Provider Network Council (PNC) Minutes
Community Mental Health of Ottawa County
Microsoft Teams
Thursday, September 29, 2022, 1pm - 3pm

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. Meeting minutes will be distributed the first week of October

II Genoa Pharmacy

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

A. Location: Ottawa County Community Mental Health Center

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 is to increase adherence to medication

1. Specialized packaging of medication into bubble cards to help keep meds organized for consumers
2. Pharmacy offers mailing of medications to the home at no additional charge as a benefit to all consumers, particularly those that have transportation challenges

C. It is Flu season

1. Flu vaccines available to anyone interested
2. New Covid boosters available to anyone interested
3. Upcoming Flu presentation and Vaccine Clinic at the Grand Haven CMH location
   a. Presentation: 10/20/2022 from noon to 1 pm
      - Everyone is welcome to come learn, participate, and ask questions
   b. Vaccine Clinic: 10/20/2022 from 1 pm to 3 pm
      - Both Flu and Covid vaccines will be available for anyone interested
      - Walk-ins are welcome
   c. If you plan to attend either portion, please RSVP to Jacob Golin via email at jgolin@miottawa.org
4. Any facilities that would like us to coordinate onsite vaccinations for interested staff/consumers, please contact Genoa Pharmacy

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. Please track these trainings internally for audit purposes, as tracking each provider's staff training is not something CMH does

3. We can provide example spreadsheets if you would like assistance developing a method for tracking these trainings

B. Website Updates

1. We are preparing to update the CMH website
2. Once updates are complete, you will be notified via email and provided a link to the website

C. CPR online training requirement

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 to 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

D. Meds Health Skill Demo reminder

1. This is an in-person class
2. Registration can be completed via the Lakeshore LMS Training website
3. In order to protect the rights and safety of consumers and reduce liability, staff cannot pass meds until they have completed this course
4. If your agency has specific challenges related to this requirement, please reach out to the Training Center for guidance or assistance

E. Diabetes and mobility classes – reminder for residential providers

1. If you serve CMH consumers with Diabetes or mobility needs, this is a required training
2. This is a one-time training with no annual requirements
3. Training can be received through us or elsewhere, but if received elsewhere it must be approved by our training department

IV Recipient Rights Updates

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

A. Incident Report and Complaint Form

1. To mitigate storage of protected health information on personal devices, you can now complete and submit these forms online - Recipient Rights - Ottawa County, Michigan (miottawa.org)
   a. Select either Online Complaint Form or Incident Report

b. Once submitted, forms are sent directly to Briana and she will review, reply, and/or route them appropriately from there
2. You can still use/submit paper copies of these forms if you prefer, but the online version is available for added convenience and to reduce instances of failure to report
3. If you would like paper Incident Reports, please contact Pam Tenbrink in IDD Services via email at ptenbrink@miottawa.org

V ProviderConnectNX Update

Kristi Chittenden, IT Coordinator
Kchittenden@miottawa.org

A. ProviderConnectNX

1. We are aware that there have been some challenges with PCNX, and we are working with our vendor to address these issues
2. We are scheduling a billing Lunch and Learn for Tuesday, 10/4/22 at noon via Zoom that will cover:
   a. Tips and tricks – a high level overview of billing and information specific to entering claims
   b. Provider Demographics report
   c. Provider Memo Ledger report
   d. Attaching third party EOBs – we will be rolling out this capability within the next week
3. The Lunch and Learn registration link will be posted in the chat and will also be sent out via email prior to next Tuesday - Meeting Registration - Zoom
4. CMH Finance team is able to schedule one-on-one trainings with anyone that needs extra assistance
5. Future roll outs:
   a. Ability to submit your own 837 rather than sending it to us for processing
   b. Ability to add more reports
      - If there is a specific report you are looking for, you can submit that request to the CMH Finance team
      - Finance will compile and pass along requests to the IT team, who will work on creating those reports

VI Fiscal Updates/Financial Considerations

Amy Bodbyl-Mast, Finance Manager
Ambodbyl-mast@miottawa.org
Krystal Spaans, Provider Compliance and Claims Supervisor
Kspaans@miottawa.org
Lauren Najmolhoda, Provider Compliance and Claims Supervisor
Lnajmolhoda@miottawa.org
General Finance/GIVA Email
cmhocfinance@miottawa.org
Claims Email
Cmhoc.claims@miottawa.org

