SERVICE UTILIZATION GUIDELINES

AGENDA

- Overview of Service Utilization Guidelines, Pre-Service/Prior Authorizations-John Pascaretti, DWIHN Director of UM
- Submitting Requests for Services-Nikki Jones and Dione Williams, Clinical Specialists
- Implementation of Assessments-LOCUS-Dione Williams, Clinical Specialist, CAFAS/PECFAS-Dione Williams, Clinical Specialist, SIS-James Kelly, Utilization Manager/HSW Coordinator
- Individual Plan of Service-Lucinda Brown, Program Administrator-Self-Determination
- Self-Directed Services-Lucinda Brown, Program Administrator-Self-Determination
- ASD Services-Tiffany Karol, Autism Clinical Specialist
- General Fund Authorization Requests-Rhianna M. Pitts, UM Administrator
- Denial and Appeals Process-Tasha Bridges, Denials and Appeals Coordinator
- Accessing the Service Utilization Guidelines-Rhianna M. Pitts, UM Administrator
- Technical Guidance-Steve Jamison, Business Analyst

HOUSEKEEPING

WHEN SUBMITTING A QUESTION IN THE CHAT, PLEASE INCLUDE YOUR NAME AND EMAIL ADDRESS

RESPONSES TO QUESTIONS SUBMITTED WILL BE POSTED ON DWIHN.ORG FOR REFERENCE 1 WEEK AFTER EACH SESSION

PRE-SERVICE/PRIOR AUTHORIZATIONS

Pre-service (prior) authorization is required for the following levels of care:

- Acute Inpatient
- Intensive Crisis Residential
- State Hospitalization
- Partial Hospitalization
- Specialized Residential
- Withdrawal Management
- Psychological Testing
- Neuropsychological Testing
- Electroconvulsive Therapy (ECT)
- All out-of-network treatment services
- Autism Spectrum Disorder (ASD) services
- Outpatient Services

SERVICE UTILIZATION GUIDELINES (SUG)…

Are reviewed and updated annually

Detail the amount and scope of services implementing evidence-based guidelines and assessments including:

Bio-Psychosocial	Level of Care Utilization Systems (LOCUS)	Supports Intensity Scale (SIS)	Child and Adolescent Functional Assessment Scale (CAFAS)	Preschool and Early Childhood Functional Assessment Scale (PECFAS)	American Society of Addiction Medicine (ASAM) criteria	Application of National Coverage Determination(MCG-Indicia)

REQUESTS FOR AUTHORIZATION

Authorization requests (with the appropriate unit amounts and dates of service) that fall within the Service Utilization Guidelines (SUGs) are automatically **APPROVED.** ****No further action is required from the CRSP.** This is applicable for SMI, SED, SED-W, MI Health Link, IDD, CWP.

Authorization requests beyond the guidelines are automatically sent to the Utilization Management queue for review by the Outpatient Services Clinical Specialists. If all requirements are met and the request for authorization is medically necessary, approval will be given within 14 days from the request date.

Authorization requests beyond the SUG requirements are still reviewed for medical necessity. If additional information is required to justify the request, the authorization is returned to the requestor.

Requests for any additional information or requests to modify/correct the authorization (ie. dates of service or amount of units requested) are documented within the "Authorizing Agent Notes" section.

The authorization request and any supplemental information and/or modifications to the request will be reviewed once it has been returned. If the request is clinically appropriate and medically necessary, it will be authorized.

If an authorization was returned, please do not submit a new authorization as it causes a system error, prolonging the review process. Please RESUBMIT THE SAME REQUEST with any additional information and/or corrections WITHIN 48 HOURS.

ASSESSMENTS

LOCUS-Level of Care Utilization System

- This Dimensional Rating System is an assessment that determines the level of intensity of a client's needs. It has six dimensions (Risk of Harm, Functional Status, Medical, Addicitive and psychiatric Co-Morbidity, Recovery Environment: stressors & Supports, Treatment and Recovery History, Engagement and Recovery Status; Used on persons age 18^
- The Service Utilization Guidelines utilize the LOCUS score to help justify the amount and intensity of services.

CAFAS

- A required assessment tool measuring 8 subscales (School, Home, Community, Behavior Towards Others, Moods/Emotions, Self-Harmful Behavior, Substance Use and Thinking/ Communication) for all children with Serious Emotional Disturbance (SED) in the CMHSP system, ages 7 through 17 years and/or as long as they are receiving children's services. The CAFAS is to be completed at intake, quarterly thereafter and at exit from CMHSP for children in this age range receiving behavioral health services.
- It is used as part of the determination of functional impairment that substantially interferes with or limits the minor's role or results in impaired functioning in family, school, or community activities.
- Used as a criteria to consider in determining the intensity of services needed, as an outcome measure (pre and post), as an aid to actively manage cases during a course of treatment, and for agency tracking and quality improvement.

PECFAS

- The PECFAS is a required assessment tool measuring 7 subscales (School/Daycare, Home, Community, Behavior Towards Others, Moods/Emotions, Self-Harmful Behavior and Thinking/ Communication) for all children with Serious Emotional Disturbance (SED) in the CMHSP system ages 4 through 6 years. The PECFAS is to be completed at intake, quarterly thereafter and at exit from CMHSP for children in this age range receiving behavioral health services.
- It is used as part of the determination of functional impairment that substantially interferes with or limits the minor's role or results in impaired functioning in the family, childcare/school or community activities.
- Used as a criterion to consider in determining the intensity of services needed, as an outcome measure (pre and post), as an aid to actively manage cases during a course of treatment, and for agency tracking and quality improvement.

https://www.michigan.gov/documents/mdhhs/PECFAS-CAFAS_Guidance_615625_7.pdf

SUPPORTS INTENSITY SCALE (SIS)

- The SIS is a tool specifically designed to measure the level of support required by a person with IDD to lead a typical, independent, and quality life in their community.
- Evidence-based, scientifically reliable and valid measure of supports needed across life areas (including impact of significant medical and behavioral concerns). The SIS focuses on measuring supports, not deficits.

