CRSP/Outpatient Provider Meeting Q&A

Friday, March 15, 2024

Virtual Meeting

10:00 am –11:00 am

1. We constantly need backdated AUTHs because the SC does not enter a new auth into MHWin in a timely manner. We have a valid IPOS, so we continue to care and make sure there is not a lapse in medically necessary services.
   A. If you have been trying to reach the SC/CRSP and have been unable to obtain an updated authorization prior to the lapse of the previous authorization, please email me at lwayna@dwihn.org with the information of whom you've tried to contact and when and I will follow up.

2. Are there any updates regarding EVV?
   A. MDHHS has updated the implementation plan for EVV across the seven impacted program areas, reflecting a phased-in approach to implementation. This updated phased-in implementation is scheduled as follows:

      Phase 1 – Medicaid FFS Home Health is slated to go live on April 1, 2024
      Phase 2 – Home Help is slated to go live on July 1, 2024
      Phase 3 – Behavioral Health, MI Health Link, MI Choice, Medicaid Managed Care Home Health, and Community Transition Services are slated to go live on September 3, 2024.
   B. The trainers for the state EVV are teaching that all claims and billing will go through the EVV. We currently enter claims into MHWIN due to our contract with DWIHN. We do not have a direct contract with Medicaid. Does this mean our contract with DWIHN will end and we will no longer use MHWIN? We are only an FMS and the information being given seems contradictory. You can reach out to me individually at gsanewsky@thearenw.org

3. What is the correct Fax number to send Spend Down Invoice letters?
   A. please send those inquiries to kmyles@dwihn.org

4. Is there a way to see what a member's spend-down amount is? MH WIN used to show this. It's very helpful for helping them monitor whether it's being met.
   A. Unfortunately, it's a hit-and-miss and at times it's not correct in MHWIN. We have asked the state several times to see if that data can be corrected. We are tracking all claim amounts on our end for those who have spend-down, typically we are setting $750 as the minimum threshold.

5. Can you send the spend down/redetermination process in a handout for providers? I'm not sure I collected the complete process. Thanks.
   A. Manny Singla will write it up and send it early next week

6. Our GF exception authorizations for H2014 and H2023 codes have been getting denied. Are these codes no longer allowed for GF?
   A. please email me at lwayna@dwihn.org and I will send you the General Fund Benefit Grid that went out in December.

7. Is DWIHN opening up more Initial RR classes? If we don't get our newly hired employees into this training within 30 days, we will get audit citations on that employee for the duration of their employment with us.
   A. At this time, the NHRRT classes will not be increased. This is because we continue to have almost half of the registered participants who are a no show for NHRRT. Although this percentage is improving, we request that Providers assure their staff to attend when scheduled to assist with this matter. Thanks.

8. Edward, we seem to have connection issues when we attempt to connect to RR training with new employees. The previous employee's name comes up when the link is submitted. Can we get a tutorial of some type? EAI Employment Resources.
   A. Good morning. Please contact the training department, and they will be able to assist you in getting the issues addressed.
   B. What is that number and contact person?
      A. it's orr.training@dwihn.org

9. What updates do you have for 837P
    A. That is basically your claims files that get submitted.

10. Will DWIHN be EVV compliant with HHA exchange in terms of claims? What will that process look like? will providers have to continue to submit claims via MHWIN?
    A. DWIHN will be EVV compliant by September 2024 which is the anticipated go live date for behavioral health services. The process has not been fully laid out & is still under development with ongoing meetings between MDHHS & HHAeXchange of which DWIHN is present.

11. Is there a new process for enrollment for CCBHC services? I'm not sure what we would need to send to access email for this.
    A. People can access CCBHC services a number of ways: 1) Directly at the CCBHC site, 2) through a typical Access Call Center screening as usual, or 3) via an email to Access Call Center with forms for situations where the person has entered services in a Crisis Screening/Crisis services situation or has entered services in a “CCBHC only” capacity, such as with third party insurance.

Detroit Wayne
Integrated Health Network
707 W. Milwaukee St.
Detroit, MI 48202-2943
Phone: (313) 833-2500
www.dwihn.org

FAX: (313) 833-2156
TDD: (800) 630-1044 RR/TDD: (888) 339-5588

Memorandum

Date: April 1, 2024
To: DWIHN Provider Network
From: Melissa Moody, VP of Clinical Operations- DWIHN
Re: Medicaid Redetermination and Deductible (spend down) Process

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Dear Provider:

There continue to be many questions surrounding Medicaid redeterminations and deductibles since the end of the Pandemic Emergency Order. This correspondence is being provided to clarify these processes.

