ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued 07/23

CHAPTER Access to Services		**CHAPTER** 02	**SECTION** 003	**SUBJECT** 0011
SECTION Utilization Management	**SUBJECT** Utilization Management			
WRITTEN BY T. Seilheimer	**REVISED BY** Amy Kandell, Latina K. Cates, Tammy Schneider, Michelle Measel-Morris		**AUTHORIZED BY** Tracey Pingitore	

I. APPLICATION:

- ☐ SCCCMHA Board
- ☒ SCCCMHA Provider & Sub-Contractors
- ☒ Direct Operated Programs
- ☒ Community Agency Contactors
- ☒ Residential Programs
- ☒ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health Authority (SCCCMHA) to align with regulatory agency's requirements shall employ a Utilization Management (UM) Team to oversee and administer its UM Program. The UM Team is charged with conducting quarterly Utilization Reviews (UR), which consists of Clinical Record Review (CRR) and clinical/Claims Verification Reviews (CVR) of randomly selected case records for direct operated programs and contract agencies. The Clinical Record Reviews (CRR) are completed to monitor clinical practice standards that promote the provision of medically effective, cost effective, and well-coordinated services. Records must also demonstrate meeting program outcomes, incorporate recovery-focused, integrated health service planning, and, include appropriate trauma, clinical and medical assessments that support the diagnosis and service provision. Claims Verification Reviews (CVR) are conducted to ensure documentation compliance related to claims submission, which include Current Procedural Terminology (CPT) Code Utilization, Modifier Utilization, staff certification, Michigan Department of Health and Human Services (MDHHS) and SCCCMHA requirements that relate to clean claims, while assuring compliance with MDHHS and Region 10 Prepaid Inpatient Health Plan (PIHP) utilization-related regulations and standards. The UM Team is accountable to the SCCCMHA Quality Improvement Council (QIC) and the SCCCMHA Board.

III. DEFINITIONS:

A. Reconsideration: A formal process in which the provider program may request a change to any quality improvement action items contained in the UR report.

B. Clinical Record Review (CRR): A comprehensive clinical review of the OASIS Electronic Health Record (EHR)to ensure compliance in the following areas:

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1. Access to services.
2. Consent and orientation to services.
3. Authorization for the Release of Information corresponds with protected released information.
4. Timeliness and thoroughness of assessments (i.e. Child and Adolescent Functional Assessment Scale (CAFAS), Preschool and Early Childhood Functional Assessment Scale (PECFAS), Level of Care Utilization System (LOCUS), PCL-5, PHQ-9, etc.).
5. Assessment of risk factors.
6. Goals and objectives are based on the results of the utilized assessments, input from the consumer/guardian served and are revised when indicated.
7. Services provided are related to the goals and objectives in the individual's plan.
8. Services provided reflect appropriate level of care and are provided within a reasonable duration.
9. Person Centered Plan/Individual Plan of Service (IPOS) is reviewed and updated every 90 days or at the request of the consumer/guardian.
10. The Discharge Plan includes a Transition Plan.
11. To ensure that when evidenced-based practices are utilized, the documentation reflects that clinician is implementing the clinical model.

C. Claims Verification Review (CVR): A review of the EHR to verify the supporting documentation accurately reflects the encountered services that took place on the specified date of services.

D. Clinical Protocols: A set of service descriptions which outline all services available to eligible individuals. The protocol descriptions define clinic services, eligibility for such services, where services may be performed and by whom (required staff credentials).

E. Concurrent Review: A review of clinical case records that are open/presently receiving services to determine the necessity and appropriateness of care provided at the current level.

F. Levels of Care for Mental Health Specialty Services: A process through which severity of service need is aligned with intensity of service, according to medical necessity criteria, as developed within the person-centered planning process. This process applies to persons receiving ongoing, non-emergent services, is configured within clinic populations (i.e. Severe Mental Illness (SMI), Co-occurring Disorder (COD), Developmental Disabilities (DD), Serious Emotional Disturbance (SED) and includes community inpatient psychiatric services.

G. Medical Necessity: The approved supports/services needed by an individual receiving services that align with a clinical protocol and are intended to treat, ameliorate, diminish or stabilize the diagnosed symptoms to maintain and improve functioning.

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H. Retrospective Review: A review of clinical case records that are closed or, more than one year old, to determine the necessity and appropriateness of care, provided at a particular level, after the services were provided.

I. Utilization Management (UM): The MDHHS system, which consists of a set of functions and activities focused on ensuring that eligible individuals receive clinically appropriate, cost-effective services, according to clinical best practice guidelines and services focused on obtaining the best possible outcomes.

J. Utilization Review (UR): The physical review of the clinical case record, provider of services and/or program.

IV. STANDARDS:

A. The SCCCMHA Board shall employ a UM Team to manage the UM Program. The UM Team shall operate in accordance with this administrative procedure guideline.

B. The UM Team shall provide annual and/or periodic assessments of the UM Program, that includes specific recommendations to improve the overall functionality of UM Program.

C. The SCCCMHA QIC shall oversee the UM Program and shall act as the final authority for the UM Program.

D. The SCCCMHA Program Director, as a standing member of the QIC, shall provide clinical oversight of the UM Program.

E. UM Program shall use a performance-based approach to identify and effectively manage financial and clinical risk, based on sound data analyses and feedback of provider performance data.

F. UM TEAM STRUCTURE:

1. Membership in the UM Team shall consist of the following core members:

   a. UM Program Director
   b. UM Support Services Director
   c. UM Supervisor
   d. UM Analyst
   e. Master's level Clinical Staff
   f. Data Management (DM) Claims Reviewer

2. The UM Team shall:

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a. Review and disseminate UR findings: CVR and/or CRR pertaining to program conformance of clinical protocols on up to 2.5% of randomly selected direct operated cases and, up to 5% if randomly selected contract agency cases per the request of the UM Program Director, targeted case records, and identified performance indicators.
b. Review and disseminate CVR pertaining to contract provider claims and identified direct run cases/programs reports with reference to under/over utilization.
c. Complete an analysis of SCCCMHA utilization data service patterns of its provider network in conjunction with UR findings and makes recommendation and plans of correction, as applicable.
d. Provide per case/program reports to direct run and contract program supervisors.
e. Generates aggregate UM reports with improvement recommendation and sends reports to program supervisors and QIC.

G. UM Team Leaders (Program Director/Support Services Director/UM Supervisor) shall be St. Clair County CMH Team Leaders.

1. Develops Annual UM Program Plan as approved by the QIC.

2. Selects/assigns clinical members to UM Team.

3. Provides as-needed clinical consultation (e.g. Evidence-based Practices (EBP), service standards, preferred practices training, etc.).

4. Presents report findings and improvement recommendations at QIC.

5. Facilitates implementation of QIC dispositions (e.g. system improvements, consultation, training, etc.)

V. PROCEDURES:

A. Direct Run and Contract Programs

UM Team Leaders

1. Develops Annual UM Program Plan with applicable recommendations.
2. Selects/assigns clinical members to UM Team.

3. Assigns cases to clinical team audit for CRR.

4. Addresses appeals.

5. Provides to program supervisors, as needed, clinical consultation (EBP, service standards, preferred practices, trainings, etc.).

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6. Presents report findings and improvement recommendations at QIC.
7. Facilitates implementation of QIC dispositions (e.g. system improvements, consultation, training, etc.)

8. Presents UM Reports at SCCCMHA Board meetings.

DM Staff

9. Develops the Audit Calendar and selects number of cases for review, during the fiscal year, for each direct run program and contract agency (primary and non-primary) program.

7. Conducts CVR (Exhibit A) each quarter or, as assigned, on identified direct run and contract program cases, per Audit Calendar.

8 Completes DM Claims Verification and Clinical Record Review (48-Hour Notice) form (Exhibit B) and transfers applicable information to UM Assessment tool, prior to sending 48 Hour notice to staff for review/comment. Upon return receipt of 48-hour notice form, missing documents, comments, etc. the UM Tool is then updated to reflect this information. All missing documents are then scanned into the electronic health record.

10. Sends 48-Hour Notice for missing documentation to program /contract agency supervisor. Missing documentation consists of Guardian's Signature page for Pre-Plan, IPOS, Periodic Review, Amendment, Consents, Release of Information, Coordination of Care Letter, etc. For direct operated, the Service Activity Log generates the claim and mirrors the (face to face) encounter. All contract agencies that do not utilize OASIS for data entry are responsible for submitting documentation, to SCCCMHA for scanning into OASIS, that accurately reflects the claim submitted (at the time of claim submission). Failure to do so may result in claims adjustment(s) after management review/approval.

11. Ensures missing documentation is scanned into EHR.

12. Forwards CVR findings, if applicable, to UM Team Leader and UM Analyst.

Clinical Member(s)

13. Conducts UR and CRR using UM Assessment (Exhibit C) on assigned case lists and identifies any care integration issues (over/under utilization, inconsistencies with clinical protocols, etc.).

14. Identifies areas of improvement and documents findings in comments section of UM Assessment tool.

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UM Analyst

15. Conducts special UR quarterly and special reviews upon request of UM Team Leaders.

16. Generates per case UM Individual Review Summary (Exhibit D) Reports and UM Review Results by Location Reports (Exhibit E). Sends reports to applicable direct run/contract agencies along with UM Memorandum (Exhibit F), Reconsideration and Disposition (Exhibit G), and Quality Improvement Action Plan (Exhibit H) to Supervisor and SCCCMHA Program Director.

Direct Run/Contract Agency Supervisors

17. Receives UM reports, UM Memorandum, and forms. Submits to UM Analyst, if applicable, reconsiderations (within 7 days of receipt of UM Reports), utilizing the Reconsideration and Disposition form (Exhibit G, Form # 1044)), and Quality Improvement Action Plan (Exhibit H, Form # 0285)(within 14 days of receipt of UM Reports).

UM Analyst

18. Receives UM Reconsiderations and Disposition (Form #1044) and Quality Improvement Action Plan (Form #0285) forms. .

19. Reviews UM Reconsiderations and Disposition (Form #1044) and Quality Improvement Action Plan (Form #2085) forms.

20. Verifies applicable responses in EHR.

21. Confers with UM Team Leader, as applicable.

22. Sends UM Reconsideration and Disposition (Form #1044) and Quality Improvement Action Plan (Form #0285) forms to Supervisors with revised UM report scores, when applicable.

23. Files UM Reconsideration and Dispositions (Form #1044) and Quality Improvement Action Plan (Form #0285) forms in electronic UM folder on Fileshare1.

24. Sends 2nd Request E-mail (Exhibit I) and for missing or incomplete Quality Improvement Action Plan form (Form #0285) as applicable.

25. Generates quarterly/annual UM aggregate reports.

B. <u>UM Quality Improvement Project – Children's Waiver (CW), Serious Emotional Disturbances Wavier (SEDW)</u>

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DM Staff

1. Runs OASIS Client Services Report for CW and SEDW programs.

2. Completes applicable CW/SEDW form (Exhibits K or L).

3. Reviews annually all CW and SEDW cases for Health Care Appraisal and Know Your Rights Acknowledgement of Receipt (Exhibit M) documentation in OASIS.

4. Sends completed CW/SEDW reports to applicable supervisor.

Program Staff / Supervisor

5. Develops/implements remedial action plan(s).

DM Staff

6. Receives program responses (missing documentation) and remedial action plan(s).

7. Forwards missing documentation and remedial actions plans to DM Scanning Department.

Data Management Scanning Department Staff

8.Scans documentation in to applicable EHR.

C. <u>UM Quality Improvement Project – Habilitation Supports Waiver (HSW)</u>

DM Staff

1. Reviews annually, all HSW cases, during certification process, for IPOS Training Log (form #0146) completion and documentation in OASIS, Health Care Appraisal with Vitals and Know Your Rights Acknowledgement of Receipt (Exhibit M) documentation in OASIS.

2. Provides information to staff and supervisors regarding missing IPOS Training Logs and Health Care Appraisals.

Staff

3. Completes IPOS Training Log (form #0146) and sends to DM Scanning Department.

Data Management Scanning Department Staff

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4. Scans IPOS Training Logs into EHR.

VI. REFERENCES:

A. MDHHS
B. PIHP/St. Clair Contract
C. CARF and other regulatory agencies

VII. EXHIBITS:

A. UM Claims Verification Report
B. Data Management Review form for Claim Verification
C. UM Assessment
D. UM Individual Review Summary Report
E. UM Review Results by Location Report
F. Memorandum 1st Request
G. Utilization Review Reconsideration and Disposition (Form #1044)
H. Quality Improvement Action Plan (Form #0285)
I. UM Case Record Review Email Templet 2nd Request
J. Children's Waiver Case Review
K. SED Wavier Case Review

VII. REVISION HISTORY:

Dates issued 09/82, 12/86, 05/89, 07/91, 12/93, 06/96, 11/98, 12/01, 02/04, 06/05, 08/07, 06/10, 08/12, 09/13, 03/15, 05/16, 05/17, 05/19, 05/21, 05/22.

EXHIBIT A

UM Claims Verification Report

														Claims Verification Criteria						Agency Response	
														IPOS (1)			MEDICAL NECESSITY (2)	DOCUMENTATION (3)		All Required Documentation Found in Chart	All Required Documentation Not in Chart
PERSON ID	EMPLOYEE LAST	EMPLOYEE FIRST	LOCATION	CPT CODE	MOD	BEGIN DATE	END DATE	B TIME	E TIME	UNITS	UNIT RATE	COST	MEDICAID	CATEGORY	IS IPOS CURRENT	CODE IS IN IPOS	AMT SCOPE DURATION	MEETS CHAPTER III	SUFFICIENT DOC IN CHART	COMMENTS	(Claim Correct)	(Claim Adjust)
12345	DOE	JOHN	Casemanagement Unit/Supports Coordination	T1016		7/1/2019		3:00 PM	3:30 PM	2	$37.94	$75.88	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Casemanagement Unit/Supports Coordination	T1016		7/2/2019		12:00 PM	12:45 PM	3	$37.94	$113.82	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Nursing Services - ST CLAIR CMH	96372		7/9/2019		10:40 AM	11:00 AM	1	$118.08	$118.08	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Casemanagement Unit/Supports Coordination	T1016		7/16/2019		10:15 AM	10:45 AM	2	$37.94	$75.88	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Casemanagement Unit/Supports Coordination	T1016		7/23/2019		10:00 AM	10:30 AM	2	$37.94	$75.88	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	PHYSICIAN SERVICES - ST CLAIR CMH	99212		7/24/2019		11:15 AM	11:25 AM	1	$99.88	$99.88	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Casemanagement Unit/Supports Coordination	T1016		8/1/2019		10:15 AM	10:45 AM	2	$37.94	$75.88	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Nursing Services - ST CLAIR CMH	96372		8/5/2019		1:45 PM	2:15 PM	1	$118.08	$118.08	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Nursing Services - ST CLAIR CMH	T1002		8/5/2019		2:15 PM	2:35 PM	2	$59.90	$119.80	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Casemanagement Unit/Supports Coordination	T1016		8/9/2019		10:30 AM	11:00 AM	2	$37.94	$75.88	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Casemanagement Unit/Supports Coordination	T1016		8/16/2019		2:00 PM	2:45 PM	3	$37.94	$113.82	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Casemanagement Unit/Supports Coordination	T1016		8/20/2019		3:15 PM	3:45 PM	2	$37.94	$75.88	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Outpatient Services	H2015	TT	8/22/2019		11:00 AM	12:00 PM	4	$31.99	$127.96	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Casemanagement Unit/Supports Coordination	T1016		8/22/2019		9:45 AM	10:00 AM	1	$37.94	$37.94	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Casemanagement Unit/Supports Coordination	T1016		8/26/2019		11:00 AM	11:15 AM	1	$37.94	$37.94	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Outpatient Services	H2015	TT	8/29/2019		11:00 AM	12:00 PM	4	$31.99	$127.96	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Nursing Services - ST CLAIR CMH	96372		8/30/2019		2:45 PM	3:10 PM	1	$118.08	$118.08	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Casemanagement Unit/Supports Coordination	T1016		9/5/2019		2:00 PM	2:45 PM	3	$37.94	$113.82	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Outpatient Services	H2015	TT	9/9/2019		11:00 AM	1:00 PM	8	$31.99	$255.92	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Casemanagement Unit/Supports Coordination	T1016		9/16/2019		11:30 AM	11:45 AM	1	$37.94	$37.94	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Outpatient Services	H2015	TT	9/19/2019		11:00 AM	12:00 PM	4	$31.99	$127.96	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Outpatient Services	H2015	TT	9/26/2019		11:00 AM	12:00 PM	4	$31.99	$127.96	Y	Random	Y	Y	Y	Y	Y			
12345	DOE	JOHN	Outpatient Services	H2015	TT	9/28/2019		8:00 AM	3:30 PM	30	$31.99	$959.70	Y	Random	Y	Y	Y	Y	Y			
								MA Claim Adjust Total:				$0.00										
								Overall Total Cost of Services:				$3,211.94										

ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY
Data Management Review Form
For Claims Verification – FY -23
(and subsequent completion of the Clinical Record Review Form)

Date: _____ **Quarter Reviewed: _____**

Location: _____ Consumer OASIS #_____Consumer Initials: _____

Supervisor: _____ Primary Case Holder: _____

Funding Source: __ Blue Cross___ Medicare____ MD DIAGNOSIS:_____ Gender:_____ POPULATION:_____

___ Children's Waiver ____ SED Waiver ____ HSW ____ SUD ____ CCBHC Demonstration:_____ Other:_____

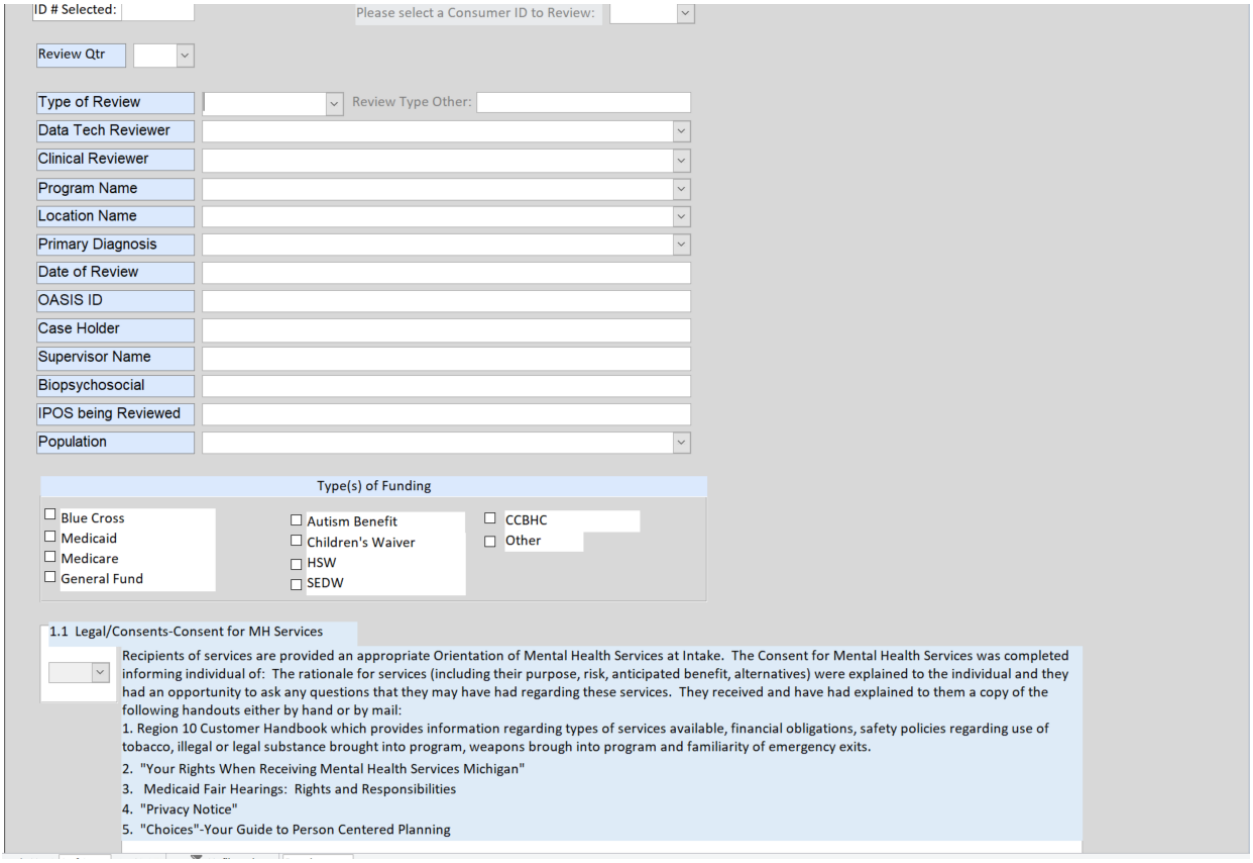
BIOPSYCHOSOCIAL DATE: _____ IPOS DATE:_____ (Is there a lapse):_____

Document	Present	Absent	Consumer/ Guardian/ Supervisor Signature Page in OASIS	Copy Given	Comments
Consent for Mental Health Services Required Annually with BIO			Required (C/G)		
Are Court Orders of Guardianship/Custody/Adoption scanned into the electronic health record?					
Pre-Plan **(Date Completed:_____)** **The Pre-Plan is only done for WAIVER CASES. Pre-Plan and IPOS cannot be done on the same day unless there is specific Documentation in the PrePlan indicating that it was individual/guardian's choice**			Required (C/G) **W/in 14 days (10 days if CW)**		
IPOS **ALL Signatures must be obtained within 35 days of IPOS Date (MD signature required for CW and ACT) (ACT requires Team members signatures on IPOS Training Log)**			Required (C/G/S) **W/in 14 days (10 days if CW)**		

Document	**Present**	**Absent**	**Consumer/ Guardian/ Supervisor Signature Page in OASIS**	**Copy Given**	**Comments**
BIOPSYCHOSOCIAL-Annually			**Supervisor Signature required W/in 14 days (10 days if CW)**		
Periodic Review(s) **Every 90 days or as indicated in IPOS (MD signature required for ACT)**			Required (C/G/S) **W/in 14 days (10 days if CW)**		
Periodic Review(s) **Every 90 days or as indicated in IPOS (MD signature required for ACT)**			Required (C/G/S) **W/in 14 days (10 days if CW)**		
Periodic Review(s) **Every 90 days or as indicated in IPOS (MD signature required for ACT)**			Required (C/G/S) **W/in 14 days (10 days if CW)**		
Amendment(s) **(Any changes to the IPOS document, new/changing needs, must be reflected by written amendment) (MD signature required for ACT)**			Required (C/G/S) **W/in 14 days (10 days if CW)**		
Amendment(s) **(Any changes to the IPOS document, new/changing needs, must be reflected by written amendment) (MD signature required for ACT)**			Required (C/G/S) **W/in 14 days (10 days if CW)**		
Amendment(s) **(Any changes to the IPOS document, new/changing needs, must be reflected by written amendment) (MD signature required for ACT)**			Required (C/G/S) **W/in 14 days (10 days if CW)**		
Adverse Benefit Determination **When IPOS is amended, the individual is denied or limited authorization of a requested service, the primary caseholder shall provide the individual a written notice 12 days prior to action.**					
Psychiatric Evaluation-Completed in OASIS or scanned into OASIS					
Medication Review-Completed in OASIS or scanned into OASIS					
Medication Review-Completed in OASIS or scanned into OASIS					

Document	Present	Absent	Consumer/Guardian/Supervisor Signature Page in OASIS	Copy Given	Comments
Consent for Psychotropic Medications					
Agreement to Take Stimulants					
Agreement to Take Benzodiazepines					
Coordination of Care with PCP- Initially upon entrance into treatment, when there is a change in medication, within two weeks of psychiatric hospitalization and annually at time of IPOS.					
Consent to Share Health Information (MDHHS) on file in OASIS when applicable.					
Consent for Telepsych Services **(One per treatment involvement)**					
Is there an OT Script (if applicable)?					
Missing Progress Notes:					
Missing Progress Notes:					
Missing Progress Notes:					
Missing Progress Notes:					
Is Satisfaction with Services documented?					
WAIVER REQUIREMENTS					
IPOS Training Logs: HSW, ACT Team, CW, HB or SEDW					
PI-Health Care Appraisal? (CW,HSW,SEDW)					
Know Your Rights Acknowledgement? (CW,HSW,SEDW)					
OTHER:					
Billing Errors:					

Is this case CCBHC Eligible?					
Is case open in WSA?					
Is Funding Source in OASIS?					
If not open and eligible - REASON					



ID # Selected:

Please select a Consumer ID to Review:

Review Qtr

Type of Review

Review Type Other:

Data Tech Reviewer

Clinical Reviewer

Program Name

Location Name

Primary Diagnosis

Date of Review

OASIS ID

Case Holder

Supervisor Name

Biopsychosocial

IPOS being Reviewed

Population

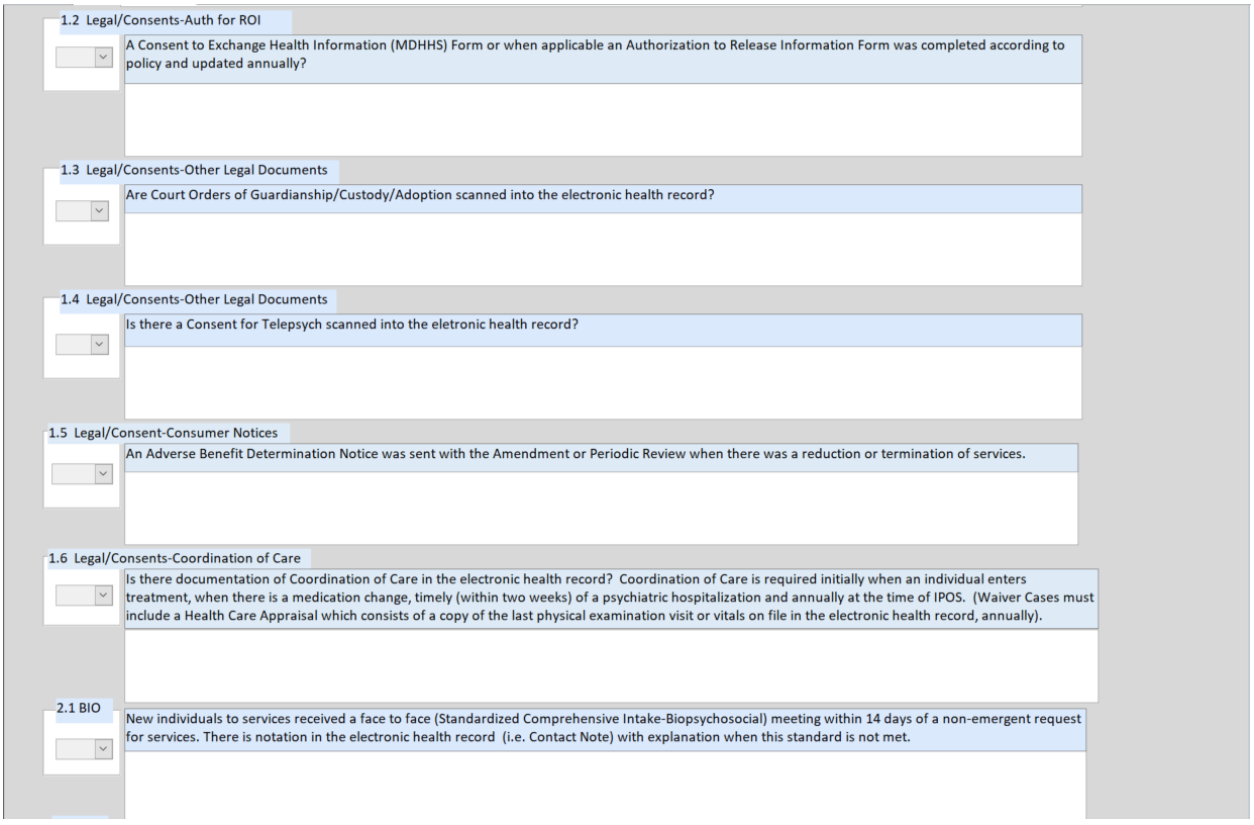
Type(s) of Funding

- ☐ Blue Cross
- ☐ Medicaid
- ☐ Medicare
- ☐ General Fund
- ☐ Autism Benefit
- ☐ Children's Waiver
- ☐ HSW
- ☐ SEDW
- ☐ CCBHC
- ☐ Other

1.1 Legal/Consents-Consent for MH Services

Recipients of services are provided an appropriate Orientation of Mental Health Services at Intake. The Consent for Mental Health Services was completed informing individual of: The rationale for services (including their purpose, risk, anticipated benefit, alternatives) were explained to the individual and they had an opportunity to ask any questions that they may have had regarding these services. They received and have had explained to them a copy of the following handouts either by hand or by mail:

1. Region 10 Customer Handbook which provides information regarding types of services available, financial obligations, safety policies regarding use of tobacco, illegal or legal substance brought into program, weapons brough into program and familiarity of emergency exits.
2. "Your Rights When Receiving Mental Health Services Michigan"
3. Medicaid Fair Hearings: Rights and Responsibilities
4. "Privacy Notice"
5. "Choices"-Your Guide to Person Centered Planning



1.2 Legal/Consents-Auth for ROI

A Consent to Exchange Health Information (MDHHS) Form or when applicable an Authorization to Release Information Form was completed according to policy and updated annually?

1.3 Legal/Consents-Other Legal Documents

Are Court Orders of Guardianship/Custody/Adoption scanned into the electronic health record?

1.4 Legal/Consents-Other Legal Documents

Is there a Consent for Telepsych scanned into the eletronic health record?

1.5 Legal/Consent-Consumer Notices

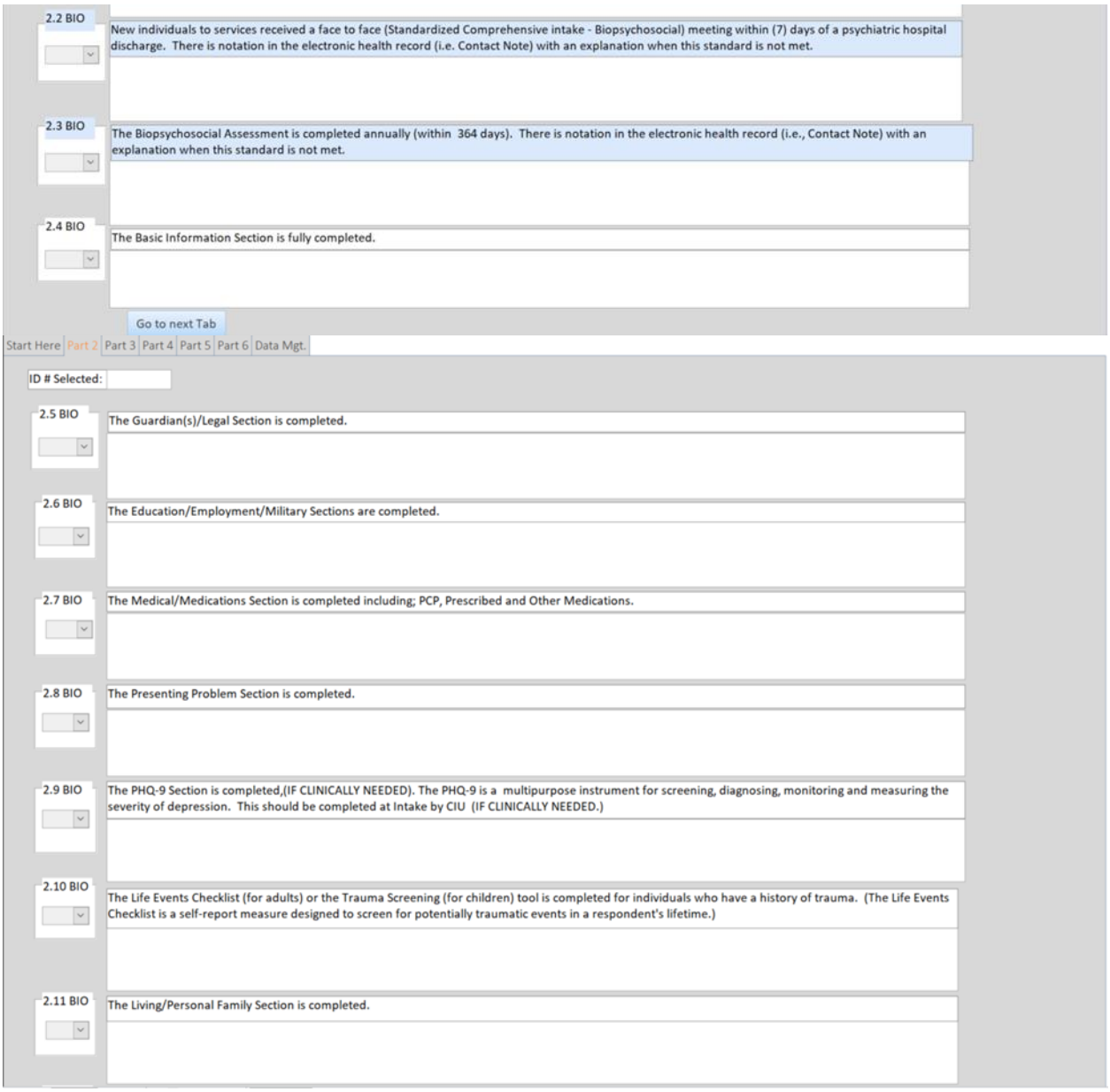
An Adverse Benefit Determination Notice was sent with the Amendment or Periodic Review when there was a reduction or termination of services.

1.6 Legal/Consents-Coordination of Care

Is there documentation of Coordination of Care in the electronic health record? Coordination of Care is required initially when an individual enters treatment, when there is a medication change, timely (within two weeks) of a psychiatric hospitalization and annually at the time of IPOS. (Waiver Cases must include a Health Care Appraisal which consists of a copy of the last physical examination visit or vitals on file in the electronic health record, annually).

2.1 BIO

New individuals to services received a face to face (Standardized Comprehensive Intake-Biopsychosocial) meeting within 14 days of a non-emergent request for services. There is notation in the electronic health record (i.e. Contact Note) with explanation when this standard is not met.



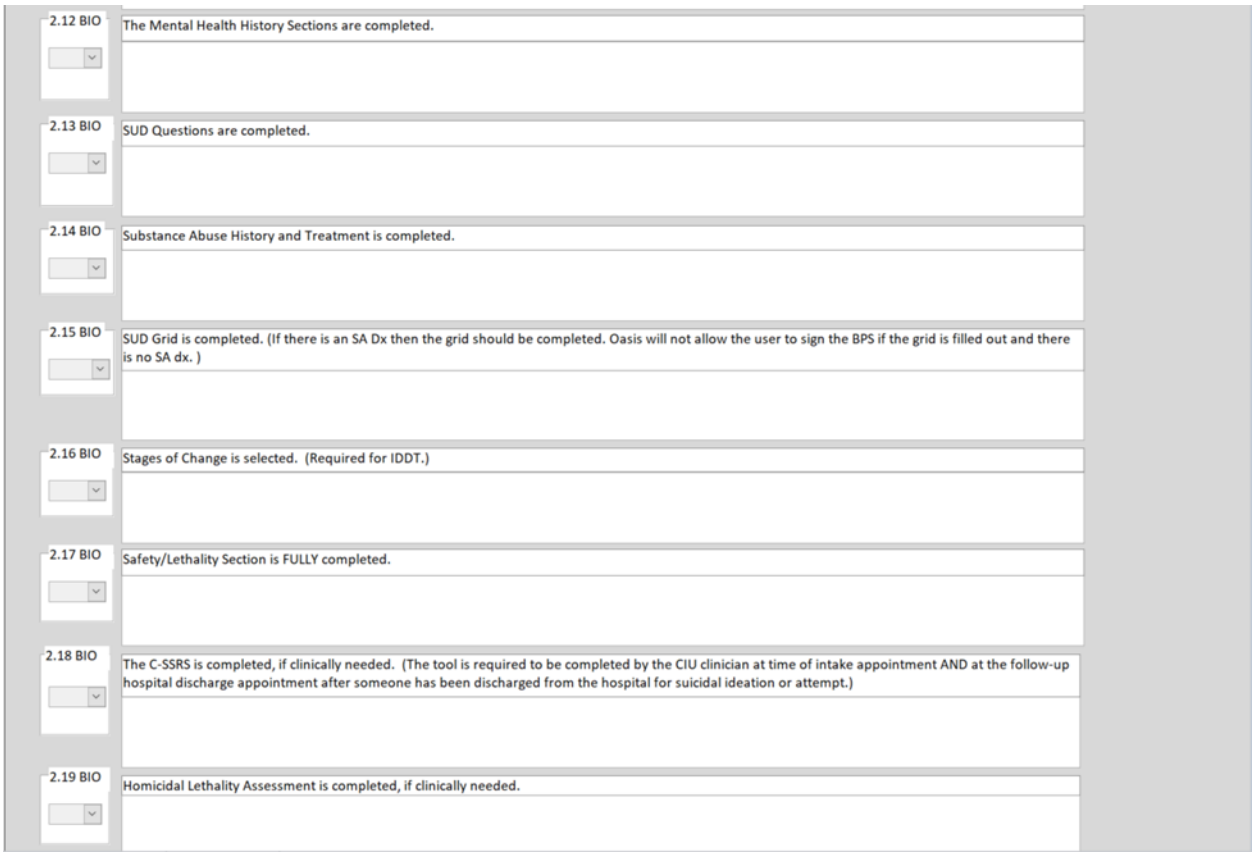
2.2 BIO	New individuals to services received a face to face (Standardized Comprehensive intake - Biopsychosocial) meeting within (7) days of a psychiatric hospital discharge. There is notation in the electronic health record (i.e. Contact Note) with an explanation when this standard is not met.
2.3 BIO	The Biopsychosocial Assessment is completed annually (within 364 days). There is notation in the electronic health record (i.e., Contact Note) with an explanation when this standard is not met.
2.4 BIO	The Basic Information Section is fully completed.

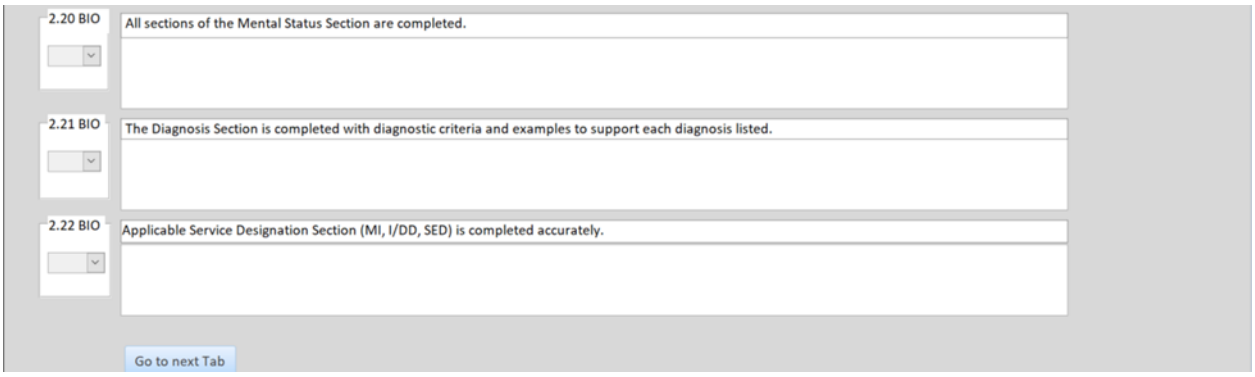
Go to next Tab

Start Here | Part 2 | Part 3 | Part 4 | Part 5 | Part 6 | Data Mgt.

ID # Selected:

2.5 BIO	The Guardian(s)/Legal Section is completed.
2.6 BIO	The Education/Employment/Military Sections are completed.
2.7 BIO	The Medical/Medications Section is completed including; PCP, Prescribed and Other Medications.
2.8 BIO	The Presenting Problem Section is completed.
2.9 BIO	The PHQ-9 Section is completed,(IF CLINICALLY NEEDED). The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. This should be completed at Intake by CIU (IF CLINICALLY NEEDED.)
2.10 BIO	The Life Events Checklist (for adults) or the Trauma Screening (for children) tool is completed for individuals who have a history of trauma. (The Life Events Checklist is a self-report measure designed to screen for potentially traumatic events in a respondent's lifetime.)
2.11 BIO	The Living/Personal Family Section is completed.


2.12 BIO
The Mental Health History Sections are completed.
2.13 BIO
SUD Questions are completed.
2.14 BIO
Substance Abuse History and Treatment is completed.
2.15 BIO
SUD Grid is completed. (If there is an SA Dx then the grid should be completed. Oasis will not allow the user to sign the BPS if the grid is filled out and there is no SA dx.)
2.16 BIO
Stages of Change is selected. (Required for IDDT.)
2.17 BIO
Safety/Lethality Section is FULLY completed.
2.18 BIO
The C-SSRS is completed, if clinically needed. (The tool is required to be completed by the CIU clinician at time of intake appointment AND at the follow-up hospital discharge appointment after someone has been discharged from the hospital for suicidal ideation or attempt.)
2.19 BIO
Homicidal Lethality Assessment is completed, if clinically needed.


2.20 BIO
All sections of the Mental Status Section are completed.
2.21 BIO
The Diagnosis Section is completed with diagnostic criteria and examples to support each diagnosis listed.
2.22 BIO
Applicable Service Designation Section (MI, I/DD, SED) is completed accurately.
Go to next Tab

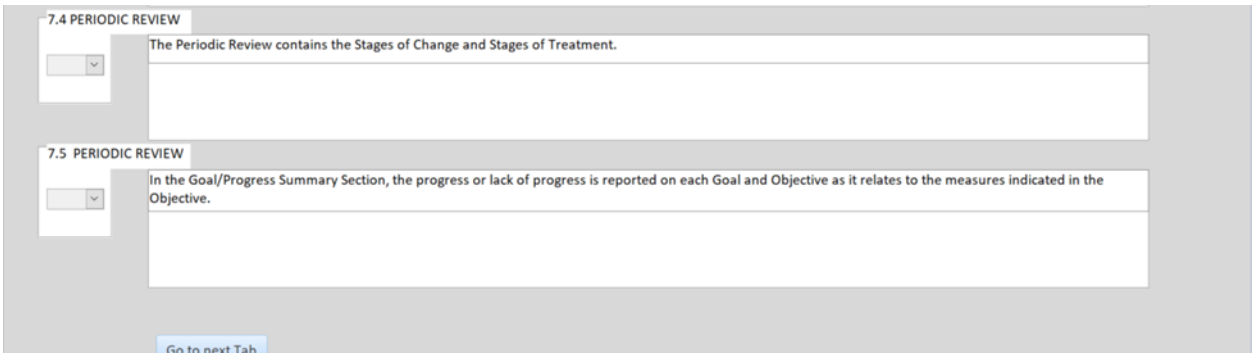
ID # Selected:

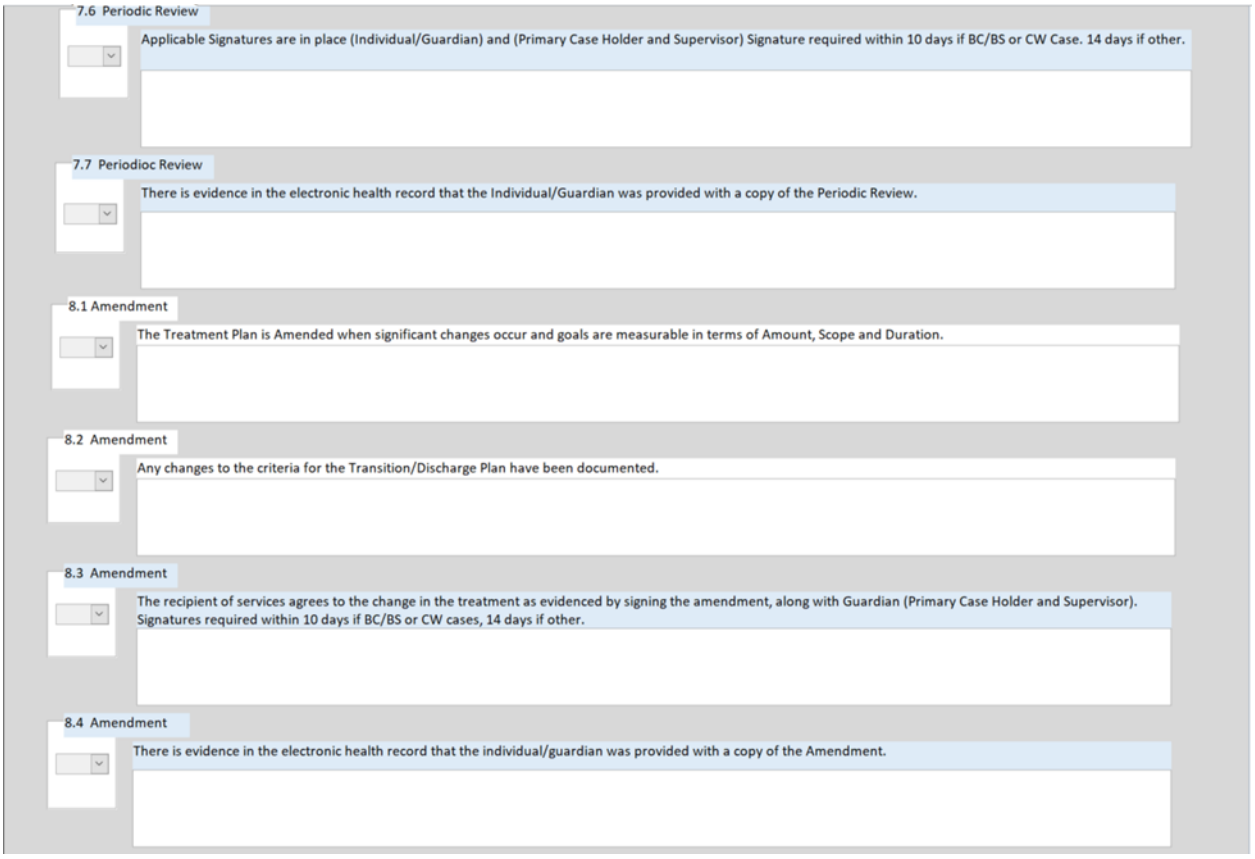
2.23 BIO	The Interpretive Summary is completed with the use of the Interpretive Summary Template.
2.24 BIO	The Disposition/Service Supports Recommendation is completed.
2.25 BIO	Applicable Signatures are in place (Primary Case Holder and Supervisor) (Signature required within 10 days if BCBS or CW case. 14 days if other.)
3.1 ASSESSMENT	The CAFAS/PECFAS Assessments were completed as indicated for SED children and adolescents.
3.2 ASSESSMENT	The LOCUS Assessment was completed as indicated for Adults with MI.
3.3 ASSESSMENT	A SIS Assessment was completed on individuals 16 and older, if the person has a Primary I/DD diagnosis. (If the guardian/individual chose not to participate in the SIS Assessment, a SIS Assessment Declined form must be scanned into the All scanned documents section.)

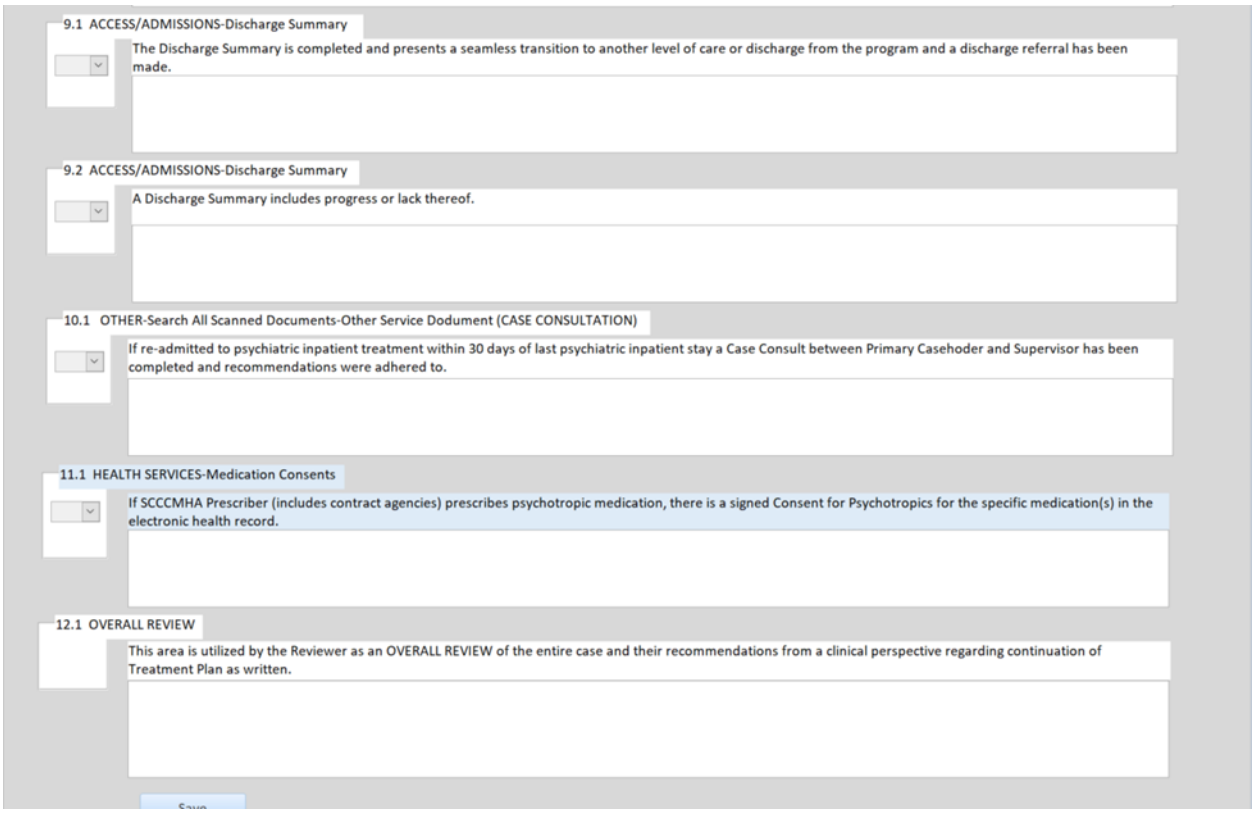
3.4 ASSESSMENT	If OT Services are being utilized and authorized, is there a Current ANNUAL OT Prescription scanned into the electronic health record?
4.1 PREPLAN	There is evidence that the individual participated in a Pre-Plan Meeting. (The Pre-Plan Meeting cannot be completed the same day as the IPOS meeting unless there is specific documentation in the PrePlan indicating that this was at the request of the Individual/Guardian)
4.2 PREPLAN	Individual and/or Guardian Signature is on Pre-Plan within 14 days (10 days if BC/BS or CW cases)
5.1 IPOS	The IPOS Meeting occurred within 35 days of the Biopsychosocial Assessment (There is notation in the electronic health record when time-frames have been extended.)
5.2 IPOS	The IPOS was reviewed or updated in accordance with the policy (Within 365 days). (There is notation in the electronic health record when time-frames have been extended.)
5.3 IPOS	There is evidence that individual's choices were honored.
5.4 IPOS	Has the individual's Hopes, Dreams, and Plans been identified?

5.5 IPOS	Has the individual's Strengths been identified?
5.6 IPOS	Has the individual's NEEDS and Health/Safety/Risks been identified and how they will be addressed?
5.7 IPOS	If there are restrictions placed on the individual, (i.e., restrictions on use of communication, finances or movement) the Behavioral Treatment Plan has been approved by the Behavioral Treatment Plan Review Committee and the DATE that the plan was approved or will be approved is provided?
5.8 IPOS	Was the individual asked if they would like to develop a Crisis Plan and if yes, was a plan completed? (Mandated for HB and ACT.)
5.9 IPOS	Goals are clear and understandable to the individual.
5.10 IPOS	Goals reflect the individual's wishes, needs, hopes and dreams as identified with the Presenting Problem.
5.11 IPOS	Goals and/or Objectives address Co-Occurring Condition if applicable.
5.12 IPOS	The Objective is understandable, measurable, clearly identifies what the person will do, the date they will achieve that action, and how progress will be measured (i.e measurement tool such as the PHQ-9, self-rating scale, etc.)
5.13 IPOS	Objectives are no longer than three months long with SED, MI, and I/DD populations.
5.14 IPOS	The Intervention Section of the IPOS lists all CPT Codes Authorized, AMOUNT of service to be provided, the SCOPE (who will provide the service), HOW the service will be provided (face to face, telephone, etc.), the LOCATION of the service (Home, Office, Community, etc.) and FREQUENCY of the service.
5.15 IPOS	Interventions address Trauma Informed resolutions.
5.16 IPOS	Authorizations are attached to the IPOS, Periodic Review or Amendment.
5.17 IPOS	**The Treatment Plan indicates services meet MEDICAL NECESSITY. (Determination is made by a professional practitioner that a specific service is medically and clinically appropriate, necessary to meet the needs of the service recipient consistent with the person's diagnosis, symptomology and functional impairments, is the most cost effective option in the least restrictive environment, and is consistent with the clinical standards of care.)**
5.18 IPOS	The Treatment Plan addresses some form of transitioning, pre-discharge planning or discharge including individual's strengths by using the Transition/Discharge Templete.

5.19 IPOS	IPOS Training Logs are attached to the IPOS for CW, HSW, SEDW, HB and ACT Team Members.
5.20 IPOS	The Recipient/Guardian of services expresses satisfaction with the Treatment Plan and Person Centered Planning Process.
5.21 IPOS	IPOS contains appropriate Signatures (Individual/Guardian, Clinician, Supervisor) within 35 days of implementation or there is notation in the electronic health record (Contact Note, Progress Note, etc.) to state otherwise. (For ACT Team, all members are required to sign off on an IPOS Training Log.)
5.22 IPOS	There is documentation in the electronic health record that the Individual/Guardian was provided with a copy of the IPOS and Budget.
6.1 SERVICES/Progress Notes	Progress Notes clearly documents what services and interventions are being provided by staff.
6.2 SERVICES/Progress Notes	Progress Notes document specific progress or lack thereof for each selected goals and objectives by the individual's input/feedback.
6.3 SERVICES/Progress Notes	Progress Notes document individual's Satisfaction with Services periodically throughout treatment.
6.4 SERVICES/Contact/Progress Notes	Contact Notes show Practitioner/other Professionals/Parapro's consistent outreach to individual receiving services.
6.5 SERVICES /Contact/Progress Notes	Are Services being provided as authorized? (Over-utilization or Under-utilization?) If not, an explanation is documented in the electronic health record (i.e., Contact/Progress Notes, Periodic Reviews, Amendment, etc.)
7.1 PERIODIC REVIEW	Periodic Reviews, for all populations (i.e. MI, I/DD, SED, etc), are scheduled and take place as specified in the IPOS (EVERY 90 DAYS) or there is documentation in the electronic health record to indicate the reason for the change/rescheduling.
7.2 PERIODIC REVIEW	The Periodic Review contains the current LOCUS/PECFAS/CAFAS Scores.
7.3 PERIODIC REVIEW	Any changes to Transition Plan/Discharge Plan have been documented and the Discharge Template was utilized.


7.4 PERIODIC REVIEW
The Periodic Review contains the Stages of Change and Stages of Treatment.
7.5 PERIODIC REVIEW
In the Goal/Progress Summary Section, the progress or lack of progress is reported on each Goal and Objective as it relates to the measures indicated in the Objective.
Go to next Tab


7.6 Periodic Review
Applicable Signatures are in place (Individual/Guardian) and (Primary Case Holder and Supervisor) Signature required within 10 days if BC/BS or CW Case. 14 days if other.
7.7 Periodioc Review
There is evidence in the electronic health record that the Individual/Guardian was provided with a copy of the Periodic Review.
8.1 Amendment
The Treatment Plan is Amended when significant changes occur and goals are measurable in terms of Amount, Scope and Duration.
8.2 Amendment
Any changes to the criteria for the Transition/Discharge Plan have been documented.
8.3 Amendment
The recipient of services agrees to the change in the treatment as evidenced by signing the amendment, along with Guardian (Primary Case Holder and Supervisor). Signatures required within 10 days if BC/BS or CW cases, 14 days if other.
8.4 Amendment
There is evidence in the electronic health record that the individual/guardian was provided with a copy of the Amendment.



9.1 ACCESS/ADMISSIONS-Discharge Summary

The Discharge Summary is completed and presents a seamless transition to another level of care or discharge from the program and a discharge referral has been made.

9.2 ACCESS/ADMISSIONS-Discharge Summary

A Discharge Summary includes progress or lack thereof.

10.1 OTHER-Search All Scanned Documents-Other Service Dodument (CASE CONSULTATION)

If re-admitted to psychiatric inpatient treatment within 30 days of last psychiatric inpatient stay a Case Consult between Primary Casehoder and Supervisor has been completed and recommendations were adhered to.

11.1 HEALTH SERVICES-Medication Consents

If SCCCMHA Prescriber (includes contract agencies) prescribes psychotropic medication, there is a signed Consent for Psychotropics for the specific medication(s) in the electronic health record.

12.1 OVERALL REVIEW

This area is utilized by the Reviewer as an OVERALL REVIEW of the entire case and their recommendations from a clinical perspective regarding continuation of Treatment Plan as written.

Save

UM Individual Review - Summary Report

8/19/2019
3:11 PM

Consumer ID : [redacted]
Reviewer Name : [redacted]
Program Name : Direct
Location : Outpatient Services

Date of Review : 5/9/2019
Type of Review : Concurrent
Current IPOS : 8/9/2019
Case Holder : [redacted]
Supervisor Name : [redacted]

Funding Source(s)

☐ General Fund ☑ Medicaid ☑ Medicare ☐ Autism ☐ CW ☐ BC ☐ HSW ☐ SEDW Other :

Consumer ID	Domain	Date of Review	Area Reviewed	Outcome	Comment
[redacted]	Access 1.1	5/9/2019	An Access Screening has been completed by ACCESS to determine service eligibility?	Yes	
[redacted]	Legal 1.2	5/9/2019	An Adequate Notice was sent to consumer/guardian initiating services?	Yes	
[redacted]	Legal 2.1	5/9/2019	Recipients of services are provided an appropriate Orientation of Mental Health Services at Intake. The Consent for Mental Health Services was completed informing individual of: The rationale for services (including their purpose,risk, anticipated benefit, alternatives) were explained to the individual and they had an opportunity to ask any questions that theymay have had regarding these services. They received and have had explained to them a copy of the following handouts either by hand or bymail: 1. Region 10 Customer Handbook which provides information regarding types of services available, financial obligations, safety policies regarding use of tobacco, illegal or legal substance brought into program, weapons brough into program and familiarity of emergency exits. 2. "Your Rights When Receiving Mental Health Services Michigan" 3. Medicaid Fair Hearings: Rights and Responsibilities 4. "Privacy	Yes	

