

WCHO PIHP POLICY for the COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN		<i>Policy and Procedure</i>	
		Timeliness of Service Provision and Documentation	
Department: Author: GERALYN HARRIS		Local Policy Number (if used)	
Revision Date	Approval Date	Implementation Date	
	10/21/08	1/18/09	
Archive Information			
Date:			
Reason:			

I. PURPOSE

To standardize the definition and process of timely provision of care, treatment, and services, and the documentation of those services, to ensure the continuity of care, treatment, and service provision.

II. POLICY

It is the policy of the Community Mental Health Partnership of Southeastern Michigan (CMHPSM) that the provision and documentation of all care, treatment, and services shall be done in a timely manner. The provision and documentation of care, treatment, and services are vital to the coordination and continuity of the care, treatment, and services. Service provision and documentation should occur in compliance with Michigan Department of Community Health (MDCH) and Joint Commission standards.

III. APPLICATION

This policy applies to the Comprehensive Specialty Services networks (CSSNs), CSSN look-a-like, and the Prepaid Inpatient Health Plan (PIHP) within the Community Mental Health Partnership of Southeastern Michigan (CMHPSM), when applicable.

All programs and services provided directly by the CMHPSM or through contractual agreements with service providers are obligated to follow these guidelines.

IV. DEFINITIONS

Adverse Action: (1) A denial or limited authorization of a requested Medicaid or non-Medicaid service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized Medicaid or previously provided non-Medicaid covered service; (3) The denial, in whole or in part, of payment for a Medicaid or non-Medicaid covered service; (4) The failure to make an authorization decision and provide notice about the decision, within standard time frames; or (5) The failure to provide Medicaid or non-Medicaid services within the standard timeframe. Additionally, the failure of the WCHO to act within the timeframes required for disposition of grievances.

CSSN: Comprehensive Specialty Services Network provider as designated by WCHO is responsible for completing, monitoring and updating the Client Financial Report and for determining as appropriate fee for all services provided. (2) CSSN - An organization that is certified as a CMHSP, including a recipient rights systems, services across all populations, has a Publicly appointed Board of Directors, and has accreditation from JCAHO.

CSSN Look-a-Like: A public entity that has a publicly appointed board of directors or has publicly appointed officials that delivers Medicaid and indigent services and is accredited.

PIHP: Prepaid Inpatient Health Plan under Medicaid

V. STANDARDS

A. General

1. All care, treatment and services, as well as documentation, must occur within the time frames outlined in the CMHPSM policies.
2. Habilitation Waiver Certifications must be completed every 12 calendar months.
3. Physician prescriptions (orders) must be obtained prior to the services of Occupational Therapy and Physical Therapy, as required.

B. Intake

1. Initial requests for services, phone call screens or walk-ins, must be documented on the Encompass system within 1 business day of the contact. The Initial Assessment screen (6 question screen) must be completed within 1 business day of the contact.
2. The Initial Assessment process must be completed within 14 calendar days of the Initial Request for Services. The Initial Assessment documentation must be completed within 2 business days of the completion of the assessment process.
3. The initial authorization for services must be completed within 2 business days of the completion of the Initial Assessment process.
4. The initial contact with the assigned staff must occur within 14 calendar days of the date of the Initial Assessment.
5. Documentation of the initial meeting with the assigned staff must occur within 1 business day of the contact.

C. Assessments

1. The Annual Bio-psychosocial (BPS) assessment documentation must be completed within 2 business days of the completion of the assessment. The

Annual BPS must occur prior to the Pre-plan and Person Centered Planning meetings.

2. All Specialty Service (Occupational Therapy, Speech and Language Therapy, Nursing, Psychology, Physical Therapy) assessment documentation must be completed within 2 business days of the completion of the assessment process.
3. Psychiatric assessment documentation must be completed within 2 business days of the completion of the assessment.
4. Omnibus Budget Reconciliation Act of 1987 (OBRA) documentation must be completed as outlined in the OBRA operations manual.
 - a. The CSSN/CSSN Look-a-Like has 4 working days (unless otherwise specified by contract,) to complete the Pre-Admission Screening (PAS,) starting from the date the DCH-3877 form is received by the CSSN/CSSN Look-a-Like to the date the PAS is submitted to the Michigan Department of Community Health OBRA office.
 - b. The CSSN/CSSN Look-a-Like has 14 calendar days to complete an Annual Resident Review (ARR,) starting from the date the DCH-3877 form is received by the CSSN/CSSN Look-a-Like, to the date the ARR is submitted to the Michigan Department of Community Health OBRA office.
 - c. The CSSN/CSSN Look-a-Like has 14 calendar days to complete an Change in Condition evaluation, starting from the date the DCH-3877 form is received by the CSSN/CSSN Look-a-Like, to the date the form is submitted to the Michigan Department of Community Health OBRA office.
 - d. The CSSN/CSSN Look-a-Like has 14 calendar days to complete a Hospital Exempted Discharge evaluation, starting from the date the DCH-3877 form is received by the CSSN/CSSN Look-a-Like, to the date the form is submitted to the Michigan Department of Community Health OBRA office.

