Provider Network Council (PNC) Minutes
Community Mental Health of Ottawa County
Microsoft Teams
Thursday, March 31st, 2022, 1pm-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.

1. **Welcome and Introductions**
   Kelly Goetzinger, Program Coordinator, Contracts and Training

   Thank you for participating in our third Virtual Provider Network Council (PNC) meeting and for the continued positive partnership we have formed over the years. We appreciate your patience with us during this pandemic.

2. **Genoa Pharmacy**
   Jacob Golin PharmD, Pharmacy Site Manager
   JGolin@genoahealthcare.com
   - **A. Located within**: Ottawa County Community Mental Health Center
     - Address: 12265 James St Building A Room 214 | Holland, MI 49424
   - **B. Phone:** (616) 499-3197
   - **C. Fax:** (616) 465-2064
   - **D.** Genoa has a 47-state network of more than 450 pharmacies and medication coordinators, who serve more than 650,000 people across the United States every year. With their strong, caring network of pharmacy professionals, they make it easier for consumers to get their medications and feel better.
   - **E.** Genoa Healthcare pharmacy provides a higher level of service in the safest way possible. They:
     - Fill all medications (not just behavioral health)
     - Mail medications (at no extra cost)
     - Assist us with prior authorizations and insurance/medication questions
     - Offer a variety of packaging options to increase adherence
     - Organize the consumer's pills based on the date and time they need to take them
     - Help consumers transfer prescriptions from other pharmacies
     - Reach out to consumers regularly to check on refills
   - **F.** This all means better medication adherence. A peer reviewed study found that consumers using a Genoa Healthcare pharmacy had medication adherence rates of more than 90% compared to about 50% at a typical retail pharmacy. These consumers also had 40% fewer hospitalizations and 18% fewer emergency room visits.
     - Client packaging options are offered by Genoa to help manage when medications need to be administered (morning, day, evening, bedtime).

1. Mailing to the homes at no additional charge.
2. There is a delivery service as well that a delivery person comes directly to the home.

- Medicare/Medicaid/Commercial Insurance – all medications can be filled at this pharmacy to make it as simple as possible for you!

G. Genoa Pharmacy is now able to administer the newly approved 2nd COVID Boosters. This can be set up with them to come into your homes or set up a clinic right in CMHOC's main office. Please feel free to reach out to them if your agency wants to set this up.

3. Training Requirements

Kelly Goetzinger, Program Coordinator, Contracts and Training
Email: kgoetzinger@miottawa.org

A. Attachment I Update

- The training center's email is: cmhtrainingcenter@miottawa.org
- Matt Postma – CMHOC's Mental Health Trainer: mpostma@miottawa.org
- Kelly brought our provider network through our Community Mental Health of Ottawa County home page to explain where they could find information on the training center https://www.miottawa.org/Health/CMH/pdf/training/Attachment1TrainingRequirements.pdf
    1. Kelly outlined on the training center's home page, there is important notice about classroom training outlined in red. This should be something that all our providers pay attention to during COVID-19 for important training updates.
    2. Lakeshore Learning Management System (LMS) is the region's platform for classroom and online courses. This learning platform is a self-registration system in which each student registers for both classroom and online courses they are required to complete. https://lakeshoretraining.org/ottawa/
- On the training website, CMHOC lists out two-three months out with classroom training that you can schedule your staff for.
- Attachment I: https://www.miottawa.org/Health/CMH/pdf/contracts/Attachment_I-Training_Requirements.pdf
    1. On page three of this document, it lists in further details of this specific training:
        a. Description
        b. Frequency
        c. When to take the training
        d. How to obtain the training
        e. Explanation of why it is a requirement

2. This training attachment is used across all the CMHSPs in our region.

- Please make sure you maintain documents of your trainings; this may be information that is request if you were ever pulled for an audit. If you need assistance in developing a tracking sheet, our training department has a template that you can utilize.

B. Training Updates

- **Hybrid First Aid CPR-AED**
  1. To register for the 1-hour skills portion on the Lakeshore LMS training website please note that the times are for 1 person only. Many times, during the day there are 6 different time slots. Starting in May 2022 there were openings for 2 people per in person segment.
  2. Example: "Ottawa-Hybrid First Aid/CPR/AED 01/04/21 - 09:00-10:00 (classroom) – TC"
  3. Once registered Matt Postma will email the information to the online training from another site (American Trauma Event Management-see below). There are multiple videos to watch and questions to answer.
     a. This can take staff anywhere between 1.5-2 hours to complete.
     b. Please note, this training isn't a training you can take partially and come back to later, it must be completed in one sitting.
  4. Once staff complete the training, they need to email Matt Postma a screen shot of their certificate of completion prior to attending their 1-hr skills session.
     a. Please make sure you have completed the training prior to attending the hands-on session. There are times where it hasn't been completed and this takes away from a time slot for someone else to attend.
     b. After completing the skills, they get their card and the training should be reflected on their Lakeshore training transcript.
     c. For a list of LARA approved CPR/FA/AED providers please go to
        - https://www.michigan.gov/lara/0,4601,7-154-89334_63294_5529_49572_49583-82382--,00.html
        - The requirement for LARA is that there is a hands-on component.

****Reminder there is a Mandt online option for training. Please contact Matt Postma with any questions****

- **MANDT Training**
    1. Online training for MANDT CANNOT be registered via the Lakeshore training site. It is done through the MANDT site and Matt must register the staff. All online training registration is conducted as followed:
        a. Supervisor/Manager/Homeowner emails Matt with name of staff and which online training they would like them to take.
        b. Matt requests a purchase of this training through our fiscal services.
        c. Courses are purchased and fiscal services emails an invoice to agency.
        d. Matt then can then assign the training to the specific staff immediately after fiscal services notifies him the course was purchased.
        e. Staff gets an email with log-in information from MANDT (not Ottawa CMH).
        f. If staff does not retrieve the information, they should notify Matt the same day. Matt can initiate a username and password reset.

- **Training Options**
    1. New Hire staff options
        a. Take Day 1,2,3 in-person (must be taken in sequence)
        b. Do Day 1 & 2 online through the MANDT website ($33.99) and do Day 3 in person.
    2. First year Recert options
        a. Take MANDT Recert in-person
        b. Take first 3 chapters online ($28.75) then come to a Day 3 in-person. This also works for people whose certification has expired.
    3. Second year+ Recerts have two options
        a. Take MANDT Recert in-person
        b. Take all 6-chapter tests as an online test ($8.25) out then come to a half-day technical skills course. This is an electronic version that is a “test-out”. Study guides are provided every year and are encouraged to review prior to taking the test. Tests can be taken anywhere.
        c. If your certification is expired, then you must cover the information on Day 1 and Day 3 (First year Recert option above).
        d. Currently half-day courses are scheduled as needed. If there is a higher volume of staff who need to

schedule the half-day courses, then Matt will put them on the calendar. As of right now they are only scheduled when needed.

