CENTRA WELLNESS NETWORK

Formerly known as

MANISTEE-BENZIE COMMUNITY MENTAL HEALTH

PROVIDER MANUAL

Centra Wellness
NETWORK

2019-2020 Edition

IMPORTANT NOTICE

This manual explains many important aspects of Centra Wellness Network, a Community Mental Health Service Provider (CMHSP). This Provider Manual, in conjunction with the Provider Contract, outlines the procedures and guidelines that providers must follow to be included in Centra Wellness Network's provider network.

Centra Wellness Network reserves the right to interpret any term or provision in this manual and to amend it at any time to the extent that there is an inconsistency between the manual and the provider contract. Centra Wellness Network reserves the right to interpret such inconsistency. The interpretation shall be binding and final.

As a network provider, you are a stakeholder with Centra Wellness Network and the Customers in the successful delivery of behavioral health services. Our charge is to work together in a cooperative, fiscally responsible manner to provide optimal care to the residents of Manistee and Benzie Counties.

This Provider Manual is an effort to develop the basis for a coordinated and consistent working relationship. As Centra Wellness Network serves as payor for and manager of delivery of services, we wish to establish clear expectations and reasonable guidelines for working together. We believe the Provider Manual needs to be dynamic and to that end we are open to receiving your ideas for improvement. We are committed to communicate with you and continually enhance our working relationship.

In the age of managed care and financial constraints, it is more important than ever to develop a competent and qualified provider network credentialed to properly serve our Customers. We view this Provider Manual as one small step in that direction. We look forward to continued dialogue and a successful relationship with each of you.

CENTRA WELLNESS NETWORK, formerly known as Manistee Benzie Community Mental Health System, is part of the Northern Michigan Regional Entity (NMRE). More information about the NMRE can be obtained by visiting their website at www.nmre.org

STRATEGIC DIRECTION STATEMENTS

VISION
We see a community where everyone's life is valued, has meaning, and each person is treated with dignity and respect.

MISSION STATEMENT
Enhancing freedom for meaningful lives through quality behavioral health care, leadership, and teamwork within our community.

VALUES
Client Focused
Transparency in Decision Making
Positive Work and Treatment Environment
Responsive to Stakeholder Needs

GUIDING PRINCIPLES AND SHARED BELIEFS
Centra Wellness Network seeks to operate in concert with the following values principles and shared beliefs:

CONTINUOUS IMPROVEMENT: Centra Wellness Network (CWN) believes in the importance of continuously assessing its performance and seeking pathways to enhance its operations and outcomes. Continuous improvement is viewed as a dynamic, never-ending process in the pursuit of excellence. Problems are viewed as opportunities for improvement, not blame. It is our belief that the best sources for ideas to enhance organizational performance and innovation come from CWN Customers, Providers, and CWN employees.

CUSTOMER/CLIENT FOCUSED: All services and organizational operations are designed to be Customer-centered, easily accessible, and delivered in a culturally and trauma competent manner. At all times Customers must be treated with dignity and respect and their views, insights, and suggestions sought out and responded to.

EMPOWERMENT: The existence of a positive work environment in which employees are empowered, respected, and recognized is essential to positive organizational performance. All CWN employees and providers should have the support, freedom, and authority necessary to perform as professionals to be a continuously improving and learning organization. CWN will provide opportunities to enhance the skills and knowledge of its network through continuing professional education and lending the concept of empowerment to those served by CWN. We believe it is vital that CWN Customers have a right to participate in determining the nature and course of any service provided. Services are designed in a way that capitalizes upon and increases the strengths, capacities and competencies of the individuals and families served, rather than to focus on the repair or control of their limitations.

FISCAL RESPONSIBILITY: Centra Wellness Network values fiscal responsibility and believes its stakeholders must maintain sensitivity to how financial and other resources are utilized. We believe it is important to use resources in a prudent, efficient, and responsible manner.

INCLUSION: Each citizen is a part of the community's mosaic, whether through work, school, residency, or leisure pursuits. Integration is being present in the community; inclusion is being an accepted and valued part of the community.

INFORMATION-DRIVEN DECISION MAKING: While doing the right thing needs to be guided by good intent, objective information must also be part of the decision-making equation. Accordingly, Centra Wellness Network believes in the importance of guiding operations based on the objective analysis of accurate, timely and accessible information. Ensuring that we are an information-driven organization requires the creation and maintenance of a technologically progressive work force and work environment.

LEADERSHIP: Centra Wellness Network will play a leading role in the community by identifying needs and, in turn, developing and delivering coordinated behavioral healthcare services that help meet those needs.

OUTCOME-FOCUSED PERFORMANCE: Centra Wellness Network believes its services and products must meet Customer expectations and be based on defined standards of effectiveness, productivity, and quality. We value clinical interventions guided by a goal-oriented and behaviorally specific service plan. Customers and payors expect positive change and solutions to problems. What we do is infinitely more important than what we say we intend to do.

PERSONAL RESPONSIBILITY: This is a companion value to empowerment. Individuals employed by and receiving services from Centra Wellness Network should be accountable for their actions and inactions. In a civilized society, empowerment and the privilege to live with broad authority and limited restrictions brings with it the requirement of personal responsibility.

PREVENTION: Centra Wellness Network-believes that the historic bias of health and human service entities for reacting to illness, injury, disease and social problems must be balanced by a commitment to address the conditions that underlie such behavioral health and social problems. CWN values its leadership role in deploying talent and resources in support of this transformation.

SEAMLESS AND COORDINATED SERVICES: It is essential that all community Providers operate in harmony so that those who are served experience seamless and well-coordinated interventions within and across agency and professional service boundaries. Centra Wellness Network values taking a leadership role in promoting the philosophy of Customer centered collaboration and service integration.

SOUND ASSESSMENT AS THE FOUNDATION TO SERVICE EXCELLENCE: In all dimensions of organizational performance, we believe comprehensive assessment and needs determination should precede planning, intervening, and evaluating the results (in that sequence) as critical stepping stones that lead to positive results with comprehensive and integrated assessment viewed as the most important.

TEAMWORK: Centra Wellness Network believes a well performing organization requires teamwork, active collaboration, and clear open communication within and among organizational programs and units. Harmony can only occur when there is a clear sense of organizational purpose and a shared commitment to a set of core values and principles. We believe that continuously demonstrating respect, courtesy, and integrity is essential and that being accessible and responding to the needs of team members is vital. We value employees as organizational stakeholders.

CHARACTERISTICS OF A SUCCESSFUL HEALTHCARE ORGANIZATION

Centra Wellness Network recognizes the presence of powerful forces which are impacting today's healthcare and human service environment, realities that must be addressed in shaping the way we conduct business. Success, perhaps even survival, will be awarded to organizations demonstrating all of the following characteristics:

- An understanding that excellence in the delivery of service must consistently be provided: excellence, that is, as defined by all stakeholders – the Customer, the payor of service, as well as the provider.
- A recognition that the customer and the payor drive the system.
- An understanding that customers/payors expect outcomes and value, not just good intent and hard work.
- A realization that being customer sensitive in all dimensions of organizational operations is an uncompromising necessity.
- A belief that progressive healthcare and human service organizations must focus on fostering customer empowerment and less on "controlling" persons with healthcare and other social/economic conditions.
- An unrelenting commitment to practice in concert with sound principles of business while recognizing that adhering to an organization's social mission is likewise essential.
- A recognition that progressive organizational performance requires good information systems; that is, the capacity for all organizational stakeholders to know in a timely, unobtrusive and user-friendly manner what is and is not occurring as the result of operations.
- An organizational environment which empowers its human resources to realize the potential that exists in everyone.

An organizational culture that fosters continuous quality improvement at all levels of the organization.

CODE OF ETHICS SUMMARY

The Code of Ethics is for members of Centra Wellness Network (CWN) and its Provider Network and has been adopted to promote and maintain the highest standards of personal conduct and professional standards among its members. As a member of the organization, a member espouses this code, thereby assuring public confidence in the integrity and service of the CWN organization.

As a member of the CWN Provider Network, you pledge yourself and/or your organization to:

- Maintain the highest standards of professional and personal conduct.
- Support the organizational Mission and Values.
- Improve public understanding of Community Mental Health services.
- Strive for personal growth in the field of Community Mental Health.
- Uphold all laws and regulations pertaining to Community Mental Health services.
- Maintain the confidentiality of privileged information.
- Impart in those you serve, and the community, a sense of confidence about the conduct and intentions of the organization.
- Maintain loyalty to the organization and pursue its objectives in ways that are consistent with the public interest.
- Refrain from using your position to secure special privilege, gain, or benefits for you or your organization.

IF YOU HAVE ANY QUESTIONS REGARDING THE CODE OF ETHICS OR IF YOU FEEL THAT AN AGENT OF CENTRA WELLNESS NETWORK HEALTH SYSTEM HAS COMMITTED AN ETHICAL VIOLATION, PLEASE ASK TO SPEAK WITH A MEMBER OF OUR CUSTOMER AND PROVIDER SERVICES OFFICE AT 1-877-398-2013.

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APPENDIX

INTRODUCTION AND MISSION

The mission of Centra Wellness Network (CWN) is enhancing freedom to lead a meaningful life through quality behavioral health care, leadership, and teamwork within our community.

As a Provider for CWN, you join a team of professionals dedicated to the management and delivery of medically necessary services. Our mutual goal is to ensure that Customers have timely access to the most clinically appropriate and least restrictive care possible in the most caring, sensitive and confidential manner possible.

Services will be provided to all Customers by a network of professional staff credentialed to work with the identified populations. This includes individuals who are living with chronic mental illness, intellectual and/or developmental disabilities, and co-occurring substance use disorders. Network paneled providers will have demonstrated clinical competencies to serve all age ranges and all groups. Regardless of provider location, all providers will be held to the same standards of service performance and customer care. CWN pledges each Customer:

- Access to services 24 hours per day, 365 days per year
- Timely response to identified clinical needs
- Clinically appropriate service authorizations and reauthorizations
- Full participation in the Person/Family Centered Planning process
- Confidential services in a caring environment
- Services with dignity and respect
- Services in a clean, comfortable and relaxing environment of care
- Claims payments to Network Providers
- Customer and stakeholder involvement
- Ongoing involvement in efforts to enhance the organization's social mission
- Health promotion initiatives and programs
- Ongoing improvements in access to public mental health, intellectual and developmental disability, substance use disorder and community support services

- Ongoing improvements in resource management and appropriate utilization of available services through behavioral health best practice (critical service pathways, standardized treatment protocols) and utilization management guidelines

- Quality services assessed continually through clinical outcome data

The Provider Manual has been developed to provide a general introduction to Centra Wellness Network and to provide specific information regarding access to care and care management of available mental health, developmental disabilities and substance use disorder services.

After reviewing the Provider Manual, please call (877) 398-2013 if you have any additional questions or informational needs. Centra Wellness Network staff is available to assist you.

PROVIDER ACCESS TO THE SYSTEM

Customer and Provider Services Line

Centra Wellness Network provides a toll-free access line for Providers and Customers. Providers and Customers can call the toll-free number of 1-877-398-2013 and the TTY is also the same (please allow time for the operator to connect).

The purpose of the Customer and Provider Services line is to provide access to meet the identified needs of providers and customers and connect them with the appropriate service or department to meet their needs.

The Customer and Provider Services line provides;

- authorization/reauthorization of behavioral healthcare services and supports,
- coordination with other providers,
- follow-up services,
- coordination of appeals/second opinions,
- access system service recommendations,
- coordination of inpatient screenings; and,
- exception authorizations for non-network providers and case finding.

The intent of Customer and Provider Services is to determine the most appropriate level of care required to address the customer's identified behavioral healthcare needs. The inquiry document shall provide clear impressions of the customer's presenting problems, the customer's expectations from treatment, the urgency of the concern, medical necessity, referral source, substance use and psychiatric history, recommendations for referral and/or support services provided by network providers and other organizations. Follow-up services are an important function the Customer and Provider Services line as it helps to link customers with services and to educate customers on the Centra Wellness Network system. The Customer and Provider Services line provides customers and referral sources with easy and timely access to services.

Crisis services are available 24 hours, 7 days a week.

Provider Services and Managed Care Operations

Phone: (877) 398-2013 and Fax (231) 882-2195

Representatives are available Monday through Friday from 8:00 a.m. until 5:00 p.m. (EST) and are responsible for:

- Intake scheduling
- Follow up services, education, and prevention referrals
- Registration for all applicable services
- Authorization and Reauthorization of all covered services
- Concurrent utilization management
- Verification of covered person's eligibility

- Verification of covered person's authorization status
- Provider applications
- Network monitoring/management
- Provider relations/education
- Consultation with Providers
- Written inquiries
- Benefit explanations
- Contractual negotiation

Claim and Billing Inquiries can be directed to the CASPER Helpdesk, available Monday through Friday from 8:00 a.m. until 5:00 p.m.

Email: chelp@centrawellness.org
Phone: 231-882-2155

How to Access Care

Providers can access care for Customers 24 hours per day, 7 days per week by calling the Customer and Providers Services line at 1-(877)-398-2013 (TTY is available).

Customer and Provider Services coordinates clinically appropriate, medically necessary care to the needs of each Customer as determined by a face-to-face clinical assessment with a member of our clinical services team. Medical necessity criteria are based on contract, national standards, and accepted professional practice. Medically necessary services must meet the following criteria:

1. Mental health (and/or substance use) services are authorized for the following purposes:

    - Assessment services to determine the presence and severity of a mental illness or substance use disorder; and/or,

    - Identification and evaluation of a mental illness or substance use disorder that is inferred or suspected: and/or,

    - Intention to treat, ameliorate, diminish or stabilize the symptoms of mental illness (or substance use) including impairment in functioning: and/or,

    - Expectation to arrest or delay the progression of a mental illness (or substance use) disorder and to forestall or delay relapse: and/or,

    - Provision of rehabilitation for the customer to attain or maintain an adequate level of functioning

2. The determination of a medically necessary service must be based upon a person/family centered planning process.

3. Services selected based upon medically necessity criteria should be:

- Delivered in a timely manner, with an immediate response in emergencies, in a location that is accessible to the Customer.

- Responsive to particular needs of multi-cultural populations and furnished in a culturally and trauma competent manner.

- Provided in the least restrictive and appropriate setting-(inpatient and residential treatment shall be used when less restrictive levels of treatment have been unsuccessful or cannot be safely provided).

- Delivered consistent with national standards of practice including standards of practice in community psychiatry, psychiatric rehabilitation, intellectually and/or developmentally disabled habilitation/rehabilitation, and substance use. This is defined by standard clinical references, and generally accepted professional practice guidelines, and is based on empirical professional experience/research; and

- Provided in sufficient amount, duration, and scope to reasonably achieve their purpose.

4. Using criteria for medical necessity, a CMHSP may:

    - Deny services that (a) are deemed ineffective for a given condition based upon professional and scientifically recognized and accepted standards of care; (b) are experimental or investigational in nature; or (c) services for which there exists an appropriate, efficacious, less-restrictive and cost-effective alternative, setting or support, that otherwise satisfies the standards for medically necessary services;

    - Not deny services solely based on preset limits on the duration of services; instead, reviews of the continued need for services shall be conducted on an individualized basis; and

    - Employ various methods to determine medical necessity, including prior authorization for certain services, concurrent utilization reviews, assessment and referral, protocols and guidelines.

5. All determinations regarding medically necessary services shall be made in a timely fashion, by appropriately trained mental health (or substance use) professionals with sufficient clinical experience.

Customer and Provider Services (CAPS) authorizes therapeutically appropriate services to the needs of each Customer as determined via the intake and annual assessment process. Therapeutically appropriate criteria are based on national standards and accepted professional practice. Appropriate services must meet these criteria:

1. Medically necessary;

2. Provided at the appropriate level of care;

3. Provided by an appropriate credentialed and privileged provider;

4. Provided in a frequency required to meet the customers need;

5. Provided in the most appropriate location to meet the customers need;

6. Meeting the customer's treatment needs (customer is making progress toward their treatment goals);

7. Provided in the least restrictive, most normalizing environment, and;

8. Satisfying the customer's standards of quality care.

Customer Intensity of Need

CAPS defines customer intensity of need as emergent, urgent, or routine as follows:

Emergent Need is a life-threatening condition in which the Customer is actively psychotic; displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others; and/or is displaying vegetative signs and is unable to care for self. CAPS staff can refer the Customer to a Centra Wellness Network Crisis Worker who can authorize emergency care.

Urgent Need is a condition in which the Customer is not actively harmful to self or others, denies having a plan or intent to harm self or others, means or intent for harm but expresses feelings of hopelessness, helplessness, or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention will progress to the need for emergency services and care. CAPS staff will call the Provider's office to alert the Provider of the urgent referral and as needed help connect the Customer to the Provider. Providers are required to see the Customer within 72 hours of a request for an urgent appointment.

Routine Need is a condition in which the Customer describes signs and symptoms which are resulting in impairment and functioning of life tasks; impact the Customer's ability to participate in daily living; and/or have markedly decreased the Customer's quality of life. CAPS staff will schedule an appointment for the Customer with an appropriate provider. Providers are asked to see the Customer within 5 days of a request for a routine appointment.

Referrals for Internal and External Providers

Internal Provider Referrals

1. CAPS completes an inquiry.

2. CAPS schedules the customer for an appointment with an intake clinician. The most appropriate clinician to work with the customer based on their identified need and credentialing requirements

will most likely be assigned the case.

3. The intake clinician completes the assessment and preliminary plan of service, utilizing a standard assessment instrument provided by Centra Wellness Network. This document will help to determine the diagnosis and recommended course of treatment. This will lead to the development of a standardized single initial Individualized/Family-Centered Plan of Service (IPOS).

4. Services are not approved by the intake clinician if medical necessity is not established or if services are not deemed therapeutically appropriate. If services are not medically necessary, the intake clinician will provide a letter to the customer explaining the decision, outlining the appeal process and reminding them of the 24 hour emergency number.

   If services are not therapeutically appropriate, the clinician will provide a letter to the customer explaining the decision. This letter will outline the appeal process and remind the customer of the 24-hour emergency number.

5. Services are approved if medical necessity is established or if services are deemed as therapeutically appropriate. The intake clinician will preliminarily authorize the services pending development of an IPOS. The Intake clinician is required to notify the Customer.

6. CAPS via the Quality Improvement Process will monitor the process for medical necessity and therapeutic appropriateness.

External Provider Referrals

1. CAPS completes the initial inquiry and determines the appropriate provider if one has not already been identified based on presenting need, CAPS then schedules an intake.

2. CAPS contacts the provider to schedule the customer for an appointment. The provider will be the most appropriately credentialed clinician likely to work with the customer and their identified need.

3. The provider clinician completes the assessment and initial Individualized/Family-Centered Plan of Service (IPOS) utilizing a standard Assessment instrument. This document is to help determine the diagnosis and recommended course of treatment, leading ultimately to the development of a standardized IPOS.

4. Within 72 hours of submission of recommendations to CAPS, CAPS will authorize services to the provider or disapprove services based on the provider recommendation.

5. Services are not approved by the CAPS if medical necessity is not established or if services are not deemed therapeutically appropriate.

   If services are not medically necessary, the provider will, within 72 hours send a letter to the customer explaining the decision, outlining the appeal process and reminding them of the 24-hour emergency number.

   If services are not therapeutically appropriate, the Provider will, within 72 hours send a letter to the

customer explaining the decision. This letter will outline the appeal process and remind the customer of the 24-hour emergency number.

6. Services are approved if medical necessity is established or if services are deemed as therapeutically appropriate. CAPS will, within 72 hours of receipt of the information from the provider, authorize the services. The Provider is required to notify the Customer.

7. CAPS via the Quality Improvement Process will monitor the process for medical necessity and therapeutic appropriateness.

Alternative Access Points for Care

Customers are encouraged to access all care functions through the toll-free number of 1-877-398-2013 (TTY is available). This is considered the single point of access however treatment, services, and care can also be accessed through other avenues. These avenues may include:

Hospital Facility Emergency Rooms
Walk – In at any Centra Wellness Network Location
Primary Care Offices
Schools
Law Enforcement Departments
Community Mental Health Service Provider Offices

When this occurs, it is the responsibility of the treating Provider and/or utilization review staff to call (877) 398-2013 to seek an authorization for treatment, services, and/or a referral to a clinically appropriate Provider.

Authorization for care must be received prior to the rendering of care for all treatment or services of care (except in the case of a medical emergency). Emergency care can be authorized up to 24 hours after the rendering of services. Unauthorized care will not be paid.

