West Michigan Community Mental Health

Provider Manual

For service contracts
October 1, 2016 – September 30, 2017

Table of Contents

Section A. Introduction to West Michigan Community Mental Health .....Page 4
- Office Locations
- Language Assistance
- Accessibility and Accommodations
- Recovery and Resiliency
- Culture of Gentleness
- Equal Employment Opportunity
- Discrimination Free and Harassment Free Workplace
- Violence Free and Weapons Free Workplace
- Drug and Alcohol Free Workplace
- Smoke Free Workplace
- Code of Ethics
- Confidentiality
- Care Coordination
- Customer Services
- Recipient Rights
- Critical Incident Reporting
- Network Management and Coordination
- Reciprocity

Section B. Access to Care.....Page 10
- Our Front Door: Service Entry
- How to Access Care
- Emergency Services
- Alternate Access Points
- Care Management

Section C. Service Eligibility .....Page 12
- Intensity of Needs
- Medical Necessity
- Therapeutic Appropriateness
- Service Selection Guidelines (SSGs)

Section D. Care Standards.....Page 14
- Referrals to Providers
- Provider Responsibilities
- Service Entry/Case Management Responsibilities
- Eligibility Verification
- First Appointment

Section E. Authorization/ Re-authorization.....Page 16
- Who does the Authorization and Reauthorization?
- Authorization Process
- Reauthorization Process
- Filing an Appeal for Non Authorization of Services

Section F. Grievance and Appeals.....Page 18
- Grievances
- Appeals
- Local Appeals
- State Appeals
- Second Opinions

Section G. Billing .....Page 20
- How Payment is Determined
- Getting Your Claim Paid
- Billing the Individual Served
- Coordination of Benefits
- Additional Paperwork with Claims
- Time Limit on Payment
- Claims Submission
- Collection of Co-payments/Deductibles

Section H. Performance Monitoring.....Page 22
- Service Enhancement
- Regulatory Management
- Provider Network Monitoring
- Stakeholder Meetings
- Provider Terminations and Sanctions

Section I. Attachments.....Page 25
- Attachment 1: Code of Ethics Policy
- Attachment 2: Your Rights
- Attachment 3: Know Your Rights
- Attachment 4: Corporate Compliance Plan

Section A. Introduction to West Michigan Community Mental Health

The West Michigan Community Mental Health (CMH) is committed to working with Providers to ensure that individuals receive comprehensive and clinically appropriate services in the most caring and confidential manner. As a Provider for CMH, you join a team of professionals dedicated to satisfaction and reaching optimal clinical outcomes. Person Centered Planning (PCP), Recovery and Resilience are guiding principles in the delivery of Services. CMH is an affiliate member of the Lakeshore Regional Entity (LRE) and is subject to its policies and procedures and State and Federal rules and regulations related to the spending of government funds.

Services are provided to all individuals by a network of professional staff credentialed to work with the identified populations. This includes individuals who have a chronic mental illness, a severe emotional disturbance, a developmental disability and/or substance use disorder. Providers will have demonstrated clinical competencies to serve all age ranges and disability groups. Regardless of provider location, all providers are held to the same standards of service performance and guarantees each individual:

- Full participation in the Person Centered Planning process
- Access to services 24 hours per day, 365 days per year
- Timely response to identified clinical needs
- Timely and clinically appropriate service authorizations and re-authorizations
- Confidential services in a caring environment
- Services with dignity and respect
- Services in a clean, comfortable and relaxing environment of care
- Individual served and stakeholder involvement
- Ongoing involvement in efforts to enhance the organization's social mission
- Ongoing improvements in access to public mental health, developmental disability, and community support services
- Ongoing improvements in care management through behavioral health best practice service and utilization management guidelines
- Quality services assessed continually through clinical outcome data.

The Provider Manual has been developed to provide a general introduction to West Michigan Community Mental Health and is part of the Provider Contract by reference.

After reviewing the Manual, please call Julie VanAgtmael or Karen Hobart at (231) 845-6294 if you have any additional questions or informational needs.

Office Locations and Phone Numbers

Lake County Office

1090 North Michigan Avenue
Baldwin, MI 49304
(231) 745-4659

Mason County Office

920 Diana Street
Ludington, MI 49431
(231) 845-6294

Oceana County Office

105 Lincoln Street
Hart, MI 49420
(231) 873-2108

Facsimile: 231-845-7095

You may reach any of the West Michigan CMH staff be calling any of the Office Locations
Toll free – 1-800-992-2061

TTY Only
1-800-790-8326

Customer Services
LRE 1-800-897-3301

Recipient Rights
1-800-992-2061

Language Assistance

- If assistance is needed for an individual who is deaf or hard of hearing, you can utilize the Michigan Relay Center (MRC) to reach your PIHP, CMHSP or service provider. Please call 7-1-1 and ask MRC to connect your call to the number you are trying to reach. West Michigan CMH can also assist by calling Customer Service at: 1-800-992-2061.

- If there is a need for a sign language interpreter, contact your West Michigan CMH Customer Service at 1-800-992-2061 so that one will be made available. Sign language interpreters are available at no cost.

- If an individual does not speak English, contact West Michigan CMH Customer Service at 1-800-992-2061 as soon as possible so that arrangements for an interpreter can be made. Language interpreters are available at no cost.

Accessibility and Accommodations

- In accordance with federal and state laws, all buildings and programs at West Michigan CMH are required to be physically accessible to individuals with all qualifying disabilities. Any individual who receives emotional, visual or mobility support from a service animal such as a dog will be given access, along with the service animal, to all buildings and programs of West Michigan CMH. For more information or questions about accessibility or service/support animals, contact West Michigan CMH Customer Service at 1-800-992-2061.

- If there is a need to request an accommodation on behalf of an individual, or a family member or a friend, you can contact West Michigan CMH Customer Service at 1-800-992-2061. You will be told how to request an accommodation (this can be done over the phone, in person and/or in writing) and you will be told who at the agency is responsible for handling accommodation requests.