Domains Measured by SIS

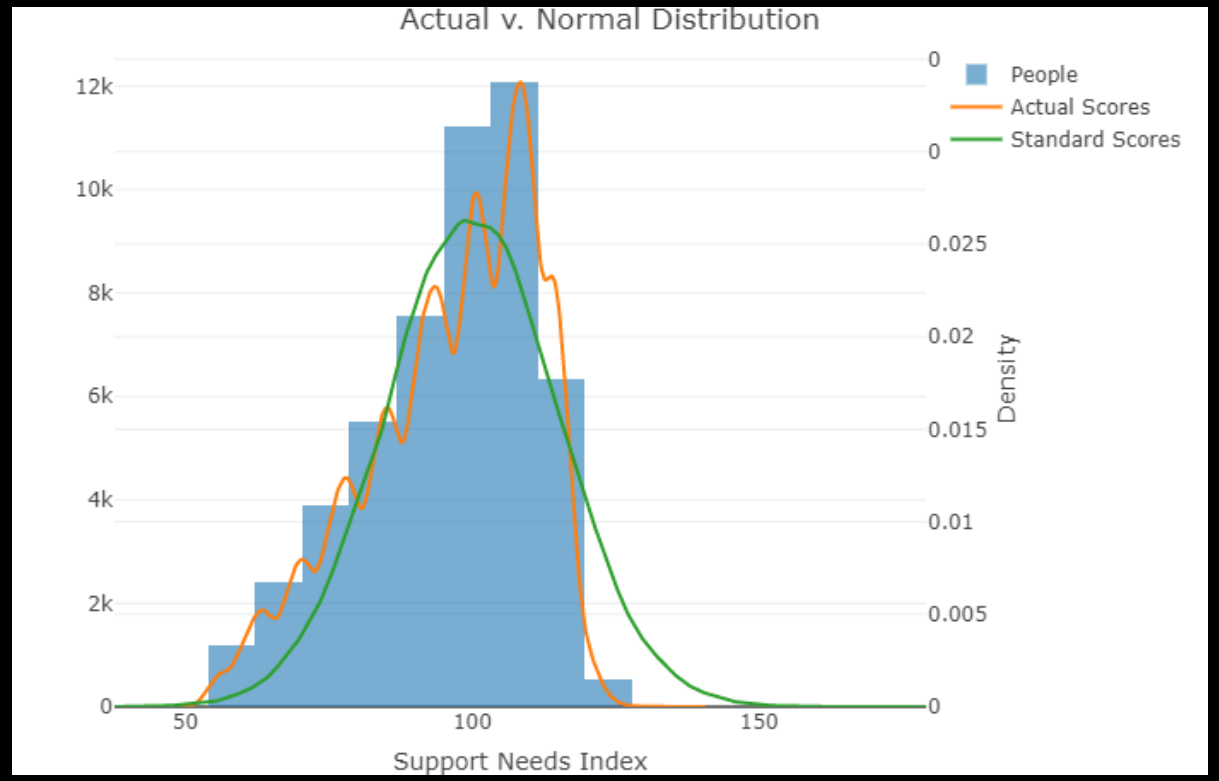
- Home Living Activities
- Community Living Activities
- Lifelong Learning Activities
- Employment Activities
- Health and Safety Activities
- Social Activities
- Protection and Advocacy
- Medical
- Behavioral

SUPPORTS INTENSITY SCALE (SIS)

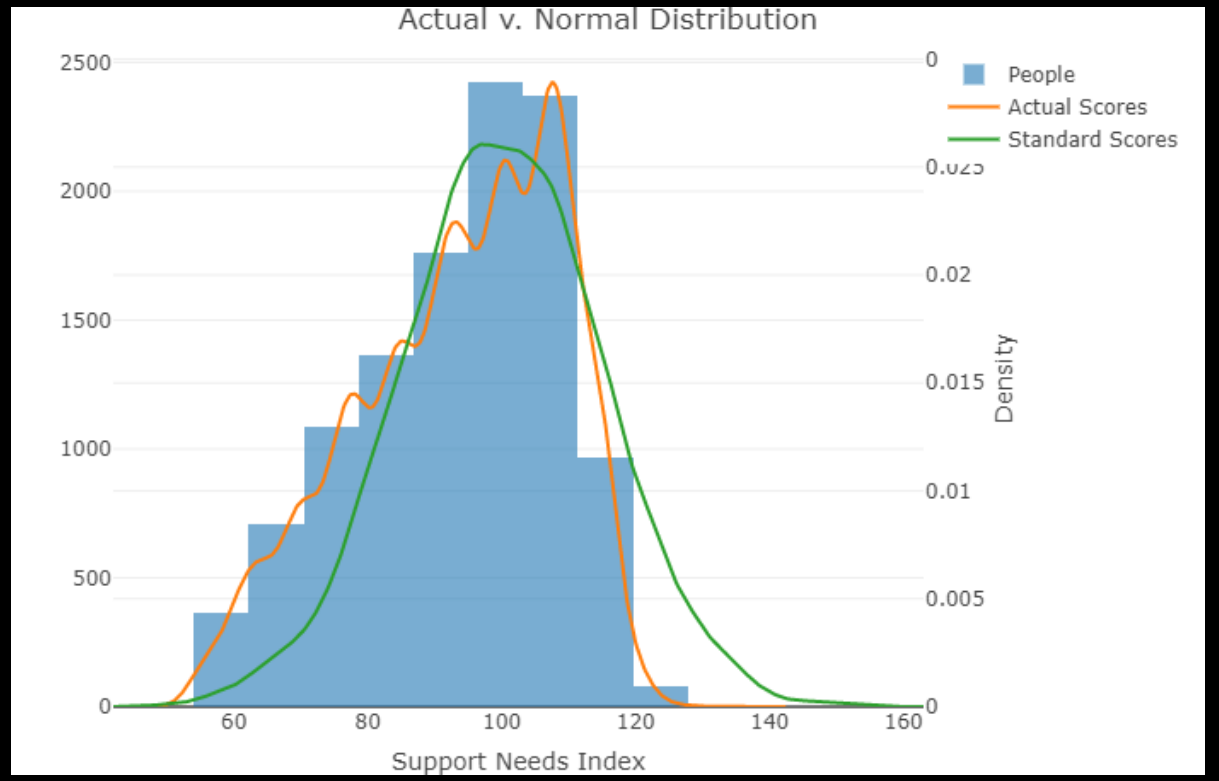
- Service Utilization Guidelines use the **Supports Needs Index** (SNI) Score
  - The SNI shows an overall summary score. An SNI of 100 is average and indicates average support needs. Scores above and below 100 show higher and lower than average supports.
  - The SNI has been normed and typically reflects normal distribution patterns.
  - SIS used to both inform the individual's person-centered plan as well as to assist in authorization requests review.

