ValueOptions Presents: Colorado Medicaid Managed Care 101 for Substance Use Disorder Providers

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Chelle Denman, CO Dir. Provider Relations, VO
Agenda

• BHO Partnerships
• Provider Relations
• Provider Credentialing and Contracting
• Uniform Services Coding Manual
• Claims Payment
• ProviderConnect Overview
• Clinical Model and New Substance Use Benefits
• Quality Management Overview
• Documentation Requirements
• Provider Record Audits
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
Local Colorado Provider Relations

Providers should call ValueOptions® at (800) 804-5040 for:

- Credentialing/re-credentialing issues
- Application status updates
- Practice Suspensions
- Any other questions or problems you may be dealing with…
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
  • FBHP Partners – (866) 245-1959
  • NBHP – (888) 296-5827

• Clinical Fax Number
  • (719) 538-1439

• Colorado Provider Relations Email
  • COProviderRelations@valueoptions.com

• National Contracting –
  • Fran Breyne Frances.breyne@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.

• Provider Newsletters Quarterly Include Medicaid Updates
HC PF: Uniform Service Coding Manual
• This document updates the billable costs for Medicaid services.

• Sets forth the requirements of billing procedure codes for covered mental health services.

• The USCS manual is a living document that is updated each year to maintain consistency between the BHO contract, the DBH contract, the State Plan Amendments, the (b)(3) waiver, and coding guidelines. Unless otherwise noted, the State has agreed that it will accept coding provided under all editions through June 30, 2012. Providers must implement the 2012 edition by July 1, 2012.
# TREATMENT SERVICES – PSYCHOTHERAPY – INDIVIDUAL PSYCHOTHERAPY

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<thead>
<tr>
<th>CPT®/HCPCS PROCEDURE CODE</th>
<th>PROCEDURE CODE DESCRIPTION</th>
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<tr>
<td>H0004</td>
<td>Behavioral health counseling and therapy, per 15 minutes</td>
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## SERVICE DESCRIPTION
Individual counseling/therapy in the planned treatment of a client’s problem(s) as identified by an assessment and listed in the treatment/service plan. The intended outcome is the management, reduction/resolution of the identified problem(s).

## MINIMUM DOCUMENTATION REQUIREMENTS

**Technical Documentation Requirements**
See Page 240

**Service Content**
1. The reason for the visit/call. What was the intended goal or agenda? How does the service relate to the treatment plan?
2. Description of the service provided
3. The therapeutic intervention(s) utilized and the individual’s response to the intervention(s)
4. How did the service impact the individual’s progress towards goals/objectives?
5. Plan for next contact(s) including any follow-up or coordination needed with 3rd parties

## NOTES
H0004 offers flexibility in terms of time increments and POS. H0004 may include unplanned telephone contact and/or planned contact if medically necessary, clinically justified, and included in the treatment/service plan. Crisis intervention is reported using H2011 in lieu of H0004.
### APPLICABLE POPULATION(S)
- Child (0-11)
- Adult (21-64)
- Geriatric (65+)
- Young Adult (18-20)

### UNIT
- Encounter
- Day

### DURATION
- 15 Minutes
- 1 Hour

### ALLOWED MODE(S) OF DELIVERY
- Face-to-Face
- Video Conf (GT)
- Telephone

### PROGRAM SERVICE CATEGORY(IES)
- SP (HE)
- Other SP (TG)
- Residential (SC)

### STAFF REQUIREMENTS
- Peer Specialist
- Bachelor’s Level (HN)
- Intern

### PLACE OF SERVICE (POS)
- CMHC (53)
- Office (11)
- Mobile Unit (15)
- Outp Hospital (22)
- ACF (13)
- Cust Care (33)
- Grp Home (14)
- Home (12)

### VALUEOPTIONS
Where do I find the USC M?

http://www.colorado.gov/cs/Satellite?c=Page&childpage_name=HC PF%2FHC PFLayout&cid=1251569171131&page_name=HC PFWrapper
Clinical Operations
A new world?
(Photo from Psychotherapy.net)
Goals-Overview