- If there is a need to request written information be made available in an alternative format, including enlarged font size, audio version or in an alternate language, contact West Michigan CMH Customer Service so arrangements for translation or accommodations can be made. The request will be completed as soon as possible, but no later than 30 days from the date of your request. This information will be made available at no cost.

Recovery and Resiliency

> "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her potential."

Recovery is an individual journey that follows different paths and leads to different locations. Recovery is a process that we enter into and is a lifelong attitude. Recovery is unique to each individual and can truly only be defined by the individual themselves. What might be recovery for one person may be only part of the process for another. Recovery may also be defined as wellness. The person-centered planning process is used to identify the supports needed for individual recovery.

In recovery there may be relapses. A relapse is not a failure, rather a challenge. If a relapse is prepared for, and the tools and skills that have been learned throughout the recovery journey are used, a person can overcome and come out a stronger individual. It takes time, and that is why recovery is a process that will lead to a future that holds days of pleasure and the energy to persevere through the trials of life.

Resiliency and development are the guiding principles for children with serious emotional disturbance. Resiliency is the ability to "bounce back" and is a characteristic important to nurture in children with serious emotional disturbance and their families. It refers to the individual's ability to become successful despite challenges they may face throughout their life.

The journey of Recovery is applied to all populations of individuals served by West Michigan CMH.

Culture of Gentleness

The Culture of Gentleness is based on the work of Dr. John McGee. At West Michigan CMH we believe that companionship and friendship go hand in hand. Companionship is the practical use of friendship. The process of forming friendships takes patience, determination and sincerity. We must be willing to share ourselves with people to teach them that they are safe with us, it's good to be loved by us, it is good to be loving and it is good to be with us.

The Four Pillars Of Companionship

You are safe with me
It is good to be loved
It is good to be loving toward others
It is good to be with me

Equal Employment Opportunity

West Michigan CMH ensures equal employment opportunities for all persons regardless of race, creed, color, religion, national origin, age, sex, marital status, height, weight, disability, or any other legally protected status as required by law.

Beyond legal requirements, we acknowledge our commitment to diversity and our belief that this strengthens our team and enables us to be more effective in our role of service.

Discrimination-Free and Harassment-Free Workplace

West Michigan CMH fully supports and complies with the laws, which are enacted to protect and safeguard the rights and opportunities of all people to seek, obtain, and hold employment without being subjected or exposed to illegal harassment or discrimination in the workplace. West Michigan CMH requires the reporting of all perceived incidents of discrimination or harassment through the appropriate channels. It is the policy of West Michigan CMH to conduct a thorough and confidential investigation into such reported matters.

West Michigan CMH prohibits retaliation against any individual who reports discrimination or harassment or participates in an investigation of such reports. Substantiated discrimination or harassment allegations will result in West Michigan CMH providing an appropriate remedy to the situation, which may include disciplinary action for the perpetrator(s) up to and including termination of association with West Michigan CMH.

Violence-Free and Weapons-Free Workplace

West Michigan CMH recognizes the need to provide for the safety and security of all staff members, independent contractors, vendors, individuals served, and visitors. Therefore, West Michigan CMH will not tolerate threats, threatening behavior, or acts of violence by or against staff members, independent contractors, vendors, individuals served, and visitors on West Michigan CMH property. This includes physical attacks, verbal or physical threats, destruction of property, intimidation, or abusive language.

West Michigan CMH prohibits all staff members, independent contractors, vendors, individuals served, and visitors, except law enforcement officers, who enter its property from carrying weapons of any kind. All staff members and independent contractors are also prohibited from carrying a weapon while in the course and scope of performing work for West Michigan CMH whether they are on West Michigan CMH property at the time or not. Staff members and independent contractors may not carry a weapon on their person or in their private vehicle while performing any work on West Michigan CMH's behalf. This policy also prohibits weapons at any West Michigan CMH sponsored functions at off-site locations.

Drug and Alcohol-Free Workplace

West Michigan CMH prohibits the possession of illegal drugs and/or alcohol; being under the influence of illegal drugs or alcohol during working hours or while on employer properties (including parking lots and employer vehicles). The provisions of the employer's drug/alcohol abuse policy are as follows:

- We believe that substance use impairs our ability to bring our full skills and talents to our work. We ask for every member of our staff to respect this commitment and to abide by the West Michigan CMH policy that speaks to this issue.

Smoke-Free Workplace

West Michigan CMH is committed to providing smoke-free facilities and vehicles for its staff members, individuals served, visitors, vendors, and other stakeholders. Smoking is prohibited on the property of all West Michigan CMH office buildings. Smoking restrictions for licensed AFC facilities owned or leased by West Michigan CMH are governed by state laws prohibiting smoking in workplaces.

Code of Ethics

West Michigan CMH values the respect it has earned from individuals served and the public. To ensure that this level of respect continues, West Michigan CMH has clearly defined its expectations for employees, contractors, volunteers, and other representatives of the Agency through its Code of Ethics. (See **Attachment 1**: West Michigan CMH Code of Ethics Administrative Policy 04-02-01)

Confidentiality

West Michigan CMH is committed to protecting all information of the individuals served; documents, disclosures and data, confidential. All information regarding an individual is confidential, including all information in the record and that obtained during the course of providing services. Information shall only be released to outside agencies and professionals in accordance with applicable Michigan and federal laws. Additional providers will comply with the language in the Service Contract.

West Michigan CMH and its officers, employees, and agents will collect and use individual clinical information and protected health information only for the purposes of providing clinical services and for supporting the delivery, treatment, payment, integrity, and quality of those services. West Michigan CMH and its officers, employees, and agents will not use or supply individual clinical and protected health information for non-health care uses, such as direct marketing, employment, or credit evaluation purposes.

.

West Michigan CMH is committed to using all information from provider including: contracts, fees, documents, disclosures and data; in a responsible manner and within professional and organizational standards of confidentiality.