Web Address
https://cmhoc.giva.net/home.cfm

A. Attachment B/Timeliness reminders *(Krystal Spaans)*

1. Reminders for Clean and Timely Claims:
    a. Please provide proper documentation if a primary insurance was billed and payment was received
    b. CMH must be billed no more than 60 days from the date of service for claims that do not require an EOB
        - Claims submitted outside of this timeframe will be denied
    c. If claims do require an EOB, you must bill us within 30 days of receipt of the EOB from the third-party payor
    d. Previously denied claims should be corrected and rebilled to CMH within 60 days of the date of denial
        - Rebilled claims submitted more than 60 days from the date of denial will be ineligible for payment
    e. Clients cannot be billed for the difference between what the provider billed and what CMH has paid
    f. You cannot accept any additional payments from the client, their family, or representative for CMH authorized services
    g. If a request is made, relevant information must be provided to CMH to conduct any necessary post payment reviews
    h. We will work to pay any claims within 30 days of submission unless there are unusual circumstances
    i. Please verify units with calculated start and stop times
    j. Residential claims – please make sure to have both the H and T codes billed for each day to avoid denial
    k. If a service requires a performing provider be selected, be sure to include this
    l. Notify us of any providers whose credentials have changed
    m. EOBs must be submitted at the time of claim submission or claim will be denied
    n. 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 *(Krystal Spaans)*

1. GIVA is our fiscal service helpdesk
2. Use GIVA to communicate any issues with rates or questions regarding payments received
3. To notify us of any issues that prevent you from meeting the 60-day requirement, create a ticket by emailing the GIVA email address or by logging into the helpdesk and creating a ticket from the dashboard
    a. Once you create a ticket, you will be given a ticket number that you can reference when you bill that service

b. This will allow the claims processor to identify and override that claim so it doesn't automatically get denied
c. If you do submit a ticket via email, do not encrypt the email as the ticketing system is secure and encrypted emails will not create a ticket
d. Tickets are addressed in the order they are received
e. Tickets are the most efficient way to receive issues and answer your questions – emailing staff directly can cause a delay in response time
f. If you are given a ticket # and your claim mistakenly gets denied, please rebill it and reference the same ticket # – you do not need to create another GIVA ticket
g. To notify us that you will be billing in reference to GIVA ticket(s), send an email containing the ticket number(s) to our Claims email address ahead of time

4. Any requests for new authorizations or changes to current authorizations need to be submitted to the Case Manager

C. 837 Files *(Krystal Spaans)*

1. Make sure you are using the correct naming convention
   a. The naming convention is detailed in the companion guide
   b. If you do not use the correct convention, it will get denied
   c. If you need a copy of the companion guide, reach out to us via the Claims email address
2. If a file was rejected, that means nothing was processed
   a. Correct errors and resubmit the entire file
      - Critical file errors – some claims were paid, and others were denied
        * Refer the Error Report for more information on what claims were paid/unpaid and why

D. Third party billing – EOB submission *(Krystal Spaans)*

1. Sent securely the day the payment is made
2. Provides a detailed description and reason for denial or payment difference

E. End of year claims processing *(Amy Bodbyl-Mast)*

1. Fiscal year ends 9/30/22 for all claims 10/2/21 thru 9/30/21
2. Claims must be submitted no later than Wednesday,10/19/22
3. Please review all claims submitted between 10/1/21 and 9/30/22 for accuracy to avoid recoupment
4. Provide a summary of any outstanding or disputed claims
   a. Include consumer # and date of services
   b. Include code(s), unit(s), and estimated liability
   c. Email summaries to CMHOCFinance@miottawa.org no later than Wednesday,11/16/22

VII Credentialing and OIG Updates

Kristen Henninges, Compliance Program Coordinator
Khenninges@miottawa.org
Amy Avery, Program Evaluator
Aavery@miottawa.org

F. Clinical Application *(Amy Avery)*

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
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

G. Criminal Background Checks *(Amy Avery)*

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

H. OIG Checks *(Amy Avery)*

1. Required at time of hire and monthly thereafter
2. Applies to all provider employees and persons joining provider Board of Directors

