

# NorthCare Network

## UTILIZATION MANAGEMENT PLAN FY09 & FY10

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# **NorthCare Network**

## **Utilization Management Plan FY09 & FY10**

### **INTRODUCTION**

NorthCare Network is the Pre-Paid Inpatient Health Plan (PIHP) of the Upper Peninsula (UP). NorthCare manages the Medicaid benefit for mental health specialty services provided by the five Community Mental Health Agencies. The NorthCare Substance Abuse Services composed of Coordinating Agency (CA) and Central Diagnostic and Referral (CDR) manage the Medicaid substance abuse services for the fifteen Upper Peninsula counties.

NorthCare has four separate units. Two units manage access for services:

- NorthCare Access and Eligibility Unit provides access to the public mental health system
- NorthCare Central Diagnostic and Referral (CDR) unit provides access for Substance Abuse services.

Two units monitor the services provided:

- NorthCare Monitoring Unit is responsible for oversight of the five Community Mental Health Boards: Copper Country, Gogebic, Hiawatha, Northpointe, and Pathways.
- NorthCare Coordinating Agency (CA) monitors the substance abuse service providers.

The NorthCare Access and Eligibility Unit is the gateway to the mental health system for people with Medicaid and for others citizens who are uninsured or underinsured (General Fund dollars are used to pay for their services). Individuals with serious mental illnesses, serious emotional disorders, developmental disorders, and co-occurring disorders may apply for routine services through the NorthCare Access Unit. Consumers with Medicaid (and people with Adult Benefit Waiver and MICHild) have a defined benefit plan. This means an individual is eligible for the services listed in the Michigan Medicaid Provider Manual that are medically necessary. Medicaid members may not be put on a waiting list. Consumers in the General Fund category have a defined contribution. This means the individual CMHSP establishes the priorities for accessing services and for what services (other than inpatient care and crisis services) will be provided in their catchment area. The CMHSP may establish a waiting list for consumers in the General Fund category.

The Central Diagnostic and Referral (CDR) provides access for Medicaid Substance Abuse services for the fifteen counties in the region. They are also responsible for a separate funding stream called Block Grant funding for individuals with low incomes or who are indigent. The NorthCare CDR is responsible for the block grant funding in the eight eastern counties in the Upper Peninsula.

NorthCare is responsible for monitoring the regional providers for compliance with federal, state, and local regulations and the legal rights assured individuals who apply and /or receive public mental health specialty services. The NorthCare Substance Abuse Services Provider Manual guides the monitoring of substance abuse services and providers. The manual is available at the NorthCare website [www.northcare-up.org](http://www.northcare-up.org).

The primary focus of this plan is utilization management of the specialty mental health services provided by the CMHSPs. The quality improvement and utilization management requirements are outlined in the Michigan Department of Community Health Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans, effective October 1, 2007 (Attachment P.6.7.1.1 of Amendment Six FY2007-09). The NorthCare Utilization Management Plan outlines the shared responsibility between NorthCare and the CMHSPs for resource management of our public dollars. For monitoring purposes, NorthCare is responsible to assure access and services to Medicaid eligible individuals residing in the service area who have a serious mental illness, a serious emotional disorder, a developmental disorder or co-occurring disorders which result in functional impairments in multiple domains of their lives. However, to assist the public in navigating mental health services in their community, the NorthCare Access & Eligibility Unit manages all calls for assistance for mental health services in the Upper Peninsula regardless of funding source.