Care Coordination

To improve the quality of services the West Michigan CMH Care Manager may want to coordinate care with the individual's medical provider who provides care for physical health. If substance abuse services are being provided, mental health care should be coordinated with those services. Being able to coordinate with all providers involved in treatment improves chances for recovery, relief of symptoms, and improved functioning. Therefore, individuals served are encouraged to sign a Release of Information so that information can be shared. If an individual does not have a doctor and needs one, contact your local Customer Services Department and staff will assist you in finding a medical provider.

Customer Services

West Michigan CMH has a Customer Services Department prepared to provide assistance. Here are just some of the ways Customer Services can help individuals served:

- Welcome and orient to services and benefits available
- Provide further assistance with understanding the available benefits or any problems relating to benefits, along with any charges, co-pays or fees
- Provide information about how to access mental health, substance abuse, primary health, and other community services
- Respond to any complaints or problems with the services individuals are receiving and provide assistance with filing a grievance or an appeal
- Provide information about LRE operations, including the organizational chart, annual reports, board member lists, board meeting schedules, and board meeting minutes
- Provide information about Michigan Department of Health and Human Services access standards, practice guidelines, and technical advisories and requirements

Customer Services staff are available to respond to calls Monday through Friday during business hours, except for holidays. If you call outside of business hours and wish to leave a message, please include your name, phone number, brief description of the reason for your call, and the best time to contact you. Customer Services staff will return your call within one business day. Contact your local Customer Services at 1-800-992-2061.

Recipient Rights

Every person who receives public mental health services has certain rights. The Michigan Mental Health Code protects some rights. Some of the rights include:

- The right to be free from abuse and neglect
- The right to confidentiality
- The right to be treated with dignity and respect
- The right to treatment suited to condition

More information about recipient rights is contained in the booklet titled "Your Rights." **Attachment 2** is a copy of the booklet accompanying this manual.

You are required to file Recipient Rights complaint any time if you think staff violated an individual's rights. A rights complaint can be made either orally or in writing.

An individual that receives substance abuse services has rights protected by the Public Health Code. More information about recipient rights is contained in the booklet titled "Know Your Rights." **Attachment 3** is the copy of the booklet accompanying this manual.

You may contact your local community mental health services program to talk with a Recipient Rights Officer with any questions you may have about Recipient Rights or to get help to make a complaint. Customer Services can also help you make a complaint. You can contact the Office of Recipient Rights at (231) 845-6294 or 1-800-992-2061 or Customer Services at: 1-800-992-2061.

Critical Incident Reporting

A critical incident is an occurrence that disrupts or adversely affects the course of care or agency business. West Michigan CMH Administrative policy 02-12-08 outlines the events to be reported to West Michigan CMH within 24 hours. In addition, MDHHS asks that critical incidents (suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error and arrest) as well as the risk events outlined in the policy.

Network Management and Coordination

The purpose of West Michigan Community Mental Health's Network Management and Coordination is to identify and contract for quality systems and services necessary to respond to the mental health and developmental disability care needs of residents of Mason, Lake and Oceana Counties.

The goal is to ensure that individuals have choice of competent contractual providers, timely access to the most clinically appropriate service possible provided in a caring and confidential manner and at a cost, which reflects value to the individual and the community.

Network Management and Coordination is committed to working with contracted providers to ensure that comprehensive and clinically appropriate services are provided to individuals, which result in optimum clinical outcomes and customer satisfaction. The contractual providers demonstrate clinical competencies for those individuals that they serve. As valued members of the service community each provider will be treated respectfully and without favoritism. In conjunction with the LRE, services include:

- Service procurement
- Provider applications
- Contract monitoring and management
- Provider relations/education
- Consultation with providers
- Claims inquiries

- Responding to written inquiries
- Benefit explanations
- Contract negotiation

A representative is available Monday through Friday 8 a.m. to 5 p.m. by calling any Office Location.

Reciprocity

Wherever practical, West Michigan CMH strives to reduce duplication of efforts by providers and other CMHSPs.

For providers who deliver services in the Lakeshore Regional Entity's counties (Lake, Mason, Oceana, Muskegon, Ottawa, Kent and Allegan), providers are instructed to use the Lakeshore Learning Management System (LMS) for training purposes. All training requirements for the type of service under contract are included in Contract in Attachment I: Training Requirements of the contract. Mandt training is offered by West Michigan CMH and provider staff are able to register for classes through the LMS.

For providers who deliver services outside of the Lakeshore Regional Entity's county catchment area, West Michigan CMH accepts training provided by other CMHSPs or the trainings approved in the Group Home Curriculum. For approval to use curriculums/methods other than Mandt and the online training modules, the provider shall make a written request to West Michigan CMH to use an alternative curriculum/method. Upon receipt of the request, West Michigan CMH will review training materials to ensure they meet all MDHHS and LRE requirements and will respond to the provider. Use of training materials other than Mandt and the online training, does not relieve the provider from keeping documentation and maintaining the training records for review during the provider or MDHHS site visits . All training requirements for the type of service under contract are included in the Contract in Attachment I: Training Requirements of the contract.

Provider Quality Reviews and Recipient Rights inspection reports are shared upon request.

Section B. Access to Care

Our Front Door: Service Entry

Service Entry is the single point of entry for services provided by West Michigan CMH or providers. Its purpose is to:

1. Assess the urgency of the situation
2. Determine eligibility for public mental health services, and
3. Refer an individual to the most appropriate provider

How to Access Care

Providers can access care for individuals served 24 hours per day, seven days per week, by calling any of the Office Locations.

Service Entry assesses the service need and eligibility for each new individual or those reentering services. The CMH Medical Necessity and Therapeutic Appropriateness criteria is based on national standards and accepted professional practice are used in making the determination.

Service Selection Guidelines (SSGs) and the Medicaid Provider Manual are used to identify the intensity of individual needs and helps determine the medical necessity of services. These intensity criteria are matched with medical necessity and therapeutically appropriate criteria to determine the most appropriate level and setting for treatment, services, and care. Service Entry and Treatment Teams utilize the SSGs to determine the appropriateness of all authorization and re-authorization requests for specific services. The Service Selection Guidelines are a companion document to the Provider Manual and are available upon request.

