Provider Network Council (PNC) Minutes
Community Mental Health of Ottawa County
Microsoft Teams
Thursday, April 13, 2023, 1:30pm – 3:30pm

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.

I Welcome and Introductions

Kelly Goetzinger, Program Coordinator, Contracts and Training
KGoetzinger@miottawa.org

A. Meeting Minutes

1. Minutes will be distributed next week via email as well as posted on the CMH website Resources - Ottawa County, Michigan (miottawa.org)

II Genoa Pharmacy

Jacob Golin, PharmD, Pharmacy Site Manager
JGolin@genoahealthcare.com

A. Location

1. Address: 12265 James St Building A Room 214, Holland, MI 49424
2. Phone: (616) 499-3197
3. Fax: (616) 465-2064

B. Pharmacy Goal: Adherence to Medication

1. Specialized packaging available for daily and as-needed medications
2. National medication adherence average: approximately 40%
3. Genoa Pharmacy medication adherence average: 92%

C. Medication Shortages

1. Genoa Pharmacy monitors the ongoing medication shortages daily
2. Please contact us if your consumers are experiencing issues with shortages, and we will do what we can to help

III Training Requirements

Kelly Goetzinger, Program Coordinator, Contracts and Training
KGoetzinger@miottawa.org

A. Attachment I Update

1. Attachment I lists your contract requirements for training
2. This document is currently being revised
   a. Content will largely stay the same, but the formatting will be easier to navigate
   b. Once finalized, we will notify you and update the CMH website accordingly
   c. Resources - Ottawa County, Michigan (miottawa.org)
   d. Training Center - Ottawa County, Michigan (miottawa.org)

B. Training Updates

1. Make sure you are tracking your trainings internally - during audits we may contact you for this information
2. We can provide examples if you would like assistance developing an internal tracking system

C. CPR Online Training Prior to In – Person Training

1. If First Aid/CPR/AED course is required for your agency, you will need to register for this course on the Lakeshore LMS training website www.lakeshoretraining.org
2. This one-hour skills portion of the course takes place virtually
3. Upon login, you will receive an email from Matt Postma via the American Trauma Event Management System
4. The course itself consists of watching videos and answering questions that follow
5. It takes approximately one to one and a half hours to complete the course
6. The course must be done in one session – you cannot return to finish it later – so make sure staff reserves enough time to complete the course
7. Take a screenshot showing proof of completion and send it to Matt Postma via email at MPostma@miottawa.org
8. Once the online portion is complete, staff can attend the in-person portion of the training facilitated by Matt Postma at our CMH offices
9. Online portion must be completed before hands-on portion can be attended

IV Recipient Rights Updates

Briana Fowler, Director of Recipient Rights
BFowler@miottawa.org

A. Recipient Rights Update

1. The 2023 Recipient Rights Update for providers is available on the lakeshore LMS training website FlexTraining Login Page (lakeshoretraining.org)
2. New staff must complete the full Recipient Rights training within 30 days of hire.

B. Annual Site Reviews

1. Annual site visits were previously conducted by another entity, however Briana will resume doing annual site visits for specialized residential homes, autism services centers, community living support locations, social rec locations, and other provider sites serving recipients at their facility
2. All local Recipient Rights officers are working collaboratively as approved by MDHHS
3. If you need any Recipient Rights information or posters, reach out to Briana or you can print them from the CMH Recipient Rights website Recipient Rights - Ottawa County, Michigan (miottawa.org/rights)
4. Briana will have extra copies with her when she conducts site visits

V Fiscal Updates/Financial Considerations

Amy Bodbyl-Mast, Finance Manger
Nicholas Sall, Assistant Finance Manager
Lauren Najmolhoda, Provider Compliance and Billing Supervisor
Krystal Spaans, Provider Compliance and Claims Supervisor
CMHOCfinance@miottawa.org

