Provider Network Council (PNC) Minutes
Community Mental Health of Ottawa County
Microsoft Teams
Thursday, March 28, 2024, 1:30pm-3:00pm

PNC Purpose Statement

This Council's purpose is to discuss and prioritize issues related to the CMHOC Provider Network. This type of forum will assure that there is a common and consistent message going out from CMHOC to the provider network.

1. **Welcome, Introductions and Overview**
   Bill Phelps, Program Coordinator, Contracts and Training

2. **Genoa Pharmacy**
   Jacob Golin, Pharmacy Site Manager
   a. **Update on Services**
      i. Primary purpose of Genoa services is to drive medication adherence
         1. See adherence statistics below
         2. Medication packaging
         3. Frequent communication with physicians
         4. To contact us, call 616-499-3197

3. **LRE Facilities Review Process Questionnaire and Follow-Up**
   Bill Phelps, Program Coordinator, Contracts and Training
   Wendi Price, Lorna Dawson, LRE
   a. **Results of December Survey**
      i. See Contracts presentation below
      ii. 18 provider responded to the survey
      iii. 11 of the 18 providers submitted comments
      iv. Specific requests include:
         1. Question 1: What questions or concerns do you have regarding LRE Site Reviews?
            a. Developing a secure portal for uploading documents for a site review
            b. Clearer information about what, when and how about the site review
            c. Concerns about disruption when LRE reviewers are requesting items that are not required at the setting. Would appreciate source document provider can reference
            d. Concerns about duplication with licensing reviews
            e. Resident plans need to be reviewed and sent for both the facility LRE survey as well as the LRE survey of each county. Are both needed?
         2. Question 2: What information would be helpful when preparing for LRE Site Review?
            a. Receipt of Audit form or a Site Review Checklist ahead of the site review is very helpful for preparation

   b. Can we receive a list of requirements/expectations that the reviewer will need when coming to do the site review?
   c. Provide source of requirements (link) to the site review tool to be clear when it's a requirement
   d. We would like to have a checklist of what is expected so we can anticipate questions that may arise.
   e. What resident records and policy/procedures can be sent in advance to make the site review more efficient?
   f. What LRE is looking for and what is expected of providers.
   g. What will LRE specifically be looking for at the Site Review? Is there a specific template guiding the site review?
   h. A list
   i. More detailed information on the pre checklist would be helpful
   j. Check sheets and lists that show the different things that will be audited.
3. Question 3: What questions or updates would you like specific to HCBS?
   a. Receipt of the Audit Form or a Site Review Checklist ahead of the site review is very helpful
   b. A document with all requirements before services can begin. Also list of ongoing training requirements.
   c. CMH Support
   d. Clarification on frequency of audits, yearly or every other year?
   e. Some county plans not documenting HCBS requirements, such as locked/unlocked bedroom doors. How can we help ensure this happens? The facility needs to write a POC for a county plan not being up to date.
   f. Any new requirements or changes from LRE or the State communicated to provider ahead of time.
   g. When a resident has needs that prevent him/her from meeting HCBS rulings, do you have samples of verbiage used by the case manager as an example to prevent citation?
4. Question 4: Are there any other questions you would like LRE to answer?
   a. Have there been any rules or guidelines changes in the past year?
5. Question 5: Are there any other questions you would like CMHOC to answer?
   a. Overall, CMHCO has been very helpful and plans are well written and up to date. Thank you

b. Help with getting ready for LRE inspections

b. Overview of LRE Facilities Review Workflow

i. See LRE presentation below

4. Training Requirements

Bill Phelps, Program Coordinator, Contracts and Training

a. Attachment I/Training Updates

i. We are doing a deep dive into training requirements to streamline the number of trainings required

b. CPR online training prior to in-person

i. There are two parts to the CPR training – online and in-person
   1. The online portion must be completed prior to attending the in-person training

5. Recipient Rights Updates

Briana Fowler, Director of Recipient Rights

a. Timely Recipient Rights Training Completion for New Hires

i. This **MUST** be completed within 30 calendar days of hire
ii. The latest data from MDHHS-ORR shows we were at 85% compliance and the benchmark is 95%

b. 2024 Recipient Rights Training and Annual Update

i. Enrollment is open

c. Medication Error/Significant Medication Error & Proper Follow-Up (PCP/Poison Control)

i. Qualified professionals - Poison Control/Primary Care Physician/Pharmacist - **MUST** be contacted anytime there are medication errors

d. Confidentiality/HIPAA

i. Refresher due to breaches
   1. All electronic communication containing Protected Health or Protected Identifiable Information must be sent securely/encrypted. Please inform Briana if this is not happening when corresponding with CMH staff.
   2. Double check recipients are the correct intended recipients before sending correspondence containing PHI/PII to avoid breaches

e. 2024 Recipient Rights Site Visits

i. Six site visits conducted so far in February
ii. To avoid duplication of site visits, Recipient Rights officers in surrounding counties divided Providers amongst themselves

f. Pre-Hire Recipient Rights Checks

i. Briana has a list of substantiated Recipient Rights violations in Ottawa County dating back to the mid-seventies that is available

g. CMHOC Requirements for Incident Report Writing vs. LARA

i. LARA has specified their updated requirements for Incident Reporting, but Ottawa County's policy has not changed
   1. Anything unusual needs to be reported

6. **Fiscal Updates/Financial Considerations**
   Nicholas Sall, Assistant Finance Manager
   Laura Peterson, Provider Compliance and Billing Supervisor
   Krystal Spaans, Provider Compliance and Claims Supervisor
   a. **See Fiscal presentation below**
      i. Timeliness Reminders
      ii. Primary Insurance
      iii. GIVA
      iv. EOBs
      v. PCNX Forms

7. **Credentialing and OIG Updates**
   Kristen Henninges, Compliance Program Coordinator
   Amy Avery, Program Evaluator
   a. **See Credentialing/Compliance presentation below**
      i. Clinical Application
      ii. Criminal Background Checks
      iii. OIG Checks
      iv. MDHHS Provider Credentialing Process

8. **Contract Updates**
   Bill Phelps, Program Coordinator, Contracts and Training
   a. **Reminders: Notice of Adverse Benefit Determination Form**
      i. See forms below
   b. **Business Association Agreement (BAA)**
      i. This is a document regarding compliance with HIPAA that will be routed to each provider for signatures annually as part of the contracting process.
   c. **Appeals and Grievances**
      i. See policy below

9. **CMH/LRE Updates**
   Bill Phelps, Program Coordinator, Contracts and Training
   a. **Electronic Visit Verification**
      i. The EVV implementation in Michigan is starting in 3 phases. Behavioral health is in Phase 3 with an anticipated go live of September 1, 2024. EVV is a validation of date, time, location, type of personal care or home health care service provided, and the individual providing and receiving the services. This information will help ensure consumers are receiving the expected care. CMH IT and Fiscal Services departments are working with the state to plan for the go live date.
   b. **MichiCANS**
      i. We continue to prepare for the MichiCANS implementation. This is a standardized assessment that helps inform the development of the Person Centered Plan. As reported, we will be rolling out in October 2024 and are working with our electronic medical record to have it

ready. Staff will be trained in the administration of the tool in the next several months.

c. **Community Health Fair**
    i. See flyer below
    ii. The Community Health Fair will be on May 16 from 3:30p-5:30p If you are interested in hosting a table email Rodrigo Mata at rmata@miottawa.org.

d. **Thank you!**
    i. **We could not do our work without all of you.**

10. Questions/Feedback

Bill Phelps, Program Coordinator, Contracts and Training

a. **See meeting chat transcript below**

11. Planning for Next Meeting

Bill Phelps, Program Coordinator, Contracts and Training

a. **Next meeting: September 26, 2024**

Genoa Pharmacy and Medication Report

Golin, Jacob

Holland - MI - 20418

Below is an overview of the organizational analysis (pharmacy business and medication adherence) utilizing medication possession ratio (MPR), gap in therapy and proportion days covered (PDC).

To see a more detailed view, please visit http://apps.genoahealthcare.com/

The adherence data provided in this report is intended to be used as a tool to help identify individuals that might benefit from further review.

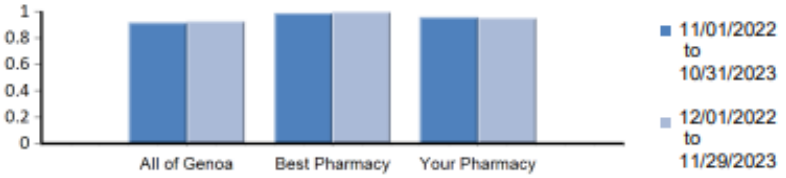
Studies suggest a correlation between a consumer's adherence to their treatment plan and rates/risks for re-hospitalization. Pharmacy data is not perfect and therefore, this should be used merely as a tool.

Report for month ending: February 29, 2024

Monthly Snapshot

Adherence: Medication Possession Ratio (MPR) - Atypical Antipsychotics

	11/01/2022 to 10/31/2023	12/01/2022 to 11/29/2023	Change
Your Pharmacy	0.96	0.95	-0.01
All Genoa	0.93	0.93	0.00
Best Pharmacy	1.00	0.99	-0.01



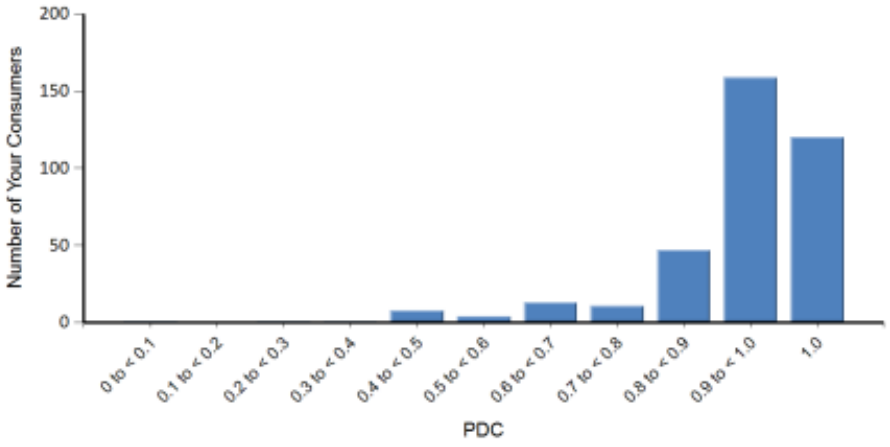
U.S. National Average: 0.5*

* Adherence to Treatment With Antipsychotic Medication and Health Care Costs Among Medicaid Beneficiaries With Schizophrenia. Gilmer, Todd P., ph.D. et al. Am J Psychiatry, April 2004; 692: 6-8. http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.161.4.692

Atypical Antipsychotic: Proportion of Days Covered

Time Span: 03/01/2023 to 02/29/2024

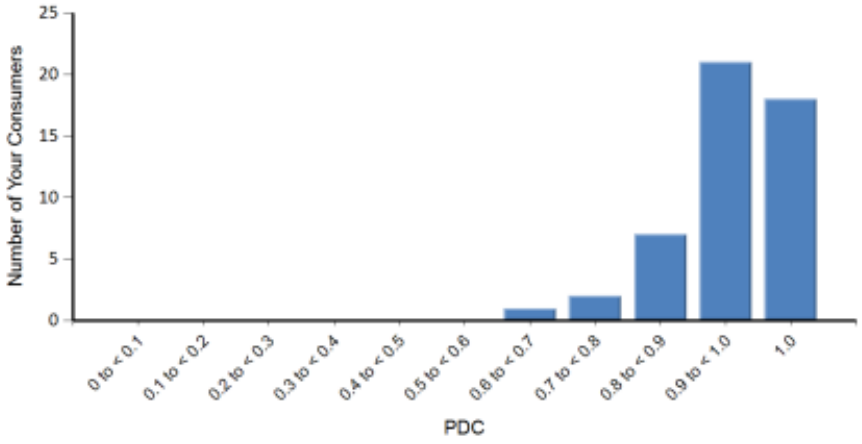
PDC	Number of Your Consumers	% of Total
0 to < 0.1	1	0.3 %
0.1 to < 0.2	0	0.0 %
0.2 to < 0.3	1	0.3 %
0.3 to < 0.4	1	0.3 %
0.4 to < 0.5	8	2.2 %
0.5 to < 0.6	4	1.1 %
0.6 to < 0.7	13	3.6 %
0.7 to < 0.8	11	3.0 %
0.8 to < 0.9	47	12.9 %
0.9 to < 1.0	159	43.6 %
1.0	120	32.9 %



Cholesterol: Proportion of Days Covered

Time Span: 03/01/2023 to 02/29/2024

PDC	Number of Your Consumers	% of Total
0 to < 0.1	0	0.0 %
0.1 to < 0.2	0	0.0 %
0.2 to < 0.3	0	0.0 %
0.3 to < 0.4	0	0.0 %
0.4 to < 0.5	0	0.0 %
0.5 to < 0.6	0	0.0 %
0.6 to < 0.7	1	2.0 %
0.7 to < 0.8	2	4.1 %
0.8 to < 0.9	7	14.3 %
0.9 to < 1.0	21	42.9 %
1.0	18	36.7 %

