Community Mental Health for Central Michigan

Provider Network Meeting Minutes

Date: May 14, 2013
Time: 10:00 – 11:45 am
Place: Isabella Office – Lake Michigan Conference Room
Meeting called by: Tonya Bondale, Provider Network Manager
Type of meeting: Regular
Note taker: Kim Harner
Attendees: Provider Network, CMHCM Staff
Attendees (via conference phone): N/A
Excused:
Absent:
cc: Executive Leadership Team, Cindy Bay-Barron, Dawn Tanner

Agenda Topic: *Welcome/Sign In*

Agenda Topic: *Announcements*

Providers are encouraged to keep CMHCM's Contract Department updated with current email addresses. We are using a new program and want to ensure that providers are receiving the materials we are sending out. Please inform Tonya Bondale, Provider Network Manager at tbondale@cmhcm.org or Mark Buss, Service Specialist at mbuss@cmhcm.org.

CenTrain Meetings will are scheduled for August 6, 2013 and February 11, 2014 from 9:00 am – 11:00 am.

CMHCM will no longer be holding the Provider Forum Meetings. We now will be holding Provider Network Meetings twice a year in May and November.

Providers are encouraged to use the *Provider Recognition Program Quarterly Direct Support Professional (DSP) Award and Provider Recognition* to help recognize DSP's ad Providers who "go the extra mile" in supporting individuals with a mental illness. These forms can be found online at http://www.cmhcm.org/for-providers/forms.html.

Karen Bressette would like to thank all the providers for their help in making the site review transition a smooth process.

Kris Stableford handed out the Critical Incident Analysis Form as well as survey to address areas of concerns about understanding how and when to fill out the form. If you would like additional information about the Critical Incident Analysis process and associated documentation, please call or email John Obermesik, CMHCM Deputy Director for Administration at jobermesik@cmhcm.org or Kris Stableford, CMHCM Recipient Rights Officer at kstableford@cmhcm.org. Kris Stableford will then compile a list of frequently asked questions and answers and this will sent on to the providers. The Critical Incident Analysis form can be online at http://www.cmhcm.org/for-providers/forms.html.

Agenda Topic: *State and Agency Update*

Presenter: Kathie Swan, Deputy Director - Services

Discussion & Conclusions: Planning continues on the formation of a new Pre-Paid Inpatient Health Plan (PIHP) in response to the Michigan Department of Community Health (MDCH) announcing a map that reduces the number of PIHP's in the state from 18 to 10.

Medicaid expansion is in jeopardy. If there are not any new monies it appears that CMHCM would take a significant reduction in funding and it will impact current services. CMHCM has had to implement a "waiting list" for individuals seeking mental health services who do not have any insurance. If new monies are available for Medicaid expansion and this would alleviate the waiting list. We urge all of you to consider contacting your legislators in support of the expansion.

Action Items, Person Responsible & Deadline: *A list of Government Contacts is attached to these minutes as well as a fact sheet for Support Medicaid Expansion.* More information can be found online at www.Michigan.gov/MiBudget2014.

Agenda Topic: *Same Day Service*

Presenter: Catherine Beagle/Angie Thomas

Discussion & Conclusions: Mecosta County implanted a pilot program for Same Day Service. If consumers requesting services and were given an appointment that day or the second day data shows the no-show rate was significantly lower. This program has only been up and running for the past 6 weeks and looking to expand Same Day Service to all counties.

Action Items, Person Responsible & Deadline:

Agenda Topic: *ABA – Autism Benefit*

Presenter: Jennifer Richardson

Discussion & Conclusions: April 1, 2013 CMHCM began to provide services to children with Autism from the ages of 18 months to 5 years old. Services provided will be:

- Psychological Evaluation to identify service needs
- Assessment to determine communication and behavioral needs
- Provide in-home specialized Applied Behavioral Analysis (ABA) treatment

Providers were asked who could help and provider 5 hours a week. CMHCM had 5 providers interested in helping with Aides.

Questions:
1. What services are available once the child ages out?
   a. Family Subsidy
   b. Respite
   c. Community Living Supports (CLS)
   d. Case Management Services

Aides will be asked to attend the individual's Person Centered Planning meeting as well.

Action Items, Person Responsible & Deadline: If you have any questions please contact Jennifer Richardson at 989-772-5938.

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Agenda Topic: **CMHCM Provider Billing Changes**

Presenter: Bryan Krogman

Discussion & Conclusions: MDCH is requiring that prepaid inpatient health plans (PIHPs) begin to report paid amount and provider identifiers for services rendered January 1, 2013 and thereafter.

- Employer Identification Number (EIN): used by employers who deliver atypical services and thus are not required to have an NPI number
- National Provider Identifier (NPI): used by professionals, organizations and corporations that delivers a service. This is a HIPAA requirement.

The website to apply for a NPI number is https://nppes.cms.hhs.gov/NPPES/Welcome.do

When submitting claims providers will are required to start adding in the start and stop times. This will not apply to the per diem rate. This will allow providers to see if services are duplicated or have already been billed.

Providers are asked to start looking at their data collection methods. This will be another requirement by October 1, 2013.

CMHCM is also asking providers to please sign up for direct deposit. Our billing/payroll department is safe, secure and protected. This form can be found on our external website - http://www.cmhcm.org/userfiles/filemanager/53/.

Action Items, Person Responsible & Deadline:

Agenda Topic: **Provider Topics**

Presenter: Provider Network

Discussion & Conclusions: Forest View Hospital now has a 24/7 dedicated assessment referral status.

Covered Employees for Obamacare – providers are worried about the cost of health care coverage for staff. CMHCM is looking into this situation and will consider the implications it poses on providers.

MDCH recently sent notification to providers to obtain names of staff who provided chore services. Do we know why this is happening?

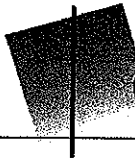Contract renewals – meeting with large providers to go over budgets and identify if any changes need to occur.

Meeting adjourned at: **11:45 a.m.**
Next meeting date: **November 12, 2013 @ 10:00 am**
Observers:
Resource Persons:
Special Notes:

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Community Mental Health for Central Michigan

PROVIDER RECOGNITION PROGRAM
QUARTERLY DIRECT SUPPORT PROFESSIONAL (DSP) AWARD

Community Mental Health for Central Michigan believes that it is important to provide recognition of its service providers and to acknowledge the many contributions of direct support staff.

The Direct Support Professionals (DSP) Recognition Program is an award program to recognize DSPs who "go the extra mile" in their support of individuals with a mental illness or developmental disability, and who serve by example, encouraging other DSPs to strive for excellence. A DSP Awards Panel comprised of individuals with disabilities will determine the winner using the award criteria. Each quarter a winner will be selected from the nominations received in the quarter. Each winner will receive a $100.00 gift card and a letter of recognition.

Award Criteria

Awards are solely based upon the information provided in the nomination. Please keep the nine core values from the **DSP Code of Ethics** in mind as you prepare your nomination. Do not simply restate the values; offer specific examples of how your nominee demonstrates or puts the values into practice. You will be notified of the decision of the Awards Panel. If you have questions or need assistance in completing a nomination, please call 1-800-317-0708 or 989-772-5938 and ask to speak to Customer Service.

This award recognizes an individual who:

- Provides <u>direct</u> support to a person/people with disabilities.
- Practices the nine core values from the DSP Code of Ethics when providing direct support.
- Has exceptional relationship(s) with person(s) supported
- Supports the person(s) in achieving their goals and dreams.
- Has a good relationship with co-workers
- Has a genuine commitment to people with disabilities
- Takes extra training to improve skills

DSP Code of Ethics:

Advocacy: As a DSP, I will advocate with the people I support for justice, inclusion, and full community participation.

Person-Centered Supports: As a DSP, my first allegiance is to the person I support: all other activities and functions I perform flow from this allegiance.

Promoting Physical and Emotional Well-Being: As a DSP, I am responsible for supporting the emotional, physical, and personal well-being of the individuals receiving support. I will encourage growth and recognize the autonomy of the individuals receiving support while being attentive and energetic in reducing their risk of harm.

