ValueOptions® Presents:
The Colorado Medicaid Community Mental Health Services Program: New Program Information

Presenters:

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Agenda

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Agenda

- Welcome and Introductions
- ValueOptions® Staff Introductions
- ValueOptions® National Overview
- Behavioral Health Organization Partnerships
- Provider Credentialing and Contracting
- Provider Relations
- Clinical Model

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Agenda (continued)

- Claims Payment
- ProviderConnect Overview
- Office of Member and Family Affairs
- Quality Management
- Compliance Overview and Chart Audit Process
- PaySpan Health Overview
- Questions and Answers

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Behavioral Health Organization Partnerships

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Behavioral Health Organization Partnerships

- Colorado Health Partnerships (CHP)

- Foothills Behavioral Health Partners (FBHPartners)

- Northeast Behavioral Health Partnership (NBHP)

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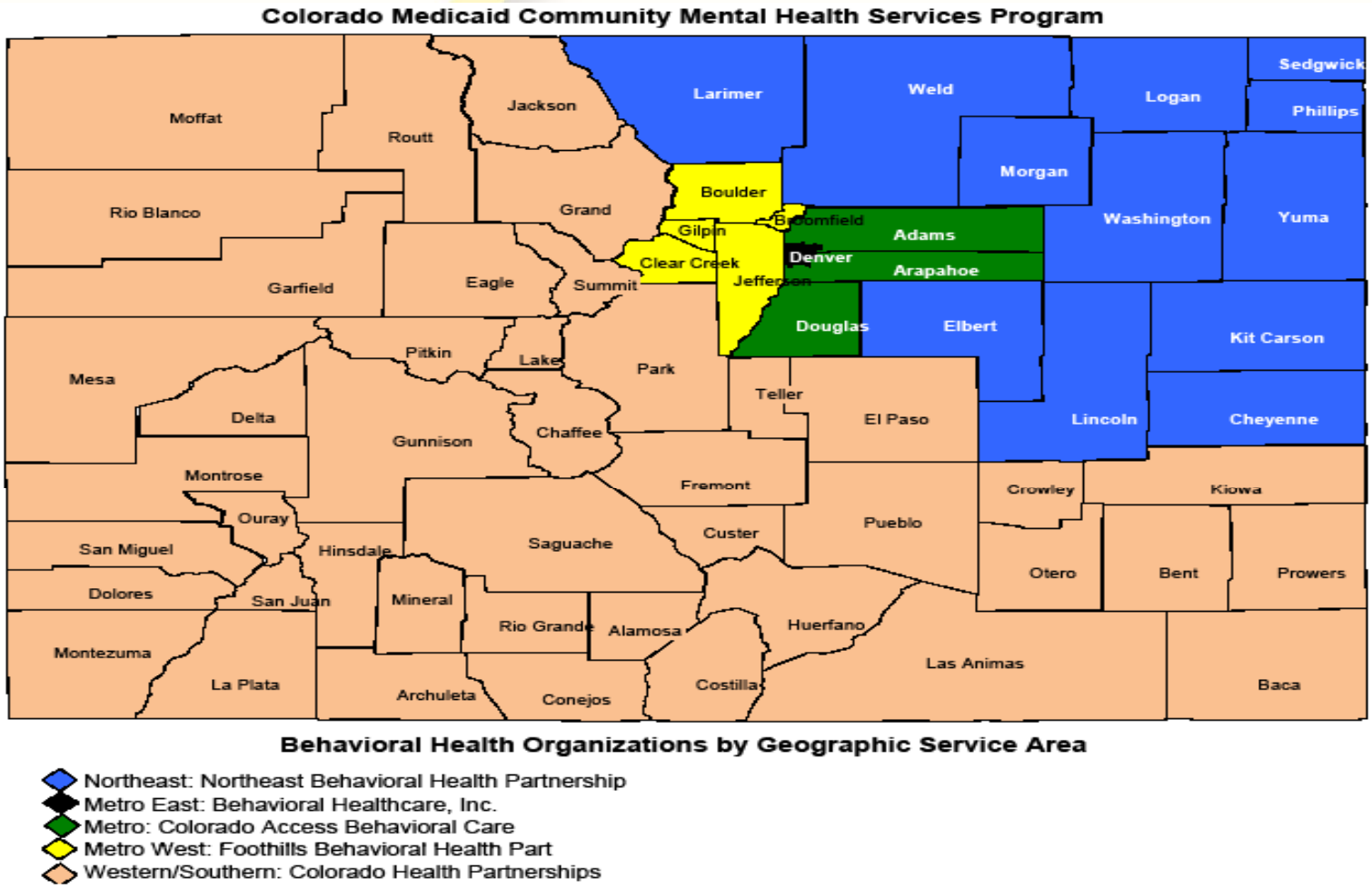
Behavioral Health Organizations by Geographic Area



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National Overview

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ValueOptions® Overview

- Leading market position in behavioral health care services
  - Second-largest in overall market share
  - Experienced and recognized leader in public sector services
  - 13% of Fortune 500 as clients
  - National presence (clients, providers and locations)
  - Respected clinical programs and interventions
- Approximately 40 million lives under contract
- 4,600 employees nationwide
- 20 major service locations
- More than 50,000 providers, more than 5,000 facilities
- Paperless provider contracting and data management
- Single, integrated, scalable system serving all lines of business
- Centralized data warehouse