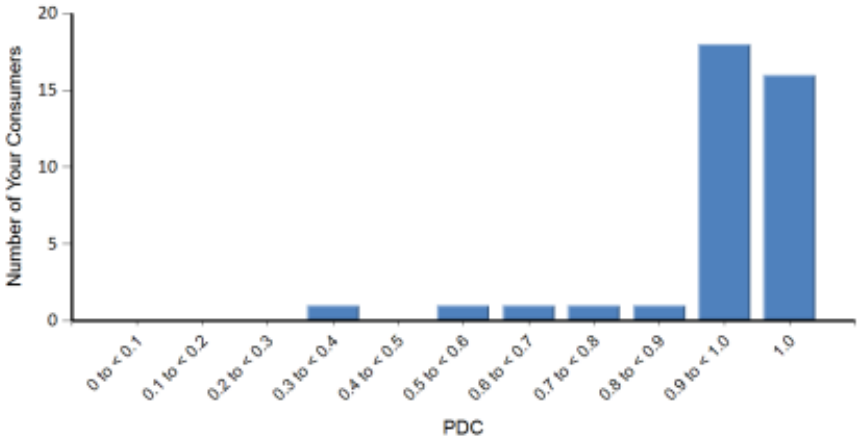


Click for a detailed report

Diabetes: Proportion of Days Covered

Time Span: 03/01/2023 to 02/29/2024

PDC	Number of Your Consumers	% of Total
0 to < 0.1	0	0.0 %
0.1 to < 0.2	0	0.0 %
0.2 to < 0.3	0	0.0 %
0.3 to < 0.4	1	2.6 %
0.4 to < 0.5	0	0.0 %
0.5 to < 0.6	1	2.6 %
0.6 to < 0.7	1	2.6 %
0.7 to < 0.8	1	2.6 %
0.8 to < 0.9	1	2.6 %
0.9 to < 1.0	18	46.2 %
1.0	16	41.0 %



Click for a detailed report

LRE FACILITIES REVIEW PROCESS QUESTIONNAIRE AND FOLLOW-UP

OVERVIEW

- Project initiated at request of Providers for better understanding of Site Review process
- Survey created to gather information from entire Provider Network
- 5 questions total
- 18 responses

QUESTIONS:

1. What concerns do you have regarding LRE Site Reviews?
2. What information would be helpful when preparing for LRE Site Reviews?
3. What questions or updates would you like specific to HCBS?
4. Are there any other questions you would like LRE to answer?
5. Are there any other questions you would like CMHOC to answer?

FINDINGS:

- CMHOC met with LRE staff to review findings

- Developed Plan
  - LRE would participate in PNC meeting to:
    - Provide overall review of LRE Site Review Process
    - Provide technical assistance with locating site review documents on the LRE website

LRE PRESENTATION

NEXT STEPS

How can CMHOC help Providers prepare for LRE Site Reviews?

LAKESHORE
REGIONAL ENTITY

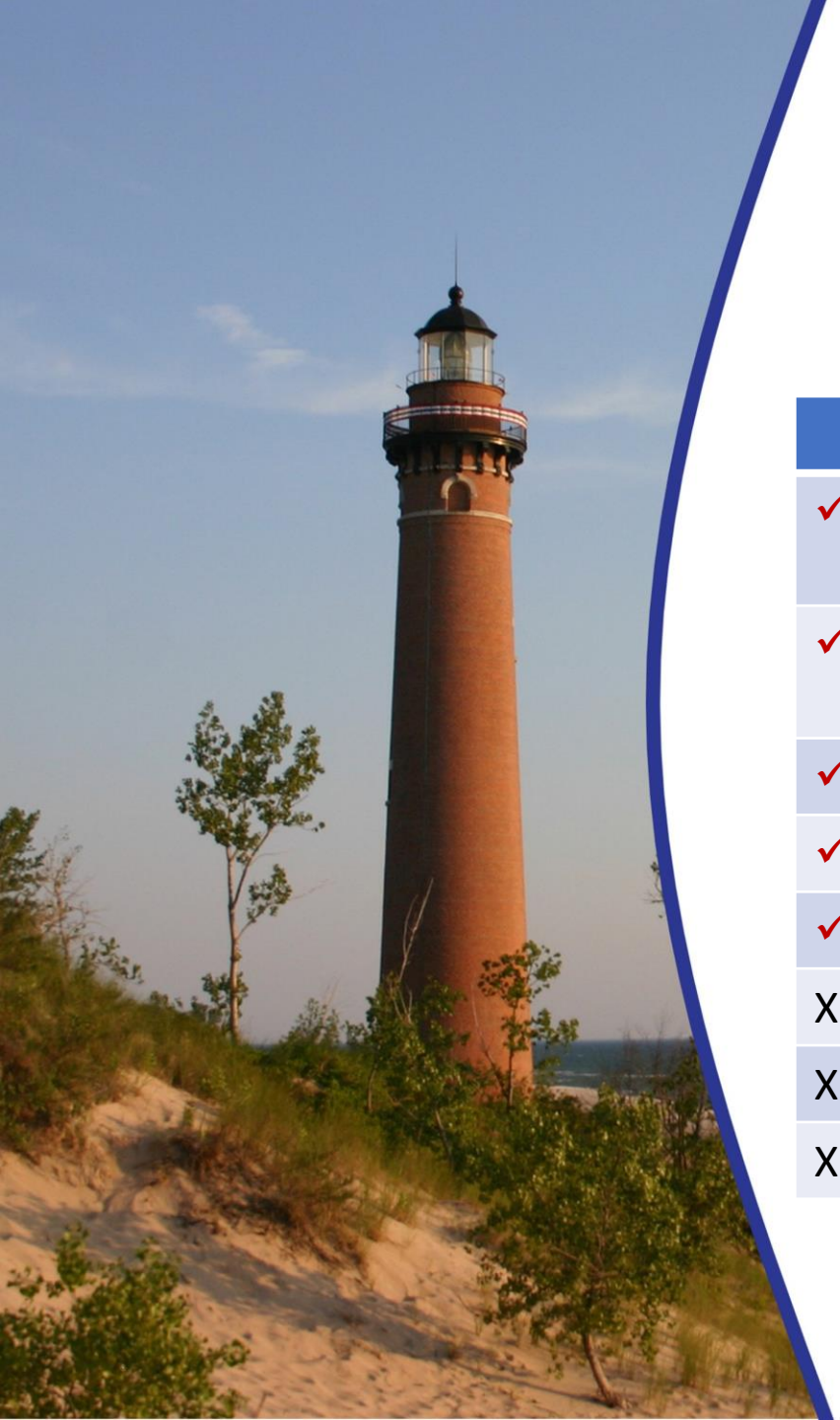
FY24 Facility Review Overview

Wendi M. Price

Chief Managed Care Officer

Interim Compliance & Privacy Officer

March 28, 2024



FY24 Facility Review Overview

Site Review versus Facility Review

Site Review (SR)	Facility Review (FR)
✓ **Desk Audit of Managed Care Functions**	X Desk Audit of Managed Care Functions
✓ **Program Specific Audit of MDHHS Policies**	X Program Specific Audit of MDHHS Policies
✓ **Clinical Chart Audits with HCBS Lens**	X Clinical Chart Audits with HCBS Lens
✓ **Credentialing Audits**	X Credentialing Audits
✓ **Training Audits**	X Training Audits
X Health and Safety	✓ **Health and Safety**
X Licensing Rules	✓ **Licensing Rules**
X HCBS Compliant IPOS	✓ **HCBS Compliant IPOS**

FY24 Facility Review Overview

Regulatory & Contractual Obligations

- 42 CFR § 438.330[1]
- 42 CFR 441.725; HCBS Final Rule[2]
- MDHHS-PIHP Contract[3]
- MDHHS QAPIP Policy, Section XV & XVI[4]
- MDHHS HCBS Technical Advisory[5]
- PIHP-CMHSP Contract[6]
- CMHSP-Provider Contract[7]

[1] eCFR 42 CFR 438.330
[2] 42 CFR 441.725 -- Person-centered service plan; Federal Register HCBS Final Rule
[3] FY24 MDHHS-PIHP Contract, Schedule A, Sections K(2)(a), K(2)(c), Q(16)(e)
[4] MDHHS QAPIP
[5] Hyperlink TBD
[6] FY23 PIHP-CMHSP Contract, Sections VIII(I)(2)(a), VIII(J), X(A)(7)(f), XIX(E)
[7] FY24 CMHSP-Provider Contract, Sections V(8) – V(10), V(26)

FY24 Facility Review Overview

Facility Review Philosophy

1. Collaborate with Network Providers to:

- **Ensure health and safety consumers through application of MDHHS policies, technical guidance, etc. as well as LARA licensing rules.**
- **Ensure compliance with the HCBS Final Rule.**

2. Provide education to Network Providers on requirements.

LAKESHORE REGIONAL ENTITY

FY24 Facility Review Overview

Facility Review Team & Responsibilities

Team Member	Primary Responsibilities
Wendi Price	Determine FR metrics, Establish FR expectations, Co-develop FR Project Plan, Revise FR tools, Research FR issues, Analyze FR data and Report results
Michelle Quinn	Co-develop FR Project Plan, Execute FR Project Plan, Standardize FR workflow/procedures/ templates, Schedule FRs, Reconcile CAP proofs, Distribute correspondence, Follow-up on CAPs
Lorna Dawson	Review IPOSs & BTPs, Educate providers on HCBS Final Rule, Reconcile CAP proofs, Follow-up on CAPs
Jody Waite	Conduct FRs, Develop CAPs, Approve/Deny CAPs, Educate providers on HCBS Final Rule and non-HCBS related requirements
Ross Ekdom	Conduct FRs, Develop CAPs, Approve/Deny CAPs, Educate providers on HCBS Final Rule and non-HCBS related requirements
Jackie Schut	Build FR tools in LIDS

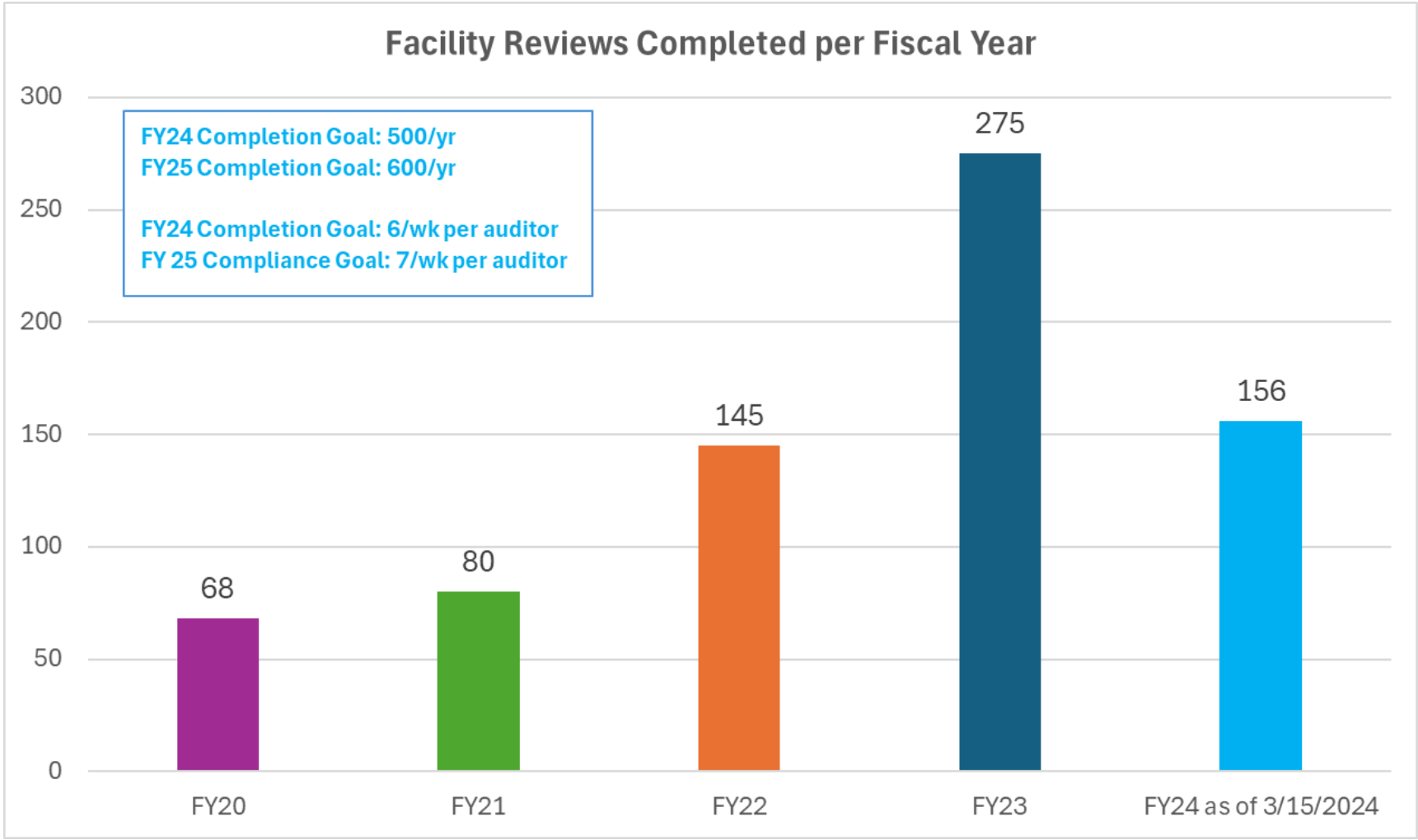
FY24 Facility Review Overview

Facility Review Workflow

Task	LRE Responsible Staff
Revise Facility Review Tool - July	Facility Review Team
Maintain Master Provider List	Michelle Quinn
Standardize Communication Templates	Michelle Quinn
Schedule Facility Review	Michelle Quinn
Sent Confirmation Email	Michelle Quinn
Facility Review Tool	
Controlling Authorities Tool	
Tips & Tricks for a Successful Facility Review	
Conduct Virtual Facility Review	Jody Waite, Ross Ekdom
Review IPOSs for HCBS Compliance when a Modification or Restriction Exists	Lorna Dawson
Review BTPs for HCBS Compliance when a Modification or Restriction Exists	Lorna Dawson
Enter Facility Review Results into LIDS (PCE Systems)	Jody Waite, Ross Ekdom
Pull Corrective Action Plan (CAP) from PowerBI and download into Microsoft® Excel	Jody Waite, Ross Ekdom
Distribute Completed Facility Review Audit (PDF) and CAP (Microsoft® Excel) via email	Michelle Quinn
CAP must be returned with proofs demonstrating compliance within 30 days	
Approve/Deny CAP	Jody Waite, Ross Ekdom
Receive Completed CAP and CAP Proofs	Michelle Quinn
Reconcile CAP Proofs	Michelle Quinn
Review CAP Proofs	Jody Waite, Ross Ekdom
Upload CAP Proofs into LIDS	Jody Waite, Ross Ekdom
Draft & Distribute Approval/Denial CAP Letter via email	Michelle Quinn