SUPPORTS INTENSITY SCALE (SIS)

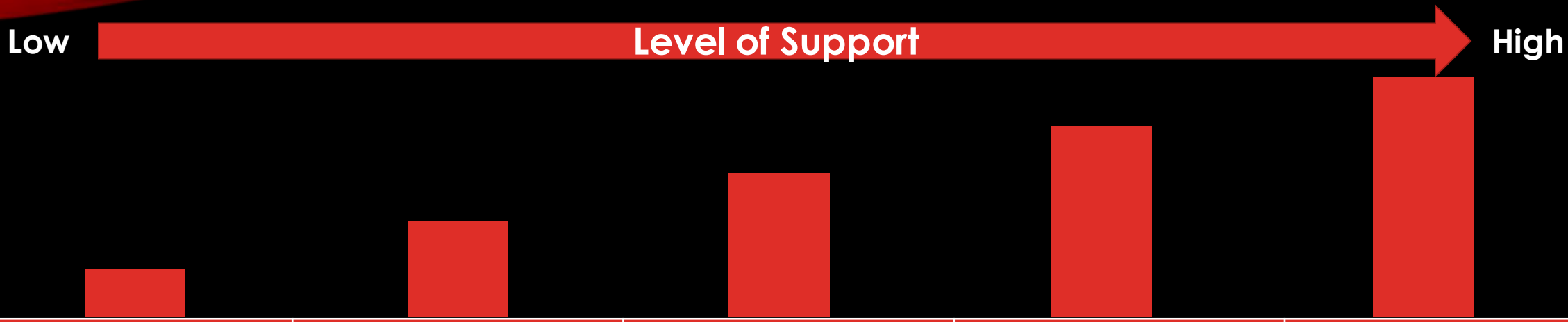
Supports Needs Index



State of Michigan



Detroit - Wayne



Level 1	Level 2	Level 3	Level 4	Level 5
<90-97		98-105	106-115	116 >
Adults in this level have some but largely mild need for support, including little to no support need for medical and behavioral challenges.	Adults in this level have modest or moderate support needs and little to no support needs for medical and behavioral challenges.	Adults in this level have little to moderate support needs as in Levels 1 and 2. They also have an increased, but not significant, support needs due to behavioral challenges.	Adults in this level have moderate to high need for support. They may have behavioral support needs that are not significant but range from none to above average	Adults in this level have high to maximum support needs. They may have behavioral support needs that are not significant but range from none to above average.

SUPPORTS INTENSITY SCALE (SIS) – SUG ISSUES

- **No SIS has been conducted (hasn't been scheduled, has been refused or deferred, etc.)**
  - If a SIS assessment is not available, the Individual's Person-Centered Plan and other supporting documentation will be utilized justify the authorization request.
- **The individual's needs fall outside the SUG guidelines**
  - Our review process addresses the needs of people who are outliers within their assigned level. This may apply to people who have needs above and beyond those addressed in the support level or they just have unique needs which are not captured and addressed within the level's service package.

