ALLEGHENY COUNTY
DEPARTMENT OF HUMAN SERVICES

OFFICE OF BEHAVIORAL HEALTH

CLIENT INFORMATION AND PAYMENT SYSTEM (CIPS)

BUSINESS PROCESS GUIDE

June 1, 2015
Version 1.0

CLIENT INFORMATION and PAYMENT SYSTEM
CIPS

Overview

CIPS providers will be able to:

- register new clients and look up relevant information for existing clients
- manage client demographics
- enter current diagnosis codes
- submit, adjust and void services rendered claims for their agency
- associate service offerings to a client receiving services from the agency
- review monthly invoices for claims information
- have new Master Provider Enterprise Repository (MPER) service offerings mapped automatically to CIPS
- email questions to: dhs-cipsproject@alleghenycounty.us

Terminology

Client ID Number is the number assigned to a client.

MCI (Master Client Index) Number is the Department of Human Services (DHS) client ID used across multiple areas of involvement (both internal and external).

Primary Provider is the responsible service coordination / case management service provider determined through the Primary Provider algorithm and will take the lead in crisis situations.

Services Rendered Claim is an encounter record describing a service provided to a specific client.

Diagnosis Code is an alphanumeric International Classification of Disease (ICD) code assigned to a specific diagnosis and used for claims and billing purposes.

CIPS user account is the personal account which will enable each user to access the system.

Service Offering is the combination of cost center, provider, and the physical location of a service (e.g. Administrative Management Services provided by the Department of Human Services at One Smithfield Street, Pittsburgh, PA) to which all services rendered claims are associated.

> Conversely, in MPER, service offerings are associated to a specific specialized service; therefore, an agency may have multiple service offerings in MPER which map to one CIPS service offering.

Specialized Service Code: A standardized procedure/service code to identify the service provided when reporting an encounter. (i.e. M0064 is used to identify “Medication visit- CRNP and PA service”).

Acronyms

AHCI: Allegheny HealthChoices, Inc.
CCBHO: Community Care Behavioral Health Organization
CCRI: Consolidated Community Reporting Initiative
CIPS: Client Information and Payment System
D&A: Drug & Alcohol
DHS: (Allegheny County) Department of Human Services
DSM: Diagnostic and Statistical Manual
eCAPS: Electronic Client and Provider System
EI: Early Intervention
FFP: Federal Financial Participation
HC: HealthChoices
ICD: International Classification of Disease
ICF: Intermediate Care Facilities
MA: Medical Assistance
MCI: Master Client Index
MH: Mental Health
MPER: Master Provider Enterprise Repository
OBH: Office of Behavioral Health
OID: Office of Intellectual Disability
SCU: Service Coordination Unit
SOID: Service Offering Identification (number)
SSN: Social Security Number

Client Data Conversion

Four (4) fiscal years of client data has been converted from eCAPS to CIPS. The following client information will be available in CIPS.

- Clients with a diagnoses
- Clients with services rendered
- Clients with SCU associations (active or closed) and who have had an
    - at least one service rendered
    - at least on diagnosis
    - an association to an SCU on or after July 1, 2014

If a closed (end-dated) SCU association was brought over from eCAPS, it should remain closed.

Historical data (2010 and prior) can be made be available upon request.

Searching and Creating Client ID Numbers

If a client has not been registered in CIPS (by another provider), the current provider can register a new client in CIPS. Before registering a new client, there will be a screen prompt to search for an existing client record in CIPS. Thorough searches are necessary to avoid duplication, that is, creating another client ID for a client. Multiple searches may be necessary to ensure the client is not already registered in CIPS. It is expected provider staff will be diligent in this task to avoid duplication.

If a client search reveals a match to an existing client record (a client ID number and information already exist in CIPS), the provider user will use that existing ID number to document the client's demographics, diagnosis code(s), priority group, and services rendered claims.

eCAPS Client ID converted to a new CIPS Client ID

Providers will be able to search for a client who was converted from eCAPS to CIPS by entering the letter **'e'** before the eCAPS client ID number on the Client Search Screen. The system will return the new client ID number that the provider will use going forward in CIPS.

The new batch process will require a CIPS client ID for all services rendered submissions. When a claim has been submitted with the eCAPS' client ID number instead of the CIPS ID number, the submitter will receive a warning. The subsequent batch report will provide the new CIPS client ID.

