COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY AND PROCEDURES MANUAL				
Chapter **Organizational Quality**	**Section** **Management Information Systems**	**Chapter** **01**	**Section** **03**	**Subject** **06**
Subject **Consumer Data Quality**	**Authorization**		**Approved: 04/26/11** **Replaces: 07/27/04**	

Updated: October 2024; Reviewed/No Updates: October 2025

I. PURPOSE: Establish standards for accurate, complete, and timely collection and reporting of consumer-related data to ensure compliance with regional, state, and federal requirements.

II. APPLICATION: All Gogebic Community Mental Health Authority (GCMHA) staff and contract entities that document or report consumer data.

III. DEFINITIONS:

A. ELMER: ***EL***ectronic ***ME***dical ***R***ecord. ELMER is the clinical practice management system used jointly by GCMHA, its contract providers, and all NorthCare affiliates for recording consumer data.

B. Direct-Run: Programs in which services are provided by staff that are directly employed by GCMHA.

C. Claim Management: Accounts Payable module in ELMER used for recording claims that correspond to service activity delivered by contract providers.

D. SAL: *S*ervice *A*ctivity *L*og. A *SAL* is an electronic form containing key reporting information such as the service code, service date, start/stop times, location, rendering staff, program, attendance, and other similar concise data values related to the service that was provided for a consumer. Each *SAL* is typically attached to a clinical document in ELMER that describes the service activity in a more detailed narrative format.

E. Created Document SAL: A SAL that is attached directly to a native electronic document created in ELMER that describes the service provided.

F. Contract SAL: A SAL that is attached to a document that has been completed by staff assigned to a Contracted Service Location in ELMER. It may be attached to a native document (i.e., Progress Note, Contract Vocational Note, etc.) or a scanned/uploaded document. The information contained in a *Contract SAL* does not get reported directly because encounter reporting for contract services is accomplished through the processing of claims within the *Claim Management* module in ELMER; however, the *Contract SAL* serves as a cross-reference for verification of the recorded/reported claims.

G. Scanned Document SAL: A SAL that is attached to a scanned document that has been authored by a direct-run staff. A *Scanned Document SAL* is often used for specialty assessments, Behavioral Treatment Committee documentation, or similar types of documents that are not native to ELMER. A *Scanned Document SAL* is included in encounter reporting because it documents services provided by direct-run staff.

H. Extended SAL: A SAL that is used primarily for batch entry of direct-run per diem services that do not have a document attached to them (i.e., recording of Personal Care (PC) and Community Living Supports (CLS) services in group homes).

I. Stand Alone SAL: A system-generated SAL that is used solely for recording the originating site fee (Q3014) for telemedicine services when applicable.

J. Daily Service Activity: Refers to service activity that is typically recorded in ELMER by the rendering staff at the time the service was provided or shortly thereafter.

K. Monthly Service Activity: Refers to service activity that is typically gathered by contract providers or group home staff and recorded in ELMER in the form of monthly batch entries.

L. BH-TEDS Data: *B*ehavioral *H*ealth *T*reatment *E*pisode *D*ata *S*et. This is the core "point-in-time" demographics data set required by the MDHHS/CMHSP Managed Specialty Supports and Services Contract.

M. Encounters: Reportable services delivered directly by GCMHA or contract providers.

IV. POLICY:

All consumer-related data recorded directly by GCMHA staff and/or on behalf of its sub-contractors shall comply with the documentation and reporting standards as specified in the Medicaid Provider Manual, Michigan Mental Health Code, and the MDHHS/CMHSP Managed Specialty Supports and Services Contract. ELMER is recognized as the primary repository for capturing, storing, and retrieving data pertaining to GCMHA consumers. Designated staff shall monitor the accuracy, completeness, and timeliness of consumer data entries in ELMER and report noncompliance to supervisory staff and/or the CEO, as appropriate.

V. PROCEDURE:

A. Services Provided in Direct-Run Programs - All care providers assigned to GCMHA direct-run programs are responsible for the accurate, complete, and timely documenting of their own service activity in ELMER. This is accomplished in part by filling out the appropriate electronic clinical form in ELMER that details the activity (i.e., Progress Notes, Para-Professional Notes, Assessments, Emergency Screenings, Discharge Summaries, Med Review Notes, etc.), and then completing the correlating information on the *SAL* attached to it - a *Created Document SAL*. Care providers are also responsible for the information contained in the *Scanned Document SALs* they sign for certain specialty services (see section V.C. below).

1. Service providers shall document procedure codes in accordance with the rules delineated in current CPT/HCPCS code manuals, the Medicaid Provider Manual, the Michigan PIHP/CMHSP Provider Qualifications document, the PIHP/CMHSP Encounter Reporting HCPCS/Revenue Codes and Costing Per Code documents, and other directives/orders published by MDHHS. GCMHA providers are not to deliver services that they are not properly credentialed/licensed to provide within their scope of practice, are not within their assigned program(s), or have not been authorized per GCMHA authorization procedures.

