Behavioral Health Utilization Management Review Policy

POLICY

Detroit Wayne Mental Health Authority's (DWMHA) Behavioral Health Utilization Review Policy describes a systematic method to manage the utilization of services provided to enrollee/members. Management of services is achieved through ongoing monitoring and evaluation of medical necessity criteria and evaluation of the appropriateness of the level of care. This policy reflects the most current National Committee for Quality Assurance (NCQA) standards for Utilization Management (UM) except in the event when there are differing contractual requirements. In such circumstances, DWMHA must adhere to the contractual requirements.

PURPOSE

To describe those standards, requirements, structures, and activities necessary to ensure the efficient and effective use of clinical care resources. To delineate procedures that ensure the delivery of cost-effective, clinically appropriate, efficient services to enrollee/members in the least restrictive setting that meets their needs and that provides measurable outcomes and enrollee/member satisfaction.

APPLICATION

This policy applies to all DWMHA staff, Contractual staff, Manager of Comprehensive Provider Network (MCPN) staff, Access Center staff, Crisis Service Vendor staff. This policy serves all populations: Adults with Severe Mental Illness (SMI), Children with Serious Emotional Disturbance (SED), Persons with Intellectual/Developmental Disabilities (I/DD) and Persons with Substance Use Disorders (SUD) and all funding streams and waiver programs such as MI Health Link, SUD, Autism Spectrum Disorder and Medicaid.

KEY WORDS

1. Adverse Determination
2. Appeal
3. Authorization
4. Behavioral Health Supports and Services
5. Care Coordination
6. Concurrent (continued stay) Review
STANDARDS

1. Utilization Management (UM) Staff

   a. DWMHA has established a UM Department whose primary responsibility is the performance of such UM activities as determinations of medical necessity pre-service, concurrent, and post-service reviews, certification, notification, discharge planning and coordination of care for the enrollees/members in the MI Health Link program, the Autism Spectrum Disorder program and the Substance Use Disorder service program.

   b. DWMHA provides oversight to the MCPNs who have been delegated the responsibility to perform the UM activities of the determinations of medical necessity pre-service, concurrent, and post-service reviews, certification, notification, discharge planning and coordination of care for the Medicaid enrollee/member as well as all other funding streams and Waiver programs.

   c. The clinical integrity of the UM program seeks to provide that enrollees/members presenting for care are appropriately monitored and that comprehensive reviews of all levels of care are provided. Those cases that appear outside of best practice guidelines or appear to be treatment outliers are referred for specialized reviews. These may include evaluation for intensive care/case management, clinical rounds, peer adviser review or more frequent staff review.

   d. The responsibility for managing the utilization of clinical care resources rests largely with the UM staff reviewers who assess the needs of and authorize the care for the enrollees/members.

   e. UM reviewers are professionals and who are trained to match the enrollee/member needs to the appropriate services, levels of care, treatment and length of stay, and community supports. This requires careful consideration of the intensity and severity of clinical data presented, with the goal of quality treatment in the least restrictive environment.

   f. The clinical UM Reviewers are accessible seven (7) days a week, twenty-four (24) hours per day via a published designated toll-free number (1-844-296-2613) to handle urgent UM requests. Non-urgent pre-service requests and/or communications received by telephone, fax, or email are handled on the next business day. Communications received after midnight on Monday through Friday are responded to on the same business day.

   g. Staff will identify themselves by name, title and organization name when answering calls.

   h. DWMHA has a designated hospital liaison whose primary responsibility is to assist with the placement of enrollees/members requiring higher levels of care.

2. Utilization Management Review Process

   a. As the initial point of entry, the Access Center is responsible for eligibility determinations. Subject to verification of eligibility of the enrollee/member by the Access Center, the caller is warm transferred to a UM Reviewer to conduct authorizations, certification reviews or for referral of an enrollee/member to a provider.
b. The UM Reviewer gathers the required clinical information, references the appropriate clinical criteria for all the services and/or level of care and determines whether the behavioral health care service(s) meet the criteria for medical necessity. DWMHA currently utilizes MCG 21st Edition as its medical necessity criteria.

c. DWMHA requires all UM decisions to be made in an objective and timely manner in order to minimize any disruption in the provision of care.

d. 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. Based on the appropriateness of care and services and the existence of medical coverage and benefits;
   3. Consistent with formal assessments of need and enrollee/member’s desired outcomes;
   4. Adjusted appropriately as enrollee/member’s needs, status, and/or service requests change;
   5. Consistent with established Clinical Practice Guidelines;
   6. Timely;
   7. Provided to the enrollee/member in writing as to the specific nature of the decision and its reasons;
   8. Provided verbally and/or in writing to the provider/practitioner as to the specific nature of the decision and its reasons;
   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 enrollee/member regarding their appeal rights if services are denied.

e. DWMHA, Access Center, Crisis Service Vendor, IRO and MCPN staff making UM decisions are not financially or otherwise compensated or incentivized to make decisions that result in under-utilization of services and/or the denial of coverage.

f. Authorizations or certifications are for a specific number of services/units or services/days and for a specific time period based on the enrollee/member’s clinical needs and provider characteristics.

g. Pre-service (prior) authorization is required for the following levels of care:
   1. Acute inpatient; and
   2. Intensive crisis residential; and
   3. State hospitalization; and
   4. Partial hospitalization; and
   5. Specialized residential; and
   6. Withdrawal Management; and
   7. Psychological testing; and
   8. Neuropsychological testing; and
   9. Electroconvulsive therapy (ECT); and
10. All out-of-network treatment services.

h. For MI Health Link enrollee/members, prior authorization is not required for other behavioral health outpatient services for initial and ongoing requests that are consistent with DWMHA UM Review Guidelines. However, requests outside the DWMHA UM Service Review Guidelines requires a review with a UM Reviewer within one (1) business day of receipt of the request. DWMHA does review requests as expeditiously as possible in order to prevent jeopardizing the life, health or ability to attain, maintain or regain maximum functioning for the enrollee/member.

