversion funding as needed to support the services and supports needed to return to the community and requires approval by the department.

**Coordinated Services and Supports Plan (CSSP).** The detailed service and support plan developed by a case manager for a participant in a publicly-funded home and community-based program.

**Data Validity.** The automatic editing by MMIS of submitted data to check that data fields are of the proper type and in the proper format.

**Department.** Minnesota Department of Human Services (DHS).

**Diagnosis-Related Group (DRG).** Diagnosis-related group is a patient classification system that standardizes prospective payment to hospitals. A DRG payment based on the care used by a “typical” patient within the group and covers all charges associated with an inpatient stay from the time of admission to discharge. Medical Assistance and the Community Alternative Care (CAC) program utilize DRGs.

**Diversion.** Diversion” refers to the use of home and community-based services to prevent or delay the use of institutional long-term care. Use diversion program types for a person who is not a resident of a long term care facility at the time of the initial referral for an assessment and opening to a program. A person will remain coded as a diversion until exited from the waiver or AC program.

**Elderly Waiver Program (EW).** A Medical Assistance program that funds home and community-based services for people 65 and older who meet the nursing facility level of care criteria, are eligible for long term care under Medical Assistance, and who choose to reside in the community.
Essential Community Supports (ECS). An ongoing program that provides some home and community-based services to individuals age 65 and older with emerging needs for these services but who do not meet nursing facility level of care criteria. Uses the same financial eligibility thresholds as AC. (Some individuals continue under transitional ECS who became ineligible for a home and community-based program or for nursing facility services when the nursing facility level of care criteria revised on January 1, 2015.)

Exceptions or Edits. Errors posting against a screening document or service agreement during editing in MMIS.

Excluded Time. Excluded time is the period of time a person spends in a:

- hospital
- sanitarium
- nursing facility
- shelter (other than an emergency shelter)
- boarding care facilities
- halfway house
- foster home
- semi-independent living domicile or services program
- regional treatment center
- facility stay based on an emergency hold
- placement in a training and habilitation program (including a rehabilitation facility or work or employment program)
- day training and habilitation program
- assisted living services
- placement under an indeterminate commitment including independent living
- supervised board and lodging facility or other institution for the hospitalization or care of human beings in a maternity home
- battered woman’s shelter
- foster care
- certified board and care or
- correctional facility

These periods affect determination of county of financial responsibility (CFR). Financial workers determine CFR and any changes to CFR that may occur over time.

Excluded Time Service. Excluded time service is the time the person participates in a rehabilitation facility which meets the definition of a long-term sheltered workshop or is receiving services from a semi-independent living services (SILS) program.

Extended Services. Services covered under EW and other waiver programs that exceed the scope, amount, frequency, and duration of a comparable regular (state plan)
Medical Assistance service, e.g. “extended personal care”, or “extended supplies and equipment”.

**Fiscal Year.** A period of time established for budgetary and accounting purposes. The state fiscal year is July 1st to June 30 of the following year. The federal fiscal year is October 1st to September 30 of the following year.

**Formal Caregivers.** Formal caregivers are persons or entities providing services employed by or under contract with a county agency or other agency or organization, public or private. Formal caregiver does not include the case manager.

**Health Risk Assessment (HRA).** A questionnaire that assists to identify a person’s health care needs, health status, and health risk factors. The purpose of the HRA is to help care coordinators set up health related appointments and needed services as soon as possible with a member. Used to gather information regarding persons' needs related to Activities of Daily Living (ADL) and Independent Activities of Daily Living (IADLs). See the forms DHS-3428H and 3427H.

**Home and Community-Based Services (HCBS).** Health and social services and supports provided to an individual or family in a non-institutional setting for the purpose of delaying or preventing institutionalization, or supporting their return to the community from an institution, by promoting, maintaining, or restoring health and independence, or minimizing the effects of illness and disability. Also referred to as Long Term Services and Supports (LTSS).

**Hospice.** A program which provides palliative and supportive care for terminally ill patients and their families directly or on a consulting basis either with the patient’s physician or other community agencies.

**Hospital.** An institution primarily engaged in providing, by or under the supervision of a physician, the diagnostic and therapeutic services for the medical diagnosis, treatment, and care of injured, disabled or sick inpatients. Classifications of hospitals: by length of stay, as teaching or non-teaching, by major type of service (psychiatric, tuberculosis, general, etc.) or by type of ownership or control (federal, state, local government, for-profit or nonprofit).

**Informal Caregivers.** Informal caregivers are family, friends, neighbors and others who provide services and assistance to persons without reimbursement for the services or support. Informal caregivers provide routine, dependable support and assistance to the individual.

**Information Transfer System (ITS).** A PC computer-based system that allows forms such as screening documents, service agreements, prior authorizations, and claim forms to be “batched entered” into the MMIS.
**Informed Choice.** The decision a person participating in a home and community-based program makes about services, including the decision to receive services either in a community or facility setting, after receiving information about all available options and the right to choose from among these options, including choices between services and providers.

**Instrumental Activities for Daily Living (IADL).** Activities necessary for independent functioning including shopping, cooking, doing housework, managing money or medications, and using the telephone. A frequently used measurement of the functional capacity to perform these activities to determine aspects of cognitive and social functioning.

**Lead Agency.** For purposes of Long Term Care Consultation services, include counties, and tribes and managed care organizations under contract with the Department to manage and administrator HCBS programs.

**Level of Care Determination.** One outcome of assessment. Facility level of care can be an acute or psychiatric hospital, a neuro-behavioral hospital, a certified nursing (including a certified boarding care) facility, or an intermediate care facility for persons with developmental disabilities (ICF/DD). Long Term Care Consultants make determinations about the need for the level of care a nursing facility provides based on criteria provided by the Department and professional judgment. Determinations of other levels of care require the involvement of other qualified professionals.

**Long Term Care Consultation Services (LTCC).** LTCC provides assistance to people with long term or chronic care needs under Minnesota Statutes, section 256B.0911. Assessment and community support planning mandated in state statutes to provide to all citizens. Long Term Care Consultants from lead agencies complete assessment of an individual applying for nursing home admission or home and community-based services, which is part of eligibility determination for publicly funded long-term care. LTCC assessments completed by lead agencies using MnCHOICES software or DHS legacy forms including forms DHS-3428 and DHS-3428A.

**Managed Care Organization (MCO).** An entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is: (1) a Federally Qualified HMO that meets the advance directives requirements of 42 CFR 489.100-104; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid Recipients within the area served by the entity, and b) meets the solvency standards of 42 CFR 438.116, section 2.37. All Minnesota MA/Minnesota Care health plans meet MCO requirements. In MN, MCO serving Medicaid enrollees are currently all non-profit organizations.
MAXIS. MAXIS is the online computer system used by financial workers which records the data that determines a person’s financial and other eligibility for various public programs.

Medicaid. The federal program which partially funds health care services, including home and community-based services in states which have included waiver plans in their MA programs, to low-income individuals authorized under Title XIX of the Social Security Act.


Medical Assistance (MA). Minnesota’s state plan program which funds health care services through a combination of state and federal funds under the provisions of Title XIX of the Social Security Act and Minnesota Statutes, Chapter 256B.

Medically Necessary. A term used to define criteria for approval of certain services or items. See criteria listed in the MN Rule part 9505.0175 (Rule 47).

Medicare. The national program which funds health care services authorized under Title XVIII of the Social Security Act for certain Social Security beneficiaries (aged, disabled, certain dependents).

Minnesota Eligibility Technology System (METS). Minnesota Eligibility Technology System is the public health portion of MNsure. MNsure is the online health insurance exchange the state developed under the Affordable Care Act. Applicants use MNsure to obtain health care coverage through the state’s public health care programs, including Medical Assistance and MinnesotaCare.

MinnesotaCare (MNCare). MNCare is a publicly subsidized health care program for Minnesotans with low income who do not have access to affordable health care coverage. Members obtain health care service through a health plan.

Minnesota Health Care Programs (MHCP). The collective term for Minnesota’s various health care programs: Senior Drug, Minnesota Senior Health Options, Medical Assistance (fee-for-service), Prepaid Medical Assistance Program (managed care), General Assistance Medical Care, and MnCare for example, and for purposes of this manual, the Alternative Care and Essential Community Supports programs.

Minnesota Health Care Programs Provider Manual. Sometimes referred to as the MA billing manual. Used by providers for claims and billing information and located on the DHS webpage under eDocs.
Minnesota Senior Care Plus (MSC+). A program in which the State contracts with health plans to cover and manage health care and Elderly Waiver services for Medical Assistance enrollees age 65 and older.

Minnesota Senior Health Options (MSHO). A program offered by the Minnesota Department of Human Services and health plans for seniors eligible for both Medicare and Medical Assistance and also provides Elderly Waiver services.

MnCHOICES. MnCHOICES is a single, comprehensive, web-based application that integrates assessment and support planning for all persons seeking access to Minnesota’s long-term services and supports. MnCHOICES embraces a person-centered approach to ensure services meet each person’s strengths, goals, preferences and assessed needs. For more information, go to: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/mnchoices/

Moving Home Minnesota (MHM). MHM is the rebalancing demonstration project to encourage the transition of eligible persons by improving the transition process from a qualified institution to community living through increasing outreach and decreasing barriers to transition.

OBRA Level I. The term used to describe one of the activities included in preadmission screening and required under state and federal law to occur prior to any admission to certified nursing or boarding care facility. Also completed as part of a Long Term Care Consultation assessment. See the form DHS-3426. Acronym is from the Omnibus Reconciliation Act passed in 1987 by the federal government, and in which the requirements for screening for developmental disability and mental illness were included.

OBRA Level II. The activities carried out by other qualified mental health or developmental disabilities professionals at referral under OBRA Level I. These professionals further evaluate and make determinations about mental illness or developmental disability, including recommendations for specialized services and psychiatric or ICF/DD level of care.

Prior Authorization (PA) Subsystem. A subsystem of the MMIS that includes all services that must be prior authorized to pay claims. This subsystem includes all LTC and DD screening documents, the waiver, AC, ECS service agreements, and Medical Assistance authorizations for certain services.

Person Master Index (PMI) Number. The number permanently assigned to an individual for identification in MMIS. Also called “Recipient ID” or “Person ID”.

Preadmission Screening (PAS). A federally mandated process for all persons entering a certified nursing or boarding care facility to screen for mental illness or developmental
disability and determine the need for nursing facility level of care and to connect them to supportive services. Completed for most admissions online by Senior LinkAge Line® staff and health care professionals seeking admission. Some determinations require a face-to-face assessment by a Long Term Care Consultant. See the form DHS-3427T for data entry into the MMIS for PAS.

**Prepaid Medical Assistance Program (PMAP).** PMAP is Minnesota’s Managed Medicaid Program for Medical Assistance recipients. State and federal funds fund PMAP. It is the largest of Minnesota’s publicly funded health care programs providing coverage for an average of 900,000 people each month. Various PMAP programs enroll children, families, single adults, people age 65 or older, and people who have disabilities. PMAP describes a variety of prepaid MA products such as MSHO or SNBC.

**Reassessment.** The face-to-face reevaluation of an HCBS program participant’s eligibility for these programs, including a reassessment of health status and need for services. It must be completed at least once a year or whenever the person’s health or needs change significantly.

**Recipient.** A person determined to be eligible for Medical Assistance or other Minnesota Health Care Program. Preferably referred to as a “participate”.

**Relocation Services Coordination (RSC).** A “state plan” service available to MA recipients of all ages for up 180 days to carry out activities such as planning for, locating, and arranging services and supports needed to permit a person to return to community settings after institutional admission.

**Representative.** A person appointed by the court as a guardian or conservator or a person designated to have power of attorney or a durable power of attorney, or a person authorized by the person under Minnesota rules part 9505.0015, subpart 8.

**Residence.** The person’s established place of abode.

**(LTC) Screening Document.** The form DHS-3427 that records in MMIS the outcome of a community or relocation assessment, or case management activity carried out under the HCBS programs.

**Service Agreement.** The form DHS-3070 that is entered on-line into MMIS which identifies services, providers, and payment information for a person receiving home care, waiver, Essential Community Supports, Moving Home Minnesota, or Alternative Care services. The on-line service agreement allows providers to bill for approved services and allows DHS to audit usage and payment data.

**Special Needs BasicCare (SNBC).** A voluntary managed care program that provides Medicaid services and/or integrated Medicare and Medicaid services to Medicaid-
eligible people with a SSA or SMRT certified disability who are ages 18 through 64. This program is available in all counties provided by six different health plans.

*People receiving home and community based waiver services or state plan PCA/HCN services are eligible for SNBC, however, payment for these services is by MA fee-for-service. The managed care organization (health plan) is responsible for authorization and payment for all basic state plan health care services.* Please see the SNBC brochure DHS-6301 on eDocs.

**State Plan.** The document which defines Medical Assistance services provided by the State of Minnesota under Title XIX of the Social Security Act for which the state receives federal financial participation (FFP). These services represent the “benefit set” for all persons with Medical Assistance.

**Transaction Control Number (TCN).** The unique 17-digit number assigned to each claim for identification purposes.

**Visit.** For purposes of MA home care, a visit is a unit of service.

**Waiver Plan.** The plan to offer waivered services submitted by the state to, and approved by, the Center for Medicare/Medicaid Services (CMS) which allows the state to receive federal financial participation for home and community-based services authorized under the Code of Federal Regulations, title 42, part 441, subpart G.

**Waivered Services.** Services defined and funded by the waiver programs such as respite, homemaker, or companion services, and extended MA home care services provided under the waiver service plan. Other waiver programs not described in this manual may differ in services in their respective plans. These services are available only to persons determined to be eligible for a waiver program by a lead agency. Minnesota’s waiver programs are:

- Brain Injury (BI) (nursing facility level of care and neurobehavioral hospital level of care)
- Community Alternative Care (CAC)
- Community Access for Disability Inclusion (CADI)
- Developmental Disabilities (DD)
- Elderly Waiver (EW)
Chapter 1 – MMIS Access and Subsystems

101.01 Introduction to MMIS

MMIS is the acronym for the Medicaid Management Information System. The current MMIS system software implemented in June 1994. It is the largest public health care payment system in Minnesota, and stores three years of online billing and claims payment history.

The Medicaid Management Information Systems (MMIS) is comprised of several integrated subsystems that are used to process health care claims payments to providers and managed care capitation payments to the DHS-contracted managed care organizations. MMIS is the system of record for provider, service authorization, third-party liability and payment data. The federal government reimburses DHS at a rate of between 75 percent and 90 percent of the cost of MMIS operations, maintenance and development.

The system incorporates:
- HIPAA-compliant, standard national billing formats to increase uniformity with other Minnesota health care payers.
- A web-based MN-ITS “front-end” system to enable providers to determine recipient eligibility, submit claims, obtain claim status and get their remittance advice free and online. More than 99 percent of Minnesota Health Care Programs (MHCP) non-pharmacy fee-for-service claims are submitted electronically via MN-ITS.
- Phone-based, batch and real-time eligibility verification systems (EVS).
- A pharmacy point-of-sale system to enable prompt, electronic processing of 99.9 percent of all drug claims.
- Interfaces with METS, MAXIS, PRISM and the Social Service Information System (SSIS).
- Nightly data downloads into the DHS Data Warehouse to incorporate claims and payment information into DHS reports and decision-making.

The MMIS is composed of various subsystems including:

Claims

This subsystem processes payment or denial of health care claims for services provided through public programs with all other subsystems supporting appropriate claims payment. In fiscal year 2017 MMIS processed approximately 37 million fee-for-service claims, 50 million encounter claims, and 28 million capitation payments to managed care organizations. DHS paid almost $11.7 billion to more than 69,000 providers, counties, tribes, and managed care organizations.

Medical claims are received through an electronic mailbox system called MN-ITS. Drug claims are also received using “point of sale” software which returns an immediate approval/denial message to the submitting pharmacy or pharmacy biller.
Recipient
In 2017, approximately 1.496 million persons received services through Minnesota Medicaid, MinnesotaCare, and state-funded health care programs. The Recipient Subsystem contains recipient health care program eligibility determination for both state supervised and county administrated programs such as Medical Assistance, MnCare, Alternative Care, etc. Financial eligibility for most public programs is determined through MAXIS for seniors and people with disabilities. Other populations may use METS for determining health care eligibility. For individuals eligible for health care, some information transfers from MAXIS or METS to MMIS, and state and county financial workers enter additional information.

Provider
Assuring that claims paid to qualified providers is a primary function of MMIS. Provider eligibility and enrollment information maintained for the 236,000 providers enrolled in Minnesota who provide services to persons participating in public programs. Types of data include demographics, licensing information, and approved or restricted services. Case managers and care coordinators are also enrolled providers and identified here.

Reference
Often referred to as the PDDD, this subsystem contains all of the necessary information regarding procedure codes, diagnosis codes, drug codes and diagnostic related groups (DRG) codes. For example, a procedure code record includes the code, a description of the service or procedure, restrictions (age, gender) and the dollar amount MMIS will pay a qualified provider for providing that service to an eligible individual. It also includes an indicator as to whether or not a procedure (service) requires prior authorization.

Prior Authorization
The purpose of this subsystem is the processing and identification of those services which need authorized by case managers, DHS staff, or DHS contractors prior to payment to a provider. Programs that use prior authorization for fee-for-service payment to providers are:

- MA Home Care including Personal Care Assistance (PCA)
- Home and Community Based Waivers (BI, CAC, CADI, DD, and EW)
- Moving Home Minnesota
- Essential Community Supports
- Alternative Care
- MA Prior Authorization (Dental, Medical, Pharmacy, and Supply)
- Day Training and Habitation (DT&H) Non-waiver Pilot Program
- Insurance Extension programs.
- Some medical transportation authorizations
- DHS also contracts with an external pharmacy review organization to approve pharmacy prior authorizations, and a medical review agent for the remaining authorizations.
Quality Control
Department of Human Services’ (DHS) staff can only access this subsystem. Information meets the federal requirement to review a sample of all claims paid to determine under- or over-payments. This federal requirement was mandatory for a period of one year as a condition of federal certification of MMIS. Currently, this subsystem runs a monthly sample of claims to review for provider billing and/or claims examiner pricing errors. Generally, it provides an audit of MMIS.

SIRS Summary Profile, SIRS Treatment Analysis, SIRS Claim Detail
The primary purpose of the Surveillance and Integrity Review Section is the development of exception reports regarding provider and recipient data which compare claims to determine if there are areas that need further review. Exception reports help identify potential fraud or abuse in MHCP, and MMIS system performance issues.

Data Security
Controlling access to MMIS information through mainframe software (ACF2) and application software written specifically for MMIS. ACF2 prevents unauthorized access to the “front door” of MMIS, while the application security prevents unauthorized access to specific data elements or screens. MMIS security staff work with security liaisons located in each county, tribe, and managed care organization, as well as in each division within DHS central office to ensure access when needed.

MARS
The Medical Assistance Reporting System (MARS) contains the reports required by the federal government as part of the conditions of federal financial participation (FFP) for MA expenditures. Only DHS staff has access to this subsystem. The MARS subsystem produces the reports and files required by Centers for Medicare and Medicaid Services (CMS), the federal office that oversees those programs.

Financial Control
The Financial Control subsystem gives staff the ability to create and update “obligations”, post receipt entries, post reimbursement requests and track financial obligation activity. Obligations include both payment and collection liabilities of DHS, the county, and individuals. County workers or DHS staff create and change obligations. This subsystem has interfaces with the MMIS Third Party Liability (TPL) Resource file, Recipient File, Provider File, Claims Processing File, Medical Assistance Reporting System (MARS), and a daily Recipient File.

Third Party Liability (TPL)
This subsystem has two selections: TPL Billing Application and TPL Resource File Application. The TPL Billing Application used by Benefit Recovery collects recovery payments on paid claims with possible third party liability. This subsystem maintains insurance carrier information for billing and reporting to providers.
The TPL Resource File Application is used to “cost avoid” and/or “pay and close” medical claims submitted by providers, and to record third party liability information for Minnesota Health Care program participants. County financial workers can add or update the information. MMIS recovered or cost avoided a total of $960.7 million in 2017 by ensuring that liable third-party payers paid for health care before using state and federal funds.

Drug Rebate
This subsystem conducts a monthly download of utilization data for drugs reimbursed by Medicaid. MMIS also creates quarterly drug rebate invoices by combining the utilization data with unit rebate amounts furnished by CMS. DHS Drug Rebate staff provides invoices to manufacturers. Tracking of payments and resolution of disputes is not one of its functions.

Managed Care
This subsystem supports the enrollment of managed care products by MHCP participants, as well as the processing of capitated payments to managed care organizations. Provider, contract, and rate information are stored here.

REPORTS
There are thousands of reports generated by MMIS. These reports are stored and accessible through Infopac, a mainframe report distribution software. Infopac is set up to retain multiple iterations of each report, and can “section” a report by agency (such as county or health plan) to prevent one agency from viewing another agency’s section of a report. Reports generated by MMIS on a regular schedule depends on need: daily, bi-weekly, monthly, quarterly, annually or on request. See Chapter 4 in this manual for more information about reports commonly requested by lead agencies.

101.02 MMIS Interface with MAXIS
MMIS depends on MAXIS for person eligibility determination functions and maintenance of all person information related to health care eligibility. MMIS interfaces with MAXIS through the Recipient Subsystem. Some information entered into MAXIS by the financial worker transfers to MMIS while other information entered into both systems.

The Recipient Subsystem collects the information from MAXIS and contains person demographic and health care program eligibility determination.

MAXIS assigns the recipient's ID number (also called Person ID number or PMI) to each person applying for most programs. It is a unique eight digit lifetime number that identifies the person in the system. This ID number does not change when the person changes programs, loses eligibility, or moves to another lead agency. If assignment of more than one PMI number, one of the numbers will be made inactive.

The PMIN Function used to assign the PMI number when there isn’t a financial worker involved in the person’s case. Examples are those people screened through the
preadmission screening program and not receiving services through a public program, or those people receiving services through the Alternative Care, Essential Community Supports, or MNCare programs who are not eligible for services through any other type of public program. MAXIS changes using the PMIN Function without the assistance of a financial worker for birthdate, marital status, name, etc. The information transfers to MMIS.

Data produced in MAXIS can only change in MAXIS. If a worker, using MMIS, notices incorrect information provided by MAXIS, the financial worker must correct the information in MAXIS. The change then transfers to MMIS.

101.03 MMIS Access and Security Features
Supervisors and the MMIS security officer in each agency determine assignments to lead agency staff of a logon ID and a security group. The security group will control access to and allow actions in subsystems through the Main Menu Screen.

The security liaison submits a request to DHS for the logon ID to gain access to MMIS. This person will also contact the department whenever a logon ID suspends due to password violations, access terminates due to no activity within 45 days, or assignment of a temporary password. Please view Session 2 of the MMIS Training Series for more information on how to log into the system and use your password, as well as how to add MMIS to your computer or laptop. Use this link to download BlueZone.

101.04 Prior Authorization Subsystem Overview
The Prior Authorization subsystem involves the processing required for the entry, maintenance, and approval of:

- Designated medical services, dental services, drugs, and supplies covered by the Medical Assistance (MA) program.
- Home care authorizations for state plan services.
- Screening documents for community, nursing home, waiver, Alternative Care, Essential Community Supports, Moving Home Minnesota, health risk assessments, and the MA Home Care programs.
- Screening documents for the Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), and Special Needs Basic Care (SNBC) programs.
101.05 Recipient Subsystem Overview

The primary objective of this subsystem is to identify all persons eligible for Minnesota Health Care Programs, and those screened or assessed through the Long Term Care Consultation Services Program.

This subsystem is the source of all eligibility determination data for MMIS, whether generated by DHS public assistance programs, the Social Security Administration, the Department of Health, or MAXIS. Information supports claims processing, management and administrative reporting, surveillance and utilization review reporting, and third party liability processing. It is also responsible for maintaining person benefit limits, controlling the buy-in process, and generating various reports.

Person eligibility, program, and demographic data obtained from the Department of Health, screening documents, the Children's Health File, and MAXIS. MAXIS provides daily updates to the Recipient Subsystem. Information edits service agreements to ensure eligibility exists for appropriate authorization and subsequent claim payment.

Waiver, Essential Community Supports program, and Alternative Care program eligibility history is created and maintained by using information from the LTC or DD screening documents. The information obtained from the screening document is:

- Waiver program eligibility. Includes program type, eligibility begin and through dates, and last screening action date on the RWVR screen in the Recipient Subsystem.
- Case manager. Includes case manager and care coordinator name, number, and begin and end dates of case manager involvement on the RMGR screen.
- Alternative Care and Essential Community Supports program eligibility. Includes the eligibility begin and end dates as well as the county of financial responsibility on the RELG screen.
- Medicare/MBI program eligibility. Includes the eligibility spans for Medicare/MBI Parts A and/or B on the RMCR screen for Alternative Care and Essential Community Supports participants.

In addition, the Alternative Care and Essential Community Supports screening document updates the Recipient Subsystem with the person's mailing address on the RCAD screen. This screen shows the current home address, the last previous home address (if any) and any alternative mailing address. On the Key Panel screen, use the case number (shown on the major program span on the RELG screen) instead of the PMI number.

Case File – Person's Addresses

The Case information is different from the Person information. You are able to view case information on everyone connected to the case record as well as the person’s home address and mailing address.
A case number is different from a PMI. The PMI number is person specific, however, all persons within a household share a case number -- it is what links individual PMI's together as being somehow related.

Steps to locating a person's case number:

1. Enter into the Recipient subsystem using the PMI number to find the case number field on the major program span of either the RSUM screen or the RELG screen.
2. Write down the person's case number, and then use the PF6 key to return to the Key Panel screen.
3. Move your cursor to the CASE NUMBER field in the second section of this screen, and enter the case number you wrote down. Press your keyboard key to move to the next screen.
4. You should now be on the RCAD (Recipient Case Address) screen. This screen shows the residential address with the current address displayed on the left side. The previous address is on the right side. The Medical Mailing Address section shows an optional address used to send mailings to an alternative person.
5. Use the PF3 or PF6 key to return to the Key panel screen.

Accessing and Viewing Data in the Recipient Subsystem

Session 5 of the MMIS Training Series provides instructions on how to log into this subsystem, navigate to the screens, read data that may cause edits to post on screening documents and service agreements as well as an explanation of different screens.

101.06 Provider Subsystem Overview

This subsystem provides comprehensive provider related information on all enrolled providers. Provider information supports claims processing, management reporting, and surveillance and utilization review functions. It supports the processing of online provider enrollment applications and information changes.

There are many types of providers. Here is a list of provider type codes and titles:

AP ..... ACUPUNCTURIST
B1...... BIRTH CENTER
C1...... CERTIFIED PROFESSIONAL MIDWIFE
DC ..... ALCOHOL AND DRUG COUNSELOR
E1...... EIDBI EARLY INTENSVE DEV/BEHVE INTER
HD ..... HEALTH CARE DELIVERY SYSTEM
PR ..... PSYCHIATRIC RESIDENTIAL FACILITY
RC ..... RECOVERY COMMUNITY ORGANIZATION
00 ..... NURSING FACILITY
01 ...... HOSPITAL
02......HOSPICE
03......INSTITUTION FOR MENTAL DISEASE
04......RENAL DIALYSIS FREE STANDING
05......ICF/MR - FACILITY
06......CHILDRENS RESIDENTIAL SERVICES
08......NF CONTROLLING ORGANIZATION
09......SCHOOL DISTRICT
10......COMMUNITY MENTAL HEALTH CENTER
11......REHABILITATION AGENCY
12......SERV FOR CHILDREN W/HAND CLIN
13......SERV FOR CHILDREN W/HAND PROV
14......SOCIAL WORKER-LICENSED IND
15......LICENSED DIETICIANS AND NUTRITIONISTS
16......CHILD AND TEEN CHECKUP CLINIC
17......REGIONAL TREATMENT CENTER
18......HOME AND COMMUNITY SRV PROV.
19......DAY TRAINING & HABILITATN CTR
20......PHYSICIAN
21......CONSUMER DIRECTED CARE
22......AMBULATORY SURGERY CENTER
23......CASE MANAGER (WAIVER)
24......PRE-PAID HEALTH PLAN PROVIDER
25......MARRIAGE AND FAMILY THERAPIST
26......MENTAL HEALTH REHAB SPECIALIST
27......MANAGED CARE HEALTH COODINATORS
28......EDI TRADING PARTNER
29......OCCUPATIONAL THERAPY
30......DENTIST
31......DENTAL HYGIENIST
32......INDEPEND DIAG TESTING FACILITY
33......CONSOLIDATED RECORDS (multiple legacy provider records)
34......BILL ENTITY FOR MENTAL HEALTH
35......OPTOMETRIST
36......PODIATRIST
37......CHIROPRACTOR
38......PERSONAL CARE PROVIDER
39......REGISTERED PHYSICAL THERAPIST
40......SPEECH PATHOLOGIST
41......LIC PSYCHIATRIC PRACTIONER
42......PSYCHOLOGIST
43......AUDIOLOGIST
44......COUNTY APPROVED CASE MNGR
45......COUNTY RESERVATIONS SRVC
46......APPROVED DAY TREATMENT CENTER
47......CNTY CNTRCT MNTL HLTH REHAB SV
48......REGIONAL SERVICES SPECIALIST
49......BILLING ENTITY FOR PHYSICAN SVCS
50......INTENSIVE RESIDENTIAL TREATMENT SERVICES (IRTS) MENTAL HEALTH
51......INDIAN HEALTH FACILITY PROV
52......FEDERALLY QUALIFIED HLTH CTR
53......RURAL HEALTH CLINIC
54......FAMILY PLANNING AGENCY
55......COMMUNITY HEALTH WORKER
56......DENTAL LAB
57......PUBLIC HEALTH CLINIC
58......COMMUNITY HEALTH CLINIC
59......COORDINATED CARE DELIVERY SYSTEM
60......HOME HEALTH AGENCY
61......PUBLIC HEALTH NURSING ORG
62......CHEMICAL DEPEND FREE STANDING
63......LICENSED PROFESSIONAL CLINICAL COUNSELOR
64......PRIVATE DUTY NURSE
65......NURSE PRACTITIONER
66......NURSE MIDWIFE
67......CERT REGISTERED NURSE ANESTH
68......CLINICAL NURSE MENTAL HEALTH
69......PHYSICIAN ASSISTANT
70......PHARMACY
72......TRANSPORT-BROKER
73......WIC PROGRAM
74......HEAD START PROGRAM
75......OPTICIAN
76......MEDICAL SUPPLIER
77......HEARING AID DISPENSER
78......OTHER NON-PHYSICIAN
79......OTHER NON-TRADITIONAL
80......LABORATORY, INDEPENDENT
81......X-RAY/DIAGNOSTIC
82......MEDICAL TRANSPORTATION PROV
83......LIEN HOLDER
84......STATE DEPARTMENT OF HEALTH
85......STATE DEPT OF HUMAN SERVICES
86......HEALTH CARE FINANCING ADMIN
87......CO-PAY PROVIDER
88......MCRE/MA ACCESS SERVICES
89......SPECIAL CONTRACT PROVIDER
90......INDIVIDUAL
91......EMPLOYER
92......GROUP PAYER
93......MANUFACTURER PHARM/MED SUPPLY
94......MEDICAL REVIEW AGENT
95......CLEARINGHOUSE
Home and community based services (HCBS) providers send applications for enrollment to the Provider Eligibility and Compliance Unit for approval. Until this process is completed and the provider is in an active status, edits will post on service agreement line items using this provider’s number.

A provider may receive the following types of letters from the Provider Enrollment Unit:

- An approval letter when a new provider:
  - Is added in an active status,
  - A record is changed from pending to active, or
  - A new service is added to the record
  Along with an approval letter, the new provider will receive a packet which consists of a welcome letter, the provider manual, a supply of claim forms and the appropriate billing instructions.
- A denial letter when a provider is determined to be ineligible or when the enrollment status changes from pending to denied.
- A reinstatement letter when an existing provider changes from a terminated status to a renewal status.
- Letters for license renewals.

A provider receives a termination letter when:

- The status is changed from active to terminated;
- The record changes to "terminated - no claims activity" status due to no claims activity in twelve months. Providers are not deleted from the Provider File and may request reinstatement; or
- The license suspension of a Medical Assistance provider. The Provider Enrollment Unit receives a list of license suspensions on a regular basis from the Minnesota Department of Health, DHS licensing, and other licensing entities.

Case Manager/Certified Assessor Provider Number Type 23
Enrollment provides a provider number for every lead agency case manager or care coordinator. This number identifies the person case managing the care plan (also called community support plan, coordinated services and support plan, collaborate care plan, and comprehensive care plan).

The LTC screening document shows the case manager provider number in the CM/HP/CA Number field on the ALT1 screen, and on the ASA1 screen of the service agreement. If a case manager contracts with several different lead agencies, it is necessary for assignment of a provider number for each lead agency.
Lead agency staff with the appropriate security enters information on the PADD screen of the Provider Subsystem to obtain a new case manager nine-digit provider number under Provider Type 23. The status must change from "pend" to "active - no pay" in order to use it on the screening document or service agreement. The effective date should be the approval date to provide case management activities.

**Care Coordinator Provider Number Type 27**

County and other staff contracted with or employed by health plans to provide care coordination activities recorded in MMIS identified on the screening documents and service agreements as a care coordinator – Provider Type 27. This will be in addition to their provider number type 23 as a county/tribal case manager. There is one provider number 27 assignment even if the care coordinator contracts with more than one health plan.

**Creating a New Provider Number Type 23 or 27**

1) Select the "PROVIDER FILE APPLICATION" from the Main Menu screen
2) On the Provider Key Panel (PKEY) screen, enter an "A" in the ACTION CODE field
3) On the PADD screen, enter the following information:
   - PROV TY (Provider Type) is either 23 or 27
   - SSN is a required field; this is a federal requirement; the Social Security Number field is not viewable by others except by DHS provider enrollment staff, as needed; it is used for numerical comparison only
   - NAME is the case manager's name, first, MI, last
   - PRAC ADDRESS is the business name (i.e., Minnesota Co Human Services)
   - CORR DATE RECD (request date, if able to get in to this field)
   - Line (1) is the street address. This needs to be the physical address, not just PO Box
   - City, state, zip
   - TEL is case manager's business phone number with area code but no dashes between the numbers. NOTE: it is important to keep this field updated. The phone number will be added to the recipient and provider service agreement letters and any other documents as needed
   - CNTY is the county code number preceded by a zero (3-digits)
   - TYPE PRAC field enter 01
   - FAX is a number that is accessible/used by the case manager
   - APP DT field is today's date
   - SORT NAME is the case manager's name, it is entered last name first (phone-book style) – no punctuation
4) Note that the pending status. Change the provider Type 23 numbers to a status “3” in order to activate the UMPI Number. You can also send a request to activate the number by emailing dhs_mhcp_provider_enrollment@state.mn.us. Include the provider number, full name, agency name, and provider type.
For Provider Type 27s, either contact the Provider Enrollment Specialist at the above email or wait for the Provider Enrollment Unit to receive a daily report showing new provider entries. They will activate the record. Until this is finished, do not use the care coordinator number type 27 on the screening document or service agreement or for receiving reports in their MN-ITS mailboxes.

5) Save your entry by using F3.

A message will appear on the screen when you use F3 if you are adding a duplicate person to the same agency who already has a provider type 23 or 27 number. This message is “Duplicate SSN found on Provider File. Provider = XXXXXXX 00”. Check the number to verify that it is not a duplicate.

If a case manager (provider type 23) works out of more than one lead agency, they can have more than one provider number. If a case manager leaves one agency and receives a new number for a different agency, then later returns to the same agency, the first number is re-activated.

Tip: A message will appear on the screen stating “Date of birth is required”. It is actually not required for these provider types. Hit F3 again and advance past it.

Another method to request a new Provider Number for type 27 is to complete the Health Care Case Coordinator – Provider Enrollment Application form DHS-4474. Fax this form to (651) 431-7462.