## OVERVIEW OF UTILIZATION MANAGEMENT PROGRAM

Over the past six years, NorthCare and the five community mental health boards have worked to create a system of care where direct clinical staff serve as the primary utilization managers. The clinician and the individual eligible for services develop an individual plan of service (IPOS). The nature and intensity of specific services to be provided are determined through the person-centered planning process, considering individual and family supports, the particular service delivery characteristics of the consumer's local community, and the individual's recovery goals. The clinician has the utilization management tools of a level of care determination based on regional standards and a regional benefit plan (available at [www.northcare-up.org](http://www.northcare-up.org)) for Medicaid consumers to guide the selection of medically necessary services at that level of care (Attachment 1). The goal of resource management is achieved by collaboration between the individual (and their family and supports) and the clinician. Together, they determine what services are reasonable and available in the community. If needs beyond the local community providers are identified, the clinician seeks direction from their supervisor.

Each Board has dedicated staff conducting retrospective reviews and providing utilization management of over and under utilization of services. The responsibilities and training required of these professionals is outlined below in Section V and are included in the Delegation Agreement attached to the individual Board's subcontract with the PIHP.

NorthCare has utilization management staff working in the Access Unit and in the NorthCare Monitoring Unit. It is the responsibility of these staff to assist in developing and analyzing

regional reports for meta analysis of utilization patterns and assuring consistent application of eligibility criteria and service provision. A key to successful utilization management is the uniform benefit plan and levels of care used at all levels of analysis.

## **NORTHCARE UTILIZATION MANAGEMENT PROGRAM FOR MANAGING THE CMHSPS**

The NorthCare Medical Director, the Chief Operating Officer, the Utilization Management Coordinator, the NorthCare Access staff and the regional Utilization Management Committee are responsible for oversight of the regional UM processes:

NorthCare Access staff utilization management responsibilities are defined in the NorthCare Access and Eligibility Procedure Manual. The unit is supervised directly by the NorthCare Medical Director. The Access staff conduct the continuing stay reviews for inpatient care for the five CMHSPs and are responsible for the documentation of those decisions.

The UM Coordinator and the regional committee develop and guide utilization review of ongoing services. The committee is composed of key UM/Clinical Supervisory staff from each of the five CMHSPs in addition to NorthCare UM and QI staff. The committee meets on a regular basis. With the implementation of the electronic medical record as of October 2008 at Pathways, and the expectation that the other Boards will be on the same system by the end of FY10, the committee work will focus on trends in service use and identifying areas for program development as the demographics of the region shift.

### NorthCare Staff Qualifications:

At a minimum, NorthCare Utilization Management personnel shall have a master's degree, and a minimum of three years of clinical experience. The UM staff shall have extensive mental health knowledge, substance abuse knowledge, and experience in quality management. Before beginning employment, all staff members must be fully credentialed. Staff member credentials are verified every two years to ensure that licensure/authorization is current. All psychiatrists conducting utilization management reviews shall: (a) be educated and experienced in the area(s) of specialty relative to the review, and (b) be Board Certified or Board Eligible in their profession and/or specialty. Denial determinations are reviewed by health care professionals who have appropriate clinical expertise in treating the consumer's condition or disease. No reviewers will have any material, professional, familial, financial, or other conflict of interest incentives for decision making.

### Utilization Management Processes

- 1) NorthCare and the CMHSPs utilization management processes are based upon three determinations:
  - Medical necessity determination for eligibility for ongoing services—Guidelines for making this determination are established by the Michigan Medicaid Provider Manual

and further direction from the NorthCare Medical Director. The CMHSPs are not required to restrict services to Medicaid consumers but must demonstrate to the PIHP that consumers meeting this definition are served in a timely way. Priority population determinations for general fund dollars -beyond the requirements in the Michigan Mental Health Code -are established by the individual CMHSPs. The NorthCare Access and Eligibility Procedure Manual describes the regional access process for routine services and for ongoing inpatient reviews. The overview of the access process is attached to this plan (Attachment 2). The complete manual is available on Quick Place, the web based collaboration site used by NorthCare and its providers. Community members may call 1-888-333-8030 for this information.