4. Fiscal Updates

Jessica Ogle, Provider Compliance and Claims, Fiscal Services (aka GIVA 😉)
Email: jogle@miottawa.org
PowerPoint presentation is attached to the meeting minutes

A. Attachment B

- Your Attachment B is the last few pages within your contract that spells out your rates and services.
- **Timeliness reminders:**
  1. For claims which DO NOT require an EOB:
     a. Claims submitted more than 60 days after the date of service will be denied.
     b. Claims submitted more than 365 days after the date of service will be denied.
  2. For claims which DO require an EOB:
     a. If Coordination of Benefits is required for a claim, the Contractor shall submit the claim 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. Claims submitted more than 365 days after the date of service will be denied.
  3. 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**
  1. Submit clean and timely claims – Clean, accurate, ready with evidence that primary insurance was properly billed, and payment was received from them
  2. The standard requirement to bill CMHOC no more than 60 days from the DOS for claims that DO NOT require an EOB. For claims that do require an EOB the requirement is to bill CMHOC within 30 days of the receipt of the EOB.
  3. Previously denied claims should be corrected and resubmitted to CMHOC within 60 days from the date of denial.
- **Year End Reminder:**
  1. Claims/Invoices: All invoices for the fiscal year are due to CMHOC by October 20, 2022. Any disputed claims and/or invoices must be reported to CMHOCFINANCE@miottawa.org by November 19, 2022.

Claims/invoices not submitted by these deadlines will be denied.

2. Disputed/Outstanding Claims: Any disputed claims, resubmissions, or claims awaiting Coordination of Benefits must be reported to CMHOCFINANCE@miottawa.org by November 19, 2022. Claims not submitted by these deadlines will be denied. Please submit a **single Excel** file of all agencies outstanding/disputed claims, including any that you are working with other CMHOC staff to resolve. The file must include consumer number, date of service(s), code(s), unit(s), and estimated liability.

- **Additional reminders:**
  1. Monitor eligibility – identifying primary payors and coordination of benefits; seek reimbursement from primary payors. Medicaid is payor of last resort
  2. CMHOC asks that all providers bill monthly or semi-monthly unless approval otherwise has been granted.
  3. Clients may not be billed for the difference between what the provider has billed and what CMH paid them, CANNOT accept additional payments from client, their family or representative for CMH authorized services
  4. If a request is made relevant information must be provided to CMH to conduct post payment reviews
  5. Clean claims will be paid within 30 days of submission, unless there are unusual circumstances

B. GIVA

- GIVA is the Fiscal Services helpdesk. https://cmhoc.giva.net/home.cfm
- Tickets are created two ways.
  1. By simply emailing cmhocfinance@miottawa.org
  2. By logging into the GIVA helpdesk and creating a ticket from the dashboard.
- GIVA allows pre-approved users the ability to create help-desk tickets for issues like missing an EOB, claims corrections, and general trouble with billing. GIVA is also where you notify Fiscal Services of issues that will negatively impact your ability to meet the 60-day billing requirement. This is where you can communicate any issues you're experiencing, rates not populating correctly in ProviderConnect, questions on EOB's or payments received, GIVA is also where you notify Fiscal Services of issues that will negatively impact your ability to meet the 60-day billing requirement.
  1. A few examples of such issues may be waiting on an authorization to be entered/updated, or a delay in rendering provider setup. When we're notified of issues

which impact your ability to meet the timeliness requirement, we give you a ticket number to reference when you can bill. This ticket number is a flag to the claims processor to override the claim/claims that are automatically denied by the 60-day billing rule.

- Tickets are addressed in the order that they are received and the most efficient way to receive help with issues and questions, please do not email staff directly as this can cause delays in your response time.
- GIVA is a secure site. Please do not send any encrypted emails to GIVA, we get an error notification, and a ticket is not created.
- When CMHOC sends you an attachment through GIVA, it does require you to login to the site. Attachments cannot be viewed through the email, so it's a good idea to familiarize yourself with the dashboard setup and login every few weeks to keep your dashboard profile active.
    1. GIVA deactivates the dashboard for a user when it hasn't been used after 30/60 days.
- When using the dashboard, you can select what's called a Nature of Request, which helps give us an idea of what the ticket is about. If you're not sure what Nature of Request your issue falls under, or if you don't see a Nature of Request that accurately describes your request, you can always default to "Other".
- If you are given a reference number and your claim is mistakenly denied, please feel free to rebill it and ref. the ticket number again, you do not have to create another GIVA ticket. Overriding claims is a very manual process and our system almost works against us b/c we're telling it to go against the way it was setup.
    1. Things do get missed in the process. Our recommendation is that in your notification email to cmhoc.claims that you're providing all the GIVA ref. numbers up front and who they're specific to, as well as any corresponding EOB's.
    2. Highlight if something is a rebill, etc. If you can detail as much information as possible in that notification email, it makes it easier to process claims against and ensure nothing gets missed.
- Requests for new auths or changes to current auths must be submitted to case manager.
- We currently have 1 full time claims processor, Gina on the left in presentation, who has been in the role for about 3 months. She processes all claims except inpatient. Maggie, in the middle in presentation, has been with the county for a few months and currently spends a couple hours a week helping to process the AFC services. Destiney, on the right in presentation, processes all

inpatient claims and helps administer the GIVA helpdesk. Please be patient with us during transition and training time.