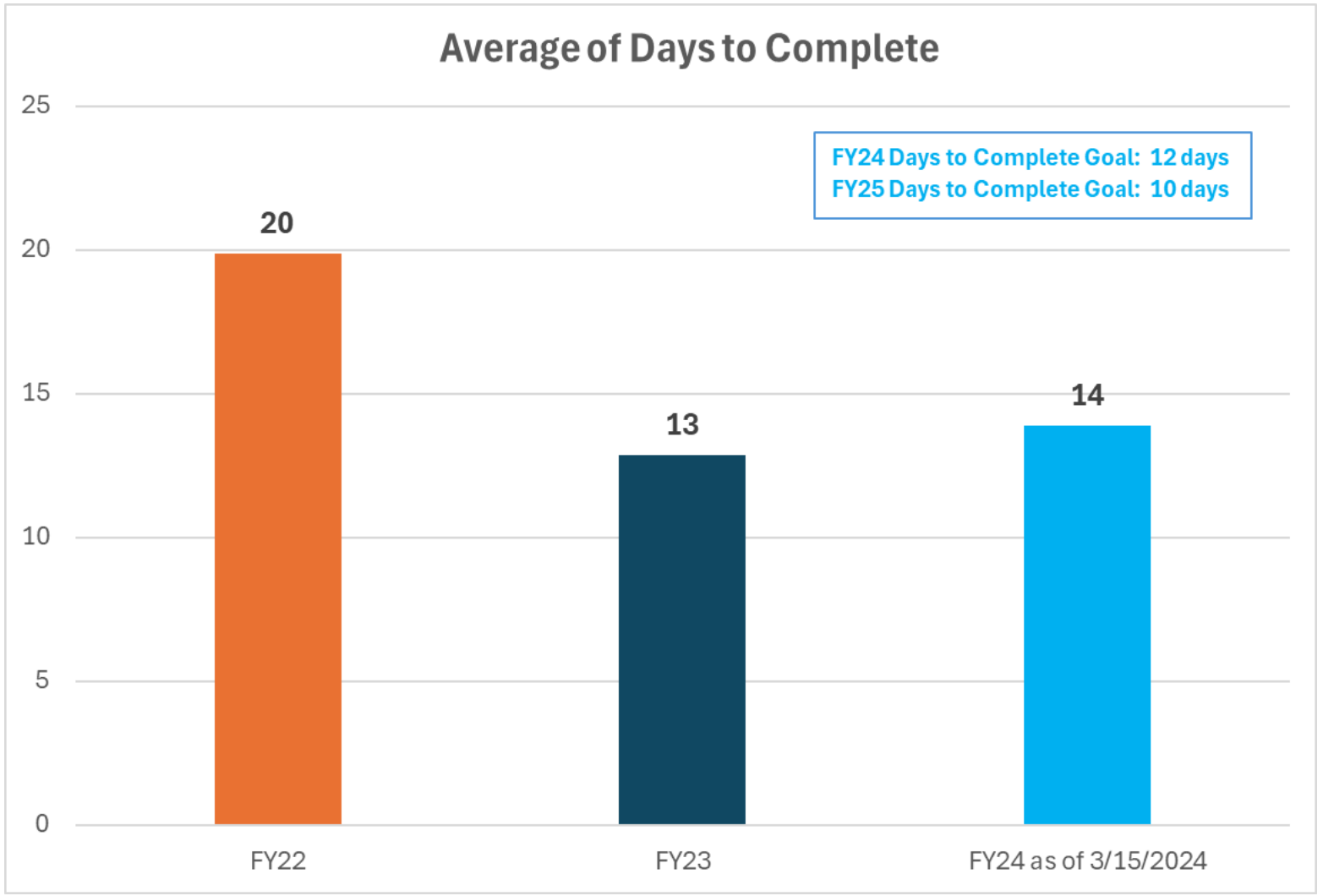
All Communications with LRE regarding Facility Reviews must be directed to: **facilitiesreviews@lsre.org**

FY24 Facility Review Overview



LAKESHORE REGIONAL ENTITY

FY24 Facility Review Overview



LAKESHORE REGIONAL ENTITY

FY24 Facility Review Overview

Ottawa Survey

1. What questions or concerns do you have regarding LRE Site Reviews?
   a. I have no information on what, when, & how about the site review. This is concerning.

      LRE: LRE, with proper staffing, conducts annual Facilities Reviews of all providers. LRE reaches out to individual providers to schedule the Facilities Reviews. Upon scheduling confirmation, LRE sends out a meeting invite with the Facilities Review tool attached or under separate email as the provider requests.

   b. They project themselves as the State Licensed Consultants

      LRE: Please provide specific examples to your CMH contact.

   c. We have concerns about the disruption it causes when the LRE reviewers are requesting items that are not required for that setting. If every item on the review list has a source (for the requirement), we can reference this and note. It can be disruptive when asked to produce something that is not required.

      LRE: LRE is would appreciate a list of the items that the LRE Facilities Review tool is asking for that are "not required for that setting." Feel free to send the list to your CMHSP contact. LRE has controlling authorities for each question that falls under the PIHP oversight requirements.

FY24 Facility Review Overview

Ottawa Survey

1. What questions or concerns do you have regarding LRE Site Reviews?
   a. Do they receive our licensing information and inspections prior to visit?

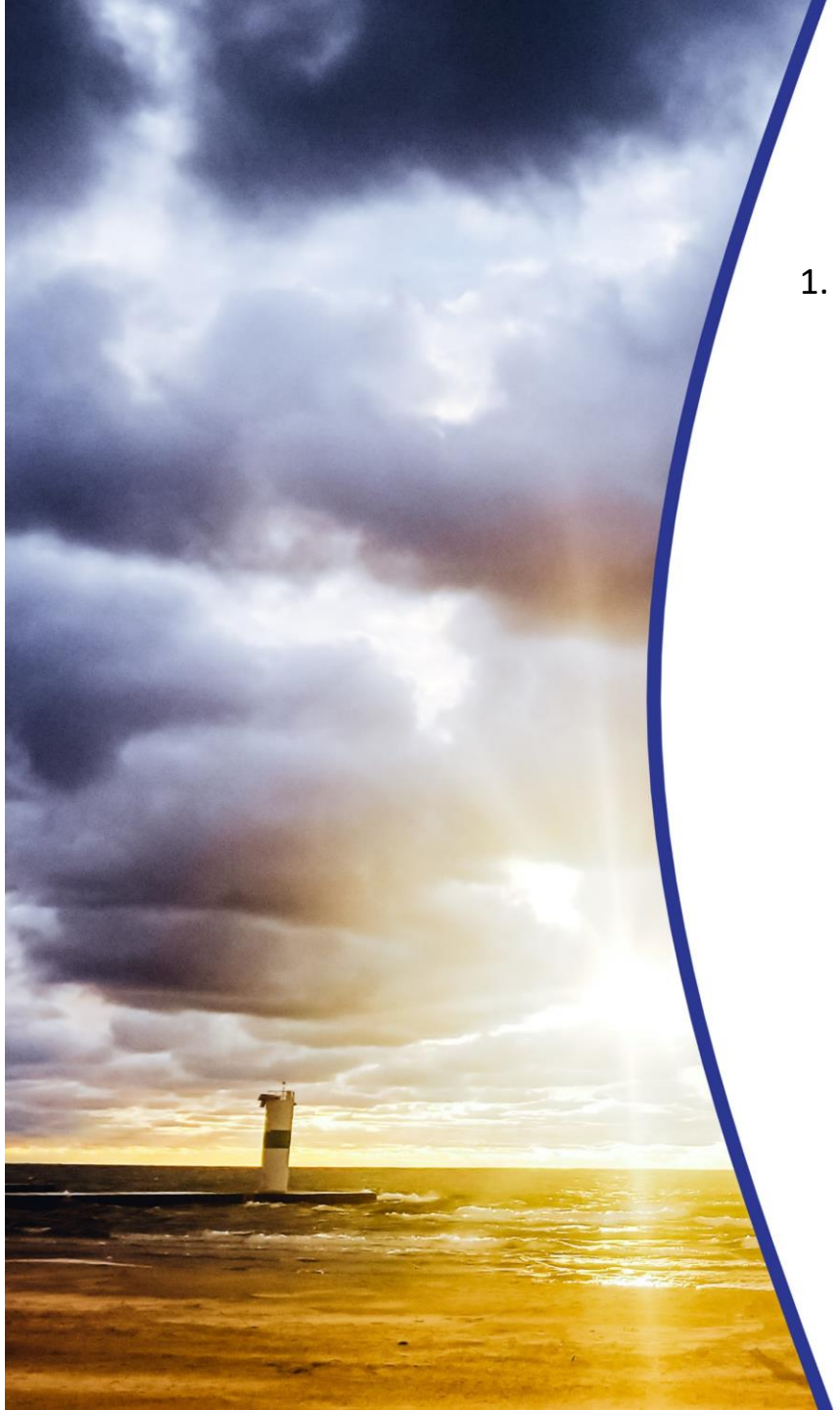
      LRE: LRE reviews the licensing information available here: https://adultfostercare.apps.lara.state.mi.us/ . LARA Licensing reports are not available to LRE. LRE has found considerable disparity in the licensing audits when conducted by different LARA licensing consultants. LRE conducts its own audit, independent of LARA.

   b. They project themselves as the State Licensed Consultants

      LRE: Please provide specific examples to your CMH contact.

   c. We have concerns about the disruption it causes when the LRE reviewers are requesting items that are not required for that setting. If every item on the review list has a source (for the requirement), we can reference this and note. It can be disruptive when asked to produce something that is not required.

      LRE: LRE is would appreciate a list of the items that the LRE Facilities Review tool is asking for that are "not required for that setting." Feel free to send the list to your CMHSP contact. LRE has controlling authorities for each question that falls under the PIHP oversight requirements.



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Ottawa Survey

1. What questions or concerns do you have regarding LRE Site Reviews?
   a. Resident plans are needing to be reviewed and sent for both the facility LRE survey as well as the LRE survey of each county. Are both needed?

      LRE: LRE is required to conduct clinical chart review during the CMHSP Site Reviews, during which LRE only takes a random sample from all consumers to select a total of 30-40 clinical charts during Site Reviews. LRE is also required to conduct annual "HCBS Physical Assessments" for all consumers, which ensures the IPOS/BTP have been distributed to the provider and the IPOSs/BTPs for each consumer that receives HCBS services complies with the HCBS Final Rule.

   b. HCBS interpretations seem to change. Something that has been known and approved for years, seem to be no longer valid.

      LRE: As previously announced years prior, on March 17, 2023, CMS mandated that all settings receiving Medicaid funding for HCBS were required to be in full compliance with the HCBS Final Rule. MDHHS published a memorandum stating that those settings that did not demonstrate 100% compliance with the HCBS Final Rule would need to find alternate non-Medicaid funding, cease HCBS with consumer/guardian permission, or discharge the consumer into a setting that demonstrated 100% compliance. This was not new information, but it was the first time that CMS/MDHHS were enforcing it. With CMS already auditing, unannounced, into settings in Indiana, New York, and Illinois, LRE is trying to ensure all Region 3 setting are HCBS Final Rule compliant. Failure to do so will result in risk to Region 3 and its consumers by way of losing Medicaid funding.

FY24 Facility Review Overview

Ottawa Survey

2. What information would be helpful when preparing for LRE Site Reviews?
   a. Receipt of the Audit Form or a Site Review checklist ahead of the site review is very helpful for preparation.

      LRE: LRE is required to conduct clinical chart review during the CMHSP Site Reviews, during which LRE only takes a random sample from all consumers to select a total of 30-40 clinical charts during Site Reviews. LRE is also required to conduct annual "HCBS Physical Assessments" for all consumers, which ensures the IPOS/BTP have been distributed to the provider and the IPOSs/BTPs for each consumer that receives HCBS services complies with the HCBS Final Rule.

   b. Can we receive a list of requirements/expectations that the reviewer will need when coming to do the site review?