A. Timeliness Reminder/Clean Claims

1. Please provide proper documentation if a primary insurance was billed and payment was received

2. CMH must be billed no more than 60 days from the date of service for claims that do not require an EOB
    a. Claims submitted outside of this timeframe will be denied
3. If claims do require an EOB, you must bill us within 30 days of receipt of the EOB from the third-party payor
4. Previously denied claims should be corrected and rebilled to CMH within 60 days of the date of denial
    a. Rebilled claims submitted more than 60 days from the date of denial will be ineligible for payment
5. Clients cannot be billed for the difference between what the provider billed and what CMH has paid
6. You cannot accept any additional payments from the client, their family, or representative for CMH authorized services
7. If a request is made, relevant information must be provided to CMH to conduct any necessary post payment reviews
8. We will work to pay any claims within 30 days of submission unless there are unusual circumstances
9. Please verify units with calculated start and stop times
10. Residential claims – please make sure to have both the H and T codes billed for each day to avoid denial
11. If a service requires a performing provider be selected, be sure to include this
12. Notify us of any providers whose credentials have changed
13. EOBs must be submitted at the time of claim submission or claim will be denied
14. If insurance doesn't offer ABA benefits, we need either the primary insurance denial or a letter on file from the insurance company stating that they do not cover ABA services

B. GIVA

1. GIVA is our Fiscal Help Desk
2. This is the platform you should use to communicate any issues with rates, payments, or timely billing
3. For issues with timely billing, we will generate a ticket number for you to reference when you bill to avoid denial
4. Request for new authorizations or changes to authorizations must be submitted to a case manager
5. Tickets can be created via email or by logging into GIVA and creating a ticket from the dashboard
    a. CMHOCfinance@miottawa.org
    b. https://cmhoc.giva.net/home.cfm
    c. If sending an email, do not encrypt or it will not create a ticket
    d. Tickets are the best way to reach us with issues
    e. If you are given a reference number and your claim is mistakenly denied, please rebill, and reference the number again
    f. If you bill using PCNX, there is a service comment box if you have a GIVA ticket number that needs to be referenced

C. EOBs

1. Sent directly to you the date your payment is made

2. Sent securely to protect consumer personal health information
3. Provides a detailed description and reason for any denial or difference in payment

D. ProviderConnectNX (PCNX)

1. New date range enhancement rolled out as of March 22, 2023
2. Many training resources available for PCNX, including:
   a. Tip sheet
   b. Training slideshow
   c. Training Q&A
   d. Training video
   e. Frequently used forms
      - PCNX Batch Listing
      - PCNX Member Ledger
      - Provider Demographics – includes authorization and rate info

E. Public Health Emergency

1. The COVID-19 PHE is set to expire at the end of the day on May 11, 2023
   a. Millions of Medicaid plans will either be changing covered services or eliminated altogether
   b. Re-verification of consumer insurance plans, particularly Medicaid plans, will be crucial for billing and payment of CMH services
   c. https://www.michigan.gov/mdhhs/end-phe/medicaid-benefit-changes

F. GT Modifier

1. Soon to be removed and replaced with updated coding regulations
2. Effective May 12, 2023
3. New rules include:
   a. Using a specific location
   b. Using modifier 95 or 93 when billing for telehealth services
4. Final bulletin for the PHE Policy can be located on the MDHHS website http://www.michigan.gov/medicaidproviders

G. Rounding Rules

1. Reverting to rules prior to the COVID-19 PHE for HCPCS reporting
2. See slideshow chart below for details

VI Credentialing and OIG Updates

Kristen Henninges, Compliance Program Coordinator
KHenninges@miottawa.org
Amy Avery, Program Evaluator
AAvery@miottawa.org

A. Clinical Application

1. The date the Program Evaluator receives the application with all attachments is date you are set up for billing
2. You will receive a confirmation email once this is set up
   a. Do not allow providers to provide services until you receive this email, or it will be denied
3. If a position requires necessary trainings, please be sure to attach proof to application
4. Make sure Clinical Applications are complete to avoid delays