C. ProviderConnect/837 Files

- **Units Billed**
  1. It is important to remember to adjust the units being billed
- **Checking on old claims/bills**
  1. Billing section – Change dates for the period you want to see what claims were submitted
  2. Consumer – Treatment section allows you to change months to see what has been billed.
- **Denial Issues**
  1. Residential H and T codes
     a. For residential claims make sure H and T codes are both billed for each day on the claim to avoid denial of the entire claim submission. If the service requires a performing provider to be selected choose from drop down list to ensure claims are not denied. When billing you do not need to include credentialing modifiers, those are added on the back end of the system based on the credentials setup for the provider in our system so if you have a provider whose credentials have changed it is important to notify us.
     b. If you bill the H2015 code you should be using H2015UJ for health and safety overnight claims, started a few months ago and not seeing it utilized
  2. Performing Provider not given
  3. Credentialing Modifiers
     a. If you are a provider who utilizes credentialing modifiers, you do not have to use them when you bill for services. CMHOC is doing this on the back end to accommodate.
- **Final Step**
  1. Email to cmhoc.claims@miottawa.org including name of Agency, any EOB's required for the claims submitted and GIVA ticket number, if applicable
- **Billing System Upgrade**
  1. Beginning in April we are going to be implementing a new billing system with new enhancements and functionality and access to more reporting. It will take us approximately 3 months to roll out, look for more communication on that

as it gets closer to summer and go live. We do anticipate the need for additional training once the system is in place and will be working closely with you to make sure your transition is smooth.

- **837 Files**
    1. **Naming Convention for Files**
        a. XXyymmdd&Z.txt
        b. XX = Agency Name; yy = Current Year; mm = Current Month; dd = Day of the Month; & = I for Institution OR P for Professional; Z = Unique File ID so multiple files can be uploaded on the same day if necessary
        c. Must be a .txt file to process correctly.
    2. **Error Reports**
        a. REJECTED FILE – Nothing in the file was processed
        b. CRITICAL FILE ERRORS – The file was processed but claims were rejected
        c. If a file was rejected nothing was processed, correct the errors, and resubmit the entire thing, this is not a valid claim submission and will not be considered in timely filing decisions for payments. Critical Errors – Some claims were paid and other were denied, refer to the error report to be directed to the lines that were not paid and the reason(s) why. We will be setting up a session for providers who want to learn how to better understand the error reports that they receive. The companion guide does a good job of explaining the process and some of the most common errors.
    3. **Most Common Errors**
        a. Performing Provider not provided
        b. Credential Modifiers Included

D. EOBs

- Sent securely the day payment is made
    1. They will give detailed description of denial reason or reason for payment difference
    2. Must be sent secure to protect consumer PHI, faster than waiting for a response from a GIVA ticket

5. Financial Considerations

Keith Falkowski, Finance Manager
Email: kfalkowski@miottawa.org
PowerPoint presentation is attached to the meeting minutes

A. Audit/Reviews

- According to your contract, a provider must obtain an annual financial audit when the total fiscal year (10/01-9/30) revenue from all sources is $750,001 or more
    1. The audit will cover Provider's fiscal year.
        a. Audit must be performed by a Certified Public Accountant (CPA) to ensure the financial statements are presented in conformance with accounting principles generally accepted in the United States of America.
        b. Management letter issued as a result of the review by the Certified Public Accountant must be submitted to CMHSP.
- According to your contract, a provider must obtain an annual financial review when total fiscal year (10/01-9/30) revenue is between $250,000 and $750,000, unless Provider is required to obtain an audit for some other reason.
    1. In cases where Provider's total fiscal year revenue is less than $250,000, CMHSP may request a financial review.
    2. The review will cover Provider's fiscal year.
    3. The review must be performed by a CPA to provide limited assurance that there are not material modifications that should be made to the financial statements in order for them to be in conformance with accounting principles generally accepted in the United States of America.
    4. Management letter issued as a result of the review by the Certified Public Accountant must be submitted to CMHSP.
- Provider's must submit the items above to CMHOC's Finance Manager and/or Contract Manager within one hundred and fifty (150) days following Provider's fiscal year end. Any deviation from this requirement must be requested in writing and in advance and must be approved by CMHOC.

B. Direct Care Wage (DCW)

L 20-28	L 20-27	L 21-76
• 4/1/20-3/31/21 • $2.00 Pay • $.24 Taxes • $2.24 Total	• 4/1/21-9/30/21 • $2.25 Pay • $.27 Taxes • $2.52 Total	• 10/1/21 -9/30/22 • $2.35 Pay • $.29 Taxes • $2.64 Total

- **Letter 22-10 – State Clarifications**
    1. "The $2.35 per hour should be paid in addition to the worker's regular wage but cannot be less than the wage being received by, or the starting wage offered to, a qualifying direct care worker on March 1, 2020. This wage increase must be recorded separately from base pay on payroll documents and labelled as "FY 2022 Provider Pay Increase"."
    2. "The Premium Pay must be recorded separately from base pay on payroll. If a direct care worker's paycheck spans more than one Premium Pay period with different Premium Pay amounts, these need to be recorded separately to show they apply to different Premium Pay periods. For example, if the paycheck spans February 21, 2021, through March 6, 2021, the period from February 21-28 applies to the $2.00 per hour Premium Pay while the period from March 1-6 applies to the $2.25 per hour Premium Pay. These should be recorded separately. The information in previously issued L Letters for Premium Pay is still accurate for those respective time periods."
    3. "All wage increase payments are subject to audit and potential recoupment. Providers should retain documentation that supports the distribution to direct care workers and that payments were made in accordance with the requirements in this letter. Section 231 of Public Act 87 of 2021 requires additional wage reporting. MDHHS is currently working on the legislatively mandated reporting requirements and will provide additional guidance once they are finalized."

C. Third Party Billing – EOB Submissions

- When Coordination of Benefits is required, the third-party EOB(s) should be submitted by secure email or fax when the billing batch is submitted to CMH.
- Submission within 30 days of receiving EOB
    1. Claim must include EOB
- 365 days after service date denied regardless of EOB Date

D. Telehealth "GT" modifier

- Providers are failing to attach the GT modifier to the service provided if it was done via telehealth. MDHHS has regulations on the PHE Extension stating that providers shall still report the "GT" modifier and the place of service. This is a requirement for ALL services reported for COVID-19 face-to-face allowance. Per MDHHS, the Federal PHE was extended through April 16, 2022, and the "GT" modifier for telehealth must continue to be reported until the PHE is "deemed" over. At that time, CMHOC will communicate this to all of our provider network.
    1. Telehealth - GT Modifier and place of service
    2. Until end of Federal PHE, currently 4/16/2022
    3. Conflicting accounts – no GT or wrong POS

****CMHOC will notify when PHE is over and there is no longer a need for GT****

6. Credentialing and OIG Updates

Kristen Henninges, Compliance Program Coordinator
Email: khennings@miottawa.org
PowerPoint presentation attached to the meeting minutes

A. Clinical Application

- The date that the Program Evaluator (Amber Cauchi/Amy Avery interim) receives the clinical application with all the attachments is the date the provider will be set up for billing.
    1. 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.
    2. 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.
    3. 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.
- When a provider has a license update, the day that the Program Evaluator (Amber Cauchi) 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.
    1. The provider will maintain policies and procedures to ensure that licenses and certifications are current and valid.
    2. 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.
    3. 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.