      LRE: LRE sends a copy of the tool to providers after they confirm the date/time of their Facilities Review. The form is also available on the LSRE website here: https://www.lsre.org/uploads/files/2024-Facility-Review-and-HCBS-Physical-Assessment.pdf

FY24 Facility Review Overview

Ottawa Survey

3. What information would be helpful when preparing for LRE Site Reviews?
   a. Receipt of the Audit Form or a Site Review checklist ahead of the site review is very helpful for preparation.

      LRE: LRE is required to conduct clinical chart review during the CMHSP Site Reviews, during which LRE only takes a random sample from all consumers to select a total of 250-350 clinical charts during Site Reviews annually. LRE is also required to conduct annual "HCBS Physical Assessments" for all consumers, which ensures the IPOS/BTP have been distributed to the provider and the IPOSs/BTPs for each consumer that receives HCBS services complies with the HCBS Final Rule.

   b. Can we receive a list of requirements/expectations that the reviewer will need when coming to do the site review?

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   c. A short list document with all requirements before services can begin. Also list of ongoing training.

      LRE: Attachment I from the Common Contract has all training requirements for the majority of services categories rendered to consumers.

FY24 Facility Review Overview

Ottawa Survey

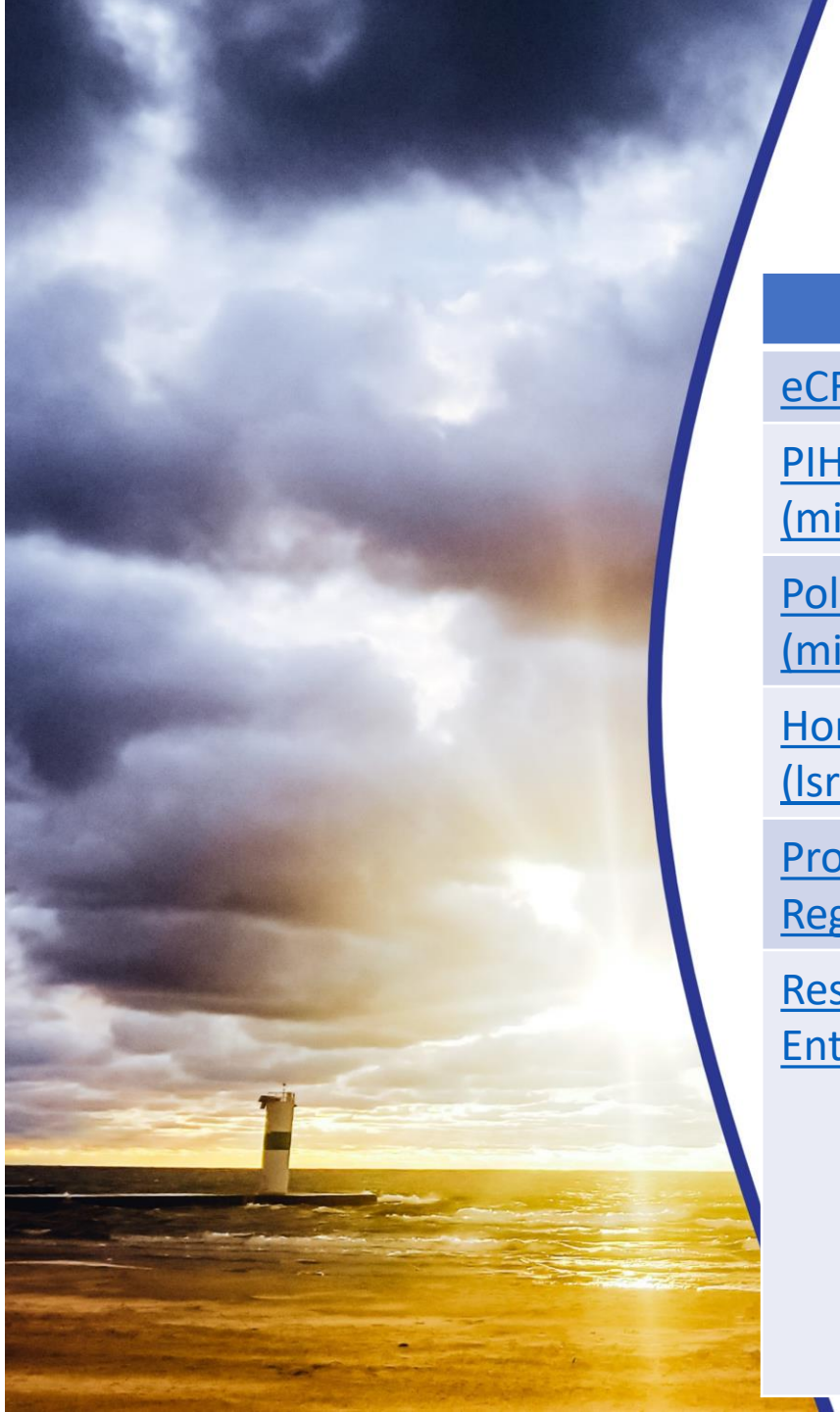
4. Are there any other questions you would like LRE to answer?
   a. Any rules or guidelines change in the past year since last visit?

      LRE: LRE provided the change log to the QI ROAT Members, who also supported the use of the FY24 Facilities Review and HCBS Physical Assessment Tool.

5. Are there any other questions you would like CMHOC to answer?

   b. Can we receive a list of requirements/expectations that the reviewer will need when coming to do the site review?

      LRE: LRE sends a copy of the tool to providers after they confirm the date/time of their Facilities Review. The form is also available on the LSRE website here: https://www.lsre.org/uploads/files/2024-Facility-Review-and-HCBS-Physical-Assessment.pdf



FY24 Facility Review Overview

Handy Hyperlinks

Hyperlink	Description
eCFR :: Home	Federal Regulations
PIHP Master Contract Template (michigan.gov)	FY24 MDHHS-PIHP Contract
Policies & Practice Guidelines (michigan.gov)	MDHHS Policies & Practice Guidelines
Homepage - Lakeshore Regional Entity (lsre.org)	LRE Website
Provider Site Review Calendar - Lakeshore Regional Entity (lsre.org)	LRE Provider Audit Calendar
Resource Library - Lakeshore Regional Entity (lsre.org)	LRE Provider Audit Tools LRE Sample Policies LRE Sample Plans LRE Sample Forms LRE Additional Links: MDHHS-5515, Michigan Sharps Collection Information, SAMPLE Spill Kit

Q&A

LAKESHORE REGIONAL ENTITY

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

OFFICE OF RECIPIENT RIGHTS – SUBSTANTIATED RIGHTS BACKGROUND CHECK

I, _____, authorize the below Recipient Rights Office to disclose to my employer all information regarding any violation(s) of recipient rights committed by me. I recognized such disclosure will not include confidential information protected by Federal, State, or common law.

Please indicate the county/counties/organizations in which you have been employed:

1. _____
2. _____
3. _____
4. _____
5. _____

In consideration for providing such information, I release, waive and relinquish any and all claims against any Recipient Rights Office, its Recipient Rights Officers, employees, agents, or other representatives arising, directly or indirectly, or relating to the furnishing of such information by them. I also waive any legally required notice, oral or written, that such information is being provided to CMHOC.

- ☐ I acknowledge that I have worked in the medical/mental health field prior to my application for employment with CMHOC. I have worked in the following counties and give my permission for CMHOC to check with that county's Recipient Rights Office.

- ☐ I have NOT worked in the medical/mental health field prior to my application for employment with CMHOC.

_____ _____
Applicant's Signature Date

_____
Previous Names Used (Please Print)

RECIPIENT RIGHTS OFFICE USE ONLY

- ☐ The above named applicant DOES NOT have any substantiated recipient rights violations.

- ☐ The above named application DOES have substantiated recipient rights violation(s).
  - Violation: Date:
  - Violation: Date:

_____ _____ _____
Recipient Rights Officer/Director Date County/CMHSP

FISCAL UPDATES

Provider Network Council (PNC) Meeting
Community Mental Health of Ottawa County

AGENDA

- Attachment B -Timeliness Reminder
- Primary Insurance
- EOB’S
- GIVA
- PCNX Forms

ATTACHMENT B
TIMELY FILING

- Claims that **DO NOT** require an EOB must be submitted within **60 days** of the DOS or it will be denied.

- Claims that **DO** require an EOB must be submitted with coordination of benefits to CMH within **90 days** of receipt of the EOB from the third-party payor. The claim shall include the third-party EOB as evidence that the primary payor was billed.

- Previously denied claims should be corrected and re-billed to the CMH within **60 days** from the date of the denial for re-processing and reimbursement. Re-billed claims submitted more than **60 days** from the date of denial will be ineligible for payment.

PRIMARY INSURANCE

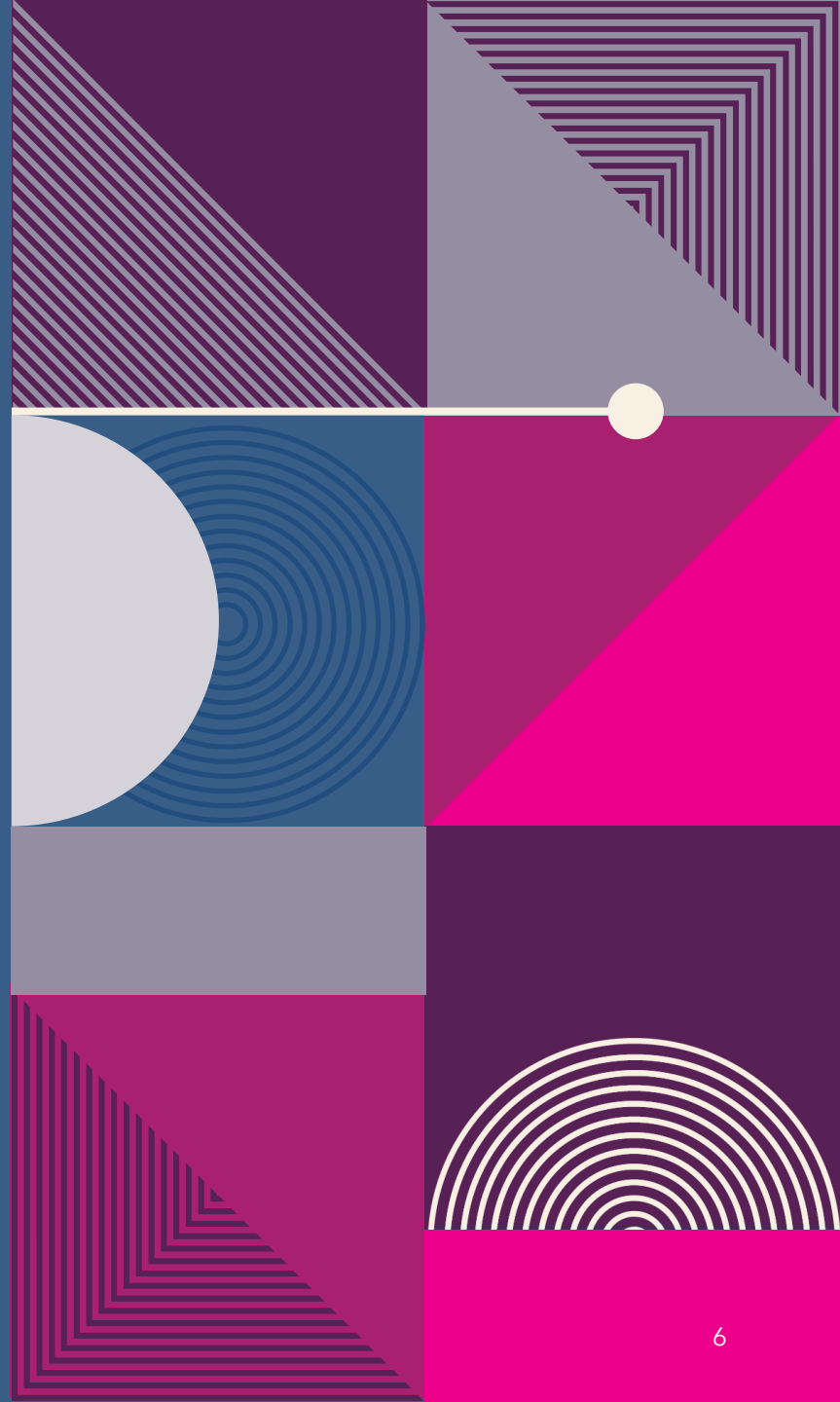
- Monitor client insurance eligibility
- Primary Insurance must be billed
- Medicaid is a payor of last resort

EOB FOR PAYMENT

- Sent securely via email the day payment is made.
- Detailed description of any denial reason or reason for a payment difference.
- Please submit additional questions to GIVA.

GIVA

- Help Desk portal for Fiscal Services:
  - https://cmhoc.giva.net/home.cfm
- GIVA Email Address:
  - CMHOCFINANCE@miottawa.org



GIVA
TWO FACTOR AUTHENTICATION

COMING SOON...

PCNX FORMS

- Provider Demographics
  - Authorizations, Rates, Providers
- PCNX Member Ledger
- PCNX Batch Listing

THANK YOU

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

Credentialing

Clinical Applications

- The date that the Program Evaluator (Amy Avery) receives the clinical application with all the attachments is the date the provider will be set up for billing.
- You will receive a confirmation email along with an approval letter once the provider has been set up for billing in Ottawa County, so please do not have your provider provide any services until this email is received as this will cause billing errors.
- In addition, if the job position requires necessary trainings/certifications (such as RBT or Recovery Coach Training, CAADC, or DP-C), professional licenses, please make sure they are attached to the application along with their highest educational transcript that they have obtained. We need to verify that they meet the qualifications before we can enter them into our system.
- Please make sure when you submit a clinical application they are completed in their entirety. If there is any missing information on the application or missing documents, this will cause a delay in the process.