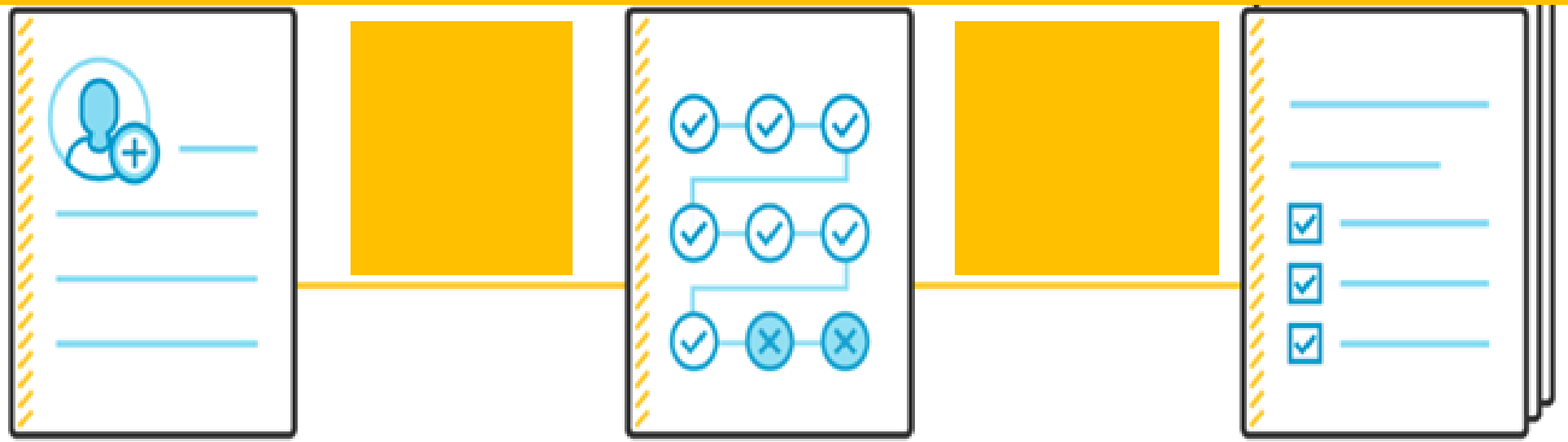
WHAT TO DO WITH THE INFORMATION FROM ASSESSMENTS?

Assessments guide the Person-Centered Planning process!

The Golden Thread

Follow the steps 1, 2, 3

The Golden Thread is the consistent presentation of relevant clinical information throughout all documentation for a member.



1. Assessment

2. Individual Plan of Service

3. Progress Notes

GOLDEN THREAD

- The Golden Thread begins with an **assessment** that clearly identifies clinical needs of the individual. All **assessments** should be used to inform the Person-Centered Planning process. Service Utilization Guidelines (SUGs) are a group of pre-approved services for members with similar needs identified in the assessments. SUGs offer a transparent and equitable level of service delivery for members with similar needs to also inform the Person Centered Planning process.

- The **Individual Plan of Service (IPOS)** provides details of supports and services recommended to meet the needs important for and important to the member.

- **Progress notes** then monitor progress of goals and services identified in the IPOS.

STEP 1: ASSESSMENT

Examples of Standardized Assessments

- SIS Assessment
- LOCUS Assessment
- CAFAS Assessment
- PECFAS Assessment
- ASAM

Assessments specific to DWIHN

- New Staff Planning Guide (SPG) for individuals living in licensed and unlicensed homes. This document is entered electronically into MHWIN.
- Old Staff Planning Guide (paper) for individuals requiring H2015 and living in a family home or supportive living. Needs to be uploaded to MHWIN.
- Respite Assessment (additional respite only)
- Biopsychosocial
- Other clinical assessments

STEP 2: INDIVIDUAL PLAN OF SERVICE (IPOS)

- **Person Centered Planning** is a PROCESS to develop the IPOS. The process should include discussion about the results of the assessments, SUGs, supports important to and for the member and specific goals the members want to achieve and the supports needed to achieve the goals. Person-centered planning is a way to ***plan*** the life a member wants. It builds upon their capacity to participate in community life, develop meaningful relationships, earn income, focus on their strengths, honors their preferences, choices, abilities, and promotes resilience and recovery.

- **Individual Plan of Service (IPOS)** is the written document which details the plan discussed through Person Centered Planning process.

STEP 2: GOALS AND OBJECTIVES

Goals must demonstrate a measurable intended outcome the member wants to achieve. They should be written in the members own words. There must be a goal for every service authorization (except SC, CSM, FI). For SC, CSM, and FI- the contribution and monitoring frequency to the goal by these services must be included in the intervention. **Ex: I want to work.**

Objectives must be **S.M.A.R.T.**

Specific

Measurable

Attainable

Relevant

Time Bound

Ex: By December 2020, Pat will be employed for at least 20 hours per week.

STEP 2: S.M.A.R.T. OBJECTIVE

TELL YOU HOW YOU KNOW IF THE GOAL IS ACCOMPLISHED.

EX: BY DECEMBER 2020, PAT WILL BE EMPLOYED FOR AT LEAST 20 HOURS PER WEEK.

- **S**pecific- State the goal clearly and must be written in observable terms.
- **M**easurable- Identify and quantify an observable method of documenting progress. Details if services helped.
- **A**ttainable- Goal should be a reasonable outcome which the member is expected to achieve. If it cannot be achieved in one year, the goal should be broken down in a smaller step.
- **R**elevant- The goal should be important to the individual and something they want to do.
- **T**ime Bound- Define the how long it will take to achieve the goal. Detail how progress will be documented.

The sum of the goals must be consistent with the authorization.

CHECKLIST FOR GOOD GOALS

The objective is S.M.A.R.T.

The intervention details all the steps to accomplish the goal. Specific interventions detailed that reflect best practices or evidenced based services to help guide the member to their desired outcome.

The intervention includes who is going to assist with each step. Detailed enough to serve as a "job description" for staff.

The intervention states what natural supports or community resources have been exhausted before requesting service authorizations.

The intervention identifies the amount, scope, and duration of services. This total should be reasonable to meet the intended outcome.

The intervention details how frequent progress on the goal will be monitored and who will do it.

STEP 3: PROGRESS NOTES

Progress notes (PN) demonstrate that services authorized are meeting the needs identified in the Individual Plan of Service. Progress notes should document progress on goals. Each note should create a comprehensive story which connect the fact that services are meeting the needs identified in the IPOS. If there is no progress, there should be discussion through the Person-Centered Planning process to determine if the goals or interventions/strategies need to be changed.