B. 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.
    1. 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.
    2. 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.

C. 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.
    1. 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.

1. 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.

D. Credentialing Questions, Comments, or Concerns:

- 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:**
  Amber Cauchi
  a. Phone Number: 616-393-5682
  b. Email: acauchi@miottawa.org
- **Interim QI Clerk Contact Information:**
  Amy Avery
  a. Phone Number: 616-393-5619
  b. Email: aavery@miottawa.org

7. Contract Updates

Tori Clark, Contract Manger
Email: tclark@miottawa.org

A. Fiscal Year 2022 Boilerplate

- Community Mental Health of Ottawa County has updated the regional boilerplate to include Certified Community Behavioral Health Clinic (CCBHC) language. This boilerplate is retro-effective 1/1/2022 so CMHOC wants to work with all of our provider network to update their current contract to this revised boilerplate. This will help you start new, so you do not have to keep track of the numerous amendments you have had from 2019-current.
- This change will not include any negotiations for new rates or services not previously discussed between CMH and the provider. This is strictly just a standard renewal of your contract with the updated CCBHC language. Please be on the lookout for this contract within the next few weeks as we put this together.

B. Updates on Website

- https://www.miottawa.org/Health/CMH/resources_index.htm#prov
- We have added the CCBHC Attachment Ks to the website for your reference
- We have also included our PNC Agenda and Minutes from the previous year so you can also review them at any time.

C. Dispute Resolution Policy

- CMHOC has a new contracting email CMHContractServices@miottawa.org. This email will be used for all contract-based questions or concerns.
- If you have a Dispute Resolution Request, please submit them to the new email so we can review and respond to your request within a timely manner.
- Attached to the minutes is CMHOC's dispute resolution policy and levels of appeals and the LRE's dispute resolution policy.

8. LRE and Beacon Updates

Lynne Doyle, Executive Director
Email: ldoyle@miottawa.org

There are some updates with the region. Several years ago, the Lakeshore Regional Entity entered a contract with Beacon Health Options for some managed care services. Recently, we received notice that they will be ending that contract and Beacon Health Options will be fully finished in July. The Lakeshore Regional Entity will take back the responsibilities as the regional PIHP.

There is a significant change in reorganization happening within Michigan Department of Health and Human Services (MDHHS). The bureaucracy that was specifically overseeing PIHPs and CMHSPs was the Behavioral Health and Developmental Disability Administration (BHHDA) has now been reorganized into a larger umbrella structure called Behavior and Physical Health Aging Services Administration (BPHASA). We are just now learning about this restructure, more to come when the information arises.

9. Questions/Feedback

Tori Clark, Contract Manager

Again, we appreciate your partnership and all your hard work you have been doing during this difficult time through the pandemic. The next Provider Network Council meeting will be announced soon and will most likely be around the August/September timeframe. Send any suggestions for agenda topics to CMHOC's Contract email at CMHContractServices@miottawa.org.

Get to know Genoa Healthcare

Genoa Healthcare has a 47-state network of more than 450 pharmacies and medication coordinators, who serve more than 650,000 people across the United States every year.

With our strong, caring network of pharmacy professionals, we make it easier for you to get your medications and feel better.

We're here for you.

www.genoahealthcare.com

(866) 763-2250

info@genoahealthcare.com

genoa healthcare

genoa healthcare

Life is complicated.

Getting your medications doesn't have to be.

Genoa Healthcare's pharmacy services can help.

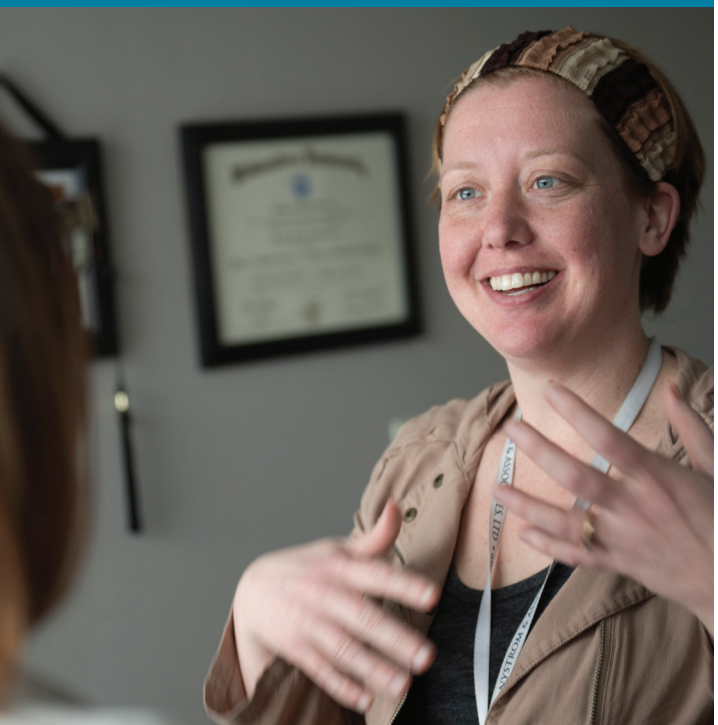
You're in good hands with Genoa Healthcare

You'll feel supported with Genoa Healthcare, a pharmacy like no other.

Our pharmacies make it easy for people all over the country to receive, refill and manage their prescriptions.

It doesn't matter where you live. We offer services in many areas, and we'll mail your medication to you at no additional cost. We also offer free delivery in some locations.

Have you already used our pharmacy through a partner program and want to continue with us? You can! Ask us how.



"They make me feel like they know and care for me."

- *Myra, consumer*

"Genoa Healthcare has been wonderful to me. The staff is so caring, and it's so convenient to get my medication."

- *Emily, consumer*

QUESTIONS? We can answer them.

We're ready to answer questions about medications, insurance plans and manufacturer assistance programs. Our pharmacies are open convenient hours, and we offer 24-hour emergency assistance.

TRANSFERS? Not a problem.

Switching pharmacies is easy. We handle everything, including contacting your current pharmacy, and transferring all your prescriptions.

COMPETITIVE PRICING? Absolutely.