- Level of Care Determinations - an individual clinical determination based on a complete psychosocial assessment; a functional assessment; provisional diagnosis and prior service history.
- Service Selection Determination - CMHSPs utilize the NorthCare Benefit Plan to determine expected services at the assessed level of care. The services authorized are:
  1. Negotiated through a person-centered planning process.
  2. Medically necessary as defined in the Michigan Medicaid Provider Manual, Chapter on Mental Health/Substance Abuse Services, Section 2.5.
  3. Based on Best Practice guidelines and evidence based practices.
  4. Provision of Services - NorthCare monitors the provision of services through prospective, concurrent and retrospective review processes.

## 2) NorthCare's utilization management process for Substance Abuse Services

- For the eligibility determination to receive substance abuse treatment funding through Medicaid, it is necessary to verify current Medicaid coverage that identifies the recipient as a resident within the CA's fifteen-county Medicaid catchment area and demonstrate "medical necessity" for services
- Levels of Care--Intensive level of care determinations are made by the Access Specialist through the NorthCare CDR screening process.
  - Intensive Outpatient (Level 2.1)
  - Residential Treatment (Level 3.3 and 3.5)
  - Sub-Acute Detox ( Level 3.7 D)
  - Methadone
  - Outpatient (1.0) Outpatient Level of Care determinations are conducted by our licensed substance abuse providers

3) Monitoring Enrollee Rights and Protections --UM staff support Customer Services and the Recipient Rights staff to assure enrollee rights and protections are provided to all Medicaid consumers. UM staff conduct:

- Chart audits to verify that consumers have been properly notified of their rights.
- Reviews of cases being managed by the Behavior Treatment Plan Review Committee (BTC) at each CMHSP to assure behavior treatment plans are developed within the person centered planning process and under the guidelines outlined in the Michigan Department of Community Mental Health Technical Requirement for Behavior Treatment Plan Review Committees and the NorthCare Behavior Management Policy.
- Focused reviews to determine whether access to services were appropriately denied.

NorthCare has delegated the authority to the CMHSPs to conduct Fair Hearings that are requested by a consumer at their agency. NorthCare requires the CMHSP to file the Hearing Notice with the NorthCare Chief Operation Officer by fax within 24 hours of being notified of a Fair Hearing Request and to file the hearing disposition findings/decisions with NorthCare. NorthCare may provide technical assistance to the CMHSP when a case is proceeding with the MDCH Administrative Tribunal.

## **ASSIGNED RESPONSIBILITIES FOR UTILIZATION MANAGEMENT ACTIVITIES BY THE PIHP AND CMHSP**

The NorthCare Delegation agreement which is attached to the Affiliate Subcontract outlines the responsibilities of the PIHP and the CMHSP (Attachment 3). The specific expectations and procedures are further delineated in the following supporting NorthCare documents available at [www.northcare-up.org](http://www.northcare-up.org)

- Access Policy
- Accessibility and Accommodation Policy
- Authorization Policy
- Credentialing/Privileging Policy
- Enrollee Rights and Protections Policy
- NorthCare Benefit Plan FY09
- Recovery Policy
- Sanction Policy
- Staff Competencies/Education Policy

### **A. NorthCare shall retain the following Service Authorization and Utilization Management activities, which specifically are not delegated to the CMHSP:**

1. Development, modification and monitoring of PIHP UM Policies, UM Plan including clinical management criteria, Regional Benefit Plan, and other standards to be used by the PIHP provider network.

2. PIHP-level Concurrent and Retrospective Reviews of CMHSP Authorizations and Utilization Management decisions/activities.
3. Final Level of Appeal for Utilization Management decisions (via retrospective reviews and/or consumer preference).
4. Adoption, dissemination, and monitoring of the application of Practice Guidelines, coordination of grant opportunities; and organizing trainings for staff and consumers in evidence based practices focused on recovery.
5. Effective September 1, 2008 all five CMHSP have routine access screening conducted by the NorthCare Access Unit.
6. NorthCare will support two information system(s) adequate to provide reports necessary for MDCH requirements for reviewing over and under utilization. NorthCare will maintain the regional Data Warehouse until the five Boards are all on the EMR platform. The Data Warehouse will continue to receive information from Copper, Gogebic, Hiawatha and Northpointe until the EMR conversion is complete. The conversion is anticipated to be complete in FY10.
7. Other activities as deemed necessary.

