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 and 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.

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**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:**

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**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

**Action Items, Person Responsible & Deadline:** Aides will be asked to attend the individual's Person Centered Planning meeting as well. If you have any questions please contact Jennifer Richardson at 989-772-5938.
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 be 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/.

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:
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 direct 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.
# PROVIDER RECOGNITION PROGRAM
QUARTERLY DIRECT SUPPORT PROFESSIONAL AWARD
NOMINATION FORM

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

<table>
<thead>
<tr>
<th>YOUR Name</th>
<th>YOUR Address</th>
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<table>
<thead>
<tr>
<th>YOUR Relationship to Nominee</th>
<th>YOUR City, State, Zip Code</th>
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<table>
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<tr>
<th>YOUR Phone Number</th>
<th>YOUR Email</th>
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</table>

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

<table>
<thead>
<tr>
<th>1. Consumer Focus/Customer Driven Services</th>
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<tbody>
<tr>
<td>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</td>
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<tr>
<th>2. Consumer Impact and Quality Improvement</th>
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<tbody>
<tr>
<td>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</td>
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<tr>
<th>3. Consumer/Provider/Community Partnering</th>
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<tr>
<td>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)</td>
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<tr>
<th>4. Promoting Education/Advocacy on Mental Health Issues</th>
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<tbody>
<tr>
<td>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</td>
</tr>
</tbody>
</table>
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:** ___________________________

<table>
<thead>
<tr>
<th>Factors that Contributed to Incident</th>
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</thead>
<tbody>
<tr>
<td>Method/Procedure</td>
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<tr>
<td>Communication</td>
</tr>
<tr>
<td>Staff Related</td>
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<tr>
<td>Environment</td>
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<tr>
<td>Equipment/Materials</td>
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<tr>
<td>Other</td>
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</table>

**How to Prevent Recurrence?**

<table>
<thead>
<tr>
<th>Factors that Contributed to Incident</th>
</tr>
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<tbody>
<tr>
<td>Method/Procedure</td>
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<tr>
<td>Communication</td>
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<tr>
<td>Environment</td>
</tr>
<tr>
<td>Equipment/Materials</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

**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**

CMHCM-930 (Revised 07/09/12)
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:
  o 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?
  o 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?
  o 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
  o Environment:
  o Was the environment noisy?
  o How much space was available to consumers and staff?
  o Was lighting adequate?
- Were any physical hazards present?
- Had Emergency Response Procedures been developed?
- **Equipment/Materials:**
  - 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 passers 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

CMHCM Provider Meeting
5/14/13
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 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
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

<table>
<thead>
<tr>
<th>County</th>
<th>US Congress</th>
<th>State Senator</th>
<th>State House</th>
</tr>
</thead>
</table>
| Osceola  | District 35 | *Darwin Booher*  
PO Box 30036  
Lansing, MI 48909-7536  
sendbooherv@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 36 | *John Moolenaar*  
PO Box 30036  
Lansing, MI 48909-7536  
serjmoolenaar@senate.michigan.gov | District 97  
*Joel Johnson*  
P.O. Box 30014  
Lansing, MI 48909-7514  
joeljohnson@house.mi.gov |
| Mecosta  | District 4  
*Dave Camp*  
Midland District  
Office  
135 Ashman Drive  
Midland, MI 48640  
Phone: 999.631.2552  
Fax: 999.631.6271  
Washington DC  
Office  
137 Cannon  
Building  
Washington DC 20515  
Toll Free: 800.342.2455 | 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 |
| Isabella | District 33 | *Judy Emmons*  
PO Box 30036  
Lansing, MI 48909-7536  
Serjemmons@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
Transportation fell through, we were late arriving.

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.

My son Michael has serious behavior issues.

Like the office and staff were friendly and professional and helpful.

Just being patient and wait.

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

Just a ride to get here.