2. Service providers shall not use anyone else's user account or password to create or digitally sign any document or its attached *SAL* in ELMER.

3. Service providers must record all fields on the *SAL* (i.e., service date, client attendance, start/stop times, location of service, etc.) in such a manner as to accurately reflect the activity they have provided. It is strictly forbidden and impermissible for staff to use the live/production area of ELMER to document fictitious, made-up, or test data of any kind unless it is specifically contained within the chart for "John Doe", MCOID #999999. There is a Training and/or Development version of ELMER available for testing or training purposes.

4. Service providers are to finalize their *Created Document SALs* (including digital signature) in accordance with the following timeliness standards:
   a. It is expected that progress notes and other routine forms of documentation for services provided in direct-run programs, whether the service occurred in the office or in the community, will be completed in close proximity to the actual time of service - preferably the same day, but no later than one (1) business day following the service. It shall never be documented before the service occurs.
   b. Bio-Psychosocial (BPS) assessments and Individual Plans of Service (IPOS) generally take longer to complete than other more regular services; therefore, documentation for services related to these types of activities is to be completed with all required signatures within five (5) business days of the actual date of service. It is emphasized, however, that Medicaid rules require a plan to be in place and signed before ongoing services may occur.
   c. When additional signatures are required (i.e., a note created by a provider needing a supervisor's signature), it is expected that all additional signers complete their review and signature within one (1) business day of receiving the documentation in ELMER. If the additional signer(s) are not at work or otherwise unavailable due to illness, vacation, etc., it is expected that they complete their review and signature within one (1) business day of returning to work.
   d. A delayed signature is allowed for circumstances where a supervising physician is not available every day/week, or instances in which additional time is required to dictate and record physicians' notes for their later signature in ELMER. In those circumstances, transcription shall be completed within five (5) business days of the actual service date, and all remaining review/correction of the documentation in ELMER is required to be completed (including physician's signature) no later than 14 calendar days from the actual date of service.
5. The Information Systems Analyst and departmental supervisory staff will run the "Unsigned Documents" report in ELMER on a regular basis (several times per month) and notify applicable staff of noncompliant *SAL* activity. Direct-Run providers are responsible for daily review and completion of items in their *Clinical Dashboard* in ELMER such as "Unsigned Documents", "ToDo Items", and "Clinical Statistics" which has links to "Kept consumer appointments with no documentation" and "Past appointments still marked as scheduled". Links to the "Staff Tickler Report" and many of the same dashboard items are also available under the *Staff To-Do List* menu to assist clinicians with upcoming or past due documentation.
6. In the event of unusual circumstances that prevented the generation of a note at the time of service, a late entry is permitted to properly account for the service; however, it should be identified as such along with the reason why it is late documented within the narrative of the progress note. Late entries are not expected to be the norm, but rather infrequent exceptions.
7. In the case of planned termination of care providers, the departing staff's caseload shall be reviewed by his/her immediate supervisor or program director to assure documentation is complete and signed prior to departure. All items in the "Staff To-Do List" in ELMER shall either be completed or assigned to alternate staff

before departure. Affected staff must be notified by departmental supervisor or director to discontinue sending documents to departing staff.

8. If departing staff is not available to complete/sign documentation, the supervisor or program director shall review all appointments with missing documentation and unsigned documents for that staff and ensure each of those documents/*SAL*s in ELMER is marked as non-billable/non-reportable using the process outlined in NorthCare SOP – ELMER Unsigned Documents for Inactive Staff Procedure.
9. In the event a signed document/*SAL* authored by a staff member that is no longer employed at GCMHA requires correction, changes may occur using the process outlined in NorthCare SOP - ELMER SAL Correction for Inactive Staff. The program director or clinical supervisor will review the documentation with the Information Systems Analyst to determine if the requested changes meet all standards as well as coding and reporting requirements. If changes are warranted, the Information Systems Analyst (or designee) will use the *Change Signed Document* function in ELMER and record the "Reason for Change" as: THIS DOCUMENT / SAL HAS BEEN CLINICALLY REVIEWED BY <CLINICAL SUPERVISOR NAME> AND VERIFIED AS REPORTABLE AND THIS SAL HAS BEEN UPDATED BY <INFORMATION SYSTEMS ANALYST NAME> TO ALLOW FOR BILLING AND ENCOUNTER REPORTING. Refer to the NorthCare SOP cited above for further details.
10. The Information Systems Analyst measures documentation timeliness and supplies the statistical information to management quarterly or more frequently as needed.