**B. The PIHP shall delegate the following Service Authorization and Utilization Management activities to the CMHSP:**

1. Identification and credentialing of designated CMHSP staff determined qualified to perform delegated Service Authorization and Utilization Management functions (i.e. authorizations and local concurrent/retrospective reviews). The CMHSP agrees to maintain an up-to-date roster of such credentialed/privileged staff and to make it available for PIHP review.
2. Initial approval or denial of requested service:
  - Initial assessment and initial authorization of psychiatric inpatient services. It is expected that the consumer experiences a welcoming environment throughout their involvement with Community Mental Health.
  - Four CMHSP will continue to electronically transmit demographic, encounter and UM data to the regional data warehouse for required state reports and over and under utilization management. Pathways will generate comparable data from the EMR in FY09 & FY10 to assure NorthCare regional aggregate and case level information.
  - Ongoing authorization of services to individuals receiving community based services utilizing the principles of recovery; standards established in NorthCare's Access Policy, Service Authorization Policy, Regional Benefit Plan, and the Utilization Management Plan.
  - Services are provided using evidence based treatments as mandated by MDCH and other best practices adopted by the individual CMHSP. Specifically, the CMHSP must demonstrate the availability of Family Psycho Education Groups, Integrated treatment for Consumers with Co-occurring Disorders, Supported Employment and other promising practices for individuals with serious mental illnesses. For children with serious emotional disturbance, treatment may be provided using Parent Management Training Oregon Model or other best practices. Services to consumers with developmental disabilities may include supports for competitive employment, independent living and community participation.
  - Grievance and Appeals management, coordination and notification, and communication with consumers regarding UM decisions, including notice of action, rights to second opinions, and grievance and appeal decisions.

- The amount, scope and duration of benefits available under the PIHP contract and/or NorthCare Benefit Plan are sufficient in detail to ensure that consumers understand the benefits to which they are entitled.
  - Procedures for obtaining benefits, including any local or PIHP authorization requirements.
  - The extent to which, and how, consumers may obtain benefits, including services from an out-of-network provider.
3. **Coordination and Continuity of Care:**  
Implement procedures to coordinate the services that the CMHSP furnishes to the consumer with the services that the consumer receives from other entities such as:
- Local DHS Office;
  - Medicaid Health Plans;
  - Area Agency and Commission on Aging (regional or local);
  - Michigan Rehabilitation Services;
  - Local Multi-purpose Coordinating Body;
  - Local Health Department;
  - Community and Migrant Health Centers;
  - Local Nursing Homes;
  - Local school systems/ISD;
  - Jobs Commission;
  - Local Primary Care Physicians (PCPs)
  - Tribal Health Centers
4. Local communication with consumers regarding the role and purpose of the PIHP's Customer Services and Recipient Rights Office in assisting each consumer (or family) with any consumer complaint, appeal or grievance.
5. Local-level Concurrent and Retrospective Reviews of CMHSP Authorization and Utilization Management decisions/activities to internally monitor authorization decisions and consistency regarding level of need with level of service following PIHP policies and reporting standards.
6. Implementation and application of PIHP Utilization Management Plan to local CMHSP operational practices.
7. Participation in the development of, dissemination, implementation, and application of Practice Guidelines. Implementation of Evidenced Based Practices as required by Medicaid regulations, MDCH and the PIHP.