Provider Involvement and the Primary Provider Algorithm

Primary Provider

A primary provider is the designated entity responsible for ensuring that a client has his or her needs met through appropriate services. The primary provider assists the client during a crisis, during a hospitalization or incarceration, and either through direct treatment/services or by connecting the client to other/additional needed services on an ongoing basis. The primary provider is determined by an algorithm (Appendix A) that is based on a hierarchy of case management services defined below:

Community Treatment Team (CTT)
Family Based Mental Health
Service Coordination or Enhanced Clinical Service Coordination (ECSC)
Justice Related Services
Transition and Community Integration Services
Administrative Service Coordination

In the event no provider is identified by the algorithm as having provided any of the above services, and the client is unable to make his or her own selection of a provider, designated staff with the Office of Behavioral Health will review the client record/history of services to determine which provider will be the primary provider. If there is no history of services, the decision will be made by OBH staff according to what is most appropriate given the client's current circumstances.

- All MH providers will have the ability to view the MH primary provider for a client whether or not they have submitted services rendered claims for that client.
- Once they have entered a claim for a client, providers will have the ability to view all MH providers associated to a client.

- Providers will have the ability to view services rendered claims from all MH providers once they have submitted a services rendered claim.
- Providers will no longer be able to view services rendered claims from other MH providers if they have not submitted services rendered claims in the past six months.

Primary Provider Algorithm

An algorithm will calculate the primary provider during the following events:

- When a service rendered claim is submitted for a client via on-line or via batch submission of claims (837p professional).

- When the provider end dates its involvement as primary provider for a client.

- The algorithm will calculate who the primary provider is based on the next case management service(s) entered after the previous provider has end-dated its involvement as the primary provider.

CIPS will show a warning notification in the notification panel on the Home Page if there is one or more clients with whom the provider has involvement, but for whom no Base or HealthChoices service rendered claims have been submitted for the previous two (2) fiscal years. The warning notification will disappear once the provider has end-dated their involvement with the client (see appendix A) or once a new service has been reported.

Provider Involvement Scenarios

- If a client is brought over from eCAPS with an active SCU and the CIPS primary provider algorithm does not find a newer provider to associate, the active SCU is designated as the primary provider
- If the client is brought over with only a closed SCU affiliation and algorithm does not find a newer provider to associate
    - The client should choose their primary provider
        - If the client does not wish to have a primary provider
            - The OBH program office will make decisions as needed.
        - If the client chooses a primary provider
            - The primary provider would then provide a service and submit a service rendered claim in CIPS and the algorithm would automatically associate them as the primary provider.
- Client has no provider affiliation – the algorithm does not find a provider to associate
    - A client with no prior involvement receives a service after July 1
    - The provider who created a client is alerted that no diagnoses or services rendered have been entered.
    - Client chooses a primary provider which the algorithm will then automatically associate once the chosen provider enters a service in CIPS.
    - If the client had an SCU association prior to 2014 but was not part of the conversion (e.g. no services or no diagnosis)
        - Client will choose a primary provider and algorithm will automatically associate once the chosen provider enters a services rendered claim in CIPS.

- Provider will document the client's choice of primary provider.

Client Service History Screen

If the associated provider agency has provided any Mental Health services to the client within the last six (6) months, based on the service record end date for the client, the provider will be able to see all Mental Health service records. Drug & Alcohol services will not be visible in CIPS.

Entering Demographic information

All demographic screens should be completed upon initial registration. *It is the responsibility of **each** provider who is serving a client to **maintain current demographic information in CIPS**.*

There are several mandatory fields that must be entered to save information on each screen though not all demographic information is mandatory. However, completing all known/applicable demographic fields is strongly recommended as will prevent the need for later client cleanup activities due to CCRI reporting requirements.

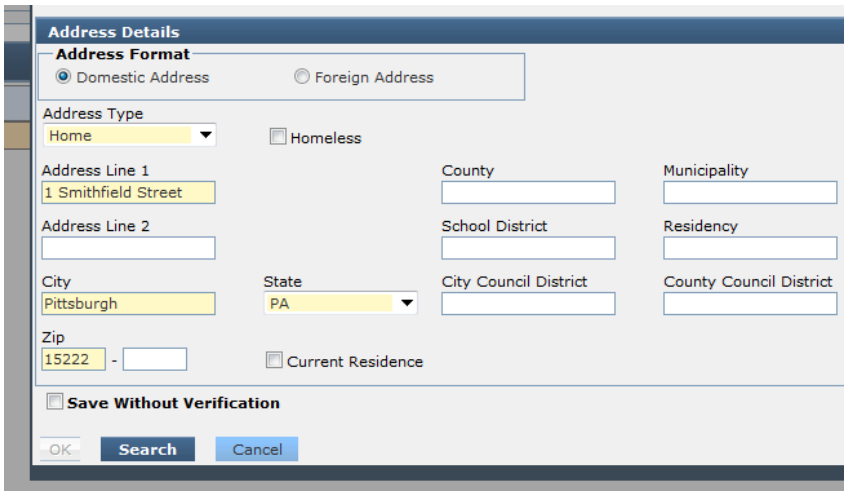
DHS is required by the state to report the following client information for CCRI.