Support Coordinators should review PNs completed by staff within the home and summarize them in their PN.

The Golden thread puts all the pieces together

The Person Centered Planning process takes into account all needs identified in the **assessment(s)** to develop the **Individual Plan of Service (IPOS)** which becomes the detailed steps to accomplish measurable goals by following the steps identified in the objectives. All success or lack thereof is documented in **progress notes (PN)**.

SELF-DIRECTED SERVICES

- During the Person-Centered Planning process, the option to Self-Direct services must be offered. A member who wants to directly select a person they know to provide an authorized service (typically respite or community living supports) can be done by entering into a Self-Directed Arrangement; the person should not go directly to a staffing agency. Please contact Lucinda Brown at lbrown@dwihn.org or see the DWIHN Self-Determination Policy for details.

- The same Service Utilization Guidelines apply.

ASD AND SUGS

Effective 7/13/20 DWIHN began to transition to auto approving a majority of authorizations for the ASD benefit.

13 July 20

13 July 20

The initial testing phase of this process started 7/13/20 with participation from the following ABA providers: Gateway Pediatric, A&C Behavioral Solutions, Healthcall, Open Door, Zelexa, and Starfish Family Services.

Barring any significant issues, the remainder of the ABA providers will be participating in the auto approval process effective 8/17/20 so that the majority of authorizations will undergo the new auto approval process.

17 Aug. 20

ASD AND SUGS: WHAT WILL STILL NEED TO BE MANUALLY APPROVED?

- Any initial behavior assessment request
- Any requested service amount above the Service Utilization Guidelines (SUGs)
- Any service requests outside of the re-evalulation end date due to COVID-19

ASD PROCESS WORKFLOW

1. ABA Providers complete ADOS 2 worksheet. Worksheet must be updated every time ADOS is completed. Worksheet is routed to DWIHN staff for review and signature.

2. ABA providers complete behavior assessment worksheet. Behavior assessment should be completed every 6 months. If there is not a behavior worksheet on file, auth cannot be auto approved. It may need to be updated more frequently if the re-evalulation end date needs to be updated.

3. ABA provider completes authorization request form, uploads forms into MHWIN and notifies CRSP of request.

4. Supports Coordinator updates IPOS (as needed and creates request referencing the auth request form.

5. Supports Coordinator reviews request prior to submission to ensure all information, including start and end dates, services, amounts, and frequencies match auth request form.

6. Supports Coordinator Submits auth request.

7. MHWIN auto approves requests that fall within the SUG's and don't have any date errors.

8. Requests for services outside the SUG's goes to DWIHN's UM Department for review. DWIHN has 14 days to issue a disposition, although most requests are reviewed in a shorter timeframe.

GENERAL FUND REQUESTS FOR UNINSURED/UNDERINSURED MEMBERS

For members who are uninsured or underinsured, the CRSP is responsible for confirming their insurance status. If it is determined that the member does not have Medicaid, they require a General Fund Exception. **The General Fund Exception benefit does not apply to new or existing consumers on Medicaid spend down or consumers receiving services through ABA.**

All General Fund Requests submitted from providers with Health Information Exchange will auto approve if they fall within the Service Utilization Guidelines for the first request.

Any subsequent requests for authorization using General Fund after the initial 90 days will route to the Utlization Management queue for review and authorization. Any providers who submit General Fund authorization requests without Health Information Exchange, will be routed to the queue for approval by the assigned Clinical Specialist.

DENIALS AND APPEALS- TASHA

Denials can be issued due to:

- Lack of Medical Necessity Criteria
- Administrative Reasons

Prior to the Formal Denial Process:

- DWIHN's UM Clincal Specialist can request additional information from the provider within forty-eight (48) hours of the request and/or;
- The UM reviewer can verbally consult with a supervisor

DENIALS AND APPEALS

Formal Denial Process:

- The physician/appropriate professional will review the case and render a decision within the following timeframes:
  - For a standard pre-service initial or continued stay review within 14 calendar days of request;
  - For an expedited/urgent pre-service initial review within 72 hours of request;
  - For a post-service (retrospective) review within 30 calendar days of request.

If the decision is to deny services, the UM Clinical Specialist or designated staff person will notify the provider and send the standardized Adequate or Advance Action Notice/ Denial of Medical Coverage Notice (If member is MI Health Link) to the provider.

DENIALS AND APPEALS

Types of Appeals:

- Medical Necessity
- Administrative

The provider and/or member has up to 60 calendar days from receipt of the standardized Adequate or Advance action notice from or from the Denial of Medical Coverage Notice form (for MI Health Link members) to request a pre-service or post-service appeal.

- Post service appeals must be in writing.