Changes to the Case Manager PADD Screen
It is important to keep the case manager information current. The service agreement letters to the person and provider(s) contain the name and phone number of the case manager listed on the PADD screen.

For Provider Type 23 numbers:
If a case manager leaves the agency, the provider number is terminated by adding a new span for one of the below status and the effective date.
• H – Deceased
• J – Voluntary

You may also contact dhs.mhcp.provider.enrollment@state.mn.us to request adding this termination type and date to the Provider Type 23 or 27 record. Include the NPI number, full name, agency name, termination date, and provider type.

If a case manager, (Provider Type 23) changes agencies, they are required to obtain a different number for the new agency and the old number terminates by the original agency. Change the Name and Sort fields when a case manager changes their name.

Contact the MHCP Provider Call Center at 651 431-2700 or 1-800-366-5411 for changes needed for health care case coordinator (Provider Type 27 UMPI numbers).
How to Access the Provider Subsystem

There are several ways to access this subsystem. Most staff will only be able to inquire on fields in the Provider Subsystem.

1. Use the F4 key on the CM/HP/CA NBR field located on the LTC screening document ALT1 screen, or the CM NBR field on the ADD1 screen of the DD screening document while in any action mode.

2. Use the F4 key while on the CM NBR field on the ASA1 screen or the PROV NBR field on the line item while in the service agreement in any action mode.

3. Use the F5 key while in the LTC or DD screening document or the service agreement which brings up a screen to enter a provider name at the top, or a person’s name at the bottom. Use the F4 key to view the Provider’s Selection screen.

4. Please see Session 4 in the MMIS Training Series for an explanation on how to use the PF keys. Session 16a explains how to navigate directly to the provider subsystem from the Main Menu screen and reviews several screens that can cause edits to appear on the service agreement.

101.07 Claims Subsystem Overview

Every other subsystem interacts in some way by maintaining data necessary for claims processing, or by processing and/or reporting on the claims data created and maintained in this subsystem. Providers are encouraged to use the Eligibility Verification System (EVS) prior to submitting a claim. This telephone system identifies the person’s eligibility for specific programs as of the time of the call.

The Provider Subsystem batch and assign a 17-digit transaction control number (TCN). This TCN provides a method of uniquely identifying any claim in the system. Claims are submitted electronically through MN-ITS.

This subsystem captures, controls, and processes claim invoice data from the time of initial receipt (on hard copy or electronic media) through final disposition, payment and application to the various claim files. Using the data contained in the most current recipient, provider, prior authorization and reference files, this subsystem will edit, audit, and process claims.

View thirty six months of claims history maintained for auditing, online inquiry and reporting purposes. Claims adjudicated (processed) prior to the 36 month retention period are stored permanently on the archived claims file. Claims maintained on the lifetime claims file require a longer retention period to accommodate audit requirements or other needs.

A claim with errors is suspended and placed in the claims file where department staff attempt to resolve the claim exceptions. Claims deny if the problems cannot be resolved.
Once in the system, all claims are subject to a complete series of edits and audits to ensure that only valid claims for eligible persons and covered services pay at appropriate rates to enrolled providers. Edits applied to each claim include data validity, recipient, provider, reference, rates, duplicate checking and utilization review auditing.

Claims process on a daily basis using various pricing methodologies to accommodate the many claim types. To arrive at the final payment amount, the system uses a fee schedule, DRG rate, or other method and subtracts applicable spenddown, co-payment, and third party payments.

Claim payment cycles typically occur on a bi-weekly basis. Every provider with claim activity in a payment cycle receives a remittance advice (RA) organized primarily by claim type and lists all claims processed in the payment cycle for the provider including paid, denied, and suspended claims. Gross adjustments and summary information are also included.

Adjudicated claims and paid/denied claims on the current month claims file and paid/denied claims on the claims history file are available for review by lead agencies using this subsystem. Claims display either in detail or in summary format with several claims per screen.

101.08 MN-ITS
The MN-ITS Eligibility Request or 270 transactions, is a web-based system designed to assist the provider to:
- verify eligibility for persons enrolled in MHCP by providing comprehensive recipient eligibility information
- submit claims
- obtain claim status
- obtain their remittance advice free and online

More than 99 percent of MHCP non-pharmacy fee-for-service claims are submitted electronically via MN-ITS. Access MN-ITS and then click “Log in Here” on the left navigation bar. Providers need to have a Username and Password to log into MN-ITS. They will be given a Username and Password upon registering for MN-ITS.

A provider will need the following information to utilize the MN-ITS Eligibility function:
- Date of Service; and
- The recipient’s PMI number; or two of the three following pieces of information:
  - Social Security Number
  - Birth Date
  - Last and First Name

The MN-ITS Eligibility Response, or the 271 transaction, provides the following categories of information:
• Major Programs and Spenddowns;
• Waivers;
• Other Eligibility Information (hospice, special transportation, co pays);
• Prepaid Health Plans;
• Designated Provider Services;
• Other Insurance;
• Medicare; and
• Benefit Limits

101.09 Eligibility Verification System (EVS)
Phone EVS is accessible by calling 651 431-2700 (press 7) or 800-657-3613. Access the system by using a push button phone with touchtone service. Providers, including case managers, will need their NPI/UMPI provider number to access data via the phone.

Additionally, a provider will need the date of service and the recipient’s PMI number or two of the three following pieces of information:
• Social Security Number
• Birth Date
• Last and First Name

The EVS provides the following categories of information:
• Major Programs and Spenddowns
• Waivers
• Other Eligibility Information (hospice, special transportation, co pays)
• Prepaid Health Plans
• Designated Provider Services
• Other Insurance
• Medicare
• Benefit Limits
Chapter 2 – LTC Screening Document

201.01 Purpose of the LTC Screening Document

Some form of the Long Term Care Screening (LTC) Document form DHS-3427 has been in use since 1984. This form documents preadmission screening and Long Term Care Consultation (LTCC) activities and public programs eligibility determination, as well as to collect information about people screened, assessed, or receiving services under home and community-based services programs (HCBS). See an introduction to the LTC Screening Document and the steps in MMIS to view saved screening documents in the MMIS Training Series, Sessions 6 and 7.

Long Term Care Consultation and Relocation Services Coordination

Each lead agency is responsible to perform certain activities under Minnesota Statutes 256B.0911 (Long Term Care Consultation). In addition, lead agencies perform other activities related to Relocation Services Coordination and case management of home and community-based services programs recorded on the Long Term Care Screening Document.

Preadmission Screening and Recording Assessment/Program Eligibility

The LTC telephone screening document forms DHS-3427 and DHS-3427T records preadmission screening of all persons entering certified nursing or certified boarding care facilities as required under Minnesota Statutes, 256.975 (PAS) and under federal OBRA legislation (Public Law 101 and 103). The LTC Screening Document DHS-3427 records assessment and program eligibility determination information for persons served under the nursing facility level of care waiver programs as well as the Alternative Care (AC) and Essential Community Supports (ECS) programs. In addition, lead agencies use this form for certain program administration activities such as reassessment, closures, and program changes.

Services Authorization and Payment

The LTC Screening Document provides an important link between assessment and eligibility determination, person information, and services authorization and payment. It plays a vital role in the processing and acceptance of service agreements. A service agreement authorizes services planned for a person eligible for the waiver, Essential Community Supports, Alternative Care, and Moving Home Minnesota programs, and permits payment to providers of those services.

Service agreement approval depends on an eligibility span recorded in MMIS. The approved screening document develops the eligibility span. Information from the LTC screening document checks against eligibility information in the Recipient Subsystem that limits the length of services approved, the type of service agreement that can be entered, and the types and amounts of services that can be approved.
Payment of LTC and NF Services

Because documents DHS-3427 and DHS-3427T play a critical role in establishing payments for a variety of long term care services, including nursing facility services, each agency must ensure timely submission of the LTC Screening Document information into MMIS. DHS strongly recommends that no more than fourteen (14) calendar days lapse between completion of any LTCC or case management activity and the submission of the data into MMIS.

Data Collection, Quality Assurance, and Management Reporting

Finally, information contained in the LTC Screening Document in combination with other data by the Department of Human Services for a variety of program evaluation purposes, including quality assurance and management reporting.

201.02 Major Activities Utilizing the LTC Screening Document

Agencies use the LTC Screening Document to record:

- Intake and referral activities undertaken by the LTCC team;
- The completion of preadmission screening of all persons entering a certified nursing or certified boarding care facility, before admission, to determine the appropriateness of the institutional placement.
- Managed care organizations continue to conduct PAS for MSHO/MSC+/SNBC members and the Senior LinkAge Line® (SLL) staff conduct screenings for all other persons not enrolled with MSHO or MSC+.
- The completion of OBRA Level I screening for the presence of mental illness or developmental disability before admission as required under federal OBRA requirements. This activity includes OBRA Level II referrals for more thorough evaluations of persons identified under the Level I screening process;
- Recommendations for services for persons screened or assessed, including institutional, formal, informal, or quasi-formal services;
- Eligibility for home and community based waiver programs based on need for institutional level of care, Alternative Care (AC), Moving Home MN (MHM), Essential Community Supports (ECS), and the authorization of services;
- Resource management to support services.
- Lead agency activities including reassessment, termination from home and community based waiver programs, and program changes. A LTC Screening Document opens, extends, or closes waiver, ECS, or AC eligibility on the Recipient Subsystem. This does not affect Medical Assistance eligibility (only financial workers may open or close MA eligibility);
- Relocation Services Coordination (RSC) activities including assessment and the election of relocation services by the person; and
- The bundle of component services provided by the Customized Living Services provider for Elderly Waiver persons.
201.03 Accessing the MMIS Prior Authorization Subsystem

If you do not have the correct security to access the Prior Authorization Subsystem, a message will appear on the Main Menu screen when you select Screenings. Contact your agency’s security officer to change your security group.

The MMIS Training series provides instruction on how to use the MMIS for the LTC Screening Document:

- Session 1 – MMIS Training Series Overview (mandatory to access other sessions)
- Session 2 – MMIS Security Log in and Passwords
- Session 3 – Basic Navigation in MMIS
- Session 4 – Using Programming Function (PF) Keys
- Session 5 – The Recipient Subsystem
- Session 6 – Introduction to the LTC Screening Document
- Session 7 – Viewing the LTC and HRA Screening Document
- Session 7a – Using Activity Types in MMIS
- Sessions 8 and 8a – Data Entering the LTC Screening Document
- Session 8b – Using Screening Document Type H for HRAs
- Session 9 – The LTC Screening Document for the MSHO and MSC+ Programs
- Session 10 – Coding the LTC Screening Document for Other Services
- Session 11 – DHS Approval of the LTC Screening Document
- Session 12 – Locating Suspended Documents for Correction or Deletion
- Session 13 – Deleting the LTC and HRA Screening Document

Other sessions focus on the service agreement listed in Chapter 3 in this manual.

201.04 Screening Document Fields

This chart shows a field by field description on the MMIS screens ALT1 – ALT6 and on the form DHS-3427.

<table>
<thead>
<tr>
<th>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section A and ALT1 Screen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Person Last Name</td>
<td>System Entered</td>
</tr>
<tr>
<td>2</td>
<td>Person First Name</td>
<td>System Entered</td>
</tr>
<tr>
<td>3</td>
<td>Middle Initial</td>
<td>System Entered</td>
</tr>
<tr>
<td>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</td>
<td>Field Name</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>4</td>
<td>PMI Number (Person Master Index)</td>
<td>Person’s own MMIS number. System Entered</td>
</tr>
<tr>
<td>5</td>
<td>Reference Number</td>
<td>To identify the individual by the agency’s unique numbering system.</td>
</tr>
<tr>
<td>6</td>
<td>Date Submitted</td>
<td>System Entered. The date the screening document is entered and saved in MMIS</td>
</tr>
<tr>
<td>7</td>
<td>Birth Date</td>
<td>This field must match the birth date on the Recipient Subsystem.</td>
</tr>
<tr>
<td>8</td>
<td>Sex</td>
<td>System Entered</td>
</tr>
<tr>
<td>9</td>
<td>Referral Date</td>
<td>The date of original referral for screening or assessment.</td>
</tr>
<tr>
<td>10</td>
<td>Next NF Visit</td>
<td>The purpose of this field is to identify the date of the next annual visit for persons under age 65. The date that is populated is 1095 days after the Activity Type Date of the most recent Activity Type 04. While the initial visit is mandatory, the annual visit allows delayed up to three years. The protected field automatically populates when using Assessment Result 43 NF Visit Every 3 Years. Use this Assessment Result value with program type 00 and Activity Type 07 when the person refuses the annual visit. The previous approved screening document must be an Activity Type 04 with Assessment Result 18.</td>
</tr>
<tr>
<td>11</td>
<td>Activity Type</td>
<td>Identifies the activity: a face-to-face assessment, a telephone screening, or a case management activity. See Section 201.05 for the definition of each type.</td>
</tr>
<tr>
<td>12</td>
<td>Activity Type Date</td>
<td>This field plays many roles. Some purposes are:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- indicates the date the lead agency performed an assessment or administrative activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- used in combination with the Referral Date for federal reporting on a timely assessment</td>
</tr>
<tr>
<td>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</td>
<td>Field Name</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
|                                                               | • sets the first day of the 60-day window allowed between the activity type date of activity types 02, 04, 06, 08, or 09 and the effective date when activity type 07 can be used to change the assessment result  
• used to indicate “as of” in the MMIS logic when new activity types are created  
• controls when activity type 08 for person turning age 65 on the BI, CAC, or CADI programs must be assessed | **13** | COS, COR, CFR  
County of Service, County of Residence and County of Financial Responsibility  
When manually entering the codes in these fields, the values will change if different from the values in the Recipient Subsystem for those eligible for Medical Assistance. Only the county financial worker may change the values in the Recipient Subsystem. The values transfers to the next entered screening document.  
COS refers to the county or tribe providing financial worker service for MA eligibility or re-determination. COR is where the person lives. For private pay and all others without financial workers, assume the COS, COR and CFR are the same (i.e. where a person lives).  
If MA does not overlap with the major program UN with eligibility type EC, then the COS, COR, and CFR fields on the ECS screening document will update the recipient subsystem’s RELG, RCIN, and RCAD screens and county fields on the ECS service agreement.  
The AC screening document will update the COS, COR, and CFR fields on the recipient’s subsystem’s RELG (for major program AC), RCIN, and RCAD screens (for AC case records) and the service agreement county fields. |
<table>
<thead>
<tr>
<th>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
</table>
| 14                                                            | LTCC County      | The county, tribal agency, or health plan who completed the screening, assessment, or other activity.  
- The county values are 001 – 087  
- SLL = Senior LinkAge Line® Staff  
- White Earth tribal agency’s code is 0B2  
- Leech Lake Tribal Band’s code is 0A4  
- Fond du Lac Tribal agency’s code is 0A4  
- Mille Lacs Tribal agency’s code is 088  
- Red Lake Nation’s agency’s code is 0A8  

The health plan values are:  
- UCM = A5658136 00 (UCare MN)  
- MED = A4057139 00 (Medica)  
- MHP = A9657134 00 (Metropolitan Health Plan replaced by HHP)  
- BPH = A0658138 00 (Blue Plus)  
- HPH = A5857139 00 (Health Partners)  
- IMC = A1060139 00 (Itasca Medical Care)  
- FPB = A8855137 00 (First Plan Blue)  
- PWH = A1551183 00 (PrimeWest Health System)  
- SCH = A0137073 00 (South Country Health Alliance)  
- HHP = A836618200 (Hennepin Health for SNBC only)                                                                                                                                                                                                                                                                                                                                                             |
| 16                                                            | Primary Diagnosis | The primary diagnosis that underlies the need for services and care. Providers receive the diagnosis code on the service agreement letter to use on their claim form if they wish.  

The following diagnosis codes for non-diagnosing providers may be used by assessors when a diagnosis from a medical record is unavailable:  
- Z74.1 need for assistance with personal care |
<table>
<thead>
<tr>
<th>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
</table>
| | | • Z73.6 limitation of activities due to disability  
• Z59.0 homelessness  
• Z13.9 encounter for screening, unspecified  
• Z59.1 inadequate housing  
• R69 illness, unspecified  
• Z59.9 problem related to housing and economic circumstance, unspecified |
| Use the following ICD-10 developmental disability diagnosis codes on both the LTC and DD Screening Documents:  
• F70 – mild intellectual disabilities  
• F71 – moderate intellectual disabilities  
• F72 – severe intellectual disabilities  
• F73 – profound intellectual disabilities  
• F78 – other intellectual disabilities  
• F79 – unspecified intellectual disabilities |
<p>| Placing the cursor on any of the diagnosis fields and using the PF4 key will show you the name of the condition represented by the number. |
| Secondary Diagnosis | The secondary diagnosis that may affect the need for care or services. See above information. |
| 18 | Is there a history of a DD diagnosis? | Records if there is a history of a developmental disability or related condition diagnosis. (Y/N) |
| 18A | If so, what is the diagnosis | Indicates the DD diagnosis. See the acceptable DD diagnosis codes listed under primary diagnosis. |
| 19 | Is there a history of a MI diagnosis? | Records if there is a history of a mental illness diagnosis (Y/N) |
| 19A | If so, what is the diagnosis | Indicates the MI diagnosis. Use diagnosis codes obtained from medical records. |
| 20 | Is there a history of a BI diagnosis? | Records if there is a history of a traumatic brain injury diagnosis (Y/N) |
| 20A | If so, what is the diagnosis? | Indicates the BI diagnosis. Use diagnosis codes obtained from medical records. |</p>
<table>
<thead>
<tr>
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<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Case Manager/Care Coordinator/ Certified Assessor Name</td>
<td>System entered based on the CM/HP/CA UMPI number entered.</td>
</tr>
<tr>
<td>23</td>
<td>Case Manager/Care Coordination/ Certified Assessor NPI/UMPI Number</td>
<td>The provider number of the county or tribal case manager assigned to the person. These staff enroll as provider type 23. The provider number of the health plan coordinator for the MSHO, MSC+, and SNBC programs. These staff enroll as provider type 27. Placing the cursor on this number and using the PF4 key will show the name of the person and their location/organization (on the PADD screen).</td>
</tr>
<tr>
<td>Section B and ALT2 Screen</td>
<td>Present at Screening/ Assessment</td>
<td>Identifies different types of people who were present at the screening or assessment. No duplicates allowed. NOTE: the County PAS Consult does not indicate that the second member of the team was physically present. It indicates that the consult occurred.</td>
</tr>
<tr>
<td>24</td>
<td>Informal Caregiver</td>
<td>Indicates if the person has an informal caregiver who provides regular services. An informal caregiver is a family member, friend, neighbor, and others who provide services and assistance without reimbursement. These individuals do not need to be living in the same household as the person assessed to receive services or support under HCBS programs. See the answer from field E.15 in form DHS-3428, or from field D.15 in form DHS-3428A. Y or N</td>
</tr>
<tr>
<td>25</td>
<td>Marital Status</td>
<td>Legal marital status</td>
</tr>
<tr>
<td>26</td>
<td>Reason(s) for Referral</td>
<td>Why the person or family is requesting a screening or assessment. Use up to two different values.</td>
</tr>
<tr>
<td>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</td>
<td>Field Name</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>27 Current Living Arrangement</td>
<td>Whom the person lives with. Value 04 is a congregate setting.</td>
<td></td>
</tr>
<tr>
<td>28 Planned Living Arrangement</td>
<td>Whom the person will live with. Value 04 is a congregate setting.</td>
<td></td>
</tr>
<tr>
<td>29 Assessment Team</td>
<td>Identifies who completed the assessment or screening. Use value 04 with the CAC program.</td>
<td></td>
</tr>
<tr>
<td>30 Hospital Transfer</td>
<td>Did the person transfer from an acute hospital to a long term care facility (nursing or certified boarding care facility)? (Y/N)</td>
<td></td>
</tr>
<tr>
<td>31 OBRA Screening Level 1</td>
<td>Was an OBRA Level 1 screening completed? (Y/N)</td>
<td></td>
</tr>
<tr>
<td>On ALT2 screen only</td>
<td>Dental Concerns</td>
<td>For SNBC and MSHO/MSC+ health risk assessments. Values are Y, N, or C (choose not to answer). Field is on the form DHS-3427H.</td>
</tr>
<tr>
<td>On ALT2 screen only</td>
<td>Have Dentist</td>
<td>For SNBC and MSHO/MSC+ health risk assessments. Values are Y, N, or C (choose not to answer). Field is on the form DHS-3427H.</td>
</tr>
<tr>
<td>32 Current Housing Type</td>
<td>The setting where the person lives. NOTE: Customized Living and 24 hour Customized Living Services are not housing types. Individuals receive services in a variety of housing types including licensed settings such as foster care, or a setting with a physical plant license such as board and lodge, as well as in the person’s apartment/home.</td>
<td></td>
</tr>
<tr>
<td>33 Planned Housing Type</td>
<td>The setting where the person will live. See above instructions.</td>
<td></td>
</tr>
<tr>
<td>34 Current Program License</td>
<td>The program license of the housing setting, where the person is currently living, if any. Foster care, or nursing facility, e.g. As of July, 2020 this field is no longer mandatory.</td>
<td></td>
</tr>
<tr>
<td>35 Planned Program License</td>
<td>The license of the housing setting where the person is planning to live, if any. Foster care, or nursing facility, e.g. As of July, 2020 this field is no longer mandatory.</td>
<td></td>
</tr>
</tbody>
</table>
| 36 OBRA Level 2 Referral                                      | • Indicate “y” if a referral was required and made as determined through the Level 1 screening, or a Level 2 screening completed prior to the Level 1 screening.  
• If the DD History field = Y, the OBRA Level 2 Referral for DD DX must be a Y. |
<table>
<thead>
<tr>
<th>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>BI/CAC Referral</td>
<td>Indicates whether a referral was required and made according to BI and CAC program requirements.</td>
</tr>
</tbody>
</table>
| Section C and ALT3 Screen General Function and History Fields 38 - 74 | • Activity of Daily Living (ADLs)  
• Case Mix A - L, V  
• Disability Certification  
• Self-Evaluation  
• Hearing  
• Communication  
• Vision  
• Mental Status Evaluation  
• Independent Activity of Daily Living (IADLs)  
• Falls  
• Hospitalizations – number within last year  
• Emergency Visits – number within last year  
• NF Stays – number within last three years  
• Ventilator Dependent | Records information obtained during a screening/assessment about the person’s strengths and areas of needed support, and past health care utilization.  
Various fields checks the case mix letter for accuracy including the ADL fields.  
The Ventilator Dependent field values 02 and 03 allow the case mix to be V for EW persons. See more information at the end of this chart.  
Reminder: the Supplemental Form for Assessment of Children under 18 (DHS 3428C) is required for all persons under age 18. This form is a determination of age-appropriate dependences.  
See the Case Mix Classification Worksheet DHS form-3428B to determine the correct case mix value.  
The family planning and sexually active fields are on the health risk assessment screening document form DHS-3427H and completed only for the SNBC health risk assessments. |
<table>
<thead>
<tr>
<th>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family Planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sexually Active</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section D and ALT4 Screen</th>
<th>Assessment Results and Exit Reasons</th>
<th>Field 75A: The outcome of the assessment activity. Choices are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>75A and 75B</td>
<td>Field 75A: The outcome of the assessment activity. Choices are:</td>
<td>01 – used only once to open to a waiver, ECS, MHM or AC program</td>
</tr>
<tr>
<td></td>
<td>02 – remain in or return to the community with services not funded by HCBS programs</td>
<td>03 – remain in or return to the community without services</td>
</tr>
<tr>
<td></td>
<td>04 – 09 institutional stays</td>
<td>08 – institutional stays</td>
</tr>
<tr>
<td></td>
<td>10 – changing from one program type to another</td>
<td>11 – reopening to the same program that was exited in the past</td>
</tr>
<tr>
<td></td>
<td>12 – used with activity type 10</td>
<td>13 – the annual reassessment visit required to continue eligibility for the waiver, ECS, MHM, or AC program.</td>
</tr>
<tr>
<td></td>
<td>18 – the NF visit for conversion case management or relocation service coordination</td>
<td>17 - 25, 31, 33, and 34 - exiting from the waiver, ECS, MHM, or AC program. With some exclusions, exit codes 17, 21 – 24, 31, 33, and 34 require the advance notice of appeal sent to the person. See more information about exit codes at the end of this chart.</td>
</tr>
<tr>
<td></td>
<td>29 – used in fields 78 – 80 or field 75A when LTCC County = SLL</td>
<td>30 – used in field 75B to indicate exit from program was due to death</td>
</tr>
<tr>
<td></td>
<td>32 – to record financial eligibility changes for the AC gross and adjusted income and asset fields</td>
<td>33 – the AC person exited the program due to estate claim recovery policy</td>
</tr>
<tr>
<td>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</td>
<td>Field Name</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>34 – the AC person exited the program due to AC fee change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>36 – to record the EW or AC person’s choice of the CDCS option</td>
<td></td>
</tr>
<tr>
<td></td>
<td>37 – to record the EW or AC person’s decision to end the CDCS option</td>
<td></td>
</tr>
<tr>
<td></td>
<td>43 – to suspend the annual NF visit for three years for fee-for-service persons under age 65</td>
<td></td>
</tr>
<tr>
<td></td>
<td>49 – AC and ECS citizenship status verified</td>
<td></td>
</tr>
<tr>
<td></td>
<td>98 – used with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Activity Type 05</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o for fields 78, 80, and 81</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o with Activity Type 07 for the BI, CAC, and CADI programs to change CDCS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o when the ECS gross income/assets or adjusted income/assets fields are changed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99 – used in field 80</td>
<td></td>
</tr>
</tbody>
</table>

Field 75B: When using an Exit Reason (values 17, 19 - 25, 31, 33, or 34) in field 75A, an Assessment Result Code 02 -11, 18, 30, or 98 must also be entered in field 75B to indicate what will happen to the person after leaving the program. Use value 30 in field 75B when the Exit code is 24 or 25.

76 | Effective Date | The effective date of the outcome identified in field 75A. This date is the start date of the eligibility span, extends the span using activity type 09 or 06, and closes the span on the RWVR (waiver) screen or the RELG (AC and ECS) screen for exit assessment results. It is used to edit against eligibility information in the Recipient Subsystem (LTC ineligibility, living arrangement, managed care enrollment, hospice period, major program) Use this date to determine the correct case mix budgets for AC, ECS, EW, and CDCS. |
<table>
<thead>
<tr>
<th>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Field Name</td>
<td>Description</td>
</tr>
<tr>
<td>77</td>
<td>Informed Choice</td>
<td>This field indicates that the person received information about and understands their rights regarding a choice between institution and community services, their right to a choice in services and providers, and the person has signed the Community Support Plan, CSSP, or CCP (forms DHS-4166 or DHS-6791B). Give this information to persons assessed for waivers and for other community assessments then mark this field as a “Y”.</td>
</tr>
<tr>
<td>78</td>
<td>Person Choice</td>
<td>The person’s choice of services and setting.</td>
</tr>
<tr>
<td>79</td>
<td>Guardian Choice</td>
<td>The choice of the person’s guardian, if any. Leave blank if there is no guardian.</td>
</tr>
<tr>
<td>80</td>
<td>Family Choice</td>
<td>The family’s choice of services and setting for the person.</td>
</tr>
<tr>
<td>81</td>
<td>LTCC/IDT Recommendation</td>
<td>The assessor’s recommended services and setting for the person. Do not use value 29.</td>
</tr>
</tbody>
</table>
| 82                                                           | Level of Care | The assessor’s determination of various levels of institutional need for care. For example, “NF Risk” indicates the person meets the nursing facility level of care.  
See the brochure DHS-7028 for a description of the NF LOC criteria. MMIS edits this determination against information contained in the screening document to verify NF LOC.  
Note: Value 02 (NF/Certified Boarding Care) is describing two types of nursing facilities. |
| 83                                                           | Case Mix Amount | The maximum monthly individual budget used for AC, ECS, or EW services. It is system entered based on case mix value. See Section 201.14 to request EW conversion budgets. |
| 84                                                           | Reasons for NF Continued Stay/CDCS Ending | This field shows:  
1) The reason(s) why the person remains in an institution after a relocation assessment is completed. Use up to two different values. |
<table>
<thead>
<tr>
<th>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2) The reasons the person ends the CDCS option. Use up to two different values</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Only on the ALT4 screen**

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relocation to Community</td>
<td>A field on the health risk assessment screening document form DHS-3427H and completed only for the SNBC health risk assessments.</td>
</tr>
</tbody>
</table>

**Section E and ALT4 Screen**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>85 – 100 Professional Conclusions</td>
<td>Summary statements regarding the assessor's conclusions about the person's needs/conditions. See the brochure DHS-3361 for more complete descriptions of these conclusions. (Use Y or N).</td>
</tr>
</tbody>
</table>

**100a PCA Complex**

Field 100a identifies if the assessment shows eligibility for 12 hours or more of PCA/CFSS per day. MMIS will add an “N” for case mixes A – H and L, a “Y” for case mix V, and post an edit for worker to add an N or Y for case mixes J, K., and I.

When the PCA Complex field = Y, the screening document is for AC or EW, and the dollar amount in the CDCS Amount or Case Mix Amount field is manually increased, edit 784 will post to route the screening document to DHS staff for approval. This routing does not occur if there is a managed care code in the LTC County field on the last screening document. If the PCA Complex field = N when these amounts are increased, MMIS will decrease the amounts.

**Section F and ALT4 Screen**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>101 – 103 Waiver/AC/ECS Eligibility Criteria</td>
<td>Verifies the person meeting the additional waiver/AC/ECS eligibility criteria. (Use Y or N).</td>
</tr>
</tbody>
</table>

104 Program Type

Indicates which program, if any, will fund planned services.

Note: Use program type 22 (temporary AC) when a person’s AC gross income and assets show they may be eligible for the MA program. Enter the opening screening document after the case manager verifies the person has submitted the MA application and asset assessment for a married couple for processing.
<table>
<thead>
<tr>
<th>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Temporary AC provides 75 days of eligibility while the MA application is pending approval with no extension or reopening.</td>
<td></td>
</tr>
<tr>
<td>105</td>
<td>MHM IND</td>
<td>Moving Home Minnesota. Add “Y” if person elected this program when assessed in the institution. Document will remain in suspense and route to DHS for approval.</td>
</tr>
<tr>
<td>106</td>
<td>CDCS</td>
<td>Shows if the person chooses the CDCS option. See section 201.09.</td>
</tr>
<tr>
<td>107</td>
<td>CDCS Amount</td>
<td>The monthly dollar cap for the CDCS services. It is system entered for EW and AC program types and manually entered for all other program types. See section 201.09.</td>
</tr>
<tr>
<td>108</td>
<td>Services</td>
<td>Mandatory for MSHO and MSC+ members receiving Elderly Waiver services. Required for reassessments (Activity Type 06 with Activity Type Date 8/1/18 or greater). The purpose is to identify if member is receiving one of these services. Values are AD (adult day), CL (customized living), FC (foster care) or NA (none). If a person has both adult day service and a residential service, choose the residential service provider for the evaluation. If answer is NA then don’t complete the Provider NPI Number, Person, and provider evaluation fields. See bulletin 18-25-04.</td>
</tr>
<tr>
<td>109</td>
<td>Provider NPI Number</td>
<td>Mandatory for MSHO and MSC+ members receiving Elderly Waiver services. Required for reassessments (Activity Type 06 and the LTCC County field = MCO code) for Activity Type Date 8/1/18 or greater. Purpose is to identify the NPI number of the provider who is providing the AD, CL, or FC services. See bulletin 18-25-04.</td>
</tr>
<tr>
<td>110</td>
<td>Person</td>
<td>Mandatory for MSHO and MSC+ members receiving Elderly Waiver services. Required for reassessments (Activity Type 06 and the LTCC County field = MCO code) for reassessments dated 8/1/18 or greater, and the Services field is not NA. Purpose is to identify if member:</td>
</tr>
<tr>
<td>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</td>
<td>Field Name</td>
<td>Description</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1) Is present and knows the provider is providing the services (value 1); 2) Does not know the provider provides these services and has a guardian/conservator to complete the questions (value 2); or 3) Does not know the provider is providing these services and has no guardian/conservator (value 3). If answer is value 3, then MMIS protects fields from Respect through Housing on the ALT5 screen. See bulletin 18-25-04.</td>
</tr>
</tbody>
</table>

**Section G (Service Plan Summary) and ALT5 Screen**

111 Service Codes | Records formal services, informal care giving, quasi formal services, and identifies the bundled component services for Elderly Waiver customized living services. May have up to eighteen different selections.  
(C) - EW customized living services provided by the CLS provider.  
(F) - Formal services are paid through funding sources such as the waiver, Alternative Care, Medical Assistance, Medicare, or private insurance.  
(I) - Informal services are unpaid services  
(Q) - Quasi-formal services require a small payment such as a stipend for a volunteer  
(M) - Moving Home MN services  
(O) - Offered  
Update this section any time using Activity Type 05 and assessment result 98. |
<table>
<thead>
<tr>
<th>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living and Adult Day Services) and ALT5 Screen</td>
<td>112 – 134</td>
<td>These questions allow the EW participant to evaluate the provider's performance in implementing the person's service plan and supporting their desired outcomes. See the Person's Evaluation of Foster Care, Customized Living, or Adult Day Service form DHS-3428Q for the valid values. Also, see the MMIS Session 9 for more information. No data entry allowed when the Services field is NA, the Person field is 3, or the Activity Type is not 06. See bulletin 18-25-04.</td>
</tr>
<tr>
<td>ALT6 Screen</td>
<td>Alternative Care and Essential</td>
<td>Always enter the first line of the address. Do NOT use colons in either address line. The second line</td>
</tr>
</tbody>
</table>

Respect (RSPT)  
Privacy (PVCY)  
Performance (PERF)  
Response (REP)  
Goal (GOAL)  
Work (WORK)  
Community (COMM)  
Funding (FUND)  
Quality (QUAL)  
Recommendation (RECM)  
Different (DIFF)  
Adult Day Services (ADYS)  
Day (DAY)  
Time (TIME)  
Food (FOOD)  
Lease (LEAS)  
Lock (LOCK)  
Share (SHAR)  
Decorate (DECO)  
Visitors (VIST)  
Access (ACCS)  
Spaces (SPAC)  
Housing (HOUS)
<table>
<thead>
<tr>
<th>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>135 - 139</td>
<td>Community Support Person’s Address</td>
<td>is optional. Information will transfer to the RCAD screen of the person’s Recipient Case Record for the AC or ECS program. Enter the address to mail service agreement letters and other DHS correspondence to the person. See Section 301.08 to correctly record changes to the AC address for fee billing.</td>
</tr>
<tr>
<td></td>
<td>CFR</td>
<td>The county of financial responsibility. The value in this field will populate the CFR field on the first screen of the screening document and on the RELG screen for major programs AC and UN for ECS.</td>
</tr>
<tr>
<td></td>
<td>Gross Income</td>
<td>AC Financial Eligibility Worksheet in field II.A (DHS-2630) or II.C (DHS-2630A). ECS Financial Worksheet in field I.C (DHS-6683A) or I.A (DHS-6683)</td>
</tr>
<tr>
<td></td>
<td>Gross Assets</td>
<td>AC Financial Eligibility Worksheet in field III.G (DHS-2630) or III.M (DHS-2630A). ECS Financial Worksheet in field II.M (DHS-6683A) or II.G (DHS-6683)</td>
</tr>
<tr>
<td></td>
<td>Adjusted Income</td>
<td>AC Financial Eligibility Worksheet Case Mix V – Assessment for Vent Dependency in field II.E (DHS 2630) or II.I (DHS 2630A.) ECS Financial Worksheet in field I.I (DHS-6683A) or I.E (DHS-6683). Round to the nearest dollar.</td>
</tr>
<tr>
<td></td>
<td>Adjusted Assets Medicare/MBI ID Number Medicare/MBI Part A Effective Period and</td>
<td>Verify this information by using the AC or ECS person’s Medicare/MBI ID card or other documentation from Medicare. Note: this information will update the RCIP screen of the Recipient Subsystem if the financial worker does not populate that screen.</td>
</tr>
<tr>
<td>Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT6</td>
<td>Field Name</td>
<td>Description</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>Medicare/MBI Part B Effective Period</td>
<td>As of April 1, 2018, new MBI cards will replace the Medicare ID card. The MBI number is a random number replacing the Social Security number. Use either number in the Medicare/MBI ID Number field. If MAXIS has the MBI number, it automatically changes this field from the Medicare to the MBI number.</td>
</tr>
<tr>
<td>136</td>
<td>AC Fee Waiver Reason</td>
<td>The reason that the person doesn’t have an AC fee obligation.</td>
</tr>
<tr>
<td>137</td>
<td>Medicare Eligible</td>
<td>Indicates if the AC or ECS person is eligible for Medicare. Placing a “Y” in this field, the Medicare/MBI ID Number field is also mandatory as well as the Medicare/MBI Part A Effective or the Medicare/MBI Part B Effective field.</td>
</tr>
<tr>
<td>138</td>
<td>AC Fee Assessed</td>
<td>Indicates if the person will be paying an AC fee. Values are Y or N.</td>
</tr>
<tr>
<td>139</td>
<td>Citizenship</td>
<td>Used for AC and ECS persons to indicate if they are a US citizen.</td>
</tr>
</tbody>
</table>

**Case Mix V – Assessment for Vent Dependency**

All waiver programs to identify an individual who is ventilator dependent may use this case mix. Consider a person ventilator dependent if they receive mechanical ventilation for life support at least six hours per day and expected to be or has been dependent on a ventilator for at least 30 consecutive days. Intermittent or PRN use of oxygen, use of oxygen monitors or apnea monitors only, nebulizer treatments or CPAP devices for snoring or sleep apnea do not fall under the definition of “mechanical ventilation for life support”.