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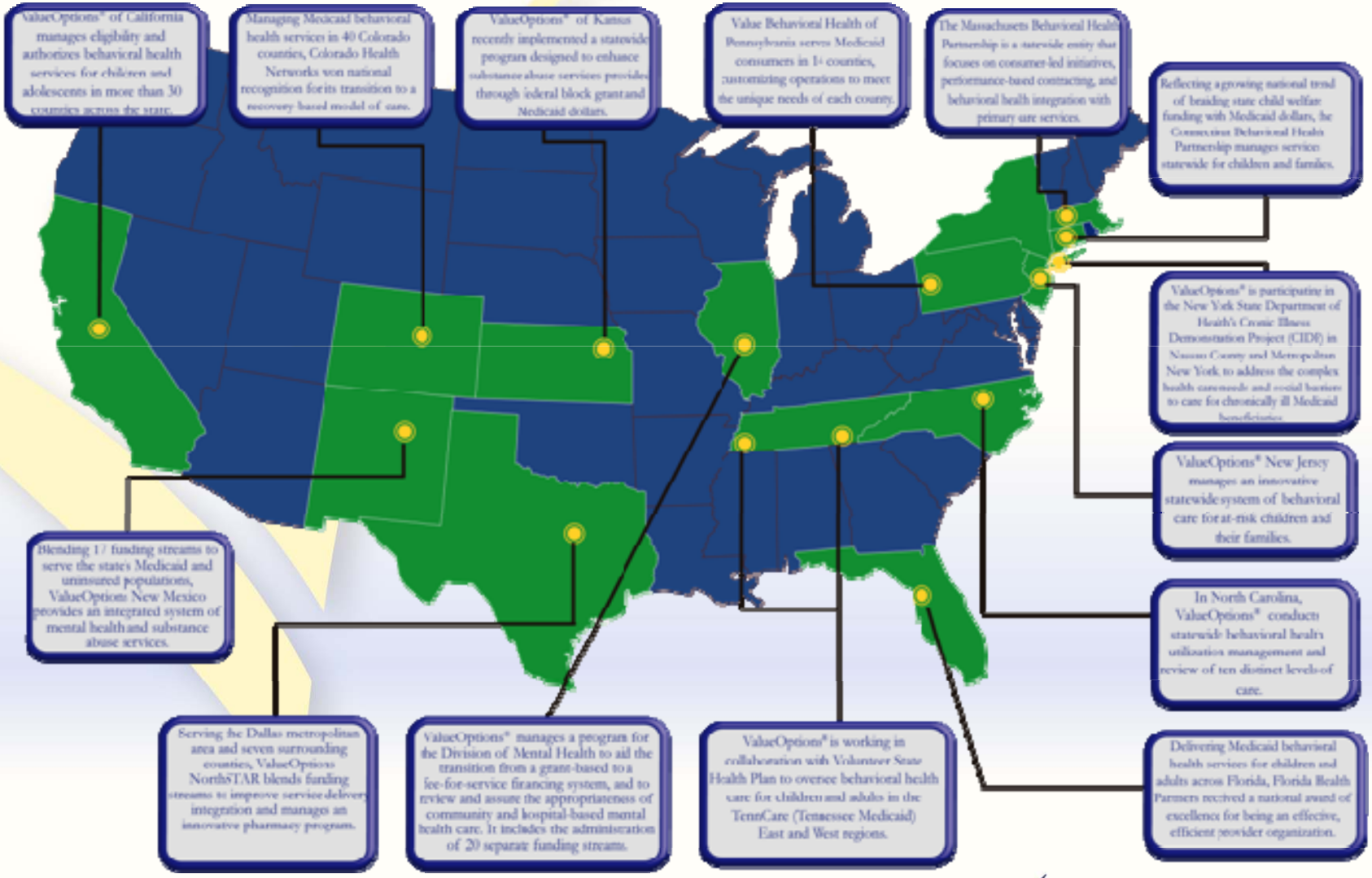
ValueOptions® Public Sector Contracts



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Provider Credentialing and Provider Contracting

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ValueOptions® Colorado Contracting & Credentialing

Why must I fill out a credentialing packet every 3 years ?

- Provider Credentialing
  - ValueOptions® is an NCQA Accredited Agency
  - NCQA Requires Credentialing Every 3 Years
  - Completion Required within 180 Days of Signature
  - CO Bureau Investigations Form

- Provider Contracting
  - ValueOptions® Provider Agreement
  - Colorado Specific Medicaid Addendum
  - Fee Schedules for Each BHO

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Provider Relations

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Local Colorado Provider Relations

- Providers should call ValueOptions® at (800) 804-5040 for:
  - Credentialing/re-credentialing issues
  - Application status updates
  - CCAR Issues

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Contact Information

- Colorado Service Center Line/Provider Relations Needs
  - (800) 804-5040
  - Fax: (719) 538-1433
- Clinical Authorization and Claims Phone Numbers
  - CHP: (800) 804-5008
  - FBHPartners: (866) 245-1959
  - NBHP: (888) 296-5827
- Clinical Fax Number
  - (719) 538-1439
- Colorado Provider Relations Email
  - COProviderRelations@valueoptions.com
- National Contracting –
  - Karolette Jame

  Karolette.james@valueoptions.com

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Provider Handbook

- Prepared as a guide to ValueOptions® policies and procedures for individual providers, affiliates, group practices, and facilities.
- Provides important information regarding the managed care features incorporated in the ValueOptions® provider contract; and also reflects the policies that are applicable to our Colorado Medicaid Contract.
- The handbook provides specific Colorado Medicaid contract requirements.
- Colorado Medicaid Provider Newsletters

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Clinical Operations

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VO Clinical Department – Contacts

Amie Adams, LMFT, Clinical Director 719 538 1441

Amie.Adams@valueoptions.com

- Oversight of call center, inpatient authorization process, supervision of Care Managers, Coordination of care with partner Mental Health Centers

Steve Coen, PhD, Clinical Peer Advisor 719 538 1453

Steve.Coen@valueoptions.com

- Oversight of all outpatient authorizations and Single Case Agreements
- Oversight of residential and Day Treatment services