1. The DWMHA UM Service Review Guidelines detail the amount and scope of services based on the Level of Care Utilization Systems (LOCUS), Supports Intensity Scale (SIS) and/or Bio Psycho Social assessments, evidence-based practice guidelines and current literature search. The duration of services is yearly.

2. The DWMHA UM Service Review Guidelines are reviewed and updated annually by DWMHA’s Chief Medical Officer and the UM Committee.

i. DWMHA, Crisis Service Vendor and the MCPNs do not require pre-service (prior) authorization of emergency room services or any emergent service required to provide stabilization of an emergent or urgent condition.

j. At all times, DWMHA, Crisis Service Vendor and/or the MCPNs will authorize coverage at the appropriate level of service for all emergency services in an appropriate setting. However, DWMHA, Crisis Service Vendor and/or the MCPNs does require authorization of post-stabilization services and inpatient admissions, after emergency room services are completed.

k. DWMHA, Crisis Service Vendor and the MCPNs provide coverage to enrollee/members if they require emergency or urgently needed services. Emergent and/or urgent care should be rendered as needed, with the notification of any admission to DWMHA, Crisis Service Vendor and/or MCPN UM Department within forty-eight (48) hours of the admission. A UM reviewer will then review the emergent/urgent admission within one (1) calendar day of receipt of the request.

l. Except where disclosure of certain information is expressly prohibited by or contrary to applicable state or federal laws or regulations, the provider must be prepared to consistently provide at least the following relevant information at the time of the initial review, as necessary and appropriate:

   1. Presenting problem including current symptoms;
   2. History of presenting problem(s);
   3. Precipitant(s) to services;
   4. Diagnosis;
   5. Current level of functioning and baseline level of functioning;
   6. Prior psychosocial, psychiatric, and substance abuse history and prior treatment;
   7. A clinical exam
   8. Results of Urinary Drug Screen;
   9. Blood Alcohol Level;
   10. Mental status;
   11. Current and Past Medications (dosage and side effects);
   12. Medical complications and significant medical history;
13. Information on consultations with the treating practitioner;
14. Evaluations from other health care practitioners and providers;
15. Support Systems;
16. Information provided by family members or significant others;
17. Specific Severity of Illness/Intensity of Service Criteria;
18. Diagnostic testing results
19. Treatment plan; and
20. Discharge Plan.

m. Except where disclosure of certain information is expressly prohibited by or contrary to applicable state or federal laws or regulations, the provider must be prepared to consistently provide at least the following relevant information at the time of the concurrent review, as necessary and appropriate:
   1. Progress toward treatment goals and any changes in treatment goals;
   2. Current and any changes in medications (dosage and side effects);
   3. Current level of functioning;
   4. Information on consultations with the treating practitioner;
   5. Evaluations from other health care practitioners and providers;
   6. Progress toward treatment goals based on the progress notes;
   7. Intensity of Service Criteria; and
   8. Status of Discharge Plan.

n. The DWMHA, Crisis Service Vendor or MCPN physician is available any time to discuss any behavioral health concerns and/or decisions with the treating provider upon request.

o. Care coordination, continuity of care and discharge planning are integral parts of the treatment process and should be addressed at each review. Enrollee/members will be assessed and referred for evaluation for case management and complex case management services post-discharge or enrollment in special programs such as Assertive Community Service (ACT).

p. All decisions are rendered according to state, federal, accreditation and other regulatory body requirements. However, DWMHA, Access Center, Crisis Service Vendor, and the MCPNs make decisions expeditiously as the enrollee/member’s health condition requires.

q. All urgent pre-service, concurrent and non-urgent pre-service and concurrent determinations are communicated telephonically to the provider/practitioner and in writing to the provider/practitioner and enrollee/member. All post-service determinations are communicated in writing to the provider/practitioner and enrollee/member.

r. When a review does not meet medical necessity criteria or there are other concerns about the quality or appropriateness of care identified, the UM Reviewer can verbally consult with the UM Supervisor.

s. Depending on the recommendations of the UM Supervisor, the UM Reviewer may also consult with a DWMHA physician (DO or MD).

t. DWMHA, Crisis Service Vendor, IRO or MCPN physician may elect to conduct a peer-to-peer review which involves a direct telephone conversation with the treating physician provider to discuss the case if the case is not meeting medical necessity or there are quality or other issues.
u. A clinical non-authorization can only be made by a physician or a physician who is certified in addiction medicine for behavioral health care denials based on medical necessity.

v. Treating physicians and providers are provided with contact information if they would like to discuss a clinical non-authorization. If contact is made within ten (10) days of determination, this will not be considered an appeal.

w. DWMHA, Access Center, Crisis Service Vendor, IRO and the MCPNs ensure that none of their staff including the physicians involved in the decision-making process benefit financially from denying treatment or encourage decisions that result in under-utilization of care or services to enrollee/members.

3. Out-of-Network Provider

a. DWMHA recognizes that enrollee/members or their authorized representative may request services from an out of network provider/practitioner because of special needs of the enrollee/member, or if no in-network provider/practitioner has the appropriate clinical expertise to provide the needed care. DWMHA, Crisis Service Vendor and/or the MCPN staff will make authorization and/or non-authorization determinations on a case by case basis.

b. If a network provider/practitioner refers an enrollee/member to an out-of-network provider due to one of the reasons above, DWMHA, Crisis Service Vendor or the MCPN will authorize the services as long as medical necessity criteria is met and the provider/practitioner being referred to has a current, unrestricted license to practice.

c. It is the expectation of DWMHA, Crisis Service Vendor or the MCPN that an out-of-network provider/practitioner make an effort to secure prior authorization before services are initiated and agrees to enter into a single case agreement with DWMHA, Crisis Service Vendor or the MCPN.