See [DHS-3428B Case Mix Classification Worksheet](#) to determine the case mix V. Responses coded 02 or 03 on the DHS-3428 or 3428A (Long Term Care Consultation Assessment) will allow the Elderly Waiver case mix budget for case mix V.

**How to Complete the Falls Questions**

1. Have you experienced any falls…….00____No 01_____Yes
   a. If 1. = 01, go to 3.
   b. If 1. = 00, go to 2.

2. If no, does concern about…….00____No 02_____Yes
   a. If 2 = 00, 00 is code for 3427.
   b. If 2= 02, 02 is code for 3427.
3. Fall with fracture in last 12 months. 00 ____No 03 ____Yes  
   a. If 3. = 00, 01 is code for 3427.  
   b. If 3. = 03, 03 is code for 3427.

**Exit Descriptions**

Please note that persons not receiving a service every month does not exit from the AC, ECS, or EW program. Some services may not be on a regular basis or provided only once. The program remains open for future services. Exiting from the program when all services are exhausted and anticipated no need for other future services. Provide the Notice of Action forms [DHS-2828A](https://example.com/dhs-2828a) or [2828B](https://example.com/2828b) to the person.

Use these values when the person exits the AC, ECS, or waiver programs. **These rules apply to activity type dates October 1, 2019 or later.**

<table>
<thead>
<tr>
<th>Exit Codes</th>
<th>Activity Type 06</th>
<th>Activity Type 07</th>
<th>Allow Retro Exit?</th>
<th>Advance Notice Needed?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>X</td>
<td></td>
<td>N</td>
<td>Y</td>
<td>When using activity type 06, the exit effective date must be a minimum of 10 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement. When using activity type 07, the effective date cannot be more than the last day of the month that follows the current month. Use for loss of eligibility for Medical Assistance Scenarios: temporary AC to EW, AC to EW, and temporary AC to AC. Write here: When using activity type 07, the effective date can be no more than the last day of the month that follows the current month.</td>
</tr>
<tr>
<td>19</td>
<td>X</td>
<td></td>
<td>N</td>
<td>N</td>
<td>Scenarios: temporary AC to EW, AC to EW, and temporary AC to AC.</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td>X</td>
<td>Y</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Exit Codes</th>
<th>Activity Type 06</th>
<th>Activity Type 07</th>
<th>Allow Retro Exit?</th>
<th>Advance Notice Needed?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>X</td>
<td>N</td>
<td>Y</td>
<td></td>
<td>The exit effective date must be a minimum of 10 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement.</td>
</tr>
<tr>
<td>21</td>
<td>X</td>
<td>N</td>
<td>Y</td>
<td></td>
<td>The exit effective date must be a minimum of 30 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement.</td>
</tr>
<tr>
<td>22</td>
<td>X</td>
<td>N</td>
<td>Y</td>
<td></td>
<td>When using activity type 06, the exit effective date must be a minimum of 10 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement when the exit reasons are not 04, 07 – 09. The effective date can be retro for activity type 07 when using exit reasons 04, 07 – 09 (facility admission) except for ECS (see exit reason 24). Advance notice is not required when using these exit reasons.</td>
</tr>
<tr>
<td>23</td>
<td>X</td>
<td>N</td>
<td>Y</td>
<td></td>
<td>The exit effective date must be a minimum of 10 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement.</td>
</tr>
<tr>
<td>24</td>
<td>X</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Can be retro to the date of the event.</td>
</tr>
<tr>
<td>Exit Codes</td>
<td>Activity Type 06</td>
<td>Activity Type 07</td>
<td>Allow Retro Exit?</td>
<td>Advance Notice Needed?</td>
<td>Notes</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>For anticipated exit dates, the effective date can be no more than the last day of the month that follows the current month.</td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The effective date of the exit is typically the same date as the opening to the program.</td>
</tr>
<tr>
<td>31</td>
<td>X</td>
<td></td>
<td>N</td>
<td>Y</td>
<td>The exit effective date must be a minimum of 10 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement.</td>
</tr>
<tr>
<td>31</td>
<td>X</td>
<td></td>
<td>N</td>
<td>Y</td>
<td>The exit effective date must be a minimum of 10 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement.</td>
</tr>
<tr>
<td>33</td>
<td>X</td>
<td></td>
<td>N</td>
<td>Y</td>
<td>The exit effective date must be a minimum of 10 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement.</td>
</tr>
<tr>
<td>34</td>
<td>X</td>
<td></td>
<td>N</td>
<td>Y</td>
<td>The exit effective date must be a minimum of 10 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement.</td>
</tr>
</tbody>
</table>

- **17** – Person lost financial eligibility for current program. If the exit is due to Medical Assistance closure then use activity type 07. One example is if the person’s spouse dies and allocated income or assets transfers back to them making them ineligible for the EW program. The person may meet the AC financial thresh hold. *The person cannot open to AC by voluntary refuse to open to or remain on MA.*

  When using Activity Type 07 the Effective Date cannot be more than the last day of the month that follows the current month.

- **19** – Person lost financial eligibility for the Alternative Care program due to spending down to the MA program and now meets the financial guidelines for Elderly Waiver and will open to that program. Alternatively, the person appears to
be MA eligible at time of the AC reassessment and needs to apply for MA. Close AC and open to temporary AC opens while they apply for MA. Alternatively, the person is exiting temporary AC to regular AC or EW after the MA decision.

The Effective Date cannot be more than the last day of the month that follows the current month. The Exit Reasons can only be 10 or 11. Do not use this code to exit the Elderly Waiver program as of Activity Type Date February 1, 2019.

- 20 – Person’s level of care changed. Change the level of care field to show the correct status at time of exiting. Examples are level of care changes from the CAC program (hospital LOC) to the CADI program (NF LOC), from the BI-NF program to the BI-NB program, from CADI to CAC, or from BI-NB to BI-NF or from ECS (no LOC) to AC (NF LOC).

Use code 20 when exiting a program and combining it with a change or reopening to a different program with newly established level of care code using 10 (change) or 11 (reopen) in field 75.

Change the level of care at reassessment only. Use activity Type 06 to exit and the new level of care code added. Use Activity Type 07 when opening to the new program.

- 21 – Person meets no level of care criteria. Only used with Activity Type 06. Change the level of care (risk status) field to 07. The Effective Date must be at least 30 and no more than 60 days in the future to meet the advance notice requirements. Use code 22 to move a person from AC to ECS.

- 22 – Person no longer meets the program's criteria other than financial or level of care. Examples are:
  - The person resides in an institution (NF, etc.,) for more than 30 days.
  - The program services cannot reasonably meet the person’s health and safety in the community. Contact the Adult Protection Services unit.
  - There are other funding sources to pay for the services such as long term care insurance, Medicare, Medical Assistance, Title 3, or private pay.
  - The person no longer needs the programs’ services.
  - The person is receiving GRH specialized services (not GRH housing) and so is not eligible for waiver services.
  - The person is exiting the waiver and opening to home care program only.
  - Exit from CADI to EW for 65th birthday

- 23 – Person chooses to leave the program.

- 24 – Person exited for reasons other than one of the other exit codes such as:
  - Incarcerated
  - Person cannot be located for reassessment visit
  - Death (use code 30 in field 75b)
- Person moved out of state
- Exiting ECS to allow the Senior LinkAge Line® staff to enter the preadmission screening for nursing home admissions.

Use code 98 in field 75B unless reason is death, then use code 30. The Activity Type must be 07.

- 25 – The program closes due to an error in opening, death, or for other reasons in which no waiver, AC, or ECS provided services. If the person refused services before they began, decide if it is prudent to provide the advance notice requirement. Using this code will remove the Elderly Waiver “slot” and delete the Elderly Waiver eligibility span from the RWVR screen. Only use with Activity Type 07. Put code 30 in field 75b if person has died. The effective date must be the same as the opening effective date.

- 26 – This code is not valid as of activity type date February 1, 2019 and later. It is not necessary to exit a person for new lead agency assignments.

- 31 – Person exits from the Alternative Care program due to no payment of the AC fee for 60 days. The person may return to the program after a 30 day waiting period. See section 301.08 for more information.

- 33 – Person chooses to exit the Alternative Care program due to estate claim recovery requirements.

- 34 – Person chooses to exit the Alternative Care program due to a change in the fee. See section 301.08 for more information on offering reduced fees.

When using exit codes, complete field 75B to record what will happen to the person now that they’ve exited the program. Use values 02 – 11, 18, 30, or 98 to indicate why the person left the program in field 75B. Use value 30 when the exit value in field 75A is 24 or 25. Exit 21 (no longer meets level of care) cannot be used with reasons 04, 07, or 08 indicating institutional admission. The Effective Date may be any day of the month and should reflect the last day of service or the last day the person is in the community. The date may overlap the date of admission to an institution.

An exit updates the end date for major program AC for Alternative Care, major program UN for Essential Community Supports, and the waiver span for all waiver programs or Essential Community Supports based on the Effective Date. Edit 109 will post if the exit screening document effective date is beyond the service agreement header end date. Change the service agreement header end date so it does not exceed the exit date. Change the Send Recipient Letter field to a Y so the person receives notice of program services closing.
Advance Notice of Appeal
For most exits, provide the notice of appeal to the person. See the above chart for exceptions. This notice contains the rights to appeal the decision for reduction, termination, or denial of services.

When a person loses level of care (exit reason 21), the Effective Date of the exit is dated at least 30 days but no more than 60 days from the date the adverse action notice was given or mailed to the person. To allow this exit date in the future, the waiver, AC, or ECS eligibility span will extend beyond the current eligibility end date if needed.

For all other exit reasons requiring advance notice, date the Effective Date of the exit at least 10 days and no more than 60 days from the date you gave or mailed the adverse action notice was given or mailed. To allow this exit date in the future, the waiver, AC, or ECS eligibility span will extend beyond the current eligibility end date if needed.

If the person appeals the program closure decision, the reopen the program back to the exit date. Delete the exit screening document. If the person loses the appeal, the close the program to the date of decision.

When exiting in the past, advance notice of action is not possible. However, the lead agency should still provide notice when possible. For example, in stances when the case manager is notified of an exit that occurred prior to the current date use activity type 07. The effective date may then be earlier than the activity type date.

Effective Date and Activity Type Date Rules
- For eligibility updates (Active Type 09) with an Activity Type Date on or after August 1, 2013 and prior to July 1, 2017:
  - The Activity Type Date for Activity Type 09 cannot be the same date as the face-to-face nor more than 90 days from the Activity Type Date of the face-to-face visit.
  - The Effective Date can be equal to the Activity Type Date of Activity Type 09 or up to 60 days in the future.
- For eligibility updates (Activity Type 09) completed on or after July 1, 2017:
  - The Activity Type Date for Activity Type 09 cannot be the same date as the face-to-face nor more than 90 days from the Activity Type Date of the face-to-face visit.
  - The Effective Date can be equal to the Activity Type Date of the last Activity Type 02 or 04 (face-to-face assessment) when all other eligibility criteria are met, and up to 60 days after the Activity Type Date for Activity Type 09 when all other eligibility criteria are met.
- The Effective Date cannot be more than 60 days after the Activity Type Date for Activity Types 01 - 04, 06, and 09.
- If Program Type = 01 - 08, 11, or 12 the Effective Date must fall within a major program MA (Medical Assistance) span.
If Program Type = 09, 10, or 22 and the Activity Type = 06, or the Assessment Result is exit values 17, 19 - 25, 31, 33, or 34, the Effective Date must fall within a major program Alternative Care (AC) span.

If Program Type = 29 the Effective Date for Activity Type 06 or Assessment Result exits values 17, 20 – 25 must fall within a major program UN with EC eligibility type.

If Program Type = 30, the Effective Date must fall within a major program MA or UN with EC eligibility type.

The Activity Type Date cannot be prior to the last approved Activity Type Date and/or the Effective Date cannot be prior to the last approved Effective Date.

If the person is exiting due to admission to an institution for more than 30 days including a continuous hospitalization period combined with a nursing home stay of more than 30 days (or for less than 30 days if requesting RSC), the Effective Date must be the date of admission.

EW Program Types: Diversion vs. Conversions

For purposes of coding the program type field, a diversion is a person who is not a resident of a long term care facility at the time of the assessment. A conversion is a person who was a resident of a long term care facility at the time of the assessment. A person who opens to a program under one of these types will remain that type until they exit the program. If the person exits the program and later returns, it should be re-determined if they are now a diversion or a conversion.

For purposes of budget payment, people who were residents of a facility for at least thirty days and enter the EW program may qualify for a monthly budget higher than those case mix or CDCS budgets available for diversions, or conversions with less than a thirty day stay. See section 201.14 for more details.

AC and ECS Citizenship Requirement

Noncitizens are not eligible for the AC or ECS program. This applies to new applicants as well as those currently on the programs. AC and ECS program applicants must attest to their citizenship or immigration status at application and have an additional 90 days to provide acceptable supporting documentation. Current program participants will also have to attest to their citizenship or immigration status and provide supporting documentation if not previously completed.

Applicants/participants attests to their citizenship or immigration status on the AC and ECS Program Eligibility Worksheets

The LTC Screening Document DHS-3427 shows the Citizenship field in section H on the ALT6 screen of the LTC Screening Document in the MMIS. The field is mandatory when:

- The Effective Date is equal to or greater than July 1, 2015; and
- The Program Type is 09, 10, 22, or 29; and
- The Assessment Result field is 01, 10, 11, or 13
The valid values are (note there isn’t a preceding zero):

- 1 – Person is a US citizen
- 2 – Citizenship is pending
- 3 – Person is not a US citizen

**Edit 278 Citizenship field is missing or invalid**

1. Complete the field with one of the above values when the screening document meets the mandatory conditions.
2. Value must be 1 when the Assessment Result is 49 and must follow a document with value 2.
3. When exiting AC or ECS due to the person’s inability to confirm citizenship (value 2 is in field) use Assessment Result 22 to avoid posting edit.

**Edit 279 Citizenship is pending**

When value is 2, the AC major program eligibility span, or the Unknown major program/waiver type Y eligibility spans for ECS will be 90 days in length instead of 365 days (AC) or ending at the end of the twelfth month (ECS). This edit is forcible. Use reassessment value 49 called Citizenship Verified when the person’s status was pending and now confirmed to be a US citizen.

In order to use this assessment result, the previous value in the citizenship field must be a 2 – citizenship is pending. As noted above, using value 2 allows only 90 days of program eligibility. If after 90 days the citizenship status is not confirmed the person must be exited from the program using Assessment Result 22 - person exited because no longer meets other eligibility criteria. Using Assessment Result 49 with citizenship value 1 will extend the eligibility spans.

To confirm the citizenship status after pending, enter a new document with Activity Type 07 and Assessment Result 49. The date receiving the citizenship documentation is the Activity Type and Effective Dates. Change the citizenship field to 1. For the AC person this will extend the eligibility span to 365 days from the last opening, reopening, or reassessment (AC) Effective Date. The eligibility span for the ECS person extends to the end of the twelfth month from the Effective Date of the last opening, reopening, or reassessment document.

Only use Assessment Result 49 if the previous screening document had a value 2 in the citizenship field. Edits will post if using code 49 for any program type other than 09, 10, or 29, or if the Activity Type is not 07.

**Edit 280 Citizenship not valid for program**

When the value is 3, the person is not eligible for the AC or ECS program. Enter an exit screening document. Change the Assessment Result to 22. If the person reaps for citizenship, reopen to the program and use value 2 in the citizenship field for a 90-day
eligibility period. If person submits additional documentation to prove citizenship, reopen the program and use value 1 in the citizenship field instead.

**Financial Eligibility Worksheets for the Alternative Care and Essential Community Support Programs**

Add the gross income and asset amounts as well as the adjusted income and asset amounts from these worksheets to section H of the LTC Screening Document (the ALT6 screen in MMIS). MMIS edits will assure that the person’s amounts fall within the financial guidelines. Change the Adjusted Asset, AC Waiver Reason, and AC Fee at any time using Activity Type 05 and Assessment Result 32. For the ECS person, use Activity Type 05 and Assessment Result 98.

Complete the financial determination for persons opening to ECS using program type 29 through one of two ECS Financial Eligibility Worksheets: [DHS-6683](#) or [DHS-6683A](#). Form 6683 is for unmarried individuals or married couples when both are requesting ECS services or a married person whose spouse is an Alternative Care or Elderly Waiver person or is living in a nursing facility.

For 6683A is for a married individual when only one spouse is requesting services.

Also, use the [DHS-6826](#) Essential Community Supports (ECS) Financial Disclosure. Persons applying for the Alternative Care program will use one of two financial worksheets.

- Form [DHS-2630](#) is for individuals or married couples when both choose the AC program or a married person who spouse is an EW recipient or living in a nursing facility
- Form [DHS-2630A](#) is for a married person who has a community spouse

**201.05 Using Activity Types**

The activity type identified in field 11 of the LTC Screening Document DHS-3427, indicates the type of screening, assessment, or other activity completed by the lead agency. Session 7A, Understanding Activity Types and their Timelines, in the MMIS Training Series covers this information.

**Activity Type 01 - Telephone Screen**

Use this activity type primarily for nursing facility admissions and some types of health risk assessments (HRAs) completed by managed care organizations. The 2013 Minnesota Legislature amended Minnesota Statutes, section 256B.0911 governing Long Term Care Consultation services by deleting the preadmission screening (PAS) activity and policy previously incorporated there.

The PAS policy and practice requirements is under Minnesota Statutes, section 256.975 governing the Minnesota Board on Aging activities. Effective November 1, 2013, and
statewide, Senior LinkAge Line® (SLL) staff complete PAS activities, including nursing facility level of care (NF LOC) determinations and OBRA Level I screenings. Additional resource information related to OBRA policy is in the User Notes in the MMIS Training Companion Guide.

While counties and tribes no longer perform telephone-based PAS activities using Activity Type 01, managed care organizations complete PAS for their enrolled members. Enter the information into MMIS using form DHS-3427T. In addition, counties and tribes receive information from SLL staff regarding admissions of HBCS program participants, for example, and may receive referrals for face-to-face assessment when NF LOC cannot be determined using the web-based PAS tools.

Lead agency staff will also see historical LTC Screening Documents for PAS completed for people in the past when performing Inquiry for a person, as well as historical health risk assessments (HRA) that were completed by telephone or mailed surveys and recorded using Activity Type 01. Record telephone or mailed survey HRAs on form DHS-3427H.

Please see bulletin 19-25-02 Preadmission Screening – Activity Required for MA-Certified Nursing Facilities for complete information.

**Activity Type 02 - Person to Person Assessment in the Community**

This activity type represents the completion of a face-to-face assessment for a person living in the community. Use this activity type to initially open to the waiver, AC or ECS programs. Activity Type 02 identifies an in-person health risk assessment when the care coordinator completed the LTCC assessment or MnCHOICES assessment as the Health Risk Assessment. The Referral Date field is changed.

Assessments completed before a facility discharge uses Activity Type 04 - Relocation/Transition. Do not use Activity Type 04 while the person is in an HCBS program.

**Activity Type 03 - Visit/Early Intervention**

This activity type represents a less-than-complete community or facility based assessment. Use it for visits that result in partial assessment, provision of information and referral, or minimal assistance with services planning. Because not all screening information is required using Activity Type 03, it has limited uses, but does document a lead agency face-to-face activity.

For example, admission to institutions are not valid client outcomes for this level of assessment since the activity type neither indicates complete community assessment nor other health care professional involvement deemed necessary to determine need for admission as occurs under preadmission screening. Nor use it to open people to HCBS programs. Never use activity Type 03 while people are participating in an HCBS program.
Limitations in MMIS:

- Indicates a face-to-face visit that was not fully completed and uses program type 00 only
- Uses Assessment Results 03 or 05
- Not used for managing any waiver, ECS, Moving Home Minnesota (MHM), or AC programs, or Relocation Services Coordination (RSC), or perform any activity in MMIS for participants of these programs

Activity Type 04 - Relocation/Transition Assessment

Activity Type 04 and Activity Type 02 operate in the same way in MMIS, with the difference being the location of the person at the time of assessment. Use this activity type to indicate a face-to-face assessment before discharges from an institution.

Used this activity type to open, reopen or change a HCBS program for the person upon discharge from the institution. The referral date field is changed. This activity type will also permit the county or tribe to document Relocation Services Coordination by using Assessment Result 18 and program type 00.

This activity type will also permit the MCO to document Relocation Services Coordination for their members by using Assessment Result 18 and Program Type 19.

Activity Type 05 - Document Change Only

This activity type supports the need to make limited changes to an approved screening document. Changes are on a new screening document rather than the initial document.

Limitations in MMIS:

- The waiver/ECS eligibility period on the RWVR screen is not changed
- No changes for the major program UN (for ECS) or AC (for Alternative Care) eligibility period on the RWVR screen
- Only use Assessment Result 32 or 98

Use Assessment Result code 32 when updating the AC financial data on the MMIS ALT6 screen.

Use Assessment Result 98 at any time (except for the initial screening document):

1) Changes to non-protected fields to correct errors or update information. If a field is protected (i.e., it cannot be changed using this activity) it contains information that is intended to be changed only on the basis of a face-to-face assessment (Activity Types 02, 04, or 06) or eligibility update (Activity Type 09). No changes for fields about assessed need.
2) Updating a screening document for purposes of increasing the EW, AC, or ECS case mix cap amount after a COLA. The dates for the Activity Type and Effective Date fields are after the COLA Effective Date.

3) Changing the Alternative Care or ECS address.

4) Updating the Service Code Summary section.

5) Updating the CM/HP/CA field. This is the most frequent use of Activity Type 05.

6) Updating the gross income and asset fields and the adjusted income and asset fields for the ECS program.

When changing the ECS county codes, and If MA does not overlap with the major program UN with eligibility type EC, then the COS, COR, and CFR fields on the ECS screening document will update the recipient subsystem’s RELG, RCIN, and RCAD screens and county fields on the ECS service agreement.

If major program MA does overlap, the Recipient Subsystem’s RELG (for major program UN with EC eligibility type), updates the COS, COR, and CFR fields on the screening document and service agreement as well as the RCIN and RCAD screens. The AC screening document will update the COS, COR, and CFR fields on the Recipient Subsystem’s RELG (for major program AC), RCIN, and RCAD screens (for AC case records) and the service agreement county fields.

Activity Type 06 - Reassessment
Use this activity type to code face-to-face assessments of individuals participating in HCBS programs (except for the DD waiver and temporary AC) on at least an annual basis (within 365 days of last assessment).

Schedule the annual visit at least 30 days prior to the waiver, ECS, or Alternative Care ending date. This will allow time for the required 30 day advance notice of the Denial, Termination, or Reduction (DTR) notice in case the visit results in the person no longer eligible due to not meeting level of care (exit code 21) or the minimum 10-day notice for termination for other exit reasons other than death or using exit codes 17, 19, 20 – 23. Using these exit codes will extend the program’s eligibility span to these exit dates if the dates fall outside of the current eligibility periods on RWVR (waiver) or RELG (ECS or AC major programs).

If the person continues on the program and no reassessment effective date is within the eligibility span, there will be a gap in eligibility for the person, a gap in possible service authorization periods, and a resulting period of ineligibility for payment to providers.

See the Community-Based Services Manual for more detailed policy information about reassessments.

There are only 2 possible outcomes of a reassessment:
• The person continues on the program, or
• The person exits from the program.
Rules:

- The activity type date records the date of the screening or visit. The effective date (field 76 on the paper form) is the first of the month for reassessments.
- This activity type cannot occur before Activity Types 02 or 04 or 09.
- Using Assessment Result 13 will extend the eligibility period for waiver or ECS programs to the last day of the following twelfth month or 365 days for the AC program. Enter a new service agreement for this new period.
- If the visit results in exiting due to the loss of the program’s level of care criteria, the effective date must be at least 30 but no more than 60 days after mailing or giving the appeal notice. Using Activity Type 06 and Assessment Result 21 will expand the eligibility end date if needed to the new exit date.
- If the visit results in closing the program using Assessment Result 17, 19, 20, 22 or 23 the effective date must be at least 10 but no more than 60 days after the appeal notice was mailed.
- If the person is exiting due to admission to an institution for more than 30 days, this may include a period of continuous hospitalization to nursing home of more than 30 days (or for less than 30 days using relocation service coordination (RSC)), the effective date of the exit must be the date of admission.

When changing the ECS county codes (COS, COR, or CFR) and If MA does not overlap with the major program UN with eligibility type EC, then the COS, COR, and CFR fields on the ECS screening document will update the recipient subsystem’s RELG, RCIN, and RCAD screens and county fields on the ECS service agreement.

The ECS screening document will update the COS, COR, and CFR fields on the Recipient Subsystem’s RELG (for major program UN), RCIN, and RCAD screens (for ECS case records) and the service agreement county fields.

**Activity Type 07 - Case Management/Administrative Activity**

This activity type identifies case management activities. Use this for specific tasks but it does not replace a face-to-face assessment or case management visit. When used as an initial opening or when exiting the person from a program, the Recipient Subsystem screens RWVR (waiver) or RELG (AC, or UN with eligibility type EC) eligibility span is added or changed.

Typically, use Activity Type 07 either to exit a person from a program or to open, reopen, or change to a new program within 60 days of a previous face-to-face assessment or eligibility update. Using Activity Type 07 protects many fields. If needing to change a protected field because of new information, a face-to-face visit is required rather than using Activity Type 07. Also, see information about the use of Activity type 10 for the AC and EW programs to update information.

Specific tasks performed with this activity type are:
1) Closing a program.
   - Use exit codes 17, 19, 22 - 25, 31, 33, or 34 with this activity type.
   - Do not use Exit Reason 21 with Activity Type 07. Exit Reason 21 uses Activity Type 06.
   - The Assessment Result 02 - 11, 18, 27, 30, or 98 indicates what will happen to the person upon exiting the program and entered into field 75B.
   - When a person is entering a nursing facility when leaving the HCBS program, the completion of any needed OBRA Level I screening is also documented (form DHS-3426).
   - If the person is exiting due to admission to an institution for more than 30 days, this can include a continuous period of hospitalization and nursing home stay of more than 30 days, (or for less than 30 days when requesting RSC), the effective date of the exit must be the date of admission.
   - If the exit is due to death, the effective date is the last day of services.
   - If the exit is due to the program opening by mistake or services refused before they began, use Exit Code 25 with an effective date the same day as the opening effective date.

2) When using Activity Type 07 and Assessment Result 19 with the AC program, only allowable codes are Exit Reasons 10 or 11. Assessment Result 19 to exit the EW program not allowed for Activity Type Dates on and after February 1, 2019.

3) Recording Relocation Service Coordination within 365 days of a face-to-face visit. See section 201.08 for more information and the MMIS training Session 10.

4) Reopening and extending a program closed due to the person appealing their program termination.

5) Activity Type 07 is used to code that the AC or ECS person is a US citizen after pending for confirmation. Use Assessment Result 49 and change the Citizenship field to 1.

6) Recording an opening to a program within 60 days of a face-to-face assessment or eligibility update. Activity Type 07 with Assessment Result 01 is a valid combination only when following Activity Type 02, 04, or 09 with Program Type 00 or 18. The Activity Type Date of Activity Type 07 must be within 60 days of the Activity Type Date of Activity Type 02, 04, or 09.

7) Activity Type 07 with Assessment Result 36 or 37 using Program Type 03, 04, 09, 10, or 22 to open or exit the Consumer Directed Community Supports (CDCS). See the scenario in Section 201.09.
8) Activity Type 07 and Assessment Result 43 with program type 00 to record the delay of the annual NF visit for three years for people under age 65 admitted to an institution. This populates the date of the next visit in the Next NF Visit field on the ALT1 screen.

9) Use Activity Type 07 and Assessment Result 98 for the BI, CAC, and CADI programs to change the CDCS Indicator field.

10) Assessment Result 26 is no longer valid for activity type dates of February 1, 2019 and later.

**Activity Type 08 – BI/CAC/CADI Reassess 65th Birthday**
Use this activity type for the person using BI, CAC, or CADI programs. The lead agency has a four-month window to conduct the in-person assessment. The four-month window includes the two months before the birthday month, the birthday month, and one month after. Like other reassessments, the person will either remain in their current program, exit to a different disability waiver program, or exit to EW if the person meets eligibility criteria and those waiver services are needed and chosen by the person. If the activity type date is prior to age 65, the effective date must be the birthdate or later.

Do not use this activity type prior to Activity Types 02, 04, or 09. When remaining on the program use Assessment Result 13.

**Returning to disability waiver after age 65**

People enrolled in the BI, CAC and CADI waivers before age 65 may remain after age 65. People who are 65 at the time of the initial waiver application are not eligible to enroll in a disability waiver. A person enrolled on a disability waiver before age 65 may reopen to a disability waiver after age 65 years if meeting all of the following criteria:

- He/she meets the eligibility requirements for the waiver
- The Elderly Waiver (EW) does not or no longer meets his/her needs
- He/she receives approval from DHS

See the [CBSM manual](#) for more policy information.

**Activity Type 09 – Eligibility Update**
Activity Type 09 is an alternative to completing another face-to-face assessment when delaying eligibility determination for reasons other than the assessment. For example, an application for MA may be pending or a delay in a planned discharge back to the community.

This activity type signifies an eligibility update by telephone rather than a face-to-face visit. While this activity type can be used up to 90 days from the date of the face-to-face assessment Activity Type 02 or 04, use Activity Type 07 within 60 days of the face-to-face assessment instead.
Use it to initially open the person to a program, reopen to a program, or to change programs following the face-to-face assessment. The activity type date cannot be the same date as the face-to-face assessment, and not more than 90 days from the activity type date of the face-to-face assessment.

Use Activity Type 09 when a delay for the initial eligibility determination. Do not use Activity Type 09 for these circumstances:

- Persons while participating in HCBS programs,
- Administrative tasks such as opening to a program within 60 days of a face-to-face visit (use Activity Type 07),
- A replacement for annual reassessments (use Activity Type 06),
- Authorizing Relocation Service Coordination within 12 months of an assessment (use Activity Type 07),
- Updating fields on the screening document (use Activity Type 05 or Activity Type 10), or
- An initial assessment. Use Activity Type 02 or 04.

Use Activity Type 09 to open, change or return to a program. However, when completed within 90 days of a face-to-face assessment, the eligibility period for a program can begin as far back as the date of the face-to-face assessment (activity type date), or up to 60 days forward from the date of the Activity Type 09 activity type date when all other eligibility criteria are met as of the effective date selected.

The end date of a waiver or program span established in MMIS using Activity Type 09 based on the activity type date of a face-to-face visit. That is, the last day of the 12th month (waiver or ECS) or 365 days (Alternative Care) from the date of the last face-to-face visit. This is to ensure assessment of program participants in person at least annually.

Use Activity Type 07 in combination with Activity Type 09, when 07 follows the eligibility update within 60 days.

- Activity Type 07 can be used to open, change or return a person to a program with an effective date of up to 60 days in the future from the activity type date of 09.
- Use Activity Type 07 within 60 days following 09 to retroactively open, change or return a person to a program as early as the date of the face-to-face assessment, when meeting all other eligibility criteria as of the effective date selected.

**Activity Type 10 – Service Change**

This activity type allows changes to the screening document fields based on a face-to-face case manager/care coordinator visit when there is a need to make changes to resources and/or changes to services.
The activity type date must be August 1, 2018 or greater. The assessment result must be 12 – Service Change. Use this activity type with the EW or AC programs. Use of Activity Type 10 will not extend or develop an eligibility span. Do not use when the person is receiving Moving Home Minnesota or Essential Community Supports services.

The information in the CM/HP/CA field when entering a screening document using Activity Type 10 must match the previous case manager/care coordinator/certified assessor (CM/HP/CA) information on the last approved screening document. If there is a different assessor from the previous assessor, enter a screening document with Activity Type 05 and Assessment Result 98 to change information in that field before entering an Activity Type 10 document to avoid edits.

Activity Type 10 is useful when:

• Annual reassessment is not due for a period of time, and
• The person has changed needs which will result in a need to change services, and
• The change in need and services will require additional resources (i.e. the person’s case mix classification has changed), and/or
• This change may also result in eligibility for 24 CL rate limits, or additional funding under CDCS.

Do not use AT 10 when meeting the person’s new service plan within existing resources, or when an annual reassessment is due within 30 days. In this case, simply perform a reassessment. See bulletin 18-25-05 for more information.

201.06 Using Assessment Results

Assessment results identify the action taken during the screening or assessment. Use field 75A of the LTC Screening Document form DHS-3427 and enter on the MMIS ALT4 screen. Use field 75B when the person is exiting the program. It identifies what the plan for the person after leaving the program.

The chart below shows the correct combination of program types with assessment results.

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Assessment Result Description/Use</th>
</tr>
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</table>
| Program Types 01 - 12, 22 Waiver (not DD) and Alternative Care Program types Used with waiver screening documents authorizing Moving Home Minnesota services | • Initial Opening to Program - 01  
• Opening to a New Program - 10  
• Reopening to Same Program – 11  
• Service Change - 12  
• Reassessments – continuing on program 13  
• Updating Alternative Care Financial Data – 32  
• Updating Essential Community Supports Financial Data = 98 |
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<tr>
<th>Program Type</th>
<th>Assessment Result Description/Use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Exiting the Program – 17, 20 - 25 (waiver), 17, 19, 20 – 25, 31, 33, or 34 (AC).</td>
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<tr>
<td></td>
<td>• Citizenship Verified – 49 (AC and ECS)</td>
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<tr>
<td></td>
<td>• Other – 98 (screening document field change)</td>
</tr>
<tr>
<td>Program Types 29 and 30 Essential Community Supports</td>
<td>Program Type 29</td>
</tr>
<tr>
<td></td>
<td>• Initial Opening to Program - 01</td>
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<td>• Opening to a New Program - 10</td>
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<td>• Reopening to Same Program - 11</td>
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<td></td>
<td>• Reassessments – continuing on program 13</td>
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<td></td>
<td>• Exiting the Program – 20, 22 – 25</td>
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<td></td>
<td>• Citizenship Verified - 49</td>
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<td></td>
<td>• Other – 98 (Updating ECS financial data)</td>
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<td></td>
<td>• Reassessments – continuing on program 13</td>
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<td>• Exiting the Program – 20, 22 – 25</td>
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<tr>
<td></td>
<td>• Citizenship Verified - 49</td>
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<tr>
<td></td>
<td>• Other – 98 (Updating ECS financial data)</td>
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<td>Program Type 00 Assessed in the Community or Institution Also used with preadmission screening activity</td>
<td>Program Type 00</td>
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<td>• Staying in Community with No Waiver/AC/ECS Services - 02</td>
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<tr>
<td></td>
<td>• Staying in Community with No Services - 03</td>
</tr>
<tr>
<td></td>
<td>• Screened/Assessed and Admitted to Institution - 04 - 09</td>
</tr>
<tr>
<td></td>
<td>• Screened/Assessed and electing Relocation Service Coordination - 18</td>
</tr>
<tr>
<td>Any program type</td>
<td>Any program type</td>
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<tr>
<td></td>
<td>• Value 29 (undecided) used in fields 78 - 80. It may be used in field 75A only when the LTCC County field = SLL.</td>
</tr>
<tr>
<td></td>
<td>• Value 98 (other) used in fields 78 – 80 unless Activity Type is 05 then use in field 75A.</td>
</tr>
<tr>
<td></td>
<td>• Value 99 (not applicable; no family) used in field 80 only</td>
</tr>
</tbody>
</table>

**Activity Type and Assessment Result Combinations**

Edits will check if the activity type in field 11 on the ALT1 screen is correct when used in combination with the assessment result in field 75a on the ALT4 screen. The information below shows the correct, allowable combinations.