**C. The PIHP will assess the CMHSP's capacity and capability for carrying out the delegated Service Authorization and Utilization Management activities on an ongoing basis. These assessments may be incorporated into the PIHP's Comprehensive Formal Site Review of the CMHSP.**

The formal assessment by the PIHP may include:

1. A site visit to the CMHSP and/or members of the respective sub-contracting network.
2. Interviews with staff that perform or manage Authorization and Utilization Management Activities.
3. Inspection and review of the CMHSP's Authorization and Utilization Management policies and procedures.
4. Review of training agendas, materials and rosters of trained and credentialed staff conducting utilization management functions.

5. Review of the CMHSP's use and application of PIHP clinical standards and criteria in making utilization management decisions including the PIHP Access Policy, Authorization Policy, UM Plan, and Regional Benefit Plan.
6. Review of the CMHSP's quality improvement program efforts to improve areas of non-compliance or poor performance.

The ongoing monitoring and assessment by the PIHP may include:

1. Concurrent and Retrospective Utilization Reviews conducted by the PIHP of clinical records on an on-going basis. These reviews shall consist of an audit of consumer clinical records:
  - to determine compliance with PIHP standards, policy and procedures,
  - to monitor the timeliness of authorization and utilization management decisions
  - to review denial of services data for trends and patterns,
  - to examine the quality of authorization and utilization management decisions,
  - to identify incongruence's of level of treatment in relationship with level of consumer need,
  - to verify the credentials and qualifications of staff making the decisions,
  - to ensure that the PIHP Grievance and Appeal, Second Opinion and Enrollee Rights and Protections policies are adhered to.
2. Review and Analysis of the CMHSP's utilization activity and reporting of services for both the 1915 (b)/(c) waivers.

The PIHP Review Team will review all assessment data.

1. If the annual assessment (or other incremental assessments via ongoing monitoring) indicates failure on the part of the CMHSP to meet PIHP policy and standards, with regard to the Authorization and Utilization Management delegated activities, it will then be referred to the PIHP for review.
2. Should the PIHP ascertain that the CMHSP is not complying satisfactorily with its delegated responsibilities, it will recommend corrective action.
3. Should the CMHSP not take immediate action to correct the areas of non-compliance within the agreed upon timeframes, the PIHP Chief Operating Officer may then recommend revocation relative to this area of delegation to the PIHP CEO and/or Performance Management Committee.

## **LEVELS OF CARE FOR MENTAL HEALTH SPECIALTY SERVICES**

**Crisis Services are available to all individuals located within the Upper Peninsula and are not defined in a separate level of care. A "crisis" is either consumer defined or an urgent intervention requested by a community referral source. Levels of Care apply to individuals who are going to receive ongoing services at the CMHSPs. (Section VI gives the Levels of Care for individuals receiving substance abuse services.)**

The Michigan Medicaid Provider Manual (July 2008) states in Mental Health Chapter Section 2.5.D that using criteria for medical necessity, a PIHP may:

- Deny services that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care; experimental or investigational in nature; or for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services
- and/or Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.
- A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

The Medicaid Provider Manual then defines the full range of services offered by the CMHSPs. The benefits an individual is eligible to receive are determined by the level of care that is medically necessary. The exact services authorized are determined by the clinical assessment and the person-centered planning process where outcomes are negotiated with the consumer. The levels of care for individuals receiving services are fully described in Attachment Four-- NorthCare Levels of Care. The NorthCare benefit plan offers a mechanism to identify over and under utilization of services at each level of care.

#### **A. Levels of Care for Adults with Serious Mental Illness and Co-occurring Disorders**

##### Level One: Brief Outpatient /Limited Services

MH 1A Brief Outpatient Services

MH 1B Supports Coordination

##### Level Two: Specialized Outpatient Specialty Mental Health Services

MH 2A Supports Coordination / Community Supports

MH 2B Intensive Case Management

MH 2C Assertive Community Treatment

##### Level Three: Residential Treatment Services

MH 3A Foster Care Homes with Specialized Care Contract with CMHSP

MH 3B Treatment Group Home

##### Level Four: Inpatient Care *(not authorized in the Benefit Plan as a routine service)*

MH 4A Acute Inpatient Care (Community)