DENIALS AND APPEALS

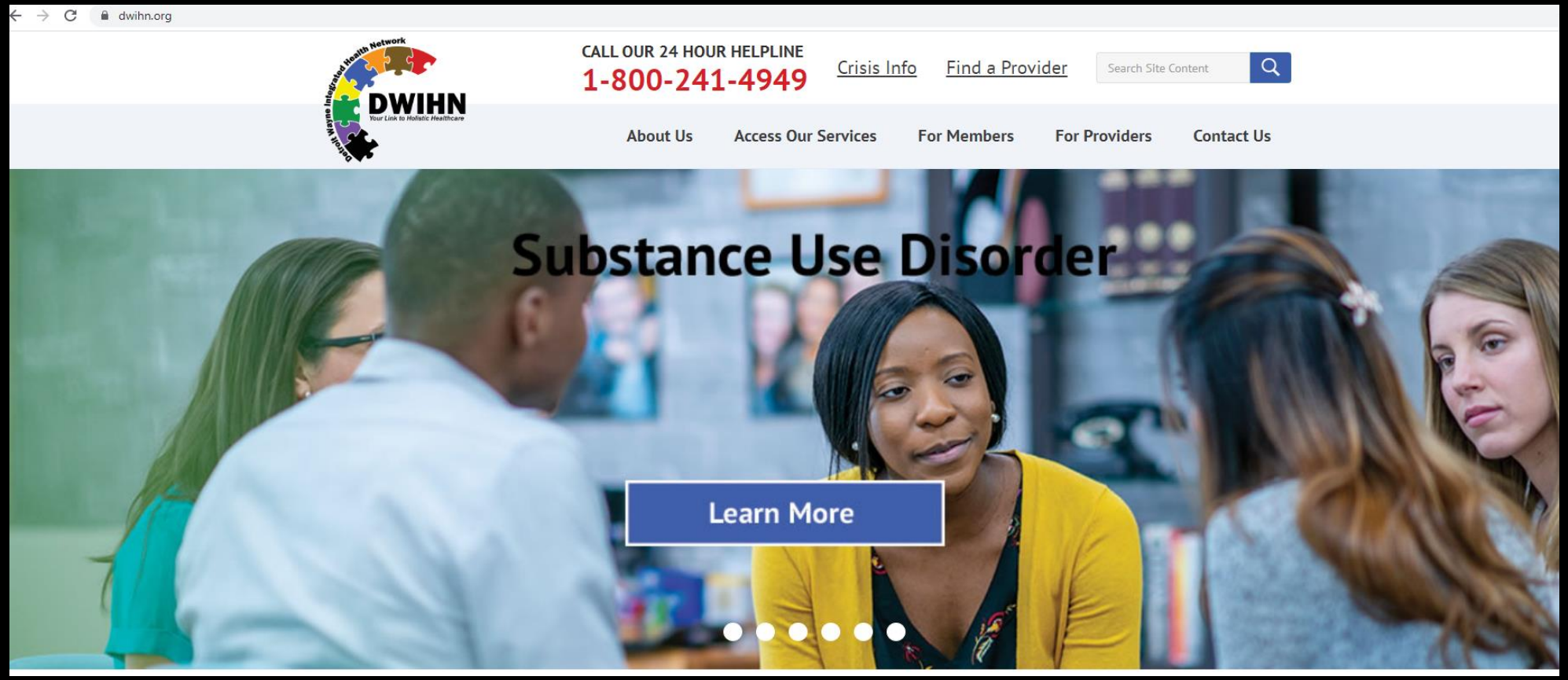
If the decision is to overturn part or all of the initial denial, DWIHN will approve your original request

If the decision is to uphold part or all of the initial denial, DWIHN's Appeals Coordinator or appropriate professional will:

Verbally notify the provider and a letter will be mailed within 24 hours of the receipt of the determination.

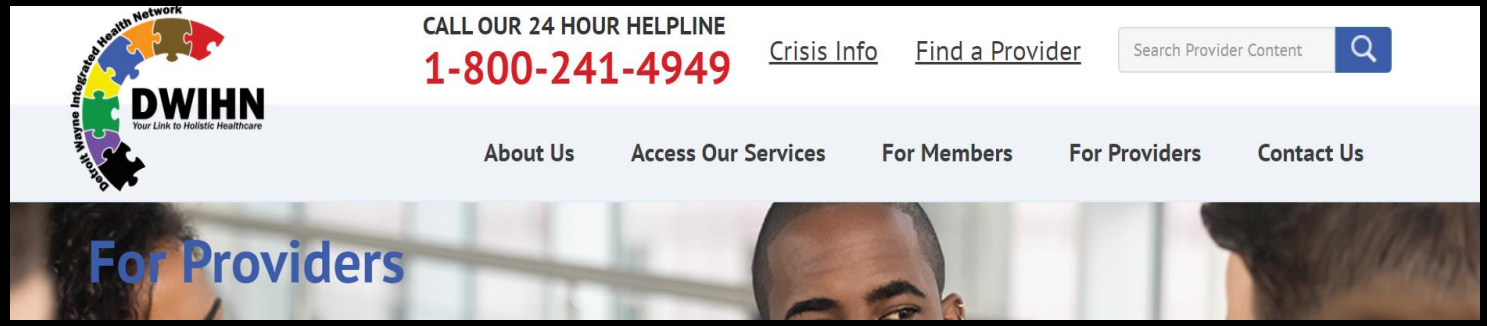
ACCESSING THE SERVICE UTILIZATION GUIDELINES

Step 1: Open DWIHN.org



ACCESSING THE SERVICE UTILIZATION GUIDELINES

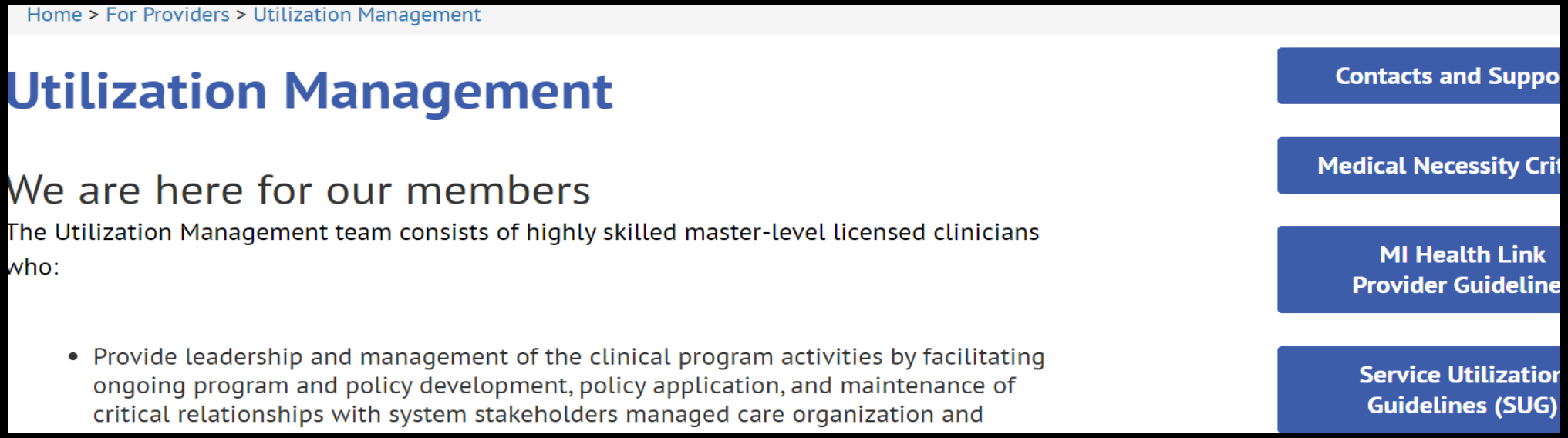
Step 2: Select "For Providers"



Step 3: Scroll down to the Utlization Management section and select "Learn More"