4. Due Process

a. DWMHA, Access Center, Crisis Service Vendor or the MCPNs will not deny services based solely on preset limits of the cost, amount, scope and duration of services. Determination of the need for services shall be conducted on an individualized basis.

b. Enrollees/members receiving, and providers/practitioners requesting behavioral health services shall have due process rights and access to the appeals processes for Medicaid and Medicare-covered services.

5. Delegated Utilization Management Functions

a. Before any delegation, DWMHA, Access Center or the MCPNs evaluate the subcontractor’s ability to perform the delegated activity or activities.

b. A written agreement specifies the activities and responsibilities designated to the subcontractor.

c. A written agreement provides guidelines for revoking delegation or imposing other sanctions.

d. DWMHA, Access Center, or the MCPN shall monitor the subcontractor’s performance on an ongoing basis and subject their performance to a formal review according to a periodic schedule established by the State, consistent with applicable federal laws, Medicaid Statutes, MDHHS Regulations and Industry Standards.

e. If DWMHA, Access Center or the MCPN identifies deficiencies or areas for improvement, the subcontractor is placed on a corrective action plan.

f. DWMHA, Access Center or the MCPN requires the subcontractor to meet the same federal and state
financial and program reporting requirements they are held to as well as those identified in the Three Way Contract, Section 2.7.7.2.

6. Coordination of Benefits (COB)
   a. This process applies to all funding streams except for the MI-Health Link Medicaid/Medicare population. This also provides guidance to define the order of coverage and payment to providers for individuals covered under more than one plan.
      1. **Coordination of Benefits (COB):** A provision used to establish the order in which behavioral health services claims are paid when more than one payer source exists.
      2. **Primary Carrier:** Medicare is the funding source that has been determined to be responsible for primary payment by applying the criteria to determine the order of benefits.
      3. **Secondary Carrier:** Medicaid is the funding source that has been determined to be responsible for secondary payment (also referred to as paying as secondary).
      4. **Explanation of Benefits (EOB):** A detailed explanation of payment or denial of a claim made by the manager of benefits/funding sources. An EOB may also be referred to as a remittance advice.
      5. **Maximum Allowable Amount:** The maximum amount that can be reimbursed between all funding sources. It is defined service by service based on DWMHA’s line of business (LOB) of the primary carrier (Medicare).

7. Utilization Management Reporting Requirements and Program Evaluation
   a. DWMHA, Access Center and the MCPNs shall maintain an electronic Utilization Management tracking system for all payers.
   b. To evaluate the success of UM processes and to ensure the accuracy, appropriateness, and consistency of UM decisions, a DWMHA Utilization Management Committee (UMC) coordinates ongoing UM review activities under the supervision of DWMHA’s Chief Medical Officer and DWMHA UM Director.
   c. Data in the form of reports or raw data shall be generated weekly, monthly, quarterly and/or annually as requested or required by contracts or accreditation requirements and is reported to the UMC.
   d. Reports cover utilization of multiple levels of care as well as enrollee/member and provider/practitioner satisfaction. Reporting measures include but are not limited to:
      1. Timeliness of UM decisions;
      2. Timeliness of UM decision notifications;
      3. Registration and disposition of appeal requests;
      4. Inpatient discharges per thousand;
      5. Emergency Department visits per thousand;
      6. Continuity of care;
      7. Recidivism rates;
      8. Services associated with a high number of enrollee/member grievances and appeals;
      9. High cost services and highly utilized service;
     10. Enrollee/member and provider satisfaction;
11. Autism benefit operations and staffing;
12. Waiver programs; and
13. Identifying demographic characteristics of enrollee/members served (i.e. gender, age, sex, diagnosis).

e. Information from these reports will be used to identify trends such as over and/or under utilization of services, problem areas for clinical intervention and quality improvement studies. Such trends will be reported to the Utilization Management Committee (UMC) and the Quality Improvement Steering Committee (QISC).

f. DWMHA does maintain a real time dashboard that is monitored weekly by the UM Director to track utilization patterns. The dashboard is available system wide.

g. The DWMHA UM Director will prepare an annual UM Program evaluation which will be reviewed by the Chief Medical Officer and presented to the UMC and QISC.

QUALITY ASSURANCE/IMPROVEMENT

1. DWMHA shall review and monitor contractor adherence to this policy as one element in its network management program and as one element of the QAPIP Goals and Objectives.

2. DWMHA’s quality improvement program must include measures for both the monitoring of and the continuous improvement of the program or process described in this policy.

3. Annually, DWMHA, Crisis Service Vendor and/or the MCPNs shall conduct Inter-Rater Reliability case reviews to measure, evaluate and ensure consistent application of the medical necessity criteria. Staff at each entity performing UM functions must review ten (10) vignettes from the MCG inter-rater module and chosen by the DWMHA UM Director or their designee and then select the appropriate clinical determination for the level of care by applying the MCG medical necessity criteria. Using MCG’s Inter-Rater Reliability tool, answers are scored, and reports generated.

4. It is the expectation of DWMHA that all staff from all entities meet or exceed an overall score of 90% or greater. In the event that a staff person does not meet this threshold of 90% or greater, a corrective action plan will be implemented with the expectation that the person pass at the next case review. Corrective action plans can involve such activities as face to face supervision, coaching and/or education and re-training.

5. One additional re-test of inter rater reliability case reviews will be given within thirty (30) days of the initial Inter-Rater Reliability case reviews and requires a score of 90% or greater.

6. If upon re-testing the staff person does not achieve 90% or greater, he/she will be subject to transfer outside the UM Department or termination.

7. The results of the Inter-Rater Reliability case reviews will be used to identify areas of variation among decision makers and/or types of decisions. The results will help to identify opportunities for improvement as well as further training needs. All staff performing pre-admission reviews and/or UM functions shall be trained at least annually on the MCG and NCD and LCD Utilization Management Criteria.