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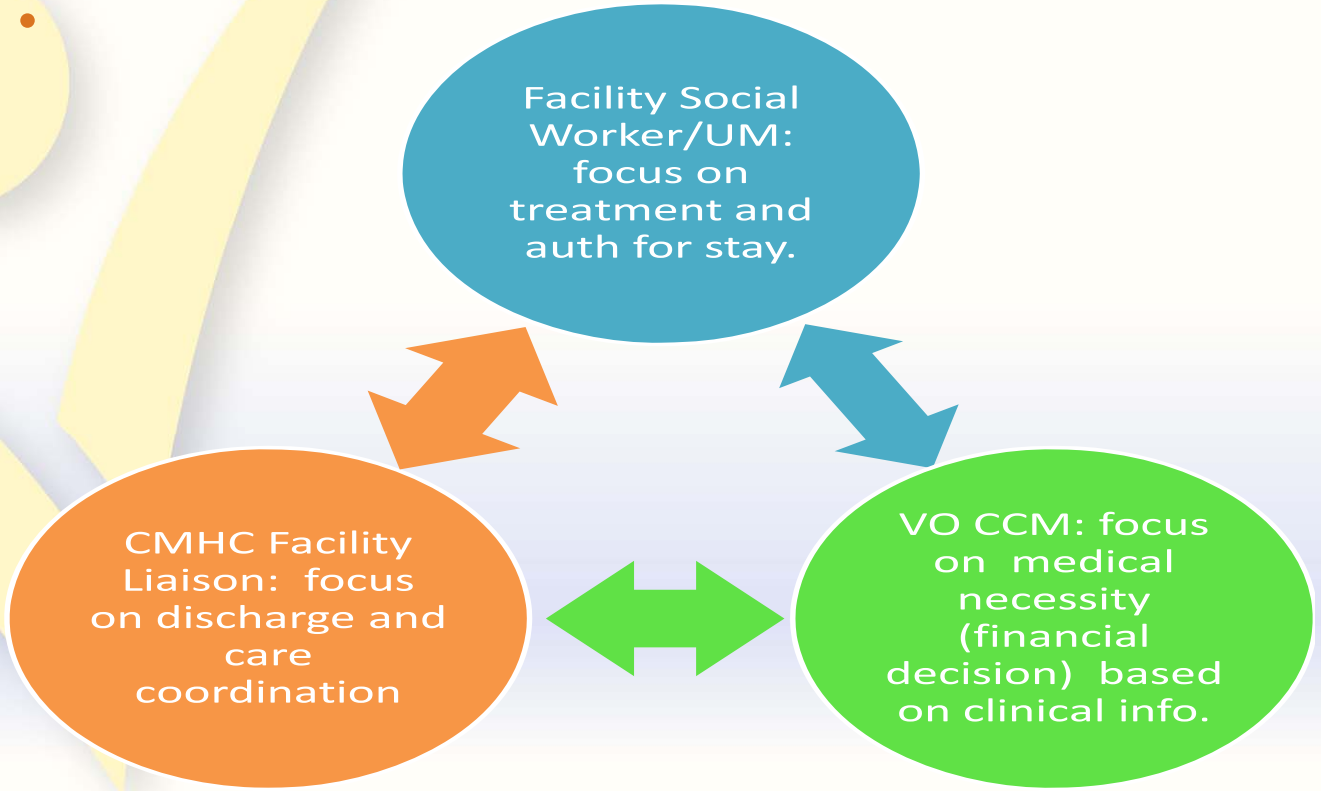
VO CO Clinical Department – Inpatient Coordination of Care



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Provider Authorizations

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Eligibility

The first step in the authorization process is determining member eligibility and assuring that they are assigned to our Behavioral Health Organization.

If you have any questions about eligibility, please call us to discuss. Our staff can check the CO Web Portal to determine eligibility if you have questions. Please be prepared to provide the following information about the member:
Medicaid number, SSN, DOB, First and Last Name

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Provider Authorizations-Inpatient

- VO partners with the local Community Mental Health Centers who must either assess member themselves prior to admit or approve VO to receive clinical information directly from the hospital to use in determining authorization

- IP hospitals- to start the authorization process, contact a VO Care Manager at:
  - **CHP: (800) 804-5008**
  - **FBHPartners: (866) 245-1959**
  - **NBHP: (888) 296-5827**
  - ***Care Managers are available 24 hours and seven days a week, including holidays***

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Provider Authorizations- Inpatient (cont.)

- The Care Manager will either:
  - Refer you to the local Mental Health Center (MHC) so the MHC can send out an evaluator . The evaluator will assess the member and call VO to obtain authorization for you. The MHC will provide you with an authorization number, or let you know if the case was sent to peer review.

OR

-- Take clinical information telephonically that you provide from your assessor, and confer with the Mental Health Center staff member to make an authorization decision.

  - Note: ** If you already have the name and phone number of your local Mental Health Center, you may call them directly to arrange for their assessor to come and evaluate the member.

    If you do this, we recommend that you still call VO to notify us of a pending admit, and that you have contacted the MHC.

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Authorization Outcomes-

- When you request an authorization, your request will either be approved and you will receive an authorization number, number of days approved, and next review date

OR

- The member may be approved for a lower level of care, and the MHC staff representative will help coordinate admission to the other level of care (such as ATU).

OR

- Authorization may be denied. Note: Clinical denials can only be issued by our Medical Director- Care Managers or MHC staff may not deny care. If authorization is denied, the VO Care Manager has reviewed the case with the M.D. They will offer you a peer to peer review- your doctor can speak with our MD within 24 hours of the initial denial decision.

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Provider Authorizations- Inpatient (cont.)

- Whether an assessor comes out to evaluate the member or the Care Manager takes clinical information telephonically from you varies from region to region. The VO Care Manager will know how this is handled for the region your member is from. The region the member is from is what dictates the process of evaluation and authorization.

- You can always call the VO Care Manager to assist you with process if you are unsure. They are available 24/7, including all holidays

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Authorizations- Inpatient- Concurrent and Coordination of Care

- Initial authorizations expire on the last day authorized.
- The hospital is responsible to call VO to request additional days on the last day authorized
- Coordination of care is required on every case, with the MHC staff member assigned to the area the member is from.
- If you are unsure who the MHC staff person is, please call VO and we can assist you.
- The MHC staff will need information about clinical needs so they can help create a successful discharge plan for our member
- The VO Care manager will use clinical information you provide to make an authorization decision for continued care.
- If Coordination of Care is not taking place as required, the VO Care manager may enter an administrative denial .

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Administrative Denials

- If a scheduled concurrent review is missed because a provider did not call or if an initial hospital request is made AFTER the day a member admitted, and the VO Care manager may enter an administrative denial.
- An Administrative Denial is a denial that is entered due to policies/procedures not being followed correctly by a provider. The care is denied due to an administrative problem, not related to the member's clinical presentation
- There is no appeal for administrative denials.

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Authorization Outcomes: Denials/Appeals

- Note: If a clinical denial is issued, a letter will be sent to your hospital, and to the member (or guardian). There are no letters for administrative denials
- For CO Medicaid, the member holds the appeal rights, there is not provider appeal option. Formal appeals need to be requested by the member. They have 20 days from the date of the denial to request an appeal
- A hospital MAY request an appeal only if a member signs a form making the hospital their Designated Client Representative, which means you can then request an appeal on their behalf.

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Retroactive authorizations

- (Most commonly care provided is inpatient for retro authorization)
- In some cases, due to the member's clinical presentation, they may not be able to provide you with accurate insurance information at the time care was provided, so the member may have active Medicaid on admission, but they cannot provide information, so you may not find out until after they are admitted. In these cases, we would consider a request for retroactive authorization.