5. The day the Program Evaluator is notified of a license update is the day the update is effective for billing
    a. If services are provided using the updated billing prior to notifying the Program Evaluator, it will cause billing issues
6. For further questions regarding credentialing, please refer to your agency's specific Attachment A on our website Resources - Ottawa County, Michigan (miottawa.org)
7. Provider must maintain policies and procedures to ensure contracted physicians and other healthcare professionals are licensed by the State of Michigan and qualified to perform services
    a. If any license is terminated, revoked, or suspended during the term of this Agreement, provider must immediately notify the LRE and CMHSP
        - Provider will maintain policies and procedures to ensure licenses and certifications are current and valid
        - Provider will maintain policies and procedures to ensure that support care staff who are not required to be licensed are qualified to perform their jobs
        - 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
        - Be sure to complete Clinical Applications in full with detailed information
            * When completing Section III: Credentials, be sure to attach any documents selected

B. Criminal Background Checks

1. Required every two years and prior to hire
2. Applies to ALL staff providing services to or interacting with individuals served by CMHSP or persons who have the authority to access or create CMHSP information
3. Must be completed through State of Michigan LARA, ICHAT, or other service as approved by the LRE prior to starting work with individuals served by CMHSP
4. Provider must inform CMHSP if any board member has been convicted of a felony or misdemeanor related to patient abuse, any type of fraud, controlled substance, or obstruction of any investigation

C. OIG Checks

1. Required at the time of hire and monthly thereafter
2. If litigation is initiated against a provider, we must be notified immediately
3. Please retain records relating to trainings, criminal background checks, and OIG checks in case of an audit

D. MDHHS Provider Credentialing/Recredentialing Process

1. Pertains to providers with healthcare professional staff who are licensed and certified
2. Initial credentialing requires a written application that is completed and signed by the healthcare professional attesting:
    a. Lack of present illegal drug use

b. History of loss of license, registration, certifications, and/or felony convictions
c. History of loss or limitations of privileges or disciplinary action
d. Correctness and completeness of application
e. Ability to perform the essential functions of the position

3. Recredentialing is required every two years
4. Behavioral Health and Developmental Disabilities Administration, Provider Credentialing (michigan.gov)

VII Contract Updates

Gina Kim, Contract Manager
CMHcontractservices@miottawa.org

A. Fiscal Year 2024 Boilerplate

1. LRE is updating the contract language and making some changes to fit current needs
2. Once approved and finalized, this will be sent out to all providers who currently have a common contract with us
3. Effective date is October 1, 2023

B. Dispute Resolution Policy

1. Any provider with a grievance must go through our dispute resolution process
2. If you need additional information outlining this formal process, please reach out
3. Dispute resolution policy and form is included below
4. We encourage you to resolve issues with the appropriate staff before filing a formal dispute

C. Reminders

1. Useful info is located on our website Resources - Ottawa County, Michigan (miottawa.org)

VIII CMH/LRE Updates

Rich Francisco, CMH Deputy Director
RFrancisco@miottawa.org

A. MDHHS Updates

1. Electronic Visit Verification (EVV) Press release
   a. HHAeXchange is the EVV vendor that was selected
   b. This is related to a compliance issue under the 21st Century Cures Act which requires that Medicaid Services has to have certain information related to a visit
   c. This will allow the State of MI to track information related to home visits such as start and stop times
   d. This will impact several service codes
   e. As more information develops, we will communicate that with you
   f. This is an open vendor solution, allowing providers who do not have an EVV solution to utilize this on the front end
   g. The ultimate goal is aggregated data at the state level
2. Standard Cost Allocation Template

a. Fiscal and IT CMH teams have been working on implementation to fulfil all MDHHS requirements

3. SIS Assessment for I/DD Population is no longer being used
   a. There may be a replacement for this assessment, but we do not have additional information at this time

B. CMH Updates

1. Health Fair on Wednesday, May 17, 2023 from 2-6 pm at Salvation Army in Holland
   a. Free to attend
   b. All community members welcome
   c. There will be health information, snacks, and giveaways
2. CCBHC Activities and Newsletter
   a. Email customer service to subscribe to the newsletter or visit the website to view the calendar of events
      - CMHcustomerservices@miottawa.org
      - Events - Ottawa County, Michigan (miottawa.org)
   b. Events are free and open to everyone

C. Michigan Mission Based Performance Indicator System (MMBPIS)

1. Indicators relate to the timeliness of access to service
2. Indicators 2 and 3 have had no benchmark for the past few years
3. We don't know what percentage we will have to meet yet, though historically it was 95%
4. The State is developing new indicators, and the benchmark will likely be lower than 95%

IX Questions/Feedback

A. Q & A

1. Credentialing
   Q: Do providers need to fill out this form for ABTs or do they bill under the BCBA/BCABA?
   A: Yes, Behavior Technicians do need to be entered into the system.
2. LRE/MDHHS Updates
   Q: Regarding EVV – was told this was not a requirement for ABA providers. Is this correct?
   A: We will include the list that was provided to us herein.