All insurance co-pays remain the same when moving to a Genoa Healthcare Pharmacy. We offer competitive pricing for medication not covered by insurance plans.

Genoa makes it easier

When you're taking your medication the way you should, you feel better about your health and wellness. It's easy to keep track of your medication with our pre-filled pill organizers.

These pre-filled pill organizers separate each day's medication, so you can tell at-a-glance when it's time for your next dose.

They are offered at no extra charge with all prescriptions filled through Genoa Healthcare.

genoa healthcare

Worried about missing a dose or a refill?

5 Ways Genoa Healthcare Pharmacy Can Help

1. Fill ALL your medications in one pharmacy
2. Free delivery
3. Free pre-filled pill organizers
4. 24-hour customer service line
5. Transfer your prescriptions for you, quickly and easily

Genoa Healthcare Pharmacy

Don’t worry about managing your medications.
We’ll take care of it.

Call or stop by our pharmacy to learn more.

www.genoahealthcare.com

genoa healthcare®

CARING • ACCOUNTABLE • RESULTS-ORIENTED • ETHICAL

genoa healthcare®

Wait, did I already take my pills?

5 Tips for Remembering to Take Your Medications

1. Use daily dose packs.

Instead of separate pill bottles for each medication, your Genoa Healthcare® pharmacist can package all your medications together. They can be put into morning, afternoon and evening packages. They are color coded to help you remember when to take them.

2. Set an alarm.

Use your clock or phone to set an alarm to remind you when to take each dose. If you don't have one, you can mark it on a paper calendar.

3. Take your pills at meal times.

If your medication is to be taken with food, take it after a full meal. If it is to be taken on an empty stomach, take it one hour before a meal. If the medicine is to be taken with water, drink at least an eight-ounce glass before taking your pills.

4. Ask someone to remind you.

Ask family, friends or caregivers to help you remember to take your pills at the right time.

5. If you forget to take it, or take it incorrectly, call your pharmacist or doctor.

They can help you figure out what you need to do.

genoa healthcare®

genoa healthcare®

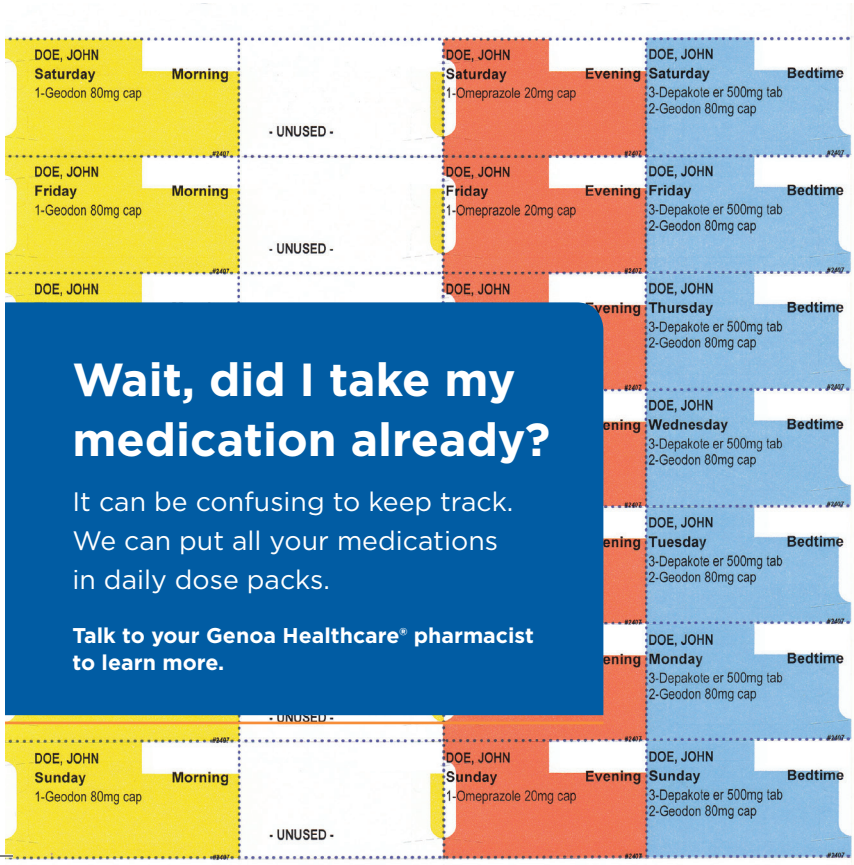
Making a trip to the pharmacy takes time.

You deserve the convenience of Genoa Healthcare® pharmacy for all your medications.

- Avoid going to more than one pharmacy by getting all your medications from Genoa Healthcare.
- You can even have them delivered directly to you at no cost.

It's easy to switch. Just call or stop by today.

genoa healthcare®



Wait, did I take my medication already?

It can be confusing to keep track. We can put all your medications in daily dose packs.

Talk to your Genoa Healthcare® pharmacist to learn more.

Break at the "nick" and peel from the liner

genoa healthcare®

CAUTION: STATE OR FEDERAL LAW PROHIBITS THE TRANSFER OF THIS DRUG TO ANY PERSON OTHER THAN THE PATIENT FOR WHOM IT WAS PRESCRIBED. **THIS PACKAGE IS NOT CHILD RESISTANT.**

FISCAL UPDATES

Jessica Ogle

PNC 03.31.22

AGENDA

ATTACHMENT B

GIVA

PROVIDER CONNECT/837

EOB's

ATTACHMENT B

- Timeliness reminders:
  - For claims which DO NOT require an EOB
    - Claims submitted more than 60 days after the date of service will be denied.
  - For claims which DO require an EOB
    - If Coordination of Benefits is required for a claim, the Contractor shall submit the claim 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.