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

Comments from Surveys:

<table>
<thead>
<tr>
<th>Question</th>
<th>Agree (1)</th>
<th>Strongly Agree (2)</th>
<th>Neutral (3)</th>
<th>Disagree (4)</th>
<th>Strongly Disagree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Agree (1)</td>
<td>the day I requested help.</td>
<td>Neutral (3)</td>
<td>Disagree (4)</td>
<td>Strongly Disagree (5)</td>
</tr>
<tr>
<td>2</td>
<td>Agree (1)</td>
<td>two days of requesting help.</td>
<td>Neutral (3)</td>
<td>Disagree (4)</td>
<td>Strongly Disagree (5)</td>
</tr>
</tbody>
</table>

Number of Surveys: 16

CMH for Central Michigan

Mecosta County

Same Day Service Pilot

Assessment: Same Day Service
### Week One (April 1 - 5)

<table>
<thead>
<tr>
<th>Screened out at Access (Yes/No)</th>
<th>Accepted Same Day Ser</th>
<th>Case Number</th>
<th>Reason for Declining</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>4325</td>
<td>6104</td>
<td>Parent busy today, needs appt. late afternoon</td>
</tr>
<tr>
<td></td>
<td>5034</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>81274</td>
<td>(blank)</td>
<td>Admission from hospital Monday at 11 am, preterm Tuesday appt.</td>
</tr>
<tr>
<td></td>
<td>81293</td>
<td>(blank)</td>
<td>Consumer is out of town today and returns tomorrow</td>
</tr>
<tr>
<td></td>
<td>90934</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>(blank)</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5089</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5037</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5100</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5105</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5107</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>91311</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Week Two (April 9 - 13)

<table>
<thead>
<tr>
<th>Screened out at Access (Yes/No)</th>
<th>Accepted Same Day Ser</th>
<th>Case Number</th>
<th>Reason for Declining</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>1992</td>
<td>6109</td>
<td>Bad weather, cant get in.</td>
</tr>
<tr>
<td></td>
<td>1905</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5122</td>
<td>(blank)</td>
<td>Unable to take same day or tomorrow due to other commitments</td>
</tr>
<tr>
<td></td>
<td>81478</td>
<td>(blank)</td>
<td>walk in referral took an hour due to intersections between 7am and 8am.</td>
</tr>
<tr>
<td></td>
<td>90290</td>
<td>(blank)</td>
<td>Mother works 7am and cannot take anyone else off.</td>
</tr>
<tr>
<td></td>
<td>81251</td>
<td>(blank)</td>
<td>Accept Same Day Appt.</td>
</tr>
<tr>
<td></td>
<td>(blank)</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Week Three (April 15 - 19)

<table>
<thead>
<tr>
<th>Screened out at Access (Yes/No)</th>
<th>Accepted Same Day Ser</th>
<th>Case Number</th>
<th>Reason for Declining</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>51010</td>
<td>5169</td>
<td>No openings for Same Day Service</td>
</tr>
<tr>
<td></td>
<td>81245</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6119</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>5119</td>
<td></td>
</tr>
</tbody>
</table>

### Week Four (April 22 - 26)

<table>
<thead>
<tr>
<th>Screened out at Access (Yes/No)</th>
<th>Accepted Same Day Ser</th>
<th>Case Number</th>
<th>Reason for Declining</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>12490</td>
<td>5223</td>
<td>Has no same day appt.</td>
</tr>
<tr>
<td></td>
<td>5125</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5292</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>81252</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>52198</td>
<td></td>
</tr>
</tbody>
</table>

### Week Five (April 29 - May 3)

<table>
<thead>
<tr>
<th>Screened out at Access (Yes/No)</th>
<th>Accepted Same Day Ser</th>
<th>Case Number</th>
<th>Reason for Declining</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>4322</td>
<td>51194</td>
<td>Did not want to finish appt until he had more insurance info.</td>
</tr>
<tr>
<td></td>
<td>4990</td>
<td>5934</td>
<td>Unable to get ride until 8-11</td>
</tr>
<tr>
<td></td>
<td>81475</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5117</td>
<td>(blank)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>81254</td>
<td>90264</td>
<td>Guardian has to complete her intake.</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
58 Consumers Screened

- Screened Out at Access: 29%
- Not Screened Out at Access: 71%

41 of the 58 Consumers Not Screened Out at Access

- Accepted Same Day Service: 33%
- Did Not Accept Same Day Service: 67%
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 18 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://autismallianc eofmichigan.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

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.
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 caregivers 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.

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.
I. Purpose and intents of reporting monetary amount with 837 v 5010 Encounters
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. Definition of terms
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.
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.