8. Monthly, the Access Center, Crisis Service Vendor and the MCPNs shall submit all (100%) denial and appeal case audits for all staff making UM decisions using the DWMHA denial and appeal tracking log and copies of cases to the UM Appeal Coordinator. The UM Appeal Coordinator will audit all denials and appeals utilizing the denial and appeal audit tools. Results of these audits will be presented to the UMC quarterly.
9. Quarterly, Access Center, Crisis Service Vendor and SMI MCPN shall also review ten (10) approved request for service cases for all staff making UM decisions. The I/DD MCPNs shall review five (5) approved request for service cases on all staff making UM decisions using the above tools.

10. It is the expectation of DWMHA that all staff from all entities meet or exceed an overall score of 85% or greater. In the event that a staff person does not meet this threshold of 85% or greater, a corrective action plan will be implemented with the expectation that the person pass at the next case review. Corrective action plans can involve such activities as face to face supervision, coaching and/or education and retraining.

11. If at the next review, the staff person does not achieve 85% or greater, he/she will be subject to transfer outside the UM Department or termination.

12. The results of the audit case reviews will be used to identify areas of variation among decision makers and/or types of decisions. The results will help to identify opportunities for improvement as well as further training needs. However, all staff performing pre-admission reviews and/or UM functions shall be trained at least annually on the MCG and NCD and LCD Utilization Management Criteria.

**COMPLIANCE WITH ALL APPLICABLE LAWS**

DWMHA staff, Access Center staff, Crisis Service Vendor staff, MCPNs staff, contractors and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

**LEGAL AUTHORITY**

1. DWMHA UM Program Description FY 16-18
2. MDHHS and DWMHA contract, October 1, 2016
3. Medicaid Provider Manual, April 1, 2017 version
4. 42 U.S.C. § 1396u-2(b)(8)
5. 42 CFR.438.201
6. Contract between United States Department of Health and Human Services, Center for Medicare & Medicaid Services in Partnership with the State of Michigan and the Integrated Care Organizations, November 1, 2016 (The Three Way Contract)

**RELATED POLICIES**

1. Appropriate Professionals for Utilization Management Decision Making Policy
2. Assessment Policy
3. Behavioral Health Service Medical Necessity Criteria Policy
4. Inter Rater Reliability Policy
5. Customer Service Member Appeal Policy
6. Standard of Conduct Policy
7. Utilization Management/Provider Appeal Policy
8. UM Affirmative Statement Policy
9. Denial of Service Policy

RELATED DEPARTMENTS

1. Clinical Practice Improvement
2. Compliance
3. Customer Service
4. Information Technology
5. Integrated Health Care
6. Managed Care Operations
7. Quality Improvement
8. Recipient Rights
9. Substance Use Disorder
10. Utilization Management

CLINICAL POLICY

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

- DWMHA Access Center Eligibility Service Review Tool.pdf
- DWMHA Access Center Flow Chart.pdf
- DWMHA Clinical Case Record Review Tool 2017.docx
- DWMHA Monitoring Plan.pdf
- DWMHA Prior Authorized Service UM Review Tool.pdf
- DWMHA UM Review Guidelines (MHL).xlsx
- IRO Physician Reviewer Documentation Form.docx
- IRO Referral Review Request Form.docx
- Out of Network Out Patient Treatment Review (OTR) Form.docx
- Physician Review Form.pdf
- UM Decision Turn Around Times for Initial Determinations.docx
- UM Provider Procedures for Behavioral Health Services Routinely Not Requiring Authorization for MI Health Link Population.docx
- UM Provider Procedures for Prior Authorized Behavioral Health Service.docx
- UM Review Procedure for Substance Use Disorders.pdf
## Approval Signatures

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OVERVIEW

Procedure Purpose: To provide procedural and operational guidance to all staff involved in behavioral health care reviews utilization management (UM) functions to ensure a clear understanding of and consistent application of these procedures system wide.

Expected Outcome: Enrollees/members will receive cost-effective, clinically appropriate, efficient services in the least restrictive setting that meets their needs and that provides measurable outcomes and enrollee/member satisfaction.

References: N/A

KEYWORDS

1. Action
2. Appeal
3. Adverse Determination
4. Authorization
5. Behavioral Health Supports and Services
6. Concurrent (continued stay) Review
7. Independent Review Organization (IRO)
8. Medical Necessity Appeal
9. Pended
10. Pre-Service (prior authorized) Review
11. Post-Service (Retrospective) Review

PROCEDURE

1. UM Reviewers are available from 8:30am to 5pm, Monday-Friday, at DWMHA, Crisis Service Vendor and the MCPNs and at the Crisis Service Vendor after hours, weekends and on holidays.
2. UM Reviewers will return calls the same day in most cases but always within one (1) calendar day.
3. Staff must identify themselves by name, title and name of organization.
4. When an expedited (urgent) pre-service authorization is required, determinations are completed within twenty four (24) hours of receipt of the request if all relevant clinical information is obtained. If all relevant clinical information is not provided, the UM Reviewer will contact the requesting provider and request the information needed within twenty four (24) hours of receipt of the initial request. DWMHA, Crisis Service Vendor or the MCPNs will give the provider forty eight (48) hours to provide the needed information.
5. Expedited pre-service determinations are completed within three (3) hours of the receipt of all necessary clinical information to conduct the review but no later than seventy two (72) hours from the receipt of the request.

6. When a non-urgent pre-service authorization is required, determinations are made as expeditiously as the enrollee/member’s health condition requires and no later than fourteen (14) calendar days of receipt of the request. If all relevant clinical information is not received, the UM Reviewer will contact the requesting provider within seventy two (72) of receipt of the request. DWMHA, Crisis Service Vendor or the MCPNs will give the provider forty eight (48) hours to provide the needed information.