FISCAL UPDATES

Provider Network Council (PNC) Meeting 04/13/2023
Community Mental Health of Ottawa County

INTRODUCTIONS

AMY BODBYL-MAST,
FINANCE MANAGER

NICHOLAS SALL,
ASSISTANT FINANCE MANAGER

LAUREN NAJMOLHODA,
PROVIDER COMPLIANCE AND CLAIMS SUPERVISOR

KRYSTAL SPAANS,
PROVIDER COMPLIANCE AND CLAIMS SUPERVISOR

Agenda

- Introductions
- Timeliness Reminder / Clean Claims
- GIVA
- EOB'S
- PCNX
- Public Health Emergency
  - GT Modifier
  - Rounding Rules

Timeliness Reminders

- 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 30 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.

Clean Claims

- When Submitting claims please make sure that all necessary information is included to ensure we can promptly process the claim for payment. Claim errors delay processing the claim for payment.
  - Performing Provider
  - Appropriate Modifiers / Credentialing
  - Start & Stop Times
  - Units Billed
  - Location of Service
- EOB's must be submitted at time of submission or claim will be denied.
- If insurance does not offer ABA benefits, we either need the primary insurance denial or a letter on file from the insurance company that they do not cover ABA services.

GIVA

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

EOB's

- SENT SECURELY THE DAY PAYMENT IS MADE
  - **They will give detailed description of any denial reason or reason for a payment difference.**

PCNX

- New Date Range Enhancement Rolled Out
- Documentation For Reference Available
- Frequently Used Forms
  - PCNX Batch Listing
  - PCNX Member Ledger
  - Provider Demographics- Includes authorization and rate information

Public Health Emergency Ending

The U.S. Department of Health and Human Services is planning for the federal Public Health Emergency (PHE) for COVID-19, declared under Section 319 of the Public Health Service Act, to expire at the end of the day on May 11, 2023.

- Millions of Michigan Medicaid plans will either be changing covered services, or plans may be eliminated all together at this time.

- Re-verification of insurance with consumers, especially Medicaid-related plans, will be crucial for billing and payment of CMH services.
- https://www.michigan.gov/mdhhs/end-phe/medicaid-benefit-changes

GT Modifers

- The GT Modifier will soon be removed and replaced with updated coding regulations.
- This policy is effective May 12, 2023
- New rules will include using a specific place of location, and usage of modifier 95 or modifier 93 when billing for Telehealth services.
- Final Bulletin for MMP 23-10 Telemedicine Policy Post-COVID-19 Public Health Emergency was released and can be located on the MDHHS Website.
- http://www.michigan.gov/medicaidproviders

Rounding Rules Update

GENERAL RULES FOR REPORTING

1a. Rounding rules for HCPCS reporting:

"Up to 15 Minutes"	15 Minutes	30 Minutes	45 Minutes	60 Minutes
1-15 = 1 unit	1-14 minutes= 0*	0-29 minutes = 0*	0-44 minutes = 0*	1-59 minutes = 0*
16-30 = 2 units	15-29 = 1 unit	30-59 = 1 unit	45-89 = 1 unit	60-119 = 1 unit
31-45 = 3 units	30-44 = 2 units	60-89 = 2 units	90-134 = 2 units	120-179 = 2 units
46-60 = 4 units	45-59 = 3 units		135-179 = 3 units	180-239 = 3 units
61-75 = 5 units	60-74 = 4 units			240-299 = 4 units
76-90 = 6 units	75-89 = 5 units			300-359 = 5 units
91-105 = 7 units	90-104 = 6 units			360-419 = 6 units
106-120 = 8 units	105-119 = 7 units			420-479 = 7 units
	120-134 = 8 units			480-539 = 8 units

* Do not report if units equal zero.