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Retro authorization- continued

- At other times, care may be provided when a member did not have active Medicaid.
- If this happens, if the member does become active with Medicaid at a later date, you may request a retro authorization for care that has already been provided
- Retro authorizations are given based on a review of the member's clinical chart
- The following details how to request a retro authorization:

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Retro authorization- continued

- Send a letter requesting retro authorization and including:
  - Member's name, Medicaid number, DOB, and Dates of Service authorization is requested for
  - Copy of EOB from primary insurance if the member has other insurance (** Medicaid is the payor of last resort and other insurance benefits need to be used prior to Medicaid)
  - Copy of the chart- including: Admission assessments, all doctor's orders, milieu/daily case notes, treatment plan, discharge plan and summary and labwork
  - We will consider the case for retroauthorization based on the clinical information available to you at the time the care was provided.

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Provider Authorizations - Outpatient

There are two main ways for a contracted provider to obtain an outpatient authorization for a member:

1) **Online: Provider Connect- our interactive web based authorization system**

2) **TeleConnect- our interactive voice response system**

3) **Providers encountering difficulties with Provider Connect or TeleConnect during the authorization process can opt out to talk with a VO staff person for assistance**

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Provider/TeleConnect Authorizations

- Access Provider Connect at www.valueoptions.com
- Go to the Provider Tab
- On the right hand side, you will be able to log in.
- OR: Call 888 556 6211 for TeleConnect:
- To obtain an authorization, you will need to have the following information available:
  - Your log in name and password
  - Member ID
  - Date of Birth
  - Requested start date of authorization
  - Level of Service (note- this will always be OUTPATIENT)
  - Type of Service (note- this will always be MENTAL HEALTH)
  - Answer questions about disability, treatment planning, medical conditions
  - Date member contacted you for appt and date you offered appt
  - Axis I diagnosis
  - CPT code for services to be provided and number of sessions requested
  - Place of service – where services will be provided

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Provider/Tele Connect Authorizations

- After all information is entered, you will receive either an authorization number, with number of units authorized and the date range for the authorization

OR

- You may receive a message that the case needs further review and that you will be contacted by a staff member to review the case. You will be contacted within 1-2 business days to resolve the authorization question

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Provider Connect/Tele Connect- tips

- Authorizations may be requested for start dates 30 days prior to today's date or 30 days in the future.
- Reasons authorizations may not be given immediately or require further review:
  - Member is under age 5 (needs treatment plan reviewed prior to auth)
  - Axis I diagnosis is not covered
  - Date of requested service is outside the auth timeframe
  - Authorization is on file for another provider (you may receive 2 sessions in this case)
  - Your prior authorization for member is not yet exhausted

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CCAR Requirements

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Contract Requirements CCAR

- CCAR requirements:
  - **Providers required to submit CCAR include:**
    - **Independent Providers**
    - **Hospitals**
    - **Single Case Agreements**
  - The providers falling in any of the categories above will receive a handout about the additional CCAR requirements and should pay close attention to the CCAR presentation.
  - CMHC providers please continue to send your CCARs to CMHCs

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CCAR Resources

- Available online
- Includes a Form for the Member to Complete
- CCAR Handbook
- CCAR Application

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Claims Payment

EDI

- ValueOptions® can receive your 837 transaction directly
- Access the ValueOptions® web site at www.valueoptions.com
- Access “For Providers” on the left hand side of the screen
- Access Handbooks – Administration - Online Services
- Required Forms referenced in Online Services are available by accessing the forms menu on the left side of the screen
- EDI help is available from eSupport Services at 1.888.247.9311 *(Mon-Fri. 8am – 6pm EST; 7am – 5pm CDT)*

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EDI File Types Accepted

- 837P
- 837I
- DirectClaim Submission
- EDI Claim Link for Windows
- Written from the Provider's Practice Management System

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Important Claims Information

Located on the relative partnership website you can find:

- **Covered Diagnosis Codes Handout**
  - List of covered diagnosis codes
- **Claims Manual**
- **Claims Filing Procedures**

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Helpful Hints for Faster Payment

- Include the Member's ID Number in the appropriate location
  - Block 1a (labeled "Insured's ID Number") on the CMS-1500 claim form
  - Patient ID Field in an electronic claim file
- If the Member ID Number is not on the claim or it is incorrect, there will be a delay in the processing of the claim
- Submit the Member ID Number from the authorization letter
- Ensure the Member is eligible for benefits on the date of service

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Helpful Hints for Faster Payment (continued)

- The National Provider Identifier (NPI) needs to be submitted on all claims
  - Block 17a (labeled “I. D. Number of Referring Physician”) on the CMS-1500 claim form
  - Block 24J (labeled “NPI”) on the CMS-1500 claim form, **OR**
  - Block 33a (labeled “NPI”) on the CMS-1500 claim form
  - Block 56 (labeled “NPI”) on the UB04 claim form
  - NPI field in an electronic claim file
- All services require an authorization
  - Please ensure the care has been authorized prior to submitting the claim

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Helpful Hints for Faster Payment (continued)

- The address where the service was rendered needs to be submitted on all claims
  - Block 32 (labeled “Service Facility Location Information”) on the CMS-1500 claim form
  - Block 1 (an “unlabeled” field) on the UB04 claim form
  - Service Facility Location field in an electronic claim file
- Special Billing Instructions for 15 Minute Incremented Service Codes
  - Reimbursement for one unit is based on the unit equaling 15 minutes
  - Bill all units rendered on one day on one claim and on one claim line
  - If multiple claims are received or the units are spread between multiple claim lines for the same date of service, we will receive “duplicate claim” edits

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Claim Submission Tips

- The mailing address for paper claims is:

  ValueOptions, Inc.
  P. O. Box 12698
  Norfolk, VA 23541
  ATTN: CO Claims

- The Colorado Claim Customer Service phone numbers are as follows:
  - Colorado Health Partnerships – 800-804-5008
  - Foothills Behavioral Health Partners – 866-245-1959
  - Northeast Behavioral Health Partnership– 888-296-5827
- Claim Timely Filing Requirements
  - Claims must be received within 90 days from the date of service
    - If the Member has primary health insurance coverage we must receive the claim within 90 days of the date on the primary carrier's Explanation of Benefit

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Claim Submission Tips (Continued)

- 90% of claims, including payments, adjustments and denials will be processed within 30 calendar days of receipt
- Paper Claim Forms Accepted:
  - CMS-1500
  - UB04
- Please submit typed (or computer generated) claims on the original (red) claim form
- Timely Filing Requirements for Appeals
- If you do not agree with a payment or denial determination please submit a written request for reconsideration within 60 days of the date on the ValueOptions® Provider Summary Voucher

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Note About Completing Claim Forms

- ***The required fields to complete on CMS 1500 and UB04 claim forms are on the Claims Submission Tip Sheet, included on the website***

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PaySpan Health and EFT Overview

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- Welcome to PaySpan Health, an enhanced payment and reconciliation solution.
- This new solution will enable you to receive faster payments through electronic deposits with complete remittance details.
- You will have numerous online capabilities!