Emergency Services

A "mental health emergency" is when a person is experiencing a serious mental illness, or a developmental disability, or a child is experiencing a serious emotional disturbance and can reasonably be expected in the near future to harm him/herself or another, or because of his/her inability to meet his/her basic needs is at risk of harm, or the person's judgment is so impaired that he or she is unable to understand the need for treatment and that their condition is expected to result in harm to him/herself or another individual in the near future. Individuals have the right to receive emergency services at any time, 24-hours a day, and seven days a week, without prior authorization for payment of care.

At any time during the day or night call:

Toll Free	1-800-992-2061
Lake County	(231) 745-4659
Mason County	(231) 845-6294
Oceana County	(231) 873-2108

Alternative Access Points of Care

Individuals are encouraged to call CMH to request services 24 hours per day, seven days per week. CMH recognizes that situations occur when Alternative Access Points for Care are necessary and has established protocols for when treatment, services and care are accessed through other avenues. These avenues may include:

- Hospital Facility/ Emergency Rooms
- Walk - In at any West Michigan Community Mental Health's office locations
- Physician's Offices
- Schools
- Law Enforcement Departments
- Community Mental Health Center Provider Offices

When this occurs, it is the responsibility of the treating provider to call the West Michigan CMH Service Entry to seek an authorization for treatment, services or care, and/or a referral to a clinically appropriate provider.

Authorization for care must be received prior to the rendering of care for all treatment or services or care, except in the case of an emergency. Emergency care including Inpatient Psychiatric care can be authorized up to 24 hours after the rendering of services. Unauthorized care will not be paid.

Care Management

CMH is responsible for ensuring Care Management for eligible persons requiring ongoing behavioral health services.

Care Managers have the function of:

- Identifying the care needs of individuals.
- Coordinating the applicable mental health, community and support services.
- Serving as resource managers.

Care Management services include the following:

- Ongoing assessment;
- Person Centered Planning;
- Identification of Support Services;
- Linking and Coordinating with other care providers and natural supports, and;
- Service Monitoring.

A representative from a Care Management Team is available Monday through Friday from 8 AM to 5 PM at any of our Office Locations. Emergency services are available at any time during the day or night by calling toll free 1-800-992-2061.

Section C. Service Eligibility

Intensity of Needs

1 Emergent Need is a life threatening condition in which the individual as a result of a diagnosed Severe Mental Illness is displaying signs and symptoms which may result in immediate self-harm or harm to others; and/or is unable to care for his/her. Service Entry or Care Management staff may refer the individual to a contracted residential or psychiatric inpatient facility.

2 Urgent Need is a condition in which the individual is not actively harmful to self or others, denies having a plan, or intent to harm self or others, or means or intent for harm, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention will progress to the need for emergency services and care. Service Entry/Care Management will contact the provider to alert the provider of the urgent referral and, as needed, help connect the individual to the provider. Providers are required to see the individual within 72 hours of a request for an urgent appointment.

3 Routine Need is a condition in which the individual describes signs and symptoms that are resulting in impairment and functioning of life tasks; impact the individual's ability to participate in daily living; and/or have markedly decreased the individual's quality of life. The Service Entry/Care Management staff will schedule an appointment for the individual with an appropriate provider. Providers are asked to see the individual within 14 days of a request for a routine appointment.

Medical Necessity

The determination of a medically necessary service must be based upon a person centered planning process. Medically necessary services must meet the following criteria:

1. Mental health (and/or substance abuse) services are authorized for the following purposes:
    a. Screening and assessment services to determine the presence and severity of a mental illness or substance abuse disorder; and/or,
    b. Identification and evaluation of a mental illness or substance disorder that is inferred or suspected: and/or,
    c. Intention to treat, ameliorate, diminish or stabilize the symptoms of mental illness (or substance abuse) including impairment in functioning: and/or,
    d. Expectation to arrest or delay the progression of a mental illness (or substance abuse) disorder and to forestall or delay relapse: and /or,
    e. Provision of rehabilitation for the individual to attain or maintain an adequate level of functioning, in order to achieve goals of community inclusion and participation, independence, or productivity.

2. The determination of a medically necessary service, support or treatment must be:
    a. Based on information provided by the individual, individuals family, and/or other individuals who know the individual; and
    b. Based on clinical information from the individuals primary care physician or clinicians with relevant qualifications who have evaluated the individual; and
    c. For beneficiaries with mental illness or developmental disabilities, based on person-centered planning; and
    d. Made by appropriately trained mental health, developmental disabilities professionals with sufficient clinical experience; and
    e. Made with federal and state standards for timeliness; and
    f. Sufficient in amount, scope and duration of the service(s) to reasonability achieve its/their purpose.
    g. Provided in sufficient amount, duration, and scope to reasonably achieve their purpose.

3. Supports, services and treatment selected based upon medically necessity criteria should be:
    a. Delivered in a timely manner, with an immediate response in emergencies in a location that is accessible to the individual.
    b. Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner.

c. Provided in the least restrictive appropriate setting: (inpatient and residential treatment shall be used when less restrictive levels of treatment have been unsuccessful or cannot be safely provided).
d. Delivered consistent with national standards of practice including standards of practice in community psychiatry, psychiatric rehabilitation, developmentally disabled habilitation/rehabilitation, and substance abuse. This is defined by standard clinical references, and generally accepted professional practice guidelines, and is based on empirical professional experience/research: and
e. Provided in sufficient amount, duration, and scope to reasonably achieve their purpose.

4. Using criteria for medical necessity, a CMHSP may:
    a. Deny services that
        i. Are deemed ineffective for a given condition based upon professional and scientifically recognized and accepted standards of care;
        ii. Are experimental or investigational in nature; or
        iii. Services for which there exists an appropriate, efficacious, less-restrictive and cost effective alternative, setting or support, that otherwise satisfies the standards for medically necessary services; and
    b. Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate keeping arrangements, protocols and guidelines.
    c. Not deny services solely based on preset limits on the duration of services; instead, reviews of the continued need for services shall be conducted on an individualized basis.