- Activity Type 02 is a face-to-face visit in the community.
  - Person will remain in the community with home and community-based services (HCBS).
  - Assessment Results 01 (initially open to program), 10 (change to a new program), or 11 (return to previous program). Enter the service agreement.
• Activity Type 02 is a face-to-face visit in the community. Person will remain in the community without HCBS services. The person may have state plan home care, for example, for services covered under other funding like long-term care insurance.
  o Assessment Result 02 (has services but not funded by HCBS) or
  o Assessment Result 03 (has no services)
• Activity Type 02 is a face-to-face visit in the community. Person to admit to an institution.
  o Assessment Results 04 – 09 (short and long-term stays in various institutions)
• Activity Type 03 is a face-to-face visit in the community but a full assessment was not completed.
  o Assessment Result 03 (no services)
  o Assessment result 05 (will reside in non-certified boarding care)
• Activity Type 04 is a face-to-face visit in the institution. Person will receive Relocation Services Coordination (RSC).
  o Assessment Result 18 – Transition planning
• Activity Type 04 is a face-to-face visit in the institution. Person will open, change, or return to an HCBS program.
  o Assessment Results 01, 10, or 11. Effective date must be on or after the discharge from the institution. Enter the service agreement.
• Activity Type 04 is a face-to-face visit in the institution. Person will return to the community with no HCBS services.
  o Assessment Results 02 or 03
• Activity Type 04 is a face-to-face visit in the institution. Person will remain in the institution.
  o Assessment Results 04 - 09
• Activity Type 04 is a face-to-face visit in the institution. Person will receive Alternative Care conversion case management while in an institution.
  o Assessment Results 01, 10, or 11. Enter a service agreement with only T1016 for up to 180 days OR
  o If person is currently on the AC program and enters the nursing facility, do not add a screening document. Close all community provider line items on the service agreement to the day of admission and begin new line item for conversion case management T1016 for up to 180 days.
• Use Activity Type 05 to make a change on the document for non-protected fields.
  o Assessment Result 98
• Activity Type 05 is used to make a change on the AC or ECS Screening Document
  o Assessment Result 32 for changes to the AC gross income/assets or adjusted income/assets fields
  o Assessment Result 98 for change to the ECS gross income/assets or adjusted income/assets fields.
• Activity Type 06 is a face-to-face assessment that occurs at least annually in the community while the person is on an HCBS program
  o Assessment Result 13 to continue on same program. MMIS creates another 365 day/12 month eligibility period.
  o Assessment Result 17, 19 – 23, 31, 33, or 34 to exit the person from the program. MMIS closes the eligibility period based on the effective date.
• Use Activity Type 07 as case management administrative activity for a variety of reasons:
  o Assessment Results 17, 19, 22 – 25, 31, 33, or 34 to exit the person from the program. See the advance notice requirements. Close the service agreement.
  o Assessment Results 01, 10, or 11 to open, reopen, or change to new HCBS program within 60 days of a face-to-face visit or eligibility update. Enter the service agreement for this new period.
  o Exiting from regular AC to open to EW, regular AC to temporary AC, temporary AC to regular AC, or temporary AC to EW using exit code19. Does not require the reopening values 10 or 11 to be within 60 days of a face-to-face visit.
  o Assessment Result 49 to record the citizenship status for AC and ECS applicants/participants.
  o Assessment Result 18 to indicate Relocation Service Coordination. Use Activity Type 07 for this purpose within 365 days of a face-to-face visit.
• Activity Type 08 as a face-to-face visit for persons turning age 65 on the BI, CAC, or CADI programs. The lead agency has a four-month window to conduct the in-person assessment. The four-month window includes the two months before the birthday month, the birthday month, and one month after.
  o Assessment Result 13 to remain on the program
  o Assessment Result 22 to exit the program
  o Assessment Result 10 to open to the EW program
  o Assessment Results 10 or 11 to reopen to the BI, CAC, or CADI program
  See the CBSM manual for more information about returning to BI, CAC, or CADI following NF admission, change to EW, and/or enrollment in managed care.
• Activity Type 09 as an eligibility update via telephone completed within 90 days of a face-to-face assessment.
  o Assessment Results 01, 10, or 11. See information in Section 201.05 regarding possible effective dates when using Activity Type 09.
  o Assessment Results 02 through 09 used for eligibility updates completed via telephone while the person is in the community or in an institution and will not open, change, or reopen to an HCBS program.
  o Assessment Results 02 or 03 used for eligibility updates via telephone while the MSHO or MSC+ person is in the community
• Activity Type 10 for EW or AC programs is a face-to-face case manager visit. It can update assessment information as needed to accommodate service changes and/or resources. The activity type will not extend the program eligibility span.
  o Assessment Result 12 (service change)
  o Use the form DHS-3428G found in eDocs.

Screening and Assessment Scenarios
We are updating and adding more screening scenarios to this section.

201.07 Mandatory Fields
Which fields are mandatory is dependent on the program type and in many cases which activity type or assessment result is used.

For Program Type 00
(Early Intervention, Institution Visits, Relocation Service Activities, Community Assessments)

<table>
<thead>
<tr>
<th>Complete the following fields for Activity Type 02 (Community Visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section A/ALT1 Screen</td>
</tr>
<tr>
<td>• Date of Birth</td>
</tr>
<tr>
<td>• Referral Date</td>
</tr>
<tr>
<td>• Activity Type</td>
</tr>
<tr>
<td>• Activity Date</td>
</tr>
<tr>
<td>• COS, COR, CFR, LTCC County</td>
</tr>
<tr>
<td>• DD, MI, BI Diagnosis History</td>
</tr>
<tr>
<td>• Case Manager/Certified Assessor Number</td>
</tr>
<tr>
<td>Section B/ALT2 Screen</td>
</tr>
<tr>
<td>• Present at Screening</td>
</tr>
<tr>
<td>• Informal Caregiver</td>
</tr>
<tr>
<td>• Reasons for Referral</td>
</tr>
<tr>
<td>• Team</td>
</tr>
<tr>
<td>• OBRA Level 1</td>
</tr>
<tr>
<td>• Current Housing</td>
</tr>
<tr>
<td>• Planned Housing</td>
</tr>
<tr>
<td>• OBRA Level 2 Referral</td>
</tr>
<tr>
<td>Section C/ALT3 Screen</td>
</tr>
<tr>
<td>• Dressing</td>
</tr>
<tr>
<td>• Grooming</td>
</tr>
<tr>
<td>• Bathing</td>
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<tr>
<td>• Eating</td>
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<tr>
<td>• Bed Mobility</td>
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<tr>
<td>• Transfer</td>
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<tr>
<td>• Walking</td>
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<tr>
<td>• Behavior</td>
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<tr>
<td>• Toilet</td>
</tr>
<tr>
<td>• Special Treatment</td>
</tr>
<tr>
<td>• Clinical Monitor</td>
</tr>
</tbody>
</table>
### Complete the following fields for Activity Type 02 (Community Visit)

- Neuro Diagnosis
- IADL fields: Self Evaluation, Mental Status Evaluation through Falls (these fields are only mandatory when age is over 17)

### Section D/ALT4 Screen:
- Assessment Results (02 or 03)
- Effective Date
- Informed Choice
- LTCC/IDT Recommendation
- Level of Care

### Section E/ALT4 Screen
When the Effective Date is less than 2/1/20, and the age is under 21, and the risk status/level of care field is 02, 04, or 05, then at least one of these fields must be a Y.

When the Effective Date field is 2/1/20 or greater, then the following fields are mandatory regardless of age: self-neglect, vulnerability, and toileting assist.

### Section F/ALT5 Screen
Complete Program Type

### Complete the following fields for Activity Type 03 (Early Intervention)

### Section A/ALT1 Screen
- Date of Birth
- Referral Date
- Activity Type
- Activity Date
- COS, COR, CFR, LTCC County
- DD, MI, BI Diagnosis History

### Section B/ALT2 Screen
- Present at Screening
- Marital Status
- Reasons for Referral
- Team
- OBRA Level 1 (must be N)
- Current Housing
- OBRA Level 2 Referral

### Section C/ALT3 Screen
No fields are completed

### Section D/ALT4 Screen:
- Assessment Results (03 or 05)
- Effective Date
- Informed Choice
- LTCC/IDT Recommendation
- Level of Care
Complete the following fields for Activity Type 03 (Early Intervention)

<table>
<thead>
<tr>
<th>Section E/ALT4 Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>When the Effective Date is less than 2/1/20, and the age is under 21, and the risk status/level of care field is 02, 04, or 05, then at least one of these fields must be a Y.</td>
</tr>
</tbody>
</table>

| When the Effective Date field is 2/1/20 or greater, then the following fields are mandatory regardless of age: self-neglect, vulnerability, and toileting assist. |

<table>
<thead>
<tr>
<th>Section F/ALT5 Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>This screen is not mandatory</td>
</tr>
</tbody>
</table>

Complete the following fields for Activity Type 04 (RSC or NF Visit)

<table>
<thead>
<tr>
<th>Section A/ALT1 Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Date of Birth</td>
</tr>
<tr>
<td>• Referral Date</td>
</tr>
<tr>
<td>• Activity Type</td>
</tr>
<tr>
<td>• Activity Date</td>
</tr>
<tr>
<td>• COS, COR, CFR, LTCC County</td>
</tr>
<tr>
<td>• DD, MI, BI Diagnosis History</td>
</tr>
<tr>
<td>• Case Manager/Certified Assessor Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section B/ALT2 Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Present at Screening</td>
</tr>
<tr>
<td>• Informal Caregiver</td>
</tr>
<tr>
<td>• Reasons for Referral</td>
</tr>
<tr>
<td>• Team</td>
</tr>
<tr>
<td>• Hospital Transfer (if Assessment Result is 07 or 08)</td>
</tr>
<tr>
<td>• OBRA Level 1</td>
</tr>
<tr>
<td>• Current Housing</td>
</tr>
<tr>
<td>• Planned Housing</td>
</tr>
<tr>
<td>• OBRA Level 2 Referral</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section C/ALT3 Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dressing</td>
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<td>• Grooming</td>
</tr>
<tr>
<td>• Bathing</td>
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<tr>
<td>• Eating</td>
</tr>
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<td>• Bed Mobility</td>
</tr>
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<td>• Toilet</td>
</tr>
<tr>
<td>• Special Treatment</td>
</tr>
<tr>
<td>• Clinical Monitor</td>
</tr>
<tr>
<td>• Neuro Diagnosis</td>
</tr>
<tr>
<td>• Case Mix</td>
</tr>
<tr>
<td>• NF Stays</td>
</tr>
</tbody>
</table>
**Complete the following fields for Activity Type 04 (RSC or NF Visit)**

- IADL fields: Self Evaluation, Mental Status Evaluation through Falls (these fields are only mandatory when age is over 17)

**Section D/ALT4 Screen:**
- Assessment Results (18 for RSC. 04 – 09 for institution visit)
- Effective Date
- Informed Choice
- LTCC/IDT Recommendation
- Level of Care
- NF Track (see edit text)
- Reason for NF Continued Stay/CDCS Ending

**Section E/ALT4 Screen**
When the Effective Date is less than 2/1/20, and the age is under 21, and the risk status/level of care field is 02, 04, or 05, then at least one of these fields must be a Y.

When the Effective Date field is 2/1/20 or greater, then the following fields are mandatory regardless of age: self-neglect, vulnerability, and toileting assist.

**Section F/ALT5 Screen**
Complete Program Type

**Section G/ALT5 Screen**
Add value 38F when the Assessment Result is 18

---

**For Program Types 01 – 12, 22, 29, and 30 (AC, BI, CAC, CADI, ECS, EW)**

Complete the following fields for Activity Type 02 – Community Visit (Opening/Reopening/Changing Program) This activity type will develop the program eligibility period.

**Section A/ALT1 Screen**
- Date of Birth
- Referral Date
- Activity Type
- Activity Date
- COS, COR, CFR, LTCC County
- Legal Representative Status
- Primary Diagnosis
- DD, MI, BI Diagnosis History
- Case Manager or Certified Assessor Number

**Section B/ALT2 Screen**
- Present at Screening
- Informal Caregiver
- Marital Status
- Reasons for Referral
- Current Living Arrangement
- Planned Living Arrangement
- Team
Complete the following fields for Activity Type 02 – Community Visit (Opening/Reopening/Changing Program) This activity type will develop the program eligibility period.

- Hospital Transfer (program types 08 and 12 only)
- OBRA Level 1
- Current Housing
- Planned Housing
- OBRA Level 2 Referral
- BI/CAC Referral (for program types 01, 02, 07, 08, 11, and 12)

**Section C/ALT3 Screen**
- Dressing
- Grooming
- Bathing
- Eating
- Bed Mobility
- Transfer
- Walking
- Behavior
- Toileting
- Special Treatment
- Clinical Monitor
- Neuro Diagnosis
- Case Mix
- Orientation
- Self-Preservation
- Disability Cert
- Hearing
- Communication
- Vision
- Vent Dependent

IADL fields: Self Evaluation, Mental Status Evaluation through Falls (these fields are mandatory for program types EW, AC, and ECS. These fields are mandatory when age is over 16 for the BI and CADI programs).

**Section D/ALT4 Screen:**
- Assessment Results (01, 10, 11)
- Effective Date
- Informed Choice
- Client Choice
- Family Choice
- LTCC/IDT Recommendation
- Level of Care

**Section E/ALT4 Screen**
When the Effective Date is less than 2/1/20, and the age is under 21, and the risk status/level of care field is 02, 04, or 05, then at least one of these fields must be a Y.
Complete the following fields for Activity Type 02 – Community Visit (Opening/Reopening/Changing Program) This activity type will develop the program eligibility period.

When the Effective Date field is 2/1/20 or greater, then the following fields are mandatory regardless of age: self-neglect, vulnerability, and toileting assist.

**Section F/ALT5 Screen**
Complete all fields except CDCS Amount. Do not use program type 30.

**Section G/ALT5 Screen**
At least one value needed for the Service Plan Summary at the top of the screen when the Activity Type is 02. For program types 03, 04, 09, 10, and 22 (EW and AC) at least one program service with a formal funding code and another formal service.

**Section H/ALT6 Screen**
For program type 29 (ECS)
- Address fields
- CFR
- AC/ECS Gross income
- AC/ECS Gross Assets
- AC/ECS Adjusted Income
- AC/ECS Adjusted Assets
- Medicare fields
- Medicare Eligible
- Citizenship

For program types 09, 10, and 22 (AC)
- Address fields
- CFR
- AC/ECS Gross income
- AC/ECS Gross Assets
- AC/ECS Adjusted Income
- AC/ECS Adjusted Assets
- Medicare fields
- AC Fee Waiver Reason
- Medicare Eligible
- AC Fee Assessed
- Citizenship
Activity Type 04 – Institution Visit  
(Opening/Reopening/Changing Program) This activity type will develop the program eligibility period. 

See the fields in the Activity Type 02 chart. The only additional field is to complete either the NF Stays and/or Hospital Stays in Section C/ALT3 screen when using activity type 04.

Activity Type 06 – Reassessment Visit for Waiver, AC, and ECS Program Types  
Re-enter the below fields that will be blank. Change fields that reflect the results of the current reassessment visit. This activity type extends the program eligibility end date for assessment result 13; or closes the program for assessment results 17, 19 – 25, 31, 33, or 34.

Section A/ALT1 Screen  
- Date of Birth  
- Activity Type  
- Activity Date  
- COS, COR, CFR, LTCC County*  
- County or Certified Assessor Number

*If MA does not overlap with the major program UN with eligibility type EC, then the COS, COR, and CFR fields on the ECS screening document will update the Recipient Subsystem’s RELG, RCIN, and RCAD screens and county fields on the ECS service agreement.

If major program MA does overlap, the Recipient Subsystem’s RELG (for major program UN with EC eligibility type), updates the COS, COR, and CFR fields on the screening document and service agreement as well as the RCIN and RCAD screens.

The AC screening document will update the COS, COR, and CFR fields on the recipient’s subsystem’s RELG (for major program AC), RCIN, and RCAD screens (for AC case records) and the service agreement county fields.

Section B/ALT2 Screen  
- Informal Caregiver  
- Current Housing

Section D/ALT4 Screen:  
- Assessment Result (13 to continue on program. Exits 17, 19 – 25, 31, 33, or 34 to close program. Note: assessment result 26 is no longer valid on or after activity type date February 1, 2019)  
- Exit Reason (use when assessment result is 17, 19 – 25, 31, 33, or 34)  
- Effective Date  
- Services (program types 03 and 04)*  
- Provider NPI (program types 03 and 04)*  
- Person (program types 03 and 04)*

Section G/ALT5 Screen
Activity Type 06 – Reassessment Visit for Waiver, AC, and ECS Program Types

Review values and change as needed for the Service Plan Summary at the top of the screen.

*The Provider Evaluation fields on the ALT4 screen and at the bottom of the ALT5 screen are mandatory only for the EW program types (03 or 04) when the LTCC County field = MCO code, and the activity type date is 8/1/18 or greater unless the Services field is NA or the Person field is a 3.

Section H/ALT6 Screen
For program types 29 or 30 (ECS)
- CFR
- AC/ECS Gross income
- AC/ECS Gross Assets
- AC/ECS Adjusted Income
- AC/ECS Adjusted Assets
- Medicare fields
- Medicare Eligible

For program types 09, 10, and 22 (AC)
- CFR
- AC/ECS Gross income
- AC/ECS Gross Assets
- AC/ECS Adjusted Income
- AC/ECS Adjusted Assets
- Medicare Eligible
- AC Fee Assessed

Activity Type 07 – Initial Opening or Exiting Program

Re-enter the below blank fields. Use Activity type 07 with Assessment Result 01 within 60 days of a face-to-face visit with Program Type 00 to begin the program eligibility span. See also Activity Type 09 in this chapter as a telephone update.

Use Activity type 07 to exit the person from the waiver, AC, or ECS program. This will close the program eligibility span to the date of the effective date field. Note: using Activity Type 07 will protect many fields.

Section A/ALT1 Screen
- Date of Birth
- Activity Type
- Activity Date
- COS, COR, CFR, LTCC County
- County or Certified Assessor Number

Section B/ALT2 Screen
- Informal Caregiver
### Activity Type 07 – Initial Opening or Exiting Program
- Current Housing

### Section D/ALT4 Screen:
- Assessment Result (01 as initial opening. Codes 17, 19 – 25, 31, 33, or 34 for exiting)
- Exit Reason (used when assessment results are 17, 19 – 25, 31, 33, or 34)
- Effective Date

### Section G/ALT5 Screen
Review values and change as needed for the Service Plan Summary at the top of the screen.

### Section H/ALT6 Screen
For program types 29 or 30 (ECS)
- Address fields (initial opening for program type 29)
- CFR
- AC/ECS Gross income
- AC/ECS Gross Assets
- AC/ECS Adjusted Income
- AC/ECS Adjusted Assets
- Medicare fields (initial opening for program type 29)
- Medicare Eligible
- Citizenship (initial opening for program type 29)

For program types 09, 10, and 22 (AC)
- Address fields (initial opening)
- CFR
- AC/ECS Gross income
- AC/ECS Gross Assets
- AC/ECS Adjusted Income
- AC/ECS Adjusted Assets
- Medicare fields (initial opening)
- AC Fee Waiver Reason (initial opening)
- Medicare Eligible
- AC Fee Assessed
- Citizenship (initial opening)

### Activity Type 08 – 65th Birthday
Re-enter the below fields that will be blank. Change fields that reflect the results of the current reassessment visit. This activity type extends the program eligibility end date beyond the 65th birthday month to continue on BI or CADI programs. Also used to exit these programs.

### Section A/ALT1 Screen
- Date of Birth
- Activity Type
- Activity Date
- COS, COR, CFR, LTCC County
### Activity Type 08 – 65th Birthday
- County or Certified Assessor Number

### Section B/ALT2 Screen
- Informal Caregiver
- Current Housing

### Section D/ALT4 Screen:
- Assessment Result (13 to continue, or 23 and 24 to exit program)
- Exit Reason (when using assessment result 23 or 24)
- Effective Date

### Section G/ALT5 Screen
Review values and change as needed for the Service Plan Summary at the top of the screen.

### Activity Type 09 – Eligibility Update Following Activity Type 02 or 04 with Program Type 00.
Re-enter the below fields that will be blank. Change fields that reflect the results of this telephone update. This activity type develops the program eligibility period.

### Section A/ALT1 Screen
- Date of Birth
- Activity Type
- Activity Date
- COS, COR, CFR, LTCC County
- County or Certified Assessor Number

### Section B/ALT2 Screen
- Informal Caregiver
- Current Housing

### Section D/ALT4 Screen:
- Assessment Result (01, 10, or 11)
- Effective Date

### Section G/ALT5 Screen
Review values and change as needed for the Service Plan Summary at the top of the screen.

### Section H/ALT6 Screen
For program types 29 (ECS)
- CFR
- AC/ECS Gross income
- AC/ECS Gross Assets
- AC/ECS Adjusted Income
- AC/ECS Adjusted Assets
- Medicare fields
### Activity Type 09 – Eligibility Update Following Activity Type 02 or 04 with Program Type 00.

- Medicare Eligible

For program types 09, 10, and 22 (AC)
- CFR
- AC/ECS Gross income
- AC/ECS Gross Assets
- AC/ECS Adjusted Income
- AC/ECS Adjusted Assets
- Medicare Eligible
- AC Fee Assessed

### Activity Type 10 – Service Change

Re-enter the below fields that will be blank. Change fields that reflect the results of the visit that require changes in the service plan and to update budget and service eligibility (this is not the annual reassessment). Use this activity type for EW and AC program types. The eligibility span does not extend using this activity type.

### Section A/ALT1 Screen
- Date of Birth
- Activity Type
- Activity Date
- COS, COR, CFR, LTCC County
- County or Certified Assessor Number (must be the same as number on the activity type 02 or 04 document. If not, enter activity type 05 document first to change the provider number to current assessor).

### Section B/ALT2 Screen
- Informal Caregiver
- Current Housing

### Section D/ALT4 Screen:
- Assessment Result (12)
- Effective Date

### Section G/ALT5 Screen
Review values and change as needed for the Service Plan Summary at the top of the screen.

### Section H/ALT6 Screen
For program types 09, 10, and 22 (AC)
- CFR
- AC/ECS Gross income
- AC/ECS Gross Assets
- AC/ECS Adjusted Income
- AC/ECS Adjusted Assets
Activity Type 10 – Service Change
- Medicare Eligible
- AC Fee Assessed

For Program Type 18 – MSHO/MSC+ Community Well Full Screening
Complete the following fields for Activity Type 02 – Community Well Screenings for Managed Care Members Using MSHO or MSC+

<table>
<thead>
<tr>
<th>Section A/ALT1 Screen</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Date of Birth</td>
<td></td>
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<tr>
<td>• Referral Date</td>
<td></td>
</tr>
<tr>
<td>• Activity Type</td>
<td></td>
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<tr>
<td>• Activity Date</td>
<td></td>
</tr>
<tr>
<td>• COS, COR, CFR, LTCC County</td>
<td></td>
</tr>
<tr>
<td>• Primary Diagnosis</td>
<td></td>
</tr>
<tr>
<td>• DD, MI, BI Diagnosis History</td>
<td></td>
</tr>
<tr>
<td>• Case Manager or Certified Assessor Number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section B/ALT2 Screen</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Present at Screening</td>
<td></td>
</tr>
<tr>
<td>• Reasons for Referral</td>
<td></td>
</tr>
<tr>
<td>• Team</td>
<td></td>
</tr>
<tr>
<td>• OBRA Level 1</td>
<td></td>
</tr>
<tr>
<td>• Current Housing</td>
<td></td>
</tr>
<tr>
<td>• OBRA Level 2 Referral</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section C/ALT3 Screen</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dressing</td>
<td></td>
</tr>
<tr>
<td>• Grooming</td>
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</tr>
<tr>
<td>• Clinical Monitor</td>
<td></td>
</tr>
<tr>
<td>• Neuro Diagnosis</td>
<td></td>
</tr>
<tr>
<td>• Case Mix</td>
<td></td>
</tr>
<tr>
<td>• Orientation</td>
<td></td>
</tr>
<tr>
<td>• Self-Preservation</td>
<td></td>
</tr>
<tr>
<td>• Disability Cert</td>
<td></td>
</tr>
<tr>
<td>• IADL fields Self Evaluation, Mental Status Evaluation through Falls</td>
<td></td>
</tr>
<tr>
<td>• Falls</td>
<td></td>
</tr>
</tbody>
</table>

Section D/ALT4 Screen:
Complete the following fields for Activity Type 02 – Community Well Screenings for Managed Care Members Using MSHO or MSC+

- Assessment Results (02 or 03)
- Effective Date
- Informed Choice
- Level of Care

Section E/ALT4 Screen
When the Effective Date field is 2/1/20 or greater, then the following fields are mandatory: self-neglect, vulnerability, and toileting assist.

Section F/ALT5 Screen
Complete program type

Section G/ALT5 Screen
At least one value is needed for the Service Plan Summary at the top of the screen

For Program Type 19 – MSHO/MSC+ Nursing Facility Screening

Complete the same fields used for Activity Type 02 – Community Well Screenings for Managed Care Members Using MSHO or MSC+ and as noted below

Section BALT2 Screen
- Planned Housing

Section C/ALT3 Screen
- Only complete the NF Stays and/or Hospital fields in this section/screen

Section D/ALT4 Screen
- Assessment Results (04 – 09)
- Reason for NF Continued Stay/CDCS Ending

Section E/ALT4 Screen
When the Effective Date field is 2/1/20 or greater, then the following fields are mandatory: self-neglect, vulnerability, and toileting assist.

Section G/ALT6 Screen
This section/screen is not mandatory

For All Program Types

Activity Type 05 – Document Change
Re-enter the below fields that will be blank. Change or add any unprotected field that needs correction.

Section A/ALT1 Screen
- Date of Birth
- Activity Type
- Activity Date
- COS, COR, CFR, LTCC County

If MA does not overlap with the major program UN with eligibility type EC, then the COS, COR, and CFR fields on the ECS screening document will update the Recipient
Activity Type 05 – Document Change

Subsystem’s RELG, RCIN, and RCAD screens and county fields on the ECS service agreement.

If major program MA does overlap, the Recipient Subsystem’s RELG (for major program UN with EC eligibility type), updates the COS, COR, and CFR fields on the screening document and service agreement as well as the RCIN and RCAD screens.

The AC screening document will update the COS, COR, and CFR fields on the recipient’s subsystem’s RELG (for major program AC), RCIN, and RCAD screens (for AC case records) and the service agreement county fields.

Section B/ALT2 Screen
  • Informal Caregiver (If program type is waiver or AC)
  • Current Housing

Section D/ALT4 Screen:
  • Assessment Results (32 or 98)
  • Effective Date

For program types 09, 10, and 22 (AC)
  • CFR
  • AC/ECS Gross income
  • AC/ECS Gross Assets
  • AC/ECS Adjusted Income
  • AC/ECS Adjusted Assets
  • Medicare Eligible
  • AC Fee Assessed

Coding Examples for Section B: Living Arrangement, Housing Type, and Program License

As of July, 2020 the Current and Planned Program License fields are no longer mandatory. The fields removed from the MMIS ALT2 screen in 2020.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Field Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person is residing and will continue to live in foster care.</td>
<td>• Current Living Arrangement = 04</td>
</tr>
<tr>
<td></td>
<td>• Planned Living Arrangement = 04 or 06</td>
</tr>
<tr>
<td></td>
<td>• Current/Planned Housing Type = 05</td>
</tr>
<tr>
<td></td>
<td>• Current/Planned Program License = 05 or 06</td>
</tr>
<tr>
<td>Person lives alone and will continue to live alone in an apartment or other home. Living alone means no one else lives with the person.</td>
<td>• Current/Planned Living Arrangement = 01</td>
</tr>
<tr>
<td></td>
<td>• Current/Planned Housing Type = 09</td>
</tr>
<tr>
<td></td>
<td>• Current/Planned Program License = 09</td>
</tr>
<tr>
<td>Person lives in an apartment and provided with assisted living services.</td>
<td>• Current/Planned Living Arrangement = 03</td>
</tr>
<tr>
<td>An apartment is a self-contained unit that includes private space for</td>
<td>• Current/Planned Housing Type = 09</td>
</tr>
<tr>
<td></td>
<td>• Current/Planned Program License = 07</td>
</tr>
<tr>
<td>Scenario</td>
<td>Field Coding</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>sleeping, cooking, dining, living, and a bathroom. <strong>They have a roommate.</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Person lives in an assisted living building with seven others. Each person has a bedroom with an attached bath. All other space for living, dining, cooking is shared accommodation. | • Current Living Arrangement = 04  
• Planned Living Arrangement = 04 or 06  
• Current/Planned Housing Type = 04  
• Current/Planned Program License = 07 |
| Person lives in a nursing facility and will return to the community to an assisted living in an apartment with spouse. | • Current Living Arrangement = 04  
• Planned Living Arrangement = 02  
• Current Housing Type = 11  
• Planned Housing Type = 09  
• Current Program License = 11  
• Planned Program License = 07 |
201.08 RSC, RSC-TCM, NF Admissions, AC Conversion Case Management, and MHM Transitional Services

The information in this section is included in Session 10 of the MMIS Training Series.

Relocation Service Coordination (RSC)

Relocation Service Coordination (RSC) will provide payment for additional assessment and service planning to assist those who need help in planning and accessing supports to return to the community. RSC-TCM cannot duplicate required NF discharge planning services. Providers receive payment for up to 180 consecutive days of targeted case management services prior to a person’s discharge.

A person may not be open to the waiver program while receiving RSC-TCM services. Close the waiver program by entering an exit screening document and closing the service agreement. See the CBSM for eligibility, timelines, limitations, billing, provider standards, and services under RCS.

If twelve months or more has passed from the last face-to-face assessment/screening and the person indicates they want to receive RSC-TCM, a new face-to-face assessment is required. To authorize RSC Targeted Case Management services and receive payment during a face-to-face assessment enter a new screening document with these fields completed in the following manner:

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 11 - Activity Type</td>
<td>Value 02 Face to Face Assessment or Value 04 Relocation/Transition Assessment</td>
</tr>
<tr>
<td>Field 24 - Present at Screening/Assessment</td>
<td>Include 04 social worker and/or Value 05 public health nurse</td>
</tr>
<tr>
<td>Field 26 - Reason(s) for Referral</td>
<td>Include 09 Request relocation to community from medical facility or 11 Reassessment</td>
</tr>
<tr>
<td>Field 32 - Current Housing Type</td>
<td>Values 02 (ICF/DD), 03 (Hospital), or 11 (NF/Certified boarding care)</td>
</tr>
<tr>
<td>Field 75A - Assessment Results</td>
<td>Value 18 Transition planning</td>
</tr>
<tr>
<td>Field 84 - Reason(s) for Assessment/CDCS Terminate</td>
<td>Enter applicable codes</td>
</tr>
<tr>
<td>Field 104 - Program Type</td>
<td>Value 00 (None)</td>
</tr>
<tr>
<td>Field 111 - Service Plan Summary</td>
<td>Include 38F Relocation Service Coordination</td>
</tr>
</tbody>
</table>

If less than twelve months have passed from the last face-to-face assessment/screening and a person requests RSC-TCM, another face-to-face
assessment is not required. Enter a new screening document with the following information:

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 11 - Activity Type</td>
<td>Value 07 Case Management/Administration Activity</td>
</tr>
<tr>
<td>Field 75A - Assessment Result</td>
<td>Value 18 Transition planning</td>
</tr>
<tr>
<td>Field 104 - Program Type</td>
<td>Value 00 (None)</td>
</tr>
<tr>
<td>Field 111 - Service Codes</td>
<td>Include value 38F Relocation Service Coordination</td>
</tr>
</tbody>
</table>

Do not enter an exit screening document when RSC services end. If the person has received a complete assessment (Activity Type 02 or 04) within 60 days of opening to a waiver program, use Activity Type 07 with Assessment Result 01, 10, or 11 to open a waiver program. If not, another face-to-face assessment will be required to open the program.

Below are case examples when to use RSC and how to code the LTC Screening Document.

Q: I have a person open to the CADI waiver that is now entering a facility and would benefit from Relocation Service Coordination Targeted Case Management. How do I open RSC-TCM?

A: Because RSC-TCM is not available for people open to a waiver, exit the person from the waiver using Activity Type 06 or 07 prior to authorizing RSC-TCM. Complete these fields:
- Current Living Arrangement as 04,
- Current Housing Type as 11,
- Assessment Result of 20 or 22 with an exit reason of 04 and activity type 06 or assessment result 22 with activity type 07,
- Assessment Result Date matching the NF admission date, and
- Service Code 38F

End the service agreement for the date the person begins RSC.

Q: I have a person who was on RSC-TCM and has discharged. How do I close RSC and reopen/open the waiver?

A: Since RSC-TCM is not a waiver service and the person can’t be on a waiver and receive RSC-TCM, essentially opening the person to a waiver closes out RSC-TCM. A new screening document reopening the waiver will close out RSC-TCM.
Q: Will RSC-TCM claims pay if not submitted prior to the person moving to the community with waiver services?

A: Yes. Submit RSC-TCM claims up to 365 days after the date of services. List code 38F on the Service Plan Summary section as a current service on every screening document entered into MMIS while the person receives that service and while providers submit claims for the service. Omitting RSC-TCM as a current service on a screening document will cause RSC-TCM claims to deny.

Q: Can I perform the Long-Term Care Consultation and open RSC-TCM at the same time?

A: RSC-TCM can be authorized on the same screening document as LTCC with Activity Type 02 or 04, the Assessment Result is 18, the Program Type is 00 and the service includes 38 (RSC-TCM). Other edits may post base on the living arrangement, current housing etc., and should be resolved based on individual criteria. In addition, if the person is under 21, DHS authorizes the nursing home placement.

Q: I have some edits posting on my LTC Screening Document when authorizing RSC-TCM.

- Edit 808 - Since RSC is only for people in an institution, the living arrangement must be 04 (Congregate Setting) when authorizing RSC-TCM.
- Edit 803 - Make sure the program type is 00 if the Assessment Result is 18. See below with edit 643.
- Edit 806 - The Service Code Indicator must be “F” (Formal) for code 38 in the Service Plan Summary section.
- Edit 650 - The Current Housing Type must be 02, 03, 11, 14, or 15.
- Edit 642 - Make sure that the program type is 00 if the Activity Type is 07.
- Edit 643 - Assessment Result 18 is not valid with any program type other than 00.