Eligibility Verification

The following information should be obtained before the first visit:

1. Confirmation of Customer's name, date of birth, and social security number.

2. Name of Customer's employer and/or health plan insurer.

3. Information about who referred the Customer for services.

4. Clinical information and benefit data as per usual contractual procedure.

During the first visit, the Provider will:

1. Utilize a standard Assessment instrument to determine the diagnosis and recommended course of treatment, leading ultimately to the development of a standardized IPOS.

2. Complete intake forms and provider documents provided by CAPS which may include:

    a. Assessment of Level of Care (including the CAFAS, Pre-CAFAS, LOCUS)
    b. Consent to Treatment
    c. Release of Information
    d. Fee forms including Financial Determination
    e. Background information
    f. Provide Customer handbook

The Provider will maintain a copy of each instrument/form in an appropriate Medical Record consistent with standards developed by Centra Wellness Network. A copy of each instrument/form will be provided to CAPS within 72 hours of date of service by mail, courier delivery, encrypted electronic mail, or fax.

Available Services

Listed below are the Levels of Care which are available to each Customer through Centra Wellness Network. For a complete review of the services available please visit www.centrawellness.org or contact the CAPS call center at 877-398-2013:

Adults with Mental Illness or Children with Severe Emotional Disturbance

- Acute
- High Intensity
- Moderate Intensity
- Low Intensity
- Maintenance

Adults or Children with Intellectual and/or Developmental Disability

- I/DD Acute
- I/DD High Intensity
- I/DD Moderate Intensity
- I/DD Low Intensity
- I/DD Maintenance

Authorization/Re-Authorization Standards

Based on input from the Provider all authorizations and re-authorizations will be issued by CAPS staff within the service limits that meet medical necessity.

The reauthorization process:

1. The provider must be proactive in the reauthorizations process. Re-authorizations must be requested within two (2) sessions or two (2) weeks, which ever comes first, of the expiration of the

current authorization.

2. The provider clinician submits documentation requesting re-authorization and demonstrating continued need for services. This may be in the form of a quarterly report, monthly report, or similar format.

3. Within 72 hours of submission to CAPS, CAPS will either approve and authorize services to the provider or disapprove services based on provider input.

4. Services are not approved if medical necessity is not established or if services are not deemed therapeutically appropriate.

   If services are not medically necessary, the provider will, within 72 hours send a letter to the customer explaining the decision, outlining the appeal process and reminding them of the 24-hour emergency number.

   If services are not therapeutically appropriate, the provider will, within 72 hours send a letter to the customer explaining the decision. This letter will outline the appeal process and remind the customer of the 24-hour emergency number.

5. Services are approved if medical necessity is established or if services are deemed as therapeutically appropriate. CAPS will, within 72 hours of receipt of the information from the provider reauthorize the services. The Provider is required to notify the Customer.

6. CAPS via the Quality Improvement Process will monitor the process for medical necessity and therapeutic appropriateness.

Utilization Management Procedure

Utilization management reviews are conducted for all levels of care with all in-and-out-of Network Providers. The goal is to formally review the Customer's clinical record to ensure quality behavioral health services are being provided at the most appropriate level of care, in the most clinically appropriate setting, in the least restrictive environment, by the most appropriate provider in the most cost-effective manner possible.

An authorization decision (authorization or denial of authorization) will occur:

1. With the initial request for care from the Customer (or from the Provider if the Customer is unable to call the Access line);

2. When further care is requested based upon a review of medical necessity therapeutic appropriateness and the Person/Family Centered Plan;

3. Significant change in Diagnosis or Level of Functioning;

4. Upon review of an emergency admission to an acute care facility; or

5. Before admission to Detox/Rehab/Crisis Stabilization facility/partial hospital program or intensive outpatient program.

Emergency Direct Admissions

1. Pre-authorization of inpatient emergency care must be obtained by calling the Centra Wellness Network prior to admission to an inpatient facility.

2. Emergency admissions will be authorized for 72 hours of treatment if the Customers situation meets emergency hospitalization criteria. After that period, Providers must follow the in-patient continued stay review process outlined below.

Psychiatric Evaluation in an Inpatient Medical Unit

Psychiatric evaluations performed through an inpatient medical unit require pre-authorization by Centra Wellness Network.

Inpatient Care

All inpatient and alternative levels of care must be pre-authorized. This can be done through the 24-hour emergency on-call clinician, a telephonic review between the Provider and Centra Wellness Network and/or through a face-to-face review process.

Inpatient Reviews

1. Pre-Authorization of inpatient care requires a telephone review between the Provider and Centra Wellness Network staff and can be initiated by calling the CAPS line.
2. If a customer is admitted to an inpatient unit, the responsible CWN team member must contact the customer and the unit within 72 hours after the admission.

3. To perform the review, Centra Wellness Network staff must have detailed documentation concerning the Customer's need for continuing care and a realistic detailed discharge plan (i.e., treatment and discharge plans, any additional services).

Normally, psychiatric admissions do not qualify as emergencies. To qualify as emergencies, the Customer must meet all the following criteria:

1. The medical record must clearly justify that the Customer was, at the time of admission, at immediate risk of serious harm to self or others. The emergency on-call clinician or other qualified mental health professional with Centra Wellness Network must do an evaluation before the admission. The medical record must include the Customer's immediate intent to

commit harm and the method and opportunity to carry out the intended harm.

2. Medical documentation must show that the Customer requires immediate and continuous skilled observation and treatment at the acute psychiatric level of care. The medical record must document an unsuccessful attempt at crisis intervention prior to admission.

3. Providers must contact Centra Wellness Network as soon as possible, but no later than within 24 hours of an emergency admission. If it is determined that a true emergency existed and notification within 24 hours occurred, benefits will be approved from the date of admission. In contrast, if the Customer's condition is determined not to be emergent, but is medically necessary, benefits will be approved from the date of receipt of the pre-authorization request.

4. If a customer is admitted to an inpatient unit is a Medicaid recipient or indigent, the provider is required to call and complete a continuing stay review daily for ongoing authorization for services.

Outpatient Reviews

1. Pre-authorization of outpatient care requires a telephone review between the Provider and CAPS staff and can be initiated by calling CAPS.

2. If a customer is seen on an emergency basis, the responsible case manager must contact the CWN within 24 hours after the contact.

3. If ongoing services are needed and there is no authorization, CAPS/Utilization Management staff must have detailed documentation concerning the Customer's need for continuing care and a realistic detailed discharge plan (i.e., treatment and discharge plans, any additional services).

Normally, Outpatient Customers do not have emergencies. For an Outpatient Customer to qualify as emergent, he/she must meet all the following criteria:

1. The medical record must clearly justify that the Customer was reporting an emergency.

2. Medical documentation must show the description of the Customer problem, the clinician's clinical impression, and their recommendation and plan for follow up. The medical record must document a successful attempt at crisis intervention.

3. Providers must contact CAPS staff as soon as possible, but no later than within 72 hours of an emergency contact. If the Customer's condition is determined not to be an emergency at that time, no payment will be rendered.

4. If a customer has an emergency contact, the responsible case manager must have follow-up with the customer within 72 hours after the expression of emergent need.

COMPLAINTS AND GRIEVANCES

It is the policy of Centra Wellness Network (CWN) that all recipients have the right to a fair and efficient process for resolving disagreements regarding their services and supports managed or delivered by CWN or their provider network.

Recipients shall not be denied services and supports for arbitrary or capricious reasons but do need to meet the definitions and criteria of medical and clinical necessity.

All recipients are to be informed of the grievance process orally and in writing at the time of initial service and the subsequent avenues available if they are not satisfied with decisions regarding services and supports received.

Please refer to Appendix VI Appeal and Grievance Policy to review the protocol for denials in:

Initial Community Mental Health Services
Denial, Reduction, Suspension, or Termination of existing services
Denial of Hospitalization
Denial of Family Support Subsidy
PAS/ARR Level II Assessments

Filing an Appeal of Non-Authorized Services

If the Customer's request for a specific service(s) is not authorized by Centra Wellness Network, you will receive telephone and written notification for emergent and urgent care placements and written notification for routine placements. The written notice will provide a detailed explanation of the medical necessity criteria utilized by CWN to make the determination of non-authorization.

Appeal Procedure

CWN is committed to providing Customers with the highest quality, confidential services.

Providers can appeal denials of authorization to the CAPS Director. Providers need to give the CAPS Director any additional information to help with the first level of appeal. If the authorization is not approved, then a rational is written by the CAPS Director. If the provider wishes to submit a second level of appeal, the provider will notify the CAPS Director in writing who will forward the first level appeal information and subsequent correspondence to the CWN Executive Director or his/her designee who reviews the information in a second level of appeal. If authorization is not approved, the customer and the provider are contacted.

PROVIDER PRACTICE REQUIREMENTS

Access and Provider Availability

All Providers (in and out of Network) should be available for appointments according to the following availability standards;

* Routine: Within 5 days of a request
* Urgent: Within 72 hours of a request
* Acute/Emergency: Within 24 hours of a request

All Providers (in and out of Network) should be available to handle their customer's emergencies.

All Providers (in and out of Network) are to ensure that they do not put the customer between CWN and themselves.

All providers (in and out of Network) will be proactive with their requests for authorizations.

Collection of Co-Payments/Deductibles

A Provider may only collect applicable deductibles, co-insurance and/or co-payments from the Customer at the time of service as authorized by CWN. Providers shall use the Ability to Pay guidelines as outlines in the Michigan Community Mental Health Code Chapter 8 Section 818 – 819 (NOTE: Additional payments or co-payments of any kind are not allowed for Medicaid only covered Customers).

CAPS will reimburse the Provider the balance up to the fee schedule maximum or negotiated per diem upon receipt of a claim form and compliance with CAPS policies and procedures. Coordination of benefits, co-payments, and deductibles vary by contract.

Quality Improvement

The Quality Improvement (QI) program monitors and systematically evaluates the care management process as well as the care delivered by Providers. The approach is clinically directed as it focuses on the appropriateness and quality of care.

The goal is to ensure that cost-effective quality care is provided to all those accessing services.

The Quality Improvement program is part of the Customer and Provider Services Department, which coordinates the review and evaluation of all aspects in delivering care. Components include:

- Problem-focused studies
- Continuous monitoring of key indicators
- Medical records review
- Assessment of access and availability
- Customer satisfaction surveys
- Provider satisfaction surveys

- Accreditation Reviews

QI assessment and summary reports are made to the Quality Improvement Committee, Medical Director, Leadership Team, and Providers (when appropriate) to identify problems, develop resolutions, and provide adequate follow-up.

Stakeholder Meetings (Consumer Advisory Board and Quality Improvement Committee)

Customer and Provider Services will have stakeholder meetings with providers on the network panel. The purpose of these meetings is to have a collaborative discussion regarding treatment of Customers in like contracted services. Stakeholders include representation from contracted providers, Customers/guardians, providers, and Customer and Provider Services. Data is to be published and shared.

Data is to be collected and published for the stakeholders. Due to the public nature of our business, data is available to others under the Freedom of Information Act. Data is collected on agreed upon performance indicators. Some potential indicators may include: Customer Satisfaction, Utilization, and Coordination Performance Outcomes. Data is to be examined at face value. The Quality Improvement Committee will review data and suggestions. Provider profiles will be considered as part of the contract selection for Network Provider Panel. The underlying goals of Stakeholder meetings are to increase competition among stakeholders, enhance overall provider performance, and resolve Provider panel issues.

Provider Reviews

Provider reviews are a summary of certain measurements of performance. It is a segment of data and is not designed to make value judgments. Provider reviews are used to compare results across a peer group or to set a standard or expectation. It can be used as part of the selection and retention guidelines of provider network. Reviews are used in decisions about referrals and as an indicator for intensity of utilization or quality review. Customer and Provider Services will use data as a consideration in rate negotiation and as a tool to focus quality improvement efforts and related training/development.

Some of the Profile Elements may include:

Cost of care
- Per case
- Per admission

Care Access Elements
- Timeliness
- Hours of availability
- Related communication/notifications

Denials
- Types of denials
- Denial disposition

Customer diagnosis and acuity
- Severity of illness indicators
- Demonstrated competencies for authorization of care

Customer satisfaction elements
- Complaints
- Survey ratings

Documentation quality control elements
- Timeliness of required components
- Required data elements
- Clinical pertinence of content

Other quality elements
- Performance on key quality indicators
- Compliance to Standards of Care
- Outcome performance measurements

Volume of activity

Source and disposition of referrals and discharges

Utilization management interface
- Adherence to policies and procedures
- Complaints

Billing practices
- Timeliness/frequency
- Accuracy
- Completeness

Statement of Confidentiality

CAPS is committed to keeping all Customer information, document disclosures and data confidential. Access to any Customer files will be exclusively limited to the CWN staff and those who are under contract to perform appeal reviews.

CAPS is committed to keeping all Provider information, document disclosures, and data confidential. Due to the public nature of our business, data collected and published for the stakeholders' meetings is available to others under the Freedom of Information Act. This information will be presented in summary form only with no identification of individual customers.

Network Monitoring

Customer and Provider Services (CAPS) is responsible for monitoring all aspects of the Provider Network. This includes but is not limited to: Provider changes and updates, re-credentialing, staff competencies

(documentation of training as well as the determination of current competencies), utilization of person/family centered planning principles, environment of care, recipient rights, geographic and specialty access, and Provider relations activities. CAPS is responsible for monitoring the Providers' compliance to care standards and outcome performance measurements.

To keep CAPS files current the Provider is responsible to provide: Re-credentialing and competency records, accreditation, licensing, liability insurance, inspection reports, and plan of correction information within the defined timelines. When CAPS receives the new information, they will update the data system and add the documentation to the Provider's file. Failure to submit current copies of expired items may result in termination of payments until the current credentialing documentation is received.

Providers can help keep files current by notifying network operations of new practice affiliations, changes in address or licensure, and facility or program involvement. Information can be submitted by faxing or by writing.

Out-of-Network providers are required to meet with the above standards if payment for services to be authorized.

Provider Terminations

VOLUNTARY TERMINATION
If a Provider chooses to terminate membership in the Provider Network, a written request should be submitted to CAPS offices prior to termination.

INVOLUNTARY
Non-adherence to performance standards or criteria may result in termination as an approved Provider. Critical areas monitored include:

- Adherence to contract stipulations
- Professional liability claims/disposition involving direct customer care
- Patterns of practice contrary to procedural standards
- Patterns of service delivery
- Billing fraud
- Unsatisfactory Medical Records Compliance Audit
- Refusal of accepting referrals
- Inability to service Customers within specified time lines

If performance standards are questioned, the Provider will be contacted by phone whenever possible or by certified mail to alert the Provider to the issue(s) and review the appropriate documentation in compliance with due process/fundamental fairness procedures.

BILLING FOR SERVICES

Getting Your Claim Paid

On June 3rd, 2016 CWN successfully launched our new custom EHR called CASPER (Client Access System Protected Electronic Record) developed by PCE Systems. In addition to many positive clinical and

administrative changes, CASPER has the capacity for electronic billing claims submission, either through 837 EDI submissions or data entry of claims, which have improved CWN's claims and adjudication processes. Unless an exception arrangement is approved by the Director of Customer and Provider Services, all claims for services provided need to be submitted electronically through CASPER.

Please note that with this submission process, CWN requires service start/end times and coordination of benefits information on the claims. Our new submission process will also help in addressing federal and state requirements for payments when using Medicaid funds. Please review your current contract as well as future contracts closely related to language about allowable timelines for claims submissions (e.g. 30 days from date of service). Claims that are submitted/received outside of the timeline specified in your contract will be denied. Through CASPER, requirements for payment will be pre-adjudicated during the time of your submission process, allowing you to make any changes, if needed. This will expedite the entire process allowing you to receive payments sooner. We are excited about the opportunity to improve our timeframe for payment to our providers.

The following documents are included in Appendices X-XII for your review/use:

- **Claims Direct Data Entry Quick Reference**: This is a step-by-step instruction list outlining how to submit a claim in CASPER.
- **CASPER System Support Reference:** Outlines contact information and instructions on how to access claims submission technical support
- **CASPER Contract Provider User Request**: This document must be completed and return for CWN to assign you a user name and password. You will not be able to submit a claim until this has been returned. Your user request will not be assigned unless all required contract documentation (signed contract, W-9, disclosures, etc.) have been completed and returned to CAPS.

Billing the Customer

1. Providers may only bill the customer when approved specifically by contract/agreement:

    - For applicable deductibles, co-insurance, and/or co-payments from the Customer at the time of service.
    - According to the Ability to Pay guidelines as outlined in the Michigan Community Mental Health Code Chapter 8 Section 818 – 819

2. Providers may not bill:

    - Non-authorized services
    - Amounts above fee schedule/per diem
    - Additional payments or co-payments

Coordination of Benefits

Coordination of benefits will be conducted with a Customer's primary health insurance carrier. Please enter the primary carriers Explanation of Benefits (EOB) with each claim submitted in CASPER as well as the

amount paid. If the necessary information is not entered the claim will be returned, thus delaying the claim payment. The Provider has up to 60 days from the date of receipt of the primary insurance carrier's EOB to submit the claim.

Additional Paperwork with Claims

Providers need to submit copies of their clinical documentation either electronically or in paper format each time a claim is submitted until written notice of release of this obligation is provided by the CAPS Director or her/his designee. Documents can be faxed ATTN: CAPS Director to 231-882-2195 or mailed ATTN: CAPS Director to 6051 Frankfort Hwy, Benzonia, MI 49616.

Claims submitted without timely submission of supporting documentation will be denied or, if payment has been issued, be reconsidered.

Time Limit

Provided all necessary information is received to process the claim, it is the goal of CWN for all claims to be paid within 30 days of receipt of a clean claim.

NOTE: Unless otherwise noted in the provider contract, claims will not be accepted thirty (30) days past the date of services unless it must be billed to primary insurance first. In this case, the claims will not be accepted after sixty (60) days from date of EOB notice unless otherwise specified by the provider contract. It is the Provider's responsibility to provide timely submission of all claims.

THE RIGHTS OF THE CUSTOMER

A Customer has the right to:

- Receive prompt access to care for mental health, intellectual/developmental disabilities and co-occurring alcohol/drug treatment needs.
- Receive information about Network Providers including their individual qualifications experience and specialty(ies).
- Be treated with respect and dignity.
- Be provided privacy and confidentiality.
- Be provided care in a non-discriminating environment.
- Ask for a different Provider if the Customer is not satisfied with the current Provider.
- Have a reasonable opportunity to choose the Provider.

- Ask questions and receive complete information about the Customer's treatment services, the Customer's medical status, and treatment options.
- Access the Customer's medical records in compliance with Federal and State laws.
- Have an opportunity to express concerns, grievances, and appeals regarding the timeliness and appropriateness of care, the authorization or non-authorization of payment for the Customer's care and any other issue that causes the Customer concern about receiving care through the CAPS access to care system.
- Receive prompt responses to Customer's concerns, grievances, and appeals.

A Customer has specific rights regarding receiving treatment services. He/she has the right to:

- Consent to treatment or to refuse treatment.
- Actively participate in the person/family centered planning (PCP) process for treatment.
- Be involved in the development of a treatment plan which provides the Customer the opportunity to help make decisions regarding the services needed.
- Participate in the development of a crisis plan which helps the Customer prevent medical, family and psychiatric crises.
- Receive emergency services when required.
- Receive available community-based self-help services that the Customer feels are required to help in his/her in recovery from mental illness, intellectual and/or developmental disabilities, and co-occurring substance use.
- Receive medically necessary services to meet the Customer's needs.
- Receive services in the least restrictive and least costly settings possible.
- Receive services that are culturally appropriate and that promote Customer satisfaction with the care received.

CUSTOMER RESPONSIBILITIES

The customer is responsible for:

- Reviewing the Guide to Behavioral Health Services so that the Customer can fully participate in and receive benefits from CWN authorized services and care.
- Abiding by the policies and procedures of Centra Wellness Network.

- Participating as a full Customer in the Centra Wellness Network authorized services and care. This means that the Customer will need to learn about and understand his/her rights as a Customer.

- Having the Customer's Provider call (877) 398-2013 for authorization of services before services begin (except if emergency services are immediately required which will allow the Provider to call within 24 hours after services begin).

- Sharing information about his/her mental health, intellectual/developmental disability, and co-occurring substance use needs with the care Provider(s) to assist in a team effort to develop treatment options.

- Actively participating in the treatment planning and service delivery process. This means the Customer will need to make personal choices about his/her care and take actions to improve his/her health and quality of life regarding the identified treatment needs.

- Providing clear and correct information about his/herself to the case manager/therapist.

- Communicating to his/her case manager/therapist about his/her perceptions of the most appropriate treatment.