Therapeutic Appropriateness

In order to meet the therapeutic appropriateness criteria a service must be:
1. Medically necessary;
2. Provided at the appropriate level of care;
3. Provided by an appropriate credentialed and privileged provider;
4. Provided in a frequency required to meet the individual's need;
5. Provided in the most appropriate location to meet the individual's need;
6. Meeting the individual's treatment needs (individual is making progress toward their treatment goals);
7. Provided in the least restrictive, most normalizing environment, and;
8. Satisfying the individual's standards of quality care.

Service Selection Guidelines (SSGs)

The SSGs and Medicaid Provider Manual contain specific clinical guidelines for each level of care including the following:
1. Description of the Service
2. Work Instructions
3. Exclusionary Criteria

A copy of the SSGs or a link to reference the Medicaid Provider Manual is available upon request.

Section D. Care Standards

CMH expects that providers use current and emerging best practice models based on industry standards and regulations. As part of the application and credentialing process, providers are required to show evidence of training and competency in practices suitable to diagnosed conditions, ages and cultural backgrounds of individuals.

Referrals to Providers

1. New to West Michigan CMH:
   In-Network: Service Entry completes a Screening and/or Assessment to determine medical necessity, the level of care, and eligibility and makes referrals to the most appropriate provider for In- Network Providers. In-Network Providers are those that have made application to be part of the Provider Network and have been approved by the Clinical Oversight Committee to provide services on an ongoing basis.

   Out-of-Network: Service Entry completes a Screening and authorizes an Assessment to the Out- of -Network Provider. The Service Entry Team bases any authorization for continued service upon review of the provider's written clinical documentation. Out-of- Network Providers are those that are not part of the West Michigan CMH Provider Network.

2. Currently receiving services from West Michigan CMH:
   Care Management determines the medical necessity, the level of care, eligibility and authorizes an Assessment to the Provider. The Care Management Team bases any authorization for continued service upon review of the Provider's written clinical documentation and the criteria used in the SSGs.

3. Service Entry or Care Management contacts the Provider to schedule the individual for an appointment with the Provider.

Provider Responsibilities

1. The provider's clinician completes an Assessment providing a diagnosis and service recommendations.
2. The Assessment is to be submitted to Service Entry/Care Management within seven (7) days of the Assessment appointment. An Assessment instrument meeting the documentation requirements and Person Centered Planning standards of the West Michigan Community Mental Health must be used.
3. If further services are authorized a Person Centered Plan is to be submitted within fourteen (14) days of the date of referral. This document is to be in a format approved by CMH

Service Entry/Care Management Responsibilities

1. Within two business days of submission of an Assessment or Person Centered Plan to Service Entry/Care Management, a determination will be made to either approve and authorize services to the provider or disapprove services.
2. Services are not approved if either medical necessity is not established or if services are not deemed therapeutically appropriate.
3. Within two business days of receipt of the information from the provider, a letter will be sent to the individual and a copy to the provider explaining the decision, outlining the appeal process and reminding them of the 24-hour emergency number.
4. If services are not therapeutically appropriate, Service Entry/Care Management will, within two business days of receipt of the information from the provider, triage the case; send a letter to the individual, a copy to the provider and a copy to the new provider explaining the decision. This letter will outline the appeal process and remind the individual of the 24-hour emergency number.
5. Services are approved if medical necessity and therapeutic appropriateness is established. The Service Entry/Care Management will, within two business days of receipt of the information from the provider, send a letter to the individual and a copy to the provider explaining the decision and informing the individual what was approved.

Eligibility Verification

The following information should be obtained before the first visit:

1. Confirmation of the individual's name, date of birth, social security number, home address and phone number
2. Name of individual's employer and/or health plan insurer
3. Information about who referred the individual for services
4. Clinical information and benefit data as per usual contractual procedure
5. Confirm County of Financial Responsibility (COFR)

First Appointment

During the first visit, the provider will initiate the following services:

1. Determine the diagnosis and recommended course of treatment; the Person Centered Plan submission standard is forty-eight (48) hours after completion of the Admission Assessment.

2. Complete intake forms provided by CMH including:
    a. Assessment of Level of Care (including the CAFAS, LOCUS, SNAP)
    b. Informed Consent To Treatment
    c. Release of Information
    d. Fee forms including Ability to pay
    e. Customer satisfaction questionnaire

3. The provider will maintain a copy of each instrument/form as in an appropriate medical record consistent with standards developed by the CMH. The original of each instrument/form will be provided to CMH within 24 hours by mail, courier delivery, or fax.

Section E. Authorization/ Re-Authorization Standards

Who Does the Authorization and Reauthorization?

A clinician in Service Entry is responsible for the assessment and authorization of NEW individuals and for preadmission screenings for ALL inpatient psychiatric hospitalizations. Continued stay reviews for additional authorizations for inpatient psychiatric services are provided by the Lakeshore Regional Entity who works directly with the hospitals.

The Care Manager is responsible for attaining authorization and reauthorization of services for individuals requiring continuing care and services with the exception of continued stays for psychiatric inpatient hospitalization.

Authorization Process

1. A provider must be enrolled as an In-Network Provider with Network Management and Coordination. Authorizations may be made to Out-of-Network Providers if it is an accredited Community Mental Health Services Program, a subcontract agency of an accredited Community Mental Health Services Program or a provider meeting the accreditation standards of CARF, COA, DNV or JCAHO. All services to be provided in a specialized residential setting require enrollment as an In Network Provider.

2. Within two business days of submission, a decision is made to either approve and authorize services to the provider or disapprove services.

3. Services are disapproved, if either medical necessity was not determined or services were not deemed therapeutically appropriate.

4. If services are not medically necessary or therapeutically appropriate an adequate notice is sent, within three business days, to the customer which explains the reason for the denial, outlines the appeal process and provides emergency numbers.

5. Services are approved if medical necessity and therapeutic appropriateness are both established. Within two business days of receipt of the information from the provider, a letter is sent to the customer and a copy to the provider explaining the decision and informing the customer what was approved.

