

Behavioral Health Operations Committee Closed Issues List

Log #	Date Received	Sender	Brief Description	Full Description	Date Sent to Assn/Dept	Agenda Date	Next Action	Action	Resolution	Closed Date
04-1	5/24/2004	Michelle Ward	Monthly release of seclusion and restraint logs to Ohio Legal Rights	Along with other providers across the state, Ohio Legal Rights has sent us several letters and made repeated phone calls demanding that we submit our seclusion and restraint logs to them on a monthly basis. OLRS wants all client identifying information kept intact. OLRS maintains they have statutory authority to access these logs. St. Vincent Family Center has not yet released these logs due to serious concerns about potential HIPAA violations. Providers across the entire state are struggling with this issue and our spending precious staff time and money looking for a solution.	05/25/04	6/11/2004	07/08/04	6/11/04 - A) Issue was tabled by the Committee as presented; implications of legal issues subject to litigation. B) Ohio Council will reframe as a new operational issue dealing with application of the Rule.	This issue is closed. The issue is a legal one which is the subject of a court action. The Ohio Council decided not to reframe the issue as an operational one.	07/08/04

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04-2	5/27/2004	Hubert Wirtz, CE	The Sum and Round requirement when submitting claims through MACSIS results in loss of revenue for providers and makes it extremely difficult to perform accurate reconciliations which negatively impacts the provider's ability to pass an audit.	The actual units of service provided are not the number of units billed in MACSIS. According to MACSIS Guidelines, all clients receiving behavioral health services funded in whole or in part with public funds administered through the boards must be enrolled in MACSIS. Providers have no way of getting reimbursed for the difference between the number of units actually provided and the number MACSIS paid for. This disconnect between number of service units provided and paid for makes reconciliation between what was submitted and the reimbursement reports (835 and RAs) extremely difficult. Without an accurate reconciliation, providers cannot expect to receive clean audits.	05/28/04	6/11/2004	07/08/04	06/11/04 - This issue will be turned over to a new MACSIS Operations Committee to be formed at the Behavioral Health Operations Committee on July 8th, 2004	Closed - After careful consideration of the analysis that was done concerning the proposals to change the rounding convention and acknowledging that the post - HIPAA sum and round convention did have a negative impact on provider revenues, the committee determined, based on constituent organizations review and feedback, that it would not be cost beneficial to the system to make the proposed changes. The committee is aware of several of the factors that are putting financial pressure on providers. Some of those factors are being addressed in other forums.	01/13/05
							09/02/04	07/08/04 - Sub-committee formed: Ohio Council - Kim Grimes (Nova Behavioral Health, Inc., Beverly Young (Marion Area Counseling Ctr.), Margaret Spurgeon (Ohio Council) OACBHA: Pat Coates (Heartland East), Barbara Miller (Montgomery ADAMH), Fonda Dawkins (OACBH) OACCA: Marcy Robbe (Children's Home of Cincinnati), Chris Cassidy (Berea Children's Home), Gary Stammmer (Buckeye Ranch) ODADAS: Doug Day, Jim Hughes ODMH: Angie Bergefurd, Racquel Graham, Joe Wiant		
								01/13/05		12/09/04 - The claims payment subcommittee reported back an analysis of several proposals involving changing in the rounding convention. The operations committee voted to table consideration of this issue until its next meeting on 01/13/05 to give to committee members an opportunity to confer with their membership about the implications of the analysis.
04-3	6/22/2004	Danielle Laverty	Delayed claim payments	We are experiencing delays in claim payments from Wayne County and Belmont County. It is taking up to three months for us to receive claim payments from these counties. These delays in claim payments are a detriment to our program as we are a non-profit organization. We receive consistent timely payments from other counties on a regular basis and would like to inquire about receiving the same timely payments from Wayne and Belmont Counties.	06/24/04	7/8/2004			Closed. Issue as presented was a local issue.	07/08/04