B. Services Provided by Sub-Contractors or GCMHA-Owned Group Homes - The Data Coordinator (or designee) is responsible for coordinating the accurate, complete, and timely recording of service activity for GCMHA-owned group homes and sub-contractors. This is accomplished through monthly batch entries into the *Extended SAL*, *Stand Alone SAL*, and/or *Claim Management* modules in ELMER. Besides notes and *Contract SALs* that are native to ELMER, other examples of source documents for verification and support of service activity may include home occupancy reports, respite sheets, fiscal intermediary payroll forms and related documents, progress notes generated from other EMRs, monthly time sheets, invoices, CMS 1500 billing forms, or electronic claims received from contracted entities.

1. Source documentation for monthly service activity is due to the Data Coordinator within 10 business days after the end of the month in which the activity occurred. The Data Coordinator (or designee) initiates a review of source documentation upon receipt and coordinates the correction of erroneous or missing information as soon as practical. The Data Coordinator will record the activity in *Claim Management*, the *Extended SAL*, and/or the *Stand Alone SAL* as appropriate within two (2) business days of receipt of a clean claim. To allow accurate measurement of claims processing timeliness, the Data Coordinator shall maintain a Claims Log and ensure that the date the clean claim was received is recorded as the "Received Date" during the claims entry process in ELMER (i.e., the "Received Date" is not necessarily the same as the date the claim is initially recorded and it is not clean if it is erroneous or missing proper supporting documentation).
2. In some instances, Contracted Service Locations may be granted access to submit their own claims electronically in ELMER. Claims recorded by contract entities in this manner still require all supporting documentation to be submitted to GCMHA

so that the information can be verified. The same timelines shall be adhered to by external claims processing staff so that claims are able to be reviewed, corrected if necessary, adjudicated, reported, and paid in accordance with established guidelines as delineated throughout this policy/procedure.

3. Batch claim entries are reviewed jointly by the Data Coordinator and Information Systems Analyst for accuracy and completeness. The Information Systems Analyst runs the "AP Claims Detail Report" and/or "Service Activity Log Download" and filters records so that the applicable data can be audited. *Contract SALs* are referenced to identify inadequate supporting documentation or inconsistencies with the claims. The Data Coordinator checks for all available third-party payment sources in the chart as identified during intake and/or prior verification activities (see GCMHA Intake Process exhibit to this policy) and ensures the Coordination of Benefits (COB) amounts and other necessary adjustments are recorded on the claims as applicable. If the contract entity knowingly refuses to bill an available third-party fund source for a covered service as required, Medicaid cannot be utilized as the payer of last resort on that claim line. In such circumstances, the Data Coordinator shall override the fund source to General Fund on the affected claim line during the adjudication process and notify the Finance Director and/or Contract Manager in the event any resulting actions may need to be considered with the contract entity. Any other errors or omissions detected during the review process are corrected/reconciled in coordination with the contract entity prior to final adjudication. The Data Coordinator will continue to adjust the Received Date on the Claims Log accordingly until all requests for correction by the contract provider have been satisfied. The Received Date will not be adjusted for errors or corrections that are the responsibility of GCMHA to fix.
4. During this review process or other data scrubbing activities, if a scenario is identified where payment of a claim must be denied in whole or in part, an Adverse Benefit Determination (ABD) Notice must be provided to any individual enrolled in Medicaid. Examples of potential scenarios where an ABD is or is not required are provided in the NorthCare SOP - Adverse Benefit Determination (ABD) Notice – Denial of Payment.
    - **a.** Upon discovery or notification of the potential need to deny payment, the Data Coordinator and Information Systems Analyst will review the issue with other applicable staff as necessary.
    - **b.** If the issue persists and is not resolved satisfactorily following the review, the Clinical Director and Finance Director will be consulted for final determination regarding denial of payment.
    - **c.** If the determination is that payment will be denied, the Clinical Director (or designee) will instruct the primary staff assigned to the consumer to complete the ABD in ELMER and follow existing procedures to provide it to the consumer. In addition, the Finance Director (or designee) will notify the provider of the payment denial, to include an explanation for the action taken.
    - **d.** After review, if the issue has been resolved or explained satisfactorily so that it complies with current rules, no ABD is necessary and the claim will continue to be processed as normal with any accompanying billing notes added by the Data Coordinator as needed.
5. The Data Coordinator generates Check Requests upon completion of the claims adjudication process in ELMER and forwards to the Finance Director for accounts

payable processing. Gogebic GCMHA shall authorize and process claims payment to the provider within 30 days following the receipt of all clean claims.