Integrity and Responsibility: As a DSP, I will support the mission and vitality of my profession to assist people in leading self-directed lives and to foster a spirit of partnership with the people I support, other professionals, and the community.

Confidentiality: As a DSP, I will safeguard and respect the confidentiality and privacy of the people I support.

Justice, Fairness, and Equity: As a DSP, I will promote and practice justice, fairness, and equity for the people I support and the community as a whole. I will affirm the human rights, civil rights, and responsibilities of the people I support.

Respect: As a DSP, I will respect the human dignity and uniqueness of the people I support, I will recognize each person I support as valuable and help others understand their value.

Relationships: As a DSP, I will assist the people I support to develop and maintain relationships.

Self-Determination: As a DSP, I will assist the people I support to direct the course of their own lives.

Nomination Process:

- Complete nomination form and be as thorough as possible in your description. You may nominate as many DSP staff as you like.
- Describe what makes your DSP nominee a stand out in the field and deserving of recognition.
- Include a minimum of two stories as examples. Do not use individual consumer names.
- Remember to consider the DSP Code of Ethics when completing the nomination.

Submit nominations to Customer Services by Fax, E-mail, or Mail
> Community Mental Health for Central Michigan
> Attention: Customer Services
> 301 South Crapo Street, Suite 100
> Mt. Pleasant, MI 48858
>
> FAX: (989) 773-1968
>
> EMAIL: kbressette@cmhcm.org

Questions: Please call (989) 772-5938 or (800) 317-0708 and ask for Customer Services.
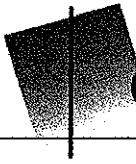
Community Mental Health for Central Michigan

PROVIDER RECOGNITION PROGRAM
QUARTERLY DIRECT SUPPORT PROFESSIONAL AWARD
NOMINATION FORM

Name of Direct Support Professional (DSP)	*Agency/Employer Name*
DSP's Address	*Agency/Employer Address*
DSP's City, State, Zip Code	*Agency/Employer City, State, Zip Code*
DSP's Email	*Employer Phone Number* ( )
DSP's Phone Number ( )	*Name of DSP's Supervisor*
Number of years DSP has worked in the field	*Phone Number or Email of Supervisor* ( )
DSP's Job Title / Position*	** Job titles vary from agency to agency. Be sure your nominee provides <u>direct</u> support to a person/people with disabilities.*
YOUR Name	*YOUR Address*
YOUR Relationship to Nominee	*YOUR City, State, Zip Code*
YOUR Phone Number ( )	*YOUR Email*

What makes your DSP nominee a stand out in the field and deserving of recognition? Please provide a minimum of two stories as examples. Do not use consumer names. Feel free to use the reverse for more details. Remember to consider the DSP Code of Ethics when writing your narrative.

Community Mental Health for Central Michigan
PROVIDER RECOGNITION

Community Mental Health for Central Michigan believes that it is important to provide recognition of its service providers, and in so doing, support staff, agency and community learning that enhances the lives of mental health consumers.

INSTRUCTIONS FOR COMPLETING THE FORM

1. Review the values stated below and then provide a written description identifying which of the values the provider has met and the reasons why. Be sure to identify the provider and include your name and telephone number in case more information is needed.

2. Mail, fax, or hand-deliver the form to CMH for Central Michigan, Attention Customer Services. The mailing address is 301 South Crapo, Mt. Pleasant, MI 48858; the fax number is (989) 773-1968.

VALUES

1. Consumer Focus/Customer Driven Services

Consumer satisfaction, Meet person-centered-plan goals (helping dreams come alive), Listening to what the person wants, Consumer on boards, advisory committees, conduct town hall meetings, Consumer employment, volunteers within organization, Consumer controls own funds, selects their own staff, select their own living situation, Consumer education, Consumer defines quality, Mission, vision, policies support self-determination, Cultural responsiveness

2. Consumer Impact and Quality Improvement

Involvement in the arts, Volunteer opportunities, Employment, Assisting in the development of natural supports, Community inclusion, Relationship development/building, Gives options to chose from, Quality improvement program that is responsive, Meets or exceeds established outcomes or benchmarks, Addresses safety issues, Access to services, Affordable, accessible housing, Grievance and appeals process/policy, Creative and innovative service provision

3. Consumer/Provider/Community Partnering

Systems change initiatives through community collaboration (HSCB participation, local and state initiatives), Advocacy group participation (Arc, RICC), Direct involvement with consumers (assistance with newsletters, micro enterprises, mentoring/teaching)

4. Promoting Education/Advocacy on Mental Health Issues

Newsletters, mental health columns, booths at health fairs, newspaper articles, Community Involvement (civic groups, service organizations, advocacy groups), Political advocacy, Sponsoring conferences and trainings, Community organization around issues

_____ has contributed to the values in the following way(s):

(Name of provider)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Completed by: _____ **Phone #:** _____

Community Mental Health for Central Michigan
CRITICAL INCIDENT ANALYSIS FORM

Consumer Name: _____   Consumer Case #: _____

Staff Name(s): _____

Site: _____   Provider Organization: _____

Date and Time of Incident: ___/___/___ _____ am/pm   CMHCM Case Holder: _____

Factors that Contributed to Incident	
Method/Procedure	
Communication	
Staff Related	
Environment	
Equipment/Materials	
Other	
How to Prevent Recurrence?	
Method/Procedure	
Communication	
Staff Related	
Environment	
Equipment/Materials	
Other	

Form Completed by:
(Supervisor/Home Manager/Designee) _____
                                                                                  Name

_____   _____   _____
Title   Phone Number   Date

SEND A COPY OF **ALL INCIDENT REPORTS** TO CMHCM OFFICE OF RECIPIENT RIGHTS **WITHIN 24 HOURS OF INCIDENT**. SEND COMPLETED CRITICAL INCIDENT ANALYSIS FORM (**this page**) TO CMHCM Sentinel Events Review Committee (SERC) C/O Secretary for Recipient Rights Dept. (301 S. Crapo St., Suite 100, Mt. Pleasant, MI, 48858. Fax: 989-773-1968) **WITHIN 30 DAYS OF INCIDENT**

INSTRUCTIONS FOR COMPLETING CRITICAL INCIDENT ANALYSIS FORM

A Critical Incident is a serious/potentially serious event that occurs while a consumer is receiving services from CMHCM or a contracted provider. Such an event requires close examination, with the goal of identifying factors that contributed to the event and making it less likely future, similar events will occur.

The following are Critical Incidents:
- Death (Note If Suicide Suspected)
- Emergency Medical Treatment Or Hospitalization Due To
  - Injury
  - Medication Error
  - Self-Harm
  - A Consumer Harming Another Person
- Hospitalization Due To Illness (2 Or More Unscheduled Admissions Not Due To Chronic Or Underlying Condition Within 12 Months)
- Apparent Or Suspected Abuse Or Neglect
- Emergency Physical Management
- Arrest Of Consumer
- Staff Called Police In Response To Consumer's Challenging Behavior
- Unauthorized Leave Of Absence

All Incident Reports (IRs) must be sent to CMHCM (to the Office of Recipient Rights and to the Recipient's Case Manager, if applicable) no later than **the next business day** following the incident described. IRs can be dropped off at or mailed to CMHCM/Mt. Pleasant, or faxed.*

If the IR describes a Critical Incident,
- Home Manager (for residential settings) or Supervisor (for other settings) should indicate on the IR that a Critical Incident Analysis form will be completed and submitted.
- Recipient Rights Advisors (RRAs) will be contacting Home Managers and Supervisors when IRs describing critical incidents are received, if there's no indication a Critical Incident Analysis form is forthcoming.
- Home Manager or Supervisor must complete the Critical Incident Analysis Form. S/he may wish to consult with the staff person who completed the initial IR. The Home Manager or Supervisor should describe factors that contributed to the incident and ways of preventing future incidents related to:
  - Method/Procedure:
    - Was the recipient's Person-Centered Plan (PCP) adequate?
    - Was the recipient's PCP complete?
    - Did written policies, protocols, and procedures exist?
    - Were staff aware of risks and thinking about how to prevent them?
  - Communication:
    - How was information provided to staff?
    - Were there barriers to communication?
    - Were staff aware of the consumer's PCP?
    - Were staff aware of the organization's procedures, policies and protocols?
    - Was information/instructions missing?
    - Was information/instructions confusing or contradictory?
  - Staff Related:
    - What were staffing levels at the time of the incident?
    - What training had staff received?
    - Did staff have skills required to implement procedures
  - Environment:
  - Was the environment noisy?
  - How much space was available to consumers and staff?
  - Was lighting adequate?