<table>
<thead>
<tr>
<th>Service Type (e.g., physician, MH therapy, OT, PT, RN)</th>
<th>Service Delivery Type</th>
<th>Billing Provider</th>
<th>Rendering Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional employed by or contracted with CMHSP/MCPN &amp; paid a salary</td>
<td>CMHSP/MCPN</td>
<td>Professional</td>
<td></td>
</tr>
<tr>
<td>CMHSP/MCPN contracts with an organization that employs or contracts with the professional</td>
<td>Organization</td>
<td>Professional</td>
<td></td>
</tr>
<tr>
<td>CMHSP/MCPN contracts directly with individual professional who bills for the service provided</td>
<td>Professional</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Type (e.g., CLS, personal care, skill building, respite, supported employment, peer)</th>
<th>Service Delivery Type</th>
<th>Billing Provider</th>
<th>Rendering Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMHSP/MCPN employees provide the service</td>
<td>CMHSP/MCPN</td>
<td>Individual</td>
<td></td>
</tr>
<tr>
<td>CMHSP/MCPN contracts with an individual who bills for the service</td>
<td>Organization or corporation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMHSP/MCPN contracts with an organization or corporation that employs workers who deliver the service</td>
<td>Sole proprietor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Type</td>
<td>Service Delivery Type</td>
<td>Billing Provider</td>
<td>Rendering Provider</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>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)</td>
<td>Organization, corporation #1</td>
<td>Organization, corporation or sole proprietor #3</td>
<td></td>
</tr>
<tr>
<td>Self-directed services (e.g., community living supports and skill building delivered by aide-level workers, independent supports coordination and psychiatry delivered by professionals)</td>
<td>Employer of record in which the beneficiary (or guardian on behalf of) hires and pays worker through a fiscal intermediary.</td>
<td>Fiscal intermediary</td>
<td></td>
</tr>
<tr>
<td>Purchase of service in which the CMHSP/MCPN pays a fiscal intermediary who pays an organization who employs the worker</td>
<td>Fiscal intermediary</td>
<td>Organization</td>
<td></td>
</tr>
<tr>
<td>Agency with choice in which the CMHSP/MCPN pays the agency that employs the workers who the beneficiary chooses</td>
<td>The agency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team-based services (ACT, home-based, wraparound)</td>
<td>CMHSP/MCPN or provider staff perform service individually or as a team</td>
<td>Refer to Professional above</td>
<td></td>
</tr>
<tr>
<td>Treatment Planning</td>
<td>CMHSP/MCPN or provider professional staff participate in the planning and report separately</td>
<td>Refer to Professional above</td>
<td>Refer to Professional above</td>
</tr>
<tr>
<td>Behavior Treatment Plan Review Committee</td>
<td>CMHSP/MCPN or provider professional staff participate on the committee but only one event is reported</td>
<td>Refer to Professional above</td>
<td>Refer to Professional above</td>
</tr>
<tr>
<td>Adaptive equipment and enhanced</td>
<td>CMHSP/MCPN or a provider purchases from a provider</td>
<td>CMHSP/MCPN or the provider</td>
<td></td>
</tr>
<tr>
<td>Service Type</td>
<td>Service Delivery Type</td>
<td>Billing Provider</td>
<td>Rendering Provider</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>pharmacy items</td>
<td>vendor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing assistance and good and services</td>
<td>CMHSP/MCPN reports a monthly total that may include multiple items from multiple vendors</td>
<td>CMHSP/MCPN or the provider</td>
<td></td>
</tr>
<tr>
<td>Respite care or CLS provided in a day or overnight camp</td>
<td>CMHSP/MCPN or a provider pays camp</td>
<td>CMHSP/MCPN or a provider</td>
<td></td>
</tr>
<tr>