3. If litigation is initiated against a provider, CMH must be notified immediately

I. Compliance *(Amy Avery)*

1. We expect that all agency providers are compliant with trainings, criminal background, and OIG checks
   a. Keep evidence of compliance in your files and available for MDHHS, LRE, and/or CMHSP audits

VII Contract Updates

Gina Kim, Contract Manger
cmhcontractservices@miottawa.org

A. CMH Dispute Resolution Policy

1. https://www.miottawa.org/Health/CMH/pdf/policies/human_resources/09(19)-Provider-Dispute-Resolution.pdf
2. CMH Dispute Resolution form
   a. Go to www.miottawa.org/health/cmh
   b. Click Community Provider Resources on the lefthand side of the screen
   c. Select Policies
   d. Scroll down to Human Resources and select Provider Dispute Resolution
   e. You'll find a guideline including the Contract Dispute Resolution Form
   f. This can be submitted to us via email at cmhcontractservices@miottawa.org
   g. We recommend reaching out and attempting to resolve issues with CMH staff prior to submitting a formal dispute, as these issues are often miscommunications and can be resolved quickly and easily

B. LRE memo re: Dispute Resolution Policy

1. You should have received an email on 8/30/22 regarding the updates to this LRE policy
2. If you go through our Dispute Resolution process and don't agree with our decision, you can contact the LRE and go through their Dispute Resolution process
3. If you did not receive this email on 8/30/22, a copy of the LRE memo and the LRE Dispute Resolution Policy will be included in the minutes

C. Reminders

1. Contracts will be sending out an email to ask you to complete a few forms, including a Provider Directory and Request for Information form
   a. Look for that email in the first week or two of October
   b. The purpose of these forms is to streamline future communication

VIII LRE Updates

Lynne Doyle, Executive Director
Ldoyle@miottawa.org

A. Contract LRE had with Beacon has ended

1. Functions Beacon was performing for the region have resumed being handled by the LRE
2. LRE has hired a lot of new staff to help reclaim these functions
3. LRE is updating their website, www.lsre.org, to include a staff directory

a. When that is rolled out, we will let you know

B. Region recently adopted revisions to operating agreement and bylaws

1. Representation for each CMH on the LRE board used to be based on population but is now fixed at three representatives per CMH, regardless of population
2. Region elected to go to a per-member-per-month funding methodology, which will now be reflective of the way MDHHS distributes funding to regional entities
3. We only recently received final rates from Medicaid, and we are still determining what that means for each individual CMH

C. Financial updates

1. LRE did receive a cut in funding for rates for fiscal year 2023, though we expect our budget should hold steady due to the Beacon contract ending
2. The ISF is fully funded, so the dollars that were being channeled to the ISF will be pushed out to the CMHs
3. It will be a tight year for us financially, but we will do what we can to push dollars out to the Provider Network and keep you informed as we get some final numbers on what our revenues are for the next year

D. Thank you

1. We appreciate your participation and attendance at this meeting – we could not do this work without all of you in the Provider Network!

IX Questions/Feedback

A. Genoa Pharmacy Questions

1. **Tom Zvirgsds question in chat: "**Do you have to receive other services for Genoa to come administer Flu shots?"
   a. **Jacob Golin response via Briana Fowler and Gina Kim:** You do not need to receive other services. As long as there is enough interest, we will vaccinate anyone. We always attempt to bill a consumer's insurance first, but if they are uninsured or having difficulties with their insurance, we can process things differently to still facilitate the vaccines at no out-of-pocket cost to the consumer.

B. Training Requirement Questions

1. **Jeanna Raterink question:** Do you have any plans to begin charging for trainings?
   a. **Kelly Goetzinger response:** This is something we've discussed recently in our regional training group. We are working internally and regionally on this right now, so we don't have an update at this time. As we discuss it more and either have a regional approach or a local procedure/policy on that, we will make sure word gets out to the Provider Network.
2. **Laura Marlatt question:** All of our therapists are already First Aid Certified. Do they need to do the online portion as well?
   a. **Kelly Goetzinger response:** If they are already certified, you'll just want to touch base with our training department to make sure we have that information and that it's a training that we would approve.