Nursing Facility Admissions Less than 30 Days

A person on the waiver program who enters a nursing facility but anticipates that they will return to the community with waiver services within 30 days, and will not use RSC, does not need to be exited from the waiver program. Close all line items on the service agreement to the last day the person was in the community. When they return to the waiver program within 30 days, add new line items to the same service agreement beginning with the new period of community living.
If the person does not return to the community within thirty days, the service agreement is closed effective the day of admission. An exit screening document is entered with an effective date the same as the admission date.

NOTE: The service agreement line item may overlap the institution period on the date of admission and the date of discharge only. See the CBSM for the screening document and service agreement process for different types of institutions.

**Alternative Care Conversion Case Management**

When a person receiving Alternative Care services enters a nursing facility and case management will continue to relocate the person back to the community, it is not necessary to enter an exit screening document. End the AC service agreement line items effective the admission date. Enter a new line item for case management conversion (T1016 – no modifier) with a begin date of the admission date. Conversion case management services have a maximum of 180 days. *The cost of the service is not added to the Total Authorize Amount field so it is not applied against the Total Cap Amount.* When the person returns to the community, the case management conversion line item is closed and the community services are re-entered on the service agreement for the new period of community stay.

The person may initially open to the AC program with **only** conversion case management during a period of nursing home stay for 180 days. When relocated to the community with AC services, the line item is closed and community services added to the same service agreement. If the person continues to be in the nursing home after 180 days, enter an exit document and close the service agreement.

If the person becomes eligible for MA, do not use AC Conversion Case Management; instead use RSC services. Close the AC service agreement to the date of admission, enter an exit screening document with an effective date the same as the admission date, and enter another screening document for RSC-TCM.

**Authorizing Moving Home Minnesota (MHM) Transitional Services**

MHM transitional services provide up to 180 days to qualified persons living in specific institutions. These services consist of the plan development (T2038 U6) and coordination (T2038 U6 UD). See the *[Moving Home Minnesota Program manual]* for information on qualified persons, institutions, and community residences. For questions, contact *[movinghomemn.mfp@state.mn.us]* or by phone at 651 431-3951 or 888-240-4756.

The LTC Screening Document contains a field called MHM field on the ALT4 screen. When placing a “Y” in this field, bill the transitional services under the MHM billing codes.

An exception is when the person enrolls with a managed care organization (MCO) under the Minnesota Health Options Services (MSHO) or Minnesota Senior Care Plus (MSC+) programs. The MCO pays the transitional services.
If RSC started but not yet billed, submit a claim for those RSC services under the MHM billing codes. If submitted, future claims deny while the person is eligible for MHM. The transitional coordination claim, if submitted by the same provider as the RSC claim, reduces by the amount paid under RSC.

To authorize MHM transitional and community services, complete these fields on the LTC Screening Document. Enter a LTC screening document even if the person enrolls with MSHO or MSC+ if they will be using MHM community services.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 11 – Activity Type</td>
<td>Value 04</td>
</tr>
<tr>
<td>Field 27 – Current Living Arrangement</td>
<td>Value 04</td>
</tr>
<tr>
<td>Field 33 – Current Housing Type</td>
<td>Value 02, 03, or 11</td>
</tr>
<tr>
<td>Field 34 – Planned Housing Type</td>
<td>Value 05 or 09</td>
</tr>
<tr>
<td>Field 75A – Assessment Result</td>
<td>Value 04, 06 – 09, or 18</td>
</tr>
<tr>
<td>Field 104 – Program Type</td>
<td>Value 00 or 19</td>
</tr>
<tr>
<td>Field 105 – MHM IND</td>
<td>Value Y</td>
</tr>
</tbody>
</table>

Service Plan Summary

For transitional services, use value NF - 34 or Other - 98 with “F” funding source.

The following community services have a source code of “M”:

- 17 – Overnight supervision
- 21 – respite in home
- 24 – mental health services
- 26 – home modifications
- 27 – caregiver training
- 45 – extended supplies/equipment
- 48 – supported employment
- 52 – PERS
- 91 – case consultant
- 92 – self-advocacy training
- 93 – comprehensive community support services
- 94 – youth assertive community treatment
- 95 – certified peer specialist
- 96 – membership fees
- 97 – transport to acquire housing/employment
- 99 – employment equipment
Transitional Services from BI, CAC, CADI, and DD Programs
See the transitional services page in the Community-Based Services Manual CBSM for more information on the covered and non-covered services.

201.09 Consumer Directed Community Supports (CDCS)
This section gives instructions for coding the waiver and Alternative Care CDCS. Persons receiving Essential Community Support services are not eligible for CDCS services. The information in this section is in Session 10 of the MMIS Training Series. See also the CDCS Policy Manual.

Consumer-directed Community Supports (CDCS) is a service that gives individuals more flexibility and responsibility for directing their services and supports, including hiring and managing direct care staff. CDCS may include traditional goods and services, as well as additional allowable services that provide needed support to persons.

CDCS not allowed for the participant during a Primary Care Utilization Review period. See the span on the PCUR screen that cannot overlap with the effective date field. Edit 442 “Services Not Allowed Due to MRRP” will post if the CDCS field equals Y. On Section G, two values record CDCS on the Service Summary Screen. They are 40 (CDCS) and 41 (Paid CDCS Parent/Spouse).

The form DHS-6633A is the Community Support Plan Addendum with budget increases.

Disability Waivers: BI, CAC, CADI, and DD Screening Document
The LTC Screening Document identifies when the person has elected the CDCS service option for the BI, CAC, and CADI programs. A field in Section F of the screening document form DHS-3427 called “CDCS” uses values “Y” or “N”.

The CDCS Amount field that follows identifies the monthly CDCS budget cap. The LTC Screening Document edit that will post is:
- Edit 441 – CDCS field is blank or invalid. If the Program Type is CAC, CADI, or BI, then enter Y or N in the CDCS field.

The DD Screening Document edit that will post is 442:
- Current Service is 48 and the MRRP field on RSUM (Minnesota Restricted Recipient Program) has a span that overlaps with the action date field.

Alternative Care and Elderly Waiver Programs
The Effective Date, Case Mix Level, and Program Type fields determines the monthly CDCS budget cap and automatically populates for the EW and AC programs. When the CDCS field = Y, the dollar amount in the CDCS Amount field will be used to cap the total amount available on the service agreement. When the CDCS field = N, the Case Mix Amount field on the screening document will be used to cap the total amount available on the service agreement. In both cases, the monthly dollar amount from the
The dollar amount may exceed these budget limits when:

1) The PCA Complex field = Y
If the dollar amount in the CDCS Amount field is manually increased, edit 784 will post to route the service agreement to DHS staff for approval. The edit does not post or routing occur if there is a managed care code in the LTC County field on the last screening document. If the PCA Complex field = N when the amount is increased, MMIS will decrease the amount.

2) EW conversions when DHS approves the higher nursing home rate
For EW conversion service agreements, if the dollar amount in the CDCS Amount field is manually increased, even when the PCA Complex field = N, edit 784 will post to route the service agreement to DHS staff for approval. The edit will not post and no routing occurs if there is a managed care code in the LTC County field on the last screening document. See the CBSM manual for eligibility, approval process, and required forms.

There are two assessment result values with the EW and AC programs. The purpose of these assessment results is to identify funding changes from AC or EW to CDCS and vice versa.

- Assessment Result 36 called “Elected Elderly CDCS” used when the person is switching to CDCS from non-CDCS services. Edit 448 “CDCS Field Equals N” will post if the CDCS field is not a Y.
- Assessment Result 37 “Elected Elderly Non-CDCS Services from CDCS” used whenever the person switches to non-CDCS services from CDCS. When this assessment result is used, field 84 Reason(s) for Continued or Long-term Institution Stay, is required to record up to two reasons why the person chose to end CDCS. Edit 449 “CDCS Field Equals Y” will post if the CDCS field is not an N.
- These assessment results will not change the eligibility span.
- The codes are not exits. If the person exits the AC or EW program, enter an exit document after assessment result 37.
- The codes allow the service agreement header amount to be limited to either the non-CDCS (EW or AC case mix level) or CDCS budget caps.

Alternative Care and Elderly Waiver Service Agreements
There are three procedure codes to identify CDCS services.

- T2028 to authorize all CDCS services. It includes the following service categories: Personal Allowance; Medical Treatment and Training, Environmental Modifications and Provisions, and Self-Direction Support Activities. The PCA Complex field on the ASA2 screen will be mandatory.
- T2040 to authorize payment for Background Checks.
• T2041 includes all activities for Required Case Management.

The service agreement assures:
• CDCS is authorized on the LTC Screening Document prior to entering the line items on the service agreement;
• Specific services are authorized when CDCS is elected;
• The total amount authorized for CDCS services is under the CDCS budget cap.
• Required Case Management is included; and
• The total amount authorized for Required Case Management is under the cap amount for Required Case Management.

Edits that may post on the CDCS service agreement are:

**Edit 443 “CDCS Not Authorized”**
This edit will post when adding T2028 to the service agreement and the CDCS field on the LTC screening is an “N”. If the CDCS field on the last LTC Screening Document was mistakenly valued as an “N”, delete that document and a new document entered with the correct value.

**Edit 445 “Service Not Allowed with CDCS”**
This edit will post if invalid services are on an EW or AC service agreement with a line item for T2028.

The only valid line items for Alternative Care service agreements are:
• T2028 (CDCS) includes all costs for T1002, T1003, T1030, T1030 GT, T1031, T1031 GT, T1021, T1019, and G0156
• T2040 (Background Checks)
• T2041 (Required Case Management)
• T1016 Conversion Case Management

The only valid services for Elderly Waiver service agreements are:
• T2040 (Background Checks)
• T2041 (Required Case Management)
• T1003 without modifier UC (LPN)
• T1002 without modifier UC (RN)
• T1021 (Home Health Aide)
• T1030 (Skilled Nurse Visit - RN)
• T1030 with modifier GT (SNV – RN, Telehomecare)
• T1031 (Skilled Nurse Visit – LPN when line item begin date is 1/1/2020 or later)
• T1031 with modifier GT (SNV – LPN, Telehomecare when line item begin date is 1/1/2020 or later)
• T1019 (PCA)
• T1019 TG (PCA Complex)
• T1019 UA (RN Supervision of PCA)
- H2015 with modifier U6 (MHM Comprehensive Community Support Services)*
- H0038 with modifier U6, or H0038 with U6 and U5, or H0038 with U6 and HQ (MHM Certified Peer Specialist)*
- S9970 with modifiers U5, U6 (MHM Membership Fees)*
- T2013 with modifier U6 (MHM Post-Discharge Case Consultation and Collaboration- Home Care Training Family per session)*
- S5111 with modifier U6 replaced T2013 U6*
- S5116 with modifier U6 (MHM Post-Discharge Case Consultation and Collaboration - Home Care Training Non Family per session)*
- S5135 with modifier U6 and UA (MHM Overnight Assistance)*

*The Moving Home Minnesota service costs do not apply against the CDCS budget cap.

You must delete any other line item or change the procedure code on the line item to one of the above.

**Edit 265 Managed Care Eligibility Open**
This edit will post if the Elderly Waiver CDCS service agreement for persons enrolled with South County Health Alliance has a header begin date on or after January 1, 2019 or a header end date on or after January 1, 2019. Close the service agreement to an end date no later than December 31, 2018 or cancel the service agreement that begins in 2019. This does not affect those EW service agreements case managed by the tribe.

**Edit 553 “Line Not Allowed for Health Plan”**
This edit will post if the Elderly Waiver CDCS service agreement for persons enrolled with South County Health Alliance and the line item begins on or after January 1, 2019. End all services no later than December 31, 2018. This does not affect those EW service agreements case managed by the tribal agency.

**Edit 672 “Total Authorized Amount Exceeded”**
This edit will no longer post, if the total authorized amounts of the line items exceed the CDCS EW or AC budget cap upon exiting.

**Edits 447 “RCM without CDCS” and 452 “RCM Cap Exceeded”**
Edit 447 will post if an approved line item for T2028 is not on the same EW or AC service agreement. Enter a line item for T2028 and change the status to “approve”.

Edit 452 will post if the total sum of all line items for T2041 exceed the RCM budget cap. Reduce the line item(s) so the total amount does not exceed this maximum.

**Edit 241 “Provider Type/Service Conflict”**
Do not use Fiscal Support Entities (FSE) provider numbers on the line item for T2028 or T2040 that begin on or after July 1, 2019. These are provider type 18 on the Provider Subsystem.
Use providers called Financial Management Services (FMS) and shown as provider type 38 on the Provider Subsystem for line items that begin on or after July 1, 2019.

BI, CAC, CADI, and DD Service Agreements

In order to authorize CDCS on a service agreement:
- The LTCC Screening Document must indicate a “Y” in the CDCS field, or
- The DD Screening Document Current Service Code is 48

Authorize CDCS as one service agreement line item.
- Enter the dates of the service span
- Use CDCS code T2028 (no modifier)
- Enter the individual’s county authorized budget amount as the requested total amount (no unit or rate)
- This amount cannot exceed the State set resource. This information is also on the Waiver Management System.

On the service agreement, put services and supports received through CDCS under a single line item for T2028 unless they are home care services specified below. Enter separate line items for state plan home care services:

- T1002 HCN- RN
- T1003 HCN- LPN
- T1030 Skilled nurse visit – RN
- T1019 PCA
- T1021 Home health aide
- T1031 Skilled nurse visit – LPN
- X5609 PPHP services (SNV, HHA, PCA and HCN for seniors in disability waivers; SN and HHA for SNBC members in disability waivers)
- T1019 UA - Supervision of PCA

Do not add the following services and supports. Payment is not through the individual CDCS budget but through the lead agency waiver budget and must be included on separate line items:
- Modifications and assistive technology that exceed $5000, which the county has approved outside of the individual CDCS budget
- T2029 Assistive Technology Equipment
- T2029 UD - Assistive Technology Assessment
- S5165 Environmental Accessibility Adaptations (EAA)/Home Install
- T1028 EAA/Home Assessment
- T1031 SNV-LPN for line begin dates on or after 1/1/20
- T2039 EAA/Vehicle Install
- T2039 UD - EAA/Vehicle Assessment
- T2040 Background checks
- T1016 UC - Case management (required case management)
- T1016 UC TF - Case management aide (this is required case management)
Service Agreement Edits

- Edit 440 – Excluded time field is blank or invalid’. Enter the Excluded Time field
- Edit 568 – Procedure code/current service mismatch. For procedure code T2028 the DD Screening Document must include Current Service Code - 48 (CDCS)
- Edit 443 – CDCS NOT ALLOWED' (CAC, CADI, & BI). For procedure code T2028 or T2040
- The LTC Screening Document CDCS field must be “Y”.
- Edit 363 – Procedure/Modifier Conflict’ Procedure code T2028 cannot be entered on an SA with a modifier.
- Edit 444 – CDCS/Other Service Conflict’ Procedure code T2028 conflicts with another service on the SA.
- Edit 241 – Provider Type/Service Conflict. See above.

BI, CAC, CADI, and DD Service Agreement Scenarios

Opening CDCS

**Scenario 1: Initial opening – person selects CDCS**
The person is not currently on the BI, CAC, or CADI waiver and selects CDCS at the initial opening to the program.
- Enter a LTC Screening Document using Activity Type 02, 04, or 07 (if within 60 days of a face to face assessment)
- Use Assessment Result 01,10,11,28
- Enter a Y in the “CDCS” field

Note: this will create a waiver span for this person.

The person is not currently on the DD waiver and selects CDCS at the initial opening to the program.
- Enter a full team screening document using Activity Type 01
- Enter a waiver-in screening document, Activity Type 04 and enter the CDCS code, 48 in Field 41 (Current Services)

**Scenario 2: At reassessment: a person already on a waiver decides to change to CDCS**
The individual is currently receiving non-CDCS services and elects at his/her reassessment to use CDCS.
For CAC, CADI, or TBI:
- Enter a LTC Screening Document using Activity Type 06
- Use Assessment Result 13
- Enter a Y in the “CDCS” field

Note: This will extend the waiver span for person.

For DD:
• Enter an Annual Review screening document using Activity Type 02 and enter the CDCS code, 48 in Field 41 (Current Services)

**Scenario 3: A person is already on a waiver and chooses CDCS, but NOT at reassessment.**
If this individual is currently, receiving non-CDCS services and elects to use CDCS immediately without waiting for his/her reassessment.
• Enter a LTC Screening Document using Activity Type 07
• Use Assessment Result 98
• Enter a Y in the “CDCS” filed. Note: This will not extend the waiver span for the person.
For DD:
• Enter a service change screening document, using Activity Type 03 and enter the CDCS code 48 in Field 41 (Current Services)

**Discontinuing CDCS**

**Scenario 1: A person who has been using CDCS chooses to discontinue that service at the time of his/her reassessment.**
For BI, CAC, and CADI:
• Enter a LTC Screening Document using Activity Type 06
• Use Assessment Result 13
• Enter an N in the “CDCS” field
Note: This will extend the waiver span for the person.
For DD:
• Enter an Annual Review screening document, Activity Type 02 and remove the CDCS code, 48 from Field 41

**Scenario 2: Person who has been using CDCS on a waiver chooses to discontinue that service at any time other than reassessment.**
For CAC, CADI, or TBI:
• Enter a LTC Screening Document using Activity Type 07
• Use Assessment Result 98
• Enter an N in the “CDCS” field Note: This will not extend the waiver span for the person.
For DD:
• Enter a service change screening document, Activity Type 03 and remove the CDCS code, 48 from Field 41 (Current Services)

**Claim Payments**
Modifiers on the claim form identify the services provided under T2028. The claim form line items must include one of the following five modifiers:
• T2028 with modifier U1 for Personal Assistance
• T2028 with modifier U2 for Medical Treatment and Training
• T2028 with modifier U3 for Environmental Modifications and Provisions
- T2028 with modifier U4 for Self-Direction Support Activities
- T2028 with modifier U8 for Support Planner

Payments from these line items will decrement the service agreement line item for T2028. To bill for Background Checks use T2040 on the claim form. To bill for Required Case Management use T2041 on the claim form. Payments for T2028 and T2041 apply toward the SIS/EW waiver obligation.

Claim Modifier 76
Claim Modifier 76 allows payment for multiple services provided on the same date or date span. When completing a claim for CDCS using procedure code T2028 when there will be more than one claim for the same date(s), use modifier U1 - U4 and/or U8 (as needed) in the MOD 1 field of the claim line item along with modifier 76 in the MOD2 field of the claim line item. By using modifier 76, the new claim(s) are not a duplicate of the initial claim.

201.10 Managed Care Programs
The Minnesota Senior Care Plus (MSC+) program, implemented in June 2005, provides eligible seniors age 65 and older with their acute care, home care, Elderly Waiver services, and the first 180 days of care in a nursing facility. The product IDs are MA30 for those members not opened to the Elderly Waiver, and MA35 for those members who are open to EW.

The Minnesota Senior Health Options (MSHO) program, implemented in 1997, is a voluntary managed care program providing eligible seniors age 65 and older all of the Medicaid services, all Medicare services under parts A, B and D, Elderly Waiver (EW) services, and the first 180 days of care in a nursing facility. The product ID is MA02. For more information on the MSHO and MSC+ screening document, please see manual Instructions for Completing and Entering the LTCC Screening Document into MMIS for the MSHO and MSC+ Programs (DHS-4669).

The Special Needs Basic Care (SNBC) is a voluntary managed care program that combines Medicare and Medicaid financing and services for people ages 18 – 64 who have a certified disability or are determined to have a disability by the local agency for individuals with developmental disabilities, and are eligible for Medical Assistance, with or without Medicare. The product IDs are MA17 and MA37. If the person is receiving qualifying IMD days of more than 15 days within the month, the major program will be IM, and the product IDs are IM17 or IM37.

SNBC offers all medically necessary Medicaid state plan services with the exception of HCBS waivers, personal care assistant, and home care nursing. If an enrollee is Medicare eligible, the SNBC plan covers all Medicare services including prescription drugs covered by the Medicare Prescription Drug Program (Part D), and any alternative services the health plan may choose to offer. See the manual Instructions for Completing and Entering the LTCC Screening Document into MMIS for the SNBC
Program (DHS-5020A) for coding specific fields on the LTC Screening Document for these types of screenings.

Service payment is through the health plan regardless if the person is in a rate cell B or not. *If the person elects a tribal agency to case manage and provide services or the tribe contracts with other providers, a service agreement authorizes and pays those services in MMIS. The health plan authorizes and pays providers who are not the tribe or contracted by the tribe.*

There are several ways to determine managed care enrollment. See Session 9 of the MMIS Training Series to identify the fields on the LTC Screening Document, the RMGR screen in the Recipient Subsystem, the role of the screening document for capitation payment, product ID, and rate cell assignment.

Disenrollment from Managed Care
Upon notification that the person will dis-enroll from MSHO or MSC+ (either by notification from the person or from the monthly disenrollment reports), the care coordinator must complete one of two actions:

1) Contact the preadmission screening unit of the county/tribe of service so EW services will continue through fee-for-service. Do not enter an exit screening document unless EW services discontinues after disenrollment.

2) It is possible that the disenrollment was due to a change in health plans. A person may not enroll in more than one health plan at the same time. Enrollment in a new health plan automatically dis-enrolls the person from the previous health plan. In some cases, there will be a lapse of one month in between enrollment spans of the old and the new health plan.

In order to assure that payments to EW providers continue for services during this period, it is necessary that there is service coordination among all parties. It will be necessary to enter a fee-for-service service agreement by the servicing county or tribe for this one month for any EW services that are continuing. The current care coordinator must provide information about services, units, and providers to the case manager.

When enrollment starts with the new health plan, the new care coordinator may complete a face-to-face visit immediately or wait until the next scheduled annual visit. *If the tribal agency is providing case management and/or one or more services, the new health plan contacts the tribe to coordinate other services.*

Community and Nursing Home Screenings
- Use program type 18 for MSHO and MSC+ community full LTC screenings and health risk assessments
- Use program type 19 for MSHO NF screenings, and Relocation Service Coordination
• Service agreements are not entered for these screenings
• See the manual DHS-4669 for the mandatory fields
• No exit screening document is entered when the person leaves the community or NF for EW
• Services provided under these screenings are billed to the health plan

Relocation Service Coordination (RSC)
This is a MA state plan service not entered on the service agreement. While the person enrolls with product ID MA02, MA35 or MA30 (MSHO or MSC+) the health plan is responsible for service payment. The care coordinator enters the screening document for Activity Type 04 with Assessment Result 18 and Program Type 19.

Moving Home Minnesota (MHM) Services
If a person chooses a community MHM service, a LTC Screening Document is entered into the MMIS with the MHM IND field = Y. Submission of the transitional plan development and coordination service claims to the health plan for payment while the member enrolls with MSHO or MSC+ programs. For questions, contact movinghomemn.mfp@state.mn.us or by phone at 651 431-3951 or 888-240-4756.

Essential Community Supports (ECS) Program
Persons who transitioned to ECS using program type 30 can enroll with MSHO, MSC+, and SNBC. These people will have a service agreement entered into MMIS while enrolled with any health plan. See Chapter 301.25.

Health Risk Assessments (HRA)
A health risk assessment is necessary at the initial contact after enrollment, on an annual basis, and if the member changes products or health plans. The screening activity type date can overlap with a waiver program if:

• The Activity Type is 01, 02, 05, or 07
• The Activity Type Date is on or after September 1, 2017
• The Assessment Result is 35, 39, 50, 51, or 98
• The Program Type is 18 or 28

Under these circumstances, the document type field on the Key panel screen will be an "H". When saving these documents, they show on the Selection screen as type L-H. These HRA documents do not follow the same rules as the type L documents. It is not necessary to delete a type H or L document in order to enter a missing document.

Enter the HRA document in any date or assessment result order. A type L document does not need deletion before entering a type H document when the dates are out of order with each other. The same is true of a type H document when a type L document is missing. See Session 8b of the MMIS Training Series for instruction on entering the HRA into MMIS as well as the manuals DHS-4669 and DHS-5020a.
The Role of the Screening Document in Rate Cell Assignment for MSHO

The monthly payment rate to the health plan for each enrollee is determined by the rate cell assigned to the member. Each rate cell has a different payment rate. This assignment is determined for the next month six days prior to the end of the current month. There are four rate cells.

- Rate Cell A for members with a living arrangement in the community with no open EW waiver span.
- Rate Cell B for members with a living arrangement in the community with an open EW waiver span.
- Rate Cell C for members aged 65 and older who is eligible for Moving Home Minnesota services while open to the Elderly Waiver program.
- Rate Cell D for members with a living arrangement of institutional and no open EW waiver span.

For rate cell B, the EW eligibility span must include the following month for the current month’s capitation. If the eligibility span ended the last day of the current month and the document entered prior to the current month’s capitation date, the rate cell will change to A for the following month. To avoid changing the rate cell from B to A, complete the annual reassessment visit that is due in the twelfth month of the eligibility span and enter the screening document into MMIS prior to the capitation date of that month. See the managed care key dates document for the capitation dates. Rate cells do not retroactively correct. Nevertheless, EW services must continue in order to meet the member’s needs regardless of the rate cell. EW services must begin on or after the date the member is found eligible for the EW program regardless if the rate cell is A or D for the first month.

The Role of the Screening Document in Rate Cell Assignment for MSC+

The same capitation process determines if the member enrolled with MSC+ with have product ID MA30 or MA35. The product ID determines the monthly payment rate the health plan will receive for each member. MA35 signifies an open waiver span is present in MMIS on the day of capitation. MA30 indicates no open waiver span is present in MMIS on the day of capitation. The screening document plays the same role. If the EW eligibility span is not open on the day of capitation, the product ID will change from MA35 to MA30. Members eligible for Moving Home Minnesota services while open to the Elderly Waiver program will be assigned rate cell C.

Persons Opened to BI, CAC, CADI, DD Programs and Enrolled in Managed Care

Members age 65 and older who continue on these disability programs and enroll with managed care may remain on these waiver programs for product ID MA02, MA35 or MA30. The county case manager will continue to manage the waiver services. Do not enter a MSHO or MSC+ screening document for members on these waiver programs. Members receiving Moving Home Minnesota services will have a fee-for-service service agreement entered for those services.
Use the Managed Care Organization/County/Tribal Agency Communication form DHS-5841 to facilitate communication about home care services between the disability waiver case manager and the MCO staff.

201.11 Reassessments and Eligibility Spans

The person opened to the waiver, ECS, and AC program must be reassessed at least once every 365 days based on the Activity Type Date field. The case manager must arrange a face-to-face visit within this period. Record the actual face-to-face visit in the Activity Type Date field. The Effective Date field can be the same date as the Activity Type Date or it can be a future date.

The date in the Effective Date field:
- Sets the begin date of the eligibility span on the RWVR screen (waiver or ECS) or RELG screen (AC or ECS) when using Assessment Results 01, 10, or 11.
- Increases the eligibility span using Assessment Result 13.
- Decreases the span for exits using Assessment Results 17, 19 – 24, 31, 33, or 34.

Alternative Care Program

Major program AC on the RELG screen of the Recipient Subsystem is a span of 365 days. The effective date for the initial opening or reopening screening document is any day within the month.

The effective date for the Activity Type 06 or exit document must fall within the AC major program span.

Waiver, AC, or ECS Eligibility Spans

For the waiver or ECS programs, the effective date of the initial opening or reopening screening document is any day within the month. The waiver or ECS twelve month eligibility span ends the last day of the twelve month and shows on the RWVR screen of the Recipient Subsystem.

For waiver or ECS reassessments, the Activity Type 06 is the first day of the month that follows the end of the eligibility period on the RWVR screen. An example is the program opens with an effective date of February 2020 will have an eligibility span that ends the last day of January 2021. The Activity Type 06 document then has an effective date of 2/1/21 to extend the eligibility period to 1/31/22. ECS reassessment documents also extends the major program UN with eligibility EC span on RELG.

When the person leaves the program due to death, the exit document with have an effective date that matches the day of death.

When the person leaves the program for any exit reason other than death or assessment results 19, 20, or 25, the effective date is at least ten days and no more than 60 days from the activity type date. When the person leaves the program for
Assessment Result 21, the effective date is at least 30 days and no more than 60 days from the activity type date.

**Reduced Eligibility Periods**
Temporary AC, program type 22, allows a 60 day span but MMIS develops a span for 75 days to change programs with no extension.

Persons currently using AC or ECS services or when initially open to these programs will have a 90-day period if the Citizenship field on the ALT6 screen shows the citizenship is pending. See section 201.04.

Persons who are ineligible for AC or waiver due to a penalty period may have a shorten eligibility period. See section 201.15.

**No Matching Waiver Segment Message**
If a reassessment or closing screening document is not the same program type as the opening screening document, the message “PWMW9687 S625-020 NO MATCHING WAIVER SEGMENT” will appear on the screen after using the PF3 key. Correct the program type field.

This message will also appear if the annual visit (Activity Type 06) activity type date is not before the end of the eligibility span. While the effective date field is up to one day after the eligibility end date for the waiver or ECS programs, the actual visit must be within the eligibility period. If the reassessment visit did not occur within the eligibility period, enter an exit screening document with an effective date that matches the last day of the current eligibility period and a reopening document with the activity and effective date of the reassessment visit to begin a new eligibility period. Close the current service agreement and open a new service agreement with the new reopening period.

See Section 201.04 for the Advance Notice of Appeals and the exception for the effective date dated after the eligibility span end date.

**201.12 Navigation**
The MMIS Training Series includes navigation in most of the sessions. The following sessions focuses more on navigation: Session 3 for using the keyboard keys and the Session 4 for the purpose and use of the programmable function (PF) keys. Session 7 for inquiry on the screening document.

**201.13 Editing the Screening Document**
Instructions on how to edit the LTC Screening Document once data is entered, how to use the edit line with the PF keys, and which MMIS screens should be referenced to assist in resolving the edits is explained in the MMIS Training Series, Sessions 8 and 8a.
201.14 DHS Approval of the Screening Document

Session 11 in the MMIS Training Series explains the processes for approving:
- the nursing home rate for Elderly Waiver conversions using form DHS-3956
- nursing home admissions for age 21 and younger
- PCA Complex field on the screening document is a Y
- CFR changes for the disability waivers
- Moving Home Minnesota screening documents

201.15 Ineligible Period for Waiver, ECS, and AC Services

Persons with an improper transfer of assets are not eligible for waiver, ECS, Alternative Care, or nursing home services during the penalty period. See the policy in the Health Care Eligibility Programs manual, section 0909.27.11. The county financial worker determines and records this ineligibility period on the RLVA screen of the Recipient Subsystem.

The Eligibility Verification System (EVS) includes a message for waiver, ECS, and AC providers that says “this person is ineligible for AC, ECS, waiver, and long term care services” when the dates of service for waiver, ECS, or AC services overlap with the penalty period.

Prior to conducting a face-to-face visit, it is good practice to check the RLVA screen to see if the person has an ineligibility span. Payments deny for waiver, ECS, and AC services during this period of ineligibility. Contact the financial worker for any questions. LTCC screening document edit 937 “Ineligible Asset Transfer” will post for all waiver opening, reopening, and reassessment screening documents in which the effective date field overlaps with a penalty period of “A, F, H, I, L, N or U”. If you receive this edit, review the RLVA screen for the penalty period. Note: the Alternative Care and ECS eligibility span overlapping with a U ineligible span will not post edits. For waiver persons, contact the financial worker to delete or close the U span if it is determined there is no penalty period. The U span appears again on the RLVA screen when adding a new MA related program.

Ineligible Codes
A = Annuity penalty
F = Pending receipt of DHS-3543 (no longer valid)
H = Home equity exceeds limit
I = Uncompensated transfer
L = Level of care criteria is not met
N = Enrollee not cooperate to determine level of care criteria
U = Undetermined

Opening or Continuing on Program
A program opening or reopening screening document (Activity Type 02 or 04 with Assessment Result 01, 10, or 11) with the effective date field falls within the above
ineligibility period post edits. Change the effective date so it is greater than the ineligibility end date.

A reassessment document (Activity Type 06 and Assessment Result 13) with the effective date field falling within the ineligibility period also posts edits. Enter an exit screening document dated prior to the penalty period begin date. Close the service agreement. Enter a reopening screening document and new service agreement for a period after the penalty periods ends.

Edit 938 “Eligibility Overlap with Ineligibility Period” will post if the assessment result is opening, reopening, or reassessment and the effective date field is prior to the ineligibility period but the end date of the waiver span (RWVR screen) or AC/ECS eligibility span (RELG screen) overlaps with an ineligible period. By forcing this edit, it allows the screening document to be approved but the eligibility span will be shortened to one day prior to the begin date of the ineligibility span on RLVA.

To continue services after the ineligibility period ends, enter an exit screening document with an effective date prior to the ineligibility begin date. Close the service agreement to this date. Date the reopening screening document one day after the ineligibility period ends. Enter the new service agreement.

Claim edit 765 “Ineligible for EW Services” will deny any waiver, ECS, or AC service in which the dates of services overlap with the penalty period.

201.16 Deleting the Screening Document
See Session 13 of the MMIS Training series for the reasons and steps to delete the LTC and HRA screening documents.

201.17 Retrieving and Resolving Suspended Screening Documents
See Session 12 of the MMIS Training Series for the steps to locate suspended screening documents by:
- your agency’s queue
- case manager or care coordinator provider number
- Infopac report
Chapter 3 – Service Agreements

301.01 Purpose of the Service Agreement Form
All home care (with some exceptions), waiver, Essential Community Supports, Moving Home MN, and Alternative Care services must be prior authorized by the case manager or health plan care coordinator prior to providing the service. The service controls the service costs by identifying the services, the time period, number of units, the provider, and the rate paid. Claims submitted by the provider must match against the service agreement to determine if the claim payment. The service agreement form, DHS-3070, is a fillable form.

301.02 Accessing the MMIS Prior Authorization Subsystem
If you do not have the correct security to access the prior authorization subsystem, a message will appear on the Main Menu screen when you select Prior Authorizations. Contact your agency’s security officer to change your security group.

The MMIS Training series provides instruction on how to use the MMIS for the service agreement:
- Session 2 – MMIS Security Log in and Passwords
- Session 3 – Basic Navigation in MMIS
- Session 4 – Using Programming Function (PF) Keys
- Session 5 – The Recipient Subsystem
- Session 14 – Introduction to Service Agreements
- Sessions 15 – Service Agreement inquiry
- Session 16 – Entering New Service Agreements into MMIS
- Session 16a – Service Agreements and Provider Edits
- Session 17 – Service Agreement Changes
- Session 18 – Alternative Care Program Fees
- Session 19 – The Elderly Waiver Customized Living Services Process
- Session 20 – Service Agreements for Managed Care Members
- Session 21 – Locating Suspended and Partially Suspended Service Agreements

Other sessions focus on the LTC screening document.