- Review common terms
- Medical Necessity
- General Authorization processes and tips
- Initial authorizations
- Concurrent authorizations
- Other funding sources when Medicaid funding ends
Terminology
Acronyms, abbreviations and other terminology

- **Behavioral health**: Mental health and/or substance use disorders and includes diagnoses and services related to mental health and/or substance use disorders
- **PHI**: Protected Health Information
- **Units**: the amount of time that a service is provided for (i.e., 15 minutes, an hour)
- **POS**: Place of Service - where the service is rendered (e.g., CMHC office, client’s home, outpatient hospital, provider office, etc.).
- **BHO**: Behavioral Health Organization - organizations that hold contracts with the Department of Healthcare Policy and Financing to administer the Behavioral Health Services Program for Medicaid members
Terminology- continued

• **BHO** - Behavioral Health Organization- organizations that hold contracts with the Department of Healthcare Policy and Financing to administer the Behavioral Health Services Program for Medicaid members

• **MSO** - Managed Service Organizations hold contracts with The Colorado Division of Behavioral Health and are responsible for oversight, quality assurance, and contract compliance of funded substance abuse treatment providers.
Authorization terms

• **Initial authorization** - first request for services to be approved and the first number of units approved.

• **Concurrent authorization** - a request for additional units to be approved for ongoing care and the number of units approved.

• **Exhausted authorization** - when all the authorized units on an authorization have been paid. Additional claims presented will be denied as no units are available on the authorization.

• **Effective date** - First Date of Service that a claim would be paid for from an authorization.

• **Expiration date** - Last Date of Service that a claim would be paid for from an authorization.
More terms!

- **Clinical denial** - Authorization of services had been denied by the Medical Director after review of information about the services, member’s condition and progress. Members hold the appeal right for this type of denial.

- **Claims denial** - A claim is not paid due to an administrative reason- wrong place of service, missing information on the claims form, etc. Providers can appeal these decisions.
Primary vs. Secondary insurance

- **Primary insurance** - the insurance that is first in line to pay for treatment.
- **Secondary insurance** - the insurance that is responsible to pay after the primary insurance has paid for services.
- **Medicaid** is always the payor of last resort, which means any other insurance would always be primary.
Medicaid can pay for services for treatment of a covered diagnosis, for covered services, that meet medical necessity criteria.

Covered diagnoses- The Colorado Community Behavioral Health Services Program identifies covered diagnoses using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

A list of these diagnoses can be located on each BHO website, links in the Resources section of this presentation.
Medical Necessity - do your notes speak to the criteria below?

- “Medically Necessary” describes a service that, in a manner in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care:
  - Is reasonably necessary for the diagnosis or treatment of a covered behavioral health disorder or to improve, stabilize or prevent deterioration of functioning resulting from such a disorder; and
  - Is clinically appropriate in terms of type, frequency, extent, site and duration;
  - Is furnished in the most appropriate and least restrictive setting where services can be safely provided; and
  - Cannot be omitted without adversely affecting the Member’s behavioral health and/or physical health conditions associated with the Member’s covered behavioral health diagnosis, or the quality of care rendered.
Documenting to demonstrate medical necessity
Treatment plans and progress notes are your chance to document, paint a picture using words—how is the member doing?

• Members should all have a treatment plan guiding their treatment.
• It should include a description of the problem, measurable goals to be met, discharge criteria, and interventions being provided to help the member meet their goal.

• Progress notes should refer to the goals on the treatment plan, and should tell the story of how the member is doing—are they making progress in achieving their goals?

• Have they had more difficulties? By reading your progress note, we should be able to see whether the member continues to need treatment, or is ready to move to less frequent treatment, or to end treatment.

