

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN	<i>Policy and Procedure</i>		
Department Utilization Management	# of Pages: 4		
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Administrative/Board of Directors Sign Off			
Administrative Signature:		Date:	
Board of Directors Signature:		Date:	

I. PURPOSE

To describe those CMHPSM standards, requirements, structures and activities necessary to ensure the efficient and effective use of clinical care resources

To ensure that consumers receive services which are medically necessary, appropriate as to type, frequency, intensity and duration and consistent with their needs and desires

To ensure that CMHPSM consumers with comparable mental health needs receive comparable services as to type, frequency, intensity and duration

II. APPLICATION

Staff responsible for service authorization decisions and their oversight

Staff responsible for the development, implementation and updating of service eligibility, entry, continuing stay and discharge criteria

Members of the Regional Utilization Review Committee and others involved in studying data-based service utilization patterns

III. DEFINITIONS

Clinical Practice Guidelines: Systematically developed standardized specifications for care to assist provider and consumer decisions about appropriate health care for specific clinical circumstances. Practice guidelines are typically developed through a formal process and are based on authoritative sources, including clinical literature and expert consensus.

Medical Necessity:	Services adequate and essential for evaluation and/or treatment of an illness or condition, as defined by DSM-IV; can be reasonably expected to improve an individual's condition or level of functioning; are in keeping with national standards of mental health practice; are provided at the appropriate and least restrictive level of care
Service Authorization:	Formally approved services identified in the person-centered plan
Utilization Management:	Procedures and clinical decisions intended to ensure that the services provided to a specific consumer at a given time are appropriate, medically necessary, and cost effective.
Utilization Review:	Analysis of the patterns of service authorization decisions and service usage in order to determine the means for increasing the value of services provided (minimize cost and maximize effectiveness/appropriateness).

IV. POLICY

- A. The responsibility for managing the utilization of clinical care resources rests in great part with professional staff members who assess the needs of and authorize care for CMHPSM consumers
- B. Decisions regarding the type, frequency, intensity and duration of services to authorize or deny must be:
 - 1. accurate and consistent with medical necessity criteria,
 - 2. consistent with regional or Medicaid Chapter III eligibility, entry, continuing stays and discharge criteria as applicable.
 - 3. consistent with formal assessments of need and consumers' desired outcomes,
 - 4. consistent with established regional Clinical Practice Guidelines,
 - 5. adjusted appropriately as consumers' needs, status, and/or service requests change,
 - 6. timely,
 - 7. provided to the consumer in writing as to the specific nature of the decision and its reasons,
 - 8. as applicable, shared with affected service providers verbally or in writing as to the specific nature of the decision and its reasons, (refer to the Provider Appeals Policy) if there are any concerns with decisions made,
 - 9. documented in the clinical case record as to the specific nature of the services authorized or denied and its reasons and

10. accompanied by the appropriate notice to consumers regarding their appeal rights with a copy of the notice placed in the consumer's clinical case record. (refer to the Consumer Grievance & Appeals Policy)
- C. The above utilization management / service authorization decisions and their associated procedures are required at numerous points during the course of service provision:
1. The completion of the Initial Assessment
 2. The completion of the Initial Person-Centered Planning Process
 3. The consumer requires or requests a more intensive or less intensive level of a current service
 4. The consumer requires or requests the addition of a new service
 5. The consumer requires or requests the termination of a current service
 6. The expiration of a service authorization
 7. The completion of the Annual or other Assessment
 8. The completion of the Annual or other Person-Centered Planning Process
 9. Consideration is being given to denying, suspending, reducing, or terminating services
- D. To ensure the accuracy and consistency of utilization management / service authorization decisions, clinical supervisors will oversee and periodically review the utilization decisions made by their staff and, as indicated, implement corrective action.
- E. Utilization management decisions to deny, reduce, suspend, or terminate services will be made by staff with appropriate clinical competencies. Through the local and/or regional credentialing process, they will have been determined to have knowledge and/or expertise in all of the following areas:
1. Evaluation
 2. Treatment planning
 3. Service authorization
 4. Service eligibility criteria
 5. CMH and community services, supports and other resources
 6. Treatment
- Clinical supervisors will oversee and periodically review these utilization decisions for accuracy.
- F. To evaluate the success of utilization management processes and to ensure the accuracy, appropriateness and consistency of utilization management decisions, a Regional Utilization Review Committee will coordinate ongoing utilization review activities.
1. Priority should be given to:
 - a. high cost services,
 - b. highly utilized services,

- c. services associated with a high number of consumer grievances and appeals,
 - d. services for which there are large differences in cost per case and/or cost per unit among individual affiliates and
 - e. services which are under and/or over utilized.
2. The Committee will evaluate the results of these activities and ensure the implementation of improvement planning / corrective action as necessary.
 3. Consideration should be given to the following utilization review methods:
 - a. Analyzing aggregated case record review data reflecting the degree to which consumers meet service eligibility criteria
 - b. Analyzing aggregated case record review data to determine the degree to which consumers meet entry criteria for a specific service
 - c. Analyzing aggregated case record review data to determine the degree to which frequency and intensity of services are consistent with medical necessity criteria
 - d. Data collection and analysis of cost per unit or cost per case for a service or program type
 - e. Data collection of average length of stay for a specified service
 - f. Data collection and analysis of consumer and provider satisfaction with the Utilization Management/Utilization Review process
 - g. Studies of under and over-utilization of services
 - h. Studies of inpatient admissions per capita
 - i. Studies of utilization of alternatives to high cost care
 4. The Committee will be responsible for the development, implementation, and evaluation and updating of Regional Service-Specific entry, continuing stay and discharge criteria.

V. EXHIBITS

None

VI. REFERENCES

- A. Balanced Budget Act
- B. JCAHO Managed Care Organization Standards
- C. JCAHO Behavioral Health Standards
- D. CMHSP Provider Appeal Policy
- E. CMHSP Consumer Grievance and Appeal Policy
- F. CMHSP Service Authorization Policy
- G. CMHSP Clinical Practice Guidelines Policy
- H. MDCH-CMHSP Managed Mental Health Supports and Services Contract
- I. Medicaid Managed Specialty Supports and Services Contract