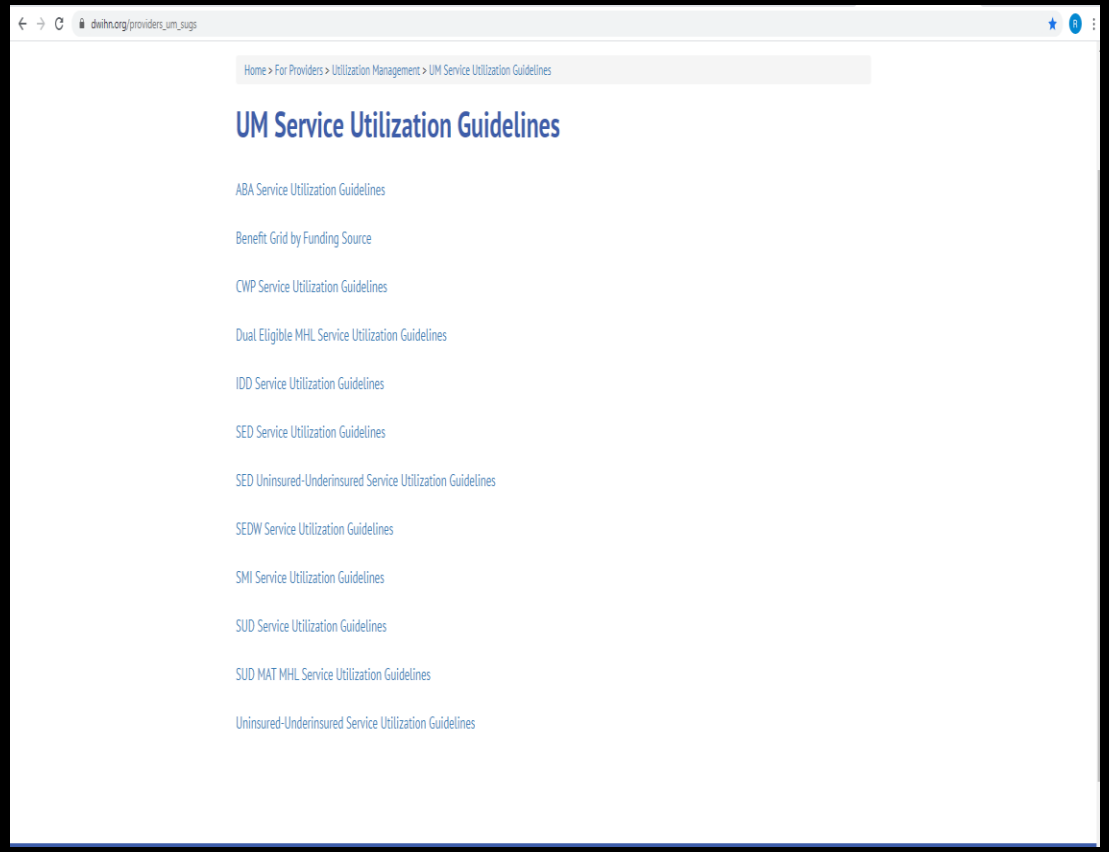
ACCESSING THE SERVICE UTILIZATION GUIDELINES

Step 4: On the right side of the screen, select Service Utilization Guidelines



ACCESSING THE SERVICE UTILIZATION GUIDELINES

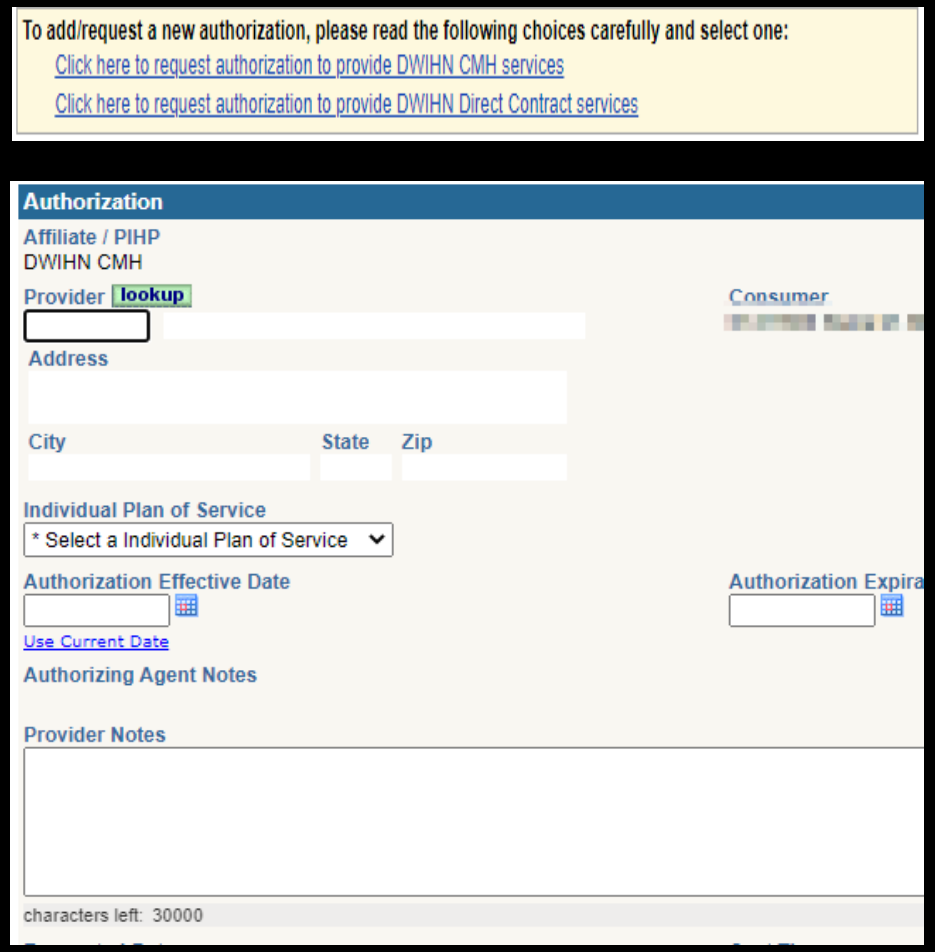
Step 5: Select desired benefit guideline.



Guidelines were last revised in May 2020.

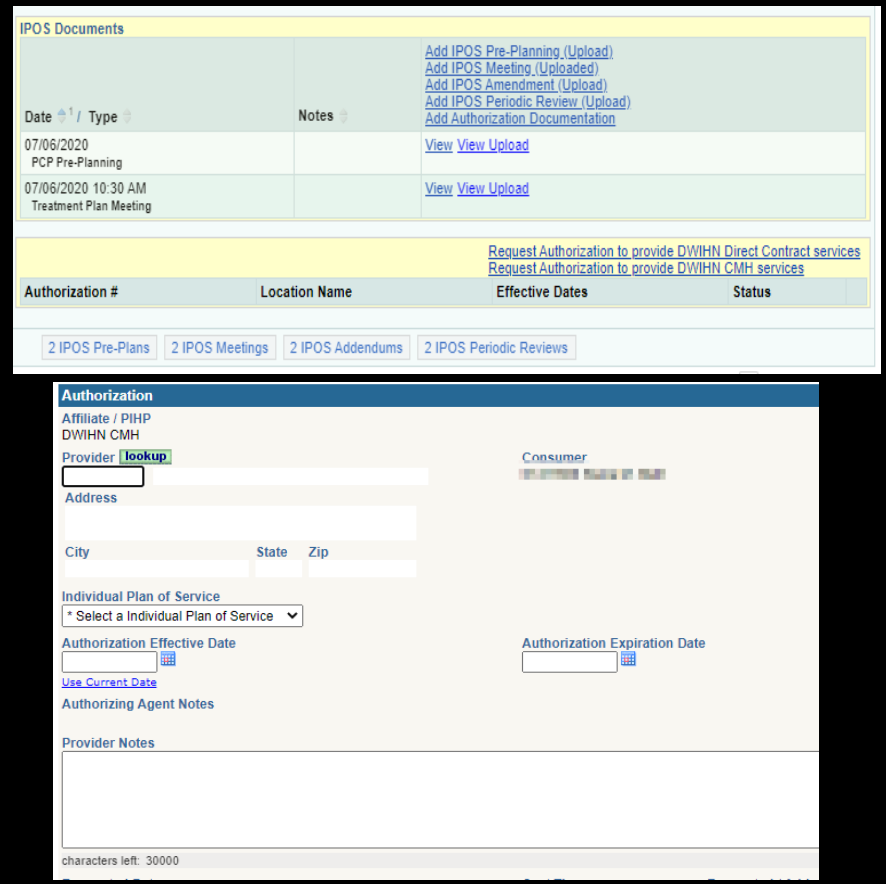
TECHNICAL ASSISTANCE

- **Traditional Authorizations**: **For providers not using a PCE based system or those on a PCE system that does not have the new IPOS module.
- Authorizations are entered from a few different menu options but the authorization is the same



TECHNICAL ASSISTANCE

IPOS entered Authorizations: Authorizations linked to the IPOS are for our providers who are on a PCE system and they have the new IPOS module active. **Note not all have this module activated yet, but all PCE system users should have the new IPOS module by 10/01/2020**



**Pictured: The authorization section within the IPOS. The user would add an authorization by clicking the correct link and complete the authorization. **

ADDITIONAL QUESTIONS

Questions Regarding Authorizations:

pihpauthorizations@dwihn.org

For Techincal Support:

MHWIN@DWIHN.org