CCRI FIELDS:

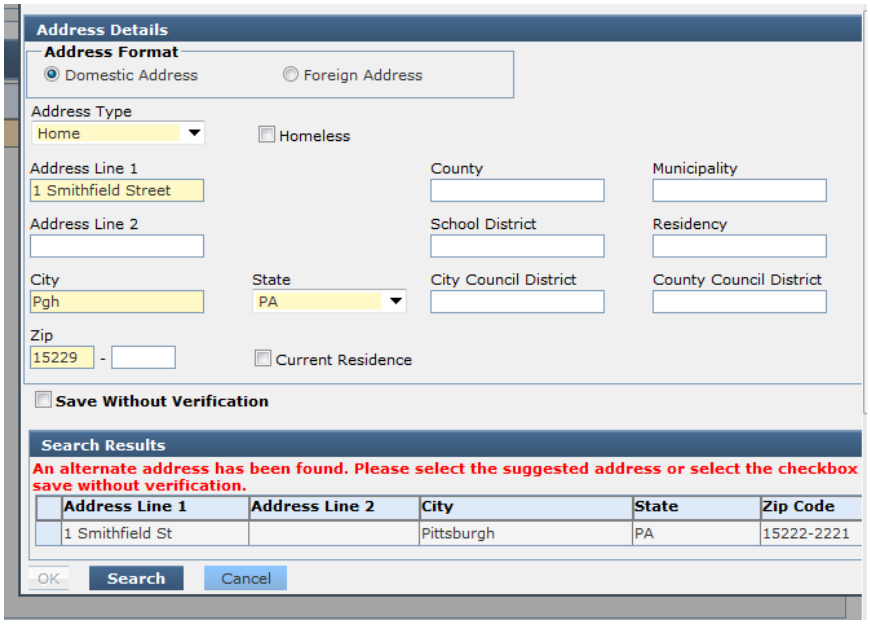
- Social Security Number (SSN)
- Last Name
- First Name
- Citizenship Status
- Race
- Date of Birth
- Living situation
- Living Situation qualifier (child residence) – depending on the Living Situation selected
- Living Situation qualifier (private ICF/ID) – depending on the Living Situation selected
- Language
- Priority Group
- Education and Vocational Status
- Veteran Status
- Marital Status
- Address
- State
- Zip Code
- Address Type
- Effective Address Begin Date

CIPS is designed to check fields identified as CCRI-required left vacant and display a warning message on the home page. To avoid warning messages listing regarding missing CCRI information; the provider user should update the fields whenever there is new or more accurate information. (See screenshots)

Address information should be maintained by each provider serving a client. Do not use the 'Save Without Verification' button unless the 'Search' button is clicked first.



If an alternate address has been found, and the address suggested is the correct address, select the correct address by clicking into the row which shows the correct address. If the suggested address is not the correct address, and it has been confirmed to be the client's correct address, ONLY then should 'Save without Verification' be used. *



*When 'Save Without Verification' is used *before* conducting an address search, the County, Municipality, School District, Residency etc. codes do not populate (fields cannot be entered manually). These fields are required for CCRI reporting. A report will be generated each month for each provider identifying the missing information. Providers will be notified of the missing fields and asked to supply the information needed.

Entering a Diagnosis Code

A provider with a relevant/current diagnosis code for the client should enter it along with the priority group on the diagnosis screen and on the services rendered screen whenever submitting services rendered claims.

- All providers submitting services rendered claims should use ICD-9 CM codes to report services that occurred prior to October 1, 2015.
- All providers submitting services rendered claims should use ICD-10 CM codes to report services occurring on or after October 1, 2015.
    - Providers will have access to view historical diagnoses from mental health assessments and services rendered.
    - Diagnoses entered in eCAPS/CIPS for services/assessments prior to October 1, 2015 using ICD-9 or DSM-IV will not automatically convert to ICD-10. Provider will have to determine and enter the appropriate ICD-10 code.
    - If a provider cannot determine an ICD-10 diagnosis code for a services rendered claim dated after October 1, 2015, please refer to the Center for Medicare and Medicaid Services General Equivalence Mappings (GEMs):

      http://www.cms.gov/Medicare/Coding/ICD10/2014-ICD-10-CM-and-GEMs.html

    - Claims will not be accepted without a current diagnosis code.