General Features

- PaySpan provider site has an online security subsystem that allows you to control each user's access to specific customer applications, individual reports and web site features.
- PaySpan provider site's security control includes controlling access to the following functions:
  - Managing accounts
  - Reconciling payments
  - Viewing payments online
  - Viewing account configuration
  - Administering user rights
  - Accessing individual rights
- PaySpan provider site logs all user activity on the PaySpan provider site.
- PaySpan provider site provides Online Help on every screen.
- PaySpan provider site supports Internet Explorer 5.0 and above.

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How do I sign up?

- Providers will need the following to start the Provider Registration and to access Payspan system:
  - Provider Identification Number (PIN) – (this is your ValueOptions® Pay to Vendor Number)
  - Tax Identification Number (TIN)
  - Bank routing information
  - Account information found Reference Document
- NOTE: Do not pull this information from a deposit slip as your bank routing information is different than what is reported on the check.
- If you do not have the registration enrollment letter, please contact the ValueOptions® Corporate Finance Department at CorporateFinance@valueoptions.com with your PIN or TIN and your registration code will be emailed to you within 3 business days.

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Pay to Vendor Number

- What is a pay to vendor number?
  - This is a vendor number issued by ValueOptions® and indicates the mailing address for all your payments.
- Can a provider have more than one pay to vendor number?
  - Yes
- Does each pay to vendor number need to be registered with PaySpan?
  - Yes

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ProviderConnect Overview

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ProviderConnect *(Provider Online Services)*

- **What is ProviderConnect?**
- **ProviderConnect is an online tool where providers can:**
  - Verify Member eligibility
  - View Authorizations
  - Request Authorizations
  - Submit Claims
  - View Claim Status
  - Access Provider Summary Voucher
  - Access and Print Authorization Letters
  - Submit inquiries to Customer Service
  - Submit updates to provider demographic information
  - Access and print forms
- ***Increased convenience & decreased administrative burden!***

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ProviderConnect Benefits

- **What are the benefits of ProviderConnect?**

- Free, online, secure application
- Easily access routine information 24 hours a day, 7 days a week
- Complete multiple transactions in a single sitting
- View and print information
- Reduce calls for routine information

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How to Access ProviderConnect?

- All In Network providers will be able to obtain online registration per provider ID number via the website
- To obtain additional logons for ProviderConnect – contact the ValueOptions® EDI Helpdesk at (888) 247-9311 and press option 3, Monday thru Friday, 8a.m. – 6 p.m. EST
  - The turn around time for additional logons is 48 hours

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How to Access ProviderConnect?

Access thru: www.valueoptions.com
within the provider section of
ValueOptions®

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Program Integrity

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Key Terms

- **Fraud** – *Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit*

  Most Medicaid payment errors are billing mistakes and are not the result of someone such as a physician, provider, or pharmacy trying to take advantage of the Medicaid Program

  *Fraud occurs when someone **intentionally** falsifies information or deceives the Medicaid Program*

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Key Terms (cont.)

- **Waste** – *Thoughtless or careless expenditure, consumption, mismanagement, use or squandering of healthcare resources, including incurring costs because of inefficient or ineffective practices, systems or controls*

- **Abuse** – *Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to health programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards*

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Key Terms (cont.)

- **Compliance Program** – *Systematic procedures instituted to ensure that contractual and regulatory requirements are being met*
- **Compliance Risk Assessment** – P*rocess of assessing a company's risk related to its compliance with contractual and regulatory requirements.*
- **Compliance Work Plan** – *Prioritization of activities and resources based on the Compliance Risk Assessment findings*
- **Program Integrity** – *Steps & activities included in the compliance program & plan specific to fraud, waste & abuse*

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Development of Program Integrity, Laws & Requirements

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History of Program Integrity

- Balanced Budget Act (BBA)
  - Amended Social Security Act (SSA) re: Healthcare Crimes
  - Must Exclude from Medicare & State Healthcare Programs those Convicted of Healthcare Offenses
  - Can Impose Civil Monetary Penalties for Anyone Who Arranges or Contracts with Excluded Parties
- Federal False Claims Act (FCA)
  - Liable for a Civil Penalty of Not Less than $5,000 & No More than $10,000, Plus 3x Amount of Damages for Those Who Submit, or Cause Another to Submit, False Claims
- Deficit Reduction Act (DRA)
  - Requires Communication of Policies & Procedures to Employees re: FCA, Whistleblower Rights and Fraud, Waste & Abuse Prevention, if Receiving More than $5M in Medicaid

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History of Program Integrity (cont.)

- 7 Basic Elements of a Compliance Program as Adopted by OIG & CMS (based on Federal Sentencing Guidelines)
  - Written Policies & Procedures
  - Compliance Officer & Compliance Committee
  - Effective Training & Education
  - Effective Lines of Communication between the Compliance Officer, Board, Executive Management & Staff (incl. an Anonymous Reporting Function)
  - Internal Monitoring & Auditing
  - Disciplinary Enforcement
  - Mechanisms for Responding to Detected Problems

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New 8th Element of a Compliance Program

- Compliance Programs Must be Effective
  - Must Show that Compliance Plans are More than a Piece of Paper
  - Must Be Able to Show an Effective Program that Signifies a Proactive Approach to the Identification of Fraud, Waste & Abuse
  - How Much Fraud, Waste & Abuse Have You Identified?
  - How Much Fraud, Waste & Abuse Have You Prevented?

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Regulatory Changes = Heightened Federal & State Awareness

- Laws & Regulations are Now Formalizing & Emphasizing the Effectiveness in Prevention, Detection & Resolution of Fraud, Waste & Abuse as well as the Recovery of Overpayments

- Fraud Enforcement and Recovery Act of 2009 (FERA)
  - Amends the FCA Intent Requirement – A False Statement Need Only be "Material to" a False Claim

  - FCA Now Prohibits Knowingly Submitting a Claim for Payment Known to be False or Fraudulent; Making/Using a False Record Material to a False Claim or to an Obligation to Pay Money to the Government; Engaging in a Conspiracy to Defraud by the Improper Submission of a False Claim; or Concealing, Improperly Avoiding or Decreasing an Obligation to Pay Money to the Government

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Regulatory Changes = Heightened Federal & State Awareness (cont.)

