**Community Mental Health Affiliation**
**of Mid-Michigan**

| **PROCEDURE #:** 2.3 | Page: 1 of 6 | **SUBJECT:** Level of Care Assessment |
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| **Related Policy(ies) #:** 2.0 | | **SUBJECT:** Clinical Policy |
| **Issuing Director:** Director of Affiliation Operations | | **Original Effective Date:** 03/10/2010 |

**REVISED DATE**

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**Review Date(s)**

| 03/18/2011 | | | | | |
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## I. PURPOSE:

This procedure is to be used as a guide in the utilization of the LOCUS tool. This tool is to be used like the CAFAS as a tool, one of several tools, used in determination of level of care needs for persons requesting services and ongoing assessment. At no time is this tool or any other tool to be used to the exclusion of good clinical assessment and the case by case review of the individual's needs.

**NOTE:** If an Affiliate CMHSP currently is utilizing an acceptable tool/method for determining level of need for persons requesting services, then that CMHSP may continue to utilize that tool/method until which time they choose to change. If an Affiliate CMHSP chooses to stop utilizing their current tool/method, then at that point, that CMHSP will adopt the use of the LOCUS tool.

## II. STANDARDS:

## III. DEFINITION(S):

A. **Affiliate**: All members of the Community Mental Health Affiliation of Mid Michigan (CMHAMM), including the PIHP.

B. **Beneficiary Eligibility:** (As found in the Medicaid Provider Manual dated January 1, 2010 as amended to exclude Developmental Disability or substance abuse without a co-occurring mental illness.)

A Medicaid beneficiary with mental illness or co-occurring disorders who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual's clinical record.

The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or co-occurring disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

<table>
<tr><th>In general, MHPs are responsible for outpatient<br>mental health in the following situations:</th><th>In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:</th></tr>
<tr><td><ul><li>The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability.</li><li>The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.</li></ul></td><td><ul><li>The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities</li><li>The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse.</li><li>The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.)<br>The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.</li></ul></td></tr>
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The "mental health conditions" listed in the table above are descriptions and are intended only as a general guide for PIHPs and MHPs in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors from the MHP and the PIHP. The critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary.

Medicaid beneficiaries who are not enrolled in a MHP, and whose needs do not render them eligible for specialty services and supports, receive their outpatient mental health services through the fee-for service (FFS) Medicaid Program when experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. Refer to the Practitioner Chapter of this manual for coverages and limitations of the FFS mental health benefit.

Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria contained in this chapter, be appropriate to the individual's needs, and meet the standards herein. A person-centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDCH/PIHP contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities.

C. **Medical Necessity: (**As defined in the Medicaid Provider Manual dated January 1, 2010.)

1. **2.5 MEDICAL NECESSITY CRITERIA**

   The following medical necessity criteria apply to Medicaid mental health and co-occurring supports and services.

   a. **2.5.A. MEDICAL NECESSITY CRITERIA**

      Mental health and co-occurring services are supports, services, and treatment:

      i. Necessary for screening and assessing the presence of a mental illness, co-occurring disorders and/or
      ii. Required to identify and evaluate a mental illness, co-occurring disorders; and/or
      iii. Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, co-occurring disorders; and/or
      iv. Expected to arrest or delay the progression of a mental illness, co-occurring disorders; and/or
      v. Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

   b. **2.5.B. DETERMINATION CRITERIA**

      The determination of a medically necessary support, service or treatment must be:

      i. Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
      ii. Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
      iii. For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
      iv. Made by appropriately trained mental health and co-occurring disorders professionals with sufficient clinical experience; and
      v. Made within federal and state standards for timeliness; and
      vi. Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
      vii. Documented in the individual plan of service.

   c. **2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP**

      Supports, services, and treatment authorized by the PIHP must be:

      i. Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
      ii. Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
      iii. Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and

iv. Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
v. Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

d. **2.5.D. PIHP DECISIONS**
Using criteria for medical necessity, a PIHP may:
i. Deny services that are:
1. Deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
2. Experimental or investigational in nature; or
3. 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
4. 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.

## IV. PROCEDURES:

Adult persons with presenting with mental illness symptoms will be assessed for determination of diagnosis and medical necessity to receive Community Mental Health Services as defined in the Medicaid Provider Manual.

A. As a part of the face to face assessment the LOCUS tool will be used to assist in the determination level of care.
B. The information contained in the assessment and utilized in completing the LOCUS will be based upon information received from the consumer, family, guardian or any interested party with the permission of the person being assessed.
C. The outcome of the tool will be included in the assessment and treatment recommendations.
D. Those persons falling outside the parameters listed below will have clinical justification for level of care authorized/provided contained in their assessment.
E. It is also expected that the tool will be used at least annually thereafter as a part of the re-assessment and planning process to determine level of care, areas in need of treatment and ongoing qualification for services.

## V. APPLICATION:

All CMHAMM Community Mental Health Service Providers.

## VI. MONITOR AND REVIEW:

This procedure will be monitored by the Director of Affiliation Operations, with input from the Improving Practices Leadership Group. The Director of Affiliation Operations reviews this policy annually, with input from the Improving Practices Leadership Group. External review will include MDCH and CMS site visits.

## VII. RELATED POLICIES AND PROCEDURES:

| CMHAMM Policy | 2.0 | Clinical |
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**ATTACHMENT A:**

**Adult Serious Mental Illness (SMI) Criteria**

➔**Please note that CMHAMM PIHP is only required to monitor the provision of Medicaid funded services. As such, affiliate boards are only required to use this for Medicaid purposes only. Other determinations of care are based upon available funding by each board**

➔**Those persons falling outside the parameters listed below will have clinical justification for level of care authorized/provided contained in their assessment.**

| Level 1<br><br>SMI Criteria Not Met <15 | Level 2<br><br>SMI Criteria Met with Prior Service - LOCUS 15-17 | Level 3<br><br>SMI Criteria Met LOCUS 18-20 | Level 4<br><br>SMI Criteria Met LOCUS 21-24 | Level 5<br><br>SMI Criteria Met LOCUS 24+ | Level 6<br><br>SMI Criteria Met LOCUS Harm to self or others of 5 |
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| Refer to Medicaid Health Plan, private insurance carrier, Medicare provider or community resources. | Refer to Medicaid Health Plan, private insurance carrier, Medicare provider or community resources. Unless ABW | Refer to CMH Core services should be considered | Refer CMH Services- ACT , ACT/IDDT, Community based Residential or Partial Hospitalization should be considered | Community based Residential, Partial Hospitalization or Crisis Residential should be considered | Psychiatric Inpatient should be considered |

**Other Eligibility Conditions**

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| Jail Diversion | Provide medically necessary services for those who qualify. |
| MPRI | Provide medically necessary services for those who qualify. |
| EPSDT | Provide medically necessary services for those who qualify. |
| OBRA | Provide medically necessary services for persons in CMHAMM nursing homes assessed by OBRA as needing specialized mental health services. |
| MHC Sec. 707 | Provide not more than 12 sessions or 4 months to a minor 14 years of age or older without parental consent. |
| Court Ordered Alternative Treatment | Supervise alternative treatment and/or provide treatment if no other provider available as some with private insurances may provide the ongoing services. |
| COFR | Provide requested services if there is capacity to do so. |