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04-4	7/19/2004	J. Wiant	Update MACSIS remittance advice reports to reflect data on the MACSIS 835 Health Care Claim/Payment Advice	<p>Several of the provider software vendors who participated in the MACSIS vendor conference calls during the HIPAA implementation recently reported that providers are reluctant to use the 835 files for posting remittance, because they are use to the MACSIS Diamond Reason Codes on the pre-HIPAA electronic remittance files (ERAs) and are less comfortable with the national standard claim adjustment reason codes on the 835. The reason codes are the codes used to describe why a claim is denied, withheld or paid a lesser rate.</p> <p>When MACSIS first went live on HIPAA EDI standards (July 2003), a sub-committee to the HIPAA EDI Committee crosswalked the MACSIS Diamond Reason Codes to the national standard codes and found this to be an arduous task due to the generic nature of the national codes. The community was also, at the time, focused on converting to the HIPAA EDI claim submission standard (837P). The national code set has since improved and there is now the time and energy to focus on 835 development.</p>	07/19/04	8/5/2004	09/02/04	Don Anderson will be taking to the Sub-committee 8/25/04.	12/09/04 - Recommendation: update MACSIS remittance advice reports effective July 1, 2005 was accepted.	12/09/04
04-5	7/29/2004	Chris Cassidy	There should be the ability to share information from MACSIS between Board and providers for billing purposes.	There is information in MACSIS that once we have the client's consent should be available to us for billing purposes. The AOD Board has never been willing to divulge information to providers	07/29/04	8/5/2004			Closed. Issue as presented was a local issue.	08/05/04

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04-6	1/7/2005	Hubert Wirtz, CE	In a resource scarce service environment characterized by increasing service demand, the issue of uncompensated and undercompensated service provision has become critical for maintaining provider capacity and solvency. An area of increasing concern involves services to Medicare eligible clients, and particularly to dually eligible clients for whom a provider must seek both Medicare and Medicaid reimbursement.	<p>The issue of services to Medicare eligible clients and particularly clients who are both Medicare and Medicaid eligible is both complex but also a good focal point for beginning to address the issue of uncompensated and undercompensated care. The behavioral health services covered by Medicare are very limited with providers generally getting less than fifty cents on the dollar for services (usually closer to 34-36 cents on the dollar). The good news is that CMS has clarified that aggregate payments that cover underpayments for provider costs does not violate federal law. The bad news is that in many areas of the state, this is not clearly understood or happening. While in theory providers have the option to decline assignment for Medicare eligibles, providers that serve Medicaid clients are required to accept assignment for Medicare clients. Most Ohio Council members serve Medicaid clients, many of whom are dually eligible for Medicare and many of whom are also often seriously mentally disable adults, one of the mental health system's priority populations.</p> <p>The issue becomes more complex for dually eligible Medicare-Medicaid clients. Medicare establishes an allowable payment amount for Medicare covered services that is well below the cost to the provider to deliver the service (remember also that for mental health services, Medicare pays 50% of the allowed charge, not the 80% for non-mental health services). Once Medicare reimburses the provider (usually in the 30-40 percent cost range), there is a crossover to Medicaid, which pays the client's deductible and copay amounts up to the Medicare established allowable amount (but is usually well below this in actual reimbursement). This process occurs outside of the normal MACSIS Medicaid claims payment process, although here again there is confusion and provider/system risk since some of</p>	01/07/05	1/13/2005	02/10/05 04/14/05 08/04/05	<p>1/13/05 - The Committee discussed this issue and indicated there needed to be clarification of the policies and regulations and a strategy developed to deal with the operational impact of those policies and regulations. A sub-committee will be convened by Don Anderson to work on this issue.</p> <p>2/10/05 - Sub-committee will meet on March 3, 2005.</p> <p>7/14/05 - Subcommittee will meet on August 4th, 2005.</p> <p>The issues related to coordination of benefits/third party liability will be revisited once the OAC Chapter 5101:3-1 rules related to these topics are amended by ODJFS. ODJFS submitted these rules into its clearance process on March 18, 2005. It is anticipated that the revisions made to these rules, as indicated in the clearance package, will help clarify provider requirements. A date for refiling these rules has not been communicated.</p> <p>A memo will be sent from the BHOC to boards and providers which clarifies a provider's ability to determine the number of Medicare clients it is willing to accept. The memo also reiterates that a subsidy payment to a provider by a local board in a lump sum amount not specific to an individual service does not violate Medicare regulations.</p> <p>The subcommittee also explored the data that was available at ODMH that could potentially help boards and providers establish a subsidy amount. It was determined that because the information available was specific to coinsurance and deductible amounts it would add little value in determining a subsidy amount.</p>	8/16/05

