



Section: Utilization Management	Policy Name: Levels of Care	Policy Number: 04.10
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**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














# 04.10 Levels of Care

Final Audit Report

2020-07-31

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The SWMBH Core Services Menu is intended as guidelines, not to be interpreted as caps on services or one-size fits all service packages. An assessment score does not directly equate to approval for services(s). Services are typically determined based on a combination of Assessment, Person-Centered Planning process, consideration of natural supports, stage of change, service history, and clinician judgement. Clinical assessments shall contain clear documentation of eligibility for PHP specialty services, as outlined in MPM BH/DD Chapter, section 1.6.; as well as documentation supporting the medical necessity of each requested/authorized service. Some court-ordered individuals may be required by judge's order into a level of care incongruent with the assessment score. Funding via PHP Medicaid funds is contingent upon documented medical necessity for the services being delivered. SWMBH is responsible to ensure that LOC guidelines are being used consistently by CMHS's, as well as to ensure that appropriate exceptions, appeal mechanisms and documentation are in place. Goal is to have a common, uniform benefit for Medicaid services across the region, informed by consistent, standardized assessments. Assessments (H0031, 90791, 90792) will be monitored outside of the Core Service Menu. Review and authorization for Acute Psychiatric Services and ECT are managed through the pre-screen and concurrent authorization processes. This list is not all-inclusive. Any other services not listed require review at the local CMHS by a Utilization Management Professional, including but not limited to: CLS/PC Per Diem, Family Training, Nutrition Services, OT/PT/SLP, Respite, Prevention Services, Psychological Testing, Skill Building, and Supported Independent Living.