3. **Tom Zvirgsds statement in chat:** "Diabetes wasn't "required" (as far as I'm aware) but we did it anyway just for quality. I don't think they asked for Diabetes/mobility trainings during audits before in OC."
    a. **Kelly Goetzinger response in chat:** "Hi Tom, I believe staff who administer Diabetic medications are required to complete this classroom course. I can look for the specific requirement citation and have that added to the minutes."
        - This is still being researched. More information to follow.

C. ProviderConnectNX Questions

1. **Janene Tarchinski statement:** It took us two days to bill some claims, but none of them were submitted because we were not told in the training or the guidelines that came out that you are only allowed to bill one unit at a time. The two days of billing that did not go through will take us over a week to bill since we now have to bill each unit individually. I want to make sure people are aware of that so they're not making the same mistakes that we made.
    a. **Kristi Chittenden response:** I would recommend reaching out to the CMH Finance team, because you should be able to bill more than one unit. We will cover these tips and tricks on using the system next week in the Lunch and Learn. I recommend coming to that and we can explore further at that time. We can also reach out to you after this meeting to see what we can do about billing in the meantime.
2. **Julie Puffer question in chat:** "I do not see the denied services report. Is it available?"
3. **Greg Bailey question in chat:** "Is there a way to open up the old provider connect? We are trying to go through the F22 year and can't see anything."
4. **Accounts Payable question in chat:** "We have problems even logging in to the new system, I e-mailed my contact information to get a new login but haven't heard back yet."
5. **Erica Porter question in chat:** "For billing, everything starting when is to go through the new system?"
6. **Janene Tarchinski question in chat:** "Can you send those instructions out for those that need to get into the old system?
7. **Janene Tarchinski question in chat:** "Will you be overriding the 60-day rule for claims?"
    a. **Kristi Chittenden response to IX.C.2-7**: Regarding the question about going through the FY20 and not seeing anything – there is a report out there, I will be going over that on Tuesday. If you sign into the new system and go to member ledger, which should be in your favorites, you will be able to see all of the services that you have already submitted and the status of whether they were approved or denied. You'll be able to see any services that we have ever processed, from both the old system and the new.

    Any login issues should be sent to CMHOCpasswordreset@miottawa.org.

    Any billing issues should be sent to the CMH Finance team through GIVA.

Overriding the 60-day rule is something you would need to discuss with CMH Finance.

8. **Beth Durkee question:** Aren't we changing to this system because there will be a lot more capacity to get information? That hasn't really been rolled out to people yet because we're just trying to get them to be able to bill. Once that piece is done, you'll start letting them know all the information they'll be able to get from the system?
    a. **Kristi Chittenden response:** That's correct. This new system gives us the ability to create reports for you. With the old system, we had no ability to create reports. There were also some issues with data transferring from the old system into our system that we should no longer be experiencing. There will also be file attach capabilities, so instead of having to send an email with documents you'll be able to upload them right into the system.

       The goal is for everyone to be happy. We are working through these challenges. As you have issues, report them. We are looking at what we can do to make it easier for you and working with our vendor to explore the options available.

D. Fiscal Updates/Financial Considerations Questions

1. **Janene Tarchinski question:** Because of the new software and all of the issues, if we can't get those claims in within 60 days will you be overriding those?
    a. **Amy Bodbyl-Mast response:** The 60-day timeline ties to requirements for reporting to the State and Federal Government as well as our County-wide yearend processing. We would like to allow for exceptions when necessary, and we are willing to work with you on a case-by-case basis, but we won't be doing a blanket extension to the 60-day deadline.

       Part of the Lunch and Learn will be teaching you how to adjust the way you're doing it to get the workflow and approach down.
2. **Sarah Vega question in chat:** "Is timely filing different for primary claims vs secondary claims? 60 days as primary and 30 days as secondary?"
    a. **Krystal Spaans response:** For primary claims, filing must be no more than 60 days from the date of service. For secondary claims, we request that you get that to us within 30 days of receiving the EOB from the primary.
3. **Nichelle Crooks question:** GT would like to request a companion guide and has questions regarding the naming convention.
    a. **Amy Bodbyl-Mast and Krystal Spaans response:** We can get you a companion guide, and the answer to your naming convention question is covered in the guide, as well.