Clinical Applications Continued

- When a provider has a license update, the day that the Program Evaluator (Amy Avery) is notified, is the day that the update is effective for billing. If they provide services using the updated billing prior to notification, then it will cause billing issues.
- If you have any further questions regarding credentialing, please refer to your specific Attachment A located on our website. If you have professionally licensed or certified staff, also refer to MDHHS's Credentialing and Re-Credentialing Processes.
- Providers will maintain policies and procedures to ensure that contracted physicians and other health care professionals (e.g., social workers, OT, etc.) are licensed by the State of Michigan and are qualified to perform their services. Providers must immediately notify the LRE and CMHSP if any license is terminated, revoked or suspended during the term of this Agreement.

Clinical Applications Continued

- The provider will ensure that licenses and certifications are current and valid.
- The provider will ensure that support care staff who are not required to be licensed are qualified to perform their jobs.
- The provider agrees to immediately notify CMHSP of any State licensure or certification investigation.
- For SUD Providers: Organizations/programs must be licensed for SUD service provision.

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

CLINICAL APPLICATION

All sections must be completed in their entirety.

The date Community Mental Health of Ottawa County (CMHOC) receives the fully completed Clinical Application is the effective date of billing for CMHOC services.

An incomplete application may result in a delay of credentialing approval and effective date.

Once an individual is credentialed and approved to provide services the agency will receive a confirmation email from the CMHOC Program Evaluator.

AGENCY NAME: _____

Provide the following **service site information** for the individual listed:

Service Site Name: _____
Service Site Address: _____
Service Site Phone Number: _____

SECTION I: PERSONNEL INFORMATION

Services cannot be provided and billed until CMHOC has credentialed the individual listed.

First and Last Name: _____
Date of Birth: _____
Sex: ☐Male ☐Female ☐Unknown
Social Security Number: _____
Date of Hire: _____
Date of Criminal Background Check: _____
Date of Medicaid Sanction Check (Office of Inspector General - OIG): _____
National Provider Identifier (NPI): _____

SECTION II: TYPE OF STAFF

Check all that apply to the services provided by the individual listed in Section I.

☐ Autism (please specify) _____
☐ Case Management/Supports Coordination
☐ Psychology/Behavior Support
☐ Occupational Therapy
☐ Physical Therapy
☐ Speech/Language Pathology
☐ Nursing
☐ Other (please specify) _____

SECTION III: CREDENTIALS

Attach the following documents appropriate to the services provided by the individual listed in Section I.

- ☐ Professional License
- ☐ Professional Certificate
- ☐ Professional Registration
- ☐ Practitioner Specialty (*mark all that apply on page 2) _____
- ☐ Highest Educational Degree
- ☐ DEA (Medical Professional only)
- ☐ Malpractice Insurance (if required by contract)

SECTION IV: AGENCY/SUPERVISION SIGNATURE

By completing the information and signing below, the agency and supervisor listed certify that the Clinical Application has been completed fully for the individual requiring credentialing by CMHOC.

Signature: _____ Date: _____

Print Name: _____

Title: _____

Revised on 1/14/2019

SUBSTANCE USE DISORDER CLINICAL APPLICATION

All sections must be completed in their entirety.

The date Community Mental Health of Ottawa County (CMHOC) receives the fully completed Clinical Application is the effective date of billing for CMHOC services.

An incomplete application may result in a delay of credentialing approval and effective date.

Once an individual is credentialed and approved to provide services the agency will receive a confirmation email from the CMHOC Program Evaluator.

AGENCY NAME: _____

Provide the following **service site information** for the individual listed:

Service Site Name: _____
Service Site Address: _____
Service Site Phone Number: _____

SECTION I: PERSONNEL INFORMATION

Services cannot be provided and billed until CMHOC has credentialed the individual listed.

First and Last Name: _____
Position: _____
Date of Birth: _____
Sex: ☐Male ☐Female ☐Unknown
Social Security Number: _____
Date of Hire: _____
Date of Criminal Background Check: _____
Date of Medicaid Sanction Check (Office of Inspector General - OIG): _____
National Provider Identifier (NPI): _____

SECTION II: TYPE OF STAFF

Check all that applies to the services provided by the individual listed in Section I.

- ☐ Treatment Supervisor (circle): CCS-M, CCS-R, or DP-CCS
- ☐ Specifically Focused Staff (specify): _____
- ☐ Treatment Adjunct Staff (specify): _____
- ☐ Intern – Internship Completion Date: _____
- ☐ Substance Abuse Treatment Specialist (SATS), NPI# _____
- ☐ Substance Abuse Treatment Practitioner (SATP), NPI# _____
- ☐ Other (specify): _____

SECTION III: CREDENTIALS

Attach the following documents appropriate to the services provided by the individual listed in Section I.

Complete the sections below for all types of staff marked in Section II.

1. **Substance Abuse Treatment Specialist:** In order to qualify as a substance abuse treatment specialist an individual must meet the criteria detailed in **any one of** the following three categories **and** be supervised* by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

   Please select the appropriate category below and provide the information requested below the item:

☐	Possesses one of the following certifications from the Michigan Certification Board of Addiction Professionals **or** a Development Plan for achievement.	☐CADC ☐CCDP ☐CADC-M ☐CCDP-D ☐CAADC ☐Dev. Plan ☐CCJP-R	MCBAP Certification Expiration Date: _____
☐	Individual has a development plan with MCBAP **and** possesses one of the following licensures: MD/DO, PA, NP, RN, LPN, LP, LLP, TLLP, LPC, LLPC, LMFT, LLMFT, LMSW, LLMSW, LBSW, or LLBSW.	License #: _____	License Expiration Date: _____
☐	Individual possesses one of the following alternative certifications. Please identify which certification:	☐ ASAM ☐APA ☐UMICAD	Certification Expiration Date: _____

2. **Substance Abuse Treatment Practitioner:** In order to qualify as a substance abuse treatment practitioner an individual must have a MCBAP development Plan in place **and** be supervised* by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

   MCBAP Development Plan Expected Completion Date: _____

3.

Levels of Care to be provided:	Service Categories:
☐ Outpatient	☐ Assessment
☐ Intensive Outpatient Program (IOP)	☐ Individual
☐ Detox	☐ Group
☐ Residential	☐ Didactic
☐ Methadone	☐ Case Management *
	☐ Peer Recovery Support **

* This employee has additional education, training, or experience qualifications for performing the duties of this position. *Please describe below (or attach an additional sheet):*

** Peer Recovery Support. Please attach an additional sheet to include responses to ALL of the following:

- Three (3) references of support;
- Current support system for PRS staff;
- Program's selection criteria for hiring PRS staff;
- How his/her recovery was verified and how recovery will be monitored;
- Date of his/her last treatment (if applicable);
- Specify types of services to be provided by PRS Associate or PRS Coach;
- Documentation of training received.

4. This employee has a degree in one of the following:
   - ☐ Social Work (circle): Masters or Bachelor's
   - ☐ Guidance & Counseling (circle): Masters or Bachelor's
   - ☐ Clinical Psychology (circle): Masters or Bachelor's
   - ☐ Physician
   - ☐ Ph.D. Psychologist
   - ☐ Other counseling related field (specify): _____
   - ☐ Other (specify): _____

SECTION IV: AGENCY/SUPERVISION SIGNATURE

Supervision for SATS and SATP staff must be provided by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications

By completing the information and signing below, the agency and supervisor listed certify that the Clinical Application has been completed fully for the individual requiring credentialing by CMHOC.

Signature: _____ Date: _____
Print Name: _____
Title: _____

Background Checks and National and State Sex Offender Registry Checks

- The provider will require Criminal Background Checks and national/state sex offender registry checks prior to hire and at a minimum of every two years for all persons (staff, management and non-management) providing services to or interacting with Individuals served by CMHSP or persons who have the authority to access or create CMHSP information.
  - Criminal Background Checks must be completed through the State of Michigan Licensing and Regulatory Affairs (LARA) Workforce Background Check system; Internet Criminal History Access Tool (ICHAT); or other service as approved by the LRE prior to starting work with Individuals.
  - Michigan Public Sex Offender Registry: https://mspsor.com/
  - National Sex Offender Registry: http://www.nsopw.gov/
  - Central Registry Check (staff who work with children): https://www.michigan.gov/mdhhs/adult-child-serv/abuse-neglect/childrens/central-registry
  - Make sure that all the screenshots from ICHAT and the Sex Offender Registry Checks are electronically date-stamped.
  - The provider shall inform CMHSP if any staff or board member has been convicted of a felony or misdemeanor related to patient abuse, health care, or any type of fraud, a controlled substance, or any obstruction of any investigation.

Sanction Checks

- Providers shall ensure an initial examination of Federal and State databases of excluded individuals (OIG and SAM) are conducted. Such examinations must take place prior to hire and monthly thereafter, for all Provider employees and those joining Provider Board of Directors. If any provider shows up on this list, you are to notify us immediately.
  - OIG (Office of Inspector General): http://exclusions.oig.hhs.gov
  - SAM (System for Award Management): www.sam.gov
- Make sure that all screenshots of the sanction checks are electronically date stamped.
- We are expecting that all agency providers are compliant with trainings, criminal background checks, and sanction checks. We ask that you keep these records in your files. Evidence of staff training, and compliance must be available for MDHHS, LRE, and/or CMHSP audits.
  - Again, if you have questions about which trainings you need to have to be compliant, please refer to Attachment I on the CMH website.

Visit our tips page to learn how to best use the Exclusions Database. If you experience technical difficulties, please email the webmaster at webmaster@oig.hhs.gov.

Search the Exclusions Database

Do not use your browser's back button while navigating through the LEIE search. Instead, use the built-in navigation features as indicated below:

Search For An Individual

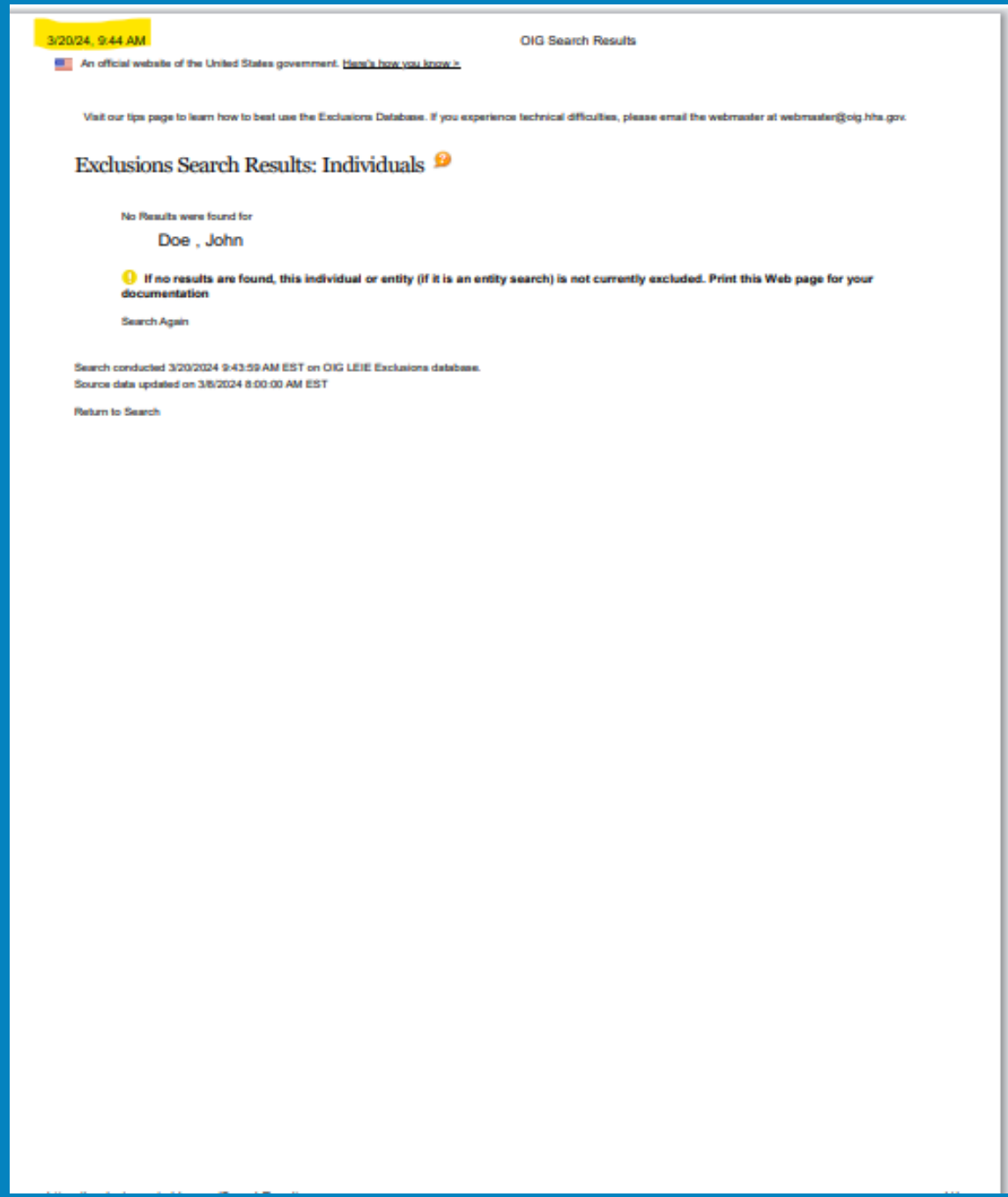
Search For Multiple Individuals | Search For A Single Entity | Search For Multiple Entities

Last Name **(and/or) First Name**

Search Clear

Related Content

- LEIE Downloadable Databases
- Monthly Supplement Archive
- Waivers
- Quick Tips
- Background Information
- Applying for Reinstatement
- Contact the Exclusions Program
- Frequently Asked Questions
- Special Advisory Bulletin and Other Guidance



3/20/24, 9:44 AM OIG Search Results

An official website of the United States government. Here's how you know >

Visit our tips page to learn how to best use the Exclusions Database. If you experience technical difficulties, please email the webmaster at webmaster@oig.hhs.gov.

