

# ValueOptions Presents: The Colorado Medicaid Community Mental Health Services Program

## Presenters:

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# Agenda

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

# Agenda

- Office of Member and Family Affairs
- Quality Management
- Compliance Overview and Chart Audit Process
- Questions and Answers

# Behavioral Health Organization Partnerships



# Behavioral Health Organization Partnerships

- Colorado Health Partnerships (CHP)



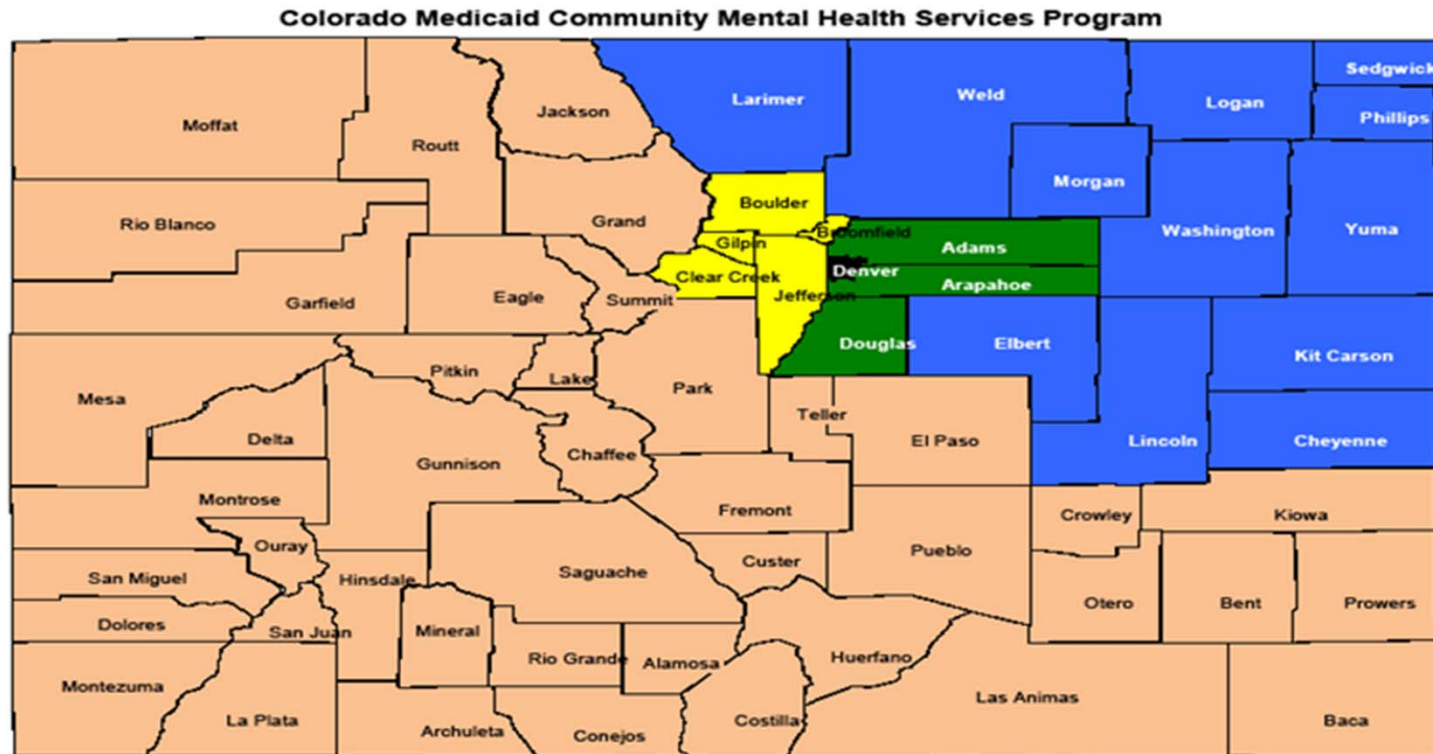
- Foothills Behavioral Health Partners (FBHPartners)



- Northeast Behavioral Health Partnership (NBHP)



# Behavioral Health Organizations by Geographic Area



**Behavioral Health Organizations by Geographic Service Area**

- ◆ Northeast: Northeast Behavioral Health Partnership
- ◆ Metro East: Behavioral Healthcare, Inc.
- ◆ Metro: Colorado Access Behavioral Care
- ◆ Metro West: Foothills Behavioral Health Part
- ◆ Western/Southern: Colorado Health Partnerships