Questions

Thank You

- Amy Bodbyl-Mast
  AMBODBYL-MAST@miottawa.org
- Nicholas Sall
  NSALL@miottawa.org
- Lauren Najmolhoda
  LNAJMOLHODA@miottawa.org
- Krystal Spaans
  KSPAANS@miottawa.org

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

Credentialing and OIG Checks

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 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.
- In addition, if the job position requires necessary trainings (such as RBT or Recovery Coach Training, CAADC, or DP-C) please make sure it is attached to the application.
- Please make sure when you submit a clinical application they are completed in their entirety. If there is 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.
- The provider 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. Provider 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 maintain policies and procedures to ensure that licenses and certifications are current and valid.
- The provider will maintain policies and procedures to 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: _____

Criminal Background Checks

- The provider will require criminal background 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.
  - The provider shall inform CMHSP if any 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.

OIG Checks

- Providers shall ensure an initial examination of Federal and State databases of excluded parties and litigation checks (OIG) are conducted. Such examinations must take place at time of hire and monthly thereafter, for all Provider employees and persons joining Provider Board of Directors. If there is litigation initiated against a provider, you are to notify us immediately.
  - Please refer to your contract 2.4 Provider Panel Eligibility Requirements Subsection 2.4.1.5 for further information.
- We are expecting that all agency providers are compliant with trainings, criminal background checks, and OIG. We ask that you keep these 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 back to Attachment I on the CMH website.

2.4 Provider Panel Eligibility Requirements

2.4.1 Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs. To ensure compliance with the Social Security Act Sections 1128, 1128A, 1156, 42 CFR 438.6, 455.10 and 45 CFR Part 76, Provider must ensure the following:

2.4.1.1 Provider and its subcontractors, board members, and employees are not debarred, suspended, proposed for debarment, declared ineligible, or excluded from a federal or state health care program.

2.4.1.2 Provider and its subcontractors, board members, and employees have not been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal/State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property.

2.4.1.3 Provider and its subcontractors, board members, and employees are not indicted or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated above (see subparagraph 2.4.1.2).

2.4.1.4 Provider and its subcontractors, board members, and employees have not within a three (3) year period preceding this Agreement had one or more public transactions (Federal, State or local) terminated for cause or default.

2.4.1.5 Provider shall ensure an initial examination of federal and state databases of excluded parties and litigation checks are conducted. Such examination must take place at the time of hire, and monthly thereafter, for all Provider employees and persons joining Provider Board of Directors.

2.4.1.6 Provider will notify CMHSP immediately when there is litigation initiated against Provider.

2.4.1.7 Provider shall immediately disclose to CMHSP any information regarding the ownership or control by a person convicted of a criminal offense described under Sections 1128(a)(b) and 1128(b)(1), (2), or (3) of the Social Security Act and if any staff member, member of the Board of Directors, manager, or person with an employment, consulting or other arrangement with Provider has been convicted of a criminal offense described under Section 1128A of the Social Security Act.

2.4.1.8 Provider agrees to immediately notify CMHSP of any threatened, proposed, or actual exclusion from any Federally-funded health care program of it or its staff.

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

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
- Link to MDHHS Credentialing and Recredentialing Policy: Behavioral Health and Developmental Disabilities Administration, Provider Credentialing (michigan.gov)

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.

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.

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

CHAPTER: **9**	SECTION: **19**	SUBJECT: **HUMAN RESOURCES – PROVIDER NETWORK**
TITLE: **PROVIDER DISPUTE RESOLUTION**		
EFFECTIVE DATE: **May 1, 2017**		REVISED DATE: **4/25/18, 3/3/20, 11/04/22**
ISSUED AND APPROVED BY: LYNNE DOYLE, EXECUTIVE DIRECTOR		

I. PURPOSE:

To outline a process by which providers contracted with Community Mental Health of Ottawa County (CMHOC) can request dispute resolution for decisions of non-service related issues, including:

A. Denial or suspension of provider panel status with cause.
B. Request for Proposal (RFP) awards/denials.
C. Claims payments and authorizations.
D. Reduction, suspension or adjustments of payments to providers.
E. Results from provider monitoring activities and/or results reported on the Provider Summary Report.
F. A sanction or decision to place provider on provisional status.
G. Credentialing or re-credentialing decisions.
H. Other non-services issues.

In accordance with MCL 330.1784, this policy does not apply to recipient rights complaints.

II. APPLICATION:

All Community Mental Health of Ottawa County (CMHOC) providers and contract providers as specified by contract.

III. DEFINITIONS:

Dispute Resolution: The process for resolving differences between two or more parties or groups.

Grievance: An official statement of a complaint over something believed to be wrong or unfair.

Appeal: A formal process which is established so that providers may request reconsideration of an action or decision that has been made by CMHOC.

Adverse Notification: A notice, by any means, that documents a denial of authorization or claim; a reduction, suspension or adjustment to a claim; or the denial of participation as a panel provider.

IV. POLICY:

It is the policy of CMHOC to monitor contracted services to assure that a continuum of quality supports/services are provided by members of the Provider Network. When contract disputes occur between parties, this policy will allow for CMHOC and providers to collaboratively resolve disputes that may arise from the contractual relationship and cannot be resolved within the normal roles between the agency and CMHOC. Providers contracted with CMHOC can submit complaints and request reconsideration (appeal) of decisions rendered by CMHOC through the Provider Dispute Resolution Process.

V. PROCEDURE:

A. Providers shall be notified of their right to request dispute resolution via the RFP decision; sanction notice; notice of change to claims payment and authorizations; notice of reductions, suspension, or adjustments of payments; and in the contractual agreements with CMHOC.

B. Providers are encouraged to resolve problems and disagreements with the appropriate CMHOC staff person prior to making a formal request for dispute resolution.

C. When a dispute cannot be resolved informally, the provider has the option of filing a formal written request for dispute resolution. Written request for dispute resolution can be made to CMHOC Contract Manager and submitted to CMHContractServices@miottawa.org. CMHOC reserves the right to use on-site claims, utilization, provider monitoring reviews and interviews with involved parties to make decisions.

D. CMHOC Contact Manager, in conjunction with the Compliance Committee, shall notify the provider in writing of a decision regarding a grievance within 30 calendar days of receipt of the request and offer an option for appeal.

E. If the provider disagrees with the final CMHOC dispute resolution decision, they may initiate an appeal in writing within 30 calendar days after receiving adverse notification from CMHOC. Written request for an appeal can be made to CMHOC Compliance Office.

1. First Level Appeal
   The appeal is reviewed by the CMHOC department overseeing the area the appeal addresses. A written decision will be issued within 30 calendar days to the provider by the department making the decision.

2. Second Level Appeal
   If the provider is dissatisfied with the decision of the Level 1 Appeal, they may file in writing for a Level 2 Appeal within 20 calendar days to the Executive Director. A written decision will be issued by the Executive Director to the provider within 30 calendar days.

3. Third Level Appeal
   If the provider is dissatisfied with the decision of the Level 2 Appeal, they may file in writing for a Level 3 Appeal within 20 calendar days to the CMHOC governing board, whose decision will be considered final. A written decision will be issued by the governing board to the provider within 30 calendar days.

F. If the provider fails to submit a timely request for appeal of the dispute resolution decision, the provider will be deemed to have accepted CMHOC's determination and will have waived all further internal or external processes regarding the issues.

VI. ATTACHMENT:

A. Provider Dispute Resolution Operational Guideline
B. Contract Dispute Resolution Request Form
C. Contract Dispute Decision Form
D. Contract Dispute Appeal Forms
   a. 1st Level Appeal
   b. 2nd Level Appeal
   c. 3rd Level Appeal
E. Contract Dispute Appeal Decision Forms
   a. 1st Level Appeal Decision
   b. 2nd Level Appeal Decision
   c. 3rd Level Appeal Decision

VI. REFERENCE:

A. Lakeshore Regional Entity Network Provider Appeals and Grievances (Policy 4.7)
B. Mental Health Code (MCL 330.1784)
C. Dispute Resolution Contractual Language (3.9)

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

CONTRACT DISPUTE RESOLUTION REQUEST FORM

To be completed by agency filing dispute resolution.