7. For post-service reviews, DWMHA, Crisis Service Vendor or the MCPN makes decisions within thirty (30) calendar days of receipt of the request. If the request lacks clinical information, the UM Reviewer may extend the non-urgent pre-service or post-service timeframes up to fifteen (15) calendar days under the following conditions:
   a. DWMHA, Crisis Service Vendor or the MCPN asks the enrollee/member or the enrollee/member’s representative for the specific information necessary to make the decision within the decision time frame;
   b. DWMHA, Crisis Service Vendor or the MCPN gives the enrollee/member or the enrollee/member’s representative at least forty five (45) calendar days to provide the information; and
   c. The extension period, within which a decision must be made by DWMHA, Crisis Service Vendor or the MCPN, begins on the date when the organization receives the response (even if not all of the information is provided or at the end of the time period given to supply the information, if no response received.

8. The time frame may be extended for other reasons such as a situation beyond the DWMHA, Crisis Service Vendor or MCPN’s control such as waiting for a consult from a specialist. DWMHA, Crisis Service Vendor or the MCPN may extend the non-urgent pre-service and post-service timeframes, once, for up to fifteen (15) calendar days.

9. DWMHA, Crisis Service Vendor or the MCPN must notify the enrollee/member or their representative of the need for an extension and the expected date of the decision using the standardized Enrollee Agreement for Request for Additional Information form.

10. The screening center staff, hospital staff, psychiatrist, physician, provider treatment team member or other utilization management staff member calls the DWMHA, Crisis Service Vendor or the MCPN’s UM Department and speaks with a UM Reviewer. The UM Reviewer will document in the case in their electronic system the caller’s name, credentials and call back phone number. The electronic system (MHWIN for DWMHA or the Crisis Service Vendor) automatically date and time stamps the entry.

11. The caller is given the opportunity to discuss any behavioral health concerns and/or decisions with a DWMHA, Crisis Service Vendor, IRO or MCPN physician upon request.

12. For the MI Health Link program, the UM Reviewer verifies eligibility and enrollment in the program in MHWIN.

13. The UM Reviewer consistently secures the following relevant information for an initial pre-service review and documents the information in their electronic system:
   - Presenting problem including current symptoms;
   - History of presenting problem(s);
   - Precipitant(s) to services;
   - Diagnosis;
   - Current level of functioning and baseline level of functioning;
   - Prior psychosocial, psychiatric, and substance abuse history and prior treatment;
   - A clinical exam;
   - Results of Urinary Drug Screen;
   - Blood Alcohol Level;
• Mental status;
• Current and Past Medications (dosage and side effects);
• Medical complications and significant medical history;
• Information on consultations with the treating practitioner;
• Evaluations from other health care practitioners and providers;
• Support Systems;
• Specific Severity of Illness/Intensity of Service Criteria;
• Diagnostic testing results
• Treatment plan; and
• Discharge Plan.

14. For Medicare covered services, the UM Reviewer will use the National Coverage Determination (NCD) criteria and/or the Local Coverage Determination (LCD) criteria first to determine if the level of care being requested is appropriate and if so, to determine the number of days/services authorized. If no NCD or LCD criteria exist then the MCG Utilization Management (UM) Criteria.

15. For Medicaid covered services, the UM Reviewer will use MCG Utilization Management (UM) Criteria to determine if the level of care being requested is appropriate for Medicaid enrollee/members and if so, to determine the number of days/services authorized.

16. For the uninsured or under insured enrollee/member, the UM Reviewer will use the MCG Utilization Management (UM) Criteria to determine if the level of care being requested is appropriate and if so, to determine the number of days/services authorized.

17. If medical necessity criteria is met for the requested level of service, the UM Reviewer will enter an authorization into their electronic system within twenty four (24) hours of the decision.

18. If the event that the DWMHA, Crisis Service Vendor or MCPN UM Reviewer has concerns or questions about the initial pre-service review, he/she may elect to verbally consult with their UM Supervisor. The UM Reviewer then documents the UM Supervisor’s name, credentials and recommendations into the case in their electronic system (MHWIN for DWMHA and the Crisis Service Vendor) which may include the recommendation to verbally consult with a DWMHA, Crisis Service Vendor, IRO or MCPN physician or to secure a formal consultation with a DWMHA, Crisis Service Vendor, IRO or MCPN physician.

19. If the UM Reviewer verbally consults with a physician, the UM Reviewer will document the name, credentials and the recommendations of the physician in the case in their electronic system.

20. If after the verbal consult, the DWMHA, Crisis Service Vendor, IRO or MCPN physician determines approval cannot be determined at this time, the UM Review will secure a formal consultation. The DWMHA or Crisis Service Vendor UM Reviewer completes the Physician Case Review form and sends the case to the queue in MHWIN for retrieval by a DWMHA physician.

21. The DWMHA or Crisis Service Vendor UM Reviewer immediately emails the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person of the physician review request in order for the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person ensure the physician reviews the case and makes a determination within the appropriate time frames using their tracking log to monitor this.

22. If using an IRO physician, the UM Reviewer completes the standardized IRO Referral Review Request form and has the DWMHA UM Appeal Coordinator forward via email the form to the IRO Medical staff person to facilitate an IRO physician review of the case.

23. The MCPNs will follow their internal procedures to ensure the MCPN reviews the case within the appropriate timeframes. However, the MCPNs will also use their tracking log as a tool to monitor the timeframes.
24. The DWMHA, IRO, Crisis Service Vendor or MCPN physician may elect to conduct a peer to peer review with the treating physician. If this is the case, the DWMHA, IRO, Crisis Service Vendor or MCPN physician will make reasonable attempts (at least two) to telephonically contact the treating physician. The DWMHA, Crisis Service Vendor or MCPN physician will document the day and time of each attempt in their electronic system. The IRO physician will document the day and time of each attempt in the standardized Physician Reviewer Documentation form.

25. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person will also document the day and time of each attempt by their physician in their tracking log. Note that the DWMHA UM Appeal Coordinator will document the day and time of each attempt by the IRO physician in the tracking log.