- o Were any physical hazards present?
- o Had Emergency Response Procedures been developed?
- o <u>Equipment/Materials:</u>
  - • Was equipment available?
  - • Was equipment used properly?
  - • Was equipment in good condition?
  - • Were surfaces safe?

CMHCM RRAs are available to provide consultation and assistance.

Completed Critical Incident Analysis Forms should be sent to the Sentinel Events Review Committee (SERC) Chairperson* within 30 days of the incident. (*Send C/O Secretary for Recipient Rights Dept., CMHCM, 301 S. Crapo St., Suite 100, Mt. Pleasant, MI, 48858, or fax to 989-773-1968)

An Incident Report Must Be Completed When:

- Abuse or Neglect is apparent or suspected*
- ANY violation of a right protected by the Michigan Mental Health Code (MMHC) is apparent or suspected**
- A consumer has been sexually abused, sexually assaulted, or abducted by someone other than staff
- Death
- Choking
- ER/Urgent Care visit due to serious illness
- Hospitalization due to serious illness (an unscheduled admission not due to chronic illness or underlying condition)
- A consumer is injured and goes to ER/Urgent Care
- A consumer is hospitalized due to injury
- A fall results in injury, or is so serious that an injury is likely to appear later
- Traffic accident
- Medication error
- Medication error that requires an ER/Urgent Care visit
- Medication error that results in hospitalization
- Medication problem: any missed or delayed dose due to circumstances beyond the med passer's control that is not covered by a protocol
- Medication refusal (including spitting out) when the medication is not ultimately taken
- Arrest
- Challenging behavior not addressed in Person-Centered Plan
- Unauthorized leave
- Emergency physical intervention
- PRN medication given in response to challenging behavior
- Staff called police about challenging behavior
- Self-harm by a consumer that requires an ER/Urgent Care visit
- Self-harm by a consumer that results in hospitalization
- A consumer harms another person, who requires an ER/Urgent Care visit
- A consumer harms another person, who is hospitalized

*Note that a staff person who learns of apparent or suspected Abuse or Neglect must make an **immediate verbal report** to a Supervisor and to the CMHCM Office of Recipient Rights (CMHCM ORR), and complete an incident report before their shift is over.

**Alleged violations of other rights protected by the MMHC must be promptly reported by staff to a Supervisor and to the CMHCM ORR, and staff must complete an incident report before their shift is over.

CRITICAL INCIDENT ANALYSIS FORM SURVEY

Name (optional): _____

Provider Agency (optional): _____

Contact Information (optional): _____

_____

I understand **why** I need to complete a Critical Incident Analysis Form.

Definitely   Pretty Much   Not Exactly   Not Really   Definitely Not

I understand **when** to complete a Critical Incident Analysis Form.

Definitely   Pretty Much   Not Exactly   Not Really   Definitely Not

I understand **how** to complete a Critical Incident Analysis Form.

Definitely   Pretty Much   Not Exactly   Not Really   Definitely Not

One question I have about completing the Critical Incident Analysis Form is _____

_____

_____.

I would appreciate it if you would complete this form and leave it on the back table.

Thanks!

--Kris Stableford, Recipient Rights Officer, CMHCM

Facts about Medicaid Expansion
Improving Care, Saving Money

Why expand Medicaid?

The expansion of Medicaid will provide health insurance for those Michiganders who need it most, while saving money and improving care for all of our citizens.

Who will be covered?

Medicaid would be expanded to 133% of the Federal Poverty Level, meaning that those living at or near poverty (about $30,000 per year for a family of four) would receive health care. In total, 320,000 Michiganders will be covered in the first year, 470,000 will be covered by 2021, and Michigan's uninsured population will drop by about 46%.

What kind of coverage will be provided?

Coverage will include access to primary care doctors, preventative care and routine checkups.

How much will it cost Michigan?

There is no net cost to the state over the next 21 years, and Michigan will save $320 million in uncompensated care costs by 2022 and $206 million in General Fund costs in 2014 alone.

Who will pay for the expansion?

Federal funds will cover 100% of the cost of Medicaid expansion from 2014 to 2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent in 2020 and subsequent years.

With the Medicaid expansion, the federal government will cover expenses Michigan pays for today, saving the state $206 million in in General Fund costs in 2014 alone. The proposed budget deposits $103 million of those savings into a new health savings fund to cover Michigan's future health care liabilities.

Will Michiganders who already have insurance benefit?

Yes. Today, uninsured citizens often turn to emergency rooms for non-urgent care because they don't have access to primary care doctors -- leading to crowded emergency rooms, longer wait times and higher cost. By expanding Medicaid, those without insurance will have access to primary care, lowering costs and improving overall health.

Will businesses benefit?

Yes. Under the Affordable Care Act, the federal government is mandating that businesses either provide health care to their employees or pay a $2,000-per-employee penalty. By expanding Medicaid, we can provide an affordable option that will help businesses stay open.

Learn more at Michigan.gov/MiBudget2014

Michigan Association of Community Mental Health Boards

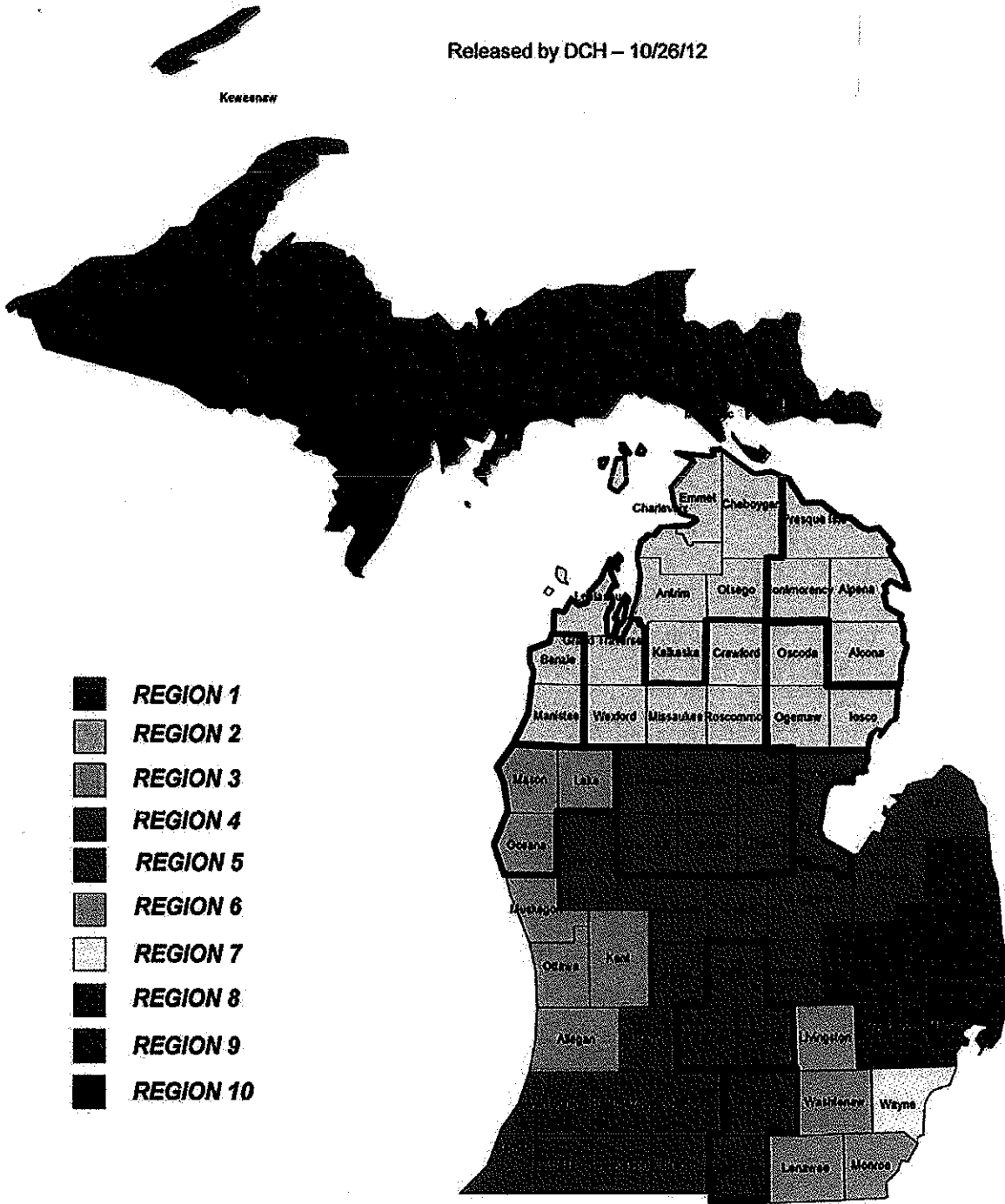## *Top 10 Reasons to Support Medicaid Expansion*