Exclusions Search Results: Individuals

No Results were found for

Doe , John

If no results are found, this individual or entity (if it is an entity search) is not currently excluded. Print this Web page for your documentation

Search Again

Search conducted 3/20/2024 9:43:59 AM EST on OIG LEIE Exclusions database.
Source data updated on 3/8/2024 8:00:00 AM EST

Return to Search

MDHHS Credentialing and Recredentialing Processes Policy

- This policy covers credentialing, temporary/provisional credentialing, and re-credentialing processes for those individual practitioners and organizational providers who are directly or contractually employed by the Prepaid Inpatient Health Plans (PIHPs), as it pertains to the rendering of specialty behavioral healthcare services within Michigan's Medicaid Program.
  - Licensed/Certified/Registered Health Care Professionals
  - Excludes AFC homes
- Re-Credentialing is to be done every two years.
- Link to MDHHS Credentialing and Recredentialing Policy: Behavioral Health and Developmental Disabilities Administration, Provider Credentialing (michigan.gov)

1. Credentialing and re-credentialing must be conducted and documented for at least the following health care professionals:
    a. Physicians (M.D.s and D.O.s)
    b. Physician's Assistants
    c. Psychologists (Licensed, Limited License, and Temporary License)
    d. Licensed Master's Social Workers
    e. Licensed Bachelor's Social Workers
    f. Limited License Social Workers
    g. Registered Social Service Technicians
    h. Licensed Professional Counselors
    i. Nurse Practitioners
    j. Registered Nurses
    k. Licensed Practical Nurses
    l. Occupational Therapists
    m. Occupational Therapist Assistants
    n. Physical Therapists
    o. Physical Therapist Assistants
    p. Speech Pathologists
    q. Board Certified Behavior Analysts
    r. Licensed Family and Marriage Therapists
    s. Other behavioral healthcare specialists licensed, certified, or registered by the State.

Initial Credentialing

Policies and procedures for the initial credentialing of individual practitioners must require:

1. A written application that is completed, signed, and dated by the individual practitioner and attests to the following elements:
    a. Lack of present illegal drug use.
    b. History of loss of license, registration, certification, and/or felony convictions.
    c. Any history of loss or limitation of privileges or disciplinary action.
    d. Attestation by the applicant of the correctness and completeness of the application.
    e. Attestation by the applicant that they are able to perform the essential functions of the position with or without accommodation.

Verification from primary sources of:

a. Licensure or certification and in good standing.
b. Board Certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training.
c. Official transcript of graduation from an accredited school and/or LARA license.
d. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all the following must be verified:
    i. Minimum five (5) year history of professional liability claims resulting in a judgment or settlement;
    ii. Disciplinary status with regulatory board or agency; and
    iii. Medicare/Medicaid sanctions.
e. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (a.), (b.), and (c.) above.

Contact information

If you have any comments, questions, or concerns about credentialing and compliance, please refer to your contract and/or feel free to reach out to us.

Program Evaluator Contact Information:
Amy Avery
Phone Number: 616-393-5682
Email: aavery@miottawa.org

Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

CREDENTIALING AND RE-CREDENTIALING PROCESSES

Effective: March 24, 2023

A. Overview:

This policy covers credentialing, temporary/provisional credentialing, and re-credentialing processes for those individual practitioners and organizational providers directly or contractually employed by Prepaid Inpatient Health Plans (PIHPs), as it pertains to the rendering of specialty behavioral healthcare services within Michigan's Medicaid program. The policy does not establish the acceptable scope of practice for any of the identified providers or practitioners, nor does it imply that any service delivered by the providers or practitioners identified in the body of the policy is Medicaid billable or reimbursable. PIHPs are responsible for ensuring that each provider and/or practitioner, directly or contractually employed, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual (MPM) requirements. Please reference the applicable licensing statutes and standards, as well as the MPM should you have questions concerning scope of practice or whether Medicaid funds can be used to pay for a specific service.

PIHPs are required to use the uniform community mental health services credentialing program established by the department in accordance with Public Act 282 of 2020.

NOTE: The individual practitioner and organizational provider credentialing process contains two primary components: initial credentialing and re-credentialing. The Michigan Department of Health and Human Services (MDHHS) recognizes that PIHPs may have a process that permits initial credentialing on a provisional or temporary basis while required documents are obtained or performance is assessed. The standards that govern these processes are in the sections that follow.

B. Credentialing Standards

1. The PIHP must have a written system in place for credentialing and re-credentialing organizational providers and individual practitioners included in the PIHP's provider network.

2. The PIHP must ensure:
   a. The credentialing and re-credentialing processes do not discriminate against:
      i. A health care professional, solely based on license, registration, or certification; or
      ii. A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

   b. Monthly checks are completed for compliance with Federal requirements that prohibit employment or contracts with organizational providers and /or individual practitioners excluded from participation under either Medicare or Medicaid.
      i. A complete list of Centers for Medicare and Medicaid Services (CMS) sanctioned providers and practitioners is available on their website at http://exclusions.oig.hhs.gov. A complete list of sanctioned providers and practitioners is available on the MDHHS website at www.michigan.gov/MDHHS. (Click on Providers, then click on Information for Medicaid Providers, then click on List of Sanctioned Providers). Evidence of monthly checks must be maintained in the organizational provider and individual practitioner credentialing file.

3. If the PIHP delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of organizational providers and/or individual practitioners that are required by this policy, the PIHP must retain the right to approve, suspend, or terminate from participation in the provision of Medicaid funded services, an organizational provider or individual practitioner selected by that entity, and meet all requirements associated with the delegation of PIHP functions. The PIHP is responsible for oversight regarding delegated credentialing or re-credentialing decisions.

4. Compliance with the standards outlined in this policy must be demonstrated through the PIHPs policies and procedures. Compliance will be assessed based on the PIHPs policies and standards in effect at the time of the credentialing/re-credentialing decision.

5. The PIHPs written credentialing policy must reflect the scope, criteria, timeliness, and process for credentialing and re-credentialing organizational providers and individual practitioners. The policy must be approved by the PIHPs governing body, and:
   a. Identify the PIHP administrative staff member and/or entity (e.g., credentialing committee) responsible for oversight and implementation of the process and delineate their role.
   b. Describe any use of participating providers or practitioners in making credentialing decisions.
   c. Describe the methodology to be used by PIHP staff members or designees to provide documentation that each credentialing or re-credentialing file was complete and reviewed prior to presentation to the credentialing committee for evaluation; and
   d. Describe how the findings of the PIHPs Quality Assessment Performance Improvement Program (QAPIP) are incorporated into the re-credentialing process.

6. PIHPs must ensure that a complete and separate credentialing/re-credentialing file is maintained for each credentialed organizational provider and individual practitioner. Each file must include:
   a. The initial credentialing and all subsequent re-credentialing applications.
   b. Information gained through primary source verification; and
   c. Any other pertinent information used in determining whether the organizational provider and/or individual practitioner met or did not meet the PIHPs credentialing and re-credentialing standards.

7. The PIHPs must maintain a written process for ongoing monitoring, and intervention, if appropriate, of organizational providers and/or individual practitioners as it relates to sanctions, complaints, and quality issues. This process must include, at a minimum, review of:
   a. Monthly Medicare/Medicaid sanction checks.
   b. Monthly State sanction checks
   c. Any limitations on licensure, registration, or certification.
   d. Beneficiary concerns which include appeals and grievances (complaints) information.
   e. Noted quality issues at the PIHP level.

C. Credentialing Individual Practitioners:

The PIHP must have a written system in place for credentialing and re-credentialing individual practitioners included in their provider network who are not operating as part of an organizational provider. The PIHP must ensure that each direct-hire or contractually employed individual practitioner meets all background checks, applicable licensing, scope of practice, contractual, and Medicaid Provider Manual (MPM) requirements.

The PIHP must conduct a search that reveals information substantially similar to information

found on an Internet Criminal History Access Tool (ICHAT) check and a national and state sex offender registry check for each new direct-hire or contractually employed practitioner.

a. ICHAT: https://apps.michigan.gov
b. Michigan Public Sex Offender Registry: https://mspsor.com
c. National Sex Offender Registry: http://www.nsopw.gov

1. Credentialing and re-credentialing must be conducted and documented for at least the following health care professionals:
    a. Physicians (M.D.s and D.O.s)
    b. Physician's Assistants
    c. Psychologists (Licensed, Limited License, and Temporary License)
    d. Licensed Master's Social Workers
    e. Licensed Bachelor's Social Workers
    f. Limited License Social Workers
    g. Registered Social Service Technicians
    h. Licensed Professional Counselors
    i. Nurse Practitioners
    j. Registered Nurses
    k. Licensed Practical Nurses
    l. Occupational Therapists
    m. Occupational Therapist Assistants
    n. Physical Therapists
    o. Physical Therapist Assistants
    p. Speech Pathologists
    q. Board Certified Behavior Analysts
    r. Licensed Family and Marriage Therapists
    s. Other behavioral healthcare specialists licensed, certified, or registered by the State.

Initial Credentialing

Policies and procedures for the initial credentialing of individual practitioners must require:

1. A written application that is completed, signed, and dated by the individual practitioner and attests to the following elements:
    a. Lack of present illegal drug use.
    b. History of loss of license, registration, certification, and/or felony convictions.
    c. Any history of loss or limitation of privileges or disciplinary action.
    d. Attestation by the applicant of the correctness and completeness of the application.
    e. Attestation by the applicant that they are able to perform the essential functions of the position with or without accommodation.

2. An evaluation of the individual practitioner’s work history for the prior five (5) years. Gaps in employment of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.

3. Verification from primary sources of:
    a. Licensure or certification and in good standing.
    b. Board Certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training.
    c. Official transcript of graduation from an accredited school and/or LARA license.
    d. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all the following must be verified:
        i. Minimum five (5) year history of professional liability claims resulting in a judgment

or settlement.
ii. Disciplinary status with regulatory board or agency; and
iii. Medicare/Medicaid sanctions.

e. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (a.), (b.), and (c.) above.

4. The PIHP must ensure that the initial credentialing of all individual practitioners applying for inclusion in the PIHP network must be completed within 90 calendar days of application submission. The start time begins when the PIHP has received a completed signed and dated credentialing application from the individual practitioner. Completion time is indicated when written communication is sent to the individual practitioner notifying them of the PIHP's decision.

Temporary/Provisional Credentialing of Individual Practitioners

Temporary or provisional credentialing of individual practitioners is intended to increase the available network of practitioners in underserved areas, whether rural or urban. PIHPs must have written policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of Medicaid Beneficiaries that practitioners be available to provide care prior to formal completion of the entire credentialing process. Temporary or provisional credentialing must not exceed **150 days**.

The PIHP must have up to **31 days** from receipt of a complete application, accompanied by the minimum documents identified below, to render a decision regarding temporary or provisional credentialing:

1. A written application that is completed, signed, and dated by the individual practitioner and attests to the following elements:
    a. Lack of present illegal drug use.
    b. History of loss of license, registration, certification, and/or felony convictions.
    c. Any history of loss or limitation of privileges or disciplinary action.
    d. Attestation by the applicant of the correctness and completeness of the application.

2. An evaluation of the individual practitioner's work history for the prior five years. Gaps in employment of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.

3. Verification from primary sources of:
    a. Licensure or certification and in good standing.
    b. Board Certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training.
    c. Official transcript of graduation from an accredited school and/or LARA license.
    d. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all the following must be verified:
        i. Minimum five (5) year history of professional liability claims resulting in a judgment or settlement.
        ii. Disciplinary status with regulatory board or agency; and
        iii. Medicare/Medicaid sanctions.
    e. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of

(a.), (b.), and (c.) above.

The PIHP's credentialing committee must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification, as outlined in this Section, should be completed.

Re-credentialing Individual Practitioners

The re-credentialing policies for physicians and other licensed, registered, or certified health care practitioners must identify written procedures that address the re-credentialing process and include requirements for each of the following:

1. Re-credentialing at least every two (2) years.
2. Submission of the current credentialing application.
3. An update of information obtained during the initial credentialing if applicable.
4. Primary Source Verification.
5. Refer to the Initial Credentialing section of this document for additional details.