E. LRE Updates Questions

1. **Sue (Centria) question:** The state approved a 5% increase in ABA for this year. Especially as it relates to 97153, are you planning on adding that to your reimbursement?
   a. **Kelly Goetzinger response:** We are working on that regionally right now and hope to have more information out in the form of a regional response soon.
2. **Sue (Centria) question:** Are you expecting to mail out any contracts or amendments for the 2023 fiscal year?
   a. **Kelly Goetzinger response:** We have 5-year contracts – Evergreen contracts in Ottawa County are limited to five years. We review them periodically and touch base with you, and if any changes are to occur, an amendment will be sent out.
3. **Tom Zvirgsds question in chat:** "Is there any discussion on staffing shortages at LRE level/ideas to address it in the region?"
   a. **Lynne Doyle response:** We are absolutely aware of that issue and are experiencing it ourselves. One solution that is being discussed at the State level is tuition reimbursement that would benefit clinicians and Bachelor's level folks. Another thing they're keeping mind is the ongoing issue of direct care worker wage. The Department knows the struggle we're going through. The hope is to have answers in the next couple of months, but unfortunately the State wasn't able to share anything other than that.

We appreciate your partnership and all your hard work. The next Provider Network Council Meeting will take place in March of 2023. The exact date will be announced soon. Please send any suggestions for agenda topics to cmhcontractservices@miottawa.org.

FISCAL UPDATES

Provider Network Council (PNC) Meeting 09/29/22
Community Mental Health of Ottawa County

Agenda

- Introductions
- Submission Dates
- Timeliness Reminder / Clean Claims
- GIVA
- Provider Connect
- 837 Files
- EOB'S

INTRODUCTIONS

AMY BODBYL-MAST,
FINANCE MANAGER

LAUREN NAJMOLHODA,
PROVIDER COMPLIANCE AND CLAIMS SUPERVISOR

KRYSTAL SPAANS,
PROVIDER COMPLIANCE AND CLAIMS SUPERVISOR

End of Year Claims Processing

CLAIMS/INVOICES FOR SERVICES PROVIDED BETWEEN 10/1/21 AND 9/30/22

- MUST BE SUBMITTED BY NO LATER THAN **WEDNESDAY, OCTOBER 19, 2022**

NOTE: Review all previously processed claims for services provided between 10/1/21 to 9/30/22 for accuracy to avoid any possible future recoupment actions

Outstanding or Disputed Claims

PROVIDE A SUMMARY OF ANY OUTSTANDING CLAIMS INCLUDING:

- CONSUMER # AND DATE OF SERVICE(S)
- CODE(S), UNIT(S), AND ESTIMATED LIABILITY

- MUST BE SUBMITTED BY NO LATER THAN **WEDNESDAY, NOVEMBER 16, 2022**

- EMAIL TO: CMHOCFinance@miottawa.org

Attachment B
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

837 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
- Credentialed Modifiers Included

EOB's

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

Questions

Thank You

- Amy Bodbyl-Mast
  AMBODBYL-MAST@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.

U.S. Department of Health & Human Services

Office of Inspector General
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:
Amy Avery
Phone Number: 616-393-5682
Email: aavery@miottawa.org

LAKESHORE REGIONAL ENTITY

CHANGING THE WAY LIVES ARE CHANGED

TO: All CMHSP Members and Subcontracted Providers

FROM: Don Avery and Jim McCormick

DATE: August 17, 2022

RE: Provider Dispute Resolution

This memo serves to provide clarity for Region 3 CMHSP Members and Subcontracted Providers on LRE's provider resolution policy and procedure. Consistent with MDHHS Policy and Practice Guideline, 42 CFR 438, and the Provider Common Contract, providers cannot appeal on behalf of a beneficiary related to Notices of Adverse Benefit Determinations without prior written consent from the beneficiary.

A Subcontracted Provider wishing to dispute any decision of or treatment by a Region 3 CMHSP Member must do so through the contractual and policy processes defined by CMHSP and/or LRE policy and procedures. Please see the attached LRE Policy 4.7 Provider Grievance for clarification and further information.