10. Medicaid expansion will keep federal tax dollars in Michigan and help create jobs here – instead of other states.

9. Medicaid expansion will contribute to a better economy and provide a healthier, more reliable workforce. This will improve Michigan's business climate, helping us retain our local businesses and recruit new businesses.

8. Uninsured Michigan citizens do not have access to preventative services and primary care doctors. To receive health care, they often turn to emergency rooms. This leads to **crowded emergency rooms**, **longer wait times** and **higher costs** for those who do have insurance.

7. Michigan businesses will avoid $54 million to $81 million a year in tax penalties for failing to provide health insurance to workers with low incomes.

6. Governor Snyder's proposal to create a "health savings account" with half of the savings generated will ensure Michigan's program is sustainable and have the necessary state revenues to pay for the program until 2034.

5. The state of Michigan will save roughly $1 billion over the next decade under Medicaid expansion, it will save $320 million in uncompensated care costs by 2022 and $206 million in General Fund costs in 2014 alone.

4. Under the expansion, Michigan's economy will receive about $30 billion in new federal funds between 2014 and 2023. These funds will help create an estimated 18,000 new jobs.

3. The best way to provide increased support for mental health services and to remove barriers and access to care is to expand Medicaid.

2. Between 400,000 – 500,000 Michiganders who currently do not have insurance would receive health care, including much needed mental health and substance use disorder services.

1. **Saves Money, Saves Lives!**

Government Contacts

County	US Congress	State Senator	State House
Osceola		**District 35** *Darwin Booher* PO Box 30036 Lansing, MI 48909-7536 sendbooher@senate.michigan.gov	**District 102** *Philip Potvin* P.O. Box 30014 Lansing, MI 48909-7514 philippotvin@house.mi.gov
Clare		**District 35** *Darwin Booher* PO Box 30036 Lansing, MI 48909-7536	**District 97** *Joel Johnson* P.O. Box 30014 Lansing, MI 48909-7514 joeljohnson@house.mi.gov
Gladwin	**District 4** *Dave Camp* <u>Midland District Office</u> 135 Ashman Drive Midland, MI 48640 Phone: 989.631.2552 Fax: 989.631.6271 <u>Washington DC Office</u> 137 Cannon Building Washington DC 20515 Toll Free: 800.342.2455	**District 36** *John Moolenaar* PO Box 30036 Lansing, MI 48909-7536 senjmoolenaar@senate.michigan.gov	**District 97** *Joel Johnson* P.O. Box 30014 Lansing, MI 48909-7514 joeljohnson@house.mi.gov
Mecosta		**District 35** *Darwin Booher* PO Box 30036 Lansing, MI 48909-7536	**District 102** *Philip Potvin* P.O. Box 30014 Lansing, MI 48909-7514 philippotvin@house.mi.gov
Midland		**District 36** *John Moolenaar* PO Box 30036 Lansing, MI 48909-7536	**District 98** *Jim Stamas* P.O. Box 30014 Lansing, MI 48909-7514 jimstamas@house.mi.gov **District 99** *Kevin Cotter* P.O. Box 30014 Lansing, MI 48909-7514 kevincotter@house.mi.gov
Isabella		**District 33** *Judy Emmons* PO Box 30036 Lansing, MI 48909-7536 Senjemmons@senate.michigan.gov	**District 99** *Kevin Cotter* P.O. Box 30014 Lansing, MI 48909-7514 kevincotter@house.mi.gov

1.31.11

Michigan PIHP Restructure

Released by DCH – 10/26/12

Legend:
- REGION 1
- REGION 2
- REGION 3
- REGION 4
- REGION 5
- REGION 6
- REGION 7
- REGION 8
- REGION 9
- REGION 10

Same Day Service Pilot
Mecosta County

CMH for Central Michigan

Date Range:
4/1/13 -
5/3/13

Number of Surveys completed: 16

Assessments Same Day Service

	Question	Strongly Agree (1)	Agree (2)	Neutral (3)	Disagree (4)	Strongly Disagree (5)
1	It was important to me that I was seen within a day or two of the day I requested help.	88%	6%	6%	0%	0%
2	I was satisfied with receiving an assessment within one or two days of requesting help.	81%	13%	6%	0%	0%

Comments from Surveys:

What challenges did you have to overcome to receive your assessment within a day or two of requesting help?

Just a ride to get here.

No challenges to overcome, I walked in and they saw me. It was the best so far.

Just being patient and wait.

None, the office and staff were friendly and professional and helped.

My son Michael has serious behavior issues.

I was scared to show my emotions and it's hard for me to talk to people. Get nervous and I move a lot and talk a lot.

Transportation fell through, we were late arriving

Same Day Service
Mecosta County Pilot

Week Five (April 29 - May 3)

Sum of Case Number				
Screened out at Access □(Yes/No)	Accepted Same Day Ser	Case Number	Reason for Declining	
N	N	4333	Did not want to finish referral until he had more insurance info.	Did NOT Accept Same Day Appt.
		4969	Unable to get ride until 5-8-13	
		5340	Warm transfer to CMIT; Did not want services	
		5341	Unable to come in today and wanted late appointment time	
		900354	Guardian has to complete her referral	
	N Total			
		2220	(blank)	Accepted Same Day Appt.
		2872	(blank)	
		4513	(blank)	
		5289	(blank)	
		5293	(blank)	
		5355	(blank)	
		900060	(blank)	
		916583	(blank)	
		928020	(blank)	
	Y Total			
N Total				
Y	(blank)	4819	(blank)	
		5318	Refer to Auto Insurance	
		5319	Refer to VA	
		703666	(blank)	
	(blank) Total			
Y Total				
Grand Total				

Week Four (April 22 - 26)

Sum of Case Number				
Screened out at Access □(Yes/No)	Accepted Same Day Ser	Case Number	Reason for Declining	
N	N	1249	No openings same day	Did NOT Accept Same Day Appt.
		5280	SIDD Referral, need time to gather info from school, ISD, etc.	
		924016	Has a job interview today, can't tomorrow	
		931441	Transportation problems	
		3676	(blank)	Accepted Same Day Appt.
		919144	(blank)	
		929232	(blank)	
N Total				
Y	(blank)	5223	(blank)	
		5235	(blank)	
		5262	(blank)	
		921986	(blank)	
Y Total				
Grand Total				

Week Three (April 15 - 19)

Sum of Case Number				
Screened out at Access □(Yes/No)	Accepted Same Day Ser	Case Number	Reason for Declining	
N	N	5190	No openings for Same Day Service	Did NOT Accept Same Day Appt.
		5206	Consumer has plans, wants appointment next week	
		5218	Family had other things planned for today	
		817589	No transport in, needed a Friday when she can borrow a car	
		905806	Parents are working today	
		931452	(blank)	Accepted Same Day Appt.
N Total				
Y	(blank)	5199	(blank)	
		5213	(blank)	
Y Total				
Grand Total				