26. The MCPN physician will follow their internal procedures to document and track all telephonic attempts in their electronic system.

27. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person will document the day and time of each attempt by their physician in their tracking log.

28. If a peer to peer review is completed, the DWMHA, Crisis Service Vendor or MCPN physician will document the results of the peer to peer review in their electronic system and render a decision about the authorization of services which will also be documented in their electronic system. The IRO physician will complete the standardized Physician Reviewer Documentation form.

29. The DWMHA, Crisis Service Vendor, IRO or MCPN physician will review the case and render a decision within the following time frames:
   a. For an urgent pre-service initial review, within seventy two (72) hours of the request;
   b. For a non-urgent (standard) pre-service initial review, within fourteen (14) calendar days of the request; or
   c. For a post-service review, within thirty (30) calendar days of the request.

30. The DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person manually checks the MHWIN queue twice a day to ensure that the DWMHA or Crisis Service Vendor physician has retrieved the case from the queue and reviews it within the appropriate time frames. The DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person will communicate daily via email, face to face or telephonically with the DWMHA or Crisis Service Vendor physician if after twenty four (24) hours for an urgent pre-service initial review or if after seven (7) days for a non-urgent pre-service initial review or a post-service review, the DWMHA or Crisis Service Vendor physician has not reviewed the case. The DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person documents all attempts (date and time) to contact the physician in their tracking log. The DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person will use their tracking log as a tool to monitor the timeframes.

31. The MCPNs and IRO Medical Review staff will follow their own internal procedures to ensure the MCPN or IRO physician reviews the case within the appropriate timeframes. However, the MCPNs will also use their tracking log as a tool to monitor this.

32. The DWMHA or Crisis Service Vendor physician will document their decision in MHWIN and document their name, title, and credentials if not done by electronic signature.

33. The DWMHA or Crisis Service Vendor physician will notify immediately the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person via email of their decision.

34. The MCPN physician will document the results/decision either in their electronic system or by manually completing a standardized form. The MCPN physician will then immediately notify the designated MCPN staff person according to their internal procedures.

35. The IRO physician will complete the standardized Physician Reviewer Documentation form and immediately fax it to the IRO Medical Review staff. The IRO Medical Review staff will, in turn, immediately email it to the DWMHA UM Appeal Coordinator.
36. If the decision is to authorize services, the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person enters the authorization in MHWIN, generates an authorization letter from MHWIN and then mails the letter to the provider and enrollee/member within twenty four (24) hours of the decision.

37. The MCPNs will follow their own internal process for securing the authorizations in their electronic system.

38. If the decision is to issue an adverse determination (non-authorization of services), the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person enters the denial in MHWIN and generates the Notice.

39. If the adverse determination is for an enrollee/member in the MI Health Link program, the standardized Notice of Denial of Medical Coverage form is used. If the adverse determination is for an enrollee/member for Medicaid covered services, the standardized Medicaid Adequate or Advance Action Notice form is used. If the adverse determination is for an uninsured or under insured enrollee/member, the standardized Uninsured or Under Insured Adequate or Advance Action Notice form is used.

40. If the Notice is manually generated, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person will scan the Notice and attach it to the case in their electronic system.

41. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person verbally notifies the practitioner/provider within three (3) hours of the adverse determination and documents the verbal notification in their electronic system including the date and time of the notification, the right to a peer to peer discussion regarding the determination, the appeal rights and process and the complete name and credentials of the person notified.

42. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor and MCPN staff person reviews the Notice to ensure it has the following:
   a. A statement of what action is being taken in easy, understandable language which does not include:
      - abbreviations or acronyms that are not defined; and
      - is culturally and linguistically sensitive to the enrollees/members’ needs; and
      - health care procedure codes that are not explained.
   b. An explanation of the action including the denial of services in amount, scope and duration if less than what is requested;
   c. The specific justification that supports, or the change in the federal or state law that requires the action including a reference to the benefit provision, guideline, protocol or other similar criterion on which the action is based and the option of the enrollee/member to have a copy of the benefit provision, guidelines or protocol, upon request;
   d. A statement that the enrollee/member and/or provider has the right to an internal appeal with DWMHA, Crisis Service Vendor or the MCPN and a description of the expedited and standard appeal process including time frames;
   e. A statement that the enrollee/member, his/her legal representative and/or provider has the opportunity to submit written comments, documents or other information relevant to an appeal;
   f. A statement that the enrollee/member and/or provider can request copies of all documents relevant to the appeal, free of charge;
   g. Informs the enrollee/member of their right to designate an authorized representative to act on their behalf as long as the enrollee/member has provided written permission by completing and forwarding the Appointment of Representative form to DWMHA, Crisis Service Vendor or MCPN;
h. A statement that an expedited or standard external review can occur the same time as an internal expedited or standard review; and
i. Includes a list of the titles and qualifications, including specialties of the individuals participating in the appeal review.

43. For Medicaid covered services, the Notice must also include the following:
   a. A statement that the enrollee/member has a right to an external to an external Medicaid Fair Hearing and an explanation of how to file a Medicaid Fair Hearing;
   b. A statement that Medicaid covered services will continue up to the end of the currently approved treatment or final decision whichever comes first if the enrollee/member requests an internal and/or external Medicaid Fair Hearing within twelve (12) calendar days from the date of the notice (per MDHHS and DWMHA contract October 1, 2016); and
   c. A statement that the enrollee/member may have to pay for the continuation of services if the result of the internal appeal or external Medicaid Fair Hearing is to uphold the denial for Medicaid covered services.

44. The DWMHA UM Appeal Coordinator, designated Crisis Center Vendor or designated MCPN staff person mails the Notice to the enrollee/member and provider within twenty four (24) hours of the verbal/oral notification.

45. The DWMHA UM Appeal Coordinator, designated Crisis Center Vendor or designated MCPN staff person documents the date and times of the verbal and written notifications in their tracking log.