D. Progress Notes

1. Progress Notes completed by clinical staff (management, hospital and jail liaisons, case managers, supports coordinators, therapists, psychiatrists, psychologists, nurses, occupational therapists, physical therapists, and speech and language therapists) must be completed within 1 business day of the care, treatment, or service.
2. Progress Notes and other documentation for Community Living Support/Personal Care services provided in a Specialized Residential group home, for Skill Building services, for Supported Employment services, and for Community Living Support services must be completed by staff that provided the service by the end of their shift. *Exceptions are for Supported Employment Enclaves, Supported Employment Work crews, or for Skill Building services whereby the activities are scheduled for a work week. For those exceptions, the staff providing the service must complete

documentation of the service provision no less than weekly, unless otherwise specified in the Person Centered Plan or other contractual agreement.

3. Progress notes and other documentation for Respite services must be completed by staff that provided the service within 24 hours from the date of the service.

E. Person Centered Planning (PCP) process

1. The Annual Review must be completed and signed, by the assigned staff, on the Encompass system within 14 calendar days of the contact.
2. The Pre-plan must be completed and signed, by the assigned staff, on the Encompass system within 1 business day of the contact. The Pre-plan meeting cannot occur on the same day as the Person Centered Plan (the exception is the Single-Service Plan of Service.) The Pre-plan must occur prior to the Person Centered Plan. Staff should start the planning process at least 14 calendar days before the expiration date of the current Person Centered Plan to assure consumers have enough time to choose an independent facilitator and to arrange the Person Centered Planning meeting.
3. All consumers must have a current Person Centered Plan. The Person Centered Plan must be completed annually. A plan cannot continue beyond 365 days. If a new Person Centered Plan will not begin by the expiration date of the current Person Centered Plan, an Interim Plan of Service must be completed. The start date of the Interim Plan of Service will be the day after the current Person Centered Plan expires.
4. The Person Centered Plan documentation must be completed and a copy sent to the consumer within 15 business days after the effective date of the Person Centered Plan. Documentation of the consumer receiving a copy of the Person Centered Plan, by mail or hand delivered, is on the Encompass system. Documentation must be completed with 1 business day of the date the Person Centered Plan was hand-delivered or mailed to the consumer.
5. Provision of care, treatment, and services authorized in Person Centered Plan must occur within 14 calendar days of the start date of the authorization for a service. Documentation must occur within 1 business day of the service provision.
6. The Person Centered Plan must be in-serviced within 30 days of the effective date of the Person Centered Plan. Documentation must occur within 1 business day of the training.
7. The Periodic Review must be completed at the frequency identified in the Person Centered Plan. The Periodic Review may occur prior to this date when a significant event occurs or to amend the Person Centered Plan. Completion of this documentation must occur within 14 calendar days of the start of the Periodic Review meeting(s.)

F. Utilization management:

1. All supervisory reviews of Person Centered Plans, Assessments, Annual Reviews, Periodic Reviews, and authorizations must be completed no later than 7 calendar days from the receipt of the document for review. Completion is defined as a signed, approved document.

VI. EXHIBITS

*GRIEVANCE AND APPEAL TIME FRAMES CAN OCCUR ANY TIME IN THE PLAN OF SERVICE CYCLE.

VII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	X	438.208 (B) (C)
Michigan Mental Health Code Act 258 of 1974	X	330.1409 (1-7), 330.1700(g), 330.1707 (1-5), 330.1712 (1-3)
Joint Commission Standards	X	PC 4.90, PC 5.60, IM 3.10, PC 15.20, PC 15.30
MDCH Medicaid Contract	X	6.4.4, 6.9.4
CMHPSM Care Coordination Policy	X	Section V (A, K)
CMHPSM CSM/Supports Coordination Policy	X	Procedure section/CSM/Supports Coordinator (2,3,5)
CMHPSM Consumer Grievance and Appeal Policy	X	Standards, section, K,L,M,N,O,P
OBRA Operations Manual-MDCH	X	