GIVA

- The Fiscal Services Helpdesk portal: **https://cmhoc.giva.net/home.cfm**
- GIVA email address: **CMHOCFINANCE@miottawa.org**

Provider Connect

- Units Billed
- Checking on old claims/bills
  - Billing section – Change dates for the period you want to see what claims were submitted
  - Consumer – Treatment section allows you to change months to see what has been billed
- Denial Issues
  - Residential H and T codes
  - Performing Provider not given
  - Credentialing Modifiers
- Final Step
  - Email to **cmhoc.claims@miottawa.org** including name of Agency, any EOB's required for the claims submitted and GIVA ticket number, if applicable
- Billing System Upgrade

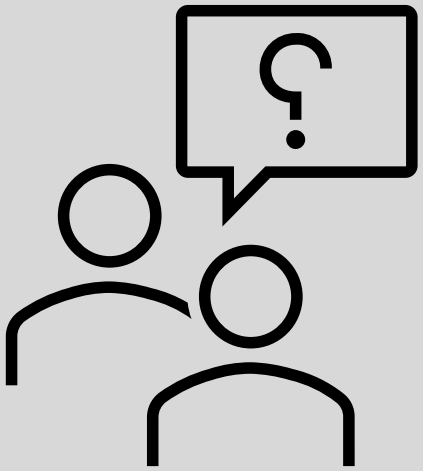
837 Files

- Naming Convention for Files
  - XXyymmdd&Z.txt
- Error Reports
  - REJECTED FILE – Nothing in the file was processed
  - CRITICAL FILE ERRORS – The file was processed but claims were rejected
- Most Common Errors
  - Performing Provider not provided
  - Credential Modifiers Included

EOB's

- Sent securely the day payment is made
  - They will give detailed description of denial reason or reason for payment difference

Questions???



General Companion Guide
837 Professional
Healthcare Claims Submission
Version 5010

Version Date: March 2021

837 Health Care Claims Transaction – Professional – version 5010

Introduction

Purpose of the Companion Guide

This document has been prepared as a Community Mental Health of Ottawa County (CMHOC) specific companion document to the ANSI ASC X12N 837, version 5010 Health Care Claims (837) transaction for professional claims. This companion guide document is only a supplement, and is not intended to contradict or replace any requirements in the ANSI ASC X12N TR3 implementation guides.

What is HIPAA?

The Health Insurance Portability and Accountability Act - Administration Simplification (HIPAA-AS) requires that CMHOC, Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services.

Purpose of the Health Care Claim (837) Implementation Guide

The X12N 837 version 5010 implementation guide for Health Care Claims has been established as the standard for claims transactions compliance as of 1/1/2012.

The HIPAA Standard TR3 Implementation guide must be used in conjunction with this document to create a compliant 837 file.

How to obtain copies of the TR3 Industry Standard Implementation Guides

The implementation guides for all HIPAA transactions are available at http://www.wpc-edi.com/content/view/817/1 .

Intended Audience

The intended audience for this document is the technical area that is responsible for submitting electronic claims transactions to CMHOC. In addition, this information should be communicated and coordinated with the provider's billing office in order to ensure the required billing information is provided to their billing agent/submitter.

837 Health Care Claims Transaction – Professional – version 5010

Testing with CMHOC

The purpose of this section is to identify the process for testing EDI transactions with CMHOC.

Testing Procedures

Before you can submit electronic transaction files for testing (or make changes from or additions to your current electronic transaction files), you must complete the following test submission procedures.

1. Contact Kristi Chittenden at CMHOC at kchittenden@miottawa.org to begin the testing process.
2. Review the CMHOC Companion Guide.
3. When you have a test file ready, contact Kristi Chittenden at kchittenden@miottawa.org for your FTP logon information.
4. Submit file through our FTP (file transfer protocols).
5. If you have any questions, please contact Kristi Chittenden at kchittenden@miottawa.org.

Test File Requirements

1. Test files must contain twenty to twenty-five test transactions.
2. Test transactions should include:
    a. A variety of different claim types that will represent normal business operations.
    b. A representative sampling of the providers for whom you are submitting claims.
3. Test files, and ultimately production files, must be named according to the guidelines below. Files that are not named correctly will not be processed.
4. Test files must be transmitted in the same format that will be used for production files.

File Naming Convention

For files transmitted to CMHOC, you must use file naming convention – **XXyymmdd&Z.txt**

XX = agency name
yy = current Year
mm = month of the current year
dd = day of the month
& = I for institutional, P for professional
Z = Unique File ID. This value allows for multiple files to be submitted per day. Use alpha or numeric values. (0-9, A-Z).

File Acceptance Requirements

1. Files must follow the correct naming convention as described above.
2. Files must be in the correct EDI Format.
3. If CMHOC is unable to process a transmitted file, the provider will be notified via email to resubmit a corrected file.
4. EDI submissions are not considered “clean” until our transactional system EDI load program completes successfully.
5. EDI submissions with format or syntax problems will be rejected and the submitter will be notified via email.

Confirmation Reports

Electronic claims confirmation reports for test files will be placed in the submitter’s FTP folders once testing has been completed.

837 Health Care Claims Transaction – Professional – version 5010

Payer Specific Data Requirements
Professional Claims (837P) Data Requirements

General:

The purpose of this section is to clarify the data elements and segments that must be used for claims transactions. This document is intended to supplement the standard HIPAA TR3 Implementation guide and to assist the submitter in creating the 837 transaction appropriately. As this is a Companion Guide, Required Segments/Elements from the HIPAA Standard Technical Report Guides that do not require further instructions specific to CMHOC are not included in the tables below. Please refer to the appropriate Technical Report (TR3) Guide for the full 837 guidelines.

Loops	Segment/Field	Field Name	Comments	Values
ISA		Interchange Control Header		
	ISA05	Interchange ID Qualifier		ZZ
	ISA06	Interchange Sender ID	Provider Tax ID	
	ISA07	Interchange ID Qualifier		ZZ
	ISA08	Interchange Receiver ID		OTTAWA
	ISA15	Usage Indicator	P – Production T – Test	
GS		Functional Group Header		
	GS02	Application Sender's Code	Submitter Tax ID	
	GS03	Application Receiver's Code		OTTAWA
	GS08	Version/Release/Industry ID Code		005010X222A1
1000A		Submitter Name		
	NM109	Identification Code	Submitter Tax ID	
1000B		Receiver Name		
	NM109	Identification Code		OTTAWA
2010BA		Subscriber Name		
	NM108	Subscriber Primary Identifier	11-digit CMH Consumer ID (Client ID in ProviderConnect with added '0' to make 11-digits)	
2300		Prior Authorization		
	REF01	Reference Identification Qualifier		G1
	REF02	Reference Identification	Authorization Number	
2310B		Rendering Provider Name	Rendering provider loop is required for all providers *except* unlicensed staff.	
	NM108	Identification Code Qualifier		XX
	NM109	Rendering Provider Identifier	Rendering Provider NPI	
2400		Service Line		
	SV101	Procedure Code	Modifiers must be in the same order they show on the authorization or in contract.	
	NTE	Line Note NTE01-Note Reference Code NTE02-Description	Use "ADD" for NTE01. For service times, include time in the following format: `NTE*ADD*SVCTIME 0000-1111~`	

			Where “0000” represents the service start time and “1111” represents the service stop time in 24 hour (military) HHMM format. “SVCTIME” must be in position 1 of the NTE02 element. “Service start time” must start in position 10 of the NTE02 element.	