<td>Institutional services delivered in a hospital</td>
<td>CMHSP/MCPN contracts with and pays hospital</td>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>Transportation Services are delivered by provider staff, or by local taxis, ambulance or transit authorities</td>
<td>CMHSP/MCPN or provider pays taxi, ambulance or transit authority</td>
<td>CMHSP/MCPN or provider</td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0080</td>
<td>Non-emergency transportation per mile — vehicle provided by volunteer (individual or organization) with no vested interest</td>
</tr>
<tr>
<td>A0090</td>
<td>Non-emergency transportation per mile — vehicle provided by individual (family member, self, neighbor) with vested interest</td>
</tr>
<tr>
<td>A0100</td>
<td>Non-emergency transportation: Taxi</td>
</tr>
<tr>
<td>A0110</td>
<td>Non-emergency transportation and bus: Intra- or interstate carrier</td>
</tr>
<tr>
<td>A0120</td>
<td>Non-emergency transportation: Mini bus, mountain area transports, or other transportation systems</td>
</tr>
<tr>
<td>A0130</td>
<td>Non-emergency transportation: Wheel chair van</td>
</tr>
<tr>
<td>A0140</td>
<td>Non-emergency transportation and air travel (private or commercial) intra or interstate</td>
</tr>
<tr>
<td>A0160</td>
<td>Non-emergency transportation: per mile- case worker or social worker</td>
</tr>
<tr>
<td>A0170</td>
<td>Transportation ancillary: parking fees, tolls, other</td>
</tr>
<tr>
<td>A0180</td>
<td>Non-emergency transportation: ancillary: lodging-recipient</td>
</tr>
<tr>
<td>A0190</td>
<td>Non-emergency transportation: ancillary: meals-recipient</td>
</tr>
<tr>
<td>A0200</td>
<td>Non-emergency transportation: ancillary: lodging - escort</td>
</tr>
<tr>
<td>A0210</td>
<td>Non-emergency transportation: ancillary: meals - escort</td>
</tr>
<tr>
<td>H0023</td>
<td>Drop-in center: 15 minutes</td>
</tr>
<tr>
<td>H0025</td>
<td>Prevention education encounter</td>
</tr>
<tr>
<td>H0038</td>
<td>Peer specialist services: 15 minutes</td>
</tr>
<tr>
<td>H0043</td>
<td>Supported housing: per diem</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>H0045</td>
<td>Respite care, out of home: per diem</td>
</tr>
<tr>
<td>H0046</td>
<td>Peer mentor services: 15 minutes</td>
</tr>
<tr>
<td>H2014</td>
<td>Skill-building, out-of-home voc rehab: 15 min</td>
</tr>
<tr>
<td>H2015</td>
<td>Comprehensive community support services: per 15 minutes</td>
</tr>
<tr>
<td>H2016</td>
<td>Comprehensive community support services: per diem</td>
</tr>
<tr>
<td>H2023</td>
<td>Supported employment: 15 min</td>
</tr>
<tr>
<td>H2030</td>
<td>Psycho-social rehab, Club House: 15 min</td>
</tr>
<tr>
<td>S5111</td>
<td>Home care, family training: encounter</td>
</tr>
<tr>
<td>S5140</td>
<td>Foster care, adult: per diem</td>
</tr>
<tr>
<td>S5145</td>
<td>Foster care, therapeutic, child: per diem</td>
</tr>
<tr>
<td>S5150</td>
<td>Respite care, unskilled: 15 min</td>
</tr>
<tr>
<td>S5151</td>
<td>Respite care, in-home: per diem</td>
</tr>
<tr>
<td>S9976</td>
<td>Lodging, per diem, not otherwise classified</td>
</tr>
<tr>
<td>T1005</td>
<td>Respite care: 15 minutes</td>
</tr>
<tr>
<td>T1012</td>
<td>Recovery services:</td>
</tr>
<tr>
<td>T1016</td>
<td>Supports Coordination</td>
</tr>
<tr>
<td>T1017</td>
<td>Targeted Case Management</td>
</tr>
<tr>
<td>T1020</td>
<td>Personal care: per diem</td>
</tr>
<tr>
<td>T2015</td>
<td>HSW, Prevocational service: hour</td>
</tr>
<tr>
<td>T2025</td>
<td>Waiver service: not otherwise classified (used for fiscal intermediary)</td>
</tr>
<tr>
<td>T2036</td>
<td>Therapeutic camping, overnight, waiver: each session</td>
</tr>
<tr>
<td>T2037</td>
<td>Therapeutic camping, day, waiver: each session</td>
</tr>
<tr>
<td>T2038</td>
<td>Community transition, waiver: per service</td>
</tr>
<tr>
<td>T5999</td>
<td>Wraparound – supply: item</td>
</tr>
</tbody>
</table>