- Arriving for scheduled appointments on time and telephoning the provider if, for any reason, he/she is not able to keep the appointment.

- Following the treatment plan as it has been created by the Customer and the treatment team. This includes taking all prescribed medications correctly and at the time(s) directed.

- Asking questions of Centra Wellness Network if something is not clear.

- Being considerate of the rights of other customers and agency staff members.

- Abide by weapons restrictions at Centra Wellness Network and Provider sites.

- Informing the provider of any changes in the Customer's life that may influence the established course of treatment.

GLOSSARY OF TERMS

Appeals/Second Opinion - A contract provider/Customer may request an appeal if payment or services are denied/unauthorized. Customers may disagree with the recommendations as determined by our Intake Provider. Customers will be informed of their right to a second opinion at the time of the screening/intake. CAPS staff and/or Recipient Rights will facilitate the Customer's concerns and will provide an opportunity to receive timely responses. A customer may request a second opinion if there is a denial of service. CAPS Director will clarify the customer's dissatisfaction with the findings/recommendations and will complete the review. There are two types of denials, which may trigger a second opinion following an inpatient screening and /or following an initial request for CWN services.

Authorization/Reauthorization of Behavioral Healthcare Services and Supports - A function performed by CAPS. The process is supported by the establishment and use of standardized clinical assessments, evaluations and level of care protocols matched to services and supports available through a network of service providers. Based on these clinical criteria and coverage of a customer's benefit plan, persons are authorized for a level of care which may include a bundle/package of predetermined services and supports, for a specific time frame or number of sessions, with stated expected outcomes. This process will include follow up with referral sources/service providers, concurrent reviews, access to an appeals process/system, coordination activities with other involved providers, monitoring and tracking of service provision and outcome with the provider and clients served.

CAPS Director – Master's level clinician responsible for the overall operation of CAPS and supervision of CAPS staff.

Capturing and Reporting Community Needs Information – CAPS staff aggregating service request data, identifying trends or demands for service, especially gaps in care and reporting such data to the CAPS Director in the assessment of community service needs.

Care Coordination with HMO/MHP - Significant coordination will be necessary with Managed Healthcare Plans (contracted HMOs with DHHS) to differentiate between medical benefits and behavioral healthcare benefits and plan responsibility for payment of disputed care.

Claims Management/Review - Assisting CWN in claims processing, by providing authorized/reauthorized services data with internal/external care providers. This process may trigger a need for a retrospective review or an appeal.

Consultation - An exchange of information with another identified entity on behalf of the customer, which may include customer history, assessment information, diagnostic impression and recommendations. Consultation requires an informed written consent by the customer or the customer's court appointed guardian or custodial parent of a minor, and a written authorization to exchange information with the identified consultation entity. CWN staff members shall verbally inform the person (or parent of a minor or empowered guardian) who is the subject of the requested consultation of the following:

- Who (community agency/service provider) requested the consultation;
- The identified reason for the requested consultation,
- CWN policy regarding confidentiality and disclosure of customer related information; and

- The time frame or period in which the information is to be exchanged.

In emergency situations where a Customer is refusing to allow CWN to share specific client related information with other services providers to access appropriate substance use, psychiatric, or medical care, the CWN staff person shall exercise and document professional judgement as to the sharing of Customer information required to meet the Customer's emergency needs to the extent allowed under Public Act 258, of 1974, as amended, or as required by other related legal acts or professional reporting requirements.

Coordination with other providers - The basic intent is to ensure the continuity and non-duplication of care and supports. CAPS staff may identify a coordination concern during the initial screening. These concerns will be shared with the network provider when authorization is given for an Assessment/Intake. The process of the Assessment/Intake may need to further clarify issues of needed service coordination and consultation.

Crisis Intervention - A method of addressing a person in crisis when seeking phone access/assistance to services Crisis is defined as a time-limited period of psychological disequilibrium which is precipitated by a sudden and significant change in the person's environment. This change demands an internal and external adjustment and expression. A loss or a threat of a loss, or a challenge coming usually precipitates the crisis in the shape of a hazardous, threatening event, threat of an individual need, and/or inability to cope. The goal of the Crisis Intervention is to reduce symptoms by labeling feelings and sources of feelings and to connect the person with resources of support, be they internal or external. This may also include helping the person act on own behalf by exploring alternatives and consequences of those alternatives and identify personal strengths and past effective problem-solving methods.

Custodial Parent - A person with legal authority for the care and custody of a minor.

Determination of Level of Care - The determination of eligibility and clinical/medical necessity for Medicaid, public funded, or third-party fee for service behavioral healthcare services and supports guided by clinical assessments, level of care protocols, examination/determination of benefit plan eligibility/coverage and/or code defined eligibility criteria. Also included are Person/Family Centered Planning guidelines and linkages with community supports for those found ineligible but requiring preventative or maintenance support.

Duty of Due Care - An unwritten legal responsibility of mental health professionals to arrange and/or provide (either directly or indirectly) mental health services which are appropriate to the Customer's condition. For instance, a Customer found to be suicidal, psychotic, and/or violent requires access to treatment intervention/services initiated/implemented by CWN that are clinically appropriate/equivalent to the Customer's condition.

Eligibility Determination - The determination of all benefits a Customer seeking help has at their disposal for behavioral healthcare services. Determining if any costs may be borne by the Customer seeking care. CAPS may need to contact insurance carriers, etc. to explore and determine benefit coverage. Enrollee benefit eligibility/or customer behavioral healthcare benefits are to be determined prior to referral to a network provider for assessment/care services.

Emergency Services - A service that is performed by a network provider for persons with presenting problems that cannot be adequately addressed by telephone crisis intervention. Direct face-to-face assessment and intervention to process the emergency, contain, de-escalate and stabilize the crisis, coordinate and triage care services with others which may include family, law enforcement and medical providers. Preauthorization for this service may not always be necessary since we anticipate multiple points of access/demand. Network providers must have 24-hour (during business and non-business hours) emergency resources availability.

Episode of Care - The period of time the Customer presented with specific symptoms and desired outcomes and the treatment/supports used to help achieve the desired outcome.

Exception Authorization for Non-Network Providers - Negotiation of rates of Providers for a service when the enrollee is out of the catchment area. Example: Customer is hospitalized while on vacation, CAPS must be able to negotiate a rate for the service. CAPS may have an established rate ceiling for all behavioral healthcare services to assist CAPS in rate negotiation with non-network providers.

Follow up - Contact with the customer following a complete/incomplete episode of care. A standardized questionnaire may be used. The intent is to determine care outcome and satisfaction. Customers may be encouraged to participate in prevention activities that promote wellness, prevention, and support. Some customers may be referred to a network provider for reassessment if behavioral healthcare services appear to be needed.

Guardian- A person with legal authority for the care and custody of an individual pursuant to an order of the Probate or Circuit Court, or a person who possess the legal rights and powers of a full guardian of the person, or the estate, or both, pursuant to an order of the Probate Court.

Informed Consent - Consent is implied when the Customer makes the first call to CAPS. At the provider level, written authorization of a customer, or a parent of a minor or guardian, authorizing the customer's participation in CWN assessment services based upon:

- Competency, which is the ability to rationally understand what is being proposed;
- Knowledge, which is adequate information to permit an informed consent; and
- Voluntarily, which means no element of force, fraud, deceit, or coercion used to obtain the written informed consent.

Initial Customer Screening - Screening includes the precipitating event, presenting symptoms, relevant history, substance use, present level of functioning, availability of support system, determination of need for second level review.

Inpatient Preadmission Screenings - The authorization of payment for inpatient psychiatric hospitalization, partial hospitalization or crisis residential services. The actual preadmission screening may be completed by an emergency service clinician serving the Customer's geographical area, then seeking authorization following the completion of an emergency service assessment.

Inquiry- A single Electronic Health Record (EHR) entry including data would have date of request, client name, DOB, Medicaid or SS#, address and county, presenting problem, disposition data, program

assignment, follow-up data. Data can be used for utilization management and performance improvement monitoring and reporting activities.

Intake Assessment –The completion of a comprehensive bio-psychosocial assessment to determine clinical/medical necessity and level of care. Authorization of other differential diagnostic assessments at the network provider level may be sought if needed for clinical/medical necessity and level of care determination.

Minor - A person who is less than 18 years of age and has not been emancipated by a court of law.

Outcome - The clinical result or health improvement expected or planned from the provision of care.

Person/Family-Centered Planning - The Customer shall be given the opportunities to express his or her needs or desired outcomes, potential support and/or treatment options to meet the expressed needs. The Customer shall be given ongoing opportunities to discuss and express his/her preferences and to make choices. Customers are provided with the opportunity to provide feedback on how they feel about services, treatment, and /or support they are receiving and their progress toward attaining valued outcomes.

Provider Network Panel - Listing of all provider network programs, including assigned clinical staff by location, discipline, and expertise/privileges.

Reassessment and Periodic Review - Review of Customer's response to services and progress toward predetermined discharge criteria or desired outcomes. This review activity may be scheduled/unscheduled and be direct/indirect. Focused periodic reviews may be directed at certain target populations with network provider/programs that are serving high volume/high risk or high cost Customers.

Receiving Cost-Effective Care Data - Receiving utilization management data detailing provider network (program) outcome performance in contrast with cost of care, by program, population group and diagnostic categories.

Recipient of Record - A Customer requesting or currently receiving CWN services, or a third party, such as law enforcement, a guardian, custodial parent of a minor, a family member, or a representative from a foster home, hospital or nursing facility requesting CWN services for a person in its care.

Referral - The process of referring an individual to an appropriate service provider as determined by screening, with consent of individual, parent, or empowered guardian.

Triage - The process of choosing, selecting, or sorting; the immediate sorting out and classification of psychiatric presenting problems so that customers may be routed to and referred to appropriate treatment needed services.

Use of Utilization Data – The CAPS system of receiving and using data, such as Customer's satisfaction, program level outcomes studies, current service reviews, the clinical accuracy of level of care protocol usage by network providers, program level length of stay data in contrast with population groups and diagnoses,

recidivism rates, all for the purpose of determining provider performance/standards compliance. Collectively, data can assist access in better linking Customers to a network provider program.

CWN Provider Manual
Appendix 1

CENTRA WELLNESS NETWORK

Board Adopted Procedure			
Procedure	02.09	**Policy Title: 02.00 Clinical Policy**	
Effective Date: 3/10/2011		**Subject: Self Determination, Choice Voucher System, and Person/Family Centered Planning**	
Review Cycle:			
Approval Validation Record			
Action		**Date**	**Board Sec'y Initials**
Full Board Vote:		3/10/11	AKH
Minutes Approved:		4/14/11	AKH
Accountability			
Board Committee:		Policy Committee	
Agency Function:		Clinical Services	
Sunset Review Begins:			
Revised Date:		12/02/2015	AKH
		5/3/2017	AKH
		10/4/2017	AKH
		6/6/2018	AKH
Review Date:		1/31/2012	AKH
		4/01/2015	AKH

CENTRA WELLNESS NETWORK
PROCEDURE 02.09 SELF-DETERMINATION, CHOICE VOUCHER SYSTEM & PERSON-FAMILY CENTERED PLANNING

I. APPLICATION:

Agency Wide.

II. POLICY:

The Centra Wellness Network (CWN) Governing Board establishes policies with related procedures to ensure that all clients are offered clinical services and supports that are based on best practice and developed through Person/Family Centered Planning. Services are delivered in a coordinated manner and, to the extent possible, are planned, delivered, and monitored in collaboration with other healthcare providers serving an individual, including, but not limited to, primary care practitioners, substance use disorder service providers, and appropriate social service entities. Collaboration will be recovery based, culturally competent and trauma informed.

CWN will establish relationships, as appropriate, with the various healthcare providers within the community to promote collaboration and coordination of care. Persons served need to sign the necessary consents needed to facilitate this collaboration.

All such services and supports shall be based on the obligations under the Mental Health Code, Administrative Rules, contractual obligations with the Michigan Department of Health and Human Services (MDHHS) and its Inter-local agreement with Manistee and Benzie counties, any other state and federal regulations, and pertinent accreditation criteria.

III. DEFINITIONS:

A. Person/Family Centered Planning:
A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices, and abilities. The person-centered/family centered planning process involves families, friends, and professionals as the individual desires or requires. Abbreviated as Person Centered Planning or PCP.

B. Self Determination:
A set of concepts and values that underscore a core belief that people who require support from the public mental health system as a result of a disability should be able to define what they need in terms of the life they seek, have access to meaningful choices, and have control over their lives.

C. Choice Voucher System:
A concrete set of methods that gives families of children receiving services and supports from the Children's Home and Community Based Waiver Program (CWP), the Habilitation Supports Waiver (HSW) and other children receiving mental health specialty services and supports meaningful authority to choose and directly hire providers or authorized services and supports.

D. Independent Facilitator:
A person chosen by the individual to guide him or her through the person centered planning process. An independent facilitator may be a family member or friend or may be an advocate recommended by a friend, provider or supports coordinator.

E. Fiscal Intermediary:
An independent legal entity (organization or individual) that acts as a fiscal agent of CWN for the purpose of assuring fiduciary accountability for the funds compromising a client's individual budget. The purpose of the fiscal intermediary is to receive funds making up a client's individual budget, and make payments as authorized by the client to providers and others parties to whom a client using the individual budget may be obligated.

F. Individual Budget:
A fixed allocation of public mental health resources, and may also include other public resources whose access involves the assistance of the CMHSP, denoted in dollar terms. The resources are agreed upon as the necessary cost of the specialty mental health services and supports needed to accomplish a client's plan of services/supports.

IV. PROCEDURE:

A. Person/Family Centered Planning:

Centra Wellness Network (CWN) will:

1. Provide written educational information to client/families on Person Centered Planning (PCP).
2. Ensure that all supports and services are developed through a PCP process following the Person Centered Planning Revised Practice Guidelines established by the Michigan Department of Health and Human Services (MDHHS) and MDHHS Person-Centered Planning Policy.
3. Ensure that PCP documentation reflects all required information as outlined in the MDHHS Person Centered Planning Revised Practice Guidelines and the MDHHS Person-Centered Planning Policy.
4. Ensure that entries to the records of clients occurs within one business day of service provided.
5. Ensure that for each PCP, a pre-planning meeting is completed that collects the following information:
    a. Who to invite;
    b. Where and when to have the PCP meeting;
    c. Who will facilitate the meeting;
    d. Who will record the meeting minutes;
    e. What topics will be discussed during the meeting (for example: dreams and desires);
    f. What topics will not be discussed during the meeting;
    g. What specific PCP tool or format will be used for the Individual Plan of Service
    h. What accommodations the person may need to meaningfully participate in the meeting.
6. The person centered planning process includes the development of an Individual Plan of Service (IPOS) which:
    a. Includes:
        i. A description of the individual's strengths, abilities, plans, hopes, interests, preferences, and natural supports;
        ii. Goals and outcomes identified by the person and how progress will be measured;
        iii. The services and supports needed by the person to work toward or achieve his or her outcomes;
        iv. Community integration considerations;
        v. The amount, scope, and duration of medically necessary services and supports;
        vi. Estimated cost of services;
        vii. The roles and responsibilities of service providers;
        viii. The person or entity responsible for monitoring the plan;
        ix. The signatures of the person and/or representative and applicable staff;
        x. The plan for sharing the IPOS with family/friends/caregivers with the permission of the person;

xi. Time line for review; and
xii. Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

b. Is reviewed and updated at least annually or more frequently based on enrollment in specific programs (i.e. Children's services, Home Based services, ACT).
c. Ensure continuity of care by providing follow-up at time of transition/discharge as appropriate.

7. Provide information/education on what an Independent Facilitator is and how to request the use of one.
8. Ensure that the Independent Facilitators are trained on the philosophy and requirements of PCP and in facilitation skills.
9. Provide education on all possible support and treatment options available to meet the needs identified as part of the PCP process.
10. Actively seek feedback from individuals receiving services/supports on satisfaction and develop quality improvement efforts from the feedback.
11. Provided ongoing training opportunities for clients, family members, staff, and other stakeholders on PCP.
12. When health and safety concerns are identified through the PCP process, information and training relative to that risk needs to be offered as a mean to reduce risk and promote safety for clients. Examples of health and safety concerns: prevention and control of infections/communicable diseases, risks associated with drug use, fire safety (detection, hazards, and suppression/escape routes, as applicable), etc.
13. All providers will meet training requirements including training on the implementation of the IPOS and when any changes occur to the plan by the appropriate professional.

B. Self Determination:

Centra Wellness Network (CWN) will:

1. Provide written educational materials on the principles of Self Determination arrangements/options that are available as outlined in the MDHHS Self Determination Policy and Practice Guideline. Participation in Self Determination arrangements is voluntary and not a requirement.
2. Provide ongoing training opportunities for clients, family members, staff, and other stakeholders on the Self Determination options available.
3. Provide information to each client on how Self Determination options/arrangements are accessed and applied.
4. For clients who elect to participate in Self Determination Arrangements,
    a. Ensure that a Self Determination Agreement is completed. For clients who wish to hire their own support staff, then an Employment Agreement must also be completed. For clients who choose to purchase services from a provider who is not under contract with CWN, then a Purchase of Services Agreement must be completed as well.
    b. Assist the client in completing an Individual Budget as requested. CWN will have a budget form available for use and will provide current costs for services/supports provided by CWN. The individual budget, once authorized, shall be provided to the client.
    c. Ensure that clients involved in Self Determination shall have the authority to select, control and direct their own specialty mental health services and supports arrangements by responsibly controlling the resources allotted in an individual budget, towards accomplishing the goals and objectives in their IPOS.

d. Actively seek feedback from clients participating in Self Determination arrangements on satisfaction and develop quality improvement efforts from the feedback.

5. Utilize a Fiscal Intermediary according to the specifications in subsection D. Fiscal Intermediaries.
6. CWN reserves the right to deny the hiring of a provider by the client (guardian/family) and/or deny payments to a provider through the self-determination individual budget arrangement, if it is determined that:
    a. The provider is unable to perform the supports/services as required in the person centered plan.
    b. The provider is unable to provide for the health and safety of the client.
    c. The provider does not meet the minimum qualifications as required by Medicaid or MDHHS.
    d. The provider fails to obtain or complete required training(s).
    e. Proof of completed background checks and references for provider was not received by CWN, if requested.
    f. Provide ongoing training opportunities for clients, family members, staff, and other stakeholders on the Self Determination options available.

C. Choice Voucher System:

Centra Wellness Network (CWN) will:

a. Offer education on the principles of the Choice Voucher System arrangements that are available as outlined in the MDHHS Choice Voucher System for Children Technical Advisory. Participation in Choice Voucher System arrangements is voluntary and not a requirement.
b. Provide information to each client on how Choice Voucher System arrangements are accessed and applied.
c. For families of clients who elect to participate in the Choice Voucher System,
    a. Ensure that a Choice Voucher Agreement is completed for each client participating in a Choice Voucher System Arrangement. For clients who wish to hire their own support staff, then an Employment Agreement must also be completed. For clients who choose to purchase services from a provider who is not under contract with CWN, then a Purchase of Services Agreement must be completed as well.
    b. Actively seek feedback from clients participating in Self Determination arrangements on satisfaction and develop quality improvement efforts from the feedback.
d. Utilize a Fiscal Intermediary according to the specifications in subsection D. Fiscal Intermediaries.

D. Fiscal Intermediaries

Centra Wellness Network (CWN) will:

a. Have at least one Fiscal Intermediary on contract (with CWN or with the PIHP) to act as the fiscal agent of CWN/PIHP and provide employer agent and support management functions to the client as requested.
b. Assure that any contracted Fiscal Intermediary is oriented to and supportive of the principles of self determination, and able to work with a range of personal styles and characteristics.
c. Exercise due diligence in establishing the qualifications, characteristics, and capabilities of the entity to be selected as a fiscal intermediary, and shall manage the use of fiscal intermediaries consistent with the Fiscal

Intermediary Technical Requirement and MDHHS Technical Assistance Advisories addressing fiscal intermediary arrangements.

V. DISCUSSION OF INTENT:

The purpose of this procedure is to ensure that all services and supports being provided by Centra Wellness Network are identified using a Person Centered Planning process and the arrangements that promote Self-Determination are made available in accordance with established best practice guidelines and state and federal regulations. Also, to ensure that services are provided in a manner that considers the health and safety of clients, family, providers and other stakeholders.

