SWMBH Operating Policy 4.10

Subject: Levels of Care	**Accountability:** Utilization Management	**Effective Date:** 1/1/2019	Pages: 3
REQUIRED BY: **BBA Section** _____ **PIHP Contract Section** _____ **NCQA Standard** _____ **Other** _____		Last Reviewed Date:	Past Reviewed Dates:
LINE OF BUSINESS: ☒ Specialty Waiver (B/C) ☒ Healthy Michigan ☐ SUD Medicaid ☐ SUD Block Grant ☒ MI Health Link ☐ OTHER:_____	**APPLICATION:** ☒ SWMBH Staff and Operations ☒ Participant CMHSPs ☐ SUD Providers ☐ MH / DD providers ☐ Other:_____	Last Revised Date:	Past Revised Dates:
Approved : _____ 12/21/18 Date: _____ 1/2/19 B.K. Reams 1/8/19		Required Reviewer: Medical Director Director of Clinical Quality Chief Administrative Officer	

I. 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 Southwest Michigan Behavioral Health (SWMBH) and its Community Mental Health (CMHs) use standardized assessments and level of care criteria to ensure equitable access to services.

II. Policy

SWMBH utilizes population-specific assessment tools with defined Levels of Care and Recommended Thresholds to assess eligibility for 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.

III. 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.

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. If the Exception is approved, the reason must be clearly documented by the utilization reviewer. Common reasons for approvals of Exception requests 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

4. 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.
5. 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.

IV. 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.

V. References

A. None

VI. Attachments

A. ADULTS WITH MENTAL ILLNESS: SWMBH LEVELS OF CARE AND RECOMMENDED SERVICE GUIDELINES