46. Concurrent (continued stay) reviews are conducted as follows:
   - If the request to extend urgent concurrent care is made prior to twenty four (24) hours before the expiration of the prescribed period of time or number of treatments and all necessary clinical information received, a determination will be made within twenty four (24) hours of receipt of concurrent review.
   - If the request to extend urgent concurrent care was NOT made prior to twenty four (24) hours before the expiration of the prescribed period of time or number of treatments, the UM Reviewer will contact provider and request the necessary information and document the request in the electronic system (MHWIN for DWMHA). DWMHA, Crisis Center Vendor or the MCPN will make a determination within seventy two (72) hours of the request to extend.

47. It is the provider’s responsibility to request additional services/days by contacting the UM Reviewer telephonically to complete a concurrent review.

48. The UM Reviewer consistently secures the following relevant information for a concurrent review and documents the information in their electronic system:
   - Progress toward treatment goals and any changes in treatment goals;
   - Current and any changes in medications (dosage and side effects);
   - Current level of functioning;
   - Information on consultations with the treating practitioner;
   - Evaluations from other health care practitioners and providers;
   - Progress toward treatment goals based on the progress notes;
   - Intensity of Service Criteria; and
   - Status of Discharge Plan.

49. For Medicare covered services, the UM Reviewer will use the National Coverage Determination (NCD) criteria and/or the Local Coverage Determination (LCD) criteria first to determine if the continued level of care being requested is appropriate and if so, to determine the number of days/services authorized. If no NCD or LCD criteria exist then the MCG Utilization Management (UM) Criteria.

50. For Medicaid covered services, the UM Reviewer will use MCG Utilization Management (UM) Criteria to determine if the continued level of care being requested is appropriate and if so, to determine the number of days/services authorized.
51. For the uninsured or under insured enrollee/member, the UM Reviewer will use the MCG Utilization Management (UM) Criteria to determine if the level of care being requested is appropriate and if so, to determine the number of days/services authorized.

52. If medical necessity criteria is met for the requested level of service, the UM Reviewer will enter an authorization into their electronic system within twenty four (24) hours of the decision.

53. If the event that the DWMHA, Crisis Service Vendor or MCPN UM Reviewer has concerns or questions about the initial pre-service review, he/she may elect to verbally consult with their UM Supervisor. The UM Reviewer then documents the UM Supervisor's name, credentials and recommendations into the case in their electronic system (MHWIN for DWMHA and the Crisis Service Vendor) which may include the recommendation to verbally consult with a DWMHA, Crisis Service Vendor, IRO or MCPN physician or to secure a formal consultation with a DWMHA, Crisis Service Vendor, IRO or MCPN physician.

54. If the UM Reviewer verbally consults with a physician, the UM Reviewer will document the name, credentials and the recommendations of the physician in the case in their electronic system.

55. If after the verbal consult, the DWMHA, Crisis Service Vendor, IRO or MCPN physician determines approval cannot be determined at this time, the UM Review will secure a formal consultation. The DWMHA or Crisis Service Vendor UM Reviewer completes the Physician Case Review form and sends the case to the queue in MHWIN for retrieval by a DWMHA physician.

56. The DWMHA or Crisis Service Vendor UM Reviewer immediately emails the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person of the physician review request in order for the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person ensure the physician reviews the case and makes a determination within the appropriate time frames using their tracking log to monitor this.

57. If using an IRO physician, the UM Reviewer completes the standardized IRO Referral Review Request form and has the DWMHA UM Appeal Coordinator forward via email the form to the IRO Medical staff person to facilitate an IRO physician review of the case.

58. The MCPNs will follow their internal procedures to ensure the MCPN reviews the case within the appropriate timeframes. However, the MCPNs will also use their tracking log as a tool to monitor the timeframes.

59. The DWMHA, IRO, Crisis Service Vendor or MCPN physician may elect to conduct a peer to peer review with the treating physician. If this is the case, the DWMHA, IRO, Crisis Service Vendor or MCPN physician will make reasonable attempts (at least two) to telephonically contact the treating physician. The DWMHA, Crisis Service Vendor or MCPN physician will document the day and time of each attempt in their electronic system. The IRO physician will document the day and time of each attempt in the standardized Physician Reviewer Documentation form.

60. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person will also document the day and time of each attempt by their physician in their tracking log. Note that the DWMHA UM Appeal Coordinator will document the day and time of each attempt by the IRO physician in the tracking log.

61. The MCPN physician will follow their internal procedures to document and track all telephonic attempts in their electronic system.

62. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person will document the day and time of each attempt by their physician in their tracking log.

63. If a peer to peer review is completed, the DWMHA, Crisis Service Vendor or MCPN physician will document the results of the peer to peer review in their electronic system and render a decision about the authorization of services which will also be documented in their electronic system. The IRO physician will complete the standardized Physician Reviewer Documentation form.
64. The DWMHA, Crisis Service Vendor, IRO or MCPN physician will review the case and render a decision within the following time frames:
   a. For an urgent pre-service initial review, within seventy two (72) hours of the request;
   b. For a non-urgent (standard) pre-service initial review, within fourteen (14) calendar days of the request; or
   c. For a post-service review, within thirty (30) calendar days of the request.

65. The DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person manually checks the MHWIN queue twice a day to ensure that the DWMHA or Crisis Service Vendor physician has retrieved the case from the queue and reviews it within the appropriate time frames. The DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person will communicate daily via email, face to face or telephonically with the DWMHA or Crisis Service Vendor physician if after twenty four (24) hours for an urgent pre-service initial review or if after seven (7) days for a non-urgent pre-service initial review or a post-service review, the DWMHA or Crisis Service Vendor physician has not reviewed the case. The DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person documents all attempts (date and time) to contact the physician in their tracking log. The DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person will use their tracking log as a tool to monitor the timeframes.