Process for Members with upcoming Medicaid Redeterminations:

- Member receives letter of redetermination from MI Bridges
- Submit the documents to the local DHS office or using the new web application online - https://newmibridges.michigan.gov/s/isd-external-afb-screen?language=en_US
- Strongly recommend to use the online portal – https://newmibridges.michigan.gov/s/isd-external-afb-screen?language=en_US
- Check status of the application online for any missing documents
- If member meets minimum eligibility the first letter that gets issued is Plan 291 eligibility
- If member documentation is complete for full Medicaid benefits, then the second letter of full Medicaid is issued
    - If a member is missing any documents, then a second letter is not issued and the member is not on full Medicaid.
    - This can be best reviewed and responded to if the application is submitted online as you don't have to wait and can check and respond immediately using link above.
    - If you submit the application manually then there will be a letter after the initial Plan 291 letter with the list of documents missing to meet full Medicaid
    - Work with member/guardian to submit any additional documents missing.

Deductible (Spend Down) Management Process:

- If a member is on spend down and receives CLS services (or any other clinical services):
    - Submit claims as early as possible in first week of the month, or as early in the month as possible, and send an email to kmyles@dwihn.org and cc msingla@dwihn.org
    - We will use all of those claims to submit documentation for the member to the MDDHS office

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- If you already have a local MDDHS office staff that you are working with, and for some reason the process is not working, you can submit the issue with details to the same two email addressed above along with member details
- We will then contact you to resolve that specific issue.

If you have any questions, please contact Katrina Myles at kmyles@dwihn.org

Thank you.

Consumer Enrollment Form

(Complete this form to make a choice)

We are asking you to choose a Clinically Responsible Service Provider (CRSP) to coordinate services.

STEP 1: Please fill out the boxes below. If you need help, please call a **DWIHN Access Center Representative at 1-800-241-4949 or (TDD) 1-866-870-2599 for the Hearing Impaired.**

Your First Name: **(Please Print)** Middle Initial: Last Name:	
Street:	
City:	Zip Code:
Date of Birth:	Birth Gender (Sex) :_____Male ________Female
Home Phone Number: ( )	
Work Phone Number: ( )	E-mail:
Cellular Phone Number: ( )	
Social Security Number: ( )	
Do you have Medicaid?_____Yes, I have Medicaid ___No, I don't have Medicaid	
Your First Language is:____English____Arabic ___Chinese ___Italian ___Polish	
____Spanish	

STEP 2: QUESTIONS: Please answer the following questions before you make a choice.

- Do you understand how to make a choice? ___Yes ___No
- Has someone talked to you about making a choice? ___Yes ___No
- Do you want someone to talk to you about making a choice? ____Yes ___No

STEP 3: Look through your Customer Service Directory to select the CRSP of your choice.

If you need help finding a provider, call a **DWIHN Access Center Representative at 1-800-241-4949.**

Revised April 2021 TD

Choose One Clinically Responsible Service Provider	
Population Served: Adults, Children/Adolescents/Youth with I/DD, SMI & SED	
☐ All Well Being Services (AWBS)	☐ Northeast Integrated Health
☐ Arab Community Center for Economic and Social Services (ACCESS)	☐ Psygenics
☐ Development Centers, Inc.	☐ Team Wellness Center
☐ Neighborhood Services Organization (NSO) ***No SED Children***	☐ The Guidance Center
Population Served: Adults, Children/Adolescents/Youth with SMI & SED	
☐ Arab American and Chaldean Council (ACC)	☐ Hegira Health, Inc.
☐ Black Family Development, Inc.	☐ Lincoln Behavioral Services
☐ Community Care Services	☐ Ruth Ellis Center
☐ Community Network Services (CNS) Healthcare	☐ Southwest Counseling Solutions
Population Served: Adults, Children/Adolescents/Youth with I/DD	
☐ Community Living Services	☐ Macomb-Oakland Regional Center, Inc. (MORC)
☐ Goodwill Industries of Greater Detroit	☐ Wayne Center
Population Served: Adults Only with I/DD	
☐ JVS Human Services	☐ Services to Enhance Potential (STEP)
Population Served: Adults Only with SMI	
☐ Central City Integrated Health (CCIH)	
Population Served: Children/Adolescents/Youth with I/DD & SED	
☐ Starfish Family Services, Inc.	☐ The Children's Center
Population Served: Children/Adolescents/Youth with SED	
☐ Assured Family Services	