6. Upon completion of the monthly claims entries, the Data Coordinator forwards certain source documents (those that were not attached to *SAL*s) to Medical Records for scanning into the appropriate section of the consumer chart in ELMER. Documents scanned in this manner without being directly attached to a *SAL* provide additional support for the service, but they are not the same as generating a *Scanned Document SAL* or *Contract SAL* (see section V.C. below).
   a. Prior to the implementation of the Residential Module in ELMER, hand-written residential progress notes by GCMHA group home staff had been submitted to Medical Records and scanned into the consumer chart as well; these legacy residential progress notes remain as scanned documents, but they do not have a *SAL* attached to them.
   b. An electronic version of Specialized Residential Progress Notes was subsequently developed and now serves as the documentation to support the Personal Care and Community Living Supports activities that group home staff provide to residential consumers. An *Extended SAL* continues to be generated separately from the Specialized Residential Progress Notes each month to report direct-run residential per diem services.
7. If data is not received or recorded within the required timeframes, the Contract Manager, applicable supervisor/program director, or other staff responsible for coordinating with the group home/contracted entity will be notified and corrective action taken.
8. Sub-Contract providers must comply with Medicaid documentation standards as described above for Direct-Run programs. To ensure compliance, the GCMHA will monitor and verify sub-contractor services per the procedures referenced in the exhibits to this policy (i.e., exhibit Service Verification Procedure, etc.) and other policies.

C. Specialty Services and Other Non-Native ELMER Documentation - There are some service activities that do not currently have an electronic form associated with them in ELMER for the purpose of direct data entry by the care provider. Some examples include:

- Occupational Therapy Assessments
- Nursing Assessments
- Psychological Assessments and Testing
- Multi-Disciplinary OBRA Level II PASARR Assessments
- Behavioral Assessments
- Behavioral Treatment Committee (BTC) Review Documents

The Data Coordinator and the Medical Records Coordinator share the responsibility for scanning (or uploading) these non-native documents into ELMER with an attached *SAL* - this may be a *Scanned Document SAL* or a *Contract SAL* depending on the contractual relationship with the provider staff.

1. The documentation for specialty assessments or BTC reviews may be dictated using a product such as Express Dictate NCH Software. Regardless, these documents may be typed by the clinician or a designated typist using a word processing application such as Microsoft Word to record the activity in the prescribed format. For direct-run staff, such documentation is required to be typed and submitted to the

Data Coordinator or the Medical Records Coordinator within five (5) business days from the actual date of service. For contract staff, all supporting documentation should be completed and submitted as close to the actual date of service as practical or as clinical needs dictate, but no later than 10 days after the end of the month in which the activity occurred per section V.B., above. Note that the paper BTC attendance logs are to be signed and dated at the time of service.

2. The Data Coordinator or the Medical Records Coordinator shall scan (or upload) this type of documentation into ELMER within two (2) business days of receipt.
   a. During the scan/upload process, the "Signature and Service Activity Log" option must be selected so that a *SAL* is attached to the scanned/uploaded document.
   b. The source document is referenced by the Data Clerk or Medical Records Coordinator to obtain pertinent *SAL* information, which is then recorded in the attached *Scanned Document SAL* or *Contract SAL*. The person creating the *SAL* must change the provider program and staff to reflect the correct program and author of the document to ensure accurate accounting of the service as well as proper routing in ELMER so that appropriate electronic signatures are obtained.
3. The author/credentialed clinician is to review, request changes, and digitally sign the *Scanned Document SAL* or *Contract SAL* within two (2) business days of receipt. As noted earlier in the **DEFINITIONS** section of this procedure, a *Scanned Document SAL* is included in encounter reporting directly, whereas a *Contract SAL* attached to supporting documentation is utilized as a cross-reference for the reportable claim to be compared to during the claims entry process described in section V.B., above.

D. **BH-TEDS and Other Demographics Data Collection -** BH-TEDS is a "point-in-time" record of demographics data gathered on consumers served by GCMHA. The accurate, complete, and timely collection of demographics data for consumers is a shared effort between the consumer, NorthCare Access, and GCMHA staff; however, the ultimate responsibility lies with the GCMHA clinician assigned as the primary staff for each case in ELMER (i.e., the PCC - Primary Care Coordinator). A primary staff assignment is required for all GCMHA consumers upon entry to services. The Information Systems Analyst and Data Coordinator review new cases regularly to ensure the admission record has been added along with the appropriate primary program and staff assignments. While the reporting of BH-TEDS data parallels the steps required in opening a clinical record, updating the clinical record, and closing/ discharging the clinical record, the processes are not automatically linked to one another and require distinct actions to complete. For more information and guidance regarding BH-TEDS coding requirements and the specifics for entering the records in ELMER, refer to the Michigan Coding Instructions for BH-TEDS as well as the BH-TEDS Training Guide.

