LAPEER COUNTY COMMUNITY MENTAL HEALTH **Date Issued** 09/19/2008
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CHAPTER Administrative	**CHAPTER** 01	**SECTION** 002	**SUBJECT** 55
SECTION Operations	**DESCRIPTION** Utilization Management Policy		
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APPLICATION:

☒CMH Staff	☐Board Members	☒Provider Network	☒Employment Services Providers
☐Employment Services Provider Agencies	☒Independent Contractors	☐Students	☒Interns
☐Volunteers	☐Persons Served		

POLICY:

Lapeer County Community Mental Health (LCCMH) has a comprehensive Utilization Management (UM) Program ensuring all persons served receive timely, clinically appropriate mental health care in the most cost-effective manner.

STANDARDS:

A. LCCMH has utilization review processes for persons served, including concurrent review, transition and discharge planning, retrospective reviews, and over and under-utilization reviews to ensure adherence with all applicable Federal, State, and Accreditation standards.

B. The LCCMH UM Committee conducts utilization reviews to ensure the UM Program is obtaining the desired outcomes.

    1. Utilization reviews are completed by reviewing supporting case chart documentation, including chart adherence to clinical protocols, clinical

documentation requirements, and clinical appropriateness of treatment planning decisions.

2. Utilization reviews are completed through a peer review process for periodic chart reviews, using high or low utilization outlier and performance criteria, annually established by the UM Committee.

3. The UM Committee may indicate specialty focused utilization reviews based upon utilization trend data being analyzed by the Committee.

C. LCCMH collects the following information in the persons served Electronic Health Record (EHR):

1. Persons served demographic data (age, disability groups, diagnosis, problems, levels of care, and treatment)

2. Data regarding the appropriateness and timeliness of admission

3. Documentation and assessment tools to help support the medical / clinical necessity of continued stay in LCCMH Services.

D. LCCMH follows Region 10 Prepaid Inpatient Health Plan (PIHP) Policy 01.05.01 Utilization Management Program for all Medicaid persons served.

E. For non-Medicaid persons served, LCCMH ensures Level I Authorization decisions are made using clinical protocols defined by the Michigan Department of Health and Human Services (MDHHS) Service Selection Guidelines and Medical Necessity Criteria. LCCMH ensures:

1. Authorizations pertain to services in the Individual Plan of Service (IPOS) of the person served, as developed through a Person-Centered Planning (PCP) process.

2. All authorizations and services are delivered in the context of the clinical protocols and practices.

3. Primary case holders requesting Level I services and Level II authorizations are appropriately trained and credentialed.

4. Supervisors authorizing Level I services are appropriately trained and credentialed.

F. As part of the UM Program, LCCMH has a Behavior Treatment Plan Review Committee to review and monitor cases requiring the use of restrictive behavioral plans and cases involving the use of psychotropic medication for behavioral control. See LCCMH Policy 01.002.45 Behavior Treatment Plan Review Committee (BTPRC).

PROCEDURES:

A. Utilization review activities are coordinated by the LCCMH UM Committee.

1. The Quality Improvement Supervisor chairs the UM Committee. The committee consists of at least the Chief Clinical Officer, the Data Management Supervisor or designee, and one staff for data entry and report writing.

2. The LCCMH UM Committee reviews LCCMH service performance and recommends any appropriate improvement and/or corrective action.

3. Utilization review reports, including findings and recommendations, are issued by the UM Committee Chair.

4. Utilization review reports are reviewed by the LCCMH Management Team.

5. A summary report is developed and presented at least annually to the LCCMH Quality Council and the LCCMH Board of Directors.

B. The UM Committee Chair works with the PIHP UM Committee to determine committee review priorities, goals and review focus / special studies for the upcoming year based on recommendations from the Annual Report.

C. The LCCMH UM Committee conducts peer review and monitoring activities. Reviews may be concurrent or retrospective.

1. The LCCMH UM Committee develops and posts an annual UM Peer Review Schedule. Reviews are conducted three quarters per year.

2. The LCCMH UM Committee develops a review tool for staff to use for peer reviews and ensures it monitors:

    a. And evaluates the quality and appropriateness of services, level of care and performance of staff.

    b. Compliance with the Level I / II authorization protocols.

    c. Compliance with MDHHS service selection guidelines, person-centered planning requirements, and case management choice guidelines.

    d. Compliance with documentation and coding standards.