Function/Service	Level 2		Level 3		Level 4		Level 5		Level 6	
	0	14**	0	14	416	14	416	14	416	14
Low / Low Intensity Community Based Services Functional Level: Low impairment of functioning in few areas, low to minimal risk of harm to self or others, able to reside independently in the community, minimal assistance with linking/ coordinating, actively utilizing self improvement and treatment skills acquired Diagnosis: Psychotic Disorders/ Mood Disorders/ Anxiety Disorders/ Personality Disorders/ Unspecified Diagnosis/ Short Term Crisis Diagnosis -well managed through medications/treatment, including EBP's/therapy Comorbidity: Low MI/Low SA Risk of psychiatric hospitalization: Minimal to low risk Treatment: Can include use of psychiatric medication but not required Recovery: Mildly stressful environment- periods of transition, living in a supportive environment, engaged with professional supports in an outpatient/office-based setting. ED/Crisis Services: Low/frequent use of ED or crisis services.	0	14**	0	14	416	14	416	14	416	14
Moderate / High Intensity Community Based Services Functional Level: Low to Moderate impairment of functioning in some areas, low to moderate risk of harm to self or others, with minimal support able to reside independently in the community, occasionally involved in risky activities, regular assistance with linking/coordinating, developing skills and self-advocacy; some deficits in ADLs, lower levels of social supports, deteriorated relationships; possible involvement in the criminal justice system Diagnosis: Psychotic Disorders/Mood Disorders/ Personality Disorders - generally well managed through medications/ treatment/support Comorbidity: High MI/High SA or Low MI/Low SA, ongoing medical conditions may exist Risk of psychiatric hospitalization: Low to moderate risk Treatment: Includes use of psychotropic medications Recovery: Moderately stressful environment ED/Crisis Services: May have moderate to frequent use of ED/Crisis Services	0	14	2675	400	416	14	416	14	416	14
High / Medically Monitored Non-Residential Services Functional Level: Significant impairment of functioning in most areas, withdrawal from social interactions, disruptions in relationships, moderate to significant risk of harm to self or others, with significant level of support, able to reside independently in the community, engaged in high risk activities and possible involvement in the criminal justice system, ADLs neglected or significantly impaired Diagnosis: Psychotic Disorders, Significant Mood Disorders possibly coupled with Personality Disorder(s) Comorbidity: High MI/High SA or High MI/Low SA, ongoing medical conditions may exist Risk of psychiatric hospitalization: Moderate to significant risk of institutionalization and/or placement outside of current community, transitioning out of specialized residential setting, frequent psychiatric hospitalizations, unstable housing, history of impulsive behaviors or suicidal ideation Treatment: Includes use of psychotropic medications; treatment needs require intensive management by multidisciplinary treatment team Recovery: History of poor response to treatment ED/Crisis Services: May have frequent use of ED or Crisis Services	0	14	2675	750	416	14	416	14	416	14
Intense / Medically Monitored Residential Services Functional Level: Potentially subacute score that could bump to this level Functional Level: inability to function in most areas, persistent danger to self and others, regardless of level of support customer unable to reside independently in the community; chronic mental illness contributes to low intellectual functioning or poor attention to ADLs; poor outcomes in other less restrictive settings, need for intensive supports to interact in the community and/or attend to medical conditions Diagnosis: Psychotic or Mood Disorders, chronic unremitting or severe exacerbation of symptoms Comorbidity: High MI/High SA or High MI/Low SA, likely have co-morbid medical conditions Psychiatric hospitalization/ institutionalization: At significant risk of institutionalization and/or placement outside of current community, possibly residing in specialized residential setting, or in SIPS with significant supports Treatment: Includes use of psychotropic medications Recovery: Poor response to treatment ED/Crisis Services: May have frequent use of ED or Crisis Services	0	14	2675	500	416	14	416	14	416	14
Acute / Medically Managed Residential Services Meets acute Intensity of Service/Severity of illness criteria	0	14	2675	500	416	14	416	14	416	14
Individuals with SMI whose LOCUS-generated level of care is 2 must be assessed for eligibility for Medicaid specialty supports and services prior to beginning services, and minimally once a year thereafter. Clinical assessment must contain clear documentation of eligibility for PHP services, in accordance with MPM BH/DD Chapter, section 1.6 and SWMBH SMI and SED Specialty Services Eligibility Policy.	0	14**	2675	400	416	14	416	14	416	14
Assertive Community Treatment (H0039)	0	14**	0	14	416	14	416	14	416	14
Behavior Treatment Review (H2000/H2000T5)	0	14**	2675	400	416	14	416	14	416	14
Clubhouse Psychosocial Rehabilitation Programs (H2030)	0	14**	2675	400	416	14	416	14	416	14
Community Living Supports 15 minutes (H2015)	0	14**	400	400	416	14	416	14	416	14
DBT (H2019)	0	14**	500	500	416	14	416	14	416	14
Family and Outpatient Therapy (9083X, 9084X)	19**	19**	19	19	416	14	416	14	416	14
Fiscal Intermediary Services (T2035)	0	14**	12	12	416	14	416	14	416	14
Group Therapy (90853)	26**	26**	30	30	416	14	416	14	416	14
Nursing Services (T1002)	10**	10**	10	10	416	14	416	14	416	14
Patient Education (59445, 59446)	6**	6**	6	6	416	14	416	14	416	14

Services / Annual Threshold for UM Review in Units

	Level 2	Level 3	Level 4	Level 5	Level 6
Peer Services (H0038)	200**	Peer Services (H0038)	Peer Services (H0038)	Peer Services (H0038)	Peer Services (H0038)
Psychiatric office visit (992XX)	7**	Psychiatric office visit (992XX)	Psychiatric office visit (992XX)	Psychiatric office visit (992XX)	Psychiatric office visit (992XX)
Supported Employment (H2023)	0	Supported Employment (H2023)	Supported Employment (H2023)	Supported Employment (H2023)	Supported Employment (H2023)
Supports Coordination (T1016)	25**	Supports Coordination (T1016)	Supports Coordination (T1016)	Supports Coordination (T1016)	Supports Coordination (T1016)
Targeted Case Management (T1017)	100**	Targeted Case Management (T1017)	Targeted Case Management (T1017)	Targeted Case Management (T1017)	Targeted Case Management (T1017)
Treatment Planning (H0032)	5**	Treatment Planning (H0032)	Treatment Planning (H0032)	Treatment Planning (H0032)	Treatment Planning (H0032)
		225	225	250	325
		7	7	7	7
		350	350	350	350
		100	125	125	125
		150	150	150	150
		3	3	3	3

and, minimally at intake and annually thereafter.  
ed/delivered using the HCPCS/CPT codes listed, with any applicable modifiers, unless otherwise indicated.