Authority and Related Directives Trace	
Federal	PL 111-256 "Rosa's Law"
State	DHHS Contract: Attachment 3.4.1.1 Michigan Department of Health and Developmental Disabilities Self-Determination Policy and Practice Guidelines); Section 712 of the Mental Health Code; DHHS Contract Choice Voucher System for Children Technical Advisory Version 3.0 December 2015; MDHHS Person Centered Planning Policy rev. 6/17/17
NMRE	NMRE Self-Determination Protocols and Guidelines #07-03-003
County	
CARF	2016 Behavioral Health Sections: 2.A-H & 3.C
Other	

CWN Provider Manual
Appendix II

CENTRA WELLNESS NETWORK

Board Adopted Procedure			
Procedure	03.09	**Policy Title: 03.00 Enrollee Rights**	
Effective Date: 3/10/2011		Subject: **Enrollee Rights**	
Review Cycle:		3 years	
Approval Validation Record			
Action		**Date**	**Board Sec'y Initials**
Full Board Vote:		3/10/2011	AHA
Minutes Approved:		4/14/2011	AHA
Accountability			
Board Committee:		Policy Committee	
Agency Function:		Enrollee Rights	
Sunset Review Begins:			
Revised Date:		3/27/2014	AHA
		2.1.2017	AHA
Review Date:			

CENTRA WELLNESS NETWORK
PROCEDURE 03.09 ENROLLEE RIGHTS

I. APPLICATION:

Agency Wide, including employees, affiliated providers and interpreters.

II. POLICY:

The Centra Wellness Network (CWN) Governing Board shall establish policies with related procedures to ensure clients are offered the rights afforded them pursuant to obligations under the Mental Health Code, Administrative Rules, contractual obligations with the Michigan Department of Health and Human Services (MDHHS), and the inter-local agreement with Manistee and Benzie Counties, any other state and federal regulations, and pertinent accreditation criteria.

III. DEFINITIONS:

N/A

IV. PROCEDURE:

Services will be provided to consumers in a manner and format that respects the rights and protections afforded them in the Balanced Budget Act (BBA) and Michigan Mental Health code and are easily understood. This includes:

A. Informational and instructional materials that are written at a 4th grade reading level or other media that:
    1. Describe the availability of covered services and supports and how to access them;
    2. Information on medication and diagnoses. (Some technical information such as prescribed medication and diagnoses may not meet the reading level criteria).

B. The following general information is available to clients and/or representative at intake or a reasonable time after beginning services in a manner appropriate to the client's condition and ability to understand:
    1. Any restrictions on the clients' freedom of choice among network providers.
    2. Medicaid and Medicaid beneficiary grievance, appeal, and fair hearing procedures and timeframes that include:
        a. The right to a fair hearing;
        b. The method for obtaining a hearing;
        c. The rules that govern representation at the hearing;
        d. The right to file grievances and appeals;
        e. The requirements and timeframes for filing a grievance or appeal;
        f. The availability of assistance in the filing process;
        g. The toll free numbers that the beneficiary can use to file a grievance or an appeal by phone;
        h. Notice that when requested by the beneficiary, benefits will continue if the beneficiary files an appeal or a request for a fair hearing within the timeframes specified and that the beneficiary may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the beneficiary; and
        i. Any appeal rights that the state chooses to make available to providers to challenge the failure to cover a service.

3. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that clients understand the benefits to which they are entitled.
4. Information on how to obtain benefits including authorization requirements.
5. Information on how to obtain benefits from out-of-network providers.
6. The extent to which, and how, after-hours and emergency coverage is provided, including:
    a. The definition of emergency medical condition, emergency services, and post-stabilization services.;
    b. Notice that prior authorization is not required for emergency services;
    c. The process and procedures for obtaining emergency services, including use of the 911 telephone system;
    d. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the Medicaid contract; and
    e. Notice that, subject to these provisions, the client has the right to use any hospital or other settings for emergency care.
7. Policy on referrals for specialty care and for other benefits not furnished by the client's primary care physician.
8. Any cost-sharing requirements.
9. Information on how and where to access benefits that are available under the state health plan but are not covered under the Northern Michigan Regional Entity (NMRE) Medicaid subcontract including cost sharing and transportation.
10. Information on advance directives procedures and applicable state law. Clients will be notified of any changes in state law as soon as possible but not later than 90 days after the effective date of the change.
11. Information upon request, regarding the structure and operation of the Prepaid Inpatient Health Plan (PIHP).
12. Notice that the PIHP and its network providers do not utilize physician incentive plans.
13. The Director of Customer and Provider Services, or designee will make a good-faith effort to provide written notice to clients of the termination of a contracted provider that provided regular care to them. The written notice shall be provided within 15 days after receipt or issuance of the termination notice.

C. Clients have the right to access information:
    1. Regarding their right to request and receive information on enrollee rights and protections at least once a year.;
    2. All information listed in section ĐA, 1-14 above.;
    3. Information pertinent to the person served in sufficient time to facilitate his or her decision making.
    4. Of their own records.
D. Clients have the right to:
    1. Be treated with respect and with consideration for their dignity and privacy.;
    2. Be free from abuse, financial or other exploitation, retaliation, humiliation and neglect; and
    3. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.;

E. Provider-Enrollee Communication
   1. Health care professionals acting within their scope of practice may advise or advocate on behalf of their client, for the following:
      a. Health status, medical care or treatment options including any alternative treatment options that may be self-administered
      b. Information needed to decide among relevant treatment options.
      c. Risks, benefits, and consequences of treatment or non-treatment.
      d. Right to participate in decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

F. The client has the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

V. DISCUSSION OF INTENT:

The purpose of this procedure is to ensure that clients receiving mental health and substance abuse services have the rights and protections afforded through Federal Regulations the Michigan Mental Health Code.

Authority and Related Directives Trace	
Federal	42§ CFR 438.10, 438.100, and 438.102
NMRE	Administrative Manual, Chapter 7 Policy 07-01-014
County	Interlocal Agreement Between Manistee and Benzie Counties 12/15/1992, Section III, and X
CARF	CARF 2016 1K
Other	CWN Procedure 03.04 Limited English Proficiency

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Appendix III

CENTRA WELLNESS NETWORK

Board Adopted Procedure			
Procedure	03.01	**Policy Title: 03.00 Enrollee Rights**	
Effective Date: 3/10/2011		**Subject: Access**	
Review Cycle:		3 years	
Approval Validation Record			
Action		**Date**	**Board Sec'y Initials**
Full Board Vote:		3/10/2011	
Minutes Approved:		4/14/2011	
Accountability			
Board Committee:		Policy Committee/Recipient Rights Committee	
Agency Function:		Access to Services	
Sunset Review Begins:			
Revised Date:		4.13.17	
Review Date:		3/27/2014	

I. APPLICATION:

Agency Wide, including employees, affiliated providers and interpreters.

II. POLICY:

The Centra Wellness Network (CWN) Governing Board shall establish policies with related procedures to ensure clients are offered the rights afforded them pursuant to obligations under the Mental Health Code, Administrative Rules, contractual obligations with the Michigan Department Health and Human Services (MDHHS), and its Inter-local agreement with Manistee and Benzie Counties, any other state and federal regulations, and pertinent accreditation criteria.

III. DEFINITIONS:

~~N/A~~

Centra Wellness Network (CWN) access system: Customer and Provider Services staff and all CWN staff from clinical programs who may be called upon to respond to crises, complete screenings, and provide intake assessments.

IV. PROCEDURE:

A. Key Functions of the Access System~~:~~
   1. Functions as the front door for obtaining services by telephone or on a walk-in basis.
   2. Screens individuals to see if they are in crisis and if so, provide a timely, appropriate response;
   3. Determines the individuals' eligibility and priority for services~~.~~;
   4. Collects information for decision-making and reporting purposes~~.~~;
   5. If not eligible, refers in a timely manner to the appropriate community resources and supports;
   6. Reaches out to the under-served and hard-to-reach populations and be accessible to the community-at-large~~.~~;
   7. Coordinates Family Support Subsidy for CWN; and
   8. Facilitates Consumer Council meetings

B. Expectations of the Access System~~:~~
   1. Staff is available, accepting, welcoming, empathetic and helpful to all residents of the State of Michigan regardless of where they live or where they contact the system.
   2. Staff reflects the MDHHS philosophies of person-centered, self-determined, recovery-oriented, trauma-informed and least restrictive environments.
   3. Staff welcomes individuals by listening to their situation, problems, and functioning difficulties using good customer service skills in a non-judgmental way;
   4. A toll-free access phone line is available 24 hours a day and 7 days per week. There is access to the phone line for hearing impaired and limited English Proficient (LEP) individuals.
      a. Phone systems have electronic caller identification.
      b. Individuals do not encounter phone trees and are not put on hold until they have spoken with a live person and had an opportunity to discuss their situation.
      c. All crisis/emergent calls are immediately transferred to a qualified professional without having to call back.
      d. No individual seeking a non-emergent screening is placed on hold for more than 3 minutes without being offered a callback or the option to speak with a paraprofessional in the interim.
      e. All non-emergent callbacks are returned within one business day of initial contact.
      f. Individuals can be transferred directly to an access worker from any extension in a Centra Wellness Network office.
   5. Provides a timely, effective response to all individuals who walk in.

   a. Urgent or emergent needs are immediately referred to the appropriate professional.
   b. Non-emergent needs are screened or other arrangements are made within 30 minutes.
6. Immediately accommodates individuals with:
   a. LEP and other communication needs
   b. Diverse cultural and other demographic backgrounds
   c. Alternative communication needs
   d. Mobility challenges
   e. Visual Impairments
7. Addresses financial considerations including county of fiscal responsibility (COFR), only after addressing urgent and emergent needs.
   a. Does not require prior authorization for crisis intervention or an access screening.
   b. Does not require any financial contribution for phone screening and referral.
   c. Provides individuals with a summary of their rights including rights to person-centered planning.
8. Offers new clients an orientation to services, emergency procedures and the Community Mental Health Guide to Services
9. Assures that new clients have access to pre-planning as soon as the eligibility has been determined.

C. Screening for Crises:
1. Staff, will assure that urgent and emergent needs are identified and addressed first. This includes understanding when issues are urgent or emergent from the individual's point of view.
2. Staff completes timely assessments, provides appropriate interventions, and timely admissions to inpatient units or alternate services when appropriate.
3. Staff will ask if the individual has existing advance directives.
4. Necessary post-stabilization services will be provided following stabilization of the crises. Individuals without Medicaid who require post-stabilization will be referred back to the access system for assistance.

D. Screening and Determining Eligibility for Services
1. Determining Coverage for mental health and/or substance abuse services shall be completed using:
   a. MDHHS/PIHP and PIHP/CMHSP contracts;
   b. Medicaid Provider Manual for a Medicaid and Medicaid Waiver beneficiary; and
   c. The Michigan Mental Health Code and Administrative Rules if the beneficiary is not eligible for Medicaid or a Medicaid Waiver.
2. An in person clinical assessment will be conducted to gather information to determine eligibility for services.
   a. The assessment will gather an adequate amount of information without duplicating information gathered to develop and appropriate plan of care and to subsequently provide appropriate and safe services.
   b. The assessment is completed by a mental health care professional within their scope of practice.
   c. A number of standardized assessment tools are used to assist in the gather of information including but not limited to PECFAS, CAFAS, ADOS-2, ADIR, LOCUS, and SIS. These tools, along with standards outlined in Section D(1) are used to determine appropriate level of care.
   d. Eligibility determined by a Master's Level clinician.
   e. Any third party payer source will be identified to provide an appropriate referral source, in or out of network.
   f. No individual will be denied service because of individual/family income or third party payer sources.

g. The referral source will be identified whether in or out of network. With the consent of the individual served, the referral source will be informed of the determination of eligibility for services.
h. When the assessment is conducted, the individual and legal representative, if applicable, will be offered a written determination of eligibility based upon established admission criteria. The written decision will include:
    i. Presenting problems and needs for services and supports;
    ii. Initial identification of the population group that qualifies the individual for services and supports (I/DD, MI, SED, SUD)~~.~~;
    iii. Co-occurring mental illness and substance use disorder;
    iv. Urgent and emergent needs including links for crisis services~~.~~;
    v. Screening deposition~~.~~; and
    vi. Rationale for admission or denial.

3. Individuals with mental health needs but who are not eligible for Medicaid or Medicaid Waiver may be placed on a waiting list with a written explanation of reasoning. Referrals to CWN Staff and Providers
4. Appointments are made with mental health professionals of the individual's choice within 14 days of the assessment.
5. Staff will follow up with the individual to make sure that the appointment was kept.
6. Individuals accepted for services have access to the person-centered-planning process.
7. Referrals are made in compliance with confidentiality requirements of 42CFR.

E. Referrals to Community Resources
1. Individuals with Medicaid who request mental health services but do not meet eligibility for specialty support and services are referred to their Medicaid Health Plans or Medicaid fee-for-service providers.
2. Individuals who request mental health or substance abuse services but who are not eligible for Medicaid or Medicaid Waiver mental health and substance abuse services, individuals who do not meet the "priority population to be served" criteria in the Michigan Mental Health Code or the Michigan Public Health Code for substance abuse services, or individuals who requests information about the other non-mental health community resources or services that are not the responsibility of the public mental health system shall referred to alternative mental health or substance abuse treatment services available in the community.
3. Staff will provide information about and help individuals connect as needed, with Customer Service, peer supports specialists, family advocates, and local community resources such as: transportation services, prevention programs, local community advocacy groups, self-help groups, service recipient groups, and other avenues of support, as appropriate and available.

V. DICUSSION OF INTENT

The purpose of this procedure is to ensure that clients served by nCentra Wellness Network receive information about access to covered services, including but not limited to, assistive supports, peer supports specialists, family advocates, and local community resources.

Authority and Related Directives Trace	
Federal	42§ CFR 438.6, 438.52, 438.100, 438.206-438.210, 438.114
State	MDHHS/CMHSP Contract, Part II, Section 3.0 and 6.3; Michigan Mental Health Code 330.1100, 330.1124, 330.1206, 330.1208, 330.1226, 330.1409, 330.1702 and 330.1706; Michigan Medicaid Provider Manual: Behavioral Health and Intellectual and Development Disability Supports and Services
NMRE	Administrative Manual, Chapter 6
County	
CARF	CARF 2016 Behavioral Health Sections 2B and 3B
Other	

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Appendix IV

CENTRA WELLNESS NETWORK

Board Adopted Procedure			
Procedure	03.04	**Policy Title: 03.00 Enrollee Rights**	
Effective Date: 3/10/2011		**Subject: Limited English Proficiency**	
Review Cycle:		3 years	
Approval Validation Record			
Action		**Date**	**Board Sec'y Initials**
Full Board Vote:		3/10/2011	ARM
Minutes Approved:		4/14/2011	ARM
Accountability			
Board Committee:		Policy Committee	
Agency Function:		Access to Services	
Sunset Review Begins:			
Revised Date:		3/27/2014	ARM
		2-1-2017	ARM
Review Date:			

CENTRA WELLNESS NETWORK
PROCEDURE 03.04 LIMITED ENGLISH PROFICIENCY

I. APPLICATION:

Agency Wide, including employees, affiliated providers and interpreters.

II. POLICY:

The Centra Wellness Network (CWN) Governing Board shall establish policies with related procedures to ensure clients are offered the rights afforded them pursuant to obligations under the Mental Health Code, Administrative Rules, contractual obligations with the Michigan Department of Health and Human Services (MDHHS), and the Inter-local agreement with Manistee and Benzie Counties, any other state and federal regulations, and pertinent accreditation criteria.

III. DEFINITIONS:

Limited English Proficient (LEP): A person, who is unable to speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies. For the purposes of this policy, LEP will also apply to individuals whose primary form of communication is something other than the oral English language.

Communication: The effective transmission of messages using spoken language, Braille, American Sign Language, or available technology as necessary.

Interpretation: The oral transmittal of a message from one language to another, considering dialect, culture, and nuance.

Reasonable Accommodations: Modifications or adjustments, which are not unduly burdensome, that assist clients or staff members to access benefits and privileges that are equal to those enjoyed by others. Examples taken from the American with Disabilities Act include making existing facilities readily accessible to and usable by persons with disabilities; acquiring or modifying equipment or assistive devices; adjusting or modifying examinations; and providing qualifies readers or interpreters.

Translation: The written interpretation of a message from one language to another, conveying the original meaning of the text with linguistic precision.

Vital Documents: Documents that include, but are not limited to, applications, consent forms, releases of information regarding participation in a program, treatment plans, notices pertaining to the reduction, suspension, denial, or termination of services or benefits, notice of the right to appeal such actions or that require a response from beneficiaries, notices advising of the availability of free language assistance, and other outreach materials.

IV. PROCEDURE:

A. The Clinical Director, or designee will ensure that clients who are LEP, visually and/or hearing impaired receive reasonable accommodation and can effectively communicate the relevant circumstances of their situation, are given adequate information about services and benefits, and are able to receive those services and benefits for which they are eligible.

B. The Director of Customer and Provider Services (CAPS), or designee will ensure that written materials will be translated for each eligible LEP demographic group that constitutes ten percent (10%) or 3,000 people, whichever is less, of the current census population.

C. The Director of CAPS, or designee will ensure that, at a minimum, vital documents will be translated for LEP demographic groups that constitute five percent (5%) or 1,000, whichever is less, of the current census population.

D. The Director of CAPS or designee will ensure that LEP demographic groups not meeting population standards of (B) or (C) receive written/oral notice of their right to receive competent oral translation of written materials.

E. Outside contract agencies used for interpretation/translation services will sign a confidentiality agreement binding the organization and its employees to observe and protect the confidentiality rights of CWN clients.

F. CWN will notify clients who are LEP, visually, and/or hearing impaired, of their right to language assistance and the availability of such assistance free of charge. This notification may include, but is not limited to:
    1. language identification cards; and
    2. posting and maintaining signs in regularly encountered languages other than English in waiting rooms, reception areas and other initial points of entry; and
    3. right to free language assistance services, in appropriate non-English languages, in brochures, booklets, outreach and recruitment information.

G. Employees of CWN should not use friends, minor children, or family members as interpreters. If, after informing the LEP person of the right to free interpreter services, the client declines such services and requests the use of a family member or friend, CWN employees may use the family member or friend if the use of such a person would not compromise the effectiveness of services or violate the client's confidentiality. If the client elects to use a family member or friend, the CWN employee should suggest that a trained interpreter should be present during the contact to ensure accurate interpretation. CWN employees should document the offer and declination in the client's record.

H. The Director of CAPS and The Clinical Director, or designees will ensure that designated staff are provided training relevant to accessing appropriate interpretation services in an expedient and professional manner, as well as where and how to obtain materials and equipment that will assist in other forms of communication.

I. CWN staff will ensure that the identified language/communication needs of a client who is LEP, visually and/or hearing impaired will be documented in the client's clinical record.

V. DISCUSSION OF INTENT:

The purpose of this procedure is to reduce barriers for clients with LEP of Centra Wellness Network and ensure meaningful and equal access to programs, services and benefits.

Authority and Related Directives Trace	
Federal	Social Security P.L. 88-352 of 1964 Title VI Non Discrimination in Federally Assisted Programs; Federal Register 65, No. 159 Order 13166 65 Improving Access to Services for Persons with LEP
State	MDHHS/CMHSP Prepaid Inpatient Health Plans and Community Mental Health Services Programs 3.3.2; Michigan Mental Health Code 330.1708
NMRE	Administrative Manual, Chapter 6
County	
CARF	CARF 2016 Standards 1L, 2B, and 3B.
Other	

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Appendix V

CENTRA WELLNESS NETWORK

Board Adopted Procedure			
Procedure	03.05	**Policy Title: 03.00 Enrollee Rights**	
Effective Date: 2/10/2011		**Subject: Out of Network Services**	
Review Cycle:			
Approval Validation Record			
Action		**Date**	**Board Sec'y Initials**
Full Board Vote:		2/10/2011	AKH
Minutes Approved:		3/10/2011	AKH
Accountability			
Board Committee:		Policy Committee	
Agency Function:		Enrollee Rights	
Sunset Review Begins:			
Revised Date:		3/27/2014	AKH
		2.01.2017	AKH
Review Date:			

CENTRA WELLNESS NETWORK
PROCEDURE 03.05 OUT OF NETWORK SERVICES

I. APPLICATION:
Agency wide, including employees, affiliated providers and interpreters.

II. POLICY:
The Centra Wellness Network (CWN) Governing Board shall establish policies with related procedures to ensure clients are offered the rights afforded them pursuant to obligations under the Mental Health Code, Administrative Rules, contractual obligations with the Michigan Department of Health and Human Services, and the Inter-Local agreement with Manistee and Benzie Counties, any other state and federal regulations, and pertinent accreditation criteria.

III. DEFINITIONS:
N/A

IV. PROCEDURE:
If Centra Wellness Network (CWN) providers are unable to provide medically necessary services covered under contract with Northern Michigan Regional Entity (NMRE), CWN will provide those services outside the Provider Network.