837 Health Care Claims Transaction – Professional – version 5010

Production with CMHOC

The purpose of this section is to identify the process for production EDI transactions with CMHOC.

File Naming Convention

For files transmitted to CMHOC, you must use file naming convention – **XXyymmdd&Z.txt**

XX = agency name
yy = current Year
mm = month of the current year
dd = day of the month
& = I for institutional, P for professional
Z = Unique File ID. This value allows for multiple files to be submitted per day. Use alpha or numeric values. (0-9, A-Z).

File Acceptance Requirements

1. Files must follow the correct naming convention as described above.
2. Files must be in the correct EDI Format.
3. If CMHOC is unable to process a transmitted file, the provider will be notified via email to resubmit a corrected file.
4. EDI submissions are not considered "clean" until our transactional system EDI load program completes successfully.
5. EDI submissions with format or syntax problems will be rejected and the submitter will be notified via email.

Important Claim Definitions

Denied Claim: A claim that the CMHOC has processed and deemed unpayable. These claims may violate the terms of the payer-patient contract, or they may contain some sort of vital error that was only caught after processing. CMHOC will include an explanation for why a claim is denied when the denied claim is sent back to the agency. Denied claims may be appealed or reconsidered for payment, but must comply with timely billing/appeal guidelines.

Rejected Claims: A claim that contains one or many errors found before the claim is processed. These errors prevent CMHOC from paying the claim as it is composed, and the rejected claim is returned to the agency in order to be corrected. An error report will be provided with the rejected claims with the expectation that rejected claims are to be corrected and resubmitted per the error report. ***A rejected claim is not a valid claim submission and will not be considered in timely filling decisions for payment.***

Claim Submission FAQ

1. I received a critical error report and I don't know what it means.
    a. First: Reference your *837 Companion Guide, Troubleshooting Tips* for common errors and resolutions. If the file was formatted incorrectly, i.e. loops and/or headers are missing from the file; you'll need to coordinate with your IT department on how to resolve the issue(s).
2. Why didn't my file go through?
    a. Files can fail to be processed for multiple reasons, the most common of which are:
        i. File was not in a text file format
        ii. The data in the file was invalid or incomplete
        iii. The file was too large

iv. Multiple errors found in the file

3. How do I send a text file?
    a. Text files should end in .txt to be converted into a text file format.
4. Why were my claims denied?
    a. Reference your EOB and *837 Companion Guide, Troubleshooting Tips* for possible solutions. If your denial is not explained in either location, submit a ticket to GIVA for resolution.

Claim Submission Troubleshooting Tips

REJECTED FILE ERRORS

The file was completely rejected if you see “Missing Required Field / Invalid Format” at the beginning of the error message. This means that nothing contained in the file was processed.

Examples include:

Missing Required Field / Invalid Format: POSTAL CODE = 49091 (Segment: N4 - BillProvCityStateZip Loop: 2010AA)

Missing Required Field / Invalid Format: IDENTIFICATION CODE QUALIFIER = (Segment: NM1 - RenderingProviderName Loop: 2420A)

Missing Required Field / Invalid Format: IDENTIFICATION CODE QUALIFIER = (Segment: NM1 - RenderingProviderName Loop: 2420A)

- If you receive this error, the entire file was rejected due to syntax error. The syntax error is that a practitioner is missing an NPI number.

<FRAMESTACK> error (data file error)

- This error generally means that the file size is too large for the system to process. This error is most commonly found at the end of the year when submitting year-to-date files. Try generating files only containing 3 months’ worth of data at a time.

File 'F:\EDI\inbound 837\file_name.txt' has already been previously processed

- This error means the file with that text name has already been processed.

CRITICAL FILE ERRORS

Critical errors mean the file was processed; however, claim(s) were rejected.

Critical Error Line: 3481 Procedure Code Not Defined In MSO CPT Code Table (H0049).

- This error means that the code submitted is not a valid code. The code may not be in the contract, it may be missing a modifier, or it may not be a valid code.

Critical Error No Contracting Provider Program found for service.

- This error means that the code and program combination is not valid. Codes are authorized by program, so while the code may be valid, the program listed may not be.
- The service billed may also have been billed under the incorrect authorization number. Double check your file for the correct auth/code combination.

Critical Error Line: 41 - Cannot locate member through policy number: 0000000000 Cannot determine member through name and policy number: 0000000000

- This Error means that the consumer policy number provided is not 11 digits. Where 0000000000 represents the policy number submitted by the agency, in a production file, the number displayed will be the number submitted by the agency.

- Submit a ticket to GIVA and request that the subscriber policy number under PA2 in Cross Episode and/or Member Enrollment be updated to reflect the 11 digit policy number.

Warning Line: 221 - Claim Level: Could not locate Performing Provider for UPIN Number: 1912305459, funding source: MUSKEGON UNIT LIMITATIONS (700), Provider: SUD,WESTERN MICHIGAN TREATMENT CENTER (711)

- This error means that the NPI of the rendering provider is either incorrect in the file, or the NPI given to CMHOC and on file for the rendering provider is incorrect. The agency will need to verify the NPI in the file. If the NPI is incorrect in the file, the NPI needs to be corrected, and the claim(s) resubmitted. If the NPI is correct in the file, a GIVA ticket will needs to be submitted to request NPI verification from CMHOC for the rendering provider.

Could not locate member ID from funding Source: OTTAWA UNIT LIMITATIONS (300) and policy number 00000000000

- This error populates when you enter the wrong consumer/ unit limitation combination. Verify that the correct unit limitation has been selected for the consumer you are billing the service for.

Diagnosis Code: Fxx.xx is invalid.

- A file with an invalid diagnosis code will not be processed. Re-check the diagnosis and re-submit the file.

File XX has already been previously processed.

- This error means the file has already been processed through the system. If you're missing an EOB, submit a ticket to GIVA.