- Patient Protection and Affordable Care Act
- (**PPACA – Healthcare Reform Act**)

  - Expands Audits & Government Programs & Requires Providers to Return Overpayments within 60-Days of Identification
  - Increases Sentencing Guidelines for Healthcare Fraud, Makes Obstructing a Fraud Investigation a Crime & Makes it Easier for the Government to Recapture Funds
  - Enhances Provider Screening & Enrollment Requirements
  - Increases Funding to Prevent, Identify & Fight Fraud by $350M over the Next 10 Years

Regulatory Changes = Heightened Federal & State Awareness (cont.)

- Patient Protection and Affordable Care Act (**PPACA – Healthcare Reform Act**)
  - Allows Federal Government Easier Sharing of Data, Identification of Criminals & Fraud Prevention
  - Requires Providers & Suppliers to Implement Compliance Programs
  - Enhances Penalties to Deter Fraud & Abuse through Stronger Civil & Monetary Penalties for Those Convicted of Fraud & Those Who Know of & Fail to Return an Overpayment (Up to $50,000 or Triple Amount of Overpayment)

Current Audit Activities

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Types of Audits

- A **Compliance** audit is a comprehensive review of an organization's adherence to contractual and regulatory guidelines to evaluate the strength and thoroughness of its compliance preparations. Auditors review polices & procedures, internal controls and risk management procedures over the course of an audit.

- A **Program Integrity** audit is a comprehensive review of an organization's adherence to contractual and regulatory guidelines to evaluate the strength and thoroughness of its efforts to prevent, detect and correct Fraud and Abuse.

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Types of Audits (cont.)

- A **Claims Billing** audit is a review of medical records and other relevant documents to determine whether the documentation supports payment of a claim for services.

State Level Activities – Compliance & Integrity Departments

- Compliance Audits
- Fraud, Waste & Abuse Audits
- Special Investigation Unit (SIU) Audits

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Federal Level Activities – Centers for Medicare & Medicaid Services (CMS)

- Medicaid Integrity Program (MIP)
  - 1st Federal Strategy to Prevent & Reduce Fraud, Waste & Abuse
  - Hire Contractors to Review Medicaid Provider Activities, Audit Claims, Identify Overpayments and Educate Providers
  - Provide Support & Assistance to States in Efforts to Combat Medicaid Fraud, Waste & Abuse
- Medicaid Integrity Group (MIG)
  - Responsible for Implementing the MIP
- Medicaid Integrity Contractors (MIC)
  - Regional Contractors Hired through the MIP to Ensure Paid Claims were:
    - Properly Documented
    - Billed Properly, Using Correct & Appropriate Codes
    - For Covered Services & Paid According to Federal & State Laws, Regulations & Policies

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Other Enforcement Entities

- U.S. Department of Health & Human Services, Office of Inspector General (OIG)
- U.S. Department of Justice (DOJ)
- Office of the State Attorney General (AG) – Medicaid Fraud Control Unit (MFCU)
- Federal Bureau of Investigation (FBI)
- Department of Insurance (DOI)

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ValueOptions' Approach

- The purpose of the Compliance program is to conduct business and interact with clients, members, providers and employees consistent with applicable laws, contractual obligations and ethical standards. Compliance is the responsibility of *all* employees.

- The purpose of Program Integrity is to support the government's goal to decrease financial loss from false claims and reduce ValueOptions risk of exposure to criminal penalties, civil damages, and administrative actions.

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ValueOptions' Approach – Program Integrity Development Plan

- ValueOptions' Program Integrity Description
  - Compliance Plan & Oversight
    - Compliance Officer/Leads & Compliance Committees
  - Program Integrity Plan:
    - Prevention:
      - Industry Partnership
      - Training & Education
      - Provider Support
      - Contractual Provisions
      - Provider Profiling & Credentialing
      - Ethics Hotline
      - Claims Edits
      - Prior Authorizations
      - Member Handbook

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ValueOptions' Program Integrity Plan (cont.)

- Audit & Detection
  - Internal/External Referral Process
  - Audits
  - Post-Processing Review of Claims
  - Data Mining & Trend Analysis
  - Special Reviews

- Investigation & Resolution
  - Investigation & Disciplinary Processes
  - Reporting Requirements

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Recognize Fraud, Waste & Abuse

- Common Fraud Schemes:
  - Billing for "Phantom Patients"
    - Ex: Billing for Members that Don't Exist
  - **Billing for Services Not Provided**
    - **Ex: Billing for Member No-Shows, Billing for Time When the Member Is Not Present**
  - Billing for More Hours than In a Day
    - Ex: One Staff Person is Providing More than 24-Hours of Service within a Day
  - Using False Credentials
    - Ex: Signing Off as Having Certification When the Credentials Expired or Were Revoked
  - Double-Billing
    - Ex: Getting Paid the Maximum Allowable Amount for the Same Service by Two Different Funders

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Recognize Fraud, Waste & Abuse (cont.)

- Misrepresenting the Diagnosis to Justify the Service
  - Ex: Stating that the Member Relapsed to Have More Days Approved, Exaggerating Symptoms to Obtain More Services
- Misrepresenting the Type or Place of Service or Who Rendered the Service
  - Ex: Stating that the Service Was Performed at Your Facility When It Was Actually Provided at the Member's Home
- Billing for Non-Covered Services
  - Ex: Billing for Educational Groups or for Computer-Based Services
- Upcoding
  - Ex: Billing for Outpatient Individual Services Instead of Outpatient Group Services (the Service Actually Performed) in Order to Obtain More Money

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Recognize Fraud, Waste & Abuse (cont.)