301.03 Service Agreement Form Fields
The service agreement form DHS-3070 and the MMIS screens ASA1 through ASA3 divide into these sections:

The General Information section and ASA1 screen provides information about the:
- person
- case manager
- beginning and ending dates of the service agreement period
- total cost of the services
- budget cap amount

<table>
<thead>
<tr>
<th>Form DHS-3070 Field Number and Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA1 Screen 1 - Document Control #</td>
<td>An eleven digit number assigned to the agreement when initially entered into MMIS Format is YDDDBBBMXXX. Y = last digit of the current year, DDD = Julian day, BBB = batch number (online, batch entry or front end), M = microfilm, XXX = counter.</td>
</tr>
<tr>
<td>Agreement Status (on MMIS screen)</td>
<td>Identifies the overall status of the service agreement based on the combination of line item statuses. Choices are: A (approved), D (denied), S (suspend), T (partially approved), and P (pend).</td>
</tr>
<tr>
<td>Current LOC/Date (on MMIS screen)</td>
<td>If the service agreement routes to DHS for approval or is routed to the lead agency queue, the three digit location code is shown here and the date it was routed to that location.</td>
</tr>
<tr>
<td>2 - Agreement Type</td>
<td>Identifies the type of program.</td>
</tr>
<tr>
<td></td>
<td>• F = CADI Conversion</td>
</tr>
<tr>
<td></td>
<td>• G = CADI Diversion</td>
</tr>
<tr>
<td></td>
<td>• H = CAC Conversion</td>
</tr>
<tr>
<td></td>
<td>• I = CAC Diversion</td>
</tr>
<tr>
<td></td>
<td>• J = EW Conversion</td>
</tr>
<tr>
<td></td>
<td>• K = EW Diversion</td>
</tr>
<tr>
<td></td>
<td>• L = BI-NF Conversion</td>
</tr>
<tr>
<td></td>
<td>• M = BI-NF Diversion</td>
</tr>
<tr>
<td></td>
<td>• N = AC Conversion (includes temporary AC)</td>
</tr>
<tr>
<td></td>
<td>• O = AC Diversion (includes temporary AC)</td>
</tr>
<tr>
<td></td>
<td>• P = BI-NB Conversion</td>
</tr>
<tr>
<td></td>
<td>• Q = BI-NB Diversion</td>
</tr>
<tr>
<td></td>
<td>• R = DD Conversion</td>
</tr>
<tr>
<td></td>
<td>• S = DD Diversion</td>
</tr>
<tr>
<td></td>
<td>• Y = Essential Community Supports (ECS)</td>
</tr>
<tr>
<td></td>
<td>• Z = Moving Home MN (MHM) under age 65 in community and not receiving waiver services</td>
</tr>
<tr>
<td>3 - Agreement Start Date</td>
<td>The beginning date of the service agreement.</td>
</tr>
<tr>
<td>4 - Agreement End Date</td>
<td>The last date of the service agreement. If left blank, a date of 366 days from the begin date will be plugged in here.</td>
</tr>
<tr>
<td>Assessment Date (ASMT DT on MMIS Screen)</td>
<td>The chemical health program uses this field and you cannot enter data in this field.</td>
</tr>
<tr>
<td>Field</td>
<td></td>
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<tr>
<td>-------</td>
<td></td>
</tr>
<tr>
<td><strong>Form DHS-3070 Field Number and Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td></td>
</tr>
<tr>
<td>5 - Provider ID Number</td>
<td>The ten digit NPI/UMPI number that identifies the provider. This field is blank for AC, ECS, MHM, or waiver service agreements.</td>
</tr>
<tr>
<td>6 - Referring Provider ID Number</td>
<td>Prior to January 1, 2019, this field identified the Elderly Waiver recipient enrolled with a health plan. It is system entered and a protected field. It currently populates with the health plan number for members using ECS services.</td>
</tr>
<tr>
<td>7 - Total Authorized Amount</td>
<td>MMIS automatically calculates this amount. It is the sum of all the approved, suspended and pended line items. See new instructions at the end of this chart to resolve edit 672 (Total Authorized Amount Exceeded) for the AC and EW service agreement and CDCS service agreement.</td>
</tr>
<tr>
<td>Cap Amount (on MMIS screen)</td>
<td>For the EW, AC, and ECS programs, this field represents the monthly case mix cap from the screening document multiplied by the number of months in the service agreement period (fields 3 and 4). When the period changes it changes the cap amount. The field is blank for the BI, CAC, CADI, and DD service agreements.</td>
</tr>
<tr>
<td>8 - Recipient Last Name</td>
<td><strong>Leave blank.</strong> MMIS will insert the name from the Recipient Subsystem.</td>
</tr>
<tr>
<td>9 - Recipient First Name</td>
<td><strong>Leave blank.</strong> MMIS will insert the name from the Recipient Subsystem.</td>
</tr>
<tr>
<td>10 - Middle Initial</td>
<td><strong>Leave blank.</strong> MMIS will insert the name from the Recipient Subsystem.</td>
</tr>
<tr>
<td>Required Case Management Cap (on MMIS screen as RCM CAP)</td>
<td>The EW and AC mandatory case management cap amount under CDCS is a protected field. The total amount for a line item for T2021 cannot exceed this cap. It is the person’s monthly RCM cap amount multiplied by the number of months in fields 3 and 4. If the period in fields 3 and 4 changes, the cap amount is also reduced or increased.</td>
</tr>
<tr>
<td>11 - Recipient ID Number (a.k.a. Person or PMI Number)</td>
<td>The identifying number assigned to the person.</td>
</tr>
<tr>
<td>Sex</td>
<td>The person’s gender. It is system entered.</td>
</tr>
<tr>
<td>12 – Birthdate</td>
<td>The format is MMDDYYYY and must match the date on the Recipient Subsystem. Use the PF4 key to view the birth date on the Recipient Subsystem. If that birth date is incorrect, the financial worker must change it. PMI numbers obtained through the PMIN Function, uses that method to change the birth date.</td>
</tr>
<tr>
<td>Form DHS-3070 Field Number and Name</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Age</td>
<td>Person’s age at the time the service agreement entered into the MMIS.</td>
</tr>
<tr>
<td>LA</td>
<td>Person’s living arrangement (from RLVA screen on the Recipient Subsystem) at the time the service agreement entered into MMIS. A value of 80 means community.</td>
</tr>
<tr>
<td>MAJ PROG</td>
<td>Person’s major program (from RELG screen on the Recipient subsystem) at the time the service agreement entered into MMIS). AC = Alternative Care MA = Medical Assistance. UN = Unknown for ECS screenings with no MA eligibility UN with eligibility type UN = OBRA Level screenings with no other major program overlapping with the effective date</td>
</tr>
<tr>
<td>County of Service, County of Residence, and County of Financial Responsibility (all on the MMIS screen)</td>
<td>The three lead agencies as identified by: • the financial worker for waiver persons • system entered for the Alternative Care and Essential Community Support programs from the fields on the screening document</td>
</tr>
<tr>
<td>Disc. Fund (Y/N) (on the MMIS screen)</td>
<td>Do not use this field.</td>
</tr>
<tr>
<td>Authorization Date (on the MMIS screen)</td>
<td>Do not use this field.</td>
</tr>
<tr>
<td>Authorizing Signature (on the MMIS screen)</td>
<td>Do not use this field.</td>
</tr>
<tr>
<td>SCH EVAL/TRMT MSG 1/2/3 Diag Range 1 from/thru Diag Range 2 from/thru (all on the MMIS screen)</td>
<td>Leave these fields blank.</td>
</tr>
<tr>
<td>AVG MO AUTH AMT AVG DAILY AUTH AMT (on the MMIS screen)</td>
<td>System entered dollar amounts.</td>
</tr>
</tbody>
</table>
ASA2 Screen (both the form and MMIS) identifies:

- if person is assessed to need 12 hours or more of PCA services
- header reason codes
- if the person’s letter is to be suppressed or generated by MMIS
- the Alternative Care fee, payment type, and effective date
- the responsible party information for those persons receiving PCA, and
- if the person is in an excluded time for persons on the disability programs

<table>
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<tbody>
<tr>
<td>TOT USED UNITS TOT USED AMT (on the MMIS screen)</td>
<td>System entered amounts based on claim payment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Form DHS-3070 Field Number and Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA2 Screen</td>
<td>This field represents if the person was assessed and eligible for 12 or more hours of PCA services for all waiver, the Alternative Care, and CDCS programs. Edit 163 will post if: 1) Left blank for line items beginning 7/1/18 or later for T1019 with or without modifiers other than UA for all waiver types and AC. 2) The modifier TG is not present on the PCA line item when the field = Y. 3) The modifier TG is present on the PCA line item when the field = N. 4) The PCA Complex field is blank when there is a line item for CDCS T2028. The line item may only be six months long. If the person initially was found not eligible for PCA complex, and then assessed and becomes eligible for PCA complex, enter a new service agreement for the PCA complex line items. When the PCA Complex field = Y, and the service agreement is for AC or EW, and the dollar amount in the CDCS Amount or Case Mix Amount field is manually increased, edit 784 will post to route the service agreement to DHS staff for approval. This routing does not occur if there is a managed care code in the LTC County field on the last screening document. If the PCA Complex field = N when these amounts are increased, MMIS will decrease the amounts.</td>
</tr>
<tr>
<td>PCA Complex</td>
<td>-------------</td>
</tr>
<tr>
<td>Form DHS-3070 Field Number and Name</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>The treating provider must have license code P2 on the PLIC screen on the Provider Subsystem in order for claim payment at the PCA Complex rate. If the person is not eligible or the treating provider does not have the P2 on file, the claim reduces to the non-complex PCA rate.</td>
<td></td>
</tr>
<tr>
<td>14 - Reason Codes (shown as STAT RSN on the ASA2 screen)</td>
<td>There are spaces for four reason codes. These codes represent text added on all service agreement letters to explain an action taken on a line item. Remember to delete the reason codes the next time you make changes to the service agreement so the text isn’t included on future letters. See the reason code list in Section 301.14. Reason code 565 adds to the first line item occurrence of T1019 with or without modifiers, except modifier UA, when the shared care field equals Y for PCA Complex.</td>
</tr>
<tr>
<td>15 - Send Recipient Letter</td>
<td>Complete this field to allow a letter from DHS to the person that identifies all the services they will be receiving, the provider, the payment amount and the period of time. If you place an “N” in this field, it suppresses the letter and you will need to send a replacement notice from your agency.</td>
</tr>
<tr>
<td>Attachment (Y/N) (on the ASA2 screen)</td>
<td>You may leave this field blank.</td>
</tr>
<tr>
<td>Send Provider Letter (on the ASA2 screen)</td>
<td>This field will default to “Y” indicating that a letter from DHS will always be sent to the provider(s).</td>
</tr>
<tr>
<td>SACTAD Number (on the ASA2 screen)</td>
<td>Tribal agencies enter data into this field.</td>
</tr>
<tr>
<td>Override Location (on the ASA2 screen)</td>
<td>This field allows the transfer of suspended or partially suspended service agreements from lead agency to DHS staff or between lead agencies by placing the routing queue ID and saving the service agreement in suspense or partial suspense. Also used when the waiver service agreement overlaps with a home care authorization causing edit 874 to post. See Section 301.13 for details.</td>
</tr>
<tr>
<td>16 – AC Fee Payment Method</td>
<td>Identifies the method of fee payment. See section 301.08 for valid values. It is a mandatory field for AC service agreements.</td>
</tr>
<tr>
<td>17 – AC Partial Payment</td>
<td>This field identifies the dollar amount of the partial fee. See Section 301.08 for more details.</td>
</tr>
<tr>
<td>18 - AC Required Fee Amount</td>
<td>To record the amount of monthly fee the AC person is obligated to pay. If none, place 0. See Section 301.08 for more information on billing and collecting AC fee.</td>
</tr>
<tr>
<td>Form DHS-3070 Field Number and Name</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>19 – AC Fee Effective Date</td>
<td>The effective date of the AC fee amount. It is a format of MM/YY. See Section 301.08 for more information on changing past fee amounts.</td>
</tr>
<tr>
<td>Claims Last Date Update (on the ASA2 screen)</td>
<td>This is the last date that a claim paid against the service agreement. An old date on a current service agreement could be an indicator of billing problems.</td>
</tr>
<tr>
<td>Input Media (on the ASA2 screen)</td>
<td>An indicator identifies if the data submitted by paper or exam entry (online).</td>
</tr>
<tr>
<td>20 - Responsible Party (Y/N)</td>
<td>This field is mandatory if there is a line item for PCA.</td>
</tr>
<tr>
<td>21 - Fiscal Intermediary (Y/N)</td>
<td>This field is mandatory if there is a line item for PCA. Place a “Y” here if the service is PCA Choice.</td>
</tr>
<tr>
<td>22 - Lives with Responsible Party (Y/N)</td>
<td>This field is mandatory if there is a line item for PCA.</td>
</tr>
<tr>
<td>23 - Excluded Time</td>
<td>Field is mandatory for BI, CAC, CADI, and DD service agreements. If T2028 is on the service agreement, this field must be valued. It identifies if the person is receiving excluded time services or not. If the person moves to another county it indicates whether the CFR will change or not. If a person is receiving excluded time services, then the CFR does not change.</td>
</tr>
<tr>
<td>24 – Responsible Party Name</td>
<td>When the Lives with Responsible Party field = Y, this field must be populated. Use up to 39 characters. Do not complete field otherwise.</td>
</tr>
<tr>
<td>DHS Comment Screen Recipient Comment Screen Provider Comment Screen (on the ASA2 screen)</td>
<td>These fields will have a “Y” shown here if there is text on any of the comment screens.</td>
</tr>
</tbody>
</table>
The Line Item section and MMIS screen ASA3 identifies those services authorized by the case manager. Each line item identifies the service, maximum number of units or dollars, the period, rate per unit, and the provider.

<table>
<thead>
<tr>
<th>DHS-3070 Field Number and Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA3 Screen 25 - Service Comments</td>
<td>There is a blank line to enter additional text about the service that will appear on the service agreement letters to the person, case manager, and the provider listed on the line item. MMIS automatically adds the name of the service based on the procedure code, but this field is mandatory for specialized supplies and equipment and environmental Accessibility Adaptations (EAA) line items. See the end of this chart for more information on the use of this field.</td>
</tr>
<tr>
<td>26 - Procedure Code</td>
<td>The code assigned to the service. Also known as HCPC. Moving your cursor to this field and using the PF4 key will bring you to the Reference Subsystem to view additional information about the service. Please see Section 301.27 for web links to the procedure code charts.</td>
</tr>
<tr>
<td>27 - Mod 1</td>
<td>This is the first modifier. Refer to the procedure code charts to determine which modifier, if any, goes with the line item procedure code.</td>
</tr>
<tr>
<td>28 - Mod 2</td>
<td>This is the second modifier.</td>
</tr>
<tr>
<td>29 - Mod 3</td>
<td>This is the third modifier.</td>
</tr>
<tr>
<td>30 - Mod 4</td>
<td>This is the fourth modifier.</td>
</tr>
<tr>
<td>REV, DRUG, DNES (on the ASA3 screen)</td>
<td>Leave these Chemical Health fields blank.</td>
</tr>
<tr>
<td>31 – Order NPI</td>
<td>This field identifies the referral provider for home care skilled nursing, home health aide, and extended home care services. This does not include PCA services. The number must be in an active status on the Provider Subsystem. Acceptable provider types are 20 (physician) and 36 (podiatrist).</td>
</tr>
<tr>
<td>32 - Start Date</td>
<td>The begin date of the service shown in field 26. If you leave this field blank, the date from field 3 (header begin date on ASA1 screen) transfers here.</td>
</tr>
<tr>
<td>33 - End Date*</td>
<td>The last day of services. If you leave this field blank, the date from field 4 (header end date on ASA1 screen) transfers here.</td>
</tr>
<tr>
<td>DHS-3070 Field Number and Name</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>34 - Requested Rate Per Unit</td>
<td>This is the dollar amount per unit paid to the provider. When using this field, the Total Units field must also have a value.</td>
</tr>
<tr>
<td>35 - Requested Total Units</td>
<td>This is the total number of units during the period identified in fields 32 and 33. If this field is valued, then field 31 must have a value.</td>
</tr>
</tbody>
</table>
| 36 - Requested Total Amount    | If fields 34 and 35 are valued, then MMIS will calculate the total amount of money. The following services may have fields 34 and 35 valued or just field 36:  
  - T2016 and T2017- supported living services, adult in-home  
  - H2011 and T2034 - 24 hour emergency services  
  - T2029 - assistive technology equipment or specialized supplies and equipment  
  - S5165 – environmental accessibility adaptations – home install  
  - x5527 - AC discretionary service  
  - S5125 - in-home family support  
  - E1399 - AC specialized supplies and equipment  
  - T2028 - consumer directed community supports  
  - S5165 U6 and T1028 U6 – MHM environmental modifications  
  - T2029 U6/NU, U6/RR, or U6/ RB – MHM specialized supplies and equipment  
  - T1999 U6 – MHM tools, clothing, and equipment for employment |
<p>| 37 - Provider NPI/UMPI Number  | The ten digit NPI/UMPI number assigned to the provider. Putting your cursor on this field and using the PF4 key will bring you to the Provider Subsystem to view data related to this provider. |
| 38 - Provider Name             | MMIS will automatically plug in the name of the provider based on the provider number. |
| 39 – Reason Codes              | Reason codes explain changes to the line item. The code text will appear on the service agreement letters. See the Reason Code chart in section 301.14. The text will continue to appear on future letters if not removed from the line item the next time the line item changes. Use up to four codes. |
| 40 - Shared Care               | This field identifies that the personal care assistant or home care nurse will provide services to more than one person at the same time in the same setting. Value is a “y”. See Sections 301.22 and 301.24 for more information on the use of this field. |</p>
<table>
<thead>
<tr>
<th><strong>DHS-3070 Field Number and Name</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>41 - Frequency</td>
<td>This field will place text on the service agreement letter for line items with T1019 without modifier UC or UA. Values are: 1 – daily restricted PCA (used with T1019, T1019 UC, T1019 TG, and T1019 TG UC) 2 – weekly (used with T1019 UA) 3 – monthly (used with T1019 UA) 5 – flexible use PCA (used with T1019, T1019 UC, T1019 TG, and T1019 TG UC) See section 301.14 for the text that will appear on the letters for T1019 and T1019 TG using values 1 or 5.</td>
</tr>
<tr>
<td>Approved Rate/Unit (on the ASA3 screen)</td>
<td>MMIS checks the requested rate against the statewide maximum cap. Some service rates are not negotiable and must be the statewide maximum rate.</td>
</tr>
<tr>
<td>Source</td>
<td>This two digit code indicates the source of the approved rate in MMIS and compares to the requested rate. Choices are:  • RQ - The requested rate was accepted  • PP – The Reference Subsystem  • RR – The Rate File  • MM – Other areas of MMIS using tables</td>
</tr>
<tr>
<td>Total Used Units/Amount (on the ASA3 screen)</td>
<td>When claims pay against the line item, the number of units paid and the dollar amounts paid will show here. To determine the days paid you must use inquiry in the Claims Subsystem.</td>
</tr>
<tr>
<td>Status Code/Date (on MMIS screen)</td>
<td>This indicates the status of the line item. A = approved S = suspend P = pending D = denied The status S or P changes to any status code. Change the status A to D as long as no claims have paid against the line item. Line items with a status D protects all fields on the line item. The line item fields protect when claims are pay also.</td>
</tr>
<tr>
<td>RFE and CTY</td>
<td>Do not add information to these fields.</td>
</tr>
<tr>
<td>RPT (Repeat)</td>
<td>The service agreement has a total of 99 line items. By placing a number here, it will copy that line item that many times. The new lines will show at the end of the current lines.</td>
</tr>
</tbody>
</table>

*When the EW or AC service agreement header begin date is 4/14/20 or greater, the line item for T1016 UC (waiver case management) or T1016 UC TF (paraprofessional) cannot exceed 120 days unless there is another approved program service.*
Exceeding the Elderly Waiver and Alternative Care Budget Caps

Background
DHS received approval from CMS to exceed the individual budget caps in order to pay Elderly Waiver or Alternative Care services authorized and provided prior to the date of death or date of institution stays of 30 or more days. Normally, when the person exits the program under these two circumstances, the case manager reduces the service agreement header end date to the last day of community services. This affects the individual budget cap by a reduction in the Total Cap Amount field on the ASA1 screen of the MMIS service agreement. The total costs of all non-denied services must not exceed the new cap amount or edit 672 posts. Below are the lead agency responsibilities and the DHS role in forcing edit 672 to allow payment.

Identifying the service agreement
1) The service agreement type is J, K, N, or O (EW and AC);
2) The service agreement header end date ends at an earlier date;
3) Edit 672 (Cap Amount Exceeded) is posting;
4) Edit 284 is not posting; and
5) There isn’t a line item for T2028 (CDCS) or T1023 (CFSS Consultation)*

Lead Agency Responsibilities
1. Place a note on the DHS Comment screen with the date of death or the admission date when the person remains in a hospital, nursing home, or other institution, for a continuous combination thereof for 30 or more days.
2. Change the service agreement header end date to the date of death or the date of admission.
3. Reduce the AC Required Fee Amount and/or AC Partial Payment fields to zero on the ASA2 screen if a dollar amount was present. Change the AC Fee Effective Date to the following month.
4. Reduce the line item end dates so they do not exceed the header end date.
5. Adjust the line item units or total amounts to cover the amount of services authorized for the new period. Not allowed: increasing the requested units and total amounts or adding a new line item.
6. Line items with edit 156 posting signifies that a payment to the line item for a date after the new closing date. See Chapter 301.17 in the manual DHS-4625 for instructions on requesting claim takebacks before changing the line item end date.
7. Resolve or force all edits except those in an informational status and 672.
8. Change the header status to S for suspend.

9. Send an email to dhs.resourcecenter@state.mn.us requesting edit 672 to be forced. Identify the service agreement number, PMI number and the lead agency staff direct contact information.

10. Use the F3 key to save the service agreement.

Notes
If edit 284 (Services over Cap) posts, edit 672 cannot be forced. Edit 284 signifies that the amount of Environmental Accessibility Adaptations (EAA) services exceed the $20,000 limit for EW or AC EAA costs over the course of the person’s “waiver year”. Check all non-denied line items for EAA services (T2039, T1028, S5165, and T2039 UD) on the service agreement and possibly on the previous service agreement if the current service agreement is less than 12 months. The sum of all lines cannot exceed $20,000. Reduce the line items to fall within the $20,000 maximum.

If the person returns to the program after the institution stay and within the same eligibility period, enter a new service agreement for the new community period.

DHS Resource Center Responsibilities
If the following are in place, the Resource Center staff have the authority to force edit 672.

   a. The lead agency has included a note in the DHS Comments screen with either the date of death or the admission date into a hospital, nursing home, or other institution, for a continuous combination thereof of 30 or more days; and

   b. The service agreement does not include a non-denied line item for T2028 or T1023.

2) Force edit 672.

3) Change the header status to A.

3) Notify the worker that edit 672 is forced, the service agreement header status is now approved, and the exit screening document can be entered; or

4) Notify the worker that forcing edit 672 isn’t possible due to other edits posting that need to be resolved, edit 284 is posting, the service agreement does not meet one of the criteria, or there are problems that do not allow the edit to be forced. Keep the header status in suspense.
*Consumer Directed Community Supports (CDCS)*

Allowing the case mix budget cap to exceed the cap amount also applies to the EW and AC service agreements using CDCS. When reducing the header end date and the Total Authorized Amount now exceeds the Cap Amount on the ASA1 screen, edit 672 does not post. MMIS automatically adds reason code 672 to the ASA2 screen. Any suspended line items cannot change to approve. The header end date is protected.

**Specialized Supplies and Equipment**

When a line item has specialized supplies and equipment (E1399 or T2029), MHM tools and equipment for employment (T1999 U6), or MHM supplies and equipment (T2029 U6/NU, U6/RR, or U6/RB) identify the item(s) in the Service Comments field. Use the DHS Comment Screen to provide a complete description along with the costs for each item, and why there is no other funding source to pay for the item(s).

AC and waiver programs do not pay for separate installation charges nor shipping and handling charges for supplies and equipment. These charges must be included in the cost of the product or item. Do not add a separate line item for these charges.

If the same provider authorizes more than one item, do not place each item on its own line unless the line covers different periods of time and these periods do not overlap. If providing the items during the same period of time, determine the total cost of all items and use one line item with a total amount (no requested rate or units fields).

The Department reviews the claims manually and takes appropriate action within 90 days according to the following guidelines:

- Does Medicare, Medical Assistance, or another payer cover the item?
- Would Medical Assistance cover the item with an approved authorization? Did the claim include an attached authorization?
- Does the description on the claim and the service agreement match on the attached authorization?

**301.04 Comment Screens**

Use the comment screens to record information or to add an explanation to the service agreement letters regarding changes on the service agreement. Remember, that any person with inquiry access to the service agreement may view your comments on all three screens.

Spell check and word wrap are not features of these screens. Text stops at the bottom of the screen for the Provider and Recipient screens. If the text does not fit onto the screen, a message will appear to delete text on the screen. Sessions 15, 16, and 16a of the MMIS Training Series discuss these screens.

The PF2 key will copy text from the APRV (provider) screen onto the ARCP (recipient) screen. This is helpful if you have the same message for everyone. If you change
multiple line items then all providers on those line items will receive the message from the APRV screen.

After typing the message on the APRV screen, press the PF2 key and the message copies to the ARCP screen. No copying messages on the ADHS or ARCP screens. Remember to delete the messages on the APRV and ARCP screens the next time you edit or add line items or the messages will appear on the letters again.

**DHS Comment Screen**

Add the following information to the DHS comment screen. Remember to date and initial the message.

- Identify each specialized medical supply and equipment item(s), the individual cost, explain how the items avoid institution, and why other funding sources such as Medical Assistance or Medicare will not pay for the item. Do not add the item if there is another third party payer source.
- Place all environmental accessibility adaptations on a different line item from the specialized medical supplies and equipment. The AC and waiver programs do not pay for ramp insurance, inspections, estimates, and design fees. Show the justification for the modification on this screen. Use a total amount instead of a rate and unit in case the total costs change. See section 301.28 for guidelines on the process to approve line items on the service agreement.
- When the person will be receiving hospice services, document that the case manager is working with the hospice case manager to coordinate services. See section 301.21.
- Indicate what services will be purchased with the AC Discretionary Services.
- Document the change in condition that necessitate adding more PCA units under T2019 UC.
- When edit 672 posts, place a note on the DHS Comment screen with the date of death or the admission date when the person remains in a hospital, nursing home, or other institution, for a continuous combination thereof for 30 or more days. See complete instructions in Section 301.03.
- The DHS Comment Screen expands to four screens. When the first screen is full, use the F11 key to bring up the next DHS screen for typing. You can tell if there is more than one DHS screen to view by the plus sign at the top right hand corner. To view all screens, the cursor must be in the screen section and use F8 to go forward and F7 to return to the beginning of the screens.

**301.05 Navigation on the Service Agreement**

The MMIS Training Series includes navigation in most of the sessions. The following sessions focuses more on navigation: Using the keyboard keys and the Next field in Session 3. The purpose and use of the programmable function (PF) keys in Session 4. Inquiry on the service agreement in Session 15.
301.06 Moving Home Minnesota (MHM) Services

Persons age 65 and older who are receiving Elderly Waiver (EW) services may also receive the following MHM services.

- Comprehensive Community Support Services (H2015 U6)
- Certified Peer Specialist (H0038 U6, U6/UA, or U6/HQ)
- Overnight Assistance (S5135 U6/UA)
- Membership Fees (S9970 U6 U5)
- Post-Discharge Case Consultation and Collaboration (T2013 U6)

The costs of these services do not apply toward the EW budget cap. Add reason code 586 to the line item Reason Code field to avoid edit 166.

Authorize Comprehensive Community Support Services, Overnight Assistance, and Certified Peer Specialist for periods up to 90 days each. If the total number of days of all line items for each one exceeds 180 days, edit 951 will post to route the service agreement to DHS for approval. See section 301.16 for more information regarding this routing.

Prior to adding services to the EW service agreement, the person must have an approved MHM screening (see sections 201.08 and 201.14), that is routed to DHS for approval. See the Moving Home Minnesota Program manual for eligibility, services, and transition coordinator information.

There are additional services provided to persons while in the nursing home to assist them in transitioning to the community. They are:

- Transitional Plan Development (T2038 U6)
- Transitional Coordination (T1017 U6)
- Pre-discharge Case Consultation and Collaboration (H2000 U6)
- Non–medical transportation to find housing (A0160 U6, A0170 U6, A0180 U6, A0190 U6, A0200 U6, or A2010 U6)

These services may not be added to the service agreement except for non-medical transportation may be used in the community to find housing or employment for persons under the age 65.

301.07 Program Eligibility Requirements

Medical Assistance is a requirement for persons requesting waiver services. County financial workers through their MAXIS system determine Medical Assistance eligibility. The person cannot open to Alternative Care (AC) by voluntary refuse to open to or remain on MA.

Persons wanting to use AC, Essential Community Supports, or Moving Home Minnesota (MHM) services must be eligible under those program’s criteria. The lead agency determines program eligibility for the waiver, AC, and ECS programs. DHS staff determine MHM eligibility.
For AC and EW service agreements with a header begin date beginning on or after April 14, 2020, a person must receive case management and a formal service that addresses a need identified in the person’s assessment related to an ADL or IADL, cognitive or behavioral needs, or medical needs for clinical monitoring. Authorize case management services for a maximum of 60 calendar days without the authorization of an additional waiver or AC service. If the cause of not authorizing an additional waiver service is the result of a transition between providers, services, or settings, then extend case management up to 120 days without another program service and without posting an edit to reduce the line item period to a maximum of 120 days.

The LTC screening document records program eligibility for AC, BI, CAC, CADI, ECS, EW and MHM programs. The DD screening document records program eligibility for the Developmental Disability program. The service agreement needs the approved screening document to determine the type of program, period, and amount of money used to authorize services. The Recipient Subsystem checks the service agreement for eligibility and will post several edits if data is missing or incorrect. See Session 5 of the MMIS Training Series for the edits, which recipient screens to view to find the information, and how to resolve the edits.

301.08 Alternative Care Fees
Persons participating in the AC program may be assessed a monthly fee to contribute to the state’s costs for the program’s services. Persons using temporary AC (program type 22) or Consumer Directed Community Supports (CDCS) are not assessed a fee. There are other exceptions listed on the LTC screening document form DHS-3427 in section H.

Fees are assessed based on the person’s AC adjusted income or their gross assets and are determined based on a corresponding percentage of the fee schedule (as of 7/1/20 - see below). Calculate the fee by applying the percentage to the average monthly cost of AC services and include case management costs.

<table>
<thead>
<tr>
<th>AC Adjusted Income*</th>
<th>Gross Assets</th>
<th>Monthly Fee Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income &lt; 100% FPG ($1064) and less than $10,000</td>
<td>No monthly fee</td>
<td></td>
</tr>
<tr>
<td>Income &gt;= 100% FPG and &lt; 150% FPG ($1,595) and less than $10,000</td>
<td>5 percent cost of AC services</td>
<td></td>
</tr>
<tr>
<td>Income &gt;= 150% FPG and &lt; 200% FPG ($2,147) and less than $10,000</td>
<td>15 percent of AC services</td>
<td></td>
</tr>
<tr>
<td>Income &gt;= 200% FPG ($2,147) OR equal to or greater than $10,000</td>
<td>30 percent of AC services</td>
<td></td>
</tr>
</tbody>
</table>

*income minus recurring and predictable medical expenses

The Department’s Special Recovery Units (SRU) billing unit sends invoices and track payments using the AC Fee fields on the ASA2 screen. The accuracy and timing of the billing process is dependent on when entering the fee information in the MMIS. On the first of the month, the SRU process locates the service agreement and records the AC
Required Fee Amount for next month’s payment. Invoices mail out on the fifth of the month showing the current amount due. Payment is due by the 15th.

It is important to update these fields whenever the fee amount changes. Any changes received by the SRU staff apply through the fourth of the month for next month’s invoice.

Request additional information from DHS.MADE@STATE.MN.US by providing the person’s initials and PMI number.

- A payment history showing billing from the day the fees began, the payment, check numbers, and dates of received checks. It also reflects all refunds and NSF transactions.
- A copy of an invoice.
- A statement showing all “Open Items/Past Due Amounts” at the time the statement is printed.
- Changes to the AC fee for the current or previous months. Also, provide month(s) of service and fee amount.
- Requests for cancelled fees or refunds.
- Billing address changes from the initial address on the ALT6 screen of the LTC screening document.

See Session 18 in the MMIS Training Series for an explanation of the AC Fee fields on the ASA2 screen, how to use the fields, and what edits could post. Overdue fees and estate recovery is also included. See the CBSM for the process and procedures and required forms.

301.09 Editing the Service Agreement
The MMIS Training Series provides instructions on how to use MMIS to enter a new service agreement in Sessions 16 and 16a. How to make changes to a saved service agreement in Session 17. When to add a service agreement for managed care members in Session 20. These sessions cover what edits may post, how to review the edit line, use the PF keys to search in MMIS for answers, and how to force and clear an edit.

301.10 Deleting Line Items
There are different methods to resolve a line item copied/repeated too many times or entered in error. Which method to use depends on if adding the new service agreement or changing an existing service agreement. Session 17 of the MMIS Training Series explains the alternative methods to use for unwanted line items for a service agreement already saved. Session 16 shows when and how to delete a line item when adding a new service agreement.

301.11 Repeating or Copying Line Items
There are four circumstances where you may want to copy/repeat a line item:
1) The provider used up all the units before the end of the line item period. To restrict the use of units by day, week, or month, add a new line item for each day, week or month of service with enough units to cover that period.

2) More than one provider will be providing the same service but at different periods or rates. Copy the line and change the provider number, the rate and/or period on the new line.

3) Closing a line item to add a new line item to show a change in the rate and/or provider.

4) The person entered an institution for less than 30 days. Close the current line items to the date of admission. When they return to the community, repeat the line items once so the new line items start with the new community period.

After entering the line item to repeat, use the PF9 key to make sure no edits post. Then go to the Repeat field at the end of the line item and add a number that represents how many lines in total. Use the PF9 key again. Edit 876 (Line Item Duplicate) now posts. Each line must be unduplicated by changing either the periods so they do not overlap, the provider number or the rate. When finished, approve the line items. See Session 17 of the MMIS Training Series for a demonstration.

301.12 Changes to an Approved Service Agreement
Session 17 of the MMIS Training Series shows you how to make changes to a service agreement saved in the MMIS. Below is a summary of the types of changes.

On the Key Panel screen, you will need to use an Action Code of “C” and the PMI number or the service agreement authorization number.

If the service agreement has a header status or any line item status of pend or suspend, all fields are updateable (signified by a green color). Some fields protect from data entering on the ASA1 and ASA3 screens, signified by a white color, for approved service agreement header or line item statuses. Furthermore, no changes allowed for denied service agreements or line items. If the service agreement header is partially suspended (T), only those line items that are not approved will have all their fields updateable.

• On the ASA1 screen with approved or partially suspended header status, only the header period end date, the birth date and the case manager number are updateable.

• On the ASA2 screen, the PCA Complex, Send Recipient Letter, Reason Code, AC Fee Payment Method, AC Fee Amount, AC Partial Payment, AC Fee Effective Date, Responsible Party, Fiscal Intermediary, Lives with Responsible Party, and Excluded Time fields are updateable.
• On the ASA3 screen, for approved line items change the start and end dates, the units, and the total amount fields.

Changing the Unit Field
Units can be increased or decreased.
1) Go to the unit field and use your "end" key to delete what is shown
2) Enter the new amount
3) Use the PF9 key to recalculate the total amount based on the new unit amount.
   You will receive an edit if the increased units put the service agreement over the EW or AC total cap amount (compare the Total Authorized Amount field to the Total Cap Amount field on the ASA1 screen). Reduce this or another line item so the total costs do not exceed the total cap amount.

You cannot decrease the units lower than the units shown in the Total Units Used field.

You will not be able to increase the units to more than what can fit within the period; such as a daily service with ten units needs ten days in the period.

Changing the Total Amount Field
See explanation for field 36 in Section 301.03 for the services allowed with a total amount instead of a rate and unit. If using the total amount field, instead of using a rate and unit, you can increase the dollar amount or decrease it, but not lower than the Total Used Amount field.

Changing Begin/End Dates
   1) The header begin date cannot be changed on an approved or partially suspended service agreement.
   2) Increase the header or line item end date when continuing services beyond the initial period. Decrease the periods if the service ends early.
   3) The header period cannot exceed 365 days nor fall outside of the waiver eligibility period (on RWVR screen), or Medical Assistance eligibility period on the RELG Screen. The AC service agreement header period must fall within the AC eligibility period (on RELG screen). The ECS service agreement header period must fall within the UN eligibility period (on RELG screen).

Changing the Line Item Status
Change the line item status from A (approved) to D (denied) as long as there is no payments against the line item (the total used units and total used amount fields are blank).
Adding a Line Item
Add a new line item while on the ASA3 screen by using the PF11 key to bring you to the next blank line item. If you keep the line item in suspense, change the header status field on the ASA1 screen from an “A” to a “T”.