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05-01	2/2/2005	Penny Wyman	In a cost based Medicaid rate model, "productivity standards" imposed by Boards for mental health services are prohibited and create the potential for federal interventions in the state's behavioral health Medicaid program.	these claims on the Medicaid side are getting processed through MACSIS also. Obviously, providers are trying to cover costs since the growth in Medicare and dually eligible clients will erode providers' ability to remain viable. For a number of years, several Boards have required the use of specific productivity standards in the development of unit rates by providers for mental health services. The specific productivity standards were determined by the Boards and resulted in a mathematical manipulation applied to unit rate development by the provider. Additionally, if the productivity standard was not achieved, providers were frequently required to justify the actual productivity level and/or create a plan of correction. In some instances, the pressure on direct service providers to comply with these standards resulted in personnel changes (therapists have left the field, others have been terminated for failure to meet performance expectations). These productivity standards were not imposed by all Boards resulting in a non-statewide practice.	02/03/05	2/10/2005	8/11/05	2/10/05 - It was agreed that ODMH and ODADAS would prepare a joint letter explaining the basic principles underlying the new uniform cost reporting rule and then distribute that letter along with a copy of the final revised version of the rule to all providers and the boards. It was also agreed that enforcement of the provisions of the rule was the responsibility of the two departments and that the letter would indicate who at the departments to contact if there are concerns about implementation of the rule. The issue will remain open until the letter has been sent. 7/14/05 - ODMH/ODADAS joint letter was reviewed explaining the basic principles of the new uniform cost reporting rule. There is to be a revision and Angie will send to committee for review. Once approved letter will be sent to Boards and Agencies with copy of the rule.	7/14/05

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06-1	7/20/2005	Christina Shaynak-	National Provider Identifier Implementation in MACSIS	<p>In May 2005, CMS announced the availability of the web-based application process for providers to obtain a National Provider Identifier. All healthcare providers exchanging data electronically via a standard transaction are required to apply for an NPI or multiple NPIs (i.e., subparts) as determined by the provider (not the health plans). NPIs must be used on all standard electronic transactions by May 23, 2007, but may be implemented sooner as determined by health plans. For example, Medicare expects to announce their transition plan to NPI by late 2006.</p> <p>As a result of this initiative, the Board Association felt it would be important to formally recognize the NPI implementation in MACSIS as a project. This project would include tasks such as identifying NPI implementation issues in MACSIS, selecting an appropriate implementation date which takes into account both system and fiscal issues, and raising awareness of expected system changes. Provider input will be key to this discussion since they are most affected by the process change and could better predict their vendor readiness and plans for subpart application. ODMH technical staff input will also be critical in selecting an implementation date.</p> <p>Attachments: CMS MedLearn Matters re: Obtaining NPIs (se0528.pdf) Draft NPI Implementation Timeline</p>	8/11/2005	9/8/05	8/11/05 - All healthcare providers exchanging data electronically via a standard transaction are required to apply for an NPI or multiple NPIs as determined by the provider. NPIs must be used on all standard electronic transactions by May 23, 2007, but may be implemented sooner as determined by health plans. The Board Association feels it would be important to formally recognize the NPI implementation in MACSIS as a project.	<p>The consensus was to have a subgroup work on this issue and bring back recommendations to the Committee. Hugh Wirtz and Cathy Lindamood will send names to Christine to represent their organizations. Christine will call Peg Burns to see if representation from her area is needed. First meeting for this group is September 15, 2005 10-2 at the Board Association.</p> <p>Peg Eichner will write a HIPAA Alter to raise the awareness regarding next steps and develop a webpage for providers to obtain more information.</p>	<p>6/8/06 - Sub-committee representatives updated the Operations Committee.</p> <p>Recommendation: Sub-committee will meet on June 14, 2006 to review the status of remaining tasks and to decide if any additional meetings are needed.</p> <p>Issue that was presented to the Operations Committee is closed.</p> <p>Workgroup will monitor providers obtaining NPI's. If this is less than 50%, the workgroup will reconvene to consider an appropriate course of action. If Operations Committee action is necessary, a new issue submission will be submitted.</p>	6/8/06

