

Practice Guidelines
of the
Community Mental Health Affiliation
of Mid-Michigan
issued by the
Community Mental Health Authority
of Clinton-Eaton-Ingham Counties,
the Prepaid Inpatient Health Plan

PREAMBLE

The purpose of the CMHAMM Practice Guidelines document is to determine eligibility for services and assist in making determinations regarding the continued necessity for care. This document, however, is **not** intended to determine nor establish case rates for services provided.

In addition, the services outlined in each of the population specific Practice Guidelines are available to any individual who meets the eligibility criteria for that service; e.g., an individual with a developmental disability is eligible to receive MI-Adult services if they meet the specific eligibility requirements outlined in the MI-Adult section of the Practice Guidelines.

GUIDING PRINCIPLES FOR PRACTICE GUIDELINES

The following documents comprise the Community Mental Health Affiliation of Mid-Michigan's Practice Guidelines, and are to be used by its members in determining medically necessary supports, services or treatment. These guidelines are based upon those guidelines established in the Michigan Medicaid Provider Manual. As with all Medicaid funds, in addition to these Practice Guidelines, providers are bound by the Medicaid Provider manual and all Medicaid bulletins. While all of these services contained in this manual are eligible for Medicaid funding, access to these services will be determined based on the criteria outlined in these documents. Least restrictive and more cost effective service(s) will be utilized whenever positive consumer driven outcomes can be achieved. If a provider would elect to use any alternative service not listed in these documents, other funding sources would have to be utilized.

REVIEW PROCESS FOR THE PRACTICE GUIDELINES:

The Affiliation Utilization Management Committee will review all updates/changes made to the Mental Health and Substance Abuse chapter within the Medicaid Provider Manual on a quarterly basis. The Utilization Management Committee will make draft updates to the Practice Guidelines reflecting the required updates/changes. These updates to the Practice Guidelines will be communicated to the Affiliation Compliance Administrator who will inform the Affiliation Director of Operations and the PIHP staff responsible for each content area that has required update/change. The PIHP staff will review the draft changes/updates made to the Guidelines and inform the Affiliation Compliance Administrator of their approval or if they have questions/comments. Once the PIHP staff approve the updates/changes, the Affiliation Compliance Administrator will inform the Director of Affiliation Operations and the Affiliation Secretary who will make the updates/changes to the Practice Guidelines posted on the Affiliation website. Once the updates have been made, the Affiliation Compliance Administrator will inform the appropriate individuals/groups within the Affiliation.

The PIHP's Practice Guidelines provide utilization management criteria for certain levels of care and qualification guidelines for enhanced/extended care services. As such, the Practice Guidelines are a framework for determining what conditions are appropriate for which service (or combination of service components), at what level of intensity, and for how long. The Practice Guidelines: (a) identify the clinical variables to be considered in the needs assessment process; (b) include Level of Care Guidelines – Utilization Management Criteria Protocols in

three basic categories; and (c) describe how Protocols are to be applied in the context of the Person-Centered Planning Process and within the parameters of the Medical Necessity Criteria.

An Interactive Planning Climate

The most important characteristic of an effective mental health service delivery system is the appropriate matching of services and supports to consumer need, based upon individual clinical conditions and circumstances, and to the maximum extent possible, personal choice. The planning climate is influenced, in large measure, by three critical and interactive dimensions – clinical conditions, the person-centered planning process, and a set of non-traditional medical necessity criteria adopted by the MDCH. It is fair to say that the relative importance or weight given to each of these dimensions will vary according to conditions and circumstances and is likely to change over time for individual consumers. No single algorithm or weighting can precisely represent the subtle variations in balance that will emerge. Nevertheless, the Level of Care Protocols provided herein provide considerable direction and guidance for consumers and service providers in reviewing these dimensions and making decisions based upon these considerations.

Needs Assessment Process – Clinical Variables

In order to develop an accurate estimation of the severity of a given illness and the required care setting or intensity of services and supports necessary to safely and appropriately treat the particular disorder, each Level of Care Protocol requires a clinical assessment of symptom acuity, functional impairments, and clinical stability (risk potential). An assessment of these variables, and the additional dimension of duration of the disorder, is generally sufficient to determine whether or not the preconditions to qualify for mental health services has been met – a primary, validated DSM-IV or ICD-9 (10) diagnosis (excluding v codes).

The Practice Guidelines provide the framework for determining who is eligible for which service (or combination of service components), at what level of intensity, and for how long.

The level of care selected as a response to consumer needed strength will depend upon the clinical assessment of Severity of Illness (SI), consumer preferences (when possible), available care settings (Intensity of Service options) and attention to the concepts of treatment suited to condition, least restrictive clinically appropriate environment and medical necessity. It is recognized that some individuals presenting with an urgent or emergent mental health problem may not require admission to any of the levels of care described in this protocol because basic crisis intervention response activities (assessment, counseling, support, etc.) are sufficient to resolve the crisis situation.

When an individual has multiple service needs that involve multiple life domains or treatment of an extended duration, the following practice shall be used:

Exploration of the potential resources for supports and services to be included in the individual's plan are to be considered in this order:

1. The individual
2. Family, friends, guardian, and significant others
3. Resources in the neighborhood and community
4. Publicly-funded supports and services available for all citizens
5. Publicly-funded supports and services provided under the auspices of the Department of Community Health and Community Mental Health Services Program

The reader will note that the differences among the criteria for various levels of care contained in these protocols are often very subtle. This reflects the interplay and influence of three interacting and often overlapping concepts: symptom acuity, functional impairments, and risk potential (clinical stability). An appreciation of these variables and their relative intensity in any particular situation is crucial for developing an estimation of the severity of a given illness, and for determining the required care setting or service intensity necessary to safely and appropriately treat the particular mental health need.

In all situations, eligibility or benefit coverage for care requires that the selected level of intensity be medically necessary. Medical necessity is defined later in these guidelines.

It is important to stress that these protocols do not constitute a standard of practice, nor are they a substitute for thorough assessment and sound clinical judgment. However, as guidelines, they are a part of a practice and utilization management system intended to guide and monitor the appropriateness of care received by consumers of public mental health services.

MEDICAL NECESSITY FOR MEDICAID MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

Medical Necessity Criteria (As contained as in Medicaid Provider Manual, Mental Health and Substance Abuse Chapter)

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability, or substance abuse disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability, or substance abuse disorder that is inferred or suspected; and/or

- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability, or substance abuse including impairment in functioning; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance abuse disorder; and/or
- Designed to assist the consumer to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

Determination Criteria

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

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

Supports, Services, and Treatment Authorized by the PIHP

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

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

- 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 consumer unsuccessful or cannot be safely provided; and
- 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.

PIHP Decisions

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 services, settings or support that otherwise satisfies the standards for medically-necessary services.
- 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 cost, amount, scope, and duration of services. Instead, determination of the need of services shall be conducted on an individualized basis.

Revised July 2009