STEP 4: Your Signature. Please sign in the box below

Signature:	Date:
Please Print Name:	
Signature of the person helping you fill out the form:	

STEP 5: Please fill out the box below if you have a legal guardian or an appointed power of attorney. If you need help, call a **DWIHN Access Center Representative at: 1-800-241-4949 or (TDD) 1-866-870-2599 for the Hearing Impaired**.

Name:	
Address:	
Phone Number: ( )	E-mail:
Relationship:____Parent:____Family Member____Spouse____Other______Guardian_______	

STEP 6: Please mail your application back to the address below (currently no walk-ins are being accepted).

DWIHN Access Center
707 W. Milwaukee
Detroit, MI 48202

You will receive a confirmation letter of your enrollment in the mail.

(Caller / Staff) Name: Email:	Name of Provider / (CRSP): Phone #:
Date of Referral/Intake:	LOC: Emergent Urgent Routine
DWIHN Access Call Center Staff Processing Call - Name:	Today's Date:
DWIHN Assigned Member ID#:	Date provider notified of enrollment status:

DWIHN Access Call Center
CCBHC - Children & Adolescents Mental Health /SUD Checklist and Enrollment Form

1. **Individual Seeking Services - Demographic Information**

   Name: ____ **DOB:** __________________

   Phone: _________________________ **SS#:** _________________________

   Address: ____ **City:** __________________

   State: ___________________________ **Zip Code:** ________________ **County:**____________

   Email: ____

   ☐ **Check box if - Yes. Declared as "Homeless"**

2. **Emergency Contact Information:**

   Name: ____________________________ **Phone:** _________________________

3. **Legal Guardian (if applicable)**
   a. **Name:** __________________________ **Phone:** __________________________

4. **Does the person have insurance? _______ Yes. What Type?**

   ☐ **Medicaid: Name of QHP** __________________________

   ☐ **Commercial Insurance; What type** ____________________

   ☐ **No. Uninsured**

   ☐ **DHS; (Foster Child-Request proof that child is a Wayne County Ward)**

   ☐ **Other System Involvement (Substance Abuse, Juvenile Justice and/or Special School Services)**

   ____

5. Does the person have a DSM-V Diagnosis?

   ☐ **Yes. What is the code?** __________________________

   ☐ **No. Inform provider that person MUST have a Diagnosis.**

   ☐ **Suicidal or Homicidal Ideations? Plans?** _______________________________

6. Is the person **impaired** in his/her ability to perform age-appropriate life activities, including:

- ☐ **Personal hygeine**
- ☐ **Self direction**
- ☐ **Activities for daily living**
- ☐ **Learning and recreation**
- ☐ **Social transactions and interpersonal relationships**
- ☐ **History of current use of prescribed psychotropic medications.**
- ☐ **History or currently psychotropic medications compliance**
- ☐ **History or currently the above issues related to use of substances (recreational drugs / alcohol)**
- ☐ **Learning/Recreation-School attendance issues/educational issues**
- ☐ **Peer relationships**
- ☐ **Parental/Guardian relationships**
- ☐ **Legal problems**

DURATION

A.) Has the person's symptoms/dysfunctions lasted for at least six months in a 12-month period;
OR
B.) Based on the current conditions/diagnosis, there is a reasonable expectation that the symptoms/dysfunction will continue for more than six months?

Yes ___ No ___

PRIOR SERVICE UTILIZATION

7. Has the person had any of the following?

- ☐ **Four or more admissions to community inpatient unit/facility in a calendar year**
- ☐ **More than 30 days in a community inpatient in a calendar year**
- ☐ **More than 60 days state hospitalization in a calendar year**
- ☐ **More than 20 mental health visits in a calendar year (e.g. individual/group therapy)**
- ☐ **Current or history of contact with the criminal justice system (arrest, jail, incarceration, parole, probation)**
- ☐ **Family history of mental health concerns**
- ☐ **Family history of substance abuse**

(Question #5 - #7 is only an FYI question. The person does not have to have any of these checked to be eligible)

8. Does the person have any current/history of substance abuse?
(Question #8 does not determine if the person is eligible or not.)