Week Two (April 8 - 12)

Sum of #				
Screened out at Access □(Yes/No)	Accepted Same Day Ser	Case Number	Reason for Declining	
N	N	1392	Bad weather, bad roads today, can't get in.	Did NOT Accept Same Day Appt.
		1965	No transportation until 4-16-13	
		5122	Unable to take same day or tomorrow due to other commitments	
		894128	walk in referral took an hour due to interactions between him and his r	
		903295	Father works to 3pm and cannot take anymore time off	
		925164	COFR/Foster Child - need to get information in place	
		919393	Referral completed after 4pm, scheduled next day 4-10	Accepted Same Day Appt.
N Total				
Y	(blank)	5118	(blank)	
Y Total				
Grand Total				

Week One (April 1 - 5)

Sum of #				
Screened out at Access □(Yes/No)	Accepted Same Day Ser	Case Number	Reason for Declining	
No	No	4362	Parent busy today, needs appt late afternoon	Did NOT Accept Same Day Appt.
		5094	(blank)	
		817364	Discharge from hospital Monday at 11 am, prefers Tuesday appt.	
		891693	Consumer is out of town today and returns tomorrow	
		5074	Late in day when referral completed, so scheduled tomorrow	Accepted Same Day Appt.
		5080	(blank)	
		922027	N/A	
No Total				
Yes	(blank)	5086	(blank)	
		5087	(blank)	
		5100	(blank)	
		5105	(blank)	
		5107	(blank)	
		926131	(blank)	
Yes Total				
Grand Total				

Mecosta County Pilot
April 1, 2013 - May 3, 2013

58 Consumers Screened

29%

71%

- Screened Out at Access
- Not Screened Out at Access

41 of the 58 Consumers Not Screened Out at Access

33%

67%

- Accepted Same Day Service
- Did Not Accept Same Day Service
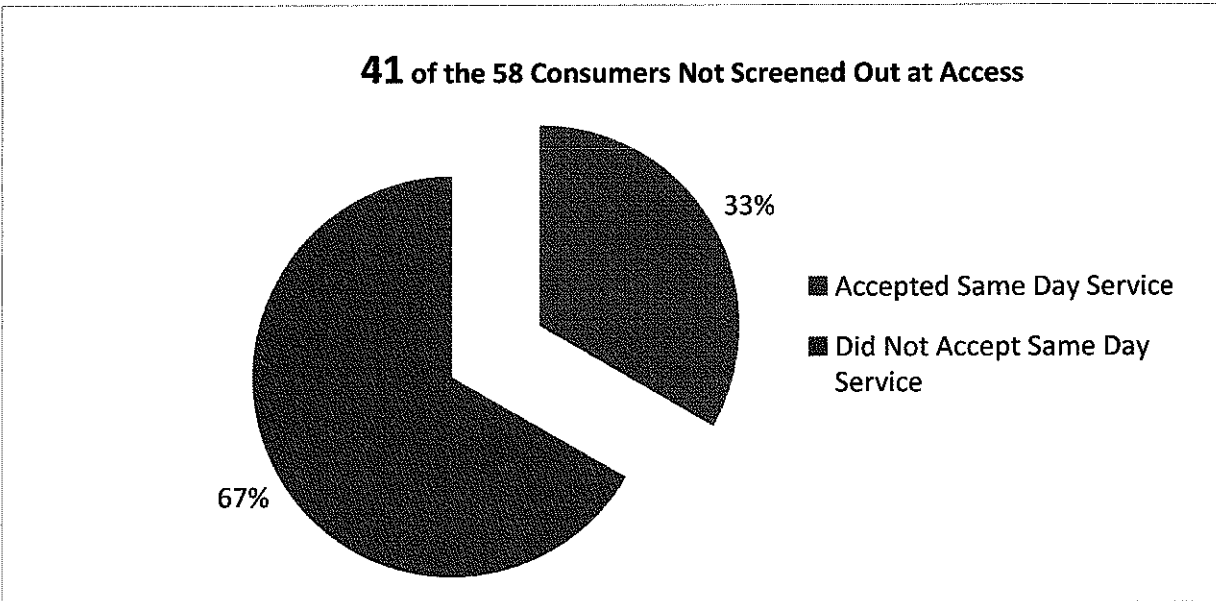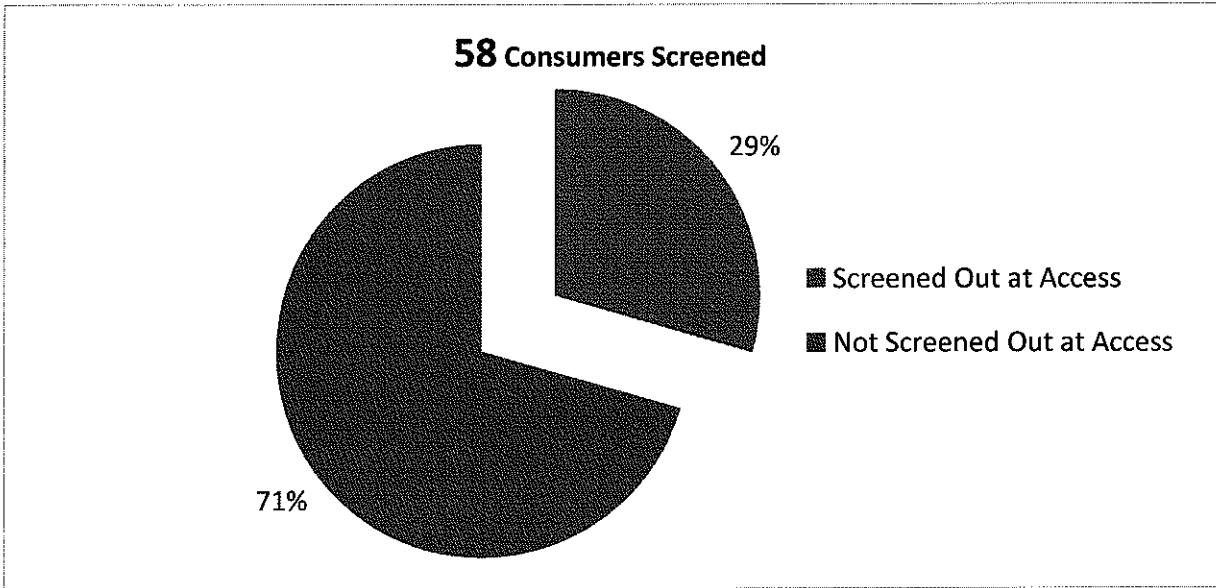
Here are some of the signs that trained professionals look for in children that have autism

- Avoid eye contact
- No big smiles or other warm, joyous expressions by 6 months
- No back and forth sharing of sounds, smiles, or other facial expressions by 9 months
- No babbling by 12 months
- No back and forth gestures, such as: pointing, showing, reaching, or waving by 12 months
- No words by 16 months
- No meaningful, two-word phrases (not including imitating or repeating) by 24 months
- Upset by minor changes
- Hand flapping, rocking back and forth
- Unusual reactions to the way things sound, smell, taste, look, or feel
- ANY loss of speech, babbling, or social skills

These are signs of autism, but do not necessarily mean your child has an autism diagnosis. However, if you are concerned about your child and think autism is a possibility, speak with your family doctor, your pediatrician, or contact CMHCM.