Date: _____

Agency: _____

Contract issue under disput is primarily (check which best apply):

☐ Claims/Reimbursement Dispute ☐ Rate Dispute

☐ Contract/Quality Dispute ☐ Other:

Describe issue under dispute (attach additional documents as needed):

☐ Supporting documentation attached

Describe actions taken so far to resolve dispute (attach additional documents as needed):

☐ Supporting documentation attached

Sign and submit to CMHOC Contract Manager:

Signature: _____

Print Name: _____

Print Title: _____

Phone/Email: _____

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

CONTRACT DISPUTE APPEAL FORM
1st Level Appeal

To be completed by agency filing dispute resolution appeal.

Date: _____

Agency: _____

Attach copies of the following documents:

☐ Contract Dispute Resolution Request form

☐ Contract Dispute Decision form

Describe reason(s) why agency disagrees with CMHOC position:

☐ Supporting documentation attached

Sign and submit appeal to CMHOC Compliance Office:

Signature: _____

Print Name: _____

Print Title: _____

Phone/Email: _____

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

CONTRACT DISPUTE APPEAL FORM
2nd Level Appeal

To be completed by agency filing dispute resolution appeal.

Date: _____

Agency: _____

Attach copies of the following documents:

☐ Contract Dispute Resolution Request form
☐ Contract Dispute Decision form
☐ Contract Dispute Appeal – 1st Level form
☐ Contract Dispute Appeal Decision – 1st Level form

Describe reason(s) why agency disagrees with CMHOC 1st Level Appeal:

☐ Supporting documentation attached

Sign and submit appeal to CMHOC Compliance Office:

Signature: _____

Print Name: _____

Print Title: _____

Phone/Email: _____

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

CONTRACT DISPUTE APPEAL FORM
3rd Level Appeal

To be completed by agency filing dispute resolution appeal.

Date: _____

Agency: _____

Attach copies of the following documents:

☐ Contract Dispute Resolution Request form
☐ Contract Dispute Decision form
☐ ontract Dispute Appeal – 1st Level form
☐ Contract Dispute Appeal Decision – 1st Level form
☐ Contract Dispute Appeal – 2nd Level form
☐ Contract Dispute Appeal Decision – 2nd Level form

Describe reason(s) why agency disagrees with CMHOC 2nd Level Appeal:

☐ Supporting documentation attached

Sign and submit appeal to CMHOC Compliance Office:

Signature: _____

Print Name: _____
Print Title: _____
Phone/Email: _____

Press Release and memo link:

- EVV Press Release.pdf
- HHAeXchange awarded the contract – an IT firm that has contracts with other states already providing EVV solutions: HHAeXchange has successfully implemented more than 34 payers and is the EVV aggregator for the states of New Jersey, West Virginia, Alabama, Minnesota, Mississippi and Illinois.
- "Personal care and home health providers will be able to use the free provider portal and its multilingual caregiver tools to report required information to enable the department to manage provider compliance and ensure participants are receiving appropriate services."
- MDHHS will be implementing an "Open Vendor Model." This model allows providers and managed care organizations to use the state EVV system at no cost, or an alternate EVV system of their choosing that directly integrates with the state system.

MDHHS portal for EVV. Where you can learn more about the what it is and what is driving this requirement which is the 21st Century Cures Act.

https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/electronic-visit-verification

What is EVV?

Electronic Visit Verification (EVV) is a validation of the date, time, location, type of personal care or home health care services provided, and individual(s) providing and receiving services. This information helps to ensure that beneficiaries, clients, or participants receive the expected care.

Beneficiaries, Clients & Participants - FAQs

A beneficiary, client, or participant in any of the following programs will require the use of EVV.