1. The out of network services will be adequate for the intended purpose.
2. The out of network services will be provided timely.
3. Covered services will be provided out of network for as long as CWN providers are unable to provide the covered service.
4. Any out of network providers must coordinate payment with CWN.
5. The cost to the client will not be more than the same service if provided in network.

V. DISCUSSION OF INTENT:
The intent of this procedure is to ensure that Medicaid enrollees receive necessary Medicaid covered services.

Authority and Related Directives Trace	
Federal	42§ CFR 438.206, 438.214; PL 105-33, BBA 438.206(b)(4),
State	MCL 400.111 (B)(12),
NMRE	Administrative Manual #05-01-009
County	Inter-local Agreement of December 1992 Section IX(j),
CARF	
Other	Board By-laws, Section 7.E.

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Appendix VI

CENTRA WELLNESS NETWORK

Board Adopted Procedure			
Procedure	03.22	**Policy Title: 03.00 Enrollee Rights**	
Effective Date: 1/13/2011		**Subject: Medicaid Beneficiary Appeals/Grievances**	
Review Cycle:		3 years	
Approval Validation Record			
Action		**Date**	**Board Sec'y Initials**
Full Board Vote:		1/13/2011	AKH
Minutes Approved:		2/10/2011	AKH
Accountability			
Board Committee:		Policy Committee	
Agency Function:		Medicaid Beneficiary Appeals/Grievances	
Sunset Review Begins:			
Revised Date:		5/8/2014	AKH
		4.5.2017	AKH
		7.5.2017	AKH
		8.9.2018	AKH
Review Date:			

I. PURPOSE STATEMENT:

Centra Wellness Network's (CWN) Governing Body establishes and evaluates policies and related procedures as required by statutory and contractual obligations.
CWN reserves the right in its sole discretion to adopt and implement policies and procedures that ensure a safe, functional and professional workplace that operates with integrity using person-centered focus and planning, trauma informed practices and respect of others, cultural sensitivity and transparency in communication and practice. Organizationally and in practice, CWN is responsive to the needs of clients, community and staff.

Any statements and procedures are subject to review and/or unilateral change, modification, suspension or cancelation in whole or in part of any published/unpublished policies or procedures without notice and without having to give cause, justification, or consideration to any employee. Recognition of these rights and prerogatives of CWN is a term and condition of and maintaining employment.

Policies and Procedures are approved by the Board and/or upon recommendation by the Executive Director or his/her designee.

II. APPLICATION:

Agency Wide.

III. DEFINITIONS:

Adverse Benefit Decision:
A decision that adversely impact's a Medicaid Beneficiary's claim for services due to:

a. The denial or limited authorization of a requested Medicaid service including the type or level of service.
b. The reduction, suspension, termination of a previously authorized Medicaid service.
c. The denial, in whole or part, of payment for a Medicaid covered service.
d. The failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for services.
e. Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
f. Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP/CMHSP.
g. Failure of the PIHP/CMHSP to act within 30 **calendar days** from the date of a request for a standard appeal.
h. Failure of the PIHP/CMHSP to act within 72 hours from the date of a request for an expedited appeal.
i. Failure of the PIHP/CMHSP to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

Additional Mental Health Services:
Supports and services available to Medicaid beneficiaries who meet the criteria for Specialty Services and Supports, under the authority of Section 1915 (b)(3) of the Social Security Act. Also referred to as "B3" waiver services.

Adequate Notice of Adverse Benefit Decision:

Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid services requested. Notice is provided on the same day the adverse benefit decision takes effect, or at the time of the signing of the individual plan of services/supports.

Advance Notice of Adverse Benefit Decision:
Written statement advising the beneficiary of a decision to suspend, reduce, or terminate Medicaid covered services that are currently provided. Notice must be provided/mailed at least 12 calendar days in advance of the date of adverse benefit decision.

Appeal:
Request for a review of an adverse benefit decision.

Authorization of Services:
The process for approving first and on-going services.

Beneficiary:
A person who is eligible for Medicaid and who is receiving or may be eligible to receive mental health services through a PIHP/CMHSP.

Consumer:
A person requesting or receiving mental health services delivered and/or managed by PIHP/CMHSP including persons with Medicaid and all others.

Expedited Appeal:
A speedy review of an adverse benefit decision, requested by the beneficiary or the beneficiary's provider when the time for the normal appeal process could jeopardize the beneficiary's life, health, or ability to maintain, attain, or regain maximum function. If requested by the beneficiary, the PIHP/CMHSP determines if an expedited appeal is warranted. If the beneficiary's provider makes or supports the request, the PIHP **MUST** grant the request.

State Fair Hearing (SFH):
Impartial state level review of a Medicaid beneficiary's appeal of an adverse benefit decision presided over by a Michigan Department of Health and Human Services (MDHHS) Administrative Law Judge. Also referred to as an "administrative hearing."

Grievance:
Medicaid Beneficiary's expression of dissatisfaction about any PIHP/CMHSP service issue other than an adverse benefit decision. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the beneficiary.

Grievance Process:
Impartial local level review of a Medicaid Beneficiary's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues **other than an** adverse benefit decision.

Grievance System:
The overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

Local Appeal Process:
Impartial local level PIHP/CMHSP review of a Medicaid beneficiary's appeal of an adverse benefit decision presided over by individuals not involved with decision-making or previous level of review.

Medicaid Services:
Services provided to a beneficiary under the Medicaid state plan, Habilitation Supports Waiver and/or 1915(b)(3) waiver of the Social Security Act.

Notice of Disposition:
Written statement of the PIHP/CMHSP decision for each local appeal and/or grievance, provided to the beneficiary.

PIHP:
Prepaid Inpatient Health Plan. CWN is an affiliate member of the Northern Michigan Regional Entity PIHP.

Recipient Rights Complaint:
Written or verbal statement by a consumer, or anyone acting on their behalf, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the Recipient Right process (Chapter 7a).

IV. POLICY STATEMENT:

The Centra Wellness Network (CWN) Governing Board shall establish policies with related procedures to ensure consumers are offered the rights afforded them pursuant to obligations under the Mental Health Code, Administrative Rules, contractual obligations with the Michigan Department of Community Health, and it's Inter-local agreement with Manistee and Benzie Counties, any other state and federal regulations, and pertinent accreditation criteria. The intent of this procedure is to ensure notification of the recipient his/her right to file appeals and grievances, including local appeals and grievances and State Fair Hearings. To provide a fair and efficient process for resolving appeals and grievances from recipients of Medicaid services or applicants for Medicaid services, related to suspension, termination, reduction or denial of services and supports and/or grievances related to services delivered by Manistee Benzie Community Mental Health and its contracted providers.

V. PROCEDURES

A. CWN is delegated by the PIHP the responsibility for the appeals/grievance processes via a written agreement consistent with 42.CFR 438.230. The complaint resolution or grievance system in place for Medicaid beneficiaries is compliant with federal regulation (42 CFR 438.228) that complies with Subpart F of part 438.
B. Characteristics of complaint resolution system:
   1. All processes will promote the resolution of concerns and improvement of the quality of care
   2. Complaints should be resolved at the level closest to service delivery when possible but information regarding access to all complaint resolution processes will be provided to the beneficiary of services.
   3. The CWN Compliance Officer or his/her designee will be the contact point for the appeals/grievance system.
   4. Beneficiaries have access to the state level fair hearing process for an appeal of an "adverse benefit decision" that includes the right:

a. To request a State fair hearing only after exhausting the local level appeal of an "adverse benefit decision" and no later than 120 calendar days from the date of the local decision.
b. To have services continued when a local appeal and/or state fair hearing is pending. The beneficiary must be informed that he/she may be responsible for the costs of the services provided while the appeal is pending based on his/her ability to pay.
c. To have a provider file an appeal and represent a beneficiary with the beneficiary's written consent. A provider may file a grievance or request for state fair hearing on behalf of the beneficiary only if the State permits the provider to act as the beneficiary's authorized representative in doing so. Punitive action may not be taken by CWN or the PIHP against a provider who acts on the beneficiary's behalf.

5. A local grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an "adverse benefit decision".

C. Service Authorizations Decisions:
1. CWN is delegated by the PIHP the responsibility for providing each Medicaid beneficiary a written service decision as required in this procedure and as quickly as the beneficiary's health condition requires (standard or expedited authorization).
2. Service Authorizations Requirements:
a. Standard Authorization – notice must be provided as expeditiously as the beneficiary's health condition requires and no later than 14 calendar days following receipt of services. If the beneficiary or provider requests an extension or if CWN/PIHP justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest then CWN/PIHP may extend the 14 calendar day time period by up to 14 additional calendar days.
b. Expedited Authorization - In cases which a provider indicates, or CWN/PIHP determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, then CWN/PIHP must make an expedited authorization decision and provide notice of the decision as expeditiously as the beneficiary's health condition requires, and no later than three (3) working days after the receipt of the request for service. If the beneficiary requests an extension, or if CWN/PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest; then CWN/PIHP may extend the three (3) working day time period by up to 14 calendar days.

D. Notice of Adverse Benefit Determination (adequate or advance):
1. CWN is delegated by the PIHP the responsibility to provide notice of adverse benefit decision to Medicaid beneficiaries when the authorized service decision constitutes an "adverse benefit decision" that is less in amount, scope, or duration than requested, or is reduced, terminated, or suspended, or when the authorization decision is not timely. In these situations, a notice of adverse benefit decision must be provided to inform the beneficiary of the basis for the adverse benefit decision taken by CWN, or intends to take and the process available to appeal the decision.
2. Notice of Adverse Benefit Determination requirements:
a. Be in writing in the primary language of the beneficiary and at a level that can be understood by the beneficiary.

b. Be provided to the requesting provider if the requested service is denied or authorized in an amount, scope, and duration that is less than requested. The notice to the provider does not have to be in writing.
c. If a Medicaid beneficiary or representative requests a local appeal within 12 calendar days of the date of adverse benefit decision the services will be reinstated until the disposition of the appeal is received.
d. If authorized services were reduced, terminated or suspended without advance notice, the services must be reinstated to the level before the adverse benefit decision.
e. If the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an adverse benefit decision, and requires a written notice of adverse benefit decision.

3. The notice of adverse benefit decision must be either Adequate or Advance:
   a. Adequate notice: is a written notice provided to the beneficiary at the time of EACH adverse benefit decision. The individual plan of service, developed through a person-centered planning process and finalized with the beneficiary, must include, or have attached, the adequate adverse benefit decision provisions.
   b. Advance notice: is a written notice required when an adverse benefit decision is being taken to reduce, suspend or terminate services that the beneficiary is currently receiving. The advance notice must be mailed 10 calendar days before the intended adverse benefit decision takes effect.
4. The content of both adequate and advance notices must include an explanation of what adverse benefit decision the CMHSP/PIHP intends to take:
   a. The reason(s) for the adverse benefit decision.
   b. 42 CFR 440.2309(d) is the basic legal authority for an adverse benefit decision to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
   c. The beneficiary's or provider's right to file a CMHSP/PIHP appeal, and instructions for doing so.
   d. The beneficiary's right to request a State fair hearing and instructions for doing so.
   e. The circumstances under which expedited resolution can be requested and instructions for doing so.
   f. An explanation that the beneficiary may represent himself or use legal counsel, a relative, a friend, or other spokesperson.
   g. In addition, an Advance notice must include and explanation of:
      - The circumstances under which services will be continued pending resolution of the appeal,
      - How to request that the services be continued, and
      - When a beneficiary may be required to pay for the services.

E. Exceptions to Advance Notice:
   1. Factual evidence of the death of the beneficiary.
   2. Signed statement by the beneficiary that he/she no longer wishes the services.
   3. Beneficiary gives information that must result in reduction or termination of service.
   4. Beneficiary has been admitted to an institution and is no longer eligible for the services(s).

5. Beneficiary's whereabouts are unknown and/or the post office returns mail indicating no forwarding address.
6. Beneficiary is receiving services elsewhere.
7. The beneficiary's physician prescribes a change in level of medical care.
8. The date of the adverse benefit decision will occur in less than 10 calendar days.

F. Timeframes for mailing Notice of Action:
1. **At least 10 calendar days** before the date of adverse benefit decision to terminate, suspend, or reduce previously authorized Medicaid covered service(s). **(Advance)**
2. **At the time of the decision** to deny payment for a service. **(Adequate)**
3. **Within 14 calendar days** of the request for a standard service authorization decision to deny or limit service(s). **(Adequate)**
4. **Within 3 working days of** the request for an expedited service authorization decision to deny or limit service(s). **(Adequate)**

G. Extension of timeframes – if the standard or expedited service authorization cannot be completed within required timeframes, the timeframe may be extended up to 14 days. If an extension is needed, the following must happen:
1. Give the beneficiary written notice, not later than the date the original timeframe expires, of the reason for the decision to extend the timeframe and the right of the beneficiary to appeal the decision if he/she disagrees with the decision.
2. Carry out the authorization process as quickly as possible but not later than the extended timeframe allows.

H. Medicaid Services Continuation or Reinstatement:
1. CWN must continue Medicaid services previously authorized while a Local Appeal or State Fair Hearing is pending if:
   a. The beneficiary requests that the services are continued, and
   b. The appeal is filed timely, and
   c. The appeal involves a termination, suspension, or reduction of a previously authorized service, and
   d. The services were ordered by any authorized provider, and
   e. The period covered by the original authorization has not expired.
2. If reinstated, the services must continue until:
   a. The beneficiary withdraws the appeal, or
   b. 12 calendar days have passed since the notice of action was mailed and an appeal has not been filed, or
   c. An appeal decision is reached that is adverse to the beneficiary, or
   d. The authorization has expired.
3. **If the appeal results in a decision to reverse an action by CWN, CWN must pay for those services.**
4. **If the outcome of an appeal reverses a decision by CWN to deny, limit, or delay services,** those services must be provided promptly and as quickly as the beneficiary's health status requires.

I. <u>State Fair Hearing Appeal Process (also known as Administrative Hearing):</u>
1. Federal regulations provide a Medicaid beneficiary the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by the local agency or its agent.
2. A Medicaid beneficiary has the right to request a fair hearing when CWN/PIHP or its contractor takes an "adverse benefit decision," or a grievance request is not acted upon within **60 calendar days.** The beneficiary has to exhaust local appeals before he/she can request a fair hearing.
3. Beneficiaries are given 120 calendar days from the notice to file a request for a fair hearing.

4. If the beneficiary, or representative, requests a Fair Hearing no later than 120 calendar days from the date of the local decision, the benefits must continue unchanged until a disposition is received.
5. If the beneficiary's services were reduced, terminated, or suspended without advance notice, CWN/PIHP must reinstate services to the level before the adverse benefit determination.
6. The parties to the state fair hearings include CWN/PIHP, the beneficiary and his or her representative, or the representative of a deceased beneficiary's estate. A Recipient Rights officer shall not be appointed to as Hearings Officer due to the inherent conflict of roles and responsibilities.
7. Expedited hearings are available.
8. CWN responsibilities:
   a. CWN is delegated by the PIHP to represent itself in Fair Hearings for appellants served by CWN.
   b. Provide adequate and advance notice and a "Request for Hearing" form with envelope to the beneficiary when adverse benefit determination is taken.
   c. Provide the address for mailing the Fair Hearing Request:

Michigan Administrative Hearing System
Department of Community Health
PO Box 30763
Lansing, MI 48909
Fax (517) 373-4147

   d. Provide assistance to the beneficiary in completing a request for hearing form as needed. The beneficiary must request the hearing in writing.
   d. Complete and submit the CWN hearing summary with supporting documents to the Administrative Tribunal within 6 days after the hearing is scheduled.
   e. Not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.

J. Local Appeal Processes:
1. The federal regulations provides a Medicaid beneficiary the right to a local appeal of an adverse benefit determination. CWN/PIHP appeals, like those for fair hearings, are initiated by an "adverse benefit determination".
2. CWN is responsible for hearing Local Appeals as delegated by the PIHP.
3. A beneficiary/consumer may request a local appeal within 45 calendar days from the date of the notice of adverse benefit determination.
4. The request may be oral but must be confirmed in writing unless expedited resolution was requested.
5. If the beneficiary/representative requests the local appeal within 12 calendar days of the notice, the service must be reinstated until a determination is reached.
6. CWN responsibility includes:
   a. Give reasonable assistance to the beneficiary/consumer to complete forms and other procedural steps including but not limited to interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. CWN toll free number is 877-398-2013.
   b. Give opportunity, before and during the appeal process, to the beneficiary to examine his/her case records, including medical records and other documents or records considered during the appeal process.
   c. Acknowledge receipt of appeal.
   d. Maintain a log of appeal requests and report to PIHP and the PIHP Quality Improvement Program as required.

e. Ensure that persons hearing the local appeal do not have previous involvement in review or decision-making and are clinicians with an appropriate background.
f. Provide the beneficiary the opportunity to present information in person and/or in writing.
g. Allow the beneficiary to include his/her representative in the appeal.
h. Provide written notice of disposition and oral notice if expedited.

7. Notice of Disposition requirements:
   a. An explanation of the decision and the date it was completed.
   b. When the disposition is not fully in the appellant's favor, notify him/her of:
      i. The right to a fair hearing and how to request it.
      ii. The right to receive disputed services while the State Fair Hearing is pending, if the hearing is requested within 120 days of the CWN disposition being issued.
      iii. The possibility that the beneficiary may be held liable for the costs of the disputed services if the outcome of the hearing upholds the CWN action.
      iv. A standard appeal must be resolved and Notice of Disposition provided within 30 calendar days from when the appeal was received.
      v. An expedited appeal must be resolved and Notice of Disposition provided no longer than 72 hours of receipt of the request for an expedited appeal.
      vi. CWN may request an extension of the timeframe by up to 14 calendar days if it can demonstrate to the State that the delay is in the best interest of the beneficiary.
      vii. If CWN denies an expedited appeal, it must follow the timeframes for a standard appeal. The beneficiary must receive prompt oral notice of the denial and follow-up written notice within 2 calendar days.
      viii. That requests for disputed services to be continued must be made to the case manager, supports coordinator, or primary therapist.

K. Local Grievance Process:
1. Federal regulations provide Medicaid beneficiaries the right to a local grievance process **for issues that are not** "adverse benefit determination."
2. CWN is delegated by the PIHP the responsibility for grievances.
3. A beneficiary/consumer, guardian or parent of a minor child or his/her legal representative, may request a grievance from CWN at any time.
4. Local grievances may be filed orally or in writing. Upon request, staff will assist the individual in filing the appropriate forms to access appeal/grievance processes.
5. The beneficiary does not have access to a State Fair Hearing unless CWN fails to respond to the request for a grievance within 60 calendar days. This becomes an adverse benefit determination and then may be appealed.
6. CWN responsibility includes:
   a. Giving reasonable assistance to the beneficiary/consumer to complete forms and other procedural steps including but not limited to interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. CWN toll free number is 877-398-2013.
   b. Acknowledging receipt of grievance.
   c. Maintaining a log of grievance requests to report to the PIHP and the PIHP Quality Improvement Program as required.

d. Ensuring that the individuals who make the decision were not involved in the previous level of decision making. That health care professionals with appropriate clinical expertise in treating a beneficiary's condition or disease review grievances involving clinical issues and grievances regarding the denial of expedited resolution of an appeal.
e. Providing written notice of the disposition within 60 calendar days from the date of filing grievance/complaint.
f. The notice must include:
    1. The results of the grievance process.
    2. The date the grievance process was concluded.
    3. The beneficiary's right to request a State Fair Hearing if the notice of disposition is more than 60 days from the date of the request for a grievance.
    4. How to access the State Fair Hearing process.
    5. Where to mail a fair hearing request:

Michigan Administrative Hearing System
Department of Community Health
PO Box 30763
Lansing, MI 48909
Fax (517) 373-4147

L. Recordkeeping requirements of beneficiary appeals and grievances:
    1. CWN will maintain an appeal and grievance log which includes the disposition.
    2. CWN will submit quarterly, a log of all appeal, grievance and second opinion requests with related dispositions to the PIHP.
    3. CWN will record the number of requests for Medicaid services, and the number of denials of Medicaid services. This will be reported to the PIHP as required.
M. Recipient Rights Complaint Process:
    1. Medicaid beneficiaries, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code.
    2. Local grievances must be reviewed for possible rights violations. If it is determined that a grievance is more appropriately a rights complaint, with permission of the recipient, the written complaint will be referred to the Office of Recipient Rights.
    3. Recipient Rights complaint requirements are articulated in CWN Procedure 03.25 Recipient Rights Complaints.