Reauthorization Process

1. The provider is responsible to request reauthorization for service prior to the authorizations expiration. NOTE: Exception is Residential and Support Service Providers in which the Care Manager is responsible for all reauthorizations.

2. Reauthorization is to be requested within two (2) sessions or two (2) weeks; whichever comes first, of the expiration of the current authorization.

3. Within two business days of submission of the reauthorization a decision is made to either approve and authorize services to the provider or disapprove services.

4. Services are disapproved, if either medical necessity was not determined or services were not deemed therapeutically appropriate.

5. If service is not medically necessary or therapeutically appropriate an adequate notice is sent, within three business days, to the customer which explains the reason for the denial, outlines the appeal process and provides emergency numbers.

6. Services are approved if medical necessity is established or if services are deemed as therapeutically appropriate. Within three business days of receipt of the information from the provider, a letter is sent to the customer and a copy to the provider explaining the decision and informing the customer what was approved.

Filing an Appeal for Non-Authorization of Services

1. Notification

   In the event that the individual's request for a specific service(s) is not authorized or reauthorized, the provider and the individual will receive both telephone and written notification for emergent and urgent care placements and written notification for routine placements. The written notice will provide a detailed explanation of the medical necessity criteria utilized to make the determination of non-authorization. Listed below is a portion of the non-authorization letter that will be sent:

   "The proposed treatment requested has been reviewed. Based on these reviews it has determined that the requested authorization/reauthorization should be denied for the following reason(s): 'Care not deemed medically necessary.' Current regulations do not allow for consumers referred by the Service Entry/Care Management to be held responsible or billed for any denied services until the day following receipt of this notice. Therefore, the consumer cannot be held responsible for payment of any denied services until the day following the date on which the consumer signs a statement from the provider (facility) outlining the specific non-covered services. The consumer has been sent a letter of notice regarding this matter."

2. Appeal Procedure

   If you do not agree with the stated reason(s) for the non-authorization of services determination, you have the right to appeal this decision based on the following review and appeal procedures:

   a. The provider or the consumer can appeal the denial of authorization/reauthorization. The consumer or the provider is to give the Service Entry/Care Management any additional information to help with the first level of appeal. If the authorization is not approved, then the Service Entry /Care Management writes a rationale and the Service Entry /Care Management Team Leader reviews the information in a second level of appeal. If authorization is not approved, the consumer and the provider are contacted.
   b. Disputes that are not resolved with CMH may be appealed to the LRE Customer Service.

Section F. Grievances and Appeals

Grievances

A **grievance** is an expression of dissatisfaction about service issues. Individuals have the right to say that they are unhappy with the services or supports, or the staff who provide them, by filing a grievance. Individuals can file a grievance *any time* by calling, visiting or writing to the local Customer Services at 1-800-992-2061, or the LRE at 1-800-897-3301.

Appeals

An **appeal** is a request to review an adverse action. Individuals/guardians will be given a notice of action when a decision is made that denies a request for services or reduces, suspends or terminates the services already being received. Individuals/guardians have the right to file an appeal when they do not agree with such a decision. There are time limits on when the appeal can be filed once the decision is received.

If individuals have Medicaid, they may request to have the previously authorized services continue while the appeal is pending if they file an appeal within 12 calendar days; if the appeal involves the termination, suspension or reduction of a previously authorized service; and if the original authorization period has not expired. If services are continued, West Michigan CMH has the right to ask individuals/guardians to repay the cost of these services if the hearing or appeal upholds the original decision, or if individuals/guardians withdraw the appeal or hearing request, or if individuals/guardians or the representative does not attend the hearing.

There are two levels of appeals – local appeals and state appeals.

Local Appeals

A local appeal must be filed within 45 calendar days of the date on the notice of action by the individual/guardian. An appeal may be requested orally, but the request must be confirmed in writing. If individuals/guardians believe the individual's life, health or well-being will be in danger by waiting the standard timeframe for the appeal to be resolved, they can ask for an expedited appeal. If the request for an expedited appeal is granted, it will be completed within 3 business days. If the request for an expedited appeal is denied, WM will try to offer a prompt oral notice and will follow up with written notice within 2 calendar days.

Individuals/guardians will have the chance to provide information or have someone speak for them regarding the appeal. Individuals/guardians, or the legal representative, also have the right to review the appeal file before and during the appeals process. Assistance is available for filing an appeal from the LRE or your local Customer Services Department.

The appeal will be resolved as quickly as possible, but no later than 45 calendar days from the day the appeal is received. A written notice of the results of the decision on the appeal will be provided.

State Appeals

There are two types of state level appeals – Medicaid Fair Hearing and Alternative Dispute Resolution Process.

1. Medicaid Fair Hearing
   If individuals have Medicaid, they can ask at any time for a fair hearing before an administrative law judge (also called a state appeal). Individuals/guardians do not have to complete the local appeal process before requesting a state appeal. Individuals/guardians have 90 calendar days from the date of notice of the action to request a hearing. If you believe the individual served life, health or well-being will be in danger by waiting the standard timeframe for the hearing to take place, ask for an expedited hearing. The Michigan Administrative Hearing System will decide whether to grant the request for an expedited hearing.

   Fair hearing requests must be in writing and signed by the individual/guardian or an authorized person. During the hearing, the individual/guardian can represent themselves or have another person represent for them. This person can be anyone they choose. This person may also request a hearing for the individual/guardian. The individual/guardian must give this person written permission to represent. The individual/guardian may provide a letter or a copy of a court order naming this person as the guardian or conservator.