MH 4B State Hospital Inpatient Care

**B. Levels of Care for Children with Serious Emotional Disorders and Co-occurring Disorders**

Level One: Brief Outpatient /Limited Services

MH 1A Brief Outpatient Services

MH 1B Supports Coordination

Level Two: Specialized Outpatient Specialty Mental Health Services

MH 2A Supports Coordination / Community Supports

MH 2B Intensive Case Management

MH 2C Home Based Services

Level Three: Residential Treatment Services

MH 3A Therapeutic Foster Care

MH 3B Treatment Group Home

Level Four: Inpatient Care *(not authorized in the Benefit Plan as a routine service)*

MH 4A Acute Inpatient Care (Community)

MH 4B State Hospital Inpatient Care

**C. Levels of Care for Adults and Children with Developmental Disabilities** *(Inpatient hospitalization is not authorized in the Benefit Plan as a routine service)*

Level 1: Basic Support services

Level 2: Enhanced Support Services

Level 3: Specialized Support Services & Habilitation Support Waiver for Adults

Level 4: Intensive Residential and Support Services

## ELIGIBILITY AND LEVELS OF CARE FOR SUBSTANCE ABUSE SERVICES

### A. General Information

Medicaid services are aimed at achieving permanent changes in an individual's behavior with respect to harmful alcohol or drug use. Lifestyle, attitudinal, and behavioral changes enhance an individual's ability to achieve his or her treatment goals and abstain from non-healthy use of substances.

Descriptions of levels of care and treatment services are paraphrased, based on the ASAM Patient Placement Criteria, Second Edition Revised (PPC-2R). Other than the initial assessment, all levels of treatment require a diagnosis of substance abuse or substance dependence in order to be reimbursable. Services shall be provided in the amount, for the duration, and with the scope that is appropriate to reasonably achieve the desired treatment objectives for the individual client.

### B. Screening/Updates

#### **Screenings and Updates are administered by qualified NorthCare staff.**

A standardized assessment instrument with a biopsychosocial orientation and application of DSM-IV criteria for substance dependence and substance abuse determines the need for intervention. A brief screening is used to determine level of care when treatment is warranted.

**Screening** – tool used to determine level of care. **Update** – Shortened version of the screening – used if client has had a screening within the last 6 months. The update is also administered if the client did not enter treatment when scheduled from a NorthCare CDR referral.

Network providers screen all clients for co-occurring disorders as part of the routine intake/assessment process. Screening information may be incorporated into the agency's intake forms, interview procedures, or in a separate screening form.

Specialty programs are available: The Salvation Army Harbor Light – Deaf/Hard of Hearing Substance Abuse Program, Closed Head Injury – Personal Therapists, Inc., Project Rehab Hispanic Program, New Hope – Women's Residential – Women and Families Program, Great Lakes Recovery Center – Adolescent Services, NorthCare refers and coordinates services based on medical necessity. In cases where clients do not meet criteria for addiction services, referrals are offered as appropriate. Consumers requesting outpatient services are assessed by the treatment provider of their choice.

## **C. Clinical**

Medical necessity determines need for services. Services are defined as clinically appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments. Services are provided in the least restrictive environment utilizing the most cost effective option. Clients are considered a federal priority when they meet one of the following criteria: 1) the client is pregnant and abusing substance abuse 2) the client is an IV drug user

## **D. Authorization of Substance Abuse Services**

### 1. Outpatient Treatment/Aftercare (Level 1.0)

Outpatient services are offered in a non-residential setting by appropriately credentialed addiction personnel. Regularly scheduled sessions of 9 or fewer contact hours occur per week may include individual, family, and/or group sessions. Limited biopsychosocial assessment (within 14 days of admission), individualized treatment planning, and appropriate documentation of progress are required components. Client will be assessed and found to meet criteria outlined in the ASAM-PPC-2R and criteria in the DSM-IV for substance dependence/substance abuse.