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06-02	12/7/2005	Hubert Wirtz	Electronic Signatures - Documentation is needed, clarifying that electronic signatures in clinical records are allowed under state certification standards and the revised code.	Several providers, over the past few years, have questioned their ability to use electronic signatures in their client's clinical health records, for fear of audit/review findings. The certification standards (5122-27-09) and the Revised Code (3701.75) clearly state that electronic signatures are allowed in client records and ODMH staff recently issued the following statement via email: "From a Medicaid perspective, electronic signatures in clinical records are acceptable as long as the agency is consistent with the electronic records Cert. Standard and the records can be retrieved in a reasonable period of time for the Medicaid Compliance/MNDR Review."		1/12/06	2/9/06	1/12/06 - (1) The committee agreed that electronic signatures are legally allowed. (2) Also agreed to draft a memorandum to the field that explained this along with the technical requirements for making the signature valid.	Closed -- Electronic Signature. Memo went out 3/13/06. Agency #C-03-06-01	3/13/06
06-3	2/24/2006	Betsy Johnson	Incident Report rule does not specify which Board a Provider is to notify when a reportable incident occurs	OAC Rules 5122-26-13 and 5122-30-16 require providers to forward incident reports "to both the department and mental health board within twenty-four hours of their discovery . . ." The rule does not clarify whether the provider is to notify the Board in which the facility is geographically located or the Board that is paying the Medicaid match. Considerable confusion exists among providers and within ODMH regarding which Board they must notify when an incident occurs. In some instances, the Board in which the facility is located is notified, and in other instances it is the Board that is paying for the cost of care that is notified.	3/1/06	03/09/06	7/13/06	6/8/06 - Subcommittee representative updated the Operations Committee. Brought forward was a draft procedure/clarification of Incident Reporting. There were various issues that were related to and were incorporated in the draft response. Three concerns were brought back to the Operations Committee: a) What is to be done with incidents involving consumers who are from out of state?, b) What is to be done with clients who are not serve with public funds?, c) Can there be a standard reporting form across regulatory agencies? Upon review it was noted that the reporting procedure was only for the Mental Health System and not the AOD System. Operations Committee asked that the subcommittee go back and outline procedures for both systems and to include (a, b, c) above. It was noted that a and b are reported to only ODMH due to certification issues, suggestions was made to have a separate form for this notification. With item c (Standard Reporting Form across regulatory agencies) subcommittee to discuss if this is feasible to have one form fo the behavioral health system as a whole.	Issue 07-2 incorporated 06-3.	10/16/06

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07-2	8/22/2006	Cathy Lindamood/	The Operations subgroup has been working on clarifying incident reporting processes. Two related issues have been identified and require additional clarification: reporting for non-publically funded clients and determination of which Board will have follow-up responsibilities.	Clarification is needed with regard to the incident reporting requirements for non-publically funded clients (example: private pay, out-of-state). Non-publically funded clients are not reported in the MACSIS system and are therefore not included in information provided to Boards. Incident reporting requirements for these clients should be consistent with HIPAA and ODMH MACSIS guidelines. The second area to be clarified involves the designation of a single Board to be the primary party in any follow-up of an incident. Providers will report incidents to the client's Board of residence; however, some Boards that contract with a provider also want to be notified of incidents regardless of the client's residence. To minimize the number of parties accessing sensitive and/or protected (PHI) information and to improve resolution timeliness, one Board should be designated as having the primary responsibility for incident follow-up.		09/14/06	Clarification of Incident Reporting Process for non-publically funded clients. The second part of this issue is determination of which Board will have follow-up responsibilities. This issue has been incorporated with issue 06-3.	Closed. Both ADADAS and ODMH have issued similar procedures clarifying that the incident report is to be sent by the reporting agency to the county board of residence and the applicable department. The department will forward the report to the contracting board, if applicable. The ODMH procedure is available on the web at : www.mh.state.oh.us/licensurecert/general/lc.resources.i ndex.html	10/16/06

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07-4	1/25/2007	Precia Stuby	The Department of Mental Health included a column on the required 040 for the amount of third party reimbursements at the agency level. (see attached) With the implementation of the Medicaid Business Plan, Boards are no longer requesting revenue information from agencies (the old 052). As a result, there is no way for a Board to complete this form with requesting the information from the providers. There was a previous agreement between the two state departments and the Boards that this information would no longer be required on the 040.	<p>Each year, the Board's in Ohio are required to submit a financial report to both the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services. The most recent forms sent by the Ohio Department of Mental Health included a column to report the amount of third party reimbursement received by provider agencies.</p> <p>With the implementation of the Uniform Cost Report, Board's have been instructed to stay out of agency revenue sources and productivity requirements. The Board's have been instructed to focus on negotiating rates for non-Medicaid and reimbursing agencies the Medicaid rate as provided on the UCR.</p> <p>There is no way for a Board to complete the required annual financial form without going directly to the agencies for this information.</p>		2/8/07		Closed. Committee agreed to omit column requiring third party funding. Holly Wilson and Angie Bergefur will compose a letter informing Boards to discontinue using this column.	2/8/07
07-5	4/19/2007	Peg Eichner	Impact of CMS Guidance Regarding NPI Implementation	On April 2, 2007, the Centers for Medicare and Medicaid Services (CMS) issued guidance on enforcement of the HIPAA National Provider Identifier (NPI) Rule (http://www.cms.hhs.gov/NationalProviderStand/Downloads/NPI_Contingency.pdf). The MACSIS NPI Workgroup has reviewed this guidance and other key factors to determine how it would impact the MACSIS environment		5/19/07		Closed. Committee will contact agencies on case by case basis to ensure compliance. Peg will send HIPAA alert regarding NPI enforcement. HIPAA Alert will include a message thanking everyone for their tireless efforts in assuring Providers are compliant prior to May 23, 2007, deadline.	5/10/07