# Provider Relations



# Local Colorado Provider Relations

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

# 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](mailto:COProviderRelations@valueoptions.com)
- National Contracting –
  - Karolette James
  - [Karolette.james@valueoptions.com](mailto:Karolette.james@valueoptions.com)

# 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



# CCAR Requirements

# 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

# CCAR Resources

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

# Claims Payment

# EDI

- ValueOptions® can receive your 837 transaction directly
- Access the ValueOptions® web site at [www.valueoptions.com](http://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*)



# Important Claims Information

- Located on the relative partnership website you can find:
  - Covered Diagnosis Codes
  - Claims Manual
  - Claims Filing Procedures

# 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

# 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

# PaySpan Health and EFT Overview



- 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.

# 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](mailto:CorporateFinance@valueoptions.com) with your PIN or TIN and your registration code will be emailed to you within 3 business days.

# 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



# ProviderConnect Overview

# 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!***

# 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

# 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

# How to Access ProviderConnect?

- Access thru: [www.valueoptions.com](http://www.valueoptions.com) within the provider section of ValueOptions®

# Clinical Operations

# VO Clinical Department - Contacts

- Amie Adams, LMFT, Clinical Director 719-538-1441  
[amie.adams@valueoptions.com](mailto: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](mailto:steve.coen@valueoptions.com)
  - Oversight of all outpatient authorizations and Single Case Agreements
  - Oversight of residential and Day Treatment services