To request a hearing, use the Request for Hearing form, or submit your hearing request in writing on any paper and mail it to:

Intake – Request for Hearing
Michigan Administrative Hearing System
P.O. Box 30763
Lansing, MI 48909

2. Alternative Dispute Resolution Process
   If the individual does not have Medicaid, the individual/guardian can ask for an Alternative Dispute Resolution through the Michigan Department of Health and Human Services. This can only be done after the completion of the Local Appeal and the individual /guardian is not in agreement with the written results of that decision. Submit the request in writing and mail it to:

Michigan Department of Health and Human Services
Program Development, Consultation and Contracts Division
Behavioral Health and Developmental Disabilities Administration
ATTN: Request for MDHHS Level Dispute Resolution
Lewis Cass Building - 320 South Walnut St
Lansing, MI 48913

Second Opinions

If an individual was denied initial access to all mental health services, or if the individual was denied psychiatric inpatient hospitalization after specifically requesting this service, the Michigan Mental Health Code allows them the right to ask for a Second Opinion.

- If initial access to all mental health services was denied, a Second Opinion will be completed within 5 business days of making the request.
- If a request for psychiatric inpatient hospitalization was denied, a Second Opinion will be completed within 3 business days of making the request.

The individual/guardian will be given detailed information about the grievance and appeal process when you first start services and then again annually. The individual/guardian may ask for this information at any time by contacting the Customer Services Department at 1-800-992-2061.

Section G. Billing

How Payment Responsibility is Determined

The table below identifies how West Michigan CMH determines who is responsible for payment to a provider.

Payor	Authorization	Payment
Medicare/Medicaid Medicare Deductible and co-insurance amounts covered by Medicaid.	No Pre-authorizations are required.	CMH will pay the balance of the Medicare deductible and co-insurance, if Medicare allowed total is less than contracted rate.
Medicare/Medicaid Medicare exhausted.	No pre-authorization. Provider notifies CMH when Medicare is exhausted. Assessment and Authorization, according to criteria, will then be completed by CMH.	CMH will pay the balance of contracted rate not covered by Medicare if criteria are met.
Commercial Insurance/Medicaid: Commercial Insurance pays % of per diem.	No pre-authorizations are required.	CMH will pay the balance of the Third Party Liability (TPL) deductible and co-insurance, if the TPL allowed amount is less than the total contracted rate, if criteria are met.
Commercial Insurance/Medicaid: Commercial Insurance pays for specified # of sessions or $ amount, and Medicaid pays the remainder.	No pre-authorization. Provider must notify CMH when the commercial insurance has been exhausted. Assessment and Authorization, according to criteria, will then be completed by CMH	CMH will pay the balance of contracted rate not covered by the TPL that meets criteria.
Medicare insurance only.	No pre-authorization	No CMH payment.

Getting Your Claim Paid

1. Check the validity of the authorization. If further care or authorization is needed, you can call Service Entry or the Care Manager.

2. Verify that you are the approved provider. The Provider named on the claim form should match the provider specified on the authorization.

3. Verify eligibility. If an individual served becomes ineligible for care before the number of sessions or units of care have been exhausted or the time period has expired, then the authorization becomes invalid.

4. Use the correct claim form.
    a. Outpatient Providers are required to file their claims on a HCFA-1500 or UB92
    b. Specialized Residential and Community Support Providers are required to submit a Personal Care and Comprehensive Community Support Services Log (West Michigan CMH Form RD 003 or RD 003E if electronic) and a Monthly Residential Occupancy Report and Invoice form.

5. Submit claim to all insurance companies with which the individual carries coverage. The notification of the decision from that insurance company should be attached to the claim form that is submitted.

6. Claims will not be accepted past one hundred twenty (120) days from the date services are provided.

7. All claims submitted must include the authorization or re-authorization number.

Billing the Individual Served

1. Providers may only bill for:
    a. Applicable deductibles, co-insurance, and/or co-payments from the individual at the time of service, or
    b. According to the Ability to Pay guidelines as outlined in the Michigan Mental Health Code Chapter 8, Section 330.1818 – 330.1819.

2. Providers may not bill:
    a. Non-authorized services
    b. Amounts above fee schedule/per diem
    c. Additional payments or co-payments for individuals covered by only Medicaid

Coordination of Benefits

Coordination of benefits will be conducted with an individual's primary health insurance carrier. Please send a copy of the primary carrier's Explanation of Benefits (EOB) with each claim submitted, as well as the amount paid on the individual's Ability to Pay. If the necessary information is not attached, the claim will be returned, thus delaying the claim payment. The provider has up to 60 days from the date of receipt of the primary insurance carrier's EOB to submit the claim.

Additional Paperwork with Claims

Providers need to submit copies of their clinical documentation (e.g., authorizations and progress notes); either electronically or in paper format, each time a claim is submitted until written notice of release of this obligation is received from CMH staff. Although authorization is a prerequisite to reimbursement, the authorization (both initially and throughout treatment) is entered into the central database system. Your claim may be processed quicker if the authorization number is on the bill claim form.

Time Limit on Payment

Provided all necessary information is received to process the claim, it is the goal of the CMH for all clean claims to be paid within 30 days of receipt.

Claims Submission

Please send claims to:

West Michigan Community Mental Health
Finance Division
920 Diana Street
Ludington, MI 49431
Facsimile: 231-845-7095

*NOTE: Claims will not be accepted one hundred twenty (120) days past the date of services unless it has to be billed to primary insurance first. In this case, the claims will not be accepted one hundred sixty (160) days from date of EOB notice. It is the Provider's responsibility to provide timely submission of all claims.

Collection of Co-Payments/Deductibles

A Provider may only collect applicable deductibles, co-insurance, and/or co-payments from the individual at the time of service. Providers shall use the Ability to Pay guidelines as outlined in the Michigan Mental Health Code Chapter 8, Section 330.1818 and 330.1819. (NOTE: Additional payments or co-payments of any kind are not allowed for Medicaid only covered individuals.) The CMH will reimburse the Provider the balance, up to the fee schedule maximum or negotiated per diem, upon receipt of a claim form and compliance with CMH policies and procedures. Coordination of benefits, co-payments, and deductibles vary by contract. A Provider will give the individual a published fee schedule at the first session.

Section H. Performance Monitoring

Service Enhancement

The Service Enhancement Team (SET) monitors and systematically evaluates the clinical service process, as well as the care delivered by Providers. The approach is clinically directed as it focuses on the appropriateness and quality of care. The goal is to ensure that cost-effective quality care is provided to all those accessing services.

