Section: Utilization Management	Policy Name: **Levels of Care**	Policy Number: **04.10**
Owner: **Director of Clinical Quality**	Reviewed By: **Director of Clinical Quality; Chief Administrative Officer; Medical Director**	Total Pages: **5**
Required By: ☐ **BBA** ☐ **MDHHS** ☐ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: Moira Kean AnneWickham AnneWickham (Jul 30, 2020 09:46 EDT) B K Ramesh B K Ramesh (Jul 31, 2020 16:34 EDT)	Date Approved: Jul 30, 2020
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☐ **SUD Providers** ☐ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **7/28/2020**

Policy: Southwest Michigan Behavioral Health (SWMBH) utilizes population-specific assessment tools with defined Levels of Care and Recommended Thresholds to assess eligibility for Prepaid Inpatient Health Plan (PIHP) Medicaid specialty behavioral health services. Levels of Care and Recommended Thresholds identify which services an individual is eligible to receive without necessitating a utilization management review.

Purpose: The federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Medicaid Managed Care Regulations (42 CFR §438.910(b)) prohibit Medicaid managed care entities, including Prepaid Inpatient Health Plans (PIHPs), from imposing less favorable treatment limitations (qualitative or non-qualitative) on mental health and substance use disorder benefits than the predominate treatment limitations which exist for medical/surgical benefits of the same class (e.g., inpatient services, ambulatory services). In Michigan, standardized criteria and assessments are employed by all PIHPs for those who request behavioral health services, to promote statewide consistency for access to Medicaid specialty behavioral health services (uniformity of benefit), and to prevent unequal treatment limitations. This policy outlines how SWMBH and its Community Mental Health (CMHs) use standardized assessments and level of care criteria to ensure equitable access to services.

Scope: Levels of Care are used to define level of need, and Core Service Menus are established to recommended service amounts for each Level of Care, for each of the Medicaid behavioral health populations served by SWMBH and regional CMHs.

Responsibilities:

A. SWMBH, CMH, and contracted provider staff use the appropriate population-specific assessment to determine individuals' Level of Care. Each Level of Care corresponds to a Core Service Menu of supports and services.

B. Staff assist individuals in developing their Person-Centered Plan of service. Services requested in the Person-Centered Plan that fall within the Core Service Menu do not require utilization management review. Services requested that fall outside of the Core Service Menu (Exceptions) are reviewed by a CMH or SWMBH Utilization Management staff member for approval or denial, prior to service delivery.

C. SWMBH Levels of Care and Core Service Menus are reviewed and modified as necessary through the SWMBH Regional Utilization Management Committee.

Definitions:

A. Core Service Menu: The services which are available with defined Recommended Thresholds for an identified population at a given Level of Care.

B. Exception: Service(s) that fall above the Recommended Threshold or outside of the Core Service Menu for a given Level of Care.

C. Level of Care: Refers to the intensity of services (setting, frequency and mode) an individual will receive during a specific stage of treatment.

D. Medical Necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. (Medicaid Provider Manual)

E. Recommended Threshold: The annual service unit limit per Level of Care at which a particular service may be requested and delivered without utilization management review and approval.

F. Uniform Benefit/Uniformity of Benefit: Consistent application of and criteria for benefit eligibility, level of care determination and service provision regardless of various demographics including geographic location, based upon the clinical and functional presentation of the person served, over time.

G. Utilization Review: The process of monitoring, evaluating medical necessity, use, delivery, cost effectiveness, appropriateness, and the efficient use of health care services provided by health care professionals on a prospective, concurrent or retrospective basis. Utilization review activities include monitoring of individual consumer records, specific provider practices and system trends. to determine appropriate application of Guidelines and Criteria in the following areas: level of care determination, Application of Service Selection Criteria, Application of Best Practice Guidelines, Consumer outcomes, Over-Utilization/under Utilization, and Review of clinical or resource utilization Outliers.

Standards and Guidelines:

A. SWMBH Levels of Care are developed, and are reviewed and modified as necessary, under the direction of the SWMBH Regional Utilization Management Committee.

B. The assessment tools used to determine Level of Care service Menus for each population are listed below.

1. The Level of Care Utilization System (LOCUS) for Psychiatric and Addiction Services is used with adults with mental illness, 18 and up.

2. The Child and Adolescent Functional Assessment Scale (CAFAS) is used with children and youth with emotional disturbances ages 7-17.
3. The Preschool and Early Childhood Functional Assessment Scale (PECFAS) is used with children with emotional disturbances ages 4-6.
4. The Supports Intensity Scale (SIS) is used with adults with intellectual and developmental disabilities, 18 and older.
5. The American Society of Addiction Medicine Patient Placement Criteria (ASAM) is used with persons with substance use disorders.