### 2. Intensive Outpatient (Level 2.1)

Intensive outpatient treatment can be provided in 9 (minimum) to 19 (maximum) hours of structured services per week. The expectation in our region is that an IOP client receives 3 four-hour days of treatment or 4 three-hour days of treatment per week. Individual therapy, group sessions, and family counseling are typically included, as well as didactic elements concerning alcohol and drugs. Client will be assessed and found to meet criteria outlined in the ASAM-PPC-2R and criteria in the DSM-IV for substance dependence/substance abuse.

### 3. Sub-Acute Detoxification (Level 3.7)/Social Detox (Level III.2D)

Sub-acute detoxification is determined by qualified medical personnel. The Clinical Institute Withdrawal Assessment (CIWA) may be used to rate the severity of withdrawal symptoms.

Social Detox emphasizes peer and social support for persons who warrant 24-hour support (ASAM Level III.2D). These services must be provided under the supervision of a certified addictions counselor. Services must have arrangement for access to licensed medical personnel as needed.

### 4. Evaluation for Appropriateness of Methadone Therapy

Marquette General Hospital provides evaluation for Methadone Therapy. Assessments are performed by addictionologist/physician, behavioral health professional, and/or other medical staff. The CDR provides referral for clients to the Center for Intensive Addiction Services at MGH. Clients appropriate for Methadone treatment are assisted in gaining entry to treatment. A contract is in place with Eastside Clinic in Petoskey and Quality Addiction Management on Green Bay.

## 5. Residential Treatment

Residential treatment may be authorized by NorthCare for up to 22 days of treatment. Admissions must be based on: medical necessity, AAR service requirements and an LOC determination based on an evaluation of the 6 assessment dimensions of the current ASAM Patient Placement Criteria.

The same standards for medical necessity are applied for substance abuse services as are used for specialty mental health services (Attachment 1).

# CLINICAL AUTHORIZATION REQUIREMENTS FOR CMHSP

## **A. Authorization Requirements for Outpatient Mental Health Services**

Ongoing services for outpatient treatment are authorized at the local provider level. The authorization standards established in the NorthCare Authorization Policy guide local procedures including decisions regarding an individual receiving services from a provider other than the Community Mental Health Board where they reside (also known as their Board of Financial Responsibility). The Michigan Mental Health Code requires an initial plan of service to be completed within seven (7) days of the assessment. NorthCare requires a comprehensive IPOS to be completed within 90 days of the clinical assessment. Each provider agency reviews the consumer's IPOS according to the frequency determined by the PCP, and that data is available to NorthCare according to the provisions in Section IV of this plan.

## **B. Authorization Requirements for Residential Treatment for Mental Health Services/Developmental Disability Supports**

Medicaid funds may be used for mental health treatment that occurs while consumers are placed in residential facilities, but may **not** be used for room and board. Residential placement and continuing stay reviews are the responsibility of the provider agency. Each CMHSP shall have a placement review committee that is responsible for monitoring all residential placements. The reviews for continuing authorization shall be conducted at a frequency defined in the IPOS or as clinically indicated.

## **C. Authorization Requirements for Community Inpatient Care for Mental Health Treatment**

### 1. Initial Authorization

NorthCare, through the local agencies, offers referral and crisis services as well as hospital emergency authorizations 24 hours a day, 7 days a week. Initial authorization (24 hours) for psychiatric inpatient treatment is the responsibility of the local CMHSP. NorthCare will be electronically notified of initial admission to an inpatient psychiatric facility immediately if within normal business hours or by 10:00 a.m. EST the next

business day if admission occurs after normal business hours. The regional emergency services screening form will be used to provide all essential data to NorthCare.