# Care Coordination

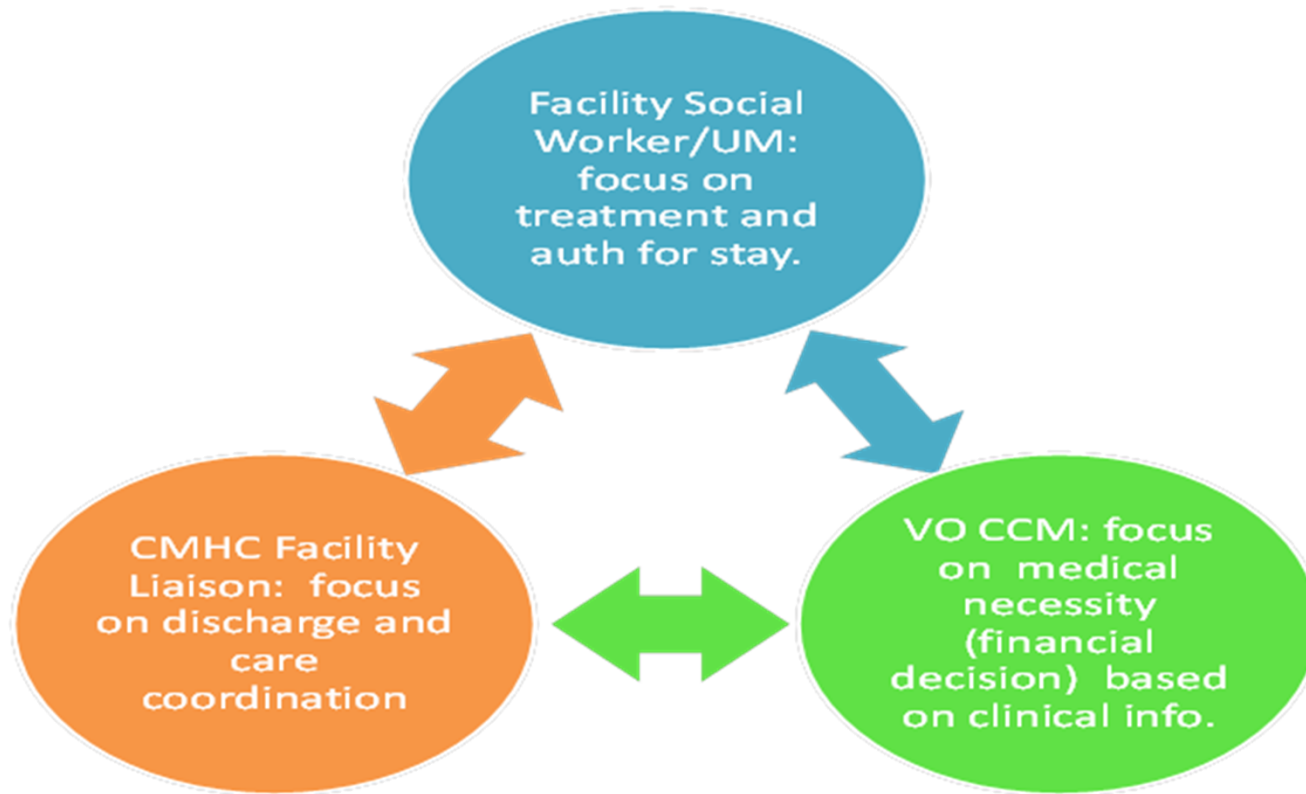


# Provider Responsibilities in Care Coordination – Transitions to different levels of care

- Coordination of services with the ValueOptions Clinical Department and field-based BHO care coordination staff around member transitions to and from higher levels of care.
- This includes active and prompt response to requests for information and participation in admission evaluation, case staffing, discharge planning as required.



# VO Clinical Department – Inpatient Coordination of Care



# Coordination of Care – Inpatient/ATU/Residential Admissions

- 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 request information about clinical needs so they can help create a successful discharge plan for our member.
- The VO Care manager talks regularly with the MHC staff who coordinate care and discharge planning to insure appropriate plans are in place.
- If Coordination of Care is not taking place as required, the VO Care manager may enter an administrative denial when further authorization is requested

# Provider Responsibilities in Coordination of Care – With PCPs

- Coordination of services and the exchange of relevant healthcare information between the member's Primary Care Physician (PCP) or a physician other than a PCP who is involved in the member's care



- Assisting members in finding a PCP. *Health Colorado gives referrals to members looking for a PCP and to providers assisting members in finding a PCP. Health Colorado can be contacted at 1-888-367-6557 or 1-303-839-2120 in the Denver metro area.*

- *Health Colorado's website also provides information on how to obtain a PCP:*

<http://www.healthcolorado.net>

# Provider Responsibilities in Coordination of Care – with other agencies/therapists

- There is more than one therapist involved. Treatment plans and modality of treatment should be planned. Progress and treatment plans should be updated regularly.
- Referrals are made for medication evaluation, testing or other therapy services so that referral questions are clear and the new provider has a good basis to begin treatment.
- Members are involved with multiple agencies.

# EPSDT: Early Periodic Screening, Diagnosis & Treatment

# EPSDT

- EPSDT is a preventative health care program with two purposes:
- To bring Medicaid children who are receiving little or no care into the medical mainstream
- To detect and correct health problems before they lead to serious, costly, handicapping conditions.
- Available to all Medicaid eligible children and youth from birth to 21 years.

# EPSDT Case Management

## EPSDT Case Management:

- Is the responsibility of the Department of Health Care Policy and Financing
- Is subcontracted to local agencies.

## EPSDT Case Managers:

- Have the responsibility to facilitate the EPSDT screening
- Help families select a PCP if requested,
- Give transportation options,
- Do follow-up on screening appointments and arrange for diagnostic and treatment services.
- Typically refer to those who are able to provide health care and other needed services within the community.



# Mental Health Services and EPSDT

- It is the policy of ValueOptions Colorado (VO CO) to coordinate Early and Periodic Screening, Diagnosis and Treatment (EPSDT) with other practitioners and agencies for clients under the age of 21 by:
  - Obtaining results of screens that indicate need for mental health intervention;
  - Referring clients who need screens to their Primary Care Physician/Pediatrician;
  - Considering results of screens in service planning; and
  - Educating Primary Care Physicians/Pediatricians about referrals for mental health services.

# EPSDT and you

- As a provider of service to Medicaid members, you are expected to coordinate care and support EPSDT by:
  - Identifying eligible children and checking with their Primary Care Physicians to determine if EPSDT screening has been completed
  - If EPSDT screening has not been done, request that the PCP completes the screening and communicates with you about any mental health needs identified so you can include these in treatment planning
  - If a child in the eligible age group does not have a PCP, contact HCPF to assist with access to EPSDT case management services.

# How do I access EPSDT for members?

- To locate the EPSDT Office serving your member, please call Health Care Policy and Financing at:

303-866-6006 or 800-221-3943

- OR go to the website:

<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1218622604254>

- Or call the BHO Office of Member and Family Affairs

# Clinical Guidelines

# Clinical Guidelines – Summaries of evidence-based, accepted approaches to behavioral treatment

Types:

## Level of Care:

which detail evidence-based approaches to specific modalities of care.