- Home Help
- Home Health
- Children's Waiver*
- Habilitation Supports Waiver*
- Waiver for Children with Serious Emotional Disturbances*
- MI Choice Waiver
- MI Health Link
- Community Transition Services

*These programs provide Behavioral Health Community Living Supports services.

Beneficiaries, clients, participants, caregivers, or providers in one of the following Medicaid programs or benefit plans will be impacted by EVV. Click on the program name to learn more about the services offered:

- Home Help - Provides personal care services to individuals who need hands-on assistance with Activities of Daily Living (ADLs) and assistance with Instrumental Activities of Daily Living (IADLs). MDHHS is responsible for approving Home Help providers for participation in the program.

- Home Health Services - A covered benefit for beneficiaries with conditions not requiring continuous medical/nursing and related care but do require health services on an intermittent basis in the home setting for the treatment of an injury, illness, or disability. Services may be provided in the home only if circumstances, conditions, or situations exist which prevent the beneficiary from being served in a physician's office or other outpatient settings.

- Children's Waiver Program * - The Children's Waiver Program (CWP) is a federal entitlement program that provides Medicaid-funded home and community-based services to children (under age 18).

- Habilitation Supports Waiver * - Beneficiaries with developmental disabilities may be enrolled in this Program to receive the supports and services as defined. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services.

- Children with Serious Emotional Disturbances Waiver * - The Children's Serious Emotional Disturbance Waiver (SEDW) provides Services that are enhancements or additions to Medicaid State Plan coverage for children up through age 18 with serious emotional disturbance, who are enrolled in the SEDW.

- MI Choice Waiver - Eligible adults who meet income and asset criteria can receive Medicaid-covered services like those provided by nursing homes but can stay in their own home or another residential setting.

- MI Health Link - A single program for qualifying individuals who are eligible for both Medicare and Medicaid. MI Health Link offers a broad range of services including medical, behavioral health, pharmacy, nursing home care, and home and community-based services.

- Community Transition Services - Transition Services are Medicaid Home and Community-Based Services (HCBS) authorized through §1915(i) of the Social Security Act to assist nursing facility residents that would like to explore community-based living options.

* These programs provide Behavioral Health Community Living Supports services.

Below is a list of terms that are commonly used when discussing Electronic Visit Verification.

- **Atypical** - The Center for Medicare and Medicaid Services (CMS) defines atypical providers as providers that do not provide health care [2]. Providers who may be enrolled in CHAMPS or Bridges and do not perform medical services (e.g. Home Help, Non-Emergency Medical Transportation (NEMT), Adult Foster Care (AFC)). Atypical providers may submit HIPAA transactions, but they do not meet the HIPAA definition of a health care provider and would not receive an NPI number.

- **Beneficiary** - An individual who receives Medicaid services. Related terms include: 'Recipient', 'Client', and 'Member'. Device - A piece of equipment or a mechanism designed to serve a special purpose or perform a special function, such as smartphones and other electronic devices. [1]

- **Electronic Visit Verification (EVV)** - Electronic Visit Verification (EVV) is a validation of the date, time, location, type of personal care or home health care services provided, and individual(s) providing and receiving services.

- **Global Positioning System (GPS)** - A navigational system using satellite signals to fix the location of a radio receiver on or above the earth's surface. [1]

- **Internet Service Provider** - A company that provides its customers with access to the Internet and that may also provide other Internet-related services (such as e-mail accounts). [1]

- **Typical** - A health care provider means a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for healthcare in the normal course of

business. Medical Providers are enrolled within CHAMPS and have an NPI (e.g. Institutional (Hospital, Nursing Home, etc.,) Professional (Practitioner, Prescriber, Pharmacy, Dental, etc.)).

SAMHSA
Substance Abuse and Mental Health Services Administration

MAY 17 HEALTH FAIR

2-6pm

Salvation Army - Holland
104 Clover Street, Holland, MI 49423

ACTIVITIES

SNACKS

GIVEAWAYS

Join us for the 2023 Community Health Fair on May 17th from 2-6pm. Local agencies will join together to provide the community with local resources, as well as health, wellness, and educational opportunities, snacks, giveaways, and a variety of activities for all ages! This event is free to all.

Scan the QR code to see a list of participating vendors.