VI. EXHIBITS

N/A

VII. REFERENCES:

Authority and Related Directives Trace	
Federal	Social Security Act: 42 CFR 431.200 et seq. (Fair Hearings); 42 CFR 438.400 et seq. (Local Appeals); 42 CFR 438.400 et seq. (Local Grievances)
State	Michigan Department of Health and Human Services, Grievance and Appeal Technical Requirement, January 2016; Michigan Mental Health Code (MHC) MCL 330.1772 (Recipient Rights Complaints), MCL 330.1705 (Medical Second Opinion); MCL 330.1786 (Notice of Decision; Appeal).
NMRE	NMRE Administrative Manual #07-03-001 (Grievance and Appeal, Fair hearing Protocol)
County	Interlocal Agreement of December 1992 Section IX(j)
CARF	CARF 2018 Behavioral Health Standards
Other	Board By-Laws, Section 7.E.

CWN Provider Manual
Appendix VII

CENTRA WELLNESS NETWORK

Board Adopted Procedure			
Procedure	05.01	**Policy Title: Network Management**	
Effective Date: 9/09/2010		**Subject: Provider Network Management**	
Review Cycle:		3 Years	
Approval Validation Record			
Action		**Date**	**Board Sec'y Initials**
Full Board Vote:		9/9/2010	AHH
Minutes Approved:		10/14/2010	AHH
Accountability			
Board Committee:		Planning and Finance Committee	
Agency Function:		Contracts	
Sunset Review Begins:			
Revised Date:		3.01.2017	AHH
		1.23.2019	AHH
Review Date:		2/26/2014	AHH

CENTRA WELLNESS NETWORK
PROCEDURE 05.01 PROVIDER NETWORK MANAGEMENT

I. PURPOSE STATEMENT:

Centra Wellness Network's (CWN) Governing Body establishes and evaluates policies and related procedures as required by statutory and contractual obligations.
CWN reserves the right in its sole discretion to adopt and implement policies and procedures that ensure a safe, functional and professional workplace that operates with integrity using person-centered focus and planning, trauma informed practices and respect of others, cultural sensitivity and transparency in communication and practice. Organizationally and in practice, CWN is responsive to the needs of clients, community and staff.
Any statements and procedures are subject to review and/or unilateral change, modification, suspension or cancelation in whole or in part of any published/unpublished policies or procedures without notice and without having to give cause, justification, or consideration to any employee. Recognition of these rights and prerogatives of CWN is a term and condition of and maintaining employment.
Policies and Procedures are approved by the Board and/or upon recommendation by the Executive Director or his/her designee.

II. APPLICATION:

Agency Wide, including employees, affiliated providers and interpreters.

III. DEFINITIONS:

Proposal Evaluation Committee:
A committee comprised of CWN staff members as assigned by the Executive Director or designee. Members that may also be included but not limited to are stakeholders, family members, consumers and/or CWN Board members will be included as appropriate. The purpose of the Proposal Evaluation Committee is to review and evaluate proposals submitted in response to an RFP or RFQ.
Request for Proposal (RFP):
A bid process used by CWN to solicit competitive proposals from community providers to address a specific service need, the price for providing the services, information regarding the proposed qualifications and capacity of the bidder to provide the services.
Request for Quote (RFQ):
A competitive bids process utilized by CWN to procure services, which includes requesting information from prospective bidders about their ability to provide services and the price of those services.

IV. POLICY STATEMENT:

The Centra Wellness Network (CWN) Governing Board shall establish policies with related procedures to ensure the maintenance of standard procedures for contract procurement, negotiation and evaluation, provider credentialing, provider orientation and training, and provider monitoring. This procedure is written to establish guidelines for the development and management of contract provider network.

V. PROCEDURES:

A. Contract Procurement
   1. Procurement of services will occur in a manner which ensures quality care and promotes the health and safety of the client in the provision of service.
   2. As required by federal procurement laws, a competitive bid process (RFP or RFQ) will be used to secure qualified and cost-effective service providers if CWN needs to engage in selective contracting to restrict or otherwise limit the number of providers in the provider network to assure adequate access to services.
   3. Under certain circumstances, CWN may contract with providers through single source procurement without a competitive procurement process. These circumstances may include any one or more of the following:

a. The service is available only from a single source
b. There is an urgent or emergent need for the service
c. After solicitation through a number of sources, there is a lack of qualified provider candidates
d. The services sought are unique or highly specialized
e. The services sought are professional services of limited quantity or short duration (e.g. Psychological testing)
f. Through the person-centered planning process the client has chosen a qualified non-network provider as his/her provider of choice.
g. Where for purposes of continuity of care and consumer stability, an existing network provider may be selected to provide a service
h. Where an Open Provider Panel is maintained in which providers agree to the CWN compensation schedule

4. Contract terms will be for a minimum of one year, unless otherwise specified. Multi-year contracts may be implemented at the discretion of CWN if warranted by funding, favorable financial terms, regulatory requirements or provider performance.

B. Application Process
1. Interested providers shall complete a Centra Wellness Network Provider Network Application form. The Director of Customer and Provider Services, or designee, will review applications for completeness. Incomplete applications will be returned to the applicant. An on-site visit may be conducted if deemed necessary.
2. Applicants will be notified by the Director of Customer and Provider Services of acceptance or denial of their application. Accepted providers shall be credentialed and privileged according to State, Northern Michigan Regional Entity (NMRE), and CWN policy and procedure. The Director of Customer and Provider Service or designee will maintain systems for tracking and filing provider applications. In instances where there is a service need or a specific service has been requested by a client and there is no provider in the county of residence, a provider will be sought from within the broader NMRE provider network. If no provider is available within the broad NMRE network, every effort will be made to locate a provider within reasonable geographic proximity. If no provider can be located in this fashion, alternative services will be identified and made available to the client. When a client expresses a preference for a non-network provider, efforts will be undertaken to enroll the provider in the network.

C. Request for Proposal/Quote
1. A Request for Proposal (RFP) or Request for Quote (RFQ) will be initiated at the discretion of the Executive Director or designee.
2. The Director of Customer and Provider Services will coordinate development of the RFP/RFQ documents and shall include input from staff, stakeholders, clients, families, and guardians as appropriate.
3. Advertisements in various media will be used for maximum exposure when competitive bidding or a Request for Quote is required. Invitations to bid will be sent to potential service providers who have previously expressed an interest in contracting for the type of service addressed by the RFP/RFQ.
4. Questions in response to an RFP/RFQ must be submitted in writing to the Director of Customer and Provider Services on or before the deadline specified in the RFP/RFQ.
5. If an RFP/RFQ needs to be revised or amended, addenda will be provided to all recipients of the initial RFP/RFQ.
6. To be considered complete, the proposal must be submitted in the specified format, arrive on or before the specified deadline to the office location of Customer and Provider Services, and be signed by an official authorized to bind

the bidder to its provisions. The proposal shall remain valid for a minimum of ninety (90) days.

7. A pre-bid conference may be scheduled for potential bidders. The date, time and place of the pre-bid conference will be included in the advertisement/posting. Attendance at the pre-bid conference may be optional or mandatory at the discretion of CWN. The purpose of the pre-bid conference shall be to provide an overview of the RFP/RFQ, to profile the population to be served, and to address questions relevant to the FRP/FRQ.

D. Bid Opening
   1. The date and time for the bid opening will be included in the RFP/RFQ.
   2. The Director of Customer and Provider Services, or designated staff, will be responsible for opening and reading the total dollar amount for the bids.
   3. Respondents to the RFP/RFQ may attend the bid-opening.
   4. The total bid amount will be recorded and maintained as an official document of the RFP/RFQ process.

E. Evaluation of Proposal/Quote
   1. A Proposal Evaluation Committee shall evaluate and rate submitted proposals. The Committee will be comprised of CWN staff as assigned by the Executive Director or designee, and may include the following: CWN Board members, stakeholders, clients and/or family members, and others as appropriate.
   2. The Director of Customer and Provider Services, or designated staff, will coordinate committee activities.
   3. Members selected for the committee will be screened to determine whether there exists conflict of interest or bias toward any of the bidders. Committee members will be required to disclose and potential conflict of interest. Disclosures shall be documented and maintained in a confidential file. A committee member shall not be required to cite the reason for the conflict of interest. Any committee member disclosing a potential conflict of interest shall be excused from further participation and a new member for the committee may be selected.
   4. Committee members shall reach group consensus on the criteria to be used to rate the bids, and shall review and evaluate the proposals. Scores and findings shall be thoroughly documented.
   5. The Director of Customer and Provider Services, or designated staff, shall ensure that each committee member has an opportunity to review the bid packages.
   6. At the discretion of the Executive Director, identities of the bidders may be concealed prior to review of bid packages by the committee. In these instances, bidder numbers will be assigned to each bid.
   7. Budget information and financial statements submitted as part of the bid will be reviewed and evaluated by the Finance Department.
   8. The review and evaluation process shall be confidential. Committee members shall not discuss or disclose information about submitted bids or the review process with anyone outside the committee.
   9. Questions requiring a response from bidders will be directed to the Director of Customer and Provider Services, or designated staff, for inquiry.
   10. Committee representative(s) shall check references furnished by the provider. Committee members may make site visits to the provider's locations. Findings from reference checks and site visits will be documented and shared only with committee members.
   11. Committee members will individually rate each bidder based on ability to meet specifications in the RFP/RFQ. Proposals which fail to address the basic elements required in the RFP/RFQ will be eliminated from consideration.

12. In the instance of an RFP the Committee will rank the bidders in order of perceived ability to meet the evaluation criteria. For RFQ the Committee will merely agree or not agree to place a potential bidder on the CWN Provider Panel.
13. For the RFP process the Director of Customer and Provider Services will review the committee's ratings and recommendations with the Executive Director, or designee.

F. Conflict of Interest
   1. No CWN employee, officer or agent shall participate in the selection, award, or administration of a contract issued by CWN if a conflict of interest exists. Such a conflict would arise when a CWN employee, officer or agent, or any member of his/her immediate family, his/her partner, or an organization which employees or is about to employ any of the parties described herein, has a financial or other interest in the organization selected for an award. The officers, employees and agents of CWN shall neither solicit nor accept gratuities, favors or anything of monetary value from contractors or providers, or from parties having sub-agreements with providers or contractors. Should any officers or employees of CWN violate this standard of conduct, CWN may take disciplinary action, in accordance with CWN procedures, as appropriate.
   2. CWN staff developing procurement solicitations shall be alert to organizational conflict of interest, as well as non-competitive practices among contractors or providers that may restrict or eliminate competition or otherwise restrain trade. In order to assure objective contractor or provider performance and eliminate unfair competitive advantage, contractors or providers that are involved in the development of draft grant applications or contract specifications, requirements, statements of work, invitation for bids and/or requests for proposals shall be excluded from competing for such procurement.

G. Contract Negotiation and Execution
   1. The Director of Customer and Provider Services, together with any additional authorized individuals, will negotiate with the recommended service provider(s) to procure contracts for service delivery. Negotiations will include consideration of past performance as a contracted service provider, if applicable, and shall be subject to funding availability.
   2. For purposes of continuity and standardization, CWN utilizes standard model contracts for all services supported by Medicaid and GF Funding.
   3. Standard contracts shall be reviewed annually to assure compliance with prevailing BBA and DHHS requirements.
   4. Contracts in the amount of $10,000 or more will be presented to the Board of Directors for approval. All contracts will be signed by Executive Director or a designee.
   5. Contracts shall be signed in duplicate. An original shall be maintained by the Director of Customer and Provider Services with a signed original sent to the provider.
   6. CWN will contact the service provider prior to the expiration of the contract to negotiate renewal.
   7. Requests to modify or amend a contract will be coordinated by the Director of Customer and Provider Services. Contract amendments shall be made in accordance with the terms and conditions of the contract. Modifications which affect the authorized total expenditures must be approved in accordance with CWN Purchasing Procedures, as applicable.

H. Provider Monitoring
   1. Director of Customer and Provider Services, or designated staff, will be responsible for coordinating provider monitoring at designated intervals throughout the term of the contract. Prior to the renewal, review of provider will

be conducted to ensure compliance with established performance indicators and other terms specified in the contract.

2. Billing claims will be verified by appropriate CWN staff for service verification, payment authorization, and payment.
3. The Director of Customer and Provider Services, and/or designated staff, will provide information to appropriate parties regarding the performance of each network provider, as well as take appropriate steps to ensure improvement and compliance with contract provisions and requirements. Performance monitoring may include, but not be limited to:
    a. Review and analysis of data and financial reports from providers.
    b. Review of utilization management and other practice information, including customer service reports.
    c. On-site review of each provider annually and as needed.
    d. Input from individual/family/stakeholder groups as appropriate.
    e. Review of Recipient Rights Reports
4. Monitoring of financial management, or financial solvency, of the Provider will be determined as follows:
    a. For Licensed Adult Foster Care Homes (AFC's) with individual contracts (Type A), solvency is determined by review of income statements, State and Federal tax returns.
    b. For Licensed AFC Facility Contracts (Type B), the Provider will annually, or as otherwise requested, submit for review: audited financial statements with written certification from a CPA, and/or financial statements with supporting documents.
    c. For Independent Contractors, contract language requires notification to CWN of any changes in their financial condition would adversely impact service deliver.
    d. For non-profit organizations, financial solvency information may also be obtained by utilizing the following website: www.guidestar.org
5. The Director of Customer and Provider Services, and/or designated staff, will coordinate the development of recommendations for improvement in the event of non-compliance with contract, network policies and procedures, as well as provider performance problems. These recommendations shall be in the form of a plan of correction, and be signed by the Provider. This Plan of Correction shall be submitted for review to CWN. In the event a provider is in continued non-compliance, the provider may be required to attend to additional actions, up to and including being removed from the Provider Network.
6. The Director of Customer and Provider Services, or designated staff, shall seek input from other staff and shall utilize various reports including Recipient Rights reports, State Licensing reports, survey results and plans of correction, among other materials, in monitoring the performance of network providers.
7. The NMRE retains the right to approve, suspend or terminate from participation in the provision of Medicaid funded services a provided selected by CWN.

I. Provider training and orientation
    1. All providers of the NMRE affiliation shall receive orientation and training to the network policies and procedures provided by CWN.
    2. If a provider is providing a service specific to a target service group or population, that provider shall be oriented in CWN Board policies and procedures for that population.
    3. Training may be via various methodologies, including copies of policies electronically, (internet, web pages and e-mail), telephone conversations, meetings and correspondence. Training shall be documented and kept in the contractor record.

4. CWN shall provide each contractor with a Provider Manual at start of service, and updates as needed thereafter. The manual shall include, minimally, the following: general agency and affiliation information, contact information, organizational charts, policies & procedures relevant to the service provider, and samples of required forms. Providers shall sign an acknowledgement of receipt of the manual.

J. Protests, disputes, and claims
In the event that there is a protest, dispute and/or claim resultant of the contract procurement process, the provider may appeal the decision by submitting a letter of protest/dispute/appeal to the Executive Director of CWN within ten (10) business days of the date of the determination notice. The letter shall state the basis for the protest/dispute/appeal and shall include any supporting documentation. All protests/disputes/appeals will be reviewed and a decision made within fourteen (14) business days of receipt of the letter. The decision of the Executive Director of CWN shall be final and binding. This process shall apply to providers employed and/or directly contracted with CWN.

VI. EXHIBITS:

N/A

VII. REFERENCES:

Authority and Related Directives Trace	
Federal	BBA 438.230 and 438.206; 2CFR §200.318-200.326, OMB Circular A-87, revised; 42CFR §438.12
State	MDHHS/CMHSP Managed Mental Health Supports and Services Contract Sections 6.4, 6.4.1, 6.4.2; MCL Section 330.1232 Act 258, P.A. 1974 as amended
Affiliation	NMRE/CWN Medicaid Subcontracting Agreement
County	Inter-local Agreement, Section IX.J, X.1
CARF	CARF 2018 Behavioral Health Section 1 (A), (E), (I)
Other	

CWN Provider Manual
Appendix VIII

CENTRA WELLNESS NETWORK

Board Adopted Procedure			
Procedure	05.02	**Policy Title: 05.00 Network Management**	
Effective Date: 2/10/2011		**Subject: Credentialing and Recredentialing**	
Review Cycle:		3 years	
Approval Validation Record			
Action		**Date**	**Board Sec'y Initials**
Full Board Vote:		2/10/2011	ARH
Minutes Approved:		3/10/2011	ARH
Accountability			
Board Committee:		Policy Committee	
Agency Function:		Credentialing and Recredentialing	
Sunset Review Begins:			
Revised Date:		1/14/2016	ARH
		7/05/2016	ARH
		3.01.2017	ARH
Review Date:		4/24/2014	ARH

CENTRA WELLNESS NETWORK
PROCEDURE 05.02 CREDENTIALING AND RECREDENTIALING

I. APPLICATION:

Customer and Provider Services and Quality Improvement.

II. POLICY:

The Centra Wellness Network (CWN) Governing Board shall establish policies with related procedures to ensure the maintenance of standard procedures for contract procurement, negotiation and evaluation, provider credentialing, provider orientation and training, and provider monitoring.

III. DEFINITIONS:

1. **Disclosing Entity** means a Medicaid provider (other than an individual practioner or group of practitioners), or a fiscal agent.
2. **Fiscal Agent** means a contractor that processes or pays vendor claims on behalf of the Disclosing Entity.
3. **Family Members** for the purposes of this procedure include spouse, parent, child or sibling.
4. **Managing Employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

IV. PROCEDURE:

A. Credentialing Individual Practitioners

1. The credentialing procedures of CWN apply to individual practitioners, employed or under contract, in the provider network consisting of:
    a. Physicians (M.D. or D.O.)
    b. Physician Assistants
    c. Nurse Practitioners
    d. Psychologists
    e. Licensed Bachelor Social Workers, Licensed Master's Social Workers, Limited License Social Workers, or Registered Social Work Technicians
    f. Licensed Professional Counselors
    g. Registered Nurses, or Licensed Practical Nurses
    h. Occupational Therapists or Occupational Therapy Assistants
    i. Physical Therapists or Physical Therapy Assistants
    j. Speech Pathologists
    k. Board Certified Behavioral Analysts
2. The CWN credentialing and re-credentialing processes do not discriminate against a provider solely on the basis of license, registration or certification; or against providers who serve high-risk populations or who specialize in the treatment of conditions that require costly treatment.
3. Providers excluded from participating under either Medicare or Medicaid will not be considered for employment or contracting. The Sanctioned Provider Listing found at the websites http://exclusions.oig.hhs.gov and at www.michigan.gov/mdch will be used to determine provider status under these programs.
4. The Department of Customer and Provider Services (CAPS) will maintain an individual file for each credentialed provider which will include:
    a. The initial credentialing and all subsequent re-credentialing applications and supporting documentation
    b. Information gained from primary source verification
    c. Any other pertinent information used in determining whether or not a provider met the credentialing standards.

B. Initial Credentialing
   1. Providers shall complete a written application attesting to the following:
      a. Lack of present illegal drug use
      b. Any history of loss of license and/or felony convictions
      c. Any history of loss or limitation of privileges or disciplinary action
      d. Attestation by the provider of the correctness and completeness of the application.
   2. CWN will perform background checks, which may include, but are not ~~be~~ limited to~~,~~ : criminal checks, verification of licensure, Medicaid/Medicare sanction listing, and sex offender tracking. Once the background checks have been performed and satisfactory results are obtained, CWN will then continue with the approval process.
   3. The Director of CAPS will review a provider's resume or work history.
   4. There will be verification from primary sources of:
      a. Licensure or certification
      b. Board Certification, if applicable, or highest level of credentials obtained, or completion of any required internships, residency programs or other post-graduate training.
      c. Documentation of graduation.
      d. National Practitioner Databank (NPDB)/ Healthcare Integrity and Protection Databank (HIPDB) query. In lieu of NPDB/HIPDB query, all of the following will be verified:
         i. A five year history of professional liability claims resulting in a judgment or settlement;
         ii. Disciplinary status with regulatory Board or Agency
         iii. Medicare/Medicaid sanctions
      e. If the provider is a physician, then the physician profile information obtained from the American Medical Association (AMA) may be used to satisfy the primary source requirements of a, b, and c above.
   5. The Director of CAPS will review the information obtained and determine whether to approve credentials.
   6. Providers will be approved to provide those services that are consistent with their professional licensure and within their scope of practice as defined by state licensure.
   7. CWN authorizes services with fully credentials providers and does not grant temporary or provisional credentials.