## Diagnosis based:

which detail evidence-based approaches to the treatment of a specific diagnosis and conditions.

# Basis of Clinical Guidelines

- Clinical guidelines are developed with input from multiple sources:
  - Research and Scientific literature
  - Members/families
  - Practitioners
  - Board certified physicians from appropriate specialties
  - Community agencies

# Level of Care Guidelines

# Level of Care Guidelines

- Level of Care guidelines consist of the following
  - Descriptions of the service/level of care
  - Admission criteria
  - Exclusion criteria
  - Continued Stay criteria
  - Discharge criteria
  - Frequency of review



# Level of Care Guidelines

- Written guidelines can be provided for the following levels of care:
  - Acute Inpatient Hospitalization
  - Alternative Treatment Unit Services
  - Wrap Around Services
  - Outpatient Services
  - Case Management Services
  - Intensive Outpatient Programs
  - Respite Care Services
  - Many others are available on our website

# Diagnosis Based Guidelines

# Diagnosis Based Guidelines

- Diagnosis based guidelines are available for the following:
  - Bipolar Disorder
  - Depressive Disorders
  - Obsessive Compulsive Disorder
  - Schizophrenia
  - Suicidal behaviors
  - Many more are available on our website

# Where can I access treatment guidelines?

- A sample packet of common level of care and diagnosis based guidelines is available for you at this training. Bipolar Disorder
- Access to the full set of guidelines is available online:
  - [http://www.nbhpartnership.com/providers/prv\\_handbook.htm](http://www.nbhpartnership.com/providers/prv_handbook.htm)
  - [http://www.coloradohealthpartnerships.com/provider/prv\\_clin\\_gd.htm](http://www.coloradohealthpartnerships.com/provider/prv_clin_gd.htm)
  - [http://www.fbhpartners.com/providers/prv\\_information.htm](http://www.fbhpartners.com/providers/prv_information.htm)

# Clinical Appeals

# What is a Clinical Appeal

- An appeal when you formally request that we review an Action that we took because you disagree with the Action.
- A clinical appeal takes place when you ask us to review an action such as denying or limiting authorization for a service, and our decision was based on member's symptoms or clinical situation.

# Clinical Appeals – 2 Types

## Standard

Standard appeals will be resolved within 10 business days of receipt of the appeal request.

## Expedited

Expedited appeals will be resolved within 3 calendar days (72 hours of receipt of appeal request)

# Standard vs. Expedited Appeals

- Expedited appeals are designed for the situation where the member or DCR/ BHO feels that use of the standard appeal timeframe (10 working days) would potentially jeopardize the life or health of the member.
- We will review each expedited appeal request for this criteria. Request for expedited appeals may be denied, and if they are, written documentation would be sent to the member/DCR with the reasons and the appeal would be reviewed according to Standard Appeal timeframes.



# Who can appeal?

- With CO Medicaid, the MEMBER holds the appeal rights, so a member or guardian can file an appeal.
- Providers do not specifically have appeal rights.
- A provider MAY appeal on behalf of a member if the member asks for this or agrees that the provider can exercise this right for them.
- For a provider to exercise appeal rights on behalf of a member, the member must sign a written authorization giving the provider the appeal right. This form is called a Designated Client Representative form.

# How do I file an appeal?

- Appeals can be filed by phone, in person, or in writing.
- Appeals must be made within thirty (30) calendar days from the date on the Notice of Action letter.
- Appeals filed by phone or in person must be followed up in writing. The Office of Member and Family Affairs(OMFA) can help members put their appeals in writing..
- Providers acting on behalf of the member MUST include the DCR form with the appeal.

# Contact information for Appeals

- Mailing/delivery address

## **Grievance/Appeal Coordinator**

7150 Campus Drive, Suite 300  
Colorado Springs, Colorado 80920

- Phone

800-804-5008 (CHP and NBHP members)

866-245-1959 (FBHPartners members)

- Fax

(719)538-1433

# What should I expect when I appeal?

- A psychiatrist who was not involved in the original authorization decision will review your case.
- The psychiatrist will review the original clinical documentation as well as any information that the member or DCR want to include as a part of the appeal. Information you include did not have to be part of the original documentation.
- A formal, written response letter will be sent to you within the timeframe for the type of appeal you submitted (10 working days for Standard appeals or 3 calendar days for Expedited appeals). This letter will inform you of the outcome of the appeal.