The system CIPS will show a warning in the notification panel on the home page if there is a deferred diagnosis in the current diagnosis set with a prompt requiring an update to the diagnosis code. A deferred diagnosis code cannot be entered if there is a valid diagnosis code previously entered.

Entering a Priority Group

The services rendered claim will be ***rejected*** if the client's MH Priority Group is missing and it has been ***more*** than 45 days between the client's start date and the service rendered start date.

The service rendered claim will be ***accepted*** if the client's MH Priority Group is missing, and it has been ***less than or equal*** to 45 days between the client's start date and the service rendered date. However, a warning message will be generated to inform the provider user that future service rendered records **will be rejected unless the Priority Group is entered.**

If a client has been associated with multiple providers, the 45 day grace period is calculated based on the client's **earliest start date**.

Adult and Child & Adolescent Mental Health Target Population descriptions can be found on the following site:

http://www.vbh-pa.com/provider/info/poms/dpwinstruction.pdf

Service Offering Mapping

When a provider creates a new service offering ID in MPER, the service offering will automatically map to CIPS. *The request will no longer have to go through the Service Desk.*

- All existing eCAPS service offering IDs will be converted and remain the same in CIPS.

- When a new service offering is created in MPER for an existing facility and can be associated to an existing CIPS service offering ID, it will be mapped by the system (e.g. when adding a new specialized service to an established CIPS service offering ID)
- When a new facility and service offering ID is created in MPER, it will be mapped by the system and assigned a new service offering ID number in CIPS.
- If a new facility is created and there are multiple service offering ID's created in MPER that are associated with one cost center all of those will be assigned to one new service offering ID number in CIPS.

Associate a Client to a Service Offering

Before a provider can submit service rendered claims for a client, the client must be associated to a provider's CIPS service offering (service and location site) using the Client Service Offerings screen.

Submitting Services Rendered Claims

Providers can submit services rendered claims through the 837p batching process and/or on-line directly into CIPS. Submitting services rendered will no longer be a two-step process.

Changes to services rendered batch processes are listed below:

- Create a Provider Claim ID – this user-created claim ID can be used to trace services back to the original system of record and/or identify any changes to original claims.
- Providers submitting the 837 claims submission file must have the ability to indicate the type of record:
    - Original – specifies that the claim record is a new/original record.
    - Adjustment – specifies that the claim record is an adjustment to a previously processed record. A record with this indicator must have an existing provider claim ID that matches the record being adjusted.
    - Void – specifies that the original claim is being voided. A record with this indicator must have an existing provider claim ID that matches the record being voided.
- **Please email dhs-cipsproject@alleghenycounty.us if you have any questions about the 837p batching process.**

A services rendered claim must be submitted for ***each date*** the client received a service(s). For example, if the client received a service on July 5, 9, and the 20, this requires three separate entries.

- A copy function, for on-line submissions, is available to submit multiple dates for services rendered claims within the same month.

FFP- Federal Financial Participation

Providers will have the ability to indicate any claim as an FFP claim in 837 Batch submissions. If the claim is indicated as an FFP claim, the provider has to enter the FFP rate. The system will compare the FFP rate entered by the provider with the rate in the Rate Card and process the payment with the lower of the two rates.

Providers will also be able to indicate any claim as an FFP claim on the Services Rendered screen in the CIPS application by checking the FFP Claim check box. If any claim is indicated as an FFP claim, the provider has to enter the FFP rate. The system will compare the FFP rate

entered by the provider with the rate in the Rate Card and process the payment with the lower of the two rates.

A client should be MA eligible for FFP claims. Please refer to the website address below for further information about FFP claims:

http://www.dhs.state.pa.us/publications/forproviders/remittanceadvicealertspromisebannerpages/C_102054

MA Eligibility Check

CIPS will check for a client's MA enrollment before processing the claims for payments. Claims will be uploaded to the State Client Information system through a process called "270/271 data exchange".

If a client has MA, CIPS will reject all MA reimbursable claims for that client. The providers should bill MA for reimbursement for the rejected claims. The system will check for retro-eligibility up to 90 days from the date of service, so that providers can meet 180 days timely filing requirement to bill MA.