D. Credentialing and Re-Credentialing Organizational Providers:

For organizational providers included in the PIHP network:

1. The PIHP must validate and at least every two (2) years that:
   a. The organizational provider completes the current credentialing application.
   b. The organizational provider is licensed or certified and in good standing as necessary to operate in the State.
   c. The organizational provider is approved by an accredited body (if a provider is not accredited, the PIHP must perform an on-site quality assessment).
   d. There are no malpractice lawsuits that resulted in conviction of criminal neglect or misconduct, settlements, and/or judgements within the last five (5) years.
   e. The organizational provider is not excluded from participation in Medicare, Medicaid, or other Federal contracts.
   f. The organizational provider is not excluded from participation through the MDHHS Sanctioned Provider list.
   g. Current insurance coverage meeting contractual expectations is on file with the PIHP.
   h. For solely community-based providers (e.g., ABA or CLS in private residences), an on-site review is not required, an alternative quality assessment is acceptable.
   i. The contract between the PIHP and any organizational provider specifies the requirement that the organizational provider must credential and re-credential their direct employees, as well as subcontracted service providers and individual practitioners in accordance with the PIHPs credentialing/re-credentialing policies and procedures (which must conform to MDHHS credentialing process).

2. The PIHP must ensure that the initial credentialing of all organizational providers applying for inclusion in the PIHP network must be completed within 90 calendar days of application submission. The start time begins when the PIHP has received a completed signed and dated credentialing application from the organizational provider. Completion time is indicated when written communication is sent to the organizational provider notifying them of the PIHP's decision.

E. Deemed Status:

Individual practitioners or organizational providers may deliver healthcare services to more than one (1) PIHP. A PIHP may recognize and accept credentialing activities conducted by any other PIHP in lieu of completing their own credentialing activities. In those instances where a PIHP

chooses to accept the credentialing decision of another PIHP, they must maintain copies of the credentialing PIHPs decisions in the organizational provider and/or the individual practitioner's credentialing file.

F. Notification of Adverse Credentialing Decision:
An individual practitioner or organizational provider that is denied credentialing or re-credentialing by the PIHP must be informed of the reasons for the adverse credentialing decision in writing by the PIHP within 30 days of the decision.

G. Appeal of Adverse Credentialing Decision:
Each PIHP must have a written appeal process that is available when credentialing or re-credentialing is denied, suspended, or terminated for any reason other than lack of need. The written appeal process must be consistent with applicable federal and state requirements. The appeal process must be included as part of an adverse credentialing decision notification letter.

H. Reporting Requirements:
The PIHP must have written procedures for reporting improper known organizational provider or individual practitioner conduct which could result in suspension or termination from the PIHPs provider network to appropriate authorities (i.e., MDHHS, the provider's regulatory board or agency, the Attorney General, etc.). Such written procedures must be consistent with current Federal and State requirements, including those specified in the MDHHS Medicaid Managed Specialty Supports and Services Contract.

I. Definitions

Individual Practitioner: An individual who is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which he/she delivers the services.

National Practitioner Databank (NPDB) and the Healthcare Integrity and Protection Databank (HIPDB): The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Workforce Evaluation and Quality Assurance, Practitioner Data Banks Branch is responsible for the management of the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. They can be located on the Internet at www.npdb-hipdb.hrsa.gov/.

Organizational provider: An entity that directly employs and/or contracts with individuals to provide health care services. Examples of organizational providers include, but are not limited to, community mental health services programs (CMHSPs); hospitals; nursing homes; homes for the aged; psychiatric hospitals, units, and partial hospitalization programs; substance abuse programs; and home health agencies.

PIHP: A PIHP is a Prepaid Inpatient Health Plan under contract with MDHHS to provide managed behavioral health services to eligible individuals.

Notice of Adverse Benefits Determination Crosswalk

	Action	Team	Type of Notice	Time Frame	Examples
IPOS Development	Individual Plan of Service developed	DD Services MI Services Child/Family	Adequate	At time of plan development	• Any time the Individual Plan of Service is developed or updated with additional services.
Changes in Scope, Amount, or Duration of Services	**Medicaid**: Reduction, suspension, or termination of current services	DD Services MI Services Child/Family SUD Services	Advance	10 days prior to proposed effective date	• Any time there is a change including reduction, suspension or termination of a currently authorized service (outside of IPOS development).
	Non-Medicaid: Reduction, suspension, or termination of current services	DD Services MI Services Child/Family	Advance	30 days prior to proposed effective date	• Any time there is a change including reduction, suspension or termination of a currently authorized service (outside of IPOS development).
Denial of Services	Denial or limited authorization of a requested service	Access SUD Services	Adequate & 2nd Opinion	At the time of notice	• Individual is denied access to services at the point of entry into the system (Access Center).
	Standard authorization decision that denies or limits services requested	DD Services MI Services Child/Family SUD Services	Adequate	Within 14 calendar days from date of receipt of request	• A request made at any time for additional or increased services that is denied.
	Denial of Hospitalization	Crisis	Adequate & 2nd Opinion	At the time of notice	• Pre-Admission screening denies request for hospitalization.
	Denial, in whole or part, of payment for a service	Crisis Access	Adequate	At the time of notice	• Continued Stay Review completed and request denied.
Timeliness	Failure to provide service within 14 days of agreed upon start date	DD Services MI Services Child/Family	Adequate	At the time of notice	• Appointment is scheduled outside of 14 days. • Service start date is outside of the agreed upon start date identified in the IPOS.
	Failure to make an authorization decision within required time frames	DD Services MI Services Child/Family Crisis Access	Adequate	At the time of notice	• Given when standard authorization decision not made within 14 days. • Given when expedited authorization decision not made within 72 hours.

Revised 8/6/19 ab

COMMUNITY MENTAL HEALTH OTTAWA COUNTY

NOTICE OF ADVERSE BENEFIT DETERMINATION

Date: Enter Mailing Date

CMHOC ID: Enter CMHOC Case #

Name: Consumer's Name
Consumer's Address

Medicaid ID: Enter Medicaid #

This is to tell you that the following action has been taken:

Enter information about the action being taken.

The action is based on the following:

Enter the rationale for the action being taken and what rule, policy or procedure was used to make the decision.

You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

If you don't agree with our action, you have the right to an Internal Appeal

You have to ask the Lakeshore Regional Entity on behalf of Community Mental Health of Ottawa County (CMHOC) for an internal appeal within 60 calendar days of the date of this notice. You, your representative or your doctor {provider} can send in your request that must include:

- Your Name
- Address
- Member number
- Reason for appealing
- Whether you want a standard or fast appeal (for an expedited or fast appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters or other informatin that explains why you need the item or service. If you are asking for a fast appeal you will need a doctor's supporting statement. Call your doctor if you need this information.

Please keep a copy of everything you send us for your records.

There are 2 kinds of internal appeals:

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days**. If you want to ask for an internal appeal, you can either call or send in a written request to:

Lakeshore Regional Entity
500 Hakes Drive, Suite 250
Norton Shores, MI 49441
customerservice@lrse.org
Phone: 800-897-3301
TTY: 711
Fax: 231-769-2071

Expedited or Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be harmed by waiting up to 30 calendar days for a decision. **We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request**. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 calendar days. To ask for a Fast Appeal, you must call: **1-800-897-3301**

Continuation of services during an Internal Appeal

If you are receiving a Michigan Medicaid service and you file your appeal within 10 calendar days of this Notice of Adverse Benefit Determination <insert 10 calendar day date>, you may continue to receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to Community Mental Health of Ottawa County.

> Your benefits for that service will continue if you request and internal appeal within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later.

You may be asked to pay for a portion of the services you received during the appeal process if the appeal outcome upholds the decision you are appealing. This is not always the case, but if you do need to pay, you will be notified of the amount.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-800-897-3301 to learn how to name your representative. TTY users call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Access to Documents

You and your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

What happens next?

- If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we will send you a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing.
- The Notice of Appeal Denial will give you additional information about the State Fair Hearings process [or Patient Right to Independent Review Act] and how to file the request.
- If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Administrative Hearing System.

Get help & more information

- CMHOC: If you need help or additional information about our decision and the internal appeal process, call Customer Services at: 616-494-5545 (TTY: 616-494-5508), Monday through Friday, 9am to 5pm. You can also visit our website at www.miottawa.org/cmh.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line; 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

The legal basis for this decision is 42 CFR 440.230(d), Michigan's Mental Health Code, Public Act 258, and/or applicable policy found in the Medicaid Provider Manual, Mental Health and Substance Abuse Services. These provide the basic legal authority for us to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination based on race, color, national origin, sex, age, or disability

IF YOU **ARE NOT** CURRENTLY A MEDICAID BENEFICIARY

AND YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE THE FOLLOWING RIGHTS:

Local Dispute Resolution Process

You may request a local appeal orally or in writing within 30 days of the date on this notice.

If you believe waiting the standard timeframe for the appeal to be resolved could seriously jeopardize your life or health or ability to attain, maintain or regain maximum function, you can ask for an expedited or faster local appeal.

To request a local appeal, contact:

Community Mental Health of Ottawa County
Chelsea Eisenlohr
12265 James Street
Holland, MI 49424
Phone: 616-393-5752
Toll Free: 877-588-4357
Fax: 616-393-5687

Non-Discrimination and Accessibility Notice

Community Mental Health of Ottawa County (CMHOC) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CMHOC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CMHOC provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 866-710-7378.

If you believe CMHOC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Customer Services Department:

Community Mental Health of Ottawa County
Customer Services Department
12265 James Street
Holland, MI 49424
866-710-7378
616-393-5687
cmhcustomerservices@miottawa.org

You can file a grievance by mail, fax or email. If you need help in filing a grievance, our Complaints and Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: Language assistance services are available to you free of charge. Also, you have the right to receive information in a different format, such as audio, Braille, or large font due to special needs at no additional cost. Call 1-800-897-3301 (TTY: 711).

1. Albanian: VINI RE: Keni në dispozicion shërbime falas të ndihmës me gjuhën. Gjithashtu, keni të drejtë të merrni informacion në një format tjetër, të tillë si audio, Braille (Braj) ose me font të madh për shkak të nevojave të posaçme pa kosto shtesë. Telefononi numrin 1-800-897-3301 (TTY: 711).

2. Arabic: انتباه: خدمات المساعدة اللُّغوية متاحة لك مجانًا. لك الحق كذلك في الحصول على المعلومات في هيئة أخرى، كالتسجيل الصوتي، أو لغة برايل، أو بخط كبير بسبب الاحتياجات الخاصة دون تكلفة إضافية. اتصل على 1-800-897-3301(TTY:711 :الهاتف النصّي)

3. Bengali:
সতকক তা: ভাষা সহায়তার সসবাসমূহ আপনাকর্ ববনামূকযে সেওয়া হকব। এ ছাড়াও, ববকেষ প্রকয়াজন সাকপকে বাড়বত সর্াকনা খরচ ছাড়াই অনে সর্াকনা ফরমোট তথা-অবিও, সেইবষ বা বড় ফকে সেকর্াকনা তথে পাওয়ার অবির্ার আপনার রকয়কছ। র্য রুন-১-৮০০-৮৯৭-৩৩০১ (টিটিওয়াই: 1-800-897-3301 (TTY: 711).

4. Chinese: 请注意：您可以免费获取语言协助服务。此外，您有权因为自己有特殊需求而获得以不同形式提供的信息，例如音频、盲文或大字体等形式，无需支付额外费用。如有上述需要，请致电 1-800-897-3301 (TTY: 711).

5. Croatian: PAŽNJA: Usluge jezične podrške dostupne su bez naknade. Također imate pravo besplatno primati informacije u različitom formatu, primjerice zvučnom, na brajici ili s velikim fontom zbog posebnih potreba. Nazovite 1-800-897-3301 (TTY tekstni telefon:711)

6. German: ACHTUNG: Sprachliche Hilfe erhalten Sie kostenlos. Wenn Sie besondere Bedürfnisse haben, haben Sie auch das Recht, kostenlos Informationen in einem unterschiedlichen Format zu erhalten, beispielsweise als Audio, Braille oder in großem Druck. Informationen erhalten Sie unter folgender Telefonnr.: 1-800-897-3301 (TTY: 711).

7. Hindi:
ध्यान दें: भाषा सहायता सेवाएं आप के लिए निःशुल्क उपलब्ध हैं। साथ ही, आपको अतिरिक्त शुल्क के बिना विशेष जरूरतों के कारण ऑडियो, ब्रेल या बड़े फ़ॉन्ट जैसे किसी अलग प्रारूप में जानकारी प्राप्त करने का अधिकार है। 1-800-897-3301 पर कॉल करें 711

8. Italian: ATTENZIONE: Sono a Sua disposizione servizi gratuiti di assistenza linguistica. Inoltre, se Lei ha particolari esigenze, ha il diritto di ricevere gratuitamente le informazioni in un formato differente, come audio, Braille o a caratteri grandi. Chiami il numero verde 1-800-897-3301 (TTY: 711).

9. Japanese: 注意：言語支援サービスは無料でご利用いただけます。 また、特別なニーズのため、オーディオ、点字、大きなフォントなどの別のフォーマットで情報を受け取る権利があります（追加料金なし）。電話1-800-897-3301（TTY：711)

10. Korean: 참고: 언어 지원 서비스는 무료로 제공됩니다. 또한 귀하는 추가 비용 없이 오디오, 점자 또는 큰 글꼴 등과 같은 다른 형식으로 정보를 받을 권리가 있습니다. 전화번호 1-800-897-3301 (TTY: 711).