The date of birth contained in the file: xx/xx/xxxx does not match the date of birth on file for member ID: 00000000000

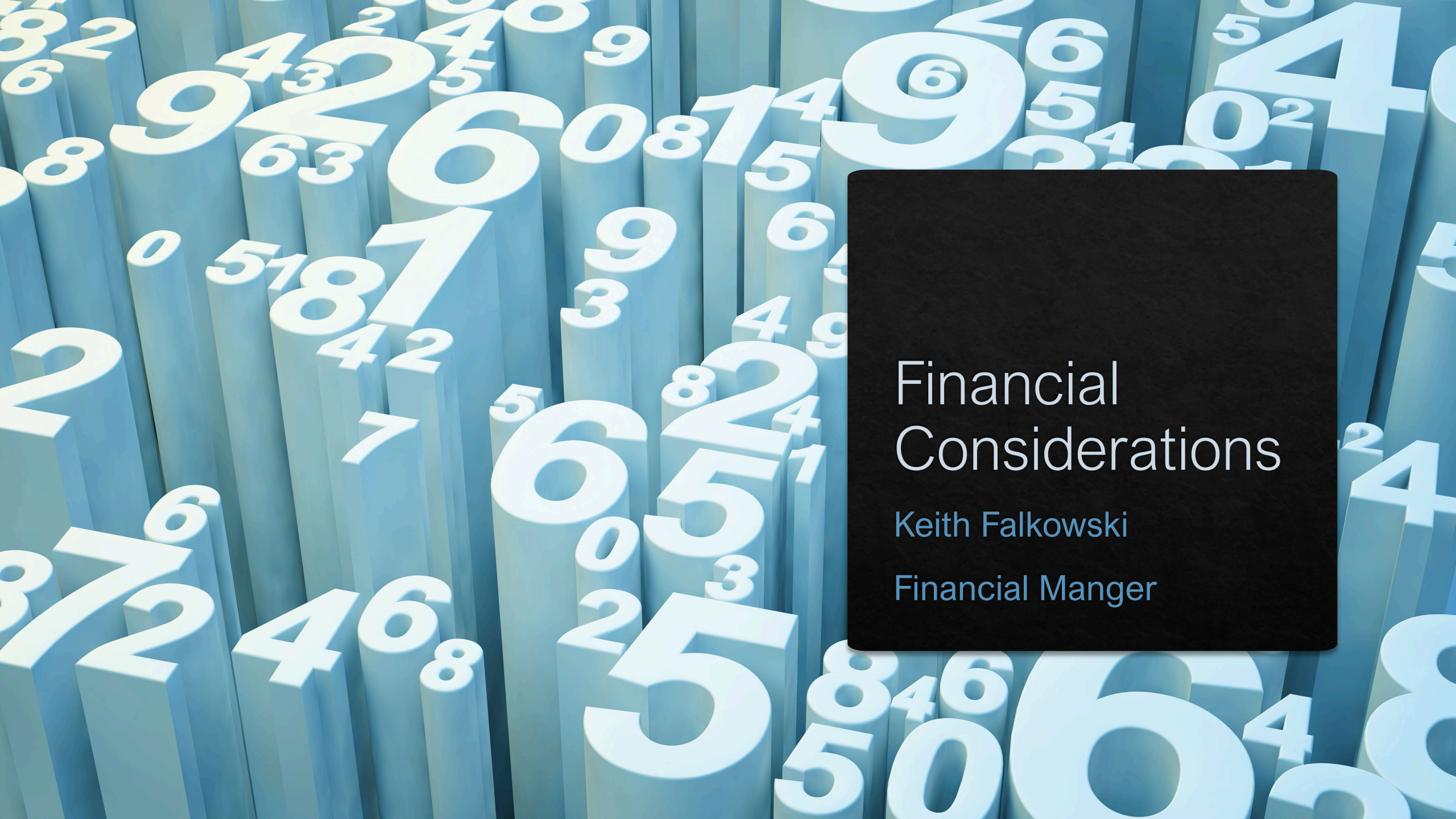
- This error means that the date of birth is incorrect in the file. Verify the DOB in the file, if the file is correct, submit a ticket to GIVA requesting that the DOB be verified in the system.

Performing Provider is not registered on date of service

- This error means that the rendering provider listed rendered a service prior to the start date associated to them in the system.

F:\EDI\inbound 837\ACIRCLEOTTCTY073020FIXB.txt - Line: 2539 - Service Level: Service Line Adjudication Information, Iteration (1). No Guarantor On File With Indicated Payer Identifier:08202

- The service was processed but the third party payment information was excluded because of system setup. The warning is saying a third party payment was made but the payor identified is not setup in Avatar. This is an internal issue not an issue on the provider side.



Financial Considerations

Keith Falkowski

Financial Manger

Financial Requirements

- Audits
  - Over $750,000
  - Provider's Fiscal Year
  - Management Letter
  - Independent CPA
- Reviews
  - $250,000 - $750,000
  - Provider's Fiscal Year
  - Independent CPA

Due to CMHOC within 150 days following Provider's year end
Must request extension in writing

Direct Care Worker Increase

L 20-28	L 20-27	L 21-76
• 4/1/20-3/31/21 • $2.00 Pay • $.24 Taxes • $2.24 Total	• 4/1/21-9/30/21 • $2.25 Pay • $.27 Taxes • $2.52 Total	• 10/1/21 -9/30/22 • $2.35 Pay • $.29 Taxes • $2.64 Total

Letter 22-10

State Clarifications

- In addition to regular wage
- Cannot be less than starting wage prior to 3/1/2020
- Recorded separately on payroll
- “FY2022 Provider Pay Increase”
- Recorded Separately from Base
- Must Reflect different pay periods
- Time periods are important
- Subject to audit
- Section 231 of Public Act 87

MDHHS is currently working on the legislatively mandated reporting requirements and will provide additional guidance once they are finalized

Third Party Billing

- When Coordination of Benefits is required, the third-party EOB(s) should be submitted by secure email or fax when the billing batch is submitted to CMH.

- Submission within 30 days of receiving EOB
- Claim must include EOB
- 365 days after service date denied regardless of EOB Date

GT Modifier

- Telehealth - GT Modifier and place of service
- Until end of Federal PHE, currently 4/16/2022
- Conflicting accounts – no GT or wrong POS
- CMHOC will notify when PHE is over and there is not longer a need for GT


Any
Questions

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

Credentialing and OIG Checks

Clinical Applications

- The date that the Program Evaluator (Amber Cauchi/Amy Avery interim) 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 (Amber Cauchi) 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.

U.S. Department of Health & Human Services

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U.S. Department of Health & Human Services

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

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:
Amber Cauchi
Phone Number: 616-393-5682
Email: acauchi@miottawa.org