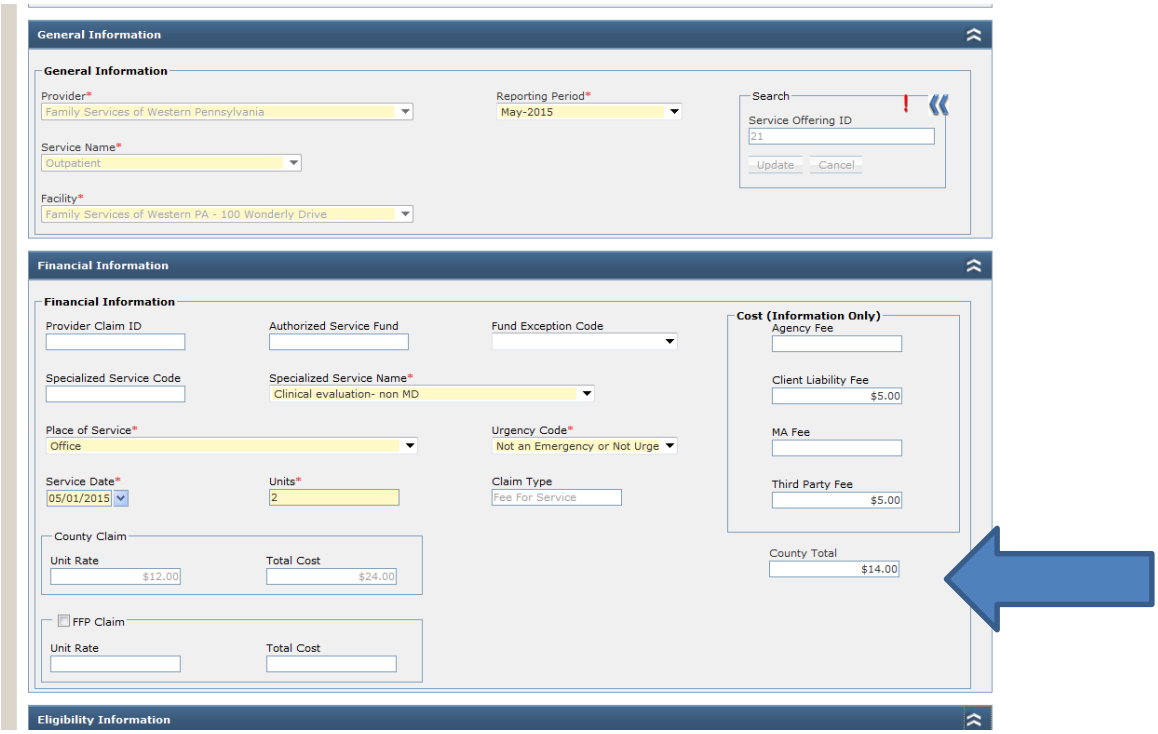
HealthChoices Eligibility Check

CIPS will check for HealthChoices (HC) Eligibility. DHS will get an HC Eligibility file from AHCI. Claims will be checked for HC eligibility and reject claims for services to be paid by HC (CCBHO).

Payment Process

There are currently three (3) payment scenarios in CIPS as follows:

1. All claims with no adjustments will be paid at the rate maintained by DHS in a Rate Card.
2. If a claim is marked as FFP, as discussed above, the system will compare the FFP rate entered with the rate in the Rate Card and process the payment using the lower of the two rates.
3. Providers will be able to enter the client liability received, and private health insurance information as shown below. The provider should also enter the Total Amount Due for these claims in the Total field which is a free text field. If an amount is entered in this field, the system will calculate the payment amount by multiplying the rate from the Rate Card and the number of units entered; comparing it with the amount entered by the provider and paying the lower of the two totals. (See screenshot)



Submit Services Rendered Claims by 10th of each month

- Claims should be submitted by the 10th of the month in order to be processed on the 15th of the month.

Timely Submissions of Services Rendered Claims (90 day cut-off date)

- The services rendered claims cut-off date is now 90 days from the date of service. If the current date is later than the 90 day cut-off date, the claim will be put 'on hold' status. The claim will not be processed for payment unless authorized by DHS/OBH. Providers should request a waiver of timely filing for these claims.
- Program funded services will not be put 'on hold'.