Resources

Autism Alliance of Michigan
http://autismallianceofmichigan.org

Autism Society of America
www.autism-society.org

Autism Society of Michigan
www.autism-mi.org

Autism Speaks
www.autismspeaks.org

Center for Disease Control
www.cdc.gov/ncbddd/autism/index.html

Michigan Alliance for Families
www.michiganallianceforfamilies.org

Michigan Department of Community Health
http://www.michigan.gov/mdch

CMHCM Locations

Clare County Office/Harrison
789 North Clare Avenue • 989.539.2141

Isabella County Office/Mt. Pleasant
301 South Crapo • 989.772.5938

Gladwin County Office/Gladwin
655 East Cedar Street • 989.426.9295

Mecosta County Office/Big Rapids
500 South Third Street • 231.796.5825

Midland County Office/Midland
218 Fast Ice Drive • 989.631.2320

Osceola County Office/Reed City
4473 220th Avenue • 231.832.2247

SPECIALIZED AUTISM PROGRAM FOR YOUNG CHILDREN

Community Mental Health for Central Michigan (CMHCM) provides services to children with autism and their Medicaid-eligible families. The program's focus is children that are 18 months through 5 years old and are diagnosed with an autism spectrum disorder. Specialized in-home services will be offered to provide support and help the child and family learn skills. Children with autism are often behind their peers in learning to communicate effectively, struggle with day-to-day social interactions, and basic daily life activities. If you are concerned that your child is behind others of his/her age, there is help available.

Community Mental Health for Central Michigan
www.cmhcm.org

Who is eligible for the Specialized Autism Program for Young Children?

- Children who are 18 months through 5 years old
- Children who meet the diagnostic criteria for an Autism Spectrum Disorder
- Children who have Medicaid or MiChild benefits

What services will CMHCM provide?

- Provide a thorough psychological evaluation by a psychologist to provide an autism diagnosis to those who are eligible and to identify service needs
- Complete an assessment to determine communication and behavioral needs
- Provide in-home specialized Applied Behavior Analysis (ABA) treatment
- Work with parents and care givers to teach skills for helping young children develop to their full potential
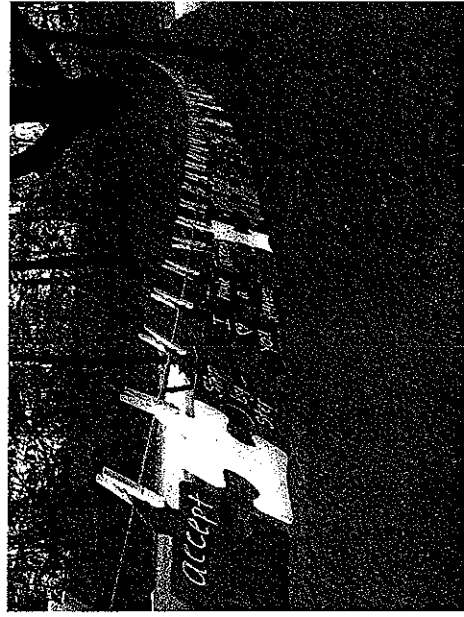
Applied Behavior Analysis (ABA) Therapy Services are provided. What is ABA?

- ABA is a scientific approach to helping children increase positive behaviors and decrease behaviors that are challenging for the child and their families.

Behaviors to increase:

- Communication (through vocalization, sign language, or pictures)
- Independent living skills
  - Toilet training
  - Tooth brushing
  - Dressing
  - Daily chores that increase independent living
- Tolerance of waiting and changing routines
- Improved social interactions

Behaviors to decrease:

- Aggression
- Tantrums
- Self-injury

If your child does not qualify for the Specialized Autism Program for Young Children, CMHCM has other services available that will provide support and assistance for your child and your family.

Research has shown that when parents are involved in the Applied Behavioral Analysis (ABA) therapy process, outcomes are more positive.

ABA is most effective with a team approach. If the behaviors that the ABA therapist teaches to the child are not generalized, reinforced, and maintained by family, then one of two things will happen: the child will lose the skill, OR the child will only display the skill for the therapist. What that might look like a child who is able to use the bathroom, but wets their underwear when they are alone with their parents. Partial success only when the therapist is around is not the goal.

An understanding of ABA and a commitment to the process is essential for success of this program.

The parents, or primary caregivers, need to know and understand the ABA therapy goals, behavior plans, and strategies so well that in the ABA therapists' absence they could independently run a therapy session.

FY'13 REPORTING OF FINANCIAL FIELDS
PRE-PAID INPATIENT HEALTH PLANS
Final Instructions
January 1, 2013

I. <u>Purpose and intents of reporting monetary amount with 837 v.5010 Encounters</u>

The Michigan Department of Community Health (MDCH) is requiring that prepaid inpatient health plans (PIHPs) begin to report paid amount and provider identifiers for services rendered January 1, 2013 and thereafter with each 837 encounter submitted for services and supports provided to public mental health recipients. The rationale for this new requirement is based on: 1) aligning requirements with those for Medicaid Health Plans; 2) obtaining accurate information about the *rates* that are paid to providers in order to understand the variation in rates among PIHPs; 3) obtaining accurate information about the *providers* in order to understand the variation in rates among PIHPs; and 4) the need to use the rate and provider information to move toward a standard price or price ranges for certain high volume and high expenditure services.

PIHPs will continue reporting the cases, units and costs of each procedure code on the annual Medicaid Utilization and Net Cost Report (MUNC). It is not expected that the sum of the MUNC-reported *costs* for each procedure code, or the total *costs* of all procedure codes will equal the sum of the *rates paid* and reported in the encounter data by procedure or total.

PIHPs should report encounters with monetary amount and provider information according to the requirements in MDCH/PIHP Contract Attachment 6.5.1.1: Encounter data is reported within 30 days after the claim for the service is adjudicated, or in cases where claims payment is not part of the PIHP's business practice, within 30 days following the end of the month in which services were delivered.

The following set of instructions was developed with the assistance of a workgroup made up of representatives from PIHPs, in consultation with the State's actuary, Milliman, Inc., and staff at MDCH's Medical Services Administration.

II. <u>Definition of terms</u>

   a. **Adjusted amount: If the paid amount does not equal the charge amount, adjustment amount must be reported as well as reason code. Required reporting with each procedure code that has a date of service beginning January 1, 2013 (See specific information about loops in Section V)**
   b. Approved amount: amount that was approved by the PIHP (not required by MDCH)
   c. Atypical provider: Atypical providers are non-health care providers who are not eligible to obtain an NPI, such as adult foster care facilities and taxi companies (See list of non-health care procedure codes and services in Section IV))
   d. **Billing provider: The organization or agency who employs the provider of services. The Billing Provider may be an individual only when the health care provider performing services is an independent, unincorporated entity.**
   e. Case rate: amount paid for a period (e.g., monthly, quarterly) for each beneficiary authorized to receive services (regardless of the amount of services delivered by a provider).
   f. Charge amount: amount charged by the provider. This is a HIPAA-required field for encounters but $0 can be reported for non-fee-for-service arrangements.

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g. CMHSP-delivered services: CMHSP employees, including individually-contracted employees who are paid a wage or salary, deliver a covered service that results in a claim or encounter.

h. Cost settled or net cost contract: payer pays provider a set dollar amount periodically (e.g., monthly, quarterly) based on an anticipated costs, then costs settles at the end of the period based on the actual expenditures incurred by a provider in the current financial period.

i. EIN: Employer Identification Number used by employers who deliver atypical services and thus are not required to have an NPI number

j. Fee-for-service: provider is reimbursed based on a submitted claim for a service rendered

k. Most current rate: a calculated rate based on previous year's amount paid to the provider, or on predicted amount that will be paid to the provider

l. **NPI number**: National Provider Identifier. Used by professionals, organizations and corporations that deliver a service.

m. **Paid amount: Required reporting with each procedure code for dates of service that begin with January 1, 2013**

    i. *"Paid amount"* through a **fee-for-service** payment model, is the actual amount paid for the procedure to the rendering provider through the adjudication process (primary payers have paid and adjustment reductions have occurred). When billing provider is the rendering provider, the amount paid to the billing provider is reported.

    ii. *"Paid amount"* through non-fee-for service payment models (e.g., case rate, sub-cap, cost-settled or CMHSP-delivered), is based on the most current rate (e.g., calculated from last year's actual rate + inflation or deflation) for the procedure paid to the billing or rendering provider after primary payers have paid and adjustment reductions processed. When the billing provider is the rendering provider, the amount paid to the billing provider is reported.

    iii. CMHSP service-related administrative costs **should** be included in the Paid Amount reported for direct run services. However, the CMHSP service-related administrative costs **should not** be included in the amount that the CMHSP paid a contracted provider. While these service-related administrative costs will not be reported in the encounter data, they will be included in the service line amounts that PIHPs report in the MUNC. Managed Care administrative costs are not to be included in any Paid Amounts reported in the encounter data.

n. **Provider: the individual, agency, organization or corporation that provided a reportable service to a beneficiary or consumer.**

o. **Rendering provider: a provider that is the person or entity who rendered the care.**

p. **SS number:** Social Security Number used by single providers who deliver atypical services and do not have an EIN or NPI.

q. Sub-capitation arrangement: amount paid for a period (e.g., month) for each group (e.g., Medicaid, ABW) of eligibles.