• Answer the question—clinically— if this person ended treatment today, what would my concern be for them?
• Is this the least restrictive way/location/environment where this member could safely receive help?
General tips for working with managed care

Active partnership in the process is helpful!
New processes = new relationships

• Communicate with the Value Options and get to know the staff members you work with often.
• Develop a reputation for being prompt, informed, honest, concise, and organized then it will go a long way to helping the review process flow smoothly.
• Know where to find additional resources if you are confused. Ask for help.
Initial authorizations

• Initial authorizations do not require the submission of a treatment plan.
• From the day we receive your authorization request, we can go back 30 days from that date, to consider any date of service within that range.
• We will need to know: the date of service, your provider number- if possible, Member’s Medicaid number, diagnosis, codes you are requesting authorizations for, and number of units you are requesting.
Initial authorizations, continued

• You can fax in the Auth request form to (719)538-1439, call us at 800 804 5008/866 245 1959, or use Provider Connect to request the authorization if you are set up in that system.

• We will notify you when the authorization has been issued, and you can view the codes and units authorized on Provider Connect.
Ok- I have my initial authorization- now what?

• Now you have some detective work to do!

• Go back to that initial start date of the authorization and determine how many units you may have already used for services you have provided.

• Determine how many units are available left on the authorization after you subtract the units you have already provided. Remember different codes have different time amounts (15 minutes vs 1 hour vs encounter). Be sure to note the start and stop time of services to know how many units you have used. See the Resources section for a link to the Uniform Services Coding Manual which lists the units value for each procedure code and the table with values for most common SUD procedure codes.

• Continue to track ongoing services, so that as you get close to running out of authorized units, you know when to request additional authorization.
Tracking services, knowing when to request additional authorizations

- Note that paid claims are not a good way to track the need for continued authorizations. This is because there is a 90 day timely filing period - you have this long after the date of service to submit your claim.

- In the meantime, you are still providing services - so you would be late on requesting additional authorizations.

- You need a good system to track with your clinical staff, what services have been/are being provided, to compare with authorized sessions.
Concurrent authorization requests

• Once you have finished your detective work, you need to note the first date of service that you don’t or won’t have an authorization for.

• Contact us to request additional sessions, noting this start date for the new authorized units. For ongoing authorizations, we will need a copy of the treatment plan, and the last 4 individual or group therapy notes. You are welcome to include any information that you feel will help show that the member meets medical necessity for continued treatment.
Clinically denied services

• If the Medical Director reviews your request for authorization and does not approve it, you will receive a letter explaining our appeals process.

• For Medicaid, the member holds the appeal right, so if you would like to act on behalf of the member, they can sign our DCR form, naming you as the Designated Client Representative. This gives you the right to appeal.

• The DCR form is on all of our BHO websites—listed in the resource section, but feel free to call us if you have questions or need assistance with this process.
Beyond Medicaid—what if a service is not authorized?

- Additional potential funding sources:
  - Probation—if a member is needing treatment and involved with probation, they may fund treatment.
  - DHS— if there is a treatment plan due to a child welfare issue, Core service dollars may be accessed.

Treatment may need to continue, if it is court ordered. Work with members to determine if another funding source besides Medicaid can assist.

If you are a provider for your local Managed Service Organization (MSO), they may be a funding source for some members.
Managed Service Organizations

• May be a source of funding for either services not covered under Medicaid, or if care is no longer medically necessary and cannot be authorized through Medicaid.

• A listing of MSO contacts by county is in the Resources section of this presentation.

Adults and Adolescents who are uninsured or underinsured and are one or more of the following priority populations are eligible for the MSO funding:

- IV drug users (use within the past 30 days)
- Persons on Involuntary Commitments
- Pregnant women - Women with Dependent Children
- Persons receiving Aid to the Needy and Disabled (AND)
Member self pay is an option if other resources have been exhausted and treatment must continue.
Additional Resources

• Covered diagnoses:
  http://www.coloradohealthpartnerships.com/provider/handbook/Section13.4_CoveredDx.pdf

USCM coding manual:
Resources - continued

- **Foothills Behavioral Health Partners** (general; handbook; guidelines)
  - www.fbhpartners.com
  - http://www.fbhpartners.com/providers/prv_information.htm

- **Colorado Health Partnerships** (general; handbook; guidelines)
  - http://www.coloradohealthpartnerships.com

- **Northeast Behavioral Health Partnership** (general; handbook; guidelines)
  - http://www.nbhppartnership.com/
### Additional resources - current units for common SUD codes:

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<thead>
<tr>
<th>Code</th>
<th>Brief code description</th>
<th>Time unit</th>
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<td>H0001</td>
<td>Evaluation/assessment</td>
<td>1 unit = 1 encounter</td>
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<td>H0004</td>
<td>Individual therapy</td>
<td>1 unit = 15 minutes</td>
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<td>H0005</td>
<td>Group Therapy</td>
<td>1 unit = 1 hour</td>
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<td>H0006</td>
<td>Case Management</td>
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<td>H0038</td>
<td>Peer Services</td>
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<td>S9445</td>
<td>Drug Screen-collection and counseling</td>
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<td>S3005</td>
<td>Detox- Safety Assessment</td>
<td>1 unit = 15 minutes</td>
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<td>T1007</td>
<td>Detox- Physical Assessment-Detox progress</td>
<td>1 unit = 15 minutes</td>
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<tr>
<td>T1019</td>
<td>Detox- Personal Care</td>
<td>1 unit = 15 minutes</td>
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<tr>
<td>T1023</td>
<td>Detox-Discharge/transition planning</td>
<td>1 unit = 1 encounter</td>
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<tr>
<td>H0020</td>
<td>Medication assisted treatment-methadone only</td>
<td>1 unit = 1 encounter</td>
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## Resources-- Managed Service Organizations

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<th>County</th>
<th>MSO</th>
<th>Phone number</th>
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<td>Adams</td>
<td>Signal Behavioral Health Network</td>
<td>(888) 604-4462</td>
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<td>(888) 604-4463</td>
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<td>Arapahoe</td>
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<td>(888) 604-4464</td>
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<td>Archuleta</td>
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<td>Boulder</td>
<td>Boulder Public Health</td>
<td>(303) 441-1275</td>
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<td>Broomfield</td>
<td>Signal Behavioral Health Network</td>
<td>(888) 604-4467</td>
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<td>Chaffee</td>
<td>Connect Care (Aspen Pointe)</td>
<td>(800) 285-1204</td>
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<td>Cheyenne</td>
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Claims Payment
Important Claims Information

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

• Claims should be filed electronically to ensure prompt payment
  • Direct Claims Submission through ProviderConnect
  • Batch 837-I
Claim Submission Tips

• 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
  • UB-04

• Reminder: Claims must be filed electronically as of 2015

• 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
Claims Payment Summary Vouchers
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<th>Mod Code</th>
<th>Provider</th>
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<th>Mod Code</th>
<th>Provider</th>
<th>Member #</th>
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<th>Allowance</th>
<th>Deductible Amount</th>
<th>Prepaid Amount</th>
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<th>Co-Ins Amount</th>
<th>Other Amount</th>
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Vendor #: A269908
NPI: 1881811867
Check #: 0000006798
Check Amount: $972.00
ValueOptions of Kansas
P.O. Box 1408
Latham, NY 12110
(866) 645-8216

PROVIDER SUMMARY VOUCHER

Date: 07/08/2010
Profile: KS2
Vendor #: A269908
NPI: 1881811867
Check #: 0000006798
Check Amount: $972.00

ValueOptions of Kansas
P.O. Box 1408
Latham, NY 12110
(866) 645-8216

PROVIDER EXAMPLE
456 MAIN STREET
LAWRENCE, KS 66047-3824

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Provider Summary

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EOP Code | Description
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BS - BILLED AMOUNT EXCEEDS FEE SCHEDULE RATE

*****************************************************************************
YOU HAVE THE RIGHT TO REQUEST A RECONSIDERATION OF THIS PAYMENT DECISION BY SUBMITTING A WRITTEN GRIEVANCE TO VALUEOPTIONS OF KANSAS' MEMBER/PROVIDER SERVICES DEPARTMENT. YOUR GRIEVANCE MUST BE RECEIVED WITHIN SIXTY (60) CALENDAR DAYS FROM THE DATE OF THIS REMITTANCE STATEMENT. ALL GRIEVANCES SHOULD BE SUBMITTED TO THE FIRST ADDRESS ON PAGE 1 OF THIS VOUCHER.
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.
Substance Use Disclosure Form
Substance Use Disclosure Form