3. The Quality Department provides written notification of the case selection to the LCCMH Clinical Supervisors. Cases may be chosen using any of the following criteria:

    a. High and low-utilization selection of both open and recently closed.

    b. Cases identified as outliers for over or under-utilization.

    c. Random selection of cases.

    d. Cases specifically requested for review by LCCMH Staff or Supervisors.

4. The Quality Department collects completed peer reviews from clinical supervisors and calculates scores for each domain and overall, by department and for the agency overall.

5. Clinical supervisors are responsible for addressing areas of non-compliance with individual staff and/or addressing themes within their department.

    a. Identified areas of non-compliance require follow-up within 60 days.

    b. The clinical supervisor works with the individual staff to bring the case into compliance and re-submits the review tool to the Quality Department to re-calculate the score.

6. Department and agency scores are shared with clinical supervisors.

DEFINITIONS:

Authorization: A key component of the Utilization Management Program. Service authorization is a process designed to help assure planned services meet medical necessity criteria and/or are appropriate to the conditions, needs, and desires of the person served. Authorization generally occurs before services are delivered, but may occur at some point during service delivery or after services have been delivered in cases of emergent situations. In all situations, all service authorizations must meet medical necessity review criteria as specified in the clinical protocols. LCCMH uses three types of service authorizations:

1. Access - Initial Service Authorization: The function performed directly by the Region 10 PIHP Access Services that:

    a. Determines eligibility for specialty benefit services;

    b. Authorizes the start of specialty services, including the initial intake, any Level II services.

2. Level I - Service Authorization: Services authorized at the LCCMH clinical supervisor level occurring as part of and an outcome to, the person-centered planning process for services meeting the medical necessity criteria in the clinical protocols, and that are specified in the Individual Plan of Service (including intensity, scope, and duration). These service authorizations are for

treatment services other than hospitalization, partial hospitalization or crisis residential.

3. Level II - Service Authorization: Is a function performed directly by the PIHP. Level II Service Authorizations prior authorize all requested Level II services (hospitalization, partial hospitalization and crisis residential) emanating from the person-centered planning process with the person served, meets the medical necessity criteria of the clinical protocols, and are specified in the Individual Plan of Service.

CAFAS: Child and Adolescent Functional Assessment Scale is a tool used to measure functioning of children and adolescents in daily life activities. It is designed to assess emotional, behavioral, psychological and substance use problems in youth.

Clinical Protocols: A set of service descriptions which outline all services available to eligible persons served. The descriptions include service definitions, eligibility criteria, service settings, appropriate service providers, and typical utilization patterns. The clinical protocols are routinely updated to reflect consistency with utilization findings (utilization trends, successful clinical outcomes / best practices) and service purchaser contracts, such as Medicaid.

Clinical Supervisor: LCCMH credentialed Bachelor's or Master's level behavioral health care professional staff with experience in system access eligibility screenings, level-of-care determinations, referrals, service authorizations (Level II), and utilization management activities.

Concurrent Review: Examining and evaluating the appropriateness of a service at the time of service request and throughout the period of service delivery.

LOCUS: Level of Care Utilization System-A tool used to assess the current clinical needs of the person served and assist in establishing the intensity of service needs.

Person Centered Planning (PCP): A process for planning and supporting the person served, building on the person's capacity to engage in activities promoting community life and honor the preferences, choices, and abilities of the person served, while ensuring specialty services address their desired services, supports, outcomes, and goals. The person centered planning process involves families, friends, and professionals as the person served desires or requires. (Michigan Department of Health and Human Services, 1998)

Retrospective Review: Examining and evaluating the appropriateness of services authorized and provided for a particular person served after the services have been rendered.

Supports Intensity Scale: A strength-based comprehensive assessment tool, for adults with an intellectual or developmental disability, measuring the person's potential support needs in personal, work-related and social activities in order to identify the type of support the person may benefit from.

Utilization Management (UM): The system which consists of a set of functions and activities focused on ensuring eligible persons served receive clinically appropriate, cost-effective services delivered according to clinical best practice guidelines, focused on obtaining the best possible outcomes.

Utilization Review (UR): The medical record review process established to ensure that the Utilization Management Program service standards, protocols, practice guidelines, and authorizations are adhered to by all service providers.

Utilization Management Committee (UMC): The designated committee responsible for providing oversight, management, and reporting of the overall UM Program on behalf of LCCMH.

REFERENCES:

LCCMH Policy 01.002.45 Behavior Treatment Plan Review Committee (BTPRC)

Region 10 PIHP Policy 01.05.01 Utilization Management Program

SK, LM, LR

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This policy supersedes
#09/08044 dated 09/19/2008.
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