- Failure to Collect Co-Insurance/Deductibles
  - Ex: Failing to Bill Another Health Insurance Before Billing Medicaid
- Inappropriate Documentation for Services Billed
  - Ex: Failing to Document a Progress Note Appropriately Supporting the Service that Was Billed
- Lack of Computer Integrity
  - Ex: Sharing Passwords with Staff
- Failure to Resolve Overpayments
  - Ex: Receiving Payment for Services Not Provided and Failing to Return the Funds to Medicaid
- Delays in Discharge to Run Up the Bill
  - Ex: Stating the Member Does Not Have a Place to Discharge to When Family is Available

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Basic Documentation Requirements: "If It's Not Documented – It Didn't Happen"

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Purposes for Documentation

- Provides Evidence Services Were Provided
- Required to Record Pertinent Facts, Findings, & Observations About an Individual's Medical History, Treatment, and Outcomes
- Facilitates Communication & Continuity of Care Among Counselors & Other Health Care Professionals Involved in the Member's Care
- Facilitates Accurate & Timely Claims Review & Payment
- Supports Utilization Review & Quality of Care Evaluations
- Enables Collection of Data Useful for Research & Education

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Basic Documentation Needs

- Start & Stop Times
  - Every Billable Activity Must Have a Service Start Time and Stop Time that Matches Time Billed
- Service Codes
  - Service Codes Submitted w/ Claims for Payment Must Match the Documentation in the Charts
- Individualized Progress Notes
  - Notes Must be Specific to the Members, Appropriately Support the Time, Type, etc. of Services Billed & Tie Back to Treatment Plans
  - The Members' Names Must be Included on All Notes
- Units Billed
  - Number of Units Billed Must Match Number of Units in Documentation
- Full Signatures w/ Credentials & Dates
  - All Documentation/Progress Notes Must be Signed & Include Credentials
- Covered vs. Non-Covered Services
  - Are Services Covered/Billable?

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Basic Documentation Needs (cont.)

- Service Definitions
  - Services Provided/Documented Must Meet the Service Definition for the Specific Code Billed
- Ensure Progress Notes are Legible
- Amendments
  - All Changes Must be Initialed & Dated, with Single Strike-Through Lines Made Through Changed Documentation

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Documentation – Additional Tips

- Activity Logs Should Not be Pre-Signed
- Progress Notes Must be Written After the Group/Individual Session
- All Entries Should be in Blue or Black Ink for Handwritten Notes, Not Pencil, No White-Out
- Keep Records Secure and Collected in One Location for Each Member

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Laws Regulating Fraud, Waste & Abuse

- False Claims Act (FCA), 31 U.S.C. §§ 3729-3733
- Stark Law, Social Security Act, § 1877
- Anti-Kickback Statute, 41 U.S.C.
- HIPAA, 45 CFR, Title II, § 201-250
- Deficit Reduction Act (DRA), Public Law No. 109-171, § 6032
- Care Programs, 42 U.S.C. § 1128B, 1320a-7b
- False Claims Whistleblower Employee Protection Act, 31 U.S.C. § 3730(h)
- Administrative Remedies for False Claims and Statements, 31 U.S.C. Chapter 8, § 3801

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Program Integrity Links

- Code of Federal Regulation
  - TITLE 42-Public Health, Chapter IV-CMS, DHHS, SUBCHAPTER C-Medical Assistance Programs, Part 455-Program Integrity: Medicaid
  - www.gpoaccess.gov/cfr/index.html
- Office of Inspector General (OIG):
  - www.oig.hhs.gov/fraud.asp
- Center for Medicare and Medicaid Services (CMS):
  - www.cms.gov/MedicaidIntegrityProgram/
- National Association of Medicaid Fraud Control Units (NAMFCU):
  - www.namfcu.net/

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ValueOptions Contact & Reporting Info:

- ValueOptions Ethics Hotline
  - 1-888-293-3027

- Report Concerns to Your Organization's Compliance Office, ValueOptions directly, or via ValueOptions' Ethics Hotline
  - Remember: You May Report Anonymously and Retaliation is Prohibited When You Report a Concern in Good Faith
  - Reporting All Instances of Suspected Fraud, Waste and/or Abuse is an Expectation and Responsibility for Everyone

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Quality Management Program

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Waiting Room Times for Scheduled Appointments

- A member who arrives on time for a scheduled appointment shall wait no longer than fifteen minutes to begin their appointment

- If a member waits longer than 15 minutes, the member shall be given the option to reschedule for the next available appointment.

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Waiting Room Times for Scheduled Appointments

- Providers who have a substantial portion of Medicaid members as part of their overall practice shall post a policy notice in the waiting area or provide wait time policy information during the intake appointment.

- Members scheduled for prescriber services should be provided a new appointment date that does not cause a delay or gap in their prescribed medication regimen

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Waiting Room Times for Scheduled Appointments

- Members indicating urgent or emergent concerns should be provided an appointment that meets the access standards for urgent/emergency requests.

- Members who wish to file a grievance regarding undue waiting room times for scheduled appointments shall be referred to the Member Advocate or the Office of Member and Family Affairs.

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Discharge Criteria Policy

- Individualized discharge criteria will be established jointly by client and provider during the treatment planning process
- Discharge criteria are noted in the client's treatment plan or elsewhere in the treatment record;
- Agreement to the criteria by client and provider are also noted in the treatment record

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Discharge Criteria Policy

- Discharge criteria may be altered due to changes in the client's circumstances by agreement of both client and provider
- Changes in criteria and agreement of both parties are noted in the treatment plan or record
- Documentation of discharge criteria will be monitored through the chart audit process

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Coordination of Care with Physical Health Providers

- Facilitation of care coordination between behavioral and physical health providers is expected, especially when a member:
- Is receiving psychiatric medications
- Has co-occurring physical and behavioral health conditions
- Is at high risk for developing physical health conditions that may be related to psychiatric medications, especially members diagnosed with serious mental illnesses, such as schizophrenia, schizoaffective disorder, bipolar disorders

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Coordination of Care with Physical Health Providers

- Document in the treatment record the name & address of any physician providing regular care to the member
- Request permission to communicate with the member's physical healthcare provider(s) using a release of information form
- If a member refuses permission, document in the treatment record

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Coordination of Care with Physical Health Providers

- If a member does not have a regular physician, recommend that the member obtain a physician, and provide information to assist the member in locating a physician.

- For members who agree to release information, communication with the physical health provider is required, as follows:

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Coordination of Care with Physical Health Providers

- Following initial psychiatric or clinical assessment, to inform the health provider the member has accessed treatment
- Following a prescription for a new medication
- Following a request from a physical healthcare provider for information

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Coordination of Care with Physical Health Providers

Please provide the following information:

- Current Axis I & Axis II diagnoses
- Current psychiatric medications
- The name of a contact person at your office
- Communication may be written or verbal. All communications should be documented in the member's treatment record.