• Consents to Disclose Substance Use Disorder Information

For each Covered Person receiving Substance Use Services, Provider shall obtain from the Covered Person an executed consent, compliant with 42 C.F.R. § 2.31, authorizing Provider to disclose information related to the Covered Person and his or her receipt of Substance Use Services to (BHO) for claims payment purposes. Such consent shall additionally authorize the re-disclosure of such information by (BHO) to the Department of Health Care Policy and Financing (the “Department”), as required by and for the purposes set forth in (BHO’s) contract with the Department. Provider shall retain and maintain each such consent for a period of at least six (6) years from the last effective date of such consent. If a Covered Person refuses to sign such a consent, Provider shall document its efforts to obtain such a consent and shall notify (BHO) prior to billing (BHO) for the provision of Substance Use Services for such Covered Persons.

• Substance Use Services – means those Covered Services related to the identity, diagnosis, prognosis, or treatment of alcohol or drug abuse.
Substance Use Disclosure Form

Patient Consent and Authorization Form for Disclosure of Substance Use Disorder Health Information to Medicaid

Member (name and information of member whose health information is being disclosed):

Name: ____________________________________________

ID# or DOB: ____________________________________________

Substance Abuse Provider: _____________________________ (“Provider”)

Background: The behavioral health organizations (BHOs) listed below contract with the State of Colorado to provide mental health and substance use services to Medicaid members. The BHOs in turn contract with Provider to provide mental health and substance use services to Medicaid members. Medicaid has assigned you to one of the BHOs for the management of your services. The BHOs process claims for services submitted by Provider. The BHOs are also required to submit information on all claims paid or processed to Colorado Medicaid for Medicaid administration purposes.

- I hereby authorize Provider to disclose my health information, including information related to my treatment for alcohol and/or drug abuse, to one of the BHOs listed below to which I have been assigned for the purpose of Provider submitting claims for payment to the BHO.
- I hereby further authorize the BHO listed below who has received and processed a claim for services delivered to me by Provider, to re-disclose such information to Colorado Department of Health Care Policy and Financing (Medicaid) for its Medicaid administration purposes as is required by the contract that the BHO has with Medicaid.

BHOs Authorized to Receive and Re-Disclose Information:

Access Behavioral Care
Behavioral Healthcare, Inc.
Colorado Health Partnerships
Footills Behavioral Health Partners, LLC
Northeast Behavioral Health Partnership

- My treatment may not be conditioned if I do not sign this form.
- I have received a copy of this signed document.
- I understand that I may revoke this authorization at any time by giving written notice to Provider, except to the extent that the Provider or the BHO has already acted on it.
- This authorization will expire on the date that I am no longer a Colorado Medicaid member or two years from the date of my signature, whichever is earlier.

Signature of Member or Legal Representative ____________________________ Date Signed ____________

Print Name of Legal Representative (if applicable) ____________________________ Relationship to Client ____________________________
Member and Family Affairs
OMFA: Member Rights

- Member rights are protected by state and federal laws. BHO providers ensure that rights are respected when providing services.
- Member rights are located on the BHO Websites for posting
- Ensure that you are following CFR 42 Part 2 and HIPAA
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.
Quality Management
Quality Management Functions

The Quality Management Department conducts monitoring activities to assure:

- That the quality of care provided meets acceptable standards, and
- That the requirements of the Behavioral Health Services Program contract are being met

- Monitoring includes:
  - Treatment record audits to ensure documentation meets required standards
  - Transition of care and coordination of services is occurring
  - Quality of care issue and critical incident investigations.
Quality Management Functions

The Quality Department also:
• manages performance improvement projects and initiatives, and
• conducts Member satisfaction surveys.

Please see the Provider Handbook for more detailed information.
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
Audit Activities
Compliance & Integrity

- Compliance Audits

- Fraud, Waste & Abuse Audits

- Special Investigation Unit (SIU) Audits
Questions and Answers
Thank You

www.chnpartnerships.com
www.fbhpartners.com
www.nbhpartnership
www.valueoptions.com