III. Identifying the "Billing and Rendering Providers"

In the chart below are the various types of services provided in the public behavioral health and intellectual/developmental disabilities services system. Since the current system has many ways that it provides and pays for services, this chart is a guide for determining who is the "billing" provider and "rendering" provider. PIHPs will identify in the 837 transaction the billing or rendering

provider with the provider's NPI number, unless the provider is "atypical" delivering non-health care services (See list in Section IV), in which case the billing provider's EIN or social security number will be reported.

Note #1:   In this chart it is assumed that for Detroit Wayne, CMHSP= MCPN or Managers of Comprehensive Provider Networks.

Note#2:   When billing provider and rendering provider are the same, billing provider is reported and rendering provider is null.

Note #3:   "Professional" referenced below means a clinician that has the ability to bill Medicare and in doing so would need an NPI number. Professional does not mean case manager or supports coordinator.

Service Type	Service Delivery Type	Billing Provider	Rendering Provider
Professional clinician (e.g., physician, MH therapy, OT, PT, RN)	Professional employed by or contracted with CMHSP/MCPN & paid a salary	CMHSP/MCPN	Professional
	CMHSP/MCPN contracts with an organization that employs or contracts with the professional	Organization	Professional
	CMHSP/MCPN contracts directly with individual professional who bills for the service provided	Professional	
Non-professional (e.g., CLS, personal care, skill building, respite, supported employment, peer)	CMHSP/MCPN employees provide the service	CMHSP/MCPN	
	CMHSP/MCPN contracts with an individual who bills for the service	Individual	
	CMHSP/MCPN contracts with an organization or corporation that employs workers who deliver the service	Organization or corporation	
	CMHSP/MCPN contracts with a sole proprietor that employees workers who deliver the service	Sole proprietor	

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Service Type	Service Delivery Type	Billing Provider	Rendering Provider
	CMHSP/MPCN contracts with an organization or corporation (#1) that subcontracts with another organization, corporation (#2), that subcontracts with another organization or corporation or sole proprietor (#3)	Organization, corporation #1	Organization, corporation or sole proprietor #3
Self-directed services (e.g., community living supports and skill building delivered by aide-level workers, independent supports coordination and psychiatry delivered by professionals)	Employer of record_in which the beneficiary (or guardian on behalf of) hires and pays worker through a fiscal intermediary.	Fiscal intermediary	
	Purchase of service in which the CMHSP/MCPN pays a fiscal intermediary who pays an organization who employs the worker	Fiscal intermediary	Organization
	Agency with choice_in which the CMHSP/MCPN pays the agency that employs the workers who the beneficiary chooses	The agency	
Team-based services (ACT, home-based, wraparound)	CMHSP/MCPN or provider staff perform service individually or as a team	Refer to Professional above	
Treatment Planning	CMHSP/MCPN or provider professional staff participate in the planning and report separately	Refer to Professional above	Refer to Professional above
Behavior Treatment Plan Review Committee	CMHSP/MCPN or provider professional staff participate on the committee but only one event is reported	Refer to Professional above	Refer to Professional above
Adaptive equipment and enhanced	CMHSP/MCPN or a provider purchases from a	CMHSP/MCPN or the provider	

Service Type	Service Delivery Type	Billing Provider	Rendering Provider
pharmacy items	vendor		
Housing assistance and good and services	CMHSP/MCPN reports a monthly total that may include multiple items from multiple vendors	CMHSP/MCPN or the provider	
Respite care or CLS provided in a day or overnight camp	CMHSP/MCPN or a provider pays camp	CMHSP/MCPN or a provider	
Institutional services delivered in a hospital	CMHSP/MCPN contracts with and pays hospital	Hospital	
Transportation Services are delivered by provider staff, or by local taxis, ambulance or transit authorities	CMHSP/MCPN or provider pays taxi, ambulance or transit authority	CMHSP/MCPN or provider	

IV. Atypical providers

Atypical providers deliver the non-health care services listed below. Some providers deliver a mix of health care and non-health care services so will have an NPI number that should be reported with the encounter even if the service is on this list. If all the services a provider delivers are non-health care services from the list below, the provider will not have an NPI number, and thus either an EIN or social security number will be reported with the encounter.

Procedure Code	Description
A0080	Non-emergency transportation per mile – vehicle provided by volunteer (individual or organization) with no vested interest
A0090	Non-emergency transportation per mile – vehicle provided by individual (family member, self, neighbor) with vested interest
A0100	Non-emergency transportation: Taxi
A0110	Non-emergency transportation and bus: Intra- or interstate carrier
A0120	Non-emergency transportation: Mini bus, mountain area transports, or other transportation systems
A0130	Non-emergency transportation: Wheel chair van
A0140	Non-emergency transportation and air travel (private or commercial) intra or interstate
A0160	Non-emergency transportation: per mile- case worker or social worker
A0170	Transportation ancillary: parking fees, tolls, other
A0180	Non-emergency transportation: ancillary: lodging-recipient
A0190	Non-emergency transportation: ancillary: meals-recipient
A0200	Non-emergency transportation: ancillary: lodging - escort
A0210	Non-emergency transportation: ancillary: meals - escort
H0023	Drop-in center: 15 minutes
H0025	Prevention education encounter
H0038	Peer specialist services: 15 minutes
H0043	Supported housing: per diem

Procedure Code	Description
H0045	Respite care, out of home: per diem
H0046	Peer mentor services: 15 minutes
H2014	Skill-building, out-of-home voc rehab: 15 min
H2015	Comprehensive community support services: per 15 minutes
H2016	Comprehensive community support services: per diem
H2023	Supported employment: 15 min
H2030	Psycho-social rehab, Club House: 15 min
S5111	Home care, family training: encounter
S5140	Foster care, adult: per diem
S5145	Foster care, therapeutic, child: per diem
S5150	Respite care, unskilled: 15 min
S5151	Respite care, in-home: per diem
S9976	Lodging, per diem, not otherwise classified
T1005	Respite care: 15 minutes
T1012	Recovery services:
T1016	Supports Coordination
T1017	Targeted Case Management
T1020	Personal care: per diem
T2015	HSW, Prevocational service: hour
T2025	Waiver service: not otherwise classified (used for fiscal intermediary)
T2036	Therapeutic camping, overnight, waiver: each session
T2037	Therapeutic camping, day, waiver: each session
T2038	Community transition, waiver: per service
T5999	Wraparound – supply: item

V. Loops and segments

Attached is a chart with the location of loops and segments from the 837 Implementation Guide

Financial Loops – Professional

-Information Taken from Health Care Claim: Professional (837) Implementation Guide ASC X12N/005010X222-