## 2. Concurrent Review

After the initial provider authorization for inpatient treatment, consumers are automatically entered into the PIHP concurrent review process to ensure monitoring and evaluation for medical necessity according to procedures outlined in the NorthCare Authorization Policy. NorthCare has delegated the responsibility of authorizing continuing inpatient stays at hospitals other than Marquette General Hospital and War Memorial to the local CMHSPs. A Notice of Action is mailed to the consumer upon discharge. At Marquette General Hospital, Notice to Medicaid and non-Medicaid consumers will be provided by NorthCare. At all other hospitals, NorthCare will provide Notice to Medicaid consumers and the CMHSPs will provide Notice to Non-Medicaid consumers. If questions arise regarding the appropriateness and necessity of the initial admission, the case is reviewed by the Staff Psychiatrist and/or Medical Director and Utilization Reviewer. The psychiatrist may determine further inpatient treatment does not meet medical necessity criteria, and issue a denial for any continuing stay. Admission information should identify a preliminary discharge plan, and ongoing discharge planning and aftercare arrangements/post-stabilization services are the responsibility of the CMHSP provider. This preliminary discharge plan developed by the CMHSP shall be documented in the hospital clinical record no later than 48 hours (2 business days) following admission. This document could be prepared by the CMHSP and faxed to the hospital or it may be requested by the CMHSP that the plan be documented by the hospital social worker. The CMHSP's are responsible for discharge and aftercare planning; however, NorthCare UM staff may be utilized for consultation and/or resource development in this process.

The CMHSP must register the authorizations with NorthCare following the review. In the event that the UM staff determines that medical necessity criteria are not met, the case is reviewed by the CMHSP staff psychiatrist or the NorthCare Medical Director, and if supported, a denial notice is given to the provider/facility.

## 3. Retrospective Review

When a retrospective review for an inpatient admission/treatment episode is warranted (i.e., retroactive Medicaid eligibility determination or a high co-insurance payment for a dually insured consumer), the provider/facility shall submit the necessary documentation to NorthCare review staff. All pertinent information will be reviewed with staff psychiatrist. A determination will be made regarding the medical necessity of the inpatient admission/treatment episode. This determination shall be made within 30 days of receipt of the information needed to conduct the review. If the admission and continuing stay are supported, all parties involved shall receive notification within one (1) business day of the decision. When a determination is made not to authorize an admission and/or continuing stay, the hospital is notified.

## D. Requirements for State Facility Placement

### 1. Authorization

Each CMHSP is responsible for authorizing any inpatient days at a state facility. NorthCare recommends at least quarterly reviews of all state facility placements and requires that the placement be reviewed by a face to face assessment by the CMHSP staff at least once a year

### 2. Discharge

Discharge planning includes submitting an application to NorthCare for Habilitation Supports Waiver for the consumer returning to the community. If a CMHSP determines not to apply for the waiver, documentation must be submitted to NorthCare with the rationale for the decision.

## CROSS REFERENCES

- Michigan Mental Health Code (Act 258 of the Public Acts of 1974 as amended)
- Michigan Medicaid Provider Manual, Mental Health/Substance Abuse Chapter available on the website [www.mdch@michigan.gov](mailto:www.mdch@michigan.gov)
- Michigan Department of Community Health Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans, effective October 1, 2007 (Attachment P.6.7.1.1 of Amendment Six FY2007-09).
- MDCH Contract Attachment P.1.4.1-10/01/08 Technical Requirement for Behavior Treatment Plan Review Committees
- NorthCare Benefit Plan available on the website [www.northcare-up.org](http://www.northcare-up.org) or by calling 1.888.333.8030

## ATTACHMENTS

- Attachment 1      Medical Necessity from the MDCH Medicaid Provider Manual
- Attachment 2      Overview of the NorthCare Access Unit
- Attachment 3      NorthCare Delegation Agreement effective 10-08
- Attachment 4      NorthCare Level of Care FY09 & FY10