V. **Loops and segments**

Attached is a chart with the location of loops and segments from the 837 Implementation Guide
<table>
<thead>
<tr>
<th>Loop</th>
<th>Field</th>
<th>Name</th>
<th>Description</th>
<th>Balancing Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>2300</td>
<td>CLM02</td>
<td>Total Claim Charge Amount</td>
<td>CLM02 is the total amount of all submitted charges of service segments in this claim</td>
<td>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</td>
</tr>
<tr>
<td>2320</td>
<td>AMT02</td>
<td>Total Payment Amount, Payer Paid Amount</td>
<td></td>
<td>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)</td>
</tr>
<tr>
<td>2320</td>
<td>CAS (CAS03, CAS06, CAS09, CAS12, CAS15, CAS18)</td>
<td>Claim Adjustment Amounts</td>
<td>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</td>
<td>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 by payer. For a given payer, the sum of all line level payment amounts (Loop ID-2430 SVD02) less any cas level adjustment amounts (Loop ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02).</td>
</tr>
<tr>
<td>2320</td>
<td>CAS (CAS01, CAS02, CAS04, CAS05...)</td>
<td>Claim Adjustment Group Code &amp; Reason Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2400</td>
<td>SV102</td>
<td>Line Item Charge Amount</td>
<td>Total charge amount for the service line</td>
<td></td>
</tr>
<tr>
<td>2430</td>
<td>SVD02</td>
<td>Service Line Paid Amount</td>
<td>The amount paid to the provider</td>
<td>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)</td>
</tr>
<tr>
<td>2430</td>
<td>CAS (CAS03, CAS06, CAS09, CAS12, CAS15, CAS18)</td>
<td>Line Adjustment Amounts</td>
<td>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</td>
<td>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).</td>
</tr>
<tr>
<td>2430</td>
<td>CAS (CAS01, CAS02, CAS04, CAS05...)</td>
<td>Line Adjustment Group Code &amp; Reason Code</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Loop</th>
<th>Claim</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2320:</td>
<td>AMT<em>D</em>8~</td>
<td></td>
</tr>
<tr>
<td>2320:</td>
<td>CAS<em>PR</em>1*8~</td>
<td></td>
</tr>
<tr>
<td>23308:</td>
<td>NM1<em>PR</em>2<em>Payer Name</em>1122933~</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Line 1</td>
<td></td>
</tr>
<tr>
<td>2430:</td>
<td>SVD<em>1122933</em>HC:2016*3~</td>
<td></td>
</tr>
<tr>
<td>2430:</td>
<td>CAS<em>OA</em>93*1~</td>
<td></td>
</tr>
<tr>
<td>2430:</td>
<td>DTP<em>573</em>D8*20130203~</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Line 2</td>
<td></td>
</tr>
<tr>
<td>2400:</td>
<td>SV1<em>HC:T1020:25</em>UN<em>1</em>11<em>1:2:3</em>N~</td>
<td></td>
</tr>
<tr>
<td>2430:</td>
<td>SVD<em>1122933</em>HC:T1020*2~</td>
<td></td>
</tr>
<tr>
<td>2430:</td>
<td>CAS<em>OA</em>93*1~</td>
<td></td>
</tr>
<tr>
<td>2430:</td>
<td>DTP<em>573</em>D8*20130203~</td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Loop</th>
<th>Claim</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2300</td>
<td>CLM*A37YH556</td>
<td>Payer ID - NM109 - Must match 2430.SVD01</td>
</tr>
<tr>
<td>2310</td>
<td>AMT*2</td>
<td>Payer ID - SVD01 Must match 2330B.NM109</td>
</tr>
<tr>
<td>2320</td>
<td>CAS<em>PR</em>1</td>
<td>Claim Adjustment Group Code - CDI: Contractual Obligation</td>
</tr>
<tr>
<td>2330B</td>
<td>NM1<em>PR</em>2 *Payer Name <em>P</em></td>
<td>Claim Adjustment Reason Code - WA: Charges are covered under a capitation agreement/managed care plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Remittance Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Remittance Date</td>
</tr>
<tr>
<td>Line 1</td>
<td></td>
<td>Payer ID - SVD01 Must match 2330B.NM109</td>
</tr>
<tr>
<td>Line 2</td>
<td></td>
<td>Payer ID - SVD01 Must match 2330B.NM109</td>
</tr>
</tbody>
</table>

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栻85栻2栻ABC Group Practice栻栻栻栻XX栻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栻EI栻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栻82栻1栻DOE栻JANE栻C栻栻栻XX栻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栻G2栻12345~

GB - State License Number, 1G - Provider URIN Number, G2 - Provider Commercial Number or 11 - Location Number

G2 - Employer ID Number (EIN)

REFERENCE IDENTIFIER
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-2010A Billing Provider.

NM1: 82 1: DOE  C  X: 1234567804

B2: 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: 123456

DB: State License Number, 1G: Provider UPIN Number, G2: Provider Commercial Number or IU Location Number
G2: Employer ID Number (EIN)

REFERENCE IDENTIFIER