Closing Approved Line Items with No Payments
If you do not want claims to pay against a line item (perhaps because the service will no longer be provided or was never provided, or the rate and/or provider number is incorrect), you need to change the line so future claims will not pay off the line item.

If the line was priced by a rate and unit, and no units were used or money paid, delete the units and total amount fields. Change the end date so that it is the same as the begin date.

If the line item used the total amount field, and no money was paid, delete the total amount field. Change the end date so it is the same as the begin date.

Closing Approved Line Items when Claims Have Been Paid
When you do not want additional claims paid from an approved line item, and a rate and unit priced the line, decrease the units to match the Total Units Paid field. If the line item priced by a total amount of money, decrease the Total Amount field to match what paid in the Total Amount Paid field.

If the closing is due to the person leaving the program for a different program use the last day the person received services as the line item end date. If edit 156 (LDOS/Paid Claim Conflict) posts, the provider billed for a service date that is after the new closing date. If this happens, the provider must complete a credit claim prior to closing the line item. They will then re-bill under the new service agreement. See Section 301.15 on Credit and Replacement Claims.

Closing Approved Line Items Because of a Rate or Provider Change
A rate change on an approved line item or a new provider is not possible. Enter a new line item as of the date of change.

1) Close the existing line item to the last date the rate or provider will be used
2) Adjust the units
3) Use the Repeat field to copy the line once. The new line will be at the end of the existing line items
4) Change the rate or provider on this new line item
5) The begin date will be the first date that the new provider or rate will be used
6) Add the balance of the units
7) Use the PF9 key and correct any edits
8) Approve the line item
Automated MMIS Changes to Service Agreements

MMIS will automatically change those saved service agreement line items when the DHS Provider Enrollment unit ends a category of service (COS), or specialty code, or there is a missing license code for the line item provider. The changes to the service agreement line item when a code is ended or missing on the provider’s record:

- Pended or approved line items ending after the COS ending date will have reason code 858 added and edit 412 posts, or edit 413 will post for specialty codes. See the PCOS and PPGM screens in the Provider Subsystem.
- Approved line items beginning after the current date will automatically change the status to pend and add reason code 858. Edit 412 and/or 413 posts.
- Suspended line items overlapping with the COS ending date will post edit 412.
- Suspended line items overlapping with the specialty code ending date, or spans more than one specialty code span with gaps in-between, will post edit 413.
- Line items that do not have the correct license code or begins prior to the license code begin date will post edit 413. See the PLIC screen in the Provider Subsystem.
- Line items with the correct license code but the license state field is not MN or XX will post edit 413. See the PLIC screen in the Provider Subsystem.

Reason code 858 will place this message on the recipient and case manager letters: “You receive this letter due to changes to the provider’s records for this service. Contact your case manager or MN Health Care Programs member helpdesk at 651 431 2670 or 1 800 657 3739 for more information.”

Reason code 858 will also place this message on the provider, billing agent, or managed care organization letter “Providers must continue to be eligible for enrollment in order for authorizations to be valid. This service line item is not currently supported”.

The suspended or pend line item cannot be approved until the provider’s record is updated by the Provider Enrollment Unit or the line item period is changed so it does not overlap with the COS or specialty code end date or it does not being prior to the license code begin date. Only the provider can contact the Provider Enrollment Unit to request a change to their record.

Daily Report

Report PWMW9332-R2086 Service Agreements for Providers with Category of Service Codes and/or Specialty Codes Ended identifies when an approved, pended, and partially suspended service agreement is changed due to a COS, license, or specialty code ending. It is on Infopac.

There are two versions of this report: PWMW9332-R2086A identifies the AC, BI, CAC, CADI, and EW program service agreements. PWMW9332-R2086B identifies the DD program service agreements. Data sorts by:
• Tribal agency when the SACTAD field is populated; or
• Agency where the case manager is located, or if no case manager on the ASA1 screen then by;
• County of financial responsibility for BI, CAC, CADI, and DD service agreements, or county of service for the AC and EW programs.

Cases appear on the report sorted by the case manager provider number listed on the service agreement. Note: It is important to keep the case manager provider field updated on the ASA1 screen whenever there is a change in case manager so the report and service agreement letters are sent to the correct person. Note: no changes made to the line item if the provider number field is not valued, or for denied line items.

Lead agency staff should review this report on a daily basis. Since case managers cannot make changes to the provider’s record, the provider must contact the department’s MHCP Provider Help Desk at (651) 431-2670 or 1-800-657-3739 to update their record.

Provider records not corrected with the COS, specialty, or license code and the person continues to need the service, the case manager will need to arrange services with a different provider.

Codes added back to the provider screen may have a gap between the date the code ended and when it was effective again. If the person requires the service during this non coverage period, the line item must be ended prior to the code ending date (remove reason code 858 from the line item) and add a new line item for a different provider beginning with the day the code was ended.

Correcting Edit 412 for Category of Service
Place the cursor on the line item provider number and use the F4 key to navigate to the PCOS screen of the Provider Subsystem. If the COS code is not listed on the PCOS screen it means the provider is not authorized to provide the service and the line item can be left in suspense, denied, changed to pend and add reason code 858. Deleting the line item using the “...” method is possible if you are adding a new service agreement.

If the COS code is listed on the PCOS screen but the line item period overlaps with the COS end date, the provider’s authorization to provide the service has ended and you can either leave the line item in suspense, change to pend and add reason code 858, or change the line item end date so it no longer overlaps with the COS end date.

If the COS code is listed on the PCOS screen but the COS ends prior to the beginning of the line item period you can either leave the line in suspense or change the status to pend and add reason code 858 so the provider receives the service agreement letter.

Correcting Edit 413 for the Specialty Code
If the PPGM screen of the Provider Subsystem does not have the correct specialty code, it means the provider cannot provide the service and the line item can be left in
suspense, denied, or changed to pend and add reason code 858. Deleting the line item using the “. . . .” method is possible if you are adding a new service agreement.

If the specialty code is listed on the PPGM screen but the line item period overlaps with the specialty end date, the provider’s authorization to provide the service has ended and you can either leave the line item in suspense, change to pend and add reason code 858, or change the line item end date so it no longer overlaps with the specialty end date.

If the specialty code is on the PPGM screen but ends prior to the line item begin date, you can either leave the line in suspense, or change the status to pend and add reason code 858.

Correcting Edit 413 for the License Code
If the correct license code is not on the PLIC screen of the Provider Subsystem it means the provider does not have the license to provide the service. Leave the line item in suspense, change the status to deny, or change to pend and add reason code 858. If you are adding a new service agreement, you can also delete the line item using the “. . . .” method.

If the license code is listed on the PLIC screen but the line item period is prior to the license begin date, the provider’s license was effective after the line item begin date and you can either leave the line item in suspense, change to pend and add reason code 858, or change the line item begin date.

See Session 16a from the MMIS Training Series for a demonstration on correcting these edits.

301.13 Closing a Service Agreement
There are many reasons to reduce the service agreement header end date and/or line item end date. In all of these cases (except when the person is enrolled with the MSC+ or MSHO program and EW is continuing fee-for-service), an exit screening document is entered showing the last date in the Effective Date field that the person will be receiving services. Change the service agreement header and line item end dates to this date. If you try to enter an exit screening document and the exit date is before the service agreement header end date, edit 109 will post requiring you to close the service agreement first.

Closing the service agreement does not close the screening file and vice versa. If the closing is due to death, the Alternative Care exit screening document will not allow payments beyond the date of death. However, close the service agreement for payment and encumbrance reports to be correct. For the waiver programs, when the financial worker closes Medical Assistance due to death, claims for dates of service after the date of death will not be payable. However, it is also necessary to close the service agreement and enter an exit screening document.
Overlapping Service Agreements with MA Home Care

If a home care agreement header period overlaps the waiver or AC service agreement header period, edit 874 - Duplicate Service Agreement, will post. This happens if the agreements are in a suspended, pend, or approved status. You can view the MA home care agreement by using the "I" in the action code field on the Key Panel screen and using agreement type “B”.

Save the new waiver service agreement overlapping with the home care authorization with the 874 edit posting and send to DHS in a suspended status using the code 580PWLMW64 in the override location field on the ASA2 screen. DHS will close the home care agreement and resolve the 874 edit. The service agreement routes back to the lead agency to resolve any other edits.

If the Alternative Care service agreement overlaps with the MA home care agreement, the case manager must email the Resource Center at dhs.resourcecenter@state.mn.us. Leave the service agreement authorization number, the header start and end dates, your name and phone number. The Resource Center staff will close the MA home care agreement and resolve the 874 edit.

The Essential Community Supports with program type 30 and Moving Home Minnesota service agreements may overlap with the MA Home Care type B authorization.

Overlapping Service Agreements with Other Programs

Edit 874 will also post if two or more service agreements overlap with any header status but deny. When changing from one program to another close the current service agreement and enter an exit screening document. Enter a new opening screening document and service agreement for the new program.

If you have not saved the service agreement and it is incorrect, use the F6 key to cancel it. If both service agreements are in a saved status, and if the header periods cannot be unduplicated, change one of the header status to D to deny. Change the Send Recipient Letter field to a N. Remove the provider numbers from the line items. This assures that no one receives a denied letter for the incorrect service agreement. Enter into the remaining service agreement in the change mode and use F9 to remove edit 874.

See Chapter 201.08 in this manual as well as Sessions 10 and 17 of the MMIS Training Series for more information on the reasons and methods to close a service agreement.

301.14 Service Agreement Letters

Recipient and Case Manager Letters

The persons on a waiver program will show their mailing address on the RCAD screen in the Case File of the Recipient Subsystem. If there is an alternative address on file, that will be used instead of the person's home address. The address for persons open
to the Alternative Care and Essential Community Supports programs is on the ALT6 screen of the screening document and transfers to the RCAD screen.

Letters print nightly during batch processing. The ASA2 screen determines if a DHS generated letter mails to the person. If the Send Recipient Letter field = N, letters are not generated for the person and the lead agency will be responsible to notify the person of the status of the services.* If the field is marked “Y”, the person receives the same type of letter that the case manager receives which shows those line items in an approved or denied status. Service agreements with a suspended header status do not produce letters. The county of service or the tribal agency receives those letters returned by the post office for wrong addresses.

County and tribal agencies may receive two letters: one is the case manager letter which lists all approved or denied line items; and the other is the agency’s provider letter which lists only those services provided by the agency.

*The exception is letters sent to the person when the service agreement line item changes from approved to pending due to the provider’s category of service or specialty code ending even if the Sent Recipient Letter field = N.

Provider Letters
The letter generated for each provider contains only the approved, denied, or pended service(s) provided by that provider. Diagnosis codes are required on the claim form for all home and community based services. The provider and billing agent letter will show the primary diagnosis code listed on the last approved screening document in which the effective date (LTCC) or action type date (DD) falls within the service agreement period. Providers may choose to use this diagnosis code or another more recent code as long as the number is valid.

If a provider requests another copy of their service agreement letter, add reason code 488 to one of their line items. Check the PADD screen of the Provider Subsystem to verify that the address is correct for that provider number. If not correct, the provider must contact the DHS Provider Enrollment Unit to change it.

General Letter Information
Letters produce when:

• The header status is initially changed from suspend to another status,
• There is a change in a field of the approved or pend line item including adding and deleting reason codes, or
• A new line item is added and changed from suspense

Letters are produced only once at the end of the work day. While the service agreement may update more than once during the day, the letter will reflect the last changes.
Each letter is a duplicate of the initial letter with any header or line item changes or line item additions. Text on the Provider and Recipient Comment screens explain changes on the new letter. This would assist the person and provider in understanding the changes since the previous letter.

The person/guardian and case manager letters receive text from the Recipient Comment screen. Provider/billing agents receive text from the Provider Comment screen at the end of the letter for all new providers, or just the provider with line item changes. No text from the DHS Comment Screen print on the letters.

Text will also appear on the letters following the first paragraph from reason codes entered on the ASA2 screen. Line item reason code text shows with that line item.

All letters will show the name of the case manager and the phone number. The case manager name is from the ASA1 screen of the service agreement. The phone number is from the PADD screen in the Provider Subsystem for that case manager number.

Keep the case manager number field on the ASA1 screen updated for new case managers. This change does not produce a new letter. Lead agency staff with correct MMIS security updates the telephone number on the PADD screen of the Provider Subsystem. This same person updates case manager information for provider type 23. See Chapter 101.06 on the process to update the PADD screen for case managers and care coordinators.

Reasons why a provider, person, or case manager may not receive a letter are the:
  • Service agreement header status = S
  • RCAD address on the Recipient Subsystem is incorrect for the person
  • Case manager provider number field on the ASA1 screen was left blank and thus will not allow case manager letters; or
  • Care coordinator (provider type 27) did not register for a MN-ITS mailbox

Additional PCA Language
An approved line item for personal care assistant code T1019 and PCA Complex Code T1019 TG will have the following text added based on the value placed in the Frequency field on the line item. This text does not apply to Alternative Care service agreement letters.

Value 1 will show “PCA/PCA Complex services are restricted. Daily and weekly usage of PCA/PCA Complex service units/hours should be close to the daily average allocation. Hours/units do not transfer from month to month. If the person uses all PCA/PCA Complex service hours/units before the end of the month, the Department cannot authorize additional PCA/PCA Complex service units. MN Statutes 256B.0659.”

Value 5 will show “The flexible use option allows persons to plan the use of authorized PCA/PCA Complex service units/hours in a flexible schedule to more effectively meet their needs. Authorized PCA/PCA Complex units/hours divide into two date spans of six months or less for one year of PCA/PCA Complex services. Persons may vary the use
of authorized PCA/PCA Complex units/hours within the start and end dates of each date span. Units/Hours cannot transfer from one line number to the next or one date span to the next. MN Statutes 256B.0655.”

Do not use values 2 and 3 for line items with T1019 or T1019 TG. Use for Supervision of PCA (T1019 UA).

When the procedure code is T1019 or T1019 TG and the Shared Care field = Y, the first approved line item will post reason code 565 with this message:

“The person has elected to receive the shared service option for PCA/PCA Complex services. This allows two or three person’s to share PCA/PCA Complex services in the same setting at the time. An agreement with consent is required to grant permission for the agency to place the person’s name in the chart of the other person they share services. The provider agency delivers services according to each individual’s plan of care. The assessment and authorization for shared services bases on the person’s 24-hour needs. Participation in a shared care arrangement does not reduce the total number of service units authorized. Minn Stat Sect 256B.0625 and 256B.0659.”

**MN-ITS Electronic Mailboxes**

Providers will receive a copy of their service agreement letters as well as the MA home care and MA authorization letters in their MN-ITS electronic mailbox. These letters are in a folder called SAL and remain there for 90 days. Providers may print the letters or save the letters to their hard drive or disc. The letters in the SAL folder show as individual lines. When opening a letter, an arrow appears to the left of the line. Opening a letter allows printing or saving.

Provider type 23 case manager service agreement letters route to both social services and public health nursing agencies’ electronic MN-ITS mailboxes and stored in a folder called CML. Tribal case manager letters route to the tribal agency’s electronic MN-ITS mailboxes and stored in a folder called CML.

Provider type 27 health plan care coordinators receive a Welcome Letter from provider enrollment informing them to register for MN-ITS if they wish to continue to receive these letters.

The letters in the CML folder show as individual line items. These lines sort in case manager provider number order. When opening a letter, an arrow appears to the left of the line. Opening a letter allows printing or saving. Both social services and public health nursing agencies mailboxes contain a copy of the case manager letter due to the inability in MMIS to determine which agency the case manager is located. Letters for independent case managers contracted with the agency are not included. Please note to change the mailbox password every 90 days. The MHCP Provider Call Center at 651 431-2700 or 1 800 366-5411 assigns temporary passwords.

Questions and problems using the MN-ITS mailbox may be directed to the Provider Call Center at 1 800 366-5411 or 651 431-2700. Ask for a work order for Tier 2.
**Reason Codes**

The below chart is a listing of reason codes that may be placed in the RSN CD fields on the ASA2 screen for all letters; or added to the line item RSN CD fields for a message only to that provider, person, and case manager.

<table>
<thead>
<tr>
<th>Code</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>416</td>
<td>The recipient has requested continued benefits pending appeal. This service agreement changed to reflect this continuation of benefits until an appeal ruling. If the recipient loses the appeal, the state reserves the right to bill the recipient for the difference between the services received and the level of services appealed. MINN. STAT. SECT 256.045, SUBD. 10.</td>
</tr>
<tr>
<td>425</td>
<td>An order of the commissioner issued regarding an appeal filed by the recipient. This service agreement is based on the order of the commissioner.</td>
</tr>
<tr>
<td>427</td>
<td>Based on an administrative review of the PCA assessment and service plan, or additional information submitted, the department has changed the service agreement.</td>
</tr>
<tr>
<td>488</td>
<td>You requested another copy of the original authorization notice. There are no changes from the original notice.</td>
</tr>
<tr>
<td>499</td>
<td>This service changed due to a rate adjustment. For billing purposes, please make sure you save this copy.</td>
</tr>
<tr>
<td>565</td>
<td>The person has elected to receive the shared service option for PCA or PCA complex services. This allows two or three persons to share PCA services in the same setting at the same time. An agreement with consent is required to grant permission for the agency to place the person’s name in the chart of the other person they share services. The provider agency delivers services according to each individual’s plan of care. The assessment and authorization for shared services based on the person’s 24-hour needs. Participation in a shared care arrangement does not reduce the total number of service units authorized. Minn Stat Sect 256B.0625 and 256B.0659.</td>
</tr>
<tr>
<td>584</td>
<td>Changes to this service are due to procedure code changes. Providers: for billing purposes, please make sure you save this copy.</td>
</tr>
<tr>
<td>586</td>
<td>This is a Moving Home Minnesota service.</td>
</tr>
<tr>
<td>598</td>
<td>Service agreement changes were due to procedure code changes. Providers: for billing purposes, please make sure you save this copy. DHS review was required for approval of the EW CLS services.</td>
</tr>
<tr>
<td>600</td>
<td>Starting January 1, 2019, Medical Assistance will directly cover the cost of this personal care assistance and/or home care nursing service agreement instead of the health plan. The health plan will continue to be the payer for other health care services. This service agreement shows the change in payer for personal care assistance services and/or home care nursing services. This service agreement uses current information from the health plan. There are no changes to the amount of services this person is eligible to receive.</td>
</tr>
<tr>
<td>Code</td>
<td>Message</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
</tr>
<tr>
<td>604</td>
<td>Starting July 1, 2018, Medical Assistance will pay an enhanced rate for personal care assistance services and the Consumer Support Grant budget will enhance if you are eligible for 12 or more hours of Personal Care Assistance services per day and have a qualified worker that meets the training requirements. This service agreement shows the change in rate for Personal Care Assistance Complex services. There are no changes to the amount of services this person is eligible to receive. The increase is required for the workers as wages and/or benefits.</td>
</tr>
<tr>
<td>700</td>
<td>Submit claims to DHS for services authorized on this agreement.</td>
</tr>
<tr>
<td>823</td>
<td>Deletion of the units and total amount for this service was necessary because the rate was incorrect.</td>
</tr>
<tr>
<td>824</td>
<td>This service replaces a duplicate service priced with an incorrect rate.</td>
</tr>
<tr>
<td>825</td>
<td>Closing this line item because the provider is no longer active under this provider number beyond the end date.</td>
</tr>
<tr>
<td>826</td>
<td>This service replaces a duplicate closed service because the provider is no longer active.</td>
</tr>
<tr>
<td>827</td>
<td>This is a new line item that authorizes a new service.</td>
</tr>
<tr>
<td>828</td>
<td>Reducing the units or total amount for this service.</td>
</tr>
<tr>
<td>829</td>
<td>The units or total amount for this service was increased.</td>
</tr>
<tr>
<td>830</td>
<td>Reducing the date span on this service. Provide the service for this new time period.</td>
</tr>
<tr>
<td>831</td>
<td>The date span on this service was increased.</td>
</tr>
<tr>
<td>832</td>
<td>The total units/amount and date span was reduced for this service. The person is no longer participating in the program as of the service agreement end date.</td>
</tr>
<tr>
<td>833</td>
<td>The person is no longer participating in the program as of the new service agreement end date. Any approved line item that began after this date is no longer valid.</td>
</tr>
<tr>
<td>834</td>
<td>This denied service agreement entered by mistake or has errors.</td>
</tr>
<tr>
<td>835</td>
<td>NOTE TO PROVIDERS: . . . . Refer to the person’s “Individual Service Plan” (DD) or “Individual Care Plan (LTC) approved by the case manager for details regarding the type, amount, frequency and duration of services to be provided.</td>
</tr>
<tr>
<td>836</td>
<td>Closing this service because the provider changed or incorrect.</td>
</tr>
<tr>
<td>837</td>
<td>This closed service replaces a duplicate service because the provider was changed or incorrect.</td>
</tr>
<tr>
<td>838</td>
<td>Please ignore this letter if it does not show information about your services.</td>
</tr>
<tr>
<td>Code</td>
<td>Message</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
</tr>
<tr>
<td>839</td>
<td>The service closes as of the new service agreement end date.</td>
</tr>
<tr>
<td>840</td>
<td>The units and total amount deleted for this service due to closing the service agreement.</td>
</tr>
<tr>
<td>841</td>
<td>This line item is no longer needed.</td>
</tr>
<tr>
<td>842</td>
<td>Closing this service agreement due to person entering the nursing facility.</td>
</tr>
<tr>
<td>843</td>
<td>Extending the date span and increasing the amount for this service.</td>
</tr>
<tr>
<td>844</td>
<td>Ending the service agreement due to a facility stay that does not allow for the service agreement to remain open.</td>
</tr>
<tr>
<td>845</td>
<td>Extending this service agreement.</td>
</tr>
<tr>
<td>857</td>
<td>This authorization has ended due to person moving to a new county of residence.</td>
</tr>
<tr>
<td>858</td>
<td>Person and Case Managers: You received this letter due to changes to the provider’s records for this service. Contact your case manager or MN Health Care Programs member helpdesk at 651 431 2670 or 1 800 657 3739 for more information.</td>
</tr>
<tr>
<td>860</td>
<td>Closing this service agreement because more than one PMI number assigned to the person. Do not use the PMI listed on this letter in the future. When you receive the new service agreement letter with the new PMI number, begin using that PMI as of the effective date of the service agreement.</td>
</tr>
<tr>
<td>861</td>
<td>Closing this service agreement because the person enrolled with a managed care program and will begin receiving waiver services through that organization. Services authorized and funded through DHS will end on the closing date and future waiver services authorized and funded through the managed care organization. To continue serving this person contact the enrollee’s health plan or health plan’s care coordinator.</td>
</tr>
<tr>
<td>862</td>
<td>This Alternative Care service agreement ended due to the person becoming eligible for Medical Assistance.</td>
</tr>
<tr>
<td>864</td>
<td>Use other more appropriate funding instead of the waiver or Alternative Care funds for payment.</td>
</tr>
<tr>
<td>865</td>
<td>Services will be ending effective the end of the waiver span or AC eligibility end date. Person is not continuing on the program.</td>
</tr>
<tr>
<td>866</td>
<td>Providers must continue to be eligible for enrollment in order for authorizations to be valid.</td>
</tr>
<tr>
<td>983</td>
<td>Denying this service due to errors.</td>
</tr>
<tr>
<td>987</td>
<td>CDCS services no longer authorized for this person.</td>
</tr>
<tr>
<td>988</td>
<td>This service agreement closed effective 12/31/18. South Country Health Alliance must approve services beginning 1/1/2019. Services provided prior to 1/1/2019 must be submitted to MN-ITS. For claims with 2019 dates of</td>
</tr>
</tbody>
</table>
301.15 Claims Processing Against the Service Agreement

Waiver, Moving Home Minnesota, Essential Community Supports, and Alternative Care claims pay against approved or partially suspended service agreements with at least one line item approved. No claims pay against any line items with a status of suspend, pend, or deny. If the person has more than one PMI number, the claim will pay against the service agreement listed on the claim form. A claim checks the following information on the service agreement.

- Does the authorization number on the claim form match a service agreement authorization number? If no, deny. If yes, continue.
- Does the claim line item match a service agreement line item’s provider number, procedure code, and dates? If no, deny. If yes, continue.
- Does the line item have a status of approved? If no, deny. If yes, continue.
- Does the rate on the claim exceed the rate on the service agreement line item? If yes, the claim will use the rate on the line item and continue. If no, it will use the rate on the claim and continue.
- Does the service agreement line item have enough units or total amount to cover the claim? If no, pay as much of the claim as possible. If yes, pay the entire claim amount.

Claims must be in a status of “to-be-paid” or “paid” within 365 days of the service date. Providers submit claims over a year old from the date of service within six months from the time of the corrected service agreement. They obtain supporting documentation including a copy of both the original previously approved service agreement and the updated or newly approved service agreement by submitting the claim electronically with an attachment by following the Electronic Claim attachment instructions.

A provider must accept reimbursement as payment in full for covered services provided to a person. This means that a provider may not request or accept payment from a recipient, their family, the local human service agency, or any other source in addition to the amount allowed under the programs except in the case of a spend down. An exception is when the person has received an insurance payment designated for the service. In this case, the provider bills the person directly to recover an insurance payment that the person has received.

Prior to submitting a claim, providers are encouraged to contact the Eligibility Verification System (EVS) to verify person eligibility once per month. EVS is a touch-tone automated telephone service providing eligibility information for each person. See Chapter 1, Section 101.09 for more information on EVS.
Beginning March 5, 2018, providers bill all HCBS services except for case management and CDCS by per day. A from/thru date will not be accepted. The service agreement line items may continue to authorize a from/thru period.

**CDCS Claims**

There are three procedure codes used with CDCS services. T2040 represents Background Checks on the service agreement and claim form. It is not a mandatory service.

T2041 represents Mandatory (Required) Case Management on the service agreement and claim form. It is a mandatory service for the EW and AC service agreement and must be included with another line item for T2028.

T2028 represents five categories. The service agreement will have a total amount on the line item representing the total cost of all CDCS services. Use the Financial Management Services (FMS) provider number on this line item. The claim form will have T2028 and up to five modifiers on the claim line item. These modifiers are:

- U1 – Personal Assurance,
- U2 – Medical Treatment and Training,
- *U3 – Environmental Modifications and Provisions,
- U4 – Self-Direction Support Activities, and
- U8 – Support Planner

**Residential Absences for Customized Living Services or Foster Care**

Residential absences are days when the person is not receiving residential services and is not in the residential setting.

Examples of residential absences include days for:

- Hospitalization
- Therapeutic leaves
- Crisis services
- Any days away such as home visits and vacation days

This policy affects customized living services and foster care.

The Center for Medicare and Medicaid Services (CMS) policy states Medicaid payment allowable for services actually provided to an eligible person. The claim must include those days and units that are not residential absences.

**301.16 Moving Home Minnesota Service Needs DHS Approval**

There are three services that need review by DHS staff when the total number of days authorized exceeds 180. Those services are:

- H2015 U6 – Comprehensive Community Support Services
- S5135 U6 UA – Overnight Assistance
• H0038 U6, H0038 U5 U6, and H0038 HQ U6 – Certified Peer Specialist

Edit 951 will post when a new line item or a changed line item period exceeds more than 180 days when totaled with all non-denied line items with the same procedure code. You will not be able to approve the new or changed line item. The service agreement will route to DHS for approval. You should add a message to the DHS Comment Screen to explain extending services. You cannot save the service agreement with an outstanding edit posting on an approved line item. Identify the approved line item that needs to be changed.

301.17 Claim and Service Agreement Corrections

Providers are responsible to verify their rate and the number of units against their contract or purchase agreement prior to billing. Additional services, units, or total amounts must be prior authorized by the case manager.

If a provider receives an underpayment because the number of units or dollar amounts does not cover the claim, correct the service agreement before the provider can submit a credit claim for the balance. The procedure is below for a credit claim.

If a provider receives an underpayment because an approved incorrect rate on a line item, the provider
1. Submits their own void (take-back) claims electronically. MHCP does not accept phone calls requesting the void (take-back). Refer to the MN-ITS User Guide for Voiding a Claim using MN-ITS.
2. Submits a partial void of a claim by replacing the claim previously paid incorrectly.

Lead agencies must follow the steps below when requesting voids for the purpose of adjusting a service authorization/agreement:

1. Contact the provider and request them to do their own void.
2. After waiting seven days if the claims are not voided you may request on behalf of the provider that the claims be voided
   a. Complete the Credit Claim Void (take-back) Request form DHS-6207 and submit it to MHCP by fax at 651 431 7616; or
   b. Send an email to dhs.void@state.mn.us enter “Attn: SA Claim Void” in the subject line.
3. After the claim is voided, check the service agreement to make sure the line item’s paid units and/or dollar amounts were added back to the line item before making changes to the line item (if changes are needed).

MHCP will:
• Void county-initiated claims within 48 hours of receipt.
• Report claim void transactions in the Reversal section of the provider’s remittance advice.
If you have questions about this information, call the MHCP Provider Call Center at (651) 431-2700 or 1-800-366-5411. Also, see Session 14 of the **MMIS Training Series** for more information on the relationship of the service agreement and claim payment.

### 301.18 Service Agreement Edits

The following sessions from the **MMIS Training Series** gives instructions on:

- Navigating on the service agreement edit line
- Using the PF4 key to view additional edit text
- Where to look in MMIS to resolve the edit
- How to force and clear an edit
- What are the different statuses

See Sessions 15, 16, and 16a.

### 301.19 Services Funded by Medicare Parts A and B

Edit 274 (Medicare Present) will post on service agreements to alert lead agency staff that the person is also eligible for Medicare Part A. The Recipient Subsystem shows the most recent eligibility span for Medicare Parts A and B on the RSUM screen. The RMCR screen will show all of the spans for parts A, B, and D.

This edit will post once if any line item period overlaps with a Medicare Part A span when the following services are AC T1030 (skilled nursing - RN), T1031 (skilled nursing LPN), AC G0299 and G0300 (RN and LPN skilled nursing), T1004 (home health aide 15 minutes), or T1021 (home health aide visit).

Edit 388 (Medicare Is Present) posts once for any line items with the following services that overlaps with a Medicare Part B span.

- **T1030** - Skilled Nurse Visit – RN
- **T1030 TG** – SNV-RN Telemedicine
- **T1031** – Skilled Nurse Visit – LPN
- **T1021** - Home Health Aide (HHA)
- **S9131** - Physical Therapy (PT)
- **S9128** - Speech Therapy (ST)
- **T1004** - Home Health Aide Extended and AC (HHA)
- **G0299** and **G0300** - (Alternative Care SN)
- **T2029** - Waiver Specialized Supply and Equipment
- **E1399** - Alternative Care Specialized Supply and Equipment

The provider must submit documentation with their claim to show Medicare denial or payment otherwise claim edit 237 (Medicare is on Recipient Eligibility File) will post to deny the waiver, Alternative Care, or home care claim.

### 301.20 Managed Care Members Receiving EW or ECS Services

DHS contracts with prepaid health plans to provide services to Medical Assistance (MA) participants. The RPPH screen in the Recipient Subsystem shows enrollment or
excluded for a managed care program. The product ID field identifies which program the person is enrolled:

- Minnesota Senior Health Options (MSHO) will show product ID MA02
- Minnesota Senior Care Plus (MSC+) will show product ID MA35 or MA30
- Special Needs Basic Care (SNBC) will show product ID MA17, MA37, IM12, IM17, or IM37
- Moving Home Minnesota (MHM) will show product MA36 while person is also opened to the Elderly Waiver program

See Session 15 of the MMIS Training Series for an explanation of the RPPH screen (as well as other screens). See Sessions 9 and 20 for more information on when to add a service agreement for a managed care member.

301.21 Persons Receiving Hospice and HCBS Services

The hospice benefit is a comprehensive package of services offering palliative care support to terminally ill individuals and their family. Hospice care is palliative, with a focus on holistic support and relieving pain and other symptoms of the terminal illness. Individuals electing the hospice benefit agree to receive only palliative care for their terminal illness or condition. They agree to forego curative care for their terminal diagnosis. In exchange, the person receives the hospice package of services. The package includes coverage for the following services when provided directly in response to the terminal illness:

- physician services
- nursing care
- medical social services
- counseling
- medical equipment and supplies
- outpatient drugs for symptom and pain control
- dietary and other counseling
- short-term inpatient care
- respite care
- home health aide and homemaker services
- speech, physical, and occupational therapy
- other items and services included in the plan of care that are otherwise covered medical services

Hospice Care Provided In Conjunction with Other MA Covered Services

DHS understands that persons facing death may have a complex set of health care needs. These needs often stem from their terminal condition. These needs may also stem from other medical conditions that either (a) pre-existed their terminal condition, or (b) arise during the course of their terminal condition but are unrelated to their terminal condition. A person should never be asked to make an “either/or” choice between an otherwise MA-covered, medically necessary service which is not related to the terminal
condition; and covered, medically necessary hospice benefit services that are related to the terminal condition.

Case Manager Approval of Services that are Concurrent with the Hospice Benefit
A forcible edit 233 will appear on the service agreement to indicate that the person has elected the hospice benefit. Following coordination with the hospice provider agency, case managers must add comments on the DHS Comment Screen of the service agreement documenting the coordination of services. The notes must indicate why continuing care services are necessary (either they are pre-existing, or they are new but treat a condition not related to the terminal condition.) Adjust the service agreement line items as needed to reflect the type and amount of services required. Changes to services continue to require a ten-day notice to persons to allow for continuity of care, person rights, and transitional needs.

Waiver, ECS, and AC Claims
An edit suspends the claim when the date of service overlaps with the hospice benefit period. Because the hospice provider becomes the primary payer of services, DHS will manually review claims to determine if payment is appropriate.

Staff review case management notes on the DHS Comment Screen time to ensure hospice provider coordination with the case manager has occurred. If it appears that the coordination by the hospice provider has not occurred, the claim will remain in suspense until the coordination process is completed. Claims pay if it appears that the coordination process has occurred.

For more details about hospice services, see the Hospice Section in the MHCP Provider Manual

301.22 Shared Service Option for PCA Services
The shared service option is personal care services provided in the same setting at the same time by the same personal care assistant (PCA) worker for two or three persons who have chosen to have services delivered in this manner. If the person is using PCA Choice Option, the same PCA Choice Provider provides all of the persons’ shared care. The person can select the Shared Care option at any time by contacting their public health nurse or case manager if on waivers or Alternative Care. Providers do not select the Shared Care option for their persons.

For more information, go to the PCA page of the PCA manual.

Use either T1019 (PCA Services), T1019 with modifier TG (PCA Complex), T1019 UC and TG (waiver extended PCA Complex), or T1019 with modifier UC (Extended PCA), on the line item when showing the shared care option on the waiver service agreement. Place a “y” in the Shared Care field. Use T1019 to the fullest extent before using the extended procedure code. The claim form will have T1019 and modifiers TT and UC for extended 1:2; or T1019 with modifiers HQ and UC for extended 1:3.
Use T1019 or T1019 TG (PCA/Complex PCA Services) on the line item with a “y” in the Shared Care field when showing the shared care option on the Alternative Care service agreement. The claim form will have T1019 and modifier TT for 1:2 or modifier HQ for 1:3. Shared PCA services are not available to AC persons if the PCA is a relative with a Relative Hardship Waiver and not an employee of a personal care provider organization. This restriction only applies to persons using AC services.

When the Share field is marked with a “Y” on the line item, it will place one of these messages on the provider letter:

- For MA PCA: provider may bill one of the following codes: T1019, T1019 TT, T1019 HQ or T1019 TG.
- For extended PCA: provider may bill one of the following codes: T1019 UC, T1019 TT UC, T1019 HQ UC, or for the EW program T1019 UC TG.

### 301.23 Flexible Use Personal Care Assistant (PCA) Services

**Flexible use PCA services** are hours/units which may vary within a service authorization period to effectively meet the needs for assistance, health and safety, and schedule of the person.