Policy 4.7

POLICY TITLE:	**NETWORK PROVIDER APPEALS AND GRIEVANCES**	**POLICY # 4.7**	
Topic Area:	**Provider Network Management**		**REVIEW DATES**
Applies to:	Entity Staff, CMHSPs, and LRE Network Providers	**ISSUED BY:** Chief Executive Officer	12/16/2021
Review Cycle:	Annually		
Developed and Maintained by:	CEO and Designee	**APPROVED BY:** Board of Directors	
Supersedes:	N/A	**Effective Date:** 12/15/2016	**Revised Date:** 12/16/2021

I. POLICY

It is the policy of the Lakeshore Regional Entity (LRE) that Network Providers have the right to submit grievances and appeals as defined in this policy.

A. Grievances may be filed by a network provider when it is perceived that the LRE or the Community Mental Health Service Program (CMHSP) have not acted fairly in decisions related but not limited to issues such as:
   1. Results reported through provider monitoring reviews.
   2. Compliance issues resulting in a sanction or decision to place the provider on a provisional status
   3. Actions related to a change in provider status
   4. Actions related to provider's non-compliance, professional competency, or conduct
   5. Overall professional conduct related to contract management and oversight.

B. Appeals may be filed relate to non-clinical issues including, but not limited to:
   1. Reduction, suspension, or adjustments to provider payments for Medicaid covered services
   2. Non-payment of Medicaid claims.
   3. Instances where there is a breach of contract or where there is potential cause for termination of the contract due to discrimination, non-compliance with applicable laws, or non-compliance with consumer recipient rights and consumer grievance procedures.
   4. Suspension or termination of a provider with cause (instances when a CMHSP has chosen to discontinue a provider's participation status within the network based on quality of care/service concerns)
   5. Credentialing or re-credentialing decisions
   6. Material breach of contract

7. Alterations to the regional common contract boilerplate language.

C. This policy does **NOT** apply to the following:
   1. Medicaid Fair Hearing Appeals or Grievances;
   2. Medical necessity appeals;
   3. Conditions that result in immediate termination (i.e., loss of required certification/licensure; suspension by the State of Michigan from participating in the Michigan Medicaid and/or Medicare programs; the provider being listed in the State of Michigan registry for Unfair Labor Practices);
   4. Contracts the LRE holds with member CMHSPs
   5. Consumer rights regarding appeals and grievances

II. PURPOSE

To outline a process by which provider complaints (grievances) and requests for reconsideration of non-clinical decisions (appeals) are resolved.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to all LRE staff, CMHSP Members, and contracted providers within the region.

IV. MONITORING AND REVIEW

This policy will be reviewed by the CEO and designees on an annual basis.

V. DEFINITIONS

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

Grievance: An expression of dissatisfaction by a provider regarding a perceived inequitable issue, aspects of interpersonal relation or other related issues.

VI. RELATED POLICIES AND PROCEDURES

A. Provider Appeal and Grievance Procedure
B. LRE Compliance Plan

VII. REFERENCES/LEGAL AUTHORITY

A. MDHHS Medicaid Managed Specialty Supports and Service Contract
B. PIHP/CMHSP Subcontract Agreement

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
12/16/2021	Removed procedure language	CEO and Designees

ORGANIZATIONAL PROCEDURE

PROCEDURE # 4.7a		EFFECTIVE DATE	REVISED DATE
TITLE:	PROVIDER APPEAL AND GRIEVANCE PROCESS	12/15/2016	12/16/2022
ATTACHMENT TO		REVIEW DATES	
POLICY #:	4.7	9/2021	
POLICY TITLE:	NETWORK PROVIDER APPEALS AND GRIEVANCES		
CHAPTER:	PROVIDER NETWORK		

I. PURPOSE

To outline a process by which provider complaints (grievances) and requests for reconsideration of non-clinical decisions (appeals) are resolved.

II. PROCEDURES

A. **Role of the Participant Community Mental Health Service Programs (CMHSP):**
As required in the PIHP/CMHSP Subcontract, participating CMHSPs are required to have a local provider grievance and appeal policy and procedure that comports with the Participant Subcontract and Medicaid regulations (*Article XIX, Section F: The Member agrees to adhere to the Payor's policies and procedures governing subcontracted provider grievances, disputes and appeals, including without limitation any grievance, dispute or appeal of changes in the subcontracted provider's status as a subcontracted provider in the Payor's subcontracted provider network.).* The CMHSP will convey its procedure for provider appeals to each of its contracted providers. The procedure must include timeframes to appeal and at least two levels to submit appeals and identify the individuals/staff responsible to respond to appeals and the timeframes by which responses to appeal must be made.

1. Prior to initiating the grievance or appeal process with the Lakeshore Regional Entity (LRE), the Provider must have accessed and completed the contracting CMHSP dispute resolution process
2. If after having completed the CMHSP dispute resolution process, a provider disagrees with the determination by the contracting CMHSP in the application process or during review of a provider's status and wishes to have the matter reviewed at a higher level, the provider may do so by submitting a written request to the LRE Chief Executive Officer or designee within thirty (30) calendar days of the disposition.
3. The request must be submitted on the LRE Grievance/Appeals Request form and include:
    a) Reason for the dispute
    b) Documentation to support the grievance/appeal

4. The Grievance/Appeals Request Form and supporting documentation should be sent to:

   Lakeshore Regional Entity
   5000 Hakes Dr, Ste. 250
   Norton Shores, MI 49441
   Fax: (888)409-9320

B. Grievances
Upon receipt of the completed Grievance/Appeals Request Form, the LRE Chief Executive Officer or designee will assist the parties in resolving the grievance issue. The decision of the LRE CEO and/or designee related to the grievance will be considered final and there will be no opportunity for reconsideration.

C. Appeals
An appeal of contract termination shall have no effect on the immediate termination of the contract and services under contract. The termination will remain in effect until the appeals process is completed and will be rescinded only if the termination is not upheld on appeal, in effect until the appeal process is completed, and will be rescinded only if the termination is not upheld on appeal.

D. Role of the Lakeshore Region Entity:

1. First Level Review: A first level review will occur as follows:
   a) Within 20 calendar days of receipt of the request.
   b) Review will be completed by three qualified individuals and may be completed by qualified individuals in the areas of finance, compliance, utilization, quality, and provider network.
   c) Members of the LRE Quality Management team may be used for this level review.
   d) A written summary of the LRE's first level review of the complaint and outcome will be given to the provider with 14 calendar days of completion

2. Second-level review: Should the first level review prove to be unsatisfactory to the appealing provider, a second level review may occur as follows:
   a) Request for second-level review must be submitted in writing to the LRE CEO within 14 days of disposition from the first level appeal.
   b) The request will be reviewed within 14 calendar days of receipt by the LRE CEO. The LRE CEO will enlist assistance from LRE Executive and/or Management staff as needed.
   c) A written summary of the LRE's second level review of the complaint and outcome will be given to the provider and involved CMHSP within 14 calendar days of completion

E. Upon completion of the second level review, the decision of the LRE CEO regarding the dispute shall be considered final.

NOTE: If a provider has been issued a dismissal notice from the network by the contracting CMHSP, the provider is considered a participating provider through the last date of participation as indicated on the notice. If the notice is received on or after the last date of participation as indicated on the notice, the provider must be given reasonable time to initiate the dispute resolution process. Any corrective action plan issued by the contracting CMHSP to the network provider regarding action being disputed by the provider shall be on hold until such time as a final decision is made by the LRE.

III. APPLICABILITY AND RESPONSIBILITY

This procedure applies to LRE Staff, member CMHSPs, and the LRE Provider Network.

IV. MONITORING AND REVIEW

This procedure will be reviewed by the COO, LRE Provider Network Managers an annual basis.

V. DEFINITIONS

Appeal: A formal process which is established so that providers may request reconsideration of an action or decision that has been made by the PIHP or CMHSP.
Grievance: An expression of dissatisfaction by a provider regarding a perceived inequitable issue, aspects of interpersonal relation or other related issues.

VI. RELATED POLICIES AND PROCEDURES

A. 4.7 Network Providers Appeals and Grievance Policy
B. LRE Compliance Plan

VII. REFERENCES/LEGAL AUTHORITY

A. MDHHS Medicaid Specialty Supports and Services Contract
B. PIHP/CMHSP Subcontract Agreement

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
9.2021	Separated from policy	Provider Network