66. The MCPNs and IRO Medical Review staff will follow their own internal procedures to ensure the MCPN or IRO physician reviews the case within the appropriate timeframes. However, the MCPNs will also use their tracking log as a tool to monitor this.

67. The DWMHA or Crisis Service Vendor physician will document their decision in MHWIN and document their name, title, and credentials if not done by electronic signature.

68. The DWMHA or Crisis Service Vendor physician will notify immediately the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person via email of their decision.

69. The MCPN physician will document the results/decision either in their electronic system or by manually completing a standardized form. The MCPN physician will then immediately notify the designated MCPN staff person according to their internal procedures.

70. The IRO physician will complete the standardized Physician Reviewer Documentation form and immediately fax it to the IRO Medical Review staff. The IRO Medical Review staff will, in turn, immediately email it to the DWMHA UM Appeal Coordinator.

71. If the decision is to authorize services, the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person enters the authorization in MHWIN, generates an authorization letter from MHWIN and then mails the letter to the provider and enrollee/member within twenty four (24) hours of the decision.

72. The MCPNs will follow their own internal process for securing the authorizations in their electronic system.

73. If the decision is to issue an adverse determination (non-authorization of services), the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person enters the denial in MHWIN and generates the Notice.

74. If the adverse determination is for an enrollee/member in the MI Health Link program, the standardized Notice of Denial of Medical Coverage form is used. If the adverse determination is for an enrollee/member for Medicaid covered services, the standardized Medicaid Adequate or Advance Action Notice form is used. If the adverse determination is for an uninsured or under insured enrollee/member, the standardized Uninsured or Under Insured Adequate or Advance Action Notice form is used.

75. If the Notice is manually generated, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person will scan the Notice and attach it to the case in their electronic system.
76. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person verbally notifies the practitioner/provider within three (3) hours of the adverse determination and documents the verbal notification in their electronic system including the date and time of the notification, the right to a peer to peer discussion regarding the determination, the appeal rights and process and the complete name and credentials of the person notified.

77. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor and MCPN staff person reviews the Notice to ensure it has the following:
   a. A statement of what action is being taken in easy, understandable language which does not include:
      ✓ abbreviations or acronyms that are not defined; and
      ✓ is culturally and linguistically sensitive to the enrollees/members’ needs; and
      ✓ health care procedure codes that are not explained.
   b. An explanation of the action including the denial of services in amount, scope and duration if less than what is requested;
   c. The specific justification that supports, or the change in the federal or state law that requires the action including a reference to the benefit provision, guideline, protocol or other similar criterion on which the action is based and the option of the enrollee/member to have a copy of the benefit provision, guidelines or protocol, upon request;
   d. A statement that the enrollee/member and/or provider has the right to an internal appeal with DWMHA, Crisis Service Vendor or the MCPN and a description of the expedited and standard appeal process including time frames;
   e. A statement that the enrollee/member, his/her legal representative and/or provider has the opportunity to submit written comments, documents or other information relevant to an appeal;
   f. A statement that the enrollee/member and/or provider can request copies of all documents relevant to the appeal, free of charge;
   g. Informs the enrollee/member of their right to designate an authorized representative to act on their behalf as long as the enrollee/member has provided written permission by completing and forwarding the Appointment of Representative form to DWMHA, Crisis Service Vendor or MCPN;
   h. A statement that an expedited or standard external review can occur the same time as an internal expedited or standard review; and
   i. Includes a list of the titles and qualifications, including specialties of the individuals participating in the appeal review.

78. For Medicaid covered services, the Notice must also include the following:
   a. A statement that the enrollee/member has a right to an external to a external Medicaid Fair Hearing and an explanation of how to file a Medicaid Fair Hearing;
   b. A statement that Medicaid covered services will continue up to the end of the currently approved treatment or final decision whichever comes first if the enrollee/member requests an internal and/or external Medicaid Fair Hearing within twelve (12) calendar days from the date of the notice (per MDHHS and DWMHA contract October 1, 2016); and
   c. A statement that the enrollee/member may have to pay for the continuation of services if the result of the internal appeal or external Medicaid Fair Hearing is to uphold the denial for Medicaid covered services.

79. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person mails the Notice to the enrollee/member and provider within twenty four (24) hours of the verbal/oral notification.

80. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person documents the date and times of the verbal and written notifications in their tracking log.
81. The above concurrent review process continues as long as the enrollee/member requires services/treatment.
82. The DWMHA UM Appeal Coordinator or designated MCPN staff person is responsible to document the discharge date and the date, time and place of the follow up appointment (NOTE if discharge from inpatient, the appointment must be within seven (7) days of discharge date) in their electronic system (MHWIN for DWMHA) within twenty four (24) hours of notification from the provider.
83. The UM Reviewer will then close the case in their electronic system.

**PROCEDURE MONITORING & STEPS**

<table>
<thead>
<tr>
<th>Who monitors this procedure:</th>
<th>DWMHA UM Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td>Utilization Management</td>
</tr>
<tr>
<td>Frequency of monitoring:</td>
<td>Monthly</td>
</tr>
<tr>
<td>Reporting provided to:</td>
<td>Director of UM or designee</td>
</tr>
<tr>
<td>Regulatory Requirement(s):</td>
<td>NCQA-UM 2, UM 3, UM 5, UM 6 &amp; UM 7, all elements; the Medicaid State Contract as of October 1, 2016 and the MI Health Link Three Way Contract as of November 1, 2016</td>
</tr>
</tbody>
</table>

**MONITORING STEPS**

1. A designated Crisis Service Vendor staff person and designated MCPN staff person must forward via email a monthly a Timeliness of Utilization Management (UM) Decision Making Report to the DWMHA UM Supervisor by the 10th of each month for compliance and monitoring.
2. The reports will be presented to the Utilization Management Committee (UMC) quarterly.
OVERVIEW

Procedure Purpose: To provide procedural and operational guidance to all staff involved in behavioral health care reviews utilization management (UM) functions for the MI