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Access to Care

- **Routine services** shall be available upon initial request within seven (7) business days
- **Outpatient follow-up appointments** within seven (7) business days after discharge from an inpatient psychiatric hospitalization
- **Outpatient follow-up appointments** or equivalent post-discharge follow-up, documented in the discharge care plan, within seven (7) business days after discharge from a residential treatment facility

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Access to Care

- **Urgent care** shall be available within twenty-four (24) hours from the initial identification of need
- **Emergency services** shall be available by phone, including TTY, within fifteen (15) minutes of the initial contact
- **In-person** within one (1) hour of contact in urban and suburban areas, in-person within two (2) hours of contact in rural and frontier areas

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Office of Member and Family Affairs (OMFA)

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Office of Member and Family Affairs (OMFA)

Helps Medicaid Members and their Families :

- Learn about Member Rights, Responsibilities, Services and Programs
- Use the grievance, fair hearing and appeals processes
- Find community resources
- Have a voice in decision making through advisory committees

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Recovery

- Peer and client-led services are an adjunct to clinical care. Many clients benefit from peer support.
- Peer support and mutual support services are available.
- OMFA manages a region-wide listing of support groups and other peer services.
- OMFA can help you access those services for your clients.

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OMFA: Member Rights

Member rights are protected by state and federal laws. BHO providers ensure that rights are respected when providing services

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Member Rights Summary

Members have the right to:

- Be treated with respect and due consideration for his/her dignity and privacy.
- Receive information about their mental health benefits and how to access them.
- Be told about the benefits, risks, and side effects of any recommended service.
- Refuse treatment except when an emergency exists or a court order is in effect.
- Participate in decisions regarding his/her health care.

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Member Rights Summary (Continued)

Members have the right to:

- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of his/her medical records, and request that they be amended or corrected.

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Member Rights Summary (Continued)

Members have the right to:

- Have an independent advocate.
- Choose a provider from the provider network or, request that a specific provider be considered for inclusion in the network.
- Receive a second opinion without a fee.
- Receive culturally appropriate and competent services.
- Receive member information in alternative formats and in Spanish.

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Member Rights Summary (Continued)

Members have the right to:

- Receive oral interpretation services if the member has communication disabilities or is a non-English speaker.
- Receive prompt notification of termination or changes in services or providers.
- Be furnished medically necessary services in accordance with Federal regulations.
- Have treatment and medical records kept confidential, except when law authorizes release of such information.

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Member Responsibilities

Members are Responsible to:

- Learn about their mental health benefits and how to use them:
- Be a partner in their care
- Follow the plan the Member and the Member's care coordinator have agreed upon
- Participate in treatment and work toward the goals in the service plan
- Take medications agreed upon between the Member and the prescriber
- Tell the therapist or doctor if the Member does not understand their service plan.,
- Tell the therapist or doctor if the Member does not agree with the service plan and if the Member wants to change it.

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Member Responsibilities (Continued)

- Give the therapist or doctor the information he or she needs to provide good care. This includes signing releases of information so that providers can coordinate care.
- Come to appointments on time. Members should call the office if they will be late, or if they can't keep their appointment.
- Cooperate with the BHO when choosing a provider or are seen by their provider. Members should inform the BHO/provider when they change their address or phone number or if you they questions about choosing a provider, or how to make an appointment.

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Member Handbook

- Contains all of the information that members need to access services.
- Contains information about member rights and how to use the grievance process.
- Members receive a handbook with their enrollment packet.
- Copies of the handbook are mailed with your provider packet.
- Contact OMFA for additional handbooks.

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Cultural Considerations

Providers are required to:

- Provide written member information in Spanish

BHO provides:

- Interpreter Services (for languages or ASL)
- Oral interpretation of written materials
- Language line
- Member materials in Spanish
- Call the Office of Member and Family Affairs for more information or to get these materials.

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Second Opinion

Clients may request a second opinion regarding evaluation or diagnosis made by the provider or medications prescribed by the provider. The BHO assists in arranging a second opinion.

There will be no charge to the client for a second opinion from another Network Provider or Mental Health Center. Independent Providers, Clients, or parents/legal guardians may request a second opinion by contacting the BHO.

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Transportation

BHO Services will be provided for persons living in nursing homes on site if the person can't reasonably travel to their appointment.

The BHO will help arrange, but will not pay, for transportation to mental health appointments.

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Medicaid Ombudsman

Helps clients who are enrolled in Medicaid managed care programs. This includes managed care programs for physical health and mental health.

Answers specific questions about Medicaid programs and services.

Assists clients to file a complaint with BHOs, MCOs, or primary care providers. (if the PCP is through a managed care program.)

Call:

- 303-830-3560
- 1-877-435-7123
- TTY: 1-888-876-8864

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Advance Directives

- Clients have the right to give advance written instructions to health care workers about the type of health care they want or do not want if they become so ill or injured that they cannot speak for themselves.
- These decisions are called *Advance Directives*
- Providers are required to ask adult clients if they have an advanced directive and if they want it placed in their record.
- Care is not dependent on having an advance directive.
- Advance Directives information should be made available to each adult client at time of intake.

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Complaints and Grievances

- Grievance process is required by regulation and the BHO reviews grievances to improve the quality of care.
- The BHO supports the rights of clients, family members and interested others to register concerns or complaints about any issues related to the mental health care received through the BHO.
- Grievance refers to any oral or written expression of dissatisfaction about any matter (other than an action) including issues about: Access and availability.

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Complaints and Grievances

- A complaint may be filed with the Mental Health Center's Client Advocate, or the ValueOptions' service center by phone, in person, or in writing, within 20 calendar days of the precipitating event.

- Providers can file a grievance on behalf of the client if they have written permission from the client to act as the clients Designated Client Representative (DCR).

- DCR form for filing a grievance must be in writing.

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Actions

An action is:

- a decision that denies, suspends, or terminates existing services;
- denies or limits the type or level of service requested by a client;
- denies payment in whole or in part for a service;
- denies a request for services outside the BHO in rural areas with only one BHO.
- Summary – an action is an adverse decision denying, reducing or terminating services.

OMFA staff is available to help a member to appeal an action.

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Appeals Procedure

- The client or DCR must contact the VO Service Center or the BHO OMFA in writing and request an appeal of the action , within 20 calendar days of the date of the action letter.
- The client can ask another person to represent them by filling out a DCR form and release of information form.
- Provider can be a party to the appeal with the client's written permission. There can be no retaliation against a provider who assists a client with an appeal
- An expedited process is available for situations where waiting will jeopardize the member.
- State fair hearing is available whether or not the client involves the OMFA.

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Contact Information

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Question and Answers

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Thank you!

www.chnpartnerships.com

www.fbhpartners.com

www.nbhpartnership.com

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