#### PCA Service Agreement Edits

- Edit 858 Frequency Period is Missing - will post if the Frequency field is blank.
- Edit 889 PCA Line > 6 Months or > 2 Lines - will post when the line item has T1019 with no modifier (state plan only) and the line item is more than six calendar months. It will also post if there are more than two line items for the same provider number for T1019 with no modifier. NOTE: This edit does not affect line items for extended PCA services.
- Edit 891 Cannot Increase Units or Amount - this edit will post when the approved line item has T1019 with no modifier (state plan only) and the units are increased. Authorize additional units under the extended PCA line item (T1019 with modifier UC). NOTE: This edit does not affect line items for extended PCA services. For AC PCA services using T1019, the edit will be forcible to allow an increase in units. DHS staff would be monitoring this edit closely to ensure that units are only increasing if there has been an assessed change in condition. Document the change in condition on the DHS Comment screen.
- Edit 442 Procedure Not Allowed Due to PCUR - will post if the line item for T1019 overlaps with a period shown on the RPCR screen. Flexible Use PCA (with the frequency field = 5) cannot overlap with this period. The provider of PCA services must be Medicare certified.
- Edit 852 – PCA Supervision is Missing/Invalid will post when a line item for T1019 with modifier UA is not present when another line item with T1019 is present.
301.24 Shared Service Option for Home Care Nursing Services

**Shared service option** for home care nursing services provided in the same setting at the same time by the same worker for persons who have entered into an agreement to share services for home care nursing.

Instructions for completing the service agreement line item:

1. Enter a line item with the procedure code, rate, and total number of units for 1:1 Home care Nursing services (T1002 for RN or T1003 for LPN).
2. On a separate line item enter the procedure code, rate, and total number of units for shared 1:2 home care nursing services (T1002 with modifier TT for RN 1:2. T1003 with modifier TT for LPN 1:2.) With extended RN or LPN, add modifier UC to the line item. Also, add a “Y” in the Shared Care field, and a “5” in the Frequency field.

The following edits will post if the information entered is not complete or correct:

- Edit 363 if the incorrect modifier number is used.
- Edit 376 if there isn’t a TT in the MOD1 field and there is a “Y” in the shared field.
- Edit 869 if no “Y” on the share care indicator field when TT is used.

Use MA home care procedure codes for home care nursing services to the fullest extent possible (for all medically necessary nursing services) before using extended home care nursing service codes on waiver service agreements.

301.25 Essential Community Supports (ECS) Program

As of January 1, 2015 persons residing in nursing homes, or who are no longer eligible for the Elderly Waiver (EW), Alternative Care (AC), Brain Injury Waiver-NF (BI), or Community Access for Disability Inclusion (CADI) programs due to not meeting the level of care standards may be eligible to receive services under this program to provide transition support and community services. People may transition from these waiver programs to the ECS program until December 31, 2015. They will remain on ECS if they continue to meet the program’s eligibility criteria. People screened after this date may not open to ECS.

ECS is also available to support people age 65 and older who are not eligible for Medical Assistance and do not meet the nursing facility level of care. There is no time limit for these screenings.

See Chapters 201.04, 201.07, and 201.10 for program eligibility requirements and how to complete the LTC screening document. The **CBSM manual** has additional information. See service agreement information in Session 15 of the **MMIS Training Series**.
Service Agreement Type Y

Service agreement type Y identifies the ECS program. Lead agency staff will enter this service agreement for their fee-for-service individuals, and any SNBC member enrolled with any health plan.

Tribal staff will enter this service agreement for their fee-for-service members and any individual enrolled with any health plan with SNBC, MSHO, or MSC+. The SACTAD field is completed.

For persons not case managed by a tribal agency and enrolled with MSHO or MSC+, the MCO will submit the service agreement to DHS for data entering unless there is an arrangement with a county or other delegate agency to enter the service agreement into the MMIS. NOTE: members enrolled with MSHO, MSC+ or SNBC products and transitioning directly from a previous waiver program to ECS will have a service agreement. These cases use program type 30 on the LTC screening document.

ECS Service Agreement Rules

1. The service agreement cannot begin prior to January 1, 2015.
2. A service agreement header may have a period up to twelve months but each individual line item is limited to six months.
3. The service agreement may overlap with a type B Home Care authorization for purposes of authorizing state plan services excluding PCA services. Individuals who are eligible for PCA are not eligible for ECS.
4. The person must be in the community with living arrangement code 80.
5. Services are limited to:
   - T1016 UC – case management
   - T1016 UC TF - paraprofessional case management
   - S5120 – chore
   - S5130 – homemaker
   - S5130 TF – homemaker with home management
   - S5130 TG – homemaker with ADL assistance
   - S5160, S5161, and S5162 - personal emergency response system
   - S5115 – family caregiver training and education
   - S5115 TF – family caregiver coaching and counseling
   - S5170 – home delivered meals
   - H2015 – community living assistance in person and remote
   - H2016 – community living assistance remote only
   - S5100 – adult day service 15 minutes
   - S5100 U7 – FADS adult day service 15 minutes
6. As of July 1, 2020, the monthly budget is $452.00 for months beginning July. The Total Cap Amount is this monthly budget multiplied by the number of months in the service agreement header period. The total budget cap will increase or decrease if the service agreement period is increased or reduced.
7. The service agreement does not include case management services for persons enrolled with managed care.

8. The total of case management and paraprofessional case management for persons opening to ECS with program type 29 on the screening document cannot exceed $600.00. The entire amount authorized will be included under the total budget cap.

9. The total for case management and paraprofessional case management for persons transitioning to ECS from the waiver program and from the nursing home using program type 30 on the screening document cannot exceed $1,200.00. $600.00 of the amount authorized for this service will be included under the total budget cap.

10. Claim payment for ECS services is through the MMIS and not submitted to MCO billers. New reason code 700 reminds providers not to bill the MCO.

11. Authorize Community Living Assistance H2015 by itself. H2016 is at least one day during the same time as H2015 (face to face) and both services approved with the same provider.

12. If a provider delivers both face-to-face (H2015) and remote (H2016) on the same day, the provider must bill the entire time of both activities under H2015. Providers must follow billing policy related to calculation of units.

301.26 Elderly Waiver Customized Living Authorization Process

The Department has required the use of the Residential Services (RSC) Tool to ensure service plans and rates for EW customized living services since January 1, 2010 to meet policy criteria. Beginning July 1, 2015 authorize the EW foster care services on the RSC tool when there is a rate change or at the person's next reassessment.

Lead agency staff cannot approve Customized Living Services (CLS) lines when entering new EW service agreements, or when adding CLS lines to existing EW service agreements in MMIS.

Lead agency staff will save the service agreements with suspended CLS lines. MMIS will automatically route the service agreement to DHS staff to audit against the RSC Tool for approval of the CLS lines. DHS will have up to five working days from the date the service agreement enters into MMIS to review CLS lines.

Instructions for Suspended Service Agreements

1. Initial suspended service agreement posts edits 140 and 414 on customized living services line item(s) T2031 or T2031 with modifier TG. Edit 414 prevents lines from being approved and will route the service agreement for DHS review when it is saved. While the lines can change to pend or deny by the worker, the line status must remain in a suspended (S) status for edit 414 to post.

2. Case managers may approve all other services except for CLS lines. A letter will be sent for other approved, pend, or denied services if the header status is a T. In order for
the service agreement to route to DHS for review of the CLS lines, the header status must be either S or T. All other edits except 140, 233, 414, informational, and forced edits, needs to be resolved. Follow the instructions on the edit text for 233.

3. Edit 414 routes the service agreement to DHS queue the following day. You can see that it has routed successfully by viewing the service agreement in inquiry (NOT C mode). The ASA1 screen will show CURR LOC/DT 584 (date) in the top right hand corner.

4. There are three outcomes from the review:
   - Approve line
   - Suspend line
   - Deny line

5. For suspended lines, DHS staff will:
   - Make a determination that the workbook does not support the service agreement line item(s).
   - Add the county of service code to the OVR LOC field on the ASA2 screen in order to route the service agreement to the lead agency’s queue. See the DHS Comments Screen for more information.
   - Keep the header status as Suspend (S), or Partially Suspended (T) for other approved lines.

6. Case manager checks for the service agreement in their agency queue or in inquiry mode using the PMI number or authorization number. If the ASA1 screen has CURR LOC/DT (agency’s 3 digit code) (date) in the top right hand corner, the review was completed. For non-approved CLS lines:
   - Check the DHS Comment Screen for an explanation.
   - Make corrections to the workbook and/or service agreement. Resubmit a new or corrected workbook as needed two days prior to correcting the service agreement.
   - Keep the CL line(s) on the service agreement in a suspended status.
   - Remove your agency code from the OVR LOC field on the ASA2 screen
   - Edit 414 posts to allow the service agreement to re-route to DHS for review.
   - Header status must remain in Suspense or Partially Suspended.
   - Add a message to the DHS Comments Screen identifying the correction.
   - Save the service agreement.
   - DHS staff has up to five working days to review.

Instructions for Adding CLS to Approved or Pended Service Agreements
1. The approved or pend service agreement posts edits 414 and 140 on CL line item(s) T2031 or T2031 with modifier TG. Edit 414 prevents approval of lines.

2. Case manager must change the header status to T from A, or change to S from P. Keep the CLS line items in a suspended status. Correct all edits except for 414, 140,
informational, or forced statuses. If edit 233 posts, follow the instructions on the edit text. Save the service agreement which routes to the DHS queue overnight.

3. Apply instructions beginning with item 3 above to these service agreements.

See Session 19 in the MMIS Training Series on this process.

301.27 Program Service Codes, Units, and Rates. COLA Process for July 1, 2020
See the maximum service rates for all programs, the rate change for EW and AC home delivered meals as of July 1, 2020, and the MMIS COLA instructions for AC and EW service agreements.

301.28 Lead Agency Guidance for EAA Services
The Department of Human Services offers the guidance and tracking process below for Environmental Accessibility Adaptations (EAA) services for people accessing a waiver or the Alternative Care program. This guidance does not replace the process for approval of additional square footage, nor will it be a suitable guidance for all home modification projects.

1) Discuss the assessment and authorization process with the individual and any other appropriate parties, e.g. family, landlord. Ensure mutual understanding that the lead agency is required to review and prior authorize all home modification projects before performing any work.

2) Determine the need and appropriateness for a modification.
   a. Consider utilizing the EAA assessment to determine a person’s modification need(s).
   b. Determine the need for an assessment professional (occupational therapist, aging-in-place specialist, accessibility specialist, or physical therapist) throughout project, e.g.:
      i. Determine needs at beginning of project
      ii. Recommend the least costly option to meet the individual’s assessed need(s)
      iii. Support lead agency to review bids for appropriateness
      iv. Determine if the modification will meet the American’s with Disabilities Act (ADA) requirements. Reference: ADA Accessibility Guidelines
   c. Consider utilizing the Technology for Home grant for assistance.

3) Coordinate, review, and accept bid(s).
   a. Solicit bid(s) from providers appropriate to the work being performed, e.g. licensed contractor. Tips for hiring a contractor from the MN Department of Labor and Industry (DOLI) or the “Home Building and Remodeling” guide published by the MN Attorney General.
   b. Conditions for the accepted bid:
i. The accepted bid needs to be the most cost-effective to meet the person's need(s), which is not necessarily the lowest bid. For example, history of lower quality work or inability to promptly complete the project.

ii. Consider documenting agreement on the project with the person's landlord, as applicable.

iii. Request itemized bids to show the cost of materials.

iv. Determine the payment schedule (see #4).

v. Utilize a service purchase agreement for non-MHCP providers (tier 2 or 3).

c. Upgrades

The program can pay for the most cost-effective home modification. Persons may choose to upgrade materials as long as the item continues to meet the person's need(s), e.g., linoleum to marble tiles. They must pay the difference for materials and any additional labor out-of-pocket.

4) Hire a Provider

To ensure that the lead agency uses a reputable provider, consider doing either or both of the following:

a. Requesting and verifying the provider(s) references

b. Researching the provider(s) on Better Business Bureau, MHCP excluded provider lists, etc.

Verifying the provider has the credential and licensing necessary to complete the home modification project. For EAA provider standards and qualifications and other waiver and Alternative Care policy information, see

c. Community-Based Services Manual (CBSM)

d. MHCP Provider Manual

e. MN DOLI (verify residential building contractor licenses, certifications, registrations, and bonding)

If the lead agency hires a non-MHCP enrolled vendor, use a service purchase agreement. For more information, see CBSM – Tier 2 and tier 3 service purchase agreements.

5) Authorization in MMIS

a. Determine the payment schedule with the provider. The lead agency has the option to authorize the home modification project on multiple lines in MMIS. Doing so may help the lead agency oversee the project's integrity. For example: (if full payment is not upon completion and inspection). For example:

   i. Line 1: materials and permits
   ii. Line 2: down payment
   iii. Line 3: completion and inspection, or final payment

b. Initially, approve Line 1 for materials and permits.

c. Maintain MMIS Lines 2 and 3 for later payment in pending status until work is completed and verified, e.g., city inspection, assessment professional, or person verification.

d. The time span for multiple MMIS lines cannot overlap.
6) Provider Integrity
   a. Building Official designated by the municipality to make a complaint against contractor’s license.
   b. MN Department of Labor and Industry, 651-284-5069 or 800-657-3944 to make a complaint against contractor’s license.
   c. DHS Member and Provider Services Division, 651-431-2700 or 800-366-5411 to report a complaint or concerns about provider qualifications.
   d. Minnesota Fraud Hotline, (651) 431-2650 or 800-657-3750 to review if fraud has occurred.
   e. County attorney to make a claim against the contractor’s bond and assist with restoration costs.
   f. Better Business Bureau, 651-699-1111 or 800-646-6222 to determine if other complaints have been filed.
   g. Home Building and Remodeling guide published by the MN Attorney General.

7) Waiver Policy Questions and Consultations
   a. Disability and Aging PolicyQuest
   b. MHCP Provider Call Center
   c. Disability Services Division Response Center (only disability waiver questions)

DHS launched an online training for lead agencies, providers, and DHS-enrolled construction companies providing the tools and resources to complete a safe and effective home modification project. This training focuses on the EAA home assessment and home installation available on the waivers and Alternative Care programs.

In this course, you will learn:

- Ways to determine if a home modification meets a person’s health and welfare or disability-related need(s)
- The value of a home modification assessment, as well as when and where to obtain one
- Best practices for case managers/care coordinators to help the person and household members navigate the construction phase of the home modification project
- What to consider if a person requires more than one modification to continue to live in the community
- Common scenarios, processes and best practices
- What you know already and what you can learn from this training (e.g., using mini quizzes).

The course is available online at TrainLink – EAA: Home Modification.
Chapter 4

401.01 Resources

Publications, Forms, and Resources Webpage

The Publications, forms, and resources webpage gives access to the following:

- DHS manuals including:
  - Community-Based Services Manual (CBSM)
  - How to Enter the Long Term Care Screening Document into MMIS for the MSHO and MSC+ Programs
  - How to Enter the Health Risk Assessment Screening Document into MMIS for the SNBC Program
  - Guidelines to the Investigation of Vulnerable Adult Maltreatment
  - Minnesota Health Care Programs (MHCP) Provider Manual
- Bulletins from the last three years
- eDocs for DHS forms and brochures
- Email Subscriptions

Related LTCC, HRA, and HCBS Program Documents

View, retrieve, or print these forms from the DHS webpage through eDocs. This is not a complete list of forms used by lead agencies in managing and administering HCBS programs.

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Form Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHS-2497</td>
<td>Long Term Care Consultation Brochure</td>
</tr>
<tr>
<td>DHS-3361</td>
<td>Nursing Facility Level of Care Brochure (people under age 21)</td>
</tr>
<tr>
<td>DHS-3428B</td>
<td>AC, BI, CADI, EW Case Mix Classification Worksheet</td>
</tr>
<tr>
<td>DHS-3428C</td>
<td>MN Long Term Care Consultation Services Form: Supplemental Form for Assessment of Children Under 18</td>
</tr>
<tr>
<td>DHS-3426</td>
<td>Level 1: Screening for Mental Illness or Developmental Disability</td>
</tr>
<tr>
<td>DHS-3427</td>
<td>LTC Screening Document: AC, BI, CAC, CADI, ECS, EW, MHM, MSC+, MSHO</td>
</tr>
<tr>
<td>DHS-3427H</td>
<td>Health Risk Assessment Screening Document: MSC+, MSHO, and SNBC (by visit)</td>
</tr>
<tr>
<td>DHS-3427HQ</td>
<td>Health Risk Assessment Screening Document by Telephone or Mailed Survey</td>
</tr>
<tr>
<td>DHS-3427T</td>
<td>LTC Screening Document: Telephone Screening</td>
</tr>
<tr>
<td>DHS-3428</td>
<td>MN LTC Consultation Services Assessment Forms</td>
</tr>
<tr>
<td>DHS-3428A</td>
<td>MN LTC Consultation Services Assessment Forms</td>
</tr>
<tr>
<td>Form Number</td>
<td>Form Name</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>DHS-3428D</td>
<td>Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan</td>
</tr>
<tr>
<td>DHS-3428H</td>
<td>Minnesota Health Risk Assessment Form</td>
</tr>
<tr>
<td>DHS-3428Q</td>
<td>Person’s Evaluation of Foster Care, Customized Living, or Adult Day Service</td>
</tr>
<tr>
<td>DHS-3548</td>
<td>AC Client Disclosure Form</td>
</tr>
<tr>
<td>DHS-3214A</td>
<td>Notice about Your Rights and Responsibilities for the Minnesota Senior Health Options</td>
</tr>
<tr>
<td>DHS-4166</td>
<td>Electronic (updateable) Community Support Plan</td>
</tr>
<tr>
<td>DHS-4801</td>
<td>Referral for an AC Estate Claim</td>
</tr>
<tr>
<td>DHS-7028</td>
<td>Nursing Facility Level of Care Criteria: Determining Service Eligibility for Medical Assistance Payment of Nursing Facility Services and Home and Community-Based programs</td>
</tr>
<tr>
<td>DHS-2828A and B</td>
<td>Long-Term Services and Supports Notice of Action</td>
</tr>
<tr>
<td>DHS-6633A</td>
<td>CDCS Community Support Plan Addendum</td>
</tr>
<tr>
<td>DHS-3956</td>
<td>Elderly Waiver Conversion Rate Request</td>
</tr>
</tbody>
</table>

**Adults**

The [Adult webpage](#) includes the following:
- Adult protection
- Deaf and hard of hearing
- Seniors
- People with disabilities

**CountyLink**

- [CountyLink](#) for counties and tribes

**Email Subscriptions to Listservs**

DHS provides [subscriptions](#) to public email lists. This page shows the Aging and Adult Services Lead Agency listserv which provides information about the Elderly Waiver, Alternative Care, Essential Community Supports, and LTCC programs as well as new bulletins, policy information, and MMIS changes.

You can also register for the Aging and Adult Services Video Conferencing listserv to receive announcements of new video conference training sponsored by the Aging and Adult Services division.

**Aging and Adult Services Division (AASD) Trainings**

The AASD suspended the video conferences for the remainder of 2020. Online modules accessible through TrainLink provide instruction on using the MMIS for the LTC screening document and service agreement. More information to access these trainings is on the [Aging Training](#) page.
Community Supports for Seniors eList
Subscribe to this eList to receive notices. It is the primary way we communicate about our programs.

401.02 Alternative Care Program Resources

PFIN Screen
The PFIN screen in the Provider Subsystem provides each lead agency with the total claims paid under the county of financial responsibility (CFR). This AC-CAP-USED field amount updates every two weeks following the MMIS warrant payment. Use the provider number associated with provider type 45 (social services) on the Provider Key Panel screen and navigate to the PFIN screen to view this information.

Alternative Care Program Reports
The following reports are available through the state’s Infopac system.

<table>
<thead>
<tr>
<th>MMIS Infopac Report</th>
<th>Data Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN190 AC Overdue Premiums</td>
<td>By county of service and tribal agency, this report will identify AC persons who have past due fees. Exit those persons who have not paid their fees, or are not participating in a payment plan after 60 days of nonpayment.</td>
</tr>
<tr>
<td>R2208 AC Cumulative Service Encumbrance And Payment (Using Date of Payment)</td>
<td>Data by county; by procedure code, unduplicated person, total units encumbered, total units used, total amount encumbered, total amount used, total days in service agreement, total days eligible, county average cost per person, county average cost per unit, county average units per person.</td>
</tr>
<tr>
<td>R2457 AC Cumulative Service Encumbrance And Payments (Using Date of Service)</td>
<td>Data by county; by procedure code, unduplicated person, total units encumbered, total units used, total amount encumbered, total amount used, total days in service agreement, total days eligible, county average cost per person, county average cost per unit, county average units per person.</td>
</tr>
<tr>
<td>R2460 AC Cumulative Service Encumbrance And Payments (Using Date of Service)</td>
<td>Data by county; per person amount encumbered, amount paid, remaining balance, total days in service agreement, average monthly encumbered, average monthly paid.</td>
</tr>
</tbody>
</table>

Authorizing AC Discretionary Services
Approval by DHS is necessary for lead agencies to administer AC “other” services, which include discretionary services. Part D: AC “Other” Services of the budget worksheets is completed.

The PFIN screen on the Provider Subsystem also provides approved lead agencies with the current and previous years' total claims paid under X5527 for discretionary services. The DIS-AMT-USED amount updates every two weeks following the MMIS warrant payment.
See form AC Application for Discretionary Services DHS-5815 to apply for discretionary service funds.

401.03 Elderly Waiver Slot Allocation Process
Federal law limits the number of people served on the Elderly Waiver program. This includes those persons enrolled in the MSHO and MSC+ programs using EW services. DHS developed a process to remain in federal compliance for not exceeding the maximum number of program participants during each waiver year. The program remains open until the Department closes it.

MMIS Tracking Process
A LTC screening document opening a person to the Elderly Waiver program using assessment result 01 (initial opening) or 10 (program change) will receive edit 269 indicating the program is still open for new people. It counts this person toward the maximum statewide cap amount for the year beginning July 1 based on the effective date.

When exiting the program, the person retains their allocation until June 30 of the current year in which they lose their "slot". If the person was reopened to the program using assessment result 11 (reopening to program) before June 30 they retain the same allocation and edit 268 posts.

There are three ways that the program can accept additional people:
1) Any approved screening document with an exit type 25 (waiver services will not be used) will allow that slot to be re-used immediately; or
2) DHS petitions the federal auditors to serve additional persons; or
3) All persons that exited from the program in the previous waiver year and did not reopen again before the end of the current waiver year will lose their slots when the new waiver year begins. These slots reassign in the new waiver year beginning July 1.

There are several factors by lead agency staff which cause this process to be inaccurate. These are:

1) Exit screening documents not entered and/or approved in a timely manner.
2) Reassessment 25 (exit, waiver services will not be used) is not used in those cases where the opening screening document was entered by mistake or the person did not use any services. Using a different exit code does not allow reusing that slot immediately.
3) The approved opening or reopening screening document has the wrong county of financial responsibility. The CFR on the major program MA span on the Recipient Subsystem carries over to the screening document. If the wrong CFR is used, that person does not show on the correct lead agency’s reports. You can check the CFR on the ALT1 screen of the opening or reopening screening document. If incorrect, the financial worker needs to
make the correction to the RELG screen. The opening or reopening screening document needs deletion and a new document entered after correction of the CFR on the RELG screen in order for the person to show on the correct lead agency’s report.

**Screening Document Edits for EW Waiver Slots**

Screening document edits assist in the accurate processing of counting participants.

**Edit 269 - Open to Elderly Waiver (Informational status = 6)**

New screening documents which have an opening assessment type (or reopening if the assessment date is in a different waiver year from the exit date) will post this informational edit during the time that the program is accepting new persons. Persons count for the current waiver year based on a current open eligibility span. The process does not take into consideration diversions and conversions, so no assignment of a new slot if they should later change from one type to another.

Screening documents that request a higher conversion case mix level by increasing the Case Mix Amount or CDCS Amount fields or, increasing these fields when the PCA Complex field = Y (except for managed care screenings) will continue to first post edit 784 (Case Mix/BIW Screening Document Requires Approval), remain in suspense, and route to DHS staff for approval. When approved, edit 269 will post if the program is open.

**Edit 268 - Reopened in Same Waiver Year as Closed (Informational status = 6)**

This edit will post on those screening documents when the reopening effective date is in the same waiver year as the exit effective date. No new assignment but the person keeps the same slot.

**Edit 270 – Waiver Slots Not Available (Deny status = 3)**

This edit posts when EW program closes because the number of people have met the maximum number allowed during a waiver year.

**Daily Report MW2216 – EW Slot Allocation Master List**

This report sorts by each county of financial responsibility and tribal agency. It identifies the PMI number, person’s name, assessment result (the last opening, reopening, reassessment, or exit), and last assessment (effective) date for each person on the program for the current waiver year.

Whenever the person exits from the program, a “Y” shows in the DEL IND column that signifies removal from the program at the end of the waiver year because the person has exited from the program.

Staff should use this report to check for two things:
1) That each person on the report are currently on the program and receiving services. People who are on this report who are no longer open to EW should have an exit screening document entered and approved.

2) Persons who are missing from the report or are not the financial responsibility of the lead agency may have the wrong CFR listed on the ALT1 screen of their opening or reopening screening document. Check this screen in MMIS. If incorrect, the financial worker will need to make changes to the RELG screen. In order to record the correct CFR on the opening or reopening screening document and allow the person to show for the correct lead agency, the document would need to be deleted and a new document entered after the CFR correction is made.

**Screening Document Scenarios**

Below are examples of different cases and the corresponding edits and reports.

Person #1 has an opening or reopening screening document. The program is open. Screening document will post edit 269. Person added to report 2216.

Person #2 exits from the program. They will remain on report 2216. A “Y” indicator shows that the person removal from the report at the end of the waiver year (June 30) if they do not reopen to the program prior to the end of the waiver year.

Person #3 is reopening during the same waiver year that they exited. Screening document will post edit 268. Person remains on report 2216 and the “Y” indicator removed.

Person #4 is reopening to the same waiver program that they exited from in a previous waiver year. Screening document will post edit 269. Person added to report 2216.

### 401.04 Program Management Reports

These reports are available for viewing online using Infopac. Most agencies can also print the reports at their offices. Infopac holds a history of past report versions and allows the printing of the entire report, selected pages, or a custom design of pages. The report is a "snapshot" of data and no changes allowed to the data or the date parameters.

The ability to print at each agency is dependent on the availability of a suitable printer. If you are interested in viewing or having the reports print directly at your agency, contact your Infopac administrator.

<table>
<thead>
<tr>
<th>Report Number</th>
<th>Report Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N821-RN190</td>
<td>AC Overdue Fees</td>
<td>This is a monthly report for the county of service and tribal agency available on the first and sixteenth of the month. It lists</td>
</tr>
<tr>
<td>Report Number</td>
<td>Report Name</td>
<td>Description</td>
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</tr>
<tr>
<td>N822-RN193</td>
<td>AC Person Information</td>
<td>This is a monthly report for the county of service and tribal agency available on the ninth day of the month. It lists Alternative Care persons who are obligated to pay a fee.</td>
</tr>
<tr>
<td>941A-R2083</td>
<td>Service Agreement/Procedure Code Rate Change</td>
<td>This is a report produced whenever MMIS automatically changes a service rate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Report R2083A shows changes to the disability waivers, Elderly Waiver, and Alternative Care programs.</td>
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<tr>
<td></td>
<td></td>
<td>- Report R2083B identifies changes to the DD program service agreements.</td>
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<tr>
<td></td>
<td></td>
<td>- Report R2083H identifies changes to the Essential Community Supports (ECS) service agreements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff will use this report to identify changed service agreements due to a &quot;COLA&quot; rate change mandated by the legislature. Check line items for accuracy and re-approval.</td>
</tr>
<tr>
<td>PWMW9332-R2086</td>
<td>Service Agreements for Providers with Category of Service, Specialty, and/or License Codes Error</td>
<td>This daily report is not a cumulative report. It identifies those service agreements which have a line item with no supporting category of service, specialty, and/or license code for the provider on the line item.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The “A” report is for the AC, BI, CAC, CADI, and EW programs. The “B” report is for the DD program. The “G” report is for the MHM program. The “H” report is for the ECS program.</td>
</tr>
<tr>
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<td>It is sorted by the SACTAD field, and if blank, by the county of case manager. If there is no case manager on the service agreement, sorting is by the COS for EW and AC</td>
</tr>
<tr>
<td>Report Number</td>
<td>Report Name</td>
<td>Description</td>
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<td>programs or the CFR for the disability programs. Case managers must check the PCOS screen (for COS code), the PPGM (for specialty code), or the PLIC (for license codes) and/or contact the provider to determine if the line item period should be adjusted or denied. Future line items automatically change the status from “approved” to “pend”. See the Automated MMIS changes to Provider Records instructions in Chapter 301.12.</td>
</tr>
<tr>
<td>9200-R2208</td>
<td>AC Cumulative Service Encumbrance and Payments (using date of payment)</td>
<td>This is a monthly report for the county of financial responsibility and tribal agency. It lists the cumulative encumbrance and payments of each procedure code as of the date of payment. Use this report to determine the total encumbered and/or paid amounts for each service during the reporting period, and to compare your county average with the state average amounts.</td>
</tr>
<tr>
<td>9061-R2216</td>
<td>EW Slot Allocation Master List</td>
<td>This is a daily report sorted by the county or tribal of financial responsibility. It should be used by the EW case managers to check that each of their persons are listed on this report, and persons who have left the program no longer show on the report. Each person on the report has a waiver “slot”. Those with a “Y” in the Delete Column are people who will keep their slot until the beginning of the new waiver year on July 1. Then, their slot is re-assigned.</td>
</tr>
<tr>
<td>9200-R2453</td>
<td>Screening Documents Approved</td>
<td>Screening documents approved within the reporting period for the case manager or health care coordinator listed on the screening document. It is not a cumulative report. This monthly report sectioned by the LTCC county field from the LTC screening</td>
</tr>
<tr>
<td>Report Number</td>
<td>Report Name</td>
<td>Description</td>
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<td>document, then by the case manager or health care coordinator name when the case manager field is populated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This report, used to track when screening documents were data entered and approved, and if a service agreement entered with the screening document's effective date.</td>
</tr>
<tr>
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<td></td>
<td>If the last claim payment date is very old, the provider(s) may be having problems submitting claims or the person is no longer receiving services.</td>
</tr>
<tr>
<td>9200-R2455</td>
<td>Suspended LTC Screening Document</td>
<td>This is a weekly report for the county, tribal agency, health plan, or county based purchasing entity associated with the case manager number. The report goes to the county identified in the LTCC County field if the case manager field is blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It identifies the screening documents that are in suspense for more than two weeks and the number of days since they were data entered. Either delete the screening document or enter a new document that corrects the problem that is keeping the document in suspense. This is a cumulative report.</td>
</tr>
<tr>
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<td>See Session 12 of the MMIS Training Series for instructions on how to find these documents in MMIS.</td>
</tr>
<tr>
<td>9200-R2457</td>
<td>LTC Cumulative Service Encumbrance and Payments (using date of service)</td>
<td>This is a monthly report for persons with a service agreement. It is sorted by: • the county of financial responsibility for all waiver and Alternative Care programs • all health plans with persons using Essential Community Supports services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It lists the cumulative encumbrance and payments of each procedure code as of the service date. Each program has a section for the current and past year. Use the report to determine the total encumbered and/or paid</td>
</tr>
<tr>
<td>Report Number</td>
<td>Report Name</td>
<td>Description</td>
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<tr>
<td>---------------</td>
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</tr>
</tbody>
</table>
| 9200-R2460    | Cumulative Encumbrance and Payments (using date of service) | This is a monthly report for persons with a service agreement. It is sorted by:  
|               |             | • the county of financial responsibility for all waiver and Alternative Care programs  
|               |             | • all health plans with persons using Essential Community Supports services  
|               |             | It lists the cumulative encumbrance and payments by person by program as of the service date. Each program has a section for the current and past year. Use the report to track the total encumbrance for each person against the total amount of claims that were paid on their behalf. |
| 9200-R2488    | AC Cumulative Service Encumbrance and Payments (using date of payment and by provider) | The report, sorted by provider name and number, runs on a biweekly basis in response to the MMIS provider pay-run cycle. Sort is alphabetically by the county of financial responsibility and tribal agency.  
|               |             | It is available for use by local AC program administrators to monitor and track provider billing and payment patterns, and to provide quality assurance oversight on the level of provider services delivered. Providers may submit claims up to 365 days from the date of service. |
| PWMW185L-R0504 | PPHP Current Enrollment Report for Worker | This report generates after capitation to report data for the next month. It sorts by financial worker service location and financial worker ID. Use the report to identify people in the servicing county who enroll with managed care. |
| PWMW1850-R0506 | PPHP Potential Enrollee Report | This report generates data after capitation and reports data for the next month. Sorting is by financial worker service location and financial worker ID.  
<p>|               |             | It identifies those people in the financial worker’s caseload of persons not currently |</p>
<table>
<thead>
<tr>
<th>Report Number</th>
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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>enrolled in managed care nor have an enrollment exclusion reason. In addition, the report includes people with an exclusion reason of YY (delayed or pending decision) or WW (delayed enrollment – new conversion counties only) for over 90 days. It assists enrollment staff with providing enrollment materials and assistance.</td>
</tr>
<tr>
<td>PWMW185L-R0507</td>
<td>MSHO/MnDHO/SNBC New Enrollee Report</td>
<td>This report generate data after capitation and identifies people who enrolled in managed care (MSHO, MSC+, and SNBC) for the following month. It is sorted by the service location and then by health plan. Use the report to identify new enrollees who are also on a waiver or Essential Community Supports program.</td>
</tr>
<tr>
<td>PWmW186D-R0510</td>
<td>Pre-capitation/Capitation Error Report (County/MCRE)</td>
<td>This report identifies members whose enrollment spans will close by MMIS for the upcoming month. Financial workers need to review the cases prior to enrollment cutoff or capitation to make the necessary updates for those cases that should continue. It is sorted by the county of service and then by financial worker ID.</td>
</tr>
<tr>
<td>PWMW185J-R0535</td>
<td>PPHP County Elderly Disenrollment Report</td>
<td>This report generates data after capitation and reports data for the following month. Sorting is by financial worker service location and financial worker ID. It shows elderly members who dis-enrolled from managed care and the reason of disenrollment. Workers may use this report to determine if the person may be eligible for Elderly Waiver, Essential Community Supports, or Alternative Care services. Please note that some persons may have dis-enrolled due to death.</td>
</tr>
<tr>
<td></td>
<td>Person Eligibility Changes</td>
<td>It is imperative that case managers and care coordinators timely notified of eligibility changes for persons receiving case management services.</td>
</tr>
</tbody>
</table>
Changes in eligibility have an impact on home and community based services, care planning, and service delivery. This report is another tool to provide that information. This report will not replace the Case Manager/Financial Worker Communication form DHS-5181.

- The report is not cumulative
- It is sorted by the case manager or care coordinator provider number
- Labeled “Report” and placed in the CML folder of the following MN-ITS accounts:
  - Provider type 23 case managers – sent to the county or tribal lead agencies’ MN-ITS mailbox
  - Provider type 27 health care coordinators – individual MN-ITS mailbox.
- Includes a page to explain data and suggest possible actions.
- Provided on a weekly basis each Friday for persons with a change in one or more of the following:
  - Medical Assistance major program begin date, end date, or county of financial responsibility (CFR)
  - Alternative Care major program begin date, end date, or county of financial responsibility (CFR)
  - Medicare Part A and or Part B begin or end date
  - PPHP Enrollment begin date, end date, health plan, product ID, or disenrollment reason
  - Living Arrangement type, begin or end date
  - LTC Ineligibility type, begin or end date
  - Waiver type, begin or end date
  - Date of death

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<thead>
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  - Medicare Part A and or Part B begin or end date
  - PPHP Enrollment begin date, end date, health plan, product ID, or disenrollment reason
  - Living Arrangement type, begin or end date
  - LTC Ineligibility type, begin or end date
  - Waiver type, begin or end date
  - Date of death |