1. For new or re-opened non-emergent cases at GCMHA, the initial primary staff assigned in ELMER will be the intake clinician that provides the Initial BPS Assessment. Non-emergent cases are typically opened by NorthCare Access through the brief screening process and assigned to the Gogebic - Assessments & Treatment Planning program. At that time, Access collects/verifies some minimal demographics, adds authorizations for the Initial BPS and Preliminary IPOS, and schedules an appointment with the intake clinician; however, an official staff

assignment in ELMER does not occur unless/until the consumer shows for the face-to-face assessment.

a. On the date of the scheduled intake, the consumer meets with the intake worker (Data Coordinator or designee) to exchange information and complete required documentation pertaining to GCMHA services. At that time, the intake worker creates a Self-Pay financial record containing income-related data as supplied by the consumer. The intake worker and consumer also review/update the other administrative-type demographics data fields under *Change Consumer Information* in ELMER (i.e., those that are not diagnostic, clinical, or medical in nature such as disability designations, CAFAS scores, DD proxy measures, health questionnaires, etc.). See Exhibit for GCMHA Intake Process for additional tasks completed at intake.

b. The intake worker creates the initial primary staff assignment indicating the clinician scheduled to complete the BPS, who is then responsible for collecting the remaining demographics data that will comprise the BH-TEDS record and meet other data collection requirements as applicable (i.e., CAFAS scores, DD proxy measures, etc.).

c. The demographics data in the *Change Consumer Information* section (if completed earlier by the intake worker) flows into the BPS in ELMER. This allows the BPS clinician to review the data without having to re-complete those fields. The BPS clinician then finishes the remaining demographics data fields per his/her clinical assessment of the consumer. Refer to exhibits to this policy for additional details.

d. On the signature page of the BPS there is a link to "Start a New MH Treatment Episode", which the clinician shall select to create the new BH-TEDS record if no current BH-TEDS record exists.

e. If there is already a current/open BH-TEDS record (i.e., one created during a recent inpatient admission), the clinician will have an additional link on the signature page to "Add TEDS Update Record" which will enable the clinician to update the demographics data in the open BH-TEDS record created during the previous service.

f. Upon adding the BH-TEDS record to the BPS, ELMER will automatically display a list of BH-TEDS validation errors on the signature page (if any exist). Any incomplete or otherwise erroneous demographics data identified/ discovered is the responsibility of the BPS clinician to correct before the system will allow the BPS to be signed. The Information Systems Analyst should be consulted for assistance with correction of errors and understanding the various nuances and rules found in the Michigan BH-TEDS Coding Instructions, the BH-TEDS Training Guide, and other references/exhibits to this procedure.

g. Upon completion of the initial BPS assessment (and preliminary IPOS if applicable), the BPS clinician is responsible for creating the staff assignment for the new PCC if ongoing services have been authorized. The new PCC is then responsible for monitoring and updating of BH-TEDS data after that which was collected at the BPS assessment. The process follows similarly for any subsequent changing of the PCC.

2. For cases whose episode of care is opened or re-opened under emergent circumstances, the initial primary staff assigned in ELMER is the clinician that provided the emergent care to the consumer. This clinician is assigned effective as

of the first face-to-face crisis activity and is responsible for the initial collection of the BH-TEDS demographics data in ELMER.

a. Similar to the BPS for non-emergent cases, the Preadmission Screen (PAS) form will also have a link to "Start a New MH Treatment Episode" on the signature page of the document, which needs to be used at the start of the new episode of care when the disposition on the PAS is other than a Diversion (i.e., Inpatient Admission, Crisis Residential, or Partial Hospitalization).

b. For PAS Diversions or Crisis Intervention Notes, a link to "Add One Time Crisis TEDS Event" (also known as a "Q" record) is available on the signature page and may be used by the emergency services clinician in these crisis-only scenarios where often only limited information is able to be collected. Note that the "Q" record should NOT be used if the consumer was hospitalized or otherwise not diverted. If the consumer has multiple crisis events, a "Q" record is only required if it has been more than 90 days since the consumer's most recent BH-TEDS submission.

c. If there is already a current/open BH-TEDS record (i.e., one created during a BPS or another recent hospital admission), the clinician will have an additional link on the signature page of the PAS to "Add TEDS Update Record". The Update record should be used on the PAS if the consumer's disability designation changed since the last BH-TEDS submission.

d. The process for adding the BH-TEDS record and addressing the validation errors is the same as described for non-emergent cases above; however, the Information Systems Analyst should be consulted for more detailed instructions and assistance with understanding the various nuances and rules found in the Michigan BH-TEDS Coding Instructions, the BH-TEDS Training Guide, and other references/exhibits to this procedure.

3. BH-TEDS data shall be monitored regularly by the PCC and the Information Systems Analyst.

a. The PCC must update all BH-TEDS data and other demographics at least annually (i.e., during the annual BPS), but may update values at any time in between annual reviews to reflect changes that may have occurred or to correct obvious inconsistencies. The "Copy" link found next to the most recent BPS Assessment in the consumer chart will pull forward the previous assessment and demographic information into an updated BPS where a BH-TEDS Update record may be attached on the signature page. This would be the most common means of updating BH-TEDS records for consumers receiving ongoing services - a stand-alone BH-TEDS form is also an available option in ELMER, but current standards are to attach all BH-TEDS records directly to the clinical forms referred to above. Note: Per MDHHS, all data on a T2 record (i.e., the point in time when BH-TEDS data is updated) must reflect the consumer as of the date of a **face-to-face** contact. It is therefore inappropriate/unacceptable to attach a BH-TEDS Update record to a BPS that was not completed in accordance with face-to-face reporting rules. In the event a Gogebic consumer is placed out of the area (or a similar situation), completion of the annual BPS and the corresponding BH-TEDS Update record is still the responsibility of the PCC and must comply with these face-to-face standards. If the procedure code used for this purpose allows for audio/visual telemedicine, that is the recommended protocol in the absence of an in person contact under these

circumstances; however, proper consent must be obtained, and it must be documented in the consumer's record/individual plan of service as required.

b. DD proxy measures, when not updated within the BPS, may also be completed as needed by selecting the "Add DD Proxy Measure" link on the consumer's Chart Documents tab in ELMER (see Exhibit DD Proxy Measures, which may be used to collect the necessary data prior to having it recorded in ELMER). CAFAS/PECFAS assessment results are automatically retrieved from the Functional Assessment System on a regular schedule (see GCMHA Policy 03-04-02 Exhibit LOF-LOC for further instructions on completing the CAFAS/PECFAS).

c. The BH-TEDS record shall be discharged/ended in conjunction with the closing of the consumer's episode of care. For consumers receiving ongoing services, the PCC is responsible for selecting the "Discharge/End Treatment Episode" link on the signature page of the clinical discharge summary form to close the BH-TEDS record. The PCC will be required to address any validation errors identified before the system will allow the discharge summary to be signed. The Data Clerk and Information Systems Analyst review emergent cases scheduled to be administratively closed and select the "Discharge/End Episode" link in the BH-TEDS area of the chart to close the BH-TEDS episode. The end date shall be consistent with the consumer's last face-to-face service per BH-TEDS coding instructions.

d. ELMER has built-in alerts and edits to flag overdue, missing, erroneous, or otherwise non-compliant documentation, including demographics data and other basic consumer information. The PCC for each consumer is responsible for reviewing these flagged items found under the *Data Issues* tab in the chart as well as the *Alerts* link in the chart header area. The PCC should review instances of validation errors that he/she is uncertain about with the Information Systems Analyst so that a determination can be made as to whether the "error" is acceptable and may be overridden, or how to fix it if it requires corrective action. The Information Systems Analyst also reviews Consumer Data Issues in the system and coordinates with staff to address as necessary.

e. The Information Systems Analyst shall coordinate with the Claims/Information Specialist at NorthCare to submit BH-TEDS batches to MDHHS for GCMHA cases (refer to MDHHS Reporting steps below).

f. The Information Systems Analyst shall monitor overall BH-TEDS error volumes for GCMHA cases. The Information Systems Analyst shall coordinate the correction of known "true" errors with the intake worker, Data Coordinator, BPS clinician, PCC, or other staff as appropriate.

g. The Information Systems Analyst shall monitor compliance with MDHHS reporting standards and alert applicable staff, including supervisors or directors if necessary, to address any deficiencies.

E. Data Scrubbing - Aside from the alerts, notices, and other system preventatives inherent within ELMER, there are some additional data scrubbing measures that GCMHA must engage in to validate the accuracy and completeness of consumer data. The Information Systems Analyst is responsible for seeing to these additional validation steps.

1. ELMER will not bill/report service activity until the supporting documentation attached to it has been completed and electronically signed by all applicable staff. Several times each month the "Unsigned Documents" report is reviewed to ensure the signature process is timely and will not impede billing/reporting cycles.
2. Periodically, especially before and after encounter file submissions, the Information Systems Analyst runs the "Service Activity Log Download" report and imports the data into a MS Access database. The records are sorted, filtered, grouped, and arranged a variety of ways to analyze the coding, staff credentials, times, costs, attached documents, client attendance, and other values contained in the *SAL* data.
    a. Values that are inconsistent with standards are brought to the attention of the responsible clinician or supervisor for explanation and/or correction.
    b. The Change Signed Document/Add SAL Change Request process is utilized to make corrections to Service Activity Logs that have already been signed by the author of the document. The author typically initiates the change unless extenuating circumstances require a supervisor, program director, or system administrator to assist as outlined earlier in section V.A. and NorthCare SOP. All requests to change SALs are logged in ELMER and can be accessed from the link to "View All Service Activity Log Change Requests", which can be filtered and/or exported to Excel for further analysis if necessary. If the service has already been billed/reported, the request is required to go through an approval process in ELMER that may require voiding of the encounter or other related adjustments. Such requests will first come to a queue to "Approve Billed SAL Change Requests", which is monitored by the Information Systems Analyst. Once the request has been reviewed, approved, and the necessary steps have been taken to void the encounter, the request is auto forwarded to the queue to "Approve Unbilled SAL Change Requests". The Information Systems Analyst then completes processing the remainder of the request by approving the SAL change (or denying it and informing the requestor of any additional steps that may be necessary).
    c. Services that have not been billed/reported are examined to identify the cause. Appropriate corrective measures are taken to see that all billable/reportable services are processed as necessary.
3. Each month, the Information Systems Analyst runs the "HSW Consumer Tracking Report", which summarizes the service activity for GCMHA HSW consumers. The Information Systems Analyst ensures all GCMHA HSW consumers are accounted for on the report and evaluates whether each consumer has had the necessary HSW services for the period. Deficiencies are addressed by the PCC and/or supervisor.
4. The "AP Claim Detail Report" is run following claims entry and at other various times as needed. In addition to the claims audit procedure described in section B above, the batch status and encounter status of each record is reviewed to ensure each claim has been fully adjudicated and reported.
        a. Claims that are missing supporting documentation, erroneous, or otherwise inconsistent with standards/requirements are brought to the attention of the responsible supervisor or contract location for explanation and/or correction. If the erroneous claims were submitted electronically by the contract location using the external AP Claim Data Entry module, the Data Coordinator may send the batch back to them for correction.

b. The Reconsider process is utilized to make corrections to claims that have already been adjudicated and/or reported. Reconsidered claims are identifiable in the AP Claim Detail Report—they will have '0' allowed units as well as $0 allowed/paid amounts and will have a claim note recorded by the Data Coordinator that explains the reason for reconsideration.

5. "Encounter Cost Reports" are run periodically by the Information Systems Analyst. The reports are analyzed to ensure appropriate use of modifiers on codes, proper cross-walking of codes, questionable/inconsistent service volumes, etc.
6. The Information Systems Analyst runs various reports on the Insurance Billing menu to ensure proper setup of fee schedules, EDI profiles, billing rules, crosswalks, and rates, verification of policies and funding sources, etc. Issues are addressed directly by the Information Systems Analyst or brought to the attention of appropriate staff for corrective action. Distribution lists such as the one for spend-down notices are also setup and used as needed to enhance proper billing procedures.
7. The Information Systems Analyst and Data Coordinator run the "NonMedicaid Months - Updated" report on a monthly or other as-needed basis. The report identifies open cases that have had at least one (1) month in the past 12 months without Medicaid eligibility. It is sorted by the fund source columns and then by Y/N values for each month to group consumers by most recent changes in Medicaid eligibility. The Data Coordinator uses the report to verify eligibility/negative action status in ELMER and/or CHAMPS. Results are discussed in detail during GF Committee meetings, and the primary clinician is contacted to ensure the consumer has complied with DHHS documentation requests, or to see if assistance is needed with applications for alternate funding sources such as Healthy Michigan. Medicaid eligibility errors are addressed with DHHS caseworkers or management as required. Other reports such as "Eligibility Month-to Month", "MHL Exceptions", and similar reports are also used periodically to confirm/analyze eligibility.
8. As a member of the regional Data Warehouse Committee, the Information Systems Analyst (in conjunction with the other committee members) is responsible for analyzing the data contained in the various models in the Diver software application. Comparisons are made using various query methods to ensure the data matches the corresponding values found in ELMER. Diver is used to support the agency's reporting objectives and needs including the identification of noncompliant data. Inaccuracies, enhancement requests, and/or other logic changes are communicated to the Data Warehouse Administrator at NorthCare. Noncompliant data is brought to the attention of appropriate staff for corrective action.

F. MDHHS Reporting - The Michigan Department of Health and Human Services (MDHHS) requires encounters to be reported for every consumer served by GCMHA. Encounters are to be submitted to MDHHS in HIPAA-compliant 837 format by the last day of the month following the month it was adjudicated. Any encounter that has not been reported by the end of the fiscal year because the adjudication process is incomplete must be submitted by December 31st. BH-TEDS data is typically submitted during the same week as encounter data. Although encounters do not currently require

a matching BH-TEDS record in order to be accepted by MDHHS as was the case previously with QI records, NorthCare must submit a registry file for each consumer or the encounters will be rejected.