C. SWMBH Levels of Care, Core Service Menus, and Recommended Thresholds define a common benefit package based on the assessment tool used for the defined population.

D. For each population area, a Core Service Menu is available for each defined Level of Care. Recommended Thresholds exist within each Core Service Menu.

E. Services that comprise the Core Service Menu for an individual's Level of Care do not require review and approval by utilization management staff if the service units requested are below the annual Recommended Threshold. Any combination of these services may be selected by the individual through the person-centered planning process, without additional authorization review, as long as Medicaid Provider Manual criteria are met, and the individual's record contains documentation of rationale of medical necessity for the service(s).

F. Certain services (e.g., personal care and community living supports in a specialized residential setting) do not have pre-approved service availability with the Core Service Menu, and require utilization management review and approval for any request, due to the Recommended Threshold being set at 0.

G. Certain services are excluded from the Level of Care guidelines. These are:
1. Screening and Emergency/Crisis services (H0002, S9484, T1023), which do not require authorization.
2. Assessments (H0031, 90791, 90792), which will be monitored outside of the Level of Care guidelines.
3. Acute Psychiatric Services and electroconvulsive therapy (ECT): Review and authorization of these services are managed through the pre-screen and concurrent authorization processes.
4. Medication Injections (96372 and 99506).

H. Services requested that are beyond the Recommended Threshold or that fall outside of the Core Service Menu for an individual's Level of Care are referred to as Exceptions. An Exception may be authorized if medical necessity is established through a utilization review.
1. Exception requests are generated following the person-centered planning process and development of the individualized plan of service (including plan amendments).
2. A utilization management professional reviews the request and makes a determination of medical necessity, including amount, scope, and duration, for the service being requested.
3. When an Exception is being reviewed, Utilization Management staff will review an individual's entire service package to assess the medical necessity of the individual's entire service array.
4. If the Exception is approved, the reason must be clearly documented by the utilization reviewer.
5. Common reasons for approvals of Exception requests for ***clinical*** services include:
    a. Recent hospitalization(s) or exacerbation of symptoms
    b. Multiple comorbidities with complex needs
    c. Multiple psychosocial needs or stressors

d. Person at risk of harm to self or others

6. The following information should be considered during Person-Centered Planning, and when reviewing Exception requests for ***supportive*** services:
    a. The degree to which the individual requires supervision and support for health and safety needs,
    b. The availability of natural supports and caregivers (with consideration of work hours),
    c. School involvement, employment/volunteer status (including retirement age), and hours worked or at school,
    d. The individual's living arrangement – family home, independent living, or licensed home,
    e. Other psychosocial and health considerations such as legal involvement or co-morbid chronic diseases,
    f. Duration in services and progress in skill development / goal attainment,
    g. Whether the request is duplicative with other available or provided services or supports (including services or supports available through non-Medicaid sources like home help, MRS, or school/the ISD),
    h. Whether the service request is the least restrictive, most cost-effective approach to address health and safety needs and/or to meet person-centered goals and objectives (e.g., if less restrictive/intensive services were in place, could the individual still make progress toward goals, and remain safe? Or, would more intensive services like inpatient or specialized residential be needed?).
7. If the Exception is denied or not approved in whole, the reason is clearly documented by the utilization management reviewer, and Notice of Adverse Action is provided.
8. Utilization review of Exception requests follow all PIHP, state, and federal policy related to Medicaid authorization requests, including but not limited to timeliness of decisions and credentials of individuals making authorization determinations.

Procedures: None

Effectiveness Criteria: N/A

References: None

Attachments:

A. 04.10A SWMBH Core Service Menu - Adults with Mental Illness
B. 04.10B SWMBH Core Service Menu - Youth with Severe Emotional Disturbances
C. 04.10C SWMBH Core Service Menu – Adults with Intellectual and Developmental Disabilities
D. 04.10D SWMBH Core Service Menu – Persons with Substance Use Disorders

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	5/31/19	Scope and Responsibilities	Added (not in previous version)	Moira Kean
1	5/31/19	Attachments	Addition of CAFAS/PECFAS Core Service Menu Updates to LOCUS Core Service Menu	Moira Kean
1	5/31/19	Standards and Guidelines, G	Added medication injection to list of services not requiring authorization	Moira Kean
2	June 2020	Standards and Guidelines, H.3	When an Exception is being reviewed, UM staff will review an individual's entire service package to assess the medical necessity of the individual's entire service array	Moira Kean
2	June 2020	Standards and Guidelines, H.5 and 6	Considerations for exception reviews for supportive services (vs clinical services)	Moira Kean
2	June 2020	Attachments	Addition of I/DD and SUD Core Service Menus	Moira Kean

04.10 Levels of Care

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