- ☐ **Yes. What is the Diagnosis Code? ______________________________**
- ☐ **Drug of Choice? ____**
- ☐ **Age of first use ______ How long has the person been currently using? ____________**
- ☐ **Yes. Reported use in the last 30 days**
- ☐ **Reported history or current substance abuse treatment provider: _________________**

☐ **How many times has the person been in substance abuse treatement? _____________**

Comments / Notes (include reason for referral or enrollment):

(Caller / Staff) Name: Email:	Name of Provider (CRSP): Contact Phone #:
Date of Referral:	LOC: Emergent Urgent Routine
DWIHN Access Call Center Staff Processing Call - Name:	Today's Date:
Assigned DWIHN Member ID#	Date Provider notified of enrollment Status

DWIHN Access Call Center
CCBHC – Adult Mental Health / SUD Checklist and Enrollment Form

1. **Individual Seeking Services - Demographic Information**

   Name: ______________________________ **DOB:** ____________

   Phone: ________________ **SS#:** ________________

   Address: ________________________________ **City:** ____________

   State: _________________ **Zip Code:** __________ **County:**________

   Email: _______________________

   ☐ **Check box if - Yes. Declared as "Homeless"**

2. **Emergency Contact Information:**

   Name: __________________ **Phone:** ________________

3. **Legal Guardian (if applicable)**

   a. **Name:** _________________ **Phone:** _________________

4. Does the person have insurance? _______ If Yes, What Type?

   ☐ **Medicaid: Name of QHP** ______________ **Medicaid ID#** _______________

   ☐ **Medicare: What parts** __________________

   ☐ **Healthy Michigan: Name of QHP** _______________

   ☐ **MI Health Link: Name of ICO** _______________

   ☐ **Commercial Insurance; What type** _____________

   ☐ **No. Uninsured**

5. Does the person have a DSM-V Diagnosis?

   ☐ **Yes. What is the code?** __________________

   ☐ **No. Inform provider that person MUST have a Diagnosis.**

   ☐ **Suicidal or Homicidal Ideations?** _________ **if Yes, Plans?** ____________________

6. Is the person impaired in his/her ability to perform age-appropriate life activities, including:

   ☐ **Personal hygeine**

- [ ] **Self direction**
- [ ] **Activities for daily living**
- [ ] **Learning and recreation**
- [ ] **History of/current use of prescribed psychotropic medications**
- [ ] **History or currently psychotropic medications compliance**
- [ ] **History or currently the above issues related to use of substance**

If over 55 years of age, loss of functional capacity in any of the following:

- [ ] **Mobility**
- [ ] **Special senses**
- [ ] **Physical stamina to perform activities of daily living or ability to communicate**
- [ ] **Ability to meet immediate needs as the result of medical conditions requiring professional supervison**
- [ ] **Conditions resulting from long-term institutionalization**

DURATION

A.) Has the person's symptoms/dysfunctions lasted for at least six months in a 12-month period; OR
B.) Based on the current conditions/diagnosis, there is a reasonable expectation that the symptoms/dysfunction will continue for more than six months? Yes ___ or No ___

PRIOR SERVICE UTILIZATION

7. Has the person had any of the following?

- [ ] **Four or more admissions to community inpatient unit/facility in a calendar year**
- [ ] **More than 30 days in a community inpatient in a calendar year**
- [ ] **More than 60 days state hospitalization in a calendar year**
- [ ] **More than 20 mental health visits in a calendar year (e.g. individual/group therapy)**
- [ ] **Current or history of contact with the criminal justice system (arrest, jail, incarceration, parole, probation)**

8. Does the person have any current/history of substance abuse?
(Question #6 does not determine if the person is eligible for SUD services or not.)

- [ ] **Yes. What is the Diagnosis Code? ______________________________**
- [ ] **Drug of Choice? ____**
- [ ] **Age of first use ______ How long has the person been currently using? ____________**
- [ ] **Yes. Reported use in the last 30 days**
- [ ] **Reported history or current substance abuse treatment provider: ________________**
- [ ] **How many times has the person been in substance abuse treatement? _____________**

Comments/notes: