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Introduction

Welcome to MHMR Tarrant. We are pleased to recognize you as a member of our Provider Network and look forward to enjoying a long and mutually satisfying contractual relationship with you.

The purpose of this Provider Manual is to educate you about the policies and procedures of MHMR TARRANT. We ask that you read this material carefully and discuss any questions you may have with Provider Relations, at (817) 569-4456.

MHMR TARRANT is staffed by a team of highly dedicated professionals experienced in managed care and the provision of services for persons who are diagnosed with mental illness. MHMR TARRANT is dedicated to providing high quality, innovative, and cost-effective management of behavioral health services.

Our philosophy is propelled by a strong commitment to service excellence supported by management flexibility and accountability. Our on-going objective is to continually refine our system so that we can excel in the delivery of quality services as we balance the best interests of our consumers, providers, and employees.

MHMR TARRANT clearly understands that open communication must exist between our service providers and our organization in order for us to be able to provide individuals in our community with the best possible care. We, therefore, invite you to share your perceptions, needs, and suggestions with our Provider Relations Coordinator, who will also, from time to time, ask you to respond to surveys to help us identify other opportunities to improve our services and to assess your satisfaction as a member of our provider network.

We will do all that we can to support your entry into our system and assure that your continued participation in our network will be beneficial for all concerned.

In this Provider Manual, references may be made to consumers, clients, and Referred Individuals. All of these terms are to be considered interchangeable. Other references that are used interchangeably are DSHS and State Authority (SA).
Mission Statement & Values

Mission Statement of
MHMR Tarrant:

To enhance the mental health and intellectual development of people in our community.

Values

- **Respect** for persons and families who are active in planning and evaluating their services
- **Recovery** as a life-long process of better health and well-being
- **Success** as positive outcomes for each person
- **Choice and participation** of persons and their families in the planning process
- **Inclusion** in the community through services that promote growth and independence
- **Safe, ethical and cost-effective services**
- **Best practices** in current research in medical, psychosocial and organizational fields
- **Collaboration** with other organizations for better services and efficiencies
Organizational Structure

The organizational structure of MHMR TARRANT includes the Mental Health and IDD Community Advisory Committees. These two committees are composed of individuals from the community, including consumers, who have a vested interest in assuring that quality services are readily available to our consumers. The committees are empowered to provide input into the planning process that will lead our organization into the future. These committees report to our Board of Trustees.

Our Chief Executive Officer is accountable to our Board of Trustees. Chiefs who report directly to the Chief Executive Officer direct both Behavioral Health and Intellectual and Developmental Disabilities (IDD) Services.

Currently, MHMR Tarrant has providers in the areas of Behavioral Health Services, Intellectual and Developmental Disabilities, and Early Childhood Intervention Services.
Important Points to Remember

Provider’s Responsibilities

It is the provider’s responsibility to render services to MHMR TARRANT consumers in accordance with the terms of the contract. The provider is required to render these services to MHMR TARRANT consumers in the same manner, adhering to the same standards, and within the same time availability as offered to all other consumers.

MHMR TARRANT does not guarantee that a MHMR TARRANT consumer or any number of MHMR TARRANT consumers will utilize any particular provider. Each consumer is given information regarding all providers in the provider network and then makes the choice of provider(s).

Providers are required to immediately call the MHMR TARRANT’s Crisis Line at (817) 335-3022 or (800) 866-2465 and to contact each consumer’s MHMR TARRANT Designated Staff Liaison to report occurrences of the following:

- Client deaths
- Suicide attempts
- Serious injuries – injuries which require medical care
- Serious medication errors
- Adverse Drug Reactions
- Allegations of homicide, attempted homicide, threat of homicide with a plan
- Incidents of restraint or seclusion
- Confirmed abuse, neglect, or exploitation
- Discovered pharmacy errors

Providers are required to inform consumers that they have the right to report any complaints about the services they are receiving to the Consumer Complaint Reporting Line at:

(817) 569-4367
or
1-888-636-6344 (toll free)

All provider complaints and/or suggestions are to be communicated to Provider Relations at (817) 569-4456.

Within one hour of witnessing or becoming aware of possible abuse/neglect/exploitation, provider is responsible for reporting the incident to the Texas Department of Family and Protective Services at 1-800-252-5400 or www.txabusehotline.org.
Referral and Authorization Processes

Referral Process

All referrals to Provider, as well as authorizations for services, will come from MH Clinical Staff. Covered Individuals who may be referred will have been in treatment with MHMR TARRANT within the past twelve months, have been determined to be a member of the Priority Population and have no other funding source for the service needed. In such cases, the Covered Individual has been screened, determined in need of crisis services, assigned an acuity level and offered a choice of Providers (if there are multiple providers for the services).

Provider will not engage in case finding or otherwise locating individuals to receive services and is prohibited from offering any gift with a value in excess of $10 to potential clients and from soliciting potential clients through direct-mail or by telephone.

Authorization and Reauthorization of Services

Provider must obtain authorization from MHMR TARRANT for Covered Services to be reimbursed by MHMR TARRANT. All authorizations for the provision of Covered Services will be made by MHMR TARRANT by means of an Authorization Number. MHMR TARRANT will not deny authorizations for Covered Individuals during pendency of court hearing for mental health commitment. In an emergency, Provider will obtain an Authorization Number from MHMR TARRANT following the provision of a Covered Service as soon as possible, but no later than the next working day. Staff will be able to verify status by contacting the MHMR TARRANT UM Coordinator, at (817) 569-4480 between the hours of 8am-5pm, Monday through Friday.

When a client is identified as needing services and agrees to participate, the UM Coordinator will authorize the type and amount of service to be provided. Information provided will include the Referred Individual’s name, the date services are to begin, the type and quantity of services to be provided, and the lapse date for the services (by when the services must be provided or will no longer be approved).
Coordination with MHMR Tarrant Clinical Staff

The primary contact person regarding any Referred Individual will be the MHMR TARRANT Child/Youth Clinical Staff who has responsibility for the overall coordination of services to the individual. All issues regarding a Referred Individual must be brought to the attention of the MHMR TARRANT Clinical Staff for assistance in resolution.

MHMR Tarrant recognizes that a team effort is needed to successfully provide services to Referred Individuals. For this reason, the Provider is seen as a valuable member of the team, having insight into successes or problems as they occur. Providers are encouraged to ask questions of the MHMR TARRANT Clinical Staff as treatment plans are developed to ensure those specific areas most important and necessary to the Referred Individual are included at that time. It is expected that regular communication will occur between the Provider, Referred Individual and MHMR TARRANT Clinical Staff, and that roles and responsibilities are tailored to meet the Referred Individual’s needs.
**Documentation**

Provider must maintain records necessary to verify services delivered and billed to MHMR Tarrant.

Provider must additionally maintain records including the following:

1. Names of all Referred Individuals enrolled with Provider
2. Evidence of licensure, certification or accreditation, as required
3. Evidence of Life Safety Code or ADA inspection and compliance, if applicable
4. Evidence of insurance coverage
5. Evidence of criminal history checks of staff
6. Evidence of required staff training
7. Doctor’s orders and medication records if medications are administered by Provider staff
8. Fire Marshall inspection and results of fire drills

Provider will retain records for a minimum of five (5) years.

Provider will receive, store, process, or otherwise deal with client information, if any, accessed or generated during services in compliance with Chapter 414, Subchapter A, Client Identifying Information, of Title 25 of the Texas Administrative Code, which is attached to this Provider Manual.

**Service Documentation**

The Provider is responsible for documenting all services in a manner consistent with quality medical practice.

**Treatment Plan Requirements**

The Provider is responsible for developing a Treatment Plan and is expected to include the MHMR TARRANT Clinical Supervisor in the development of that plan. Treatment Plans must be signed by the assigned Provider staff and the client and a copy provided to the Local Authority Clinical Supervisor upon request. The discharge plan should be developed early in the treatment process and is expected to be comprehensive, to include recommendations for treatment goals and strategies to be implemented following discharge.

**Progress Notes**

Progress Notes must be completed for all services rendered. These notes must reflect the service that took place and the individual’s progress or lack of progress towards the anticipated service outcome.
Claims and Billing

Payor of Last Resort

If the individual has a third party payor, Provider must bill that payor for services. Local Authority will only pay for authorized services for those Covered Individuals who have no other payor or whose payor does not cover the Authorized service. Local Authority will consider on a case-by-case basis whether to authorize and pay for services that extend beyond the individual’s third party coverage. For example, Local Authority may authorize and pay for additional services when the individual has exceeded the annual or lifetime maximum on their insurance coverage. Local Authority will not pay the difference between the third party’s rate and the standard or negotiated rates for services. Provider is expected to make arrangements with families regarding the payment of any required co-pay amounts based on third party coverage. Provision of medically necessary services is to be based on clinical issues apart from financial limitations.

Claim Submission

MHMR Tarrant provides an internet website portal to allow for claims to be submitted over a secure connection. The Provider inputs claim data directly into the MHMR TARRANT website. Instructions for claim submission via the gateway portal are included on page 9 and following.

Explanation of Benefits Report:

Explanation of Benefit reports (EOBs) are created when a specific claim (not the entire file) has reached final status of denied or paid. Claims processed await final status from Medicaid before the claims are reported back to the provider with a final status. EOB codes for non-paid claims are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CU</td>
<td>Calculated Units Incorrect</td>
</tr>
<tr>
<td>DE</td>
<td>Denied - Coverage not current</td>
</tr>
<tr>
<td>DN</td>
<td>Denied, No Prior Authorization</td>
</tr>
<tr>
<td>DS</td>
<td>Duplicate Service</td>
</tr>
<tr>
<td>INV</td>
<td>Invalid Client ID</td>
</tr>
<tr>
<td>LN</td>
<td>Too Long from Service to Claim</td>
</tr>
<tr>
<td>PA</td>
<td>Paid as Authorized</td>
</tr>
<tr>
<td>PD</td>
<td>Pended, No Prior Authorization</td>
</tr>
<tr>
<td>PE</td>
<td>Pended, Coverage not current</td>
</tr>
<tr>
<td>PAB</td>
<td>Paid amount Billed</td>
</tr>
<tr>
<td>PLA</td>
<td>Paid Less than claimed</td>
</tr>
<tr>
<td>PN</td>
<td>Over Authorization limit</td>
</tr>
<tr>
<td>PZ</td>
<td>Paid Zero Dollars by Insurance</td>
</tr>
</tbody>
</table>

Appeal of Denial

If a claim is denied and Provider feels the claim should be paid, Provider must resubmit the claim and appeal the decision within 30 days of receipt of denial. Appeals of claim denials must be made in writing to:

Kevin McClean, Director of Contracts Management/Provider Relations
MHMR Tarrant
P.O. Box 2603
Fort Worth, Texas 76113
Claims & Billing
Gateway Portal User’s Manual

Using the Web Interface

1. Access to the website can only be granted by going through the MHMR Tarrant IT department. To obtain a user ID and password contact the MHMR Tarrant Director of Contracts Management/Provider Relations at 817.569.4456 or providerrelations@mhmrtc.org

2. Finding the Website

   Go to web address https://gateway.mhmrtc.org/

3. User Login

   Enter your assigned user ID and password. Click on the “Log In” button.

4. If you have logged in incorrectly, it will display the message “Null
User” and refresh the page until you enter the correct username and password. Please contact IT if you do not have the correct log in information.

5. If you have logged in correctly, the following service entry screen will display.

6. Understanding Data Entry Requirements

A grid of text fields is displayed to represent data for one encounter. All fields are required unless otherwise specified.

   a. Prov ID
      - Enter the 4 character provider identifier assigned by MHMR.
      - If you logged in as a provider, this field will automatically default to your ID. If you have two provider IDs, make sure this matches the one you want to use. It can be edited.

   b. Service Date
• Enter the date of service.
• Formats accepted
  o mm/dd/yy
  o or mmddyy
  o mm/dd/yyyy
• For example, a service date of October 5, 2005 can be entered as 100505 or 10/05/05 or 10/05/2005.

c. Time In / Time Out
• Enter the start time for the service. Enter the end time for the service.
• Formats accepted (Time In, Time Out displayed for three-thirty pm to five pm example)
  o hh:mm (military) 15:30, 17:00
  o hh.mm (military) 15.30, 17.00
  o hh:mm AM/PM 03:30 AM, 05:00 PM
  o hh.mm AM/PM 03.30 AM, 05.00 PM
• Note: Must use leading zeros where necessary when using a decimal to replace colon.

d. Service Code
• Enter the code used to bill or report the service.
• It is the service code on the claim
• It is also located on the letter of authorization.

e. Diagnosis Code * (Required for MH providers only)
• Format is XXXXX or XXXXXX
• These are the standard DSM IV codes without the decimal points.

f. Staff Id * (Required for MH providers only)
• Enter a unique staff id of the person who provided the service.

g. License Type
• Enter the server type of the person who provided the service.
• Format is a 2-digit code.
• Specific values are accepted based on the codes below.
• Please contact Pam Nash at 817-569-4436 for further questions regarding which codes to use.
h. Location
- Enter the location where the service took place.
- Value must be one of the 2-character codes below.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HM</td>
<td>Home</td>
</tr>
<tr>
<td>OF</td>
<td>Office/clinic</td>
</tr>
<tr>
<td>GH</td>
<td>General Medical Hospital</td>
</tr>
<tr>
<td>JA</td>
<td>Jail or juvenile detention center</td>
</tr>
<tr>
<td>SC</td>
<td>School</td>
</tr>
<tr>
<td>SF</td>
<td>Service facility, e.g. nursing home, detox center, sheltered workshop</td>
</tr>
<tr>
<td>OT</td>
<td>Other</td>
</tr>
<tr>
<td>SH</td>
<td>State mental health facility</td>
</tr>
<tr>
<td>SR</td>
<td>State intellectual and developmental disability facility</td>
</tr>
<tr>
<td>CS</td>
<td>Community Setting not otherwise described</td>
</tr>
<tr>
<td>NF</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>CI</td>
<td>Community IMD</td>
</tr>
<tr>
<td>CH</td>
<td>State funded community hospital, Lubbock, Houston, and Galveston only.</td>
</tr>
</tbody>
</table>
i. Client ID
- Enter the 9 digit MHMR client ID.
- Must have leading zeros if less than 9 digits.

j. Provider Client ID (optional)
- Provider may choose to enter their own client ID for tracking services
- No specific format.

k. Encounter Type – Choose from the following codes that describe the encounter (or intended encounter type if no-show). Defaults to “F”, if not modified.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Face to face</td>
</tr>
<tr>
<td>E</td>
<td>Video telehealth or telemedicine</td>
</tr>
<tr>
<td>T</td>
<td>Telephone</td>
</tr>
</tbody>
</table>

l. Appointment Type
- Please choose from the following codes that describe the nature of the appointment.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Scheduled appointment for service kept</td>
</tr>
<tr>
<td>2</td>
<td>Unscheduled service</td>
</tr>
<tr>
<td>3</td>
<td>Scheduled appointment canceled by provider</td>
</tr>
<tr>
<td>4</td>
<td>Consumer cancellation or no show</td>
</tr>
</tbody>
</table>

- If a no-show is reported, the service must be marked as non-billable and the time in/out should be the same to indicate zero client time.
- Defaults to “1” if not modified.

m. Recipient Code
- Choose from the following codes to indicate the recipient (or intended recipient) of the service.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Consumer</td>
</tr>
<tr>
<td>2</td>
<td>Collateral</td>
</tr>
<tr>
<td>3</td>
<td>Consumer and family member/LAR simultaneously</td>
</tr>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
- Defaults to “1”, if not modified.

n. Billable Check Box
- Automatically defaults to billable.
- Uncheck this box, only if you want to report encounter data that is not billable. No-shows are considered non-billable.

6. After you enter the data for one claim, hit the “Done” button on the right side of the screen. A grid will display below showing the data that has been added to the batch.

- The grid displays the duration calculated in hours for the Time In and Time Out entered. Be sure to verify this is correct.

- The data in the text-fields defaults to what the user entered previously to reduce the amount of entry. Only changes need to be made before submitting another service to the batch.

- As services are added they are displayed in the grid for review before submission.
The system will not allow a duplicate entry and will display an error message in red at the top of the screen as follows.

Client ID, Date/Time, or Service Code must be different in each line.

The system also does some validation on the date and time format where possible. Error messages will display in red to address these issues. Please contact Steven Forrester of Information Technology if assistance is needed interpreting the error messages.

Claim Dollar Amount will be entered.

7. Editing/Deleting Data from the Batch Before Submission

- Edits can be done within the grid during review before submission.
- To make an edit hit the “Edit” button on the left side of the claim that needs to be updated. The fields become editable in text fields as displayed below (in line 3 of the grid) and two buttons appear to the left of the data. “Update” and “Delete” buttons.

- You can make the necessary changes and hit the “Update” button. To delete the entire entry, hit the “Delete” button and the grid will display an empty line to confirm there was a deletion.

8. Submitting a Batch
• Once you have entered the amount of claims/encounter data that you choose to batch together, the data can be submitted for validation.

• Hit the “Submit” button in the top left corner of the page.

• The grid will be cleared and you will receive a batch reference code filename with a .xml extension. It will display at the top of the page above the “Submit” button.

• You must record this code in case there are any issues you need to bring to the attention of IT. It is the way the batch is tracked.

• This reference code will also be used by you to check if any errors were caught in the validation process before any claims are processed.

9. Checking Errors

• In order to catch errors early in the process, the batch data will be validated for errors so that they can be resubmitted and processed in a timely manner before the claim gets denied.

• Some of the error checks include:
  o Valid client ID
  o Valid provider ID
  o Valid service code
  o Valid location code
  o Valid license type
  o Gateway portal will also search for the correct authorization number for
billable services. This does not have to be entered. If the authorization number is not found and it is marked as billable, then that will also generate an error. Fund source is also looked up for billable services that have an authorization.

- Within a few seconds after you have submitted a batch, your response file will be available.
- You must hit the “Check Responses” button located in the upper left hand corner of the page. The number of responses available is displayed under the button. You must refresh the page in order for this number to be updated as you submit any batches.
- When you hit the “Check Responses” button, the following screen will be displayed.

This will display a list of batches submitted under your log in.

- Choose the one that matches the reference code displayed after you submitted the batch.
- The text area will display the response for the batch that you choose.
- You may also choose to print the response by hitting the “Print Response” button.
- If the batch had no errors you will receive the message:
  Starting processing on file:
  <path name to xml reference file name>
  Finished processing
  Successfully wrote to CMHC file <CMHC filename with
If the file contained errors the response will display an error message with the data submitted that caused the error. Errors need to be researched and resubmitted in another batch. Good “claims” in the batch will go on to be processed. They do not need to be resubmitted. The response should also display a message with the CMHC filename and date stamp to be processed with the claims that went through. If there is a message stating no output was sent to CMHC or there is no CMHC file name at the end of the response file, then none of the claims submitted within the batch went through. Please contact the MHMR IT Dept. if you believe it is a mistake.

10. **Correcting Errors**
- Once you have researched the errors, the data can be resubmitted via the web page in another batch.
- Data in the first batch that was accepted will go on to be processed.

11. **Processing Claims**
- For MHMR staff, you will find the batch in MCO waiting to be processed. The name of the file will match the CMHC file name in the response file for the batch.
- You can run the Edit/Check claims process to find any claim files that need to be processed.

Using the SFTP file transfer Method
1. In this method, providers are allowed to transfer a file to MHMR instead of manually entering the data. The file must be in a specific format.

### 2. File Format

The file format for the input file will be an XML document. The root element will be `<Services>`. `<Provider>` will be the next element with ID as an attribute. All billable/non-billable services are child elements within the Provider element. All service details are attributes of the service element. See below for details.

**XML Schema**

```xml
<?xml version="1.0" encoding="UTF-8" ?>
<Services>
  <Provider ID=""/>
    <Service MHMRClienID="" ProviderClientID="" LocationCode=""
      ServerType="" StaffID="" ServiceDate="" ServiceTime=""
      ServiceDuration="" ServiceCode="" TotalAmountBilled=""
      DiagnosisCode="" Billable="" AppointmentTypeCode=""
      EncounterTypeCode="" RecipientCode="" ProgressNotes="" />
  </Provider>
</Services>
```
Provider element
Supplies information related to a particular provider

Attributes
1. **ID** (4 chars)

Service element
Supplies information about each service

Attributes
1. **MHMRCClientID** (9 chars) Insert leading zeros if <9 chars
2. **ProviderClientID** (10 chars max) (optional field)
3. **LocationCode** (state defined codes, must be one of the following)

<table>
<thead>
<tr>
<th>Possible Values</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>HM</td>
<td>Home</td>
</tr>
<tr>
<td>OF</td>
<td>Office/clinic</td>
</tr>
<tr>
<td>GH</td>
<td>General Medical Hospital</td>
</tr>
<tr>
<td>JA</td>
<td>Jail or juvenile detention center</td>
</tr>
<tr>
<td>SC</td>
<td>School</td>
</tr>
<tr>
<td>SF</td>
<td>Service facility, e.g. nursing home, detox center, sheltered workshop</td>
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<tr>
<td>OT</td>
<td>Other</td>
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<td>SH</td>
<td>State mental health facility</td>
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<tr>
<td>SR</td>
<td>State intellectual and developmental disability facility</td>
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<tr>
<td>CS</td>
<td>Community Setting not otherwise described</td>
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</tr>
<tr>
<td>CI</td>
<td>Community IMD</td>
</tr>
<tr>
<td>CH</td>
<td>State funded community hospital, Lubbock, Houston, and Galveston only.</td>
</tr>
</tbody>
</table>

4. **ServerType**

The CMHC license type codes will be used and converted to the state codes by us.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Physician</td>
</tr>
<tr>
<td>03</td>
<td>Psychologist/PhD.</td>
</tr>
<tr>
<td>05</td>
<td>APN/Prescrip Authority Only</td>
</tr>
<tr>
<td>07</td>
<td>LMSW-ACP</td>
</tr>
<tr>
<td>09</td>
<td>LMFT</td>
</tr>
<tr>
<td>11</td>
<td>LMFT Temporary License</td>
</tr>
<tr>
<td>13</td>
<td>LPC</td>
</tr>
<tr>
<td>16</td>
<td>LMSW</td>
</tr>
<tr>
<td>17</td>
<td>Dietician</td>
</tr>
<tr>
<td>19</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>21</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>23</td>
<td>Speech Therapist</td>
</tr>
<tr>
<td>25</td>
<td>Music Therapist</td>
</tr>
<tr>
<td>27</td>
<td>Cert Recreational Therapist</td>
</tr>
<tr>
<td>29</td>
<td>RN</td>
</tr>
<tr>
<td>31</td>
<td>LVN</td>
</tr>
<tr>
<td>33</td>
<td>Cert. Medication Aide</td>
</tr>
<tr>
<td>----</td>
<td>---------------------</td>
</tr>
<tr>
<td>35</td>
<td>QMHP/QMHP-CS</td>
</tr>
<tr>
<td>37</td>
<td>QMRP</td>
</tr>
<tr>
<td>39</td>
<td>Psychological Associate</td>
</tr>
<tr>
<td>43</td>
<td>QMHP-P/CSSP</td>
</tr>
<tr>
<td>44</td>
<td>Para Prof/NOT QMHP or QMRP</td>
</tr>
<tr>
<td>45</td>
<td>LCDC</td>
</tr>
<tr>
<td>47</td>
<td>Counselor in Training (C.I.T)</td>
</tr>
<tr>
<td>49</td>
<td>Dentist</td>
</tr>
<tr>
<td>50</td>
<td>Other Prof/NOT LPHA</td>
</tr>
<tr>
<td>51</td>
<td>Other</td>
</tr>
<tr>
<td>52</td>
<td>EIS-EL</td>
</tr>
<tr>
<td>53</td>
<td>EIS-FQ</td>
</tr>
<tr>
<td>98</td>
<td>Residential Staff</td>
</tr>
</tbody>
</table>

5. **StaffID** – provider’s staff ID  
6. **ServiceDate** - mmddyy is format required  
7. **ServiceTime** - hh:mm AM/PM is format required  
8. **ServiceDuration** – hh:mm  
9. **ServiceCode** (8 chars max)  
10. **TotalAmountBilled** (dollar format with two decimal places ex. 5.00)  
11. **DiagnosisCode** (6 digit numeric field without decimal. The diagnosis code cannot be more than 6 characters.  
12. **Billable** (The value can either be “True” or “False”)

**Optional Fields**

13. **AppointmentTypeCode**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Scheduled appointment for service kept</td>
</tr>
<tr>
<td>2</td>
<td>Unscheduled service</td>
</tr>
<tr>
<td>3</td>
<td>Scheduled appointment canceled by provider</td>
</tr>
<tr>
<td>4</td>
<td>Consumer cancellation or no show</td>
</tr>
</tbody>
</table>

**Values 3 and 4 must have “00:00” for service duration field**

14. **EncounterTypeCode**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Face to face</td>
</tr>
<tr>
<td>E</td>
<td>Video telehealth or telemedicine</td>
</tr>
<tr>
<td>T</td>
<td>Telephone</td>
</tr>
</tbody>
</table>

15. **RecipientCode**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Consumer</td>
</tr>
<tr>
<td>2</td>
<td>Collateral</td>
</tr>
<tr>
<td>3</td>
<td>Consumer and family member/LAR simultaneously</td>
</tr>
</tbody>
</table>
16. ProgressNotes – free text

**Note:**
Non-billable encounters must be reported in this file. For non-billable encounters all rules apply with the following requirements.
Billable = "False"
AmountBilled= "0.00"

3. Once the file is in the correct format and tests have been run for verification, a file can be transferred.

4. To transfer the file

- An SFTP client must be downloaded on the machine of the person who will transfer the file. This is only done once.
- The client is an executable file that can be sent to the provider via email.
- Open the SFTP client
- Enter the assigned username and password
- Enter “email.mhmrtc.org” for the host name without the quotes.

- Hit the “Log In” button
- A screen displays with file navigation on the left side
and two directories for the provider on the right side—an inbound and outbound.

- You can drag the xml input file from the left side into the inbound directory on the right side.

**Note:** The xml file name is not restricted so a provider is allowed to name it anything. Be sure to use a file naming convention that is easy to track and ensures each file has a unique name so that no files are overwritten.
The above message displays after a file is dropped into the directory. Hit the “Copy” button to copy the file to the Inbound directory.

The outbound directory is where you will find any error responses for the file you transfer. It will be available within an hour after transfer. Only service data for those that have errors need to be resubmitted after corrections are made. Do not resubmit the whole batch. Open the response file that matched the name of the input file with the word “response” in front of it.
Please contact the MHMR IT department for help in understanding the error messages or for any questions.

Contact Information
MHMR of Tarrant County Help Desk
ITAutomated.Helpdesk@mhmrtc.org
817-569-4357

Appeal of Denial

If a claim is denied and Provider feels the claim should be paid, Provider must resubmit the claim and appeal the decision within 30 days of denial. Appeals or resubmission after the 90-day window for filing with Medicaid will not be paid. Appeals of claim denials must be made in writing to:

Kevin McClean, Director of Contracts Management/Provider Relations
MHMR of Tarrant County
P.O. Box 2603
Fort Worth, Texas 76113
Reporting Requirements

Critical Incidents

Providers are **required to call (817) 335-3022** with information regarding the occurrence of any of the following critical incidents immediately:

1. Deaths
2. Suicide Attempts
3. Serious Injuries – injuries which require medical care
4. Serious Medication Errors – the incorrect or wrongful administration of a medication (such as a mistake in dosage, route of administration or intended individual), a failure to prescribe or administer the correct drug, medication omission, failure to observe the correct time for administration, or lack of awareness of adverse effects of drug combinations which place the Referred Individual’s health at risk so that immediate medical intervention or enhanced surveillance on behalf of the Referred Individual is required.
5. Adverse Drug Reaction (ADR) – those responses which are above and beyond the common side effects usually encountered with each medication (unless they are extreme cases). They are undesired and unintended, possibly harmful responses to a drug administered at a normal dosage. Responses may include problems related to cumulative effects, tolerances, and dependency for single-drug administered and drug-drug interactions or multiple drugs administered. Reportable ADRs require some change in the clinician’s care of the client, including the option of discontinuing the medication, modifying the dose, prolonging hospitalization, or taking action to initiate supportive care.
6. Allegations of Homicide, Attempted Homicide, Threat of Homicide with a Plan
7. Confirmed Abuse, Neglect, or Exploitation
8. Discovered Pharmacy Errors – a pharmacy dispensing error including one or more of the following:
   a. Incorrect Label or Directions for Use
   b. Failure To Place Warning Label on Container as appropriate
   c. Incorrect Medication
   d. Incorrect Strength
   e. Incorrect Quantity
   f. Expired Medication
   g. Contraindicated Drug
9. Hospitalizations
10. 911 Called
11. Physical Aggression
12. Auto Accident
13. Fire
14. DNR Order (Do Not Resuscitate)
15. Elopement (Missing Person)
16. Infectious Diseases
17. Criminal Activity
18. Litigation Threat

The MHMR TARRANT Clinical Staff for the Referred Individual must also be notified.
Staff Training

Overview

If Provider is licensed or accredited by a state of federal regulatory agency, some training requirements may be waived. In such cases, the Provider is required to provide external audit reports related to accreditation, licensure or certification. If Provider is not licensed or accredited, the Provider is required to provide training to all staff working with Local Authority clients.

In any case, Provider may submit training policies, procedures and materials to verify that training requirements are met. Training may be provided by the Provider or obtained from another entity as long as the training is related to the required job competencies, as determined by Local Authority. The Providers may receive assistance, upon request, from Local Authority with regard to training. Local Authority will charge for training provided to Provider staff.

Scheduling Training with MHMR TARRANT

Provider is responsible for ensuring all staff receive required training. Provider may elect to purchase required training from the MHMR TARRANT Training Center and, upon request, MHMR TARRANT will provide a calendar of monthly training opportunities for the following month to the Provider. Provider may register staff for classes by sending a fax listing the names of those who will attend to The Training Center at (817) 569-4493 at least one week prior to the scheduled class. Provider will be billed for any persons registered for classes who do not attend unless The Training Center receives a cancellation notice by fax at least twenty-four (24) hours prior to the scheduled class.

Required Training Elements

Provider, its employees and agents who routinely perform any job duty in proximity to persons served must demonstrate competency in the safe management of verbally and physically aggressive behavior (SAMA) before contact with persons served and annually thereafter.

Provider, its employees and agents must demonstrate a thorough understanding of the relevant elements of reporting, investigating, and preventing abuse, neglect, and exploitation (Client Rights Class) before contact with persons served and annually thereafter.

Provider, its employees and agents must receive, read, and understand the MHMR TARRANT Compliance Plan. Provider will agree to abide by the principles contained in the Compliance Plan, including its responsibility to report any known or suspected violations of the Plan.
Credentialing and Clinical Supervision

All staff must complete credentialing process.
LPHA and QMHP staff may not provide professional services until credentialed.

Provider Qualifications

All service providers must have a high school education (or GED), be 18 years of age, and not have been convicted of a crime relevant to a person’s duties including any sexual offense, drug-related offense, homicide, theft, assault, battery, or any crime involving personal injury or threat to another person. Provider is required to provide external audit reports, if any, related to accreditation, licensure or certification. Programs must meet the requirements of those licenses, certifications or accreditations with regard to medication storage, handling, administration and documentation. Providers holding professional licenses and/or certifications must maintain those licenses and/or certifications in good standing with their respective licensing/certifying bodies.

Credentialing

LPHA -- If Provider has its own credentialing process which meets or exceeds standards set forth by Local Authority’s Credentialing Committee, credentialing of staff at the LPHA level may be delegated to the Provider. If credentialing of LPHA level staff is not delegated to Provider, Provider must submit an Application for Credentialing as MHMR TARRANT Outpatient Provider form on each LPHA person. Local Authority will then credential these individuals.

Licensed Practitioner of the Healing Arts (LPHA) - An individual who is:
   A. a physician (M.D. or D.O.) licensed to practice medicine in Texas;
   B. a licensed or certified doctoral-level psychologist as defined in Texas Civil Statues §4495b;
   C. a licensed masters social worker (LMSW)--Advanced Clinical Practitioner (ACP) as defined in the Human Resources Code, Chapter 50; or
   D. a licensed professional counselor (LPC) as defined in Texas Civil Statues §4512g
   E. a licensed Advanced Practice Nurse (APN) as defined in Title 22 TAC, Part II, Chapter 219; or
   F. a licensed marriage and family therapist (LMFT) as defined in Title 22 TAC, Chapter 801.

QMHP - As there is no certification or credentialing process for QMHPs outside the MHMR system, Local Authority will credential all Provider staff at the QMHP level. Provider will submit an Application for Certification as MHMR TARRANT QMHP and original college transcripts for persons wishing to serve as QMHPs to Local Authority as part of the credentialing process.

Qualified Mental Health Professional (QMHP) - A person with at least a bachelor's degree from an accredited college or university with a major in social, behavioral, or human services or is a registered nurse, and:
   A. is clinically supervised by a Licensed Professional of the Healing Arts, and
   B. has demonstrated competency in the work to be performed.
Clinical Supervision

Provider is responsible for ensuring all Provider staff receives appropriate and needed clinical supervision. The requirements shown below are minimum requirements. It is expected that a staff needing additional supervision would receive it as necessary to ensure the quality of the services provided. Supervision meetings, training and chart reviews must be documented and available for review.

Clinical Supervision of a QMHP - Clinical oversight of a QMHP by Provider’s licensed physician, doctoral level psychologist, LPC, LMSW-ACP (LPHA), LMFT, clinical nurse specialist (CNS) in psych/mental health, or APN, including:
A. minimum of 1 hour/month clinical supervision;
B. minimum of 1 hour/quarter of one-on-one supervision;
C. minimum of 4 hours training annually with participation by clinical supervisor, at least 1 hour of which focuses on ethical and therapeutic boundary issues; and
D. review by clinical supervisor of one chart quarterly based on areas specified in demonstrated competency. The clinical supervisor’s focus during these chart reviews is not to replicate Quality Management audits, but to examine whether the QMHP is providing clinically appropriate interventions and services and properly documenting their actions. RNs are supervised by Advanced Nurse Practitioners or, in the absence of an Advanced Nurse Practitioner, by physicians.
LA Quality Management/Contract Monitoring

Contract Monitoring

Local Authority’s Quality Management Department will conduct a variety of reviews, including but not limited to:

- Site Assessments, Infection Control, Safety, and Environmental Reviews
- Clinically focused chart reviews, including Electronic Health Records (EHR).
- Verification of required staff training
- Verification of credentialing of staff
- Verification of documentation of clinical supervision
- Special reviews based on complaints or other client related incidents

Reviews will be scheduled in advance with Provider whenever possible. The Local Authority contact person for Quality Management Reviews is:

Tim Wells, QM Program Manager
3840 Hulen
Fort Worth, Texas 76107
(817) 569-4458
Provider Quality Management

Trends and Patterns
Provider is required to have a mechanism or system in place to monitor the quality of the services provided. This includes a clinical review of records (separate from Clinical Supervision by an LPHA or QMHP) to determine any patterns or trends, implement corrective action or training and monitor for correction. Reports including this information must be provided to Local Authority at least quarterly.

External Survey Reports
If Provider is certified, accredited or licensed by any external agency (such as JCAHO), any findings from that external agency, relevant to the quality of services provided under this contract must be reported to Local Authority. Provider should send a copy or summary of the external report to Local Authority with documentation of corrective action required.
Provider Profile

MHMR Tarrant will collect and maintain information about each Provider’s performance. Such information is reviewed by the Quality Management Committee, the MH Community Advisory Committee, and will include, but is not limited to:

- Number of individuals referred for services
- Number of individuals declined
- Numbers of individuals currently in services
- Number of confirmed abuse, neglect, or exploitation events
- Number of consumer complaints and percentage resolved in thirty (30) days
- Number of critical incidents (medication errors, serious injuries, etc.)
- Consumer satisfaction rating
- Percentage compliance with documentation, billing standards, DSHS standards outcomes, and health/safety standards
Complaints

Complaints from Referred Individuals
Provider must inform Referred Individuals that they may file a complaint with MHMR TARRANT regarding the Provider by calling:

(817) 569-4429
or
1-888-636-6344

MHMR Tarrant will provide notepads to Provider containing this information.

Referred Individuals may also call MHMR Tarrant with suspicions of rights violations, abuse, neglect or exploitation at (817) 569-4429.

Referred Individuals may also call the Texas Department of Family and Protective Services at 1-800-252-5400 or www.txabusehotline.org.

Complaints from Provider
MHMR Tarrant desires a successful partnership with Provider to best serve the Referred Individuals. To this end, MHMR TARRANT encourages Provider to call with concerns, problems and complaints regarding MHMR TARRANT’s operations and interactions with Provider. Complaints should be directed to the Provider Relations @ (817) 569-4456. Every effort will be made to address the issues involved.

Compliance
A compliance program is intended to identify and reduce risk, and improve internal controls. It is the duty of every employee or contractor of MHMR Tarrant to assist in the prevention, detection and correction of any instances

Compliance Hotline
1-800-500-0333

This 24/7 hotline is available to report suspected instances of noncompliance. The hotline is answered by outside personnel to ensure anonymity. These reports are investigated, and the results are then reviewed by a Compliance Committee, which makes recommendations to improve controls within MHMR Tarrant.

The Compliance Program, directed by Compliance Officer Paul Duncan, seeks to ensure that MHMR Tarrant employees provide ethical services and comply with MHMR’s Standards of Conduct. The compliance efforts include a full-time auditing staff that reviews billings for compliance with Medicaid rules and regulations. Examples of noncompliance would include:

- Using an incorrect billing code
- Billing for services not provided
- Billing for services with inadequate or missing documentation
Sanctions, Appeals and Contract Termination

MHMR Tarrant will take punitive action for actions that pose a hazard to Referred Individuals or potentially violate Service guidelines.

Sanctions

MHMR Tarrant will impose sanctions if Provider does not maintain quality services in compliance with state and federal standards. Decisions regarding sanctions are made by the Quality Management Committee. Notice of Default or Notice of Termination will be sent by certified mail to the Provider. Sanctions may include, but are not limited to:

a. Immediate termination of contract
b. Withholding of new referrals
c. Withholding of outstanding payments, in whole or in part
d. Request for recoupment of funds paid to Provider for services
e. Fines, charge backs or offsets against future payments
f. Suspension of contract and referral of existing Referred Individuals elsewhere, pending appeal

Appeal Process

If Provider wishes to appeal a decision by MHMR Tarrant to impose a sanction, Provider must notify Provider Relations in writing within seven (7) days of receipt of a Notice of Default or Notice of Termination of the request for appeal. If Provider has additional information, not taken into consideration at the time the Sanction was imposed, documentation must be submitted with the request for appeal. Correspondence must be sent to:

Kevin McClean, Director of Contracts Management/Provider Relations
MHMR Tarrant
3840 Hulen
Fort Worth, Texas 76107

Appeals of Sanctions will be reviewed by the Quality Management Committee. Provider may be present at the meeting at which the appeal is discussed.

Contract Termination

If the contract is terminated, Provider is expected to cooperate with MHMR TARRANT in the transfer of Referred Individuals to other providers.
References

Texas Administrative Code:
*Rules of the Texas Department of State Health Services Title 25, Part II*

Relevant Rules Grid
- Chapter 404, Subchapter E……… Rights of Persons Receiving Mental Health Services
- Chapter 414, Subchapter A…………..Client-Identifying Information
- Chapter 403, Subchapter B………….Charges for Community-Based Services
- Chapter 405, Subchapter A……….. Prescribing Medications
- Chapter 405, Subchapter K…………Deaths of Persons Served by DSHS Facilities or Community Behavioral Health and Intellectual and Developmental Disabilities Centers (rev.6/95)
- Chapter 414, Subchapter L…………Abuse, Neglect, and Exploitation in Local Authorities and Community Centers
- Chapter 411, Subchapter G…………..Community MHMR Centers
- Chapter 412, Subchapter G………….Mental Health Community Services Standards
- Chapter 414, Subchapter K…………..Criminal History Clearances