Loop	Field	Name	Description	Balancing Rules
2300	CLM02	Total Claim Charge Amount	CLM02 is the total amount of all submitted charges of service segments in this claim	For 5010, the total claim charge amount reported in Loop ID-2300 CLM02 must balance to the sum of all the service line charge amounts reported in Loop ID-2400 SV102
2320	AMT02	Total Payment Amount, Payer Paid Amount		Balancing of claim payment information is done payer to payer. For a given payer, the sum of all line level payment amounts (Loop ID-2430 SVD02) less any claim level adjustment amounts (Loops ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02)
2320	CAS (CAS03, CAS06, CAS09, CAS12, CAS15, CAS18)	Claim Adjustment Amounts	The adjustment amounts at the claim level (e.g., patient deductible). Adjustment amounts within the CAS segment **decrease** the payment amount when the adjustment amount is **positive**, and **increase** the payment amount when the adjustment is **negative**	There are two different ways the claim information must balance. They are as follows: 1) Claim Charge Amounts The total claim charge amount reported in Loop ID-2300 CLM02 must balance to the sum of all service line charge amounts reported in Loop ID-2400 SV102. 2) Claim Payment Amounts Balancing of claim payment information is done payer to payer by payer. For a given payer, the sum of all line level payment amounts (Loop ID-2430 SVD02) less any claim level adjustment amounts (Loop ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02).
2320	CAS (CAS01, CAS02, CAS04, CAS05…)	Claim Adjustment Group Code & Reason Code		
2400	SV102	Line Item Charge Amount	Total charge amount for the service line	
2430	SVD02	Service Line Paid Amount	The amount paid to the provider	Line level balancing occurs independently for each individual Line Adjudication Information Loop. In order to balance, the sum of the line level adjustment amounts and line level payments in each Line Adjudication Information loop must balance to the provider's charge for that line (Loop ID-2400 SV102)
2430	CAS (CAS03, CAS06, CAS09, CAS12, CAS15, CAS18)	Line Adjustment Amounts	The adjustment amount for the submitted charge for the line. Adjustment Amounts within the CAS segment **increase** the payment amount when the adjustment amount is **positive**, and **decrease** the payment amount when the adjustment is **negative**	In order to balance the sum of the line level adjustment amounts and line level payments in each Line Adjudication Information loop must balance to the provider's charge for that line (Loop ID-2400 SV102).
2430	CAS (CAS01, CAS02, CAS04, CAS05…)	Line Adjustment Group Code & Reason Code		

The payer for each line payment is identified in Loop ID-2430 SVD01. This identifier must match the identifier of the corresponding payer identifier reported in Loop ID-2330B NM109.

Example 1 – Fee for Service:

Loop	Claim	Notes
2300:	CLM*A37YH556*▨***11:B:1*Y*A*Y*I*P~	
2320:	AMT*D*▨~	
2320:	CAS*PR*1*▨~	
2330B:	NM1*PR*2*Payer Name*****PI*111122333~	Payer ID – NM109 - Must match 2430 SVD01
	Line 1	
2400:	SV1*HC:H2016:25*▨*UN*1*11** 1:2:3 *N~	
2430:	SVD*111122333*▨* HC:H2016* 3~	Payer ID – SVD01 Must match 2330B NM109
2430:	CAS*OA*93*▨~	
2430:	DTP*573*D8*20130203~	Remittance Date
	Line 2	
2400:	SV1*HC:T1020:25*▨*UN*1*11** 1:2:3 *N~	
2430:	SVD*111122333*▨* HC:T1020* 2~	Payer ID – SVD01 Must match 2330B NM109
2430:	CAS*OA*93*▨~	
2430:	DTP*573*D8*20130203~	Remittance Date

Calculations:

Claim Charge Amount = (Line 1 Charge Amount + Line 2 Charge Amount)
100 = 80 + 20 = 100

Claim Payment Amount = (Line 1 Payment + Line 2 Payment) – Claim Adjustment Amount
80 = (70 + 15) - 5

Line Item 1 Charge Amount = (Line 1 Payment) + (Line 1 Adjustments)
80 = 70 + 10

Line Item 2 Charge Amount = (Line 2 Payment) + (Line 2 Adjustments) =
20 = 15 + 5

Notes:

Loop 2300 CLM02: The Total Claim Charge Amount must be greater than or equal to zero.

Loop 2320 AMT02 (Claim Payment Amount): It is acceptable to show "0" as the amount paid.

Loop 2400 SV102 (Line Charge Amount): Zero "0" is an acceptable value for this element.

Loop 2430 SVD02 (Line Payment Amount): Zero "0" is an acceptable value for this element.

Example 2 – Capitated Arrangement:

Loop	Claim	Notes
2300:	CLM*A37YH556*▮* * * 11:B:1*Y*A*Y*I*P~	
2320:	AMT*D*▮~	
2320:	CAS*PR*1*▮~	
2330B:	NM1*PR*2***Payer Name** * * * * PI* 11122333~	Payer ID = NM109 Must match 2430 SVD01

Line 1

Loop	Claim	Notes
2400:	SV1*HC:H2016:25*▮* UN*1*11* * 1:2:3* N~	
2430:	SVD*11122333* ▮* HC:H2016* *3~	Payer ID = SVD01 Must match 2330B NM109
2430:	CAS*CO* * 24* ▮~	
2430:	DTP*573*D8*20130203~	Remittance Date

Line 2

Loop	Claim	Notes
2400:	SV1*HC:T1020:25*▮* UN*1*11* * 1:2:3* N~	
2430:	SVD*11122333* ▮* HC:T1020* *2~	Payer ID = SVD01 Must match 2330B NM109
2430:	CAS*CO* 24 * ▮~	Claim Adjustment Group Code – CO (Contractual Obligation); Claim Adjustment Reason Code – 24 Charges are covered under a capitation agreement / managed care plan
2430:	DTP*573*D8*20130203~	Remittance Date

Calculations:

Claim Charge Amount = (Line 1 Charge Amount + Line 2 Charge Amount)
0 = 0 + 0

Claim Payment Amount = (Line 1 Payment + Line 2 Payment) – Claim Adjustment
150 = (70 + 85) - 5

Line Item 1 Charge Amount = (Line 1 Payment) + (Line 1 Adjustments)
0 = 70 + (-70)

Line Item 2 Charge Amount = (Line 2 Payment) + (Line 2 Adjustments)
0 = 85 + (-85)

Provider Reporting Loops:

2010AA — BILLING PROVIDER NAME

NM1 - BILLING PROVIDER NAME

NM1 ✻ 85 ✻ 2 ✻ ABC Group Practice ✻ ✻ ✻ ✻ XX ✻ 1234567890~

85 - Billing Provider
1 – Person or 2 - Non-Person Entity
Name – Last or Organization Name
XX - Centers for Medicare and Medicaid Services National Provider Identifier
Identification Code - NPI

REF - BILLING PROVIDER TAX IDENTIFICATION (Atypical Provider)

REF ✻ EI ✻ 123456789~

EI - Employer's Identification Number or SY - Social Security Number
Billing Provider Tax Identification Number

2310B — RENDERING PROVIDER NAME – Claim Level

NM1 - RENDERING PROVIDER NAME

NM1 ✻ 82 ✻ 1 ✻ DOE ✻ JANE ✻ C ✻ ✻ ✻ XX ✻ 1234567804~

82 - Rendering Provider
1 – Person or 2 - Non-Person Entity
Name - Last or Organization Name
XX - Centers for Medicare and Medicaid Services National Provider Identifier
Identification Code - NPI

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION

REF ✻ G2 ✻ 12345~

0B - State License Number, 1G - Provider UPIN Number, G2 - Provider Commercial Number or LU Location Number

G2 - Employer ID Number (EIN)

REFERENCE IDENTIFIER

2420A — RENDERING PROVIDER NAME – Line Level

NM1 - RENDERING PROVIDER NAME

Situational Rule: Required when the Rendering Provider NM1 information is different than that carried in the Loop ID-2310B Rendering Provider
OR
Required when Loop ID-2310B Rendering Provider is not used AND this particular line item has different Rendering Provider information than that which is carried in Loop ID-2010AA Billing Provider.

NM1*82*1*DOE*JANE*C***XX*1234567804~

82 - Rendering Provider
1 – Person of 2 - Non-Person Entity
Name - Last or Organization Name
XX - Centers for Medicare and Medicaid Services National Provider Identifier
Identification Code - NPI

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION

REF*G2*12345~

0B - State License Number, 1G - Provider UPIN Number, G2 - Provider Commercial Number or LU Location Number

G2 - Employer ID Number (EIN)

REFERENCE IDENTIFIER