C. Re-Credentialing
   Licensed, registered, or certified providers will be re-credentialed every two years, to include:
   1. An update of information obtained during the initial credentialing process.
   2. A review of Medicare/Medicaid sanctions.
   3. Primary source verification of license, registration, or certification.
   4. Review of grievances, complaints, and appeals information.
   5. Review of quality concerns as evidenced by QI findings or other sources of information on service quality.

D. Organizational Providers
   1. At the time of initial application, providers shall submit an application for Northern Michigan Regional Entity (NMRE) network participation, a signed authorization to perform a background check, and a signed contract. The background checks may include, but not be limited to, criminal checks, verification of licensure, Medicaid/Medicare sanction listing, and sex-offender tracking.

2. Once the background checks have been performed and satisfactory results obtained then CWN will continue with the contract approval process.
3. CWN will perform background checks initially and every two years to assure that the licensure to operate is current and that the provider has not been excluded from Medicaid or Medicare participation.

E. Disclosure of Ownership
1. CWN/NMRE shall comply with all requirements to obtain, maintain, disclose and furnish required information about ownership and control interests, business transactions, and criminal convictions.
2. CWN/NMRE shall assure that all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment, or services are also in compliance with federal and State requirements.
   CWN/NMRE will require disclosure statements for any contractor who receives $25,000 or more per year. CWN/NMRE requires each applicable contractor to identify their "managing employee(s)" in policy or procedure.
   a. CWN/NMRE defines their managing employees as: CEO and CFO.
   b. CWN/NMRE Board Members will also be required to submit disclosure statement.
3. Disclosure statement for individuals and/or entities with 5% or more direct and/or indirect ownership will include the following required information:
   a. Name and address of any person (individual or corporation) with an ownership or controlling interest in the disclosing entity. The address for corporate entities must include primary business address, every business location and PO Box location.
   b. Date of birth and social security number of each person with an ownership or controlling interest in the disclosing entity.
   c. In the case of a corporation, other tax identification number for an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent or more interest.
   d. Whether the person (individual or corporation) with an ownership or controlling interest in the disclosing entity is related to another person with an ownership or controlling interest in the disclosing entity, as a spouse, parent, child, or sibling, or whether the person (individual or corporation) with an ownership or controlling interest in any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or controlling interest as a spouse, parent, child, or sibling.
   e. The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or controlling interest.
   f. The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity.
   g. The identity of any individual who has an ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicaid, Medicare, or Title XX services program since the inception of those programs.
4. Disclosure statement for entities without ownership (e.g. PIHP & CMHSPs) will include the following required information:
   a. Name and address of the disclosing entity. The address must include primary business address, every business location, and P.O. Box location.
   b. Other tax identification number of the disclosing entity, if applicable.

   c. The name, address, date of birth, and Social Security number of all managing employees and Board of Directors of the disclosing entity.
   d. Disclosure of ownership or controlling interest in any other provider entity, subcontractor, or wholly owned supplier.
   e. Disclosure of criminal convictions, sanctions, exclusions, debarment and termination.

5. CWN/NMRE has a process to obtain disclosure information from its providers/contractors at any of the following times:
   a. When the provider submits a provider application;
   b. Upon execution of the provider agreement;
   c. During re-credentialing or re-contracting.
   d. Within 35 days of any change in ownership of a disclosing agency.
6. Monitoring of Provider Networks: CWN/NMRE will conduct search of all required databases at time of hire or contract and monthly thereafter for as long as the individual or entity is employed or under contract. The database searches will also be performed monthly on all disclosing entities and on any individuals with ownership or control interest identified on the disclosure form. Network Providers will communicate all database search matches to NMRE within three (3) business days of discovery. Network Providers shall demonstrate evidence of monthly searches and findings, upon request, and at least annually as part of the annual performance and compliance review. NMRE ensures all contractors have a process for obtaining attestation of criminal convictions and full ~~disclosers~~ disclosures (identified in 42CFR Part 455 Subpart B) from managing employees, board of directors, individuals with beneficial ownership, and individuals with an employment, consulting or other arrangement with the contractor or subcontractor. NMRE will monitor for compliance at least annually.
7. Reporting Criminal Convictions: CWN will notify NMRE within three business days when disclosures are made by subcontractors with regard to those offenses as detailed in sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. NMRE will notify the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Program Development, Consultation and Contracts of any applicable disclosures within three (3) business days.
8. Contract Language:
   CWN/NMRE requires contractors, through written agreements, to have processes for obtaining attestation of criminal convictions and full disclosure of ownership statements identified in 42 CFR Part 455 Subpart B. Contractors must also have procedures to report to CWN/NMRE any individuals with criminal convictions described under 1128 (a) and 1128 (b)(1)(2) or (3) of the Social Security Act, or individuals that have had civil monetary penalties or assessments imposed under section 1129 A of the Act.
9. Reporting Criminal Convictions -Contract providers will notify NMRE within three (3) business days when disclosures are made by subcontractors with regard to those offenses as detailed in sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. NMRE will notify the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Program Development, Consultation and Contracts of any applicable disclosures within three (3) business days.
10. Failure to fully complete the disclosure form as required within thirty five (35) days of request or the submission of false or misleading information to

CWN/NMRE will be subject to contractual sanctions up to and including immediate suspension of funding and termination of the contractual agreement.

11. (Exhibit attached – Disclosure Statement forms)

F. Adverse Credentialing Decisions
An individual practitioner or organizational provider that is denied credentialing or re-credentialing by CWN will be informed of the reasons for the adverse decision on writing by the Director of CAPS.

G. Appeal Process
In the event that a credentialing or re-credentialing application is denied or a provider is suspended or terminated for any reason other than need, the provider may appeal the decision by submitting a letter of appeal to the Executive Director of CWN within ten (10) business days of the date of the determination notice. The letter shall state the basis for the appeal and shall include any supporting documentation. All appeals will be reviewed and a decision made within fourteen (14) business days of receipt of the appeal letter. The decision of the Executive Director of CWN shall be final and binding. This appeal process shall apply to providers employed and/or directly contracted with CWN.

H. Reporting
The Director of Customer and Provider Services shall report any conduct by a member of the CWN provider network that results in the suspension or termination from the provider network to NMRE who will, in turn, report the conduct to the appropriate authorities and any other federal and State entities as specified in the Medicaid Managed Specialty Supports and Services Contract.

IV. DISCUSSION OF INTENT:

The intent of this procedure is to establish guidelines for credentialing and re-credentialing individuals and organizational providers directly or contractually employed by CWN.

Authority and Related Directives Trace	
Federal	42CFR 438.214; 42CFR 438.12; 42CFR 455, Subpart B; Social Security Act, Sections 1128(a) & (b)(1) (2) or (3)
State	MDHHS/PIHP Medicaid Managed Specialty Supports and Service Concurrent 1915(b)/(c) Waiver Program Contract, Sections 34.0 and Contract Attachment P.7.1.1; State of Michigan Medicaid Provider Manual, Chapter 2 Michigan Medicaid Provider Manual -General information for Providers; Section 2 Provider Enrollment, 2.1 Provider Ownership and Control Disclosures
NMRE	NMRE Procedure 05-02-002
County	Interlocal Agreement of December 1992 Section IX(j)
CARF	CARF 2016 Behavioral Health Section 1.I.
Other	CWN Board By-Laws, Section 7.E.

CMHSP

Disclosure of Ownership, Controlling Interest and Management Statement

CMHSPs must comply with federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 CFR §455.104–106. CMHSPs are required to collect disclosure of ownership, controlling interest and management information from providers that participate in the Medicaid and/or the Children's Health Insurance Program (CHIP) managed care network pursuant to a Medicaid and/or CHIP State Contract with the State Agency and the federal regulations set forth in 42 CFR Part §455. Required information includes: 1) the identity of all owners and others with a controlling interest of 5% or greater; 2) certain business transactions as described in 42 CFR §455.105; 3) the identity of managers and others in a position of influence or authority; and 4) criminal conviction information for the provider, owners and managers. The information required includes, but it is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).

Completion and submission of a Disclosure Statement is a condition of participation in the Medicaid and/or CHIP managed care network and is a contractual obligation with Centra Wellness Network (CMHSP) for services to members under Medicaid and CHIP benefit plans. Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider contract, or termination of existing provider contracts.

This Statement should be submitted with the initial contract and updated every three (3) years or at the renewal of the contract and at any time there is a revision to the information, change in ownership, or upon a request for updated information. A Statement must be provided within 35 days of a request for this information. Physician and health care professional members of a group practice that are credentialed or enrolled into the Medicaid or CHIP managed care program by Centra Wellness Network or by a delegate of Centra Wellness Network must submit a signed Individual Provider Statement attesting to the requirements under these regulations at the time of credentialing, enrollment, or contracting, if requested by Centra Wellness Network or by a delegate of Centra Wellness Network. ***Any members of a group practice that have an ownership or controlling interest in the Provider Entity identified below, or is related to another owner of the Provider Entity, must submit a signed Individual Provider Statement.***

Detailed instructions and a glossary for capitalized terms can be found at the end of this form. If attachments are included, please indicate to which section those attachments refer.

Please fill out the entire section. Every field must be complete. If fields are left blank, the form will not be processed and will be returned for corrections/completeness. If the form is unreadable due to illegible handwriting, the form will not be processed.

As applicable, if Provider Entity is a medical group or facility, attach a roster of individual providers covered under this Statement. Please include provider name, address, date of birth, and social security number.

I. Contracted Provider Entity Information

Type of disclosing entity *(choose appropriate category)*:
___Individual Contracted Practitioner
___Individual Member of a Medical Group
___Sole Proprietor
___Partnership
___Non-Profit
_X_ Corporation
___Limited Liability Corporation (LLC)
___Government/Public Entity
___Other:_____

If affiliated with a Group, do you have a Private Practice as well? **Yes** ___ **No** ___

Name of Person Completing the Form: John Jones

Title: Director of Operations

Phone Number: 989-234-3333

Fax: 989-234-1234

Email: JohnJones@michhealth.org

Legal Name (**"Provider Entity"**): Michigan Health Care, Inc.

DBA Name (if different from Provider Entity Legal Name):

Complete Address (must include at least one street address; corporations must include the primary business address *and* **every** business location **and P.O. Box address**):

Street	City	State	ZipCode
22227 Long Horn Dr	San Antonio	TX	78202

Additional Addresses (list **all** Practice locations and P.O. Box addresses – attach a separate sheet if necessary):
2233 Greenhaven Way, Lansing, MI, 48906; 100 Hampton Blvd, Lansing, MI, 48906
P.O. Box 1234, Lansing, MI, 48901; P.O. Box 12, Grand Rapids, MI, 49501

**Federal Tax ID/SSN #:	*Medicaid ID #:	*National Provider ID (NPI) #:	*CAQH #:
37-123456	681234567	1691234567	6PAB1

These fields cannot be left blank; "N/A" non-applicable and "applied for" are acceptable responses.
****Individual providers please use social security number; field cannot be left blank: "N/A" non-applicable and "applied for" are acceptable responses.***

Disclosure of Ownership, Controlling Interest and Management Statement

II. Provider Entity Ownership Information

Are there any individuals or organizations/corporations with a Direct or Indirect Ownership or Controlling Interest of 5% or more in the Provider Entity? **Yes** X **No** ____

If Yes, list the name, title, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership or Controlling Interest in the Provider Entity of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, **every business location and P.O. Box address** of each organization, corporation, or entity having an Ownership or Controlling Interest of 5% or greater. (42 CFR §455.104) ***Attach additional sheets as necessary.***

Name of Owner	Title	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	** SSN (individual) and/or TIN (organization) *List both as applicable*	% Interest
Fred Blarney	Brd Chair	08/07/1962	1122 Green Rd, Gwinn, MI, 49841	123-45-6789	20%
(Michigan Health Care Inc. is a fictitious Non-Profit Hospital. Fred is the Board Chair of a 5 person Board of Directors... All 5 Board members would be listed here if they have a "controlling interest" (see definition) and, because there are 5 Board members (and no other owners), each Board member would list a 20% Interest in the Health Care Provider Entity.					

*** SSN and TIN required under §455.104; see Sect 4313 of Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No. 22*

III. Ownership in Other Providers & Entities

Do any of the **owners** (not including parties with only a control interest) *identified in* ***Section II*** have an Ownership or Controlling Interest in *any other provider or entity* that would qualify as a **disclosing** entity? **Yes** ____ **No** X

If Yes, list the name of **the other disclosing entity** in which the **Owner** identified in **Section II** also has an Ownership or Controlling Interest. (42 CFR §455.104(b)(3)) ***Attach additional sheets as necessary. See glossary for definition.***

Name of Owner from Section II	Name of *Other Disclosing Entity*	% Interest
(This section is for "Owners" of the Provider Entity ONLY. If an Owner of the Provider Entity had at least 5% ownership in one or more additional 'Disclosing Entity(s)', then that information would go here.)		

IV. Subcontractor Ownership

Does the Provider Entity have an ownership or controlling interest of 5% or more in any subcontractor? **Yes** X **No** ___ **(if Yes,** list the information below; if No, go on to **Section V)**

If Yes to the previous question, does any other individual or organization also have an ownership or controlling interest in the same subcontractor? **Yes** X **No** ___ **(if Yes,** list the information below; if No, go on to **Section V)**

List the name and percent of ownership for any Subcontractor, along with the name and percent of ownership of each individual or organization (*identified in* ***Section II*** or otherwise), and TIN if organization, with an Ownership or Controlling Interest in that Subcontractor. (42 CFR §455.104(b)(1)(iii)) ***Attach additional sheets as necessary.***

Legal Name of Subcontractor	Name of Owner from Section II or Other Owner *(if applicable)*	Tax ID# *(if Organization)*	% Interest
Psychiatry Services of MI	Michigan Health Care, Inc.	37-123456	33%
Psychiatry Services of MI	Jason Blarney	N/A	27%

(This section is probably one of the most complex parts of the regulation as it deals with relationships among parties at two different levels. On the surface, this information may not seem relevant when enrolling providers. However, in this 'Subcontractor Ownership' scenario, Fred Blarney (identified in ***Section II*** *above) is a Board Member of (with a 20% Controlling Interest in) Michigan Health Care, Inc which owns 33% of Psychiatry Services of MI. Jason Blarney (in* ***Section IV*** *above), who has 27% ownership in Psychiatry Services of MI, represents "any other individual or organization with an ownership or controlling interest in the same subcontractor". In* ***Section V,*** *you will see why this information is imperative as you will find out that Jason Blarney is Fred Blarney's son. Relationship information can become useful in an investigation where there may be collusion among family members of different organizations which are engaged in fraudulent or abusive activities.)*

Disclosure of Ownership, Controlling Interest and Management Statement

V. Familial Relationships of All Owners

Are any of the individuals identified in **Sections II or IV** related to each other? **Yes** X **No** ____

If Yes, list the individuals identified and the relationship to each other (e.g., spouse, domestic partner, sibling, parent, child) (42 CFR §455.104(b)(2)) ***Attach additional sheets as necessary.***

Name of Owner 1	Name of Owner 2	Relationship
Fred Blarney	Jason Blarney	Father / Son

Disclosure of Ownership, Controlling Interest and Management Statement

VI. Criminal Convictions, Sanctions, Exclusions, Debarment, and Terminations*

1. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity, ever been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or had civil money penalties or assessments imposed under section 1128A of the Act since the inception of those programs? (See 42 CFR §455.106) ___**Yes** _X_**No**

If Yes, list those persons and the required information below. ***Attach additional sheets as necessary.***

Name N/A		
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**	**State of Conviction**
Complete Address (Street/City/State/Zip)		
Matter of the Offense		
Date of Conviction(mm/dd/yyyy)	**Date of Reinstatement(mm/dd/yyyy)**	

2. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **sanctioned, excluded or debarred** from Medicaid, Medicare, CHIP or a Title XX program since the inception of those programs? (See 42 CFR §455.436) ___**Yes** _X_**No**

If Yes, list those persons and the required information below. ***Attach additional sheets as necessary.***

Name N/A		
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**	
Complete Address (Street/City/State/Zip)		
Reason for Sanction, Exclusion or Debarment		
Date(s) of Sanctions, Exclusions or Debarments (mm/dd/yyyy)	**Date of Reinstatement (mm/dd/yyyy)**	**List all States where currently excluded:**

3. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program since January 1, 2011? (See 42 CFR §455.416(c)) ___**Yes** _X_**No**

If Yes, list those persons and the required information below. ***Attach additional sheets as necessary.***

Name N/A			
DOB (mm/dd/yyyy)	**SSN(individual) or TIN (entity)**		
Complete Address (Street/City/State/Zip)			
Reason for Termination			
Date of Termination (mm/dd/yyyy)	**State that originated Termination**	**Date of Reinstatement (mm/dd/yyyy)**	**Terminated from Medicare?** Yes_____ No_____

**At any time during the Contract period, it is the responsibility of the Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (See Fed. Register, Vol. 44, No. 138)*

Disclosure of Ownership, Controlling Interest and Management Statement

VII. Business Transaction Information**

1. Business Transactions - Subcontractors: Has the Provider Entity had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period? _X_ **Yes** ___ **No**

If Yes, list the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) ***Attach additional sheets as necessary.***

Name of **Subcontractor** (see footnote at bottom of page) *Information will be provided within 35 days of request*		Subcontractor's SSN (individual) or TIN (entity):	
Subcontractor's Street Address	City	State	ZIP
Name of Subcontractor's Owner	Subcontractor's Owner's SSN/TIN		
Subcontractor's Owner's Street Address	City	State	ZIP

2. Significant Business Transactions – Wholly Owned Suppliers: Has the Provider Entity had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period?
___ **Yes** _X_ **No**

If Yes, list the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (42 CFR §455.105(b)(2))
Attach additional sheets as necessary. See Glossary for definition.

Name of **Supplier** (see footnote at bottom of page) *N/A*		Supplier's SSN (individual) or TIN (entity)	
Supplier's Street Address	City	State	ZIP

3. Significant Business Transactions – Subcontractors: Has the Provider Entity had any Significant Business Transactions with a Subcontractor exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? _X_ **Yes** ___ **No**

If Yes, list the information for Subcontractor with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (42 CFR §455.105(b)(2))
Attach additional sheets as necessary. See Glossary for definition.