1. PCE (the vendor for ELMER) programs the system to ensure the files are in the prescribed HIPAA-compliant format. The Information Systems Analyst monitors the accuracy of data in the various segments of the 837 and reports issues to NorthCare and/or PCE as needed.
2. Encounter batches are created in ELMER each month by NorthCare billing/ reporting staff. Each subsequent monthly batch incorporates all preceding months for the current fiscal year in case there were unreported or corrected encounters that need to be submitted for those preceding months.
    a. The process typically begins with NorthCare creating the encounter batches on Monday of the last full week of the month following the service month. Aside from the data scrubbing procedures described above, there are many system edits programmed into ELMER that validate the integrity of encounters and the values in various system setup menus necessary for proper reporting. Upon processing the batches, the system will flag claims/encounters that do not meet the reporting criteria contained in the ELMER logic. The Information Systems Analyst reviews the monthly encounter batches and coordinates the resolution of any errors detected. Once the errors are resolved, the batches are reprocessed.
    b. The Information Systems Analyst notifies NorthCare billing/reporting staff that the encounter data has been verified and can be finalized. NorthCare finalizes the batches, creates the registry file, and schedules submission to MDHHS - usually by Friday of the last full week of the month. NorthCare normally submits the registry file to MDHHS at least one (1) day prior to encounter submission.
    c. After encounters have been submitted to MDHHS, NorthCare will notify GCMHA of any 4950 errors or rejections. The Information Systems Analyst coordinates resolution of the errors/rejections. Corrected encounters are re-submitted as part of the following month's encounter file.
3. BH-TEDS batches are created in ELMER each month by the Information Systems Analyst. The date range for all batches is from the first date of the fiscal year through the last date of the month scheduled to be reported.
    a. Before batches are finalized, the Information Systems Analyst reviews the errors link for the batch being processed to address any preliminary validation errors. The "Admissions Maintenance Report" is used heavily by the Information Systems Analyst in coordination with the Data Coordinator to review BH-TEDS data and other key information related to the episode of care. As further validation, the "Missing Admissions" report in PCE Standard Reports is also utilized periodically to identify cases that do not have a matching BH-TEDS admission for each clinical admission and vice versa. The Information Systems Analyst and Data Coordinator coordinate with applicable staff to correct these issues in addition to any others that are discovered during routine monitoring, data scrubbing, and help desk calls throughout the month.
    b. The BH-TEDS batches are scheduled to be finalized and submitted by NorthCare on the last Friday of each month, usually in conjunction with the encounter submission timeframe.

c. Following submission, NorthCare monitors the MDHHS database and marks the BH-TEDS batches in ELMER with the relevant status. Any response errors are analyzed and addressed at the local and/or regional level, as applicable.

4. The Information Systems Analyst monitors overall encounter totals throughout the fiscal year. At year-end (and at other times as needed), the Information Systems Analyst uses various mechanisms (i.e., "Service Activity Log Download", "AP Claim Detail Report", Diver, MDHHS Data Extracts (when available), CHAMPS, etc.) to ensure all activity has been reported prior to December 31st and that no discrepancies exist. Year-end "cleanup" files are submitted prior to December 31st so that all cost reporting activities may commence as scheduled in accordance with MDHHS requirements. System malfunctions or any other issues found to be impeding the accurate and timely reporting of required data to MDHHS are brought to the attention of NorthCare, PCE, and/or GCMHA supervisory staff as needed.

VI. REFERENCES AND LEGAL AUTHORITY: MDHHS/CMHSP Managed Specialty Supports and Services Contract – Attachment C6.5.1.1; PIHP/CMHSP Provider Qualifications Chart; PIHP/CMHSP Encounter Reporting Costing Per Code and Code Chart; NPI Reporting Guidelines for 837 Encounter Transactions; HIPAA 5010 Encounter and Companion Guides; Health Care Procedure Coding System (HCPCS) Manual; Current Procedural Terminology (CPT) Manual; MDHHS Medicaid Provider Manual; NorthCare Directive – Documentation and SAL Requirements for Services Provided by Sub-Contractors or CMHSP Staff; NorthCare Directive – Documentation in Consumer Record; NorthCare 837 & QI File Processing Schedule; GCMHA Policy 03-02-01 (Access/Gatekeeping); GCMHA Policy 02-03-04 (Billing); Michigan BH-TEDS Coding Instructions; BH-TEDS Training Guide; GCMHA Policy 03-04-02 Exhibit LOF-LOC; Instructions for Generating CAFAS® and PECFAS® Aggregate Reports; NorthCare SOP – ELMER Unsigned Document for Inactive Staff Procedure; NorthCare SOP – ELMER SAL Correction for Inactive Staff; NorthCare SOP – Adverse Benefit Determination (ABD) Notice – Denial of Payment

VII. EXHIBITS: Service Verification Procedure; GCMHA Intake Process; BH-TEDS Cheat Sheet; QI Health Conditions Form; DD Proxy Measures; HSW Tracking; Voiding Encounters for a Retroactive HSW; Consumer SSN Verification Procedure; Foster Care License Number Documentation Procedure; Consumer EOB Procedure; Closing Cases in ELMER