Year-end closing for FY 14-15:

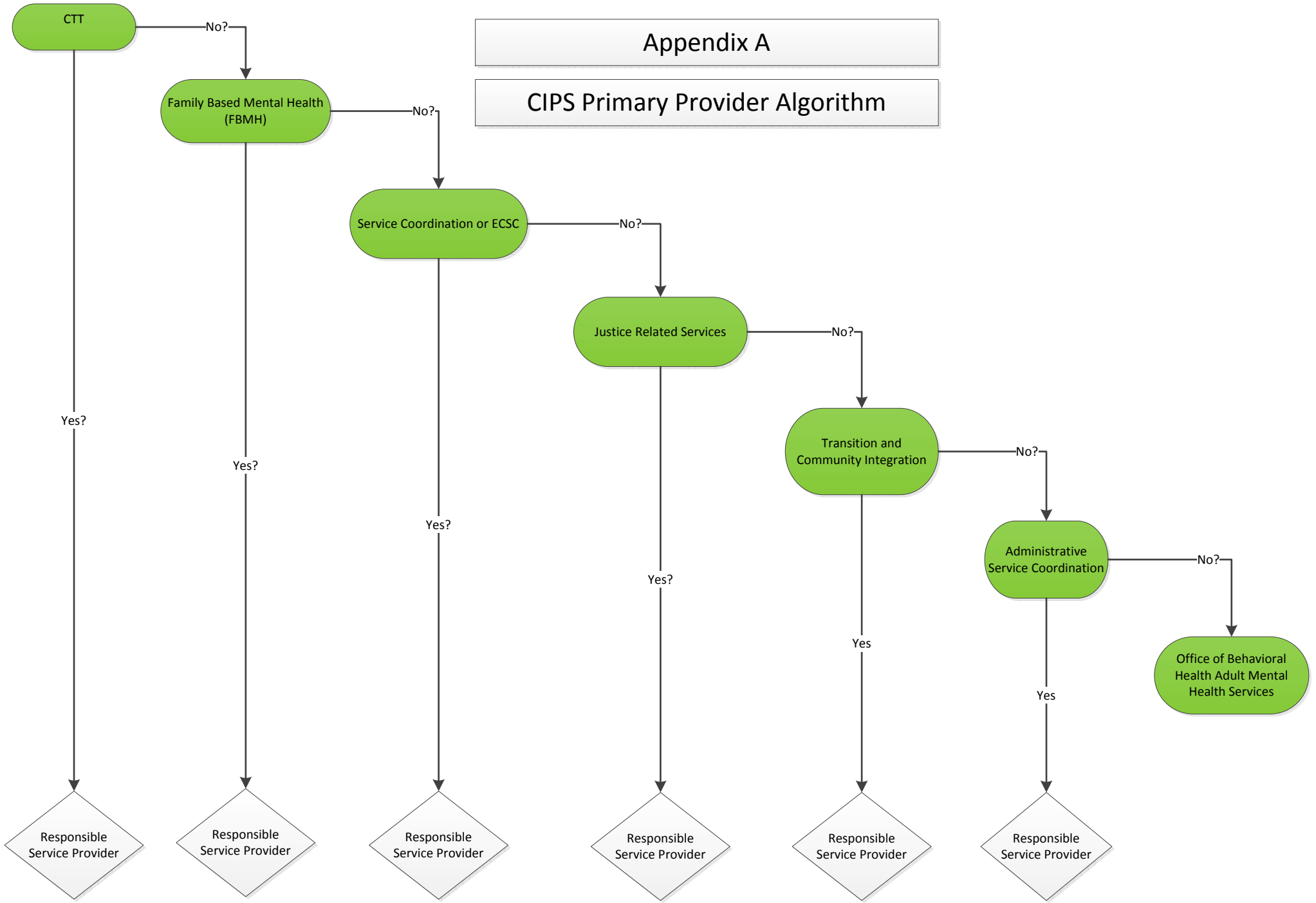
- Providers will be able to submit FY 14-15 services rendered claims in CIPS beginning July 1, 2015.
- Providers can submit FY 14-15 claims until December 31, 2015.
- DHS Fiscal will be using the August 8 run date report to close the FY 14-15.
- All of the reports will be generated from CIPS only.

Year-end closing cut-off is December 15:

- The services rendered claims submission batch will accept original services rendered claims and put them on hold status if they are received beyond year-end closing. i.e., service rendered start date is in the previous fiscal year and current date is after December 15 of the following the fiscal year.
- The claims submission batch will accept adjustment/void records and put them on hold status if they are received after the cut-off date.
- The claims/payment processing batch will not pick up records in on hold status.

Appendix A

CIPS Primary Provider Algorithm



5/29/15