UM Review Results by Location

10/24/2019
10:12 AM

Location : **Casemanagement Unit/Supports Coordination**

Special Studies : **Other**

Type of Review : **Concurrent**

Start Date : 5/9/2019

End Date : 5/9/2019

# of Reviews : 5

Consumer ID	Domain	Date of Review	Items Cited for Non-Compliance		Comment
[redacted]	Amendment 6.6	5/9/2019	The recipient of services agrees to changes in the treatment as evidence by signing the amendments, along with guardian and (Primary Case Holder and Supervisor) Signature required within 10 days if BC/BS or CW Case, 14 days if other). MD Signature required for CW and BC Cases.	No	Amendment signatures by Guardian utilizing the Absentee Signature Page are over 14 days out from date of service of 12/27/2018 and 11/5/2018.
[redacted]		5/9/2019	QIDM Comments Section :		
[redacted]	BIO 3.17	5/9/2019	Mental Status Section is completed including; Appearance, Attitude, Behavior, Mood/Affect, Motor Activity, Judgement, Orientation, Insight, Thought Process, Abstract Reasoning, Language Function, Memory, Cognitive Functioning and Perception and Psychosis.	No	Please be sure to fill out each section of the mental status section. It is noted that individual's mood is checked as "remarkable" but no comments were made to discuss this. Please fix if in error or note what made mood remarkable.
[redacted]	BIO 3.21	5/9/2019	Service Eligibility Criteria Section is completed.	No	Box D under SMI eligibility is not checked and substance use is not noted in BPS - please fix.
[redacted]	BIO 3.28	5/9/2019	The PHQ9 Assessment was completed? (When Depressive or BPD symptoms occur).	No	Please complete PHQ9 annually for individuals with depressive sx.
[redacted]	Preplan 4.2	5/9/2019	Individual and/or Guardian signature on Pre-Plan within 14 days. (10 days for BCBS and CW Cases)	No	No, Guardian's Signature dated 4/29/2019 for 5/31/2018 Pre Plan.
[redacted]	IPOS 4.22	5/9/2019	Treatment Plan addresses some form of transitioning, pre discharge planning or discharge or departure from the program, including individual's strengths.	No	Please more specifically discuss pre discharge planning including decrease in services/transitions to less restrictive care.

Memorandum

To: (Program Supervisor)
CC: UM Team Leader
From: UM Analysis
Date:
Re: **UR:** Case Record Review Packet 1st Request

In accordance with SCCCMHA administrative procedures, the SCCCMHA Utilization Management Team (UMT) recently conducted a Utilization Review (UR) of your program's clinical case records.

Attached to this cover memo are Utilization Reviews (UR): Case Record Review (CRR) findings recently obtained from clinical case record(s) at your program via: UM Location Compliance Report and/or UM Individual Review Reports. Also included are the UR Reconsideration and Disposition Form and the Quality Improvement Action Plan form.

The purpose of the UR is to ensure that persons served by the SCCCMHA Provider Network receive timely, appropriate behavioral healthcare within the range of the individual's benefit plan.

The UR is also designed to ensure the SCCCMHA Provider Network is complying with all Federal and State regulatory guidelines, and is adhering to SCCCMHA clinical practices and protocols as per aligned with MDHHS Levels of Care for Mental Health Specialty Services.

Please review with each applicable case holder the CRR Quality Improvement items (No answers) noted in the attached Individual Summary Report. Please write in your CRR per-item response on the enclosed Quality Improvement Action Plan (QIP).

Send copies of all completed QIP reports back to my office **within 14 calendar days of the issuance of this memo**. (Send **reconsiderations within 7days.**) Send your responses directly to Latina Cates, UM Analyst, at SCCCMHA Administration**.**

If you have any questions or appeal issues (UM administrative procedures #02.003.0011), please do not hesitate to contact me.
Thank you for your time and consideration.

St. Clair County Community Mental Health Authority

Utilization Management
~Utilization Review Reconsideration and Disposition~

This top section is completed by the Program/Contract Supervisor. It is completed within fourteen (7) calendar days of the issuance of the UR report. All other UR report program response and improvement action directives not under reconsideration must be addressed by the Program/Contract Supervisor within thirty (14) calendar days of UR report issuance. **Please address one reconsideration per form**.

Program: _____ Supervisor: _____

Reconsideration Filing Date: _____

Reconsideration Request (the specific UR Finding being reconsidered for review):
Case Number: _____ UR Finding Number: _____

Reason for Reconsideration (Attach copies as applicable):
_____
_____
_____

_____
_____

Program Supervisor (signature): _____
****

This bottom section is completed by the UM Chair within seven (7) calendar days of receipt of the reconsideration request. The completed form is sent back to the Program Supervisor.

Date of receipt of reconsideration request_____

Relevant CRR Indicator_____ Relevant CVR Indicator_____

Review of Information: _____
_____
_____
_____

Discussion:_____
_____
_____
_____
_____

Disposition: ( ) Concur With UR Finding ( ) Modify UR Finding ( ) Overturn UM Recommendation

UM Team Lead Signature: _____Date: _____

cc: UM Administrative File
UM Analyst

St. Clair County Community Mental Health Authority

Quality Improvement (QI) Action Plan

Instructions:

For each case record, document the corrective action(s) taken to meet the standard, which is required for each "No" answer identified in the UM Individual Review Summary Report. Submit completed form within 30 business days of email delivery date, to Latina Cates, UM Analysist. Lcates@scccmh.org

Program Name: _____ **Location number:** _____

Case record number: _____

Item number: _____ QI Description: _____
Item number: _____ QI Description: _____
Item number: _____ QI Description: _____
Item number: _____ QI Description: _____
Item number: _____ QI Description: _____

Case record number: _____

Item number: _____ QI Description: _____
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Case record number: _____

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Item number: _____ QI Description: _____
Item number: _____ QI Description: _____
Item number: _____ QI Description: _____

Submitted by: _____ Title: _____ Date: _____

Case Record Review E-MAIL Template – 2nd Request

To: (Program Supervisor)
From: UM Analysis
CC: UM Team Leader
Subject: Case Record Review 2nd Request

The Utilization Management (UM) Quality Improvement Plan for the UM reviews was sent to you on _____, and due to this office on _____, has not been received. Please be advised you have five (5) business days to submit the required QIP.

Regard UM review case records:

Thank you for your time and follow through on the QIP for the UM reviews

Name
Title
Department
Phone number

CW CASE REVIEW

Supervisor to review with Primary Case Holder and Return To
Data Management within (14) Days of Receipt.

Date of Review:

Month(s) of Services Reviewed:

☐Jan ☐Feb ☐Mar ☐Apr ☐May ☐Jun ☐Jul ☐Aug ☐Sept ☒Oct ☒Nov ☒Dec

Case#: **Primary Case Holder:**

Supervisor: Click here to enter text.

An ongoing process has been developed to review all CW services to ensure that services and supports are provided as specified in the IPOS including type, amount, scope, duration and frequency.

Technical Assistance provided by MDHHS during FY-23 Audit:

-Ranges are no longer acceptable, if still present at next MDHHS review this will be counted as a citation.

-Amount/Scope/Duration must be included in the goal writing process, not just the authorizations.

-When making goals measurable be sure to include a baseline for comparison.

-Annual health care appraisals (including VITAL SIGNS) are a new Performance Indicator. The CW Program requires an annual medical examination so this PI should be met through that requirement.

Billed CPT CODES	CODE IS IN IPOS	Amount and Frequency	Services Provided as indicated in IPOS

Category of Care Narrative to include: Points from Children's Waiver Decision Guide Table (# of Caregivers, Health Status of Caregivers, Additional Dependent Children, Additional Children with Special Needs, Night Interventions and School) Yes__No___

Annual Medical Examination Report Yes__ No___

Annual Waiver Certification Form Yes___ No___

Know Your Rights Sign-Off Sheet? Yes ___No___

PLAN OF CORRECTION:

_____ _____

Primary Case Holder Signature/Date Supervisor Signature/Date

SED WAIVER CASE REVIEW

Supervisor to review with Primary Case Holder and Return To
Data Management within (14) Days of Receipt.

Date of Review: Click here to enter a date.

Month(s) of Services Reviewed:

☐Jan ☐Feb ☐Mar ☐Apr ☐May ☐Jun ☐Jul ☐Aug ☐Sept ☐Oct ☐Nov ☐Dec

Case#: **Primary Case Holder:**

Supervisor: Click here to enter text.

An ongoing process has been developed to review all SED services to ensure that services and supports are provided as specified in the IPOS including type, amount, scope, duration and frequency.

Technical Assistance provided by MDHHS during FY-23 Audit:

Ranges are no longer acceptable, if still present at next MDHHS review this will be counted as a citation.
Amount/Scope/Duration must be included in the goal writing process, not just the authorizations.
When making goals measurable be sure to include a baseline for comparison.
Annual health care appraisals (including VITAL SIGNS) are a new Performance Indicator. You may want to request a copy of last office visit (including vitals), when sending out COC letter to PCP.

Billed CPT CODES	CODE IS IN IPOS	Amount and Frequency	Services Provided as indicated in IPOS

Comments:

Annual Health Care Appraisal? Yes___ No___

KNOW YOUR RIGHTS Sign-Off Sheet? Yes ___ No ___

PLAN OF CORRECTION:

_____ _____

Primary Case Holder Signature/Date Supervisor Signature/Date