# State Fair Hearings

- In addition to the Appeal process, members/DCR's have access to a State Fair Hearing.
- Hearings must also be requested within 30 calendar days of the date of the Notice of Action. Due to this deadline, we encourage members not to wait for appeal decisions if they want a State Fair Hearing.
- An appeal does not have to be filed first- the BHO appeal process can be started at the same time, or skipped and a request for State Fair Hearing filed instead.
- To request a hearing, contact:

Office of Administrative Courts

633 17th Street, Suite 1300

Denver, CO 80202

Phone: 303-866-2000 Fax :303-866-5909.

# State Fair Hearings – Additional assistance available for members/guardians/DCR's

## BHO OMFA Assistance

- From the Office of Member and Family Affairs at:

800-804-5008 (CHP and NBHP Members)

866-245-1959 (FBHPartners Members)

## Ombudsman Assistance

- Assistance from the Ombudsman for Medicaid Managed Care at:

1-877-435-7123,  
(TTY: 1-888-876-8864)

- **Mail:**

303 E 17th Ave, Suite 105,  
Denver, CO, 80203

- **e-mail:**

help123@maximus.com.

# Office of Member and Family Affairs (OMFA)

# 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



# 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.

# OMFA: Member Rights

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

# Member Right 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.

# Member Right 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.
  - Have an independent advocate.
  - Choose a provider from the provider network or, request that a specific provider be considered for inclusion in the network.

# Member Right Summary (Continued)

- Members have the right to:
  - Receive a second opinion without a fee.
  - Receive culturally appropriate and competent services.
  - Receive member information in alternative formats and in Spanish.
  - 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.

# 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.

# 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.

# 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.



# 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.

# 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.

# 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.

# 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

# 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.

# 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, **wait times, and customer service issues.**

# 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 **30** 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 client's Designated Client Representative (DCR).
- DCR form for filing a grievance must be in writing

# 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 are available to help a member to appeal an action.



# 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 **30** 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 **BHO**.

# Contact Information

## **Haline Grublak**

ValueOptions®

Office of member and Family Affairs

7150 Campus Dr. Suite 300

Colorado Springs, CO 80920

719-538-1443

Fax: 719-538-1460

Haline.Grublak@valueoptions.com

## **Jennifer Euler**

Northeast Behavioral Health

Office of Member and Family Affairs

1300 N 17<sup>th</sup> Ave

Greeley, CO 80631

970-347-2367 or

1-888-296-5827

Fax: 970-392-1354

Jennifer.Euler@valueoptions.com

## **Hazel Bond**

Foothills Behavioral Health Partners

Office of Member and Family Affairs

9101 Harlan St., #100

Westminster, CO 80031

303-432-5956

Fax: 303-432-5970

Hbond@fbhpartners.com

# Quality Management

# 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.
- 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

# 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.

# 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
- 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

# Coordination of Care with Physical Health Providers: A performance improvement project

- 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

# 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
- 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.



# Coordination of Care with Physical Health Providers

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

# 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.

# 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.

# 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

# Development of Program Integrity, Laws & Requirements

# 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

# Regulatory Changes = Heightened Federal & State Awareness (continued)

- 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 (continued)

- 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)



# Audit Activities

# Compliance & Integrity Departments

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

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

- Medicaid Integrity Program (MIP)
  - 1<sup>st</sup> 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

# 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)

# 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

# Recognize Fraud, Waste & Abuse (Continued)

- 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

# Recognize Fraud, Waste & Abuse (Continued)

- 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

**Basic Documentation Requirements:  
“If it’s not documented – It didn’t  
happen”**



# 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?

# Basic Documentation Needs (Continued)

- 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

# 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

# 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

# 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](http://www.gpoaccess.gov/cfr/index.html)
- Office of Inspector General (OIG):
  - [www.oig.hhs.gov/fraud.asp](http://www.oig.hhs.gov/fraud.asp)
- Center for Medicare and Medicaid Services (CMS):
  - [www.cms.gov/MedicaidIntegrityProgram/](http://www.cms.gov/MedicaidIntegrityProgram/)
- National Association of Medicaid Fraud Control Units (NAMFCU):
  - [www.namfcu.net/](http://www.namfcu.net/)



# ValueOptions Contract & 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



# Questions and Answers

# Thank You

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