11. Polish: UWAGA: Usługi językowe zapewniane są bezpłatnie. Mają Państwo również prawo uzyskać te informacje bez dodatkowych kosztów w innej postaci, np. nagrania dźwiękowego, alfabetem Braille'a lub większą czcionką w związku ze szczególnymi potrzebami. Proszę zadzwonić pod numer: 1-800-897-3301 (TTY: 711).

12. Russian: ВНИМАНИЕ: Услуги по оказанию языковой помощи предоставляются вам бесплатно. Кроме того, учитывая индивидуальные потребности, вы имеете право на получение информации в удобном для вас формате, например, аудио, шрифт Брайля или крупным шрифтом, без каких-либо дополнительных затрат. Позвоните по телефону 1-800-897-3301 (TTY: 711).

13. Spanish: ATENCIÓN: Hay servicios de asistencia con idiomas a su disposición, sin costo. Además, tiene derecho a recibir información en un formato diferente, como audio, Braille o fuente grande debido a necesidades especiales, sin costo adicional. Llame al 1-800-897-3301 (TTY: 711).

14. Tagalog: BIGYANG PANSIN: Ang mga serbisyo ng pantulong sa wika ay handa ninyong magagamit nang walang bayad. At, mayroon kayong karapatang makatanggap ng impormasyon sa ibang format, tulad ng audio, Braille, o malaking font sanhi ng mga espesyal na pangangailangan nang walang dagdag na bayad. Tumawag sa 1-800-897-3301 (TTY: 711).

15. Vietnamese: CHÚ Ý: Dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị. Ngoài ra, quý vị có quyền nhận thông tin ở định dạng khác, chẳng hạn như âm thanh, chữ nổi hoặc phông chữ lớn do nhu cầu đặc biệt mà không mất thêm chi phí. Hãy gọi 1-800-897-3301 (TTY: 711).

CHAPTER: **4**	SECTION: **46**	SUBJECT: **INDIVIDUAL CARE TO CONSUMERS**
TITLE: **GRIEVANCE AND APPEAL**		
EFFECTIVE DATE: **05/18/2021**		REVISED DATE: **05/18/2021; 02/22/2022**
ISSUED AND APPROVED BY:  EXECUTIVE DIRECTOR		

I. POLICY:

Community Mental Health of Ottawa County (CMHOC) will establish and maintain a due process system that is compliant with the State, Federal and Balanced Budget Act regulations as indicated in the Michigan Department of Health and Human Services (MDHHS) Contract and Prepaid Inpatient Health Plan (PIHP) Contract to ensure all beneficiaries the right to a fair and efficient process for resolving disagreements regarding their services and supports. Grievances and Appeals will be coordinated through the Customer Services Department.

This policy and any corresponding policies in no way requires the beneficiary to utilize due process prior to the filing of a Recipient Rights complaint pursuant to Chapter 7 and 7a of the Michigan Mental Health Code.

II. PURPOSE:

To ensure all individuals receiving services from CMHOC have access to due process for resolving grievances and disputes related to the denial, reduction, suspension, or termination of services and supports.

III. APPLICATION:

All mental health programs, services, and facilities directly operated by or under contract with CMHOC.

IV. DEFINITIONS:

A. **Adverse Benefit Determination:** A decision that adversely impacts a consumer's claim for services due to denial, reduction, suspension, termination, or limited authorization of a service. *42 CFR 438.400*
B. **Adequate Notice of Adverse Benefit Determination:** Written statement advising the consumer of a decision to deny or limit authorization of services requested, which notice must be provided on the same date the Adverse Benefit Determination takes effect. *42 CFR 438 (c)(2)*
C. **Advance Notice of Benefit Determination:** Written statement advising the

consumer of a decision to reduce, suspend or terminate services currently provided, which notice must be provided/mailed to the individual at least ten (10) calendar days prior to the proposed date the Adverse Benefit Determination is to take effect. *42 CFR 438.404 (c)(1); 42 CFR 431.211*

D. **Date of Action:** The date on which CMHOC proposes to deny, suspend, reduce, or terminate a service.
E. **Due Process:** The process CMHOC implements to handle appeals of an Adverse Benefit Determination and/or grievances, as well as process to collect and track information about them. *LRE Due Process Policy 6.6*
F. **Expedited Appeal:** The expeditious review of an Adverse Benefit Determination, requested by a beneficiary or the beneficiary's provider, when the time necessary for the standard appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. *42 CFR 48.410(a)*
G. **Grievance:** An expression of dissatisfaction about service issues other than an Adverse Benefit Determination. Possible subjects for grievances include but are not limited to: quality of care of services provided, aspects of interpersonal relationships between a service provider and the individual, failure to respect the individual's rights regardless of whether remedial action is requested, or an individual's dispute regarding an extension of time proposed by CMHOC to make a service authorization decision. *42 CFR 438.400; LRE Due Process Policy 6.6*
H. **Local Appeal:** A review at the local level by CMHOC or the Lakeshore Regional Entity, the PIHP for CMHOC, of an Adverse Benefit Determination as defined above. A written decision from the PIHP will be provided to the consumer within thirty (30) calendar days after the appeal is received. *42 CFR 438.408(b)(2)*
I. **MDHHS Alternative Dispute Resolution Process:** Impartial State level review, presided over by the MDHHS, of an appeal. This process is available to Non-Medicaid consumers, only after the Local Appeals Resolution Process has been exhausted.
J. **Michigan Office of Administrative Hearings and Rules (MOAHR):** The entity charged by the MDHHS with the responsibility for conducting State Fair Hearings.

V. **PROCEDURE:** All grievances and appeals received by Community Mental Health of Ottawa County will be resolved following the processes outlined in the "Grievance and Appeal Technical Requirement – PIHP Grievance and Appeal System for Medicaid Beneficiaries" for Medicaid beneficiaries and the "CMHSP Local Dispute Resolution Process" for non-Medicaid consumers. The Notice of Adverse Benefits Determination Crosswalk provides guidance on timelines for providing adequate and advance notices when services have been denied, reduced, suspended, terminated, or limited an authorization of services. Substance Use Disorder (SUD) treatment services provided by the SUD Provider Network also follow the same process.

Only in the following circumstances can an exception to the Advance Notice definition occur:

a. CMHOC has factual information confirming the death of a beneficiary
b. CMHOC receives a clear, written statement signed by the beneficiary that:
    i. They no longer want services; or

ii. Gives information that requires termination or reduction of services and indicates they understand that this must be the result of supplying that information

c. The beneficiary has been admitted to an institution where they are ineligible under the plan for further services
d. The beneficiary's whereabouts are unknown, and the post office returns CMHOC mail directed to them indicating no forwarding address
    i. Should the beneficiary's whereabouts become known during the time they are eligible for services, the agency will follow 42 CFR 431.231—Reinstating Services
e. CMHOC establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth
f. A change in the level of medical care is prescribed by the beneficiary's physician
g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act
h. The date of action will occur in less than ten (10) days, in accordance with 42 CFR 483.15(bh)(4)(ii) and (b)(8), which provides exception to the thirty (30) days notice requirements of 42 CFR 483.15(b)(4)(i)
i. The CMHSP has facts (preferably verified through secondary sources) indicating that action should be taken because of probably fraud by the beneficiary (in this case, CMHOC may shorten the period of advance notice to five (5) days before the date of action.)

In the event a consumer requests a second opinion, in addition to following the resolution processes outlined in the "Grievance and Appeal Technical Requirement – PIHP Grievance and Appeal System for Medicaid Beneficiaries" and the "CMHSP Local Dispute Resolution Process", CMHOC will also follow all second opinion resolution processes identified in the Michigan Mental Health Code, MCL 300.1705, and the Code of Federal Regulations, 42 CFR 438.206(b)(3).

In the event the aforementioned "Grievance and Appeal Technical Requirement – PIHP Grievance and Appeal System for Medicaid Beneficiaries" and the "CMHSP Local Dispute Resolution Process" guidelines are revised, Community Mental Health of Ottawa County will evaluate the grievance and appeals processes for compliance to these documents and update policies and procedures as necessary.

VI. ATTACHMENTS:

A. Notice of Adverse Benefits Determination Crosswalk

VII. REFERENCES:

A. Medicaid Managed Specialty Supports and Services Program—Appeal and Grievance Resolution Process Technical Requirement
B. MDHHS/CMHSP Managed Mental Health Supports and Services Contract –

Attachment C6.3.2.1: CMHSP Local Dispute Resolution Process

C. PA 516 of 1996
D. Social Security Act
E. 42 CFR 431.213—Exceptions from advance notice
F. 42 CFR 431.213—Notice in cases of probable fraud
G. 42 CFR 431.211—Advance Notice
H. 42 CFR 431.231—Reinstating Services
I. 42 CFR 438.408(b)(2)—Resolution and Notification: Grievances and Appeals
J. 42 CFR 438(c)(2)—Managed Care: Enrollee Rights and Protections
K. 42 CFR 438.400—Statutory Basis, Definitions, and Applicability
L. 42 CFR 438.404—Timely and Adequate Notice of Adverse Benefit Determination
M. Michigan Mental Health Code
N. Lakeshore Regional Entity Policy # 6.6: Due Process

Community Health Fair 2024

All are welcome!

Free Event!

May 16th
3:30-5:30pm


RESOURCES


SNACKS


ACTIVITIES


COMMUNITY

Join us for the 2024 Community Health Fair on May 16th from 3:30 to 5:30pm! Local agencies will be providing resources and promoting health and wellness in our community. Scan the QR code to learn more.

FLOWCODE

PRIVACY.FLOWCODE.COM

Salvation Army Holland

104 Clover St, Holland, MI

Substance Abuse and Mental Health Services Administration

SAMHSA

www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

[3/28 1:17 PM]
3/28 1:17 PM Meeting started
[3/28 1:33 PM] Briana Fowler

I can go see if he is available.

[3/28 1:46 PM] Jennel (External)

Autism of America would appreciate a copy of this presentation. Thank you!

like 1

[3/28 1:48 PM] Nicole Chulski

We will be sure to include this presentation when we distribute the minutes for this meeting

[3/28 1:52 PM] Edwin with Adia AFC

I wanted to ask why we have to have fire alarms in each and every room in AFCs, even though we have fire alarms on main areas or the hallways. Thanks!

[3/28 1:55 PM] Melissa Frash (Community Alliance)

How does this apply to the Self-D clients?

[3/28 2:22 PM] Unknown User

How much notice should we expect prior to a review?

[3/28 2:23 PM] Laura Esese
I had LRE review in January for all my homes
I'm I to go through ones more ?
[3/28 2:23 PM] Unknown User

yes, thank you

[3/28 2:24 PM] Laura Esese
Will I expect another one again from you?
[3/28 2:24 PM] Laura Esese
9 homes
[3/28 2:24 PM] Laura Esese
Ottawa
[3/28 2:25 PM] Laura Esese
N180
[3/28 2:25 PM] Laura Esese
Mantcolm

[3/28 2:25 PM] Laura Esese
Right door
[3/28 2:31 PM] Nadine-Care Provider Solutions (Guest)

The library is great! Thank you for all the toolsand resources! They are very helpful.

[3/28 2:37 PM] Unknown User

I apologize i need to leave for another meeting.

[3/28 2:44 PM] Nadine-Care Provider Solutions (Guest)

If using an email that is not encrypted is it acceptable to use the initials only of a resident and no other identifying information when sending the message?

[3/28 2:47 PM] Melissa Frash (Community Alliance)

Can you send me the form for a Rights check? Thanks

[3/28 2:47 PM] Jennel (External)

I would love that as well please!

[3/28 2:54 PM] Pamela Ramirez (External)
Please send me a copy of RR check as well. Thank you 😊

Pamela Ramirez, FMS Operation Manager with HR Alliance.
Pramirez@hragroup.net

Happy Easter 🫵
[3/28 2:54 PM] Erica Porter (External)

Hi, how do I get a new ACH/EFT form to switch banks for Our Hope Association's payments?

[3/28 2:58 PM] Nicole Chulski

Hi Erica, I can send you a new Vendor Direct Deposit form.

[3/28 2:58 PM] Nicholas Sall
Erica Porter

Hi, how do I get a new ACH/EFT form to switch banks for Our Hope Association's payments?

Please email our Accounts Payable Department - APgroup@miottawa.org
[3/28 2:58 PM] Unknown User

Who do we contact for billing and payment issues? Where can we get rates with CPT codes?

[3/28 2:59 PM] Anna Bednarek

I have to leave for another meeting. Nicole/Bill will send out my Deputy Director updates with the minutes. Thank you for all you do, we appreciate you.! We could not do our work without all of you.

[3/28 2:59 PM] Nicholas Sall

Please submit a Giva Ticket to

- CMHOCFINANCE@miottawa.org

[3/28 2:59 PM] Nicholas Sall
Kelly Denham

Who do we contact for billing and payment issues? Where can we get rates with CPT codes?

Please email: CMHOCFINANCE@miottawa.org

[3/28 3:00 PM] Briana Fowler

A sample of a RR Check (one that I use internally at CMHOC) has been sent to Nicole. She will include the sample with the minutes.

[3/28 3:16 PM] Tracy Christenson (External)

Will EVV be required for AFC homes?

[3/28 3:17 PM] Melissa Frash (Community Alliance)

Thank You

[3/28 3:18 PM] Melissa Frash (Community Alliance)

Happy Easter

[3/28 3:18 PM] William Phelps

you too Melissa

[3/28 3:42 PM]
3/28 3:42 PM Meeting ended: 2h 24m 54s