Name of **Subcontractor** (see footnote at bottom of page) *Information will be provided within 35 days of request*		Subcontractor's SSN (individual) or TIN (entity)	
Subcontractor's Street Address	City	State	ZIP
Name of Subcontractor's Owner	Subcontractor's Owner's SSN/TIN		
Subcontractor's Owner's Street Address	City	State	ZIP

This information must be provided and/or updated within 35 days of a request. Medicaid payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received. (42 CFR §455.105)

*(The information in **Section VII** does not need to be completed at the time of this request. However, you must have this information readily available to submit within 35 days of a request from either the Secretary of the Department of Health and Human Services or by Northern Michigan Regional Entity (NMRE).)*

Disclosure of Ownership, Controlling Interest and Management Statement

VIII. Management & Control

1. Managing Employees: Does the Provider Entity have any Managing Employees? ___Yes ___No

If Yes, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of Provider Entity (general manager, business manager, administrator, director, or other individual), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104) ***Attach additional sheets as necessary.***

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN	Title
Dr Dennis Shrug	09/27/1952	123 Jones Dr, Lansing, MI, 48906	112-80-4444	Medical Director
Ron Wriggle	12/14/1971	6543 Way Rd, Lansing, MI, 48906	383-83-8383	CEO
Steven Stanley	11/01/1963	78 Johnson Blvd, Lansing, MI, 48906	123-45-6789	CFO

2. Agents: Does the Provider Entity have any Agents? ___Yes _X_ No

If Yes, list all Agents that have been delegated the authority to obligate or act on behalf of Provider Entity, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104) ***Attach additional sheets as necessary.***

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN
N/A			

3. Board of Directors: Does the Provider Entity have a Board of Directors? _X_ Yes ___No

If Yes, list each member of the Board of Directors or Governing Board for corporations, including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104) ***Attach additional sheets as necessary.***

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN	Title
Fred Blarney	08/07/1962	1122 Green Rd, Gwinn, MI, 49841	123-45-6789	Board Chair
Steve Stone	01/13/1979	374 Wayback Way, Petoskey, MI, 49770	987-65-4321	Board member
Please see attached (This is where you would attach additional sheets to include all Board members. Note, SSN is MANDATORY)				

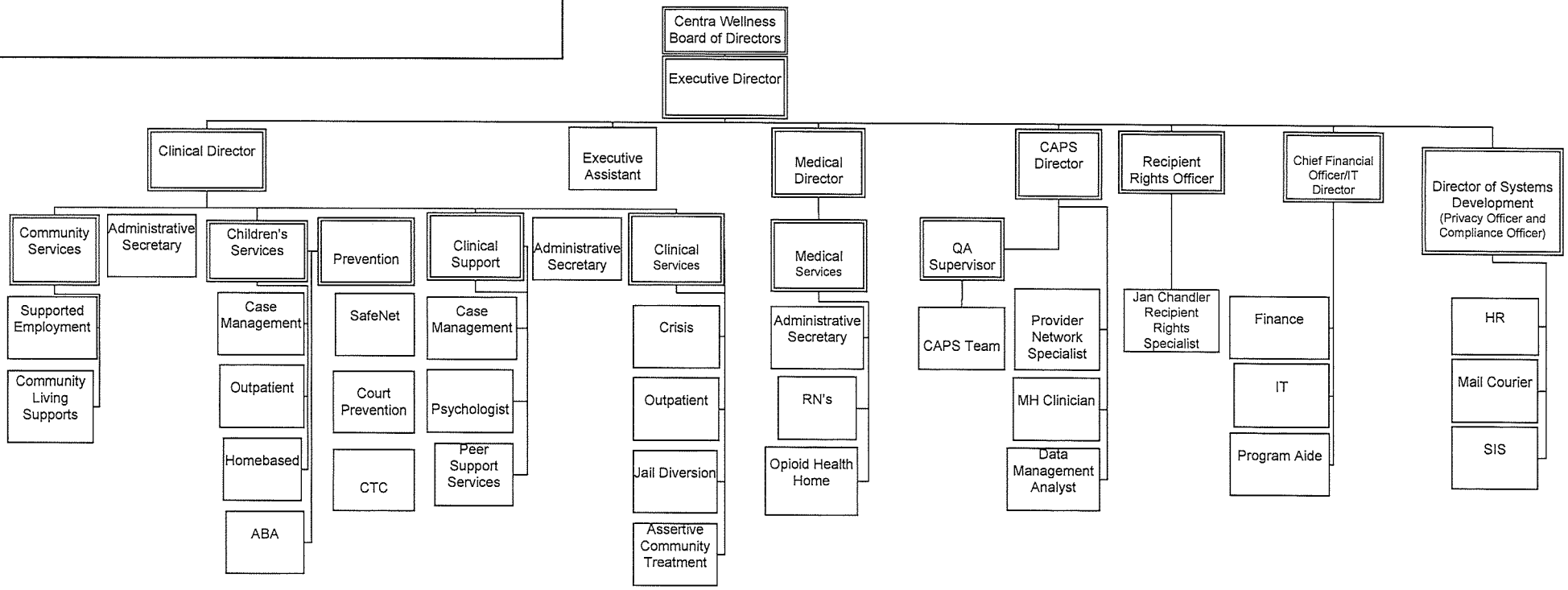
Through signature below, I hereby certify that any employees or contractors providing services pursuant to a contract with Centra Wellness Network are screened with the applicable background check including, but not limited to, verification against the OIG's List of Excluded Individuals & Entities (https://oig.hhs.gov/exclusions/index.asp)and the System for Award Management (SAM) www.sam.gov and any applicable state, federal or other governmental exclusion or sanction databases and that the information provided herein is true, accurate and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of a claim and/or termination of the contract.

Signature _____ Title (indicate if authorized Agent) _____

Full Name (please print) _____ Date _____

Telephone _____ FAX _____ Email _____

CWN Provic Manual
Appendix IX



Centra Wellness
NETWORK

CENTRA WELLNESS NETWORK ORGANIZATION CHART

2019

CWN Provider Manual
Appendix X

Centra Wellness
NETWORK

CASPER SYSTEM USER ACCESS REQUEST

Type of Change *(✓ one)*	☐ New	☐ Change	☐ Inactive
Date of Request		Effective Date of Change	
First & Last Name of User			
User Phone Number			
User E-mail Address			
Title/Role			
Agency			
Site(s)			
Supervisor	Name		
	Phone	E-mail	
Compliance Officer Contact Information	Name		
	Phone	E-mail	
Permission Type	Billing Function ☐ Y ☐ N	Authorization Review ☐ Y ☐ N	EOB View ☐ Y ☐ N
Will you be submitting an 837/835 EDI Transaction?	☐ Y ☐ N		

The intent of this request form is to monitor who is accessing client information which is protected under HIPAA laws. By utilizing our CASPER System, you agree to notify Centra Wellness Network immediately upon termination of an employee with access to this system.

Representative Signature _____ Date _____

Centra Wellness NETWORK

Provider User Manual

CASPER

WEBSITE

www.pcesecure.com/casper

TABLE OF CONTENTS

CASPER System Support

CHelp@centrawellness.org

(231) 882-2155

Typical Response Time: Monday-Friday between 8 AM-5 PM

For reporting issues, please provide the following information, if applicable:

- User Name
- Client ID
- Screen (upper right corner)
- Section
- Steps you took and what happened
- Screen shots are helpful as well

All authorization/contract information is still handled by our CAPS department. Our IT department handles tech support items and those should go through the CASPER Help e-mail.

Also, we require that any confidential information (client identifying or confidential text or imagines in the e-mail) be sent to us securely. We use a system called Zix for this. You must set up an account in order to view/send attachments. Below is the link to the instructions and information about Zix:

http://www.uapguide.com/centra-wellness-network/customer/introduction

This is the link to set-up a Zix account:

https://web1.zixmail.net/s/login?b=centrawellness

Contract providers must provide a signed CASPER system user access request prior to utilization. Once this has been submitted, you will be notified of the login information.

We look forward to working with you!

Sincerely,

CASPER Help

ENTER NEW CLAIMS

1 **Claim Submission (AP)** Left Side of Screen

2 (1) Enter New Claims
View authorized service and enter claims. +myPage

3 Case #: Last Name:
Authorization Number:
☐ Check this box to show all authorizations
If not checked, only authorizations that expired less than a year ago will be shown.
SEARCH
Search for Authorization

4 View Authorization
Enter HCFA-1500
Click on Enter HCFA-1500

5

21	A		B	C	D			E	F	G	H	I	J	K
	Dates Of Service				Procedures/ Service									
	From	To	POS	TOS	CPT/HCPCS	Mod(s)		Diagnosis	Charges	Units	Family Plan	EMG	COB	Local Use
+ Copy					90801			1						
+ Copy					H2011			1						
+ Copy														

Enter Claim Information

6 SAVE Click SAVE

7 Enter more claims if applicable

8 **Claim Submission (AP)** Left Side of Screen

9 Step (2) - Review and Send Batch of Entered Claims to CMH for Payment
View a list of claim batches that have been entered. You can review the claims in each batch and send batches to CMH to request payments.

10 View Claims in Batch
Adjudication Report
Submit Claims to CMH
View Batch Info

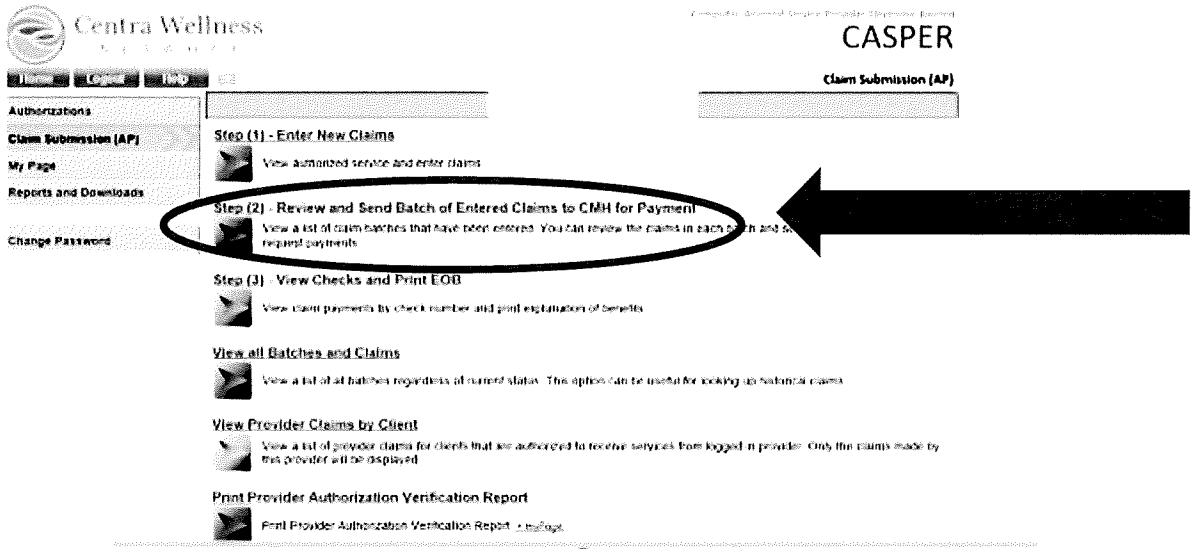
11 Click on the Messages Icon (Top of Screen)

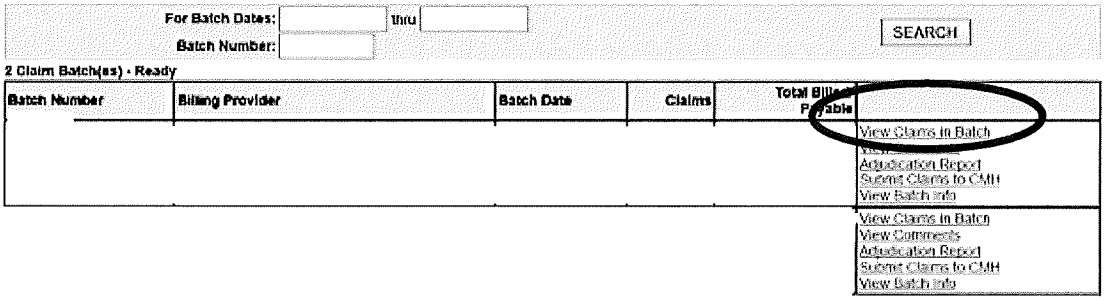
12 Message/Report
Adjudication Report for Batch Number xxxxxx (PDF)
Click on the Report Link and view the report

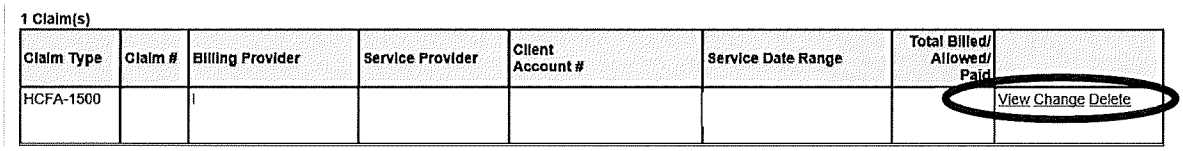
13 View Claims in Batch
Adjudication Report
Submit Claims to CMH
View Batch Info

14 View Claims in Batch
Adjudication Report
Submit Claims to CMH
View Batch Info

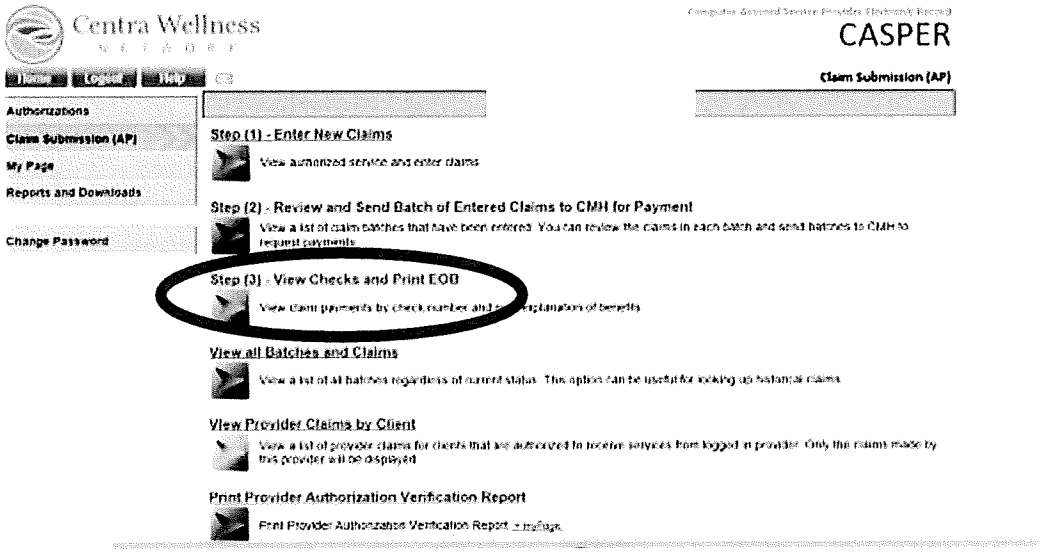
VIEW/CORRECT/DELETE CLAIMS IN BATCH

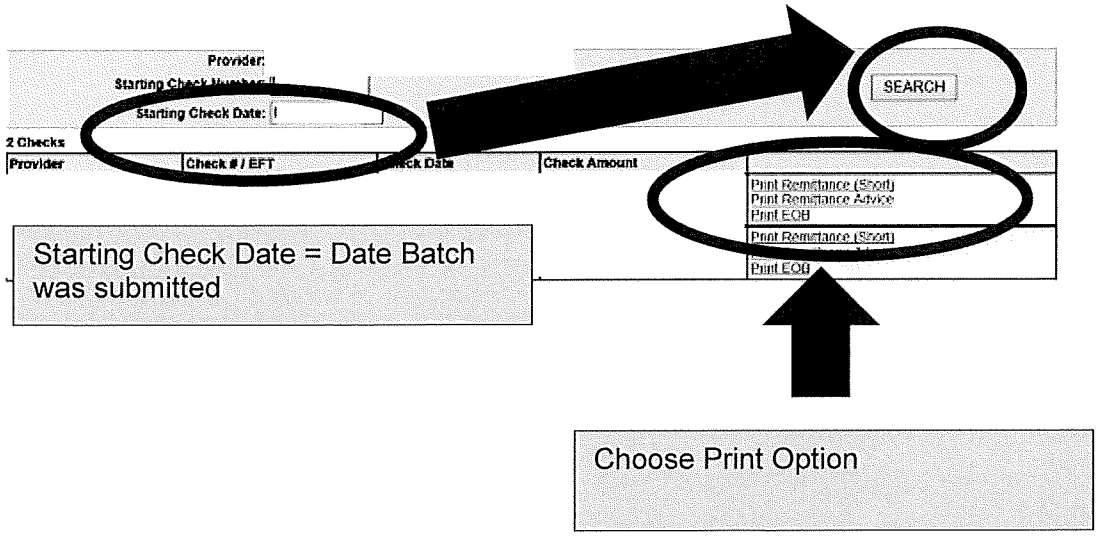




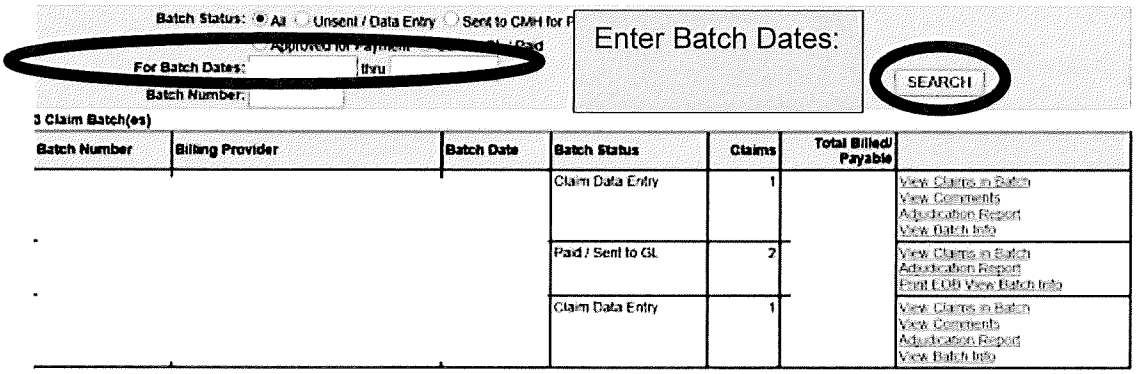


VIEW CHECKS AND PRINT EOB





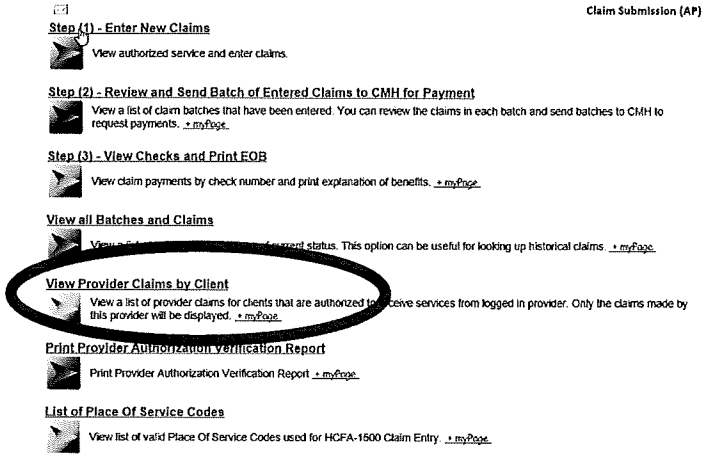
VIEW ALL BATCHES AND CLAIMS

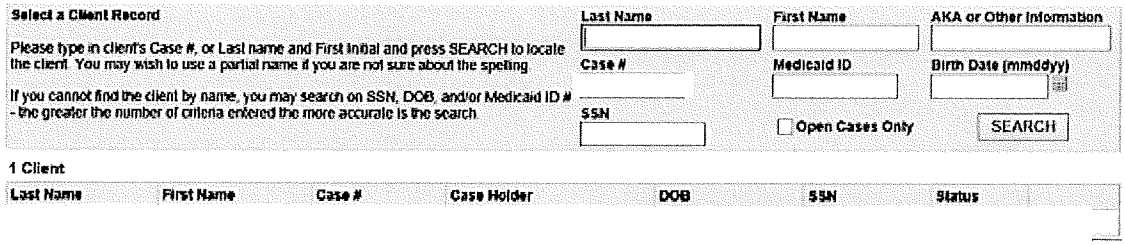


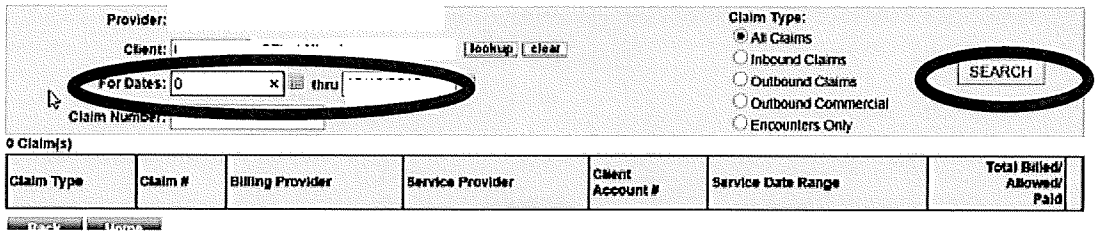
Adjudicated - Pending Approval

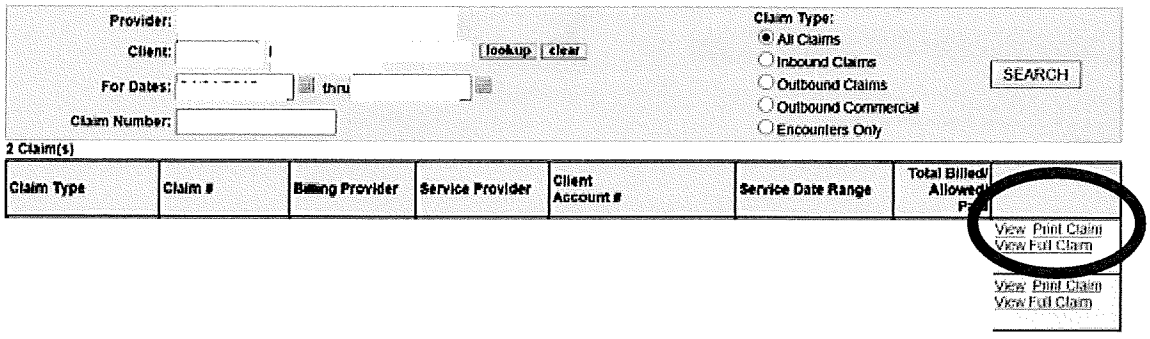
Batch Status =
Claim Data Entry = has not been submitted to CWN
Paid/Sent to GL = Payment has been made
Adjudicated – Pending Approval – Claim is being processed by CWN

VIEW PROVIDER CLAIMS BY CLIENT









PRINT PROVIDER AUTHORIZATION VERIFICATION REPORT