The SET coordinates the review and evaluation of all aspects in delivering of care. Components include:

- Problem-focused studies
- Continuous monitoring of key indicators (Stakeholder meetings)
- Clinical records review
- Assessment of access and availability
- Customer satisfaction surveys
- Provider satisfaction
- Site Surveys
- Accreditation Reviews

Summary reports are made to the Performance Improvement Oversight Committee, Medical Director, Executive Team, and Providers (when appropriate) in order to identify problems, develop resolutions, and provide adequate follow-up.

Regulatory Management

West Michigan CMH is formally committed to the integration of regulatory management into its culture and operations that include:

a. Compliance with all laws and regulations applicable to Authority operations

b. Adherence to the spirit of compliance guidance issued by the Office of the Inspector General of the United States Department of Health and Human Services

c. Adherence to the letter and spirit of the Health Insurance Portability and Accountability Act (HIPPA) of 1996 and regulations promulgated there under and

d. Meeting The Commission on Accreditation of Rehabilitation Facilities (CARF) standards related to regulatory management

Providers are required to participate in the West Michigan Community Mental Health's regulatory management program designed to detect and reduce fraud and abuse; and protect and promote the privacy and security of confidential customer information. (See **Attachment 4**: Corporate Compliance Plan)

Providers are required to comply with the Deficit Reduction Act and to:

- Report, in good faith, any incidence of false claim fraud, waste or abuse of public funding to the organization.
- Understand the provisions of the Michigan False Claim Act, the Michigan Whistleblowers' Protection Act and the Federal False Claims Act.
- Report a situation the Provider becomes aware of that is potentially a violation of the False Claim Act, or an otherwise reportable occurrence.

The CMH Compliance Officer is the primary point of contact for monitoring and reporting on matters relating to regulatory management.

Provider Network Monitoring

In conjunction with the LRE, WM Network Management and Coordination is responsible for monitoring the aspects of the contracted Provider Network. This includes, but is not limited to, provider changes and updates, re-credentialing, staff competencies (documentation of training as well as the determination of current competencies), utilization of person centered planning principles, environment of care, recipient rights, geographic and specialty access, and Provider relation's activities. Contract operations are responsible for monitoring the providers' compliance to care standards and

outcome performance measurements. Regular reports are submitted to the Clinical Oversight Committee regarding such items as recommendations for network membership, credentialing and any sanctions imposed by West Michigan CMH.

To keep the Network Management and Coordination files current, the provider is responsible to provide re-credentialing and competency, accreditation, licensing, liability insurance, inspection reports, and plan of correction information within defined time lines and in accordance with the Contract.

When new information is received it will update the data system and add the documentation to the Provider's file. Failure to submit current copies of expired items may result in termination of benefit payments until the current Credentialing documentation is received.

Out-of-Network providers are required to meet accepted standards. A completed application, credentialing and full contract may not be required if one of the following is met:

- The provider is a CMH
- The provider has accreditation by, CARF, COA, DNV or JCAHO
- The provider is a contractual agency in good standing with the CMH in the county in which it is located

Providers are to keep files current by notifying network operations of new practice affiliations, change in key staff (i.e., home managers), and changes in address or licensure, insurance and facility or program involvement. Information can be submitted by faxing or by writing.

Provider Monitoring References: Section One - 2.8 Contract Monitoring/Performance Evaluation/Plan of Correction and Section Three - 3. Delegation of the Service Contract for more details.

Stakeholder Meetings

Network Management and Coordination holds stakeholders' meetings with In-Network Providers. The goal of Stakeholder meetings is to measure the health of the network and to identify ways to improve services to individuals served. The Stakeholders' meetings are a collaborative discussion regarding care and services to individuals who are using like contracted services. Data collected from a variety of information sources is used as indicators of the networks performance. Meetings are scheduled at least two times per year for the identified Stakeholder groups.

Data is to be collected and published for the stakeholders' meetings. Due to the public nature of our business, data is available to others under the Freedom of Information Act. Data is collected on agreed upon performance indicators. Some potential indicators may include Customer Satisfaction, Utilization, Coordination of Care, and Treatment/Service Outcomes. Data is examined and performance that does not meet the established thresholds is analyzed to identify areas for improvement. The CMH Performance Improvement Oversight Committee reviews data and recommendations.

Provider Terminations and Sanctions

Refer to the Common Contract- Section Three – 3.9 Dispute Resolution and 3.11 Termination of Contract, Service(s), or Program(s)

1. Voluntary Terminations: If a Provider chooses to terminate membership in the Provider Network, a written request should be submitted to the CMH offices thirty (30) days prior to termination.

2. Sanctions: Non-adherence to performance standards or criteria may result in sanctions. Critical areas monitored include:
    a. Adherence to contract stipulations
    b. Professional liability claims/disposition involving direct individual care
    c. Patterns of practice contrary to procedural standards
    d. Patterns of service delivery
    e. Billing fraud
    f. Unsatisfactory Medical Records Compliance Audit
    g. Refusal of accepting referrals
    h. Inability to service individuals within specified time lines

3. Sanctions may include

a. Withholding all or part of a payment otherwise due to Provider;
b. Offsetting against payments currently due to Provider any amount previously paid to Provider for claims determined on retroactive review to be ineligible for reimbursement;
c. Requiring Provider to repay CMH for services not meeting standards defined in the contract
d. Termination of Provider status

4. If performance standards are questioned, the Provider will be contacted by phone, whenever possible, or by certified mail to alert the Provider to the issue(s) and review the appropriate documentation in compliance with due process/fundamental fairness procedures.

5. If you do not agree with the stated reason(s) for the non-authorization of services determination, refer to your Contract - Section 3.9 Dispute Resolution, for next steps.

Section I: Attachments (under separate PDF files)

Attachment 1: Code of Ethics Policy

Attachment 2: Your Rights

Attachment 3: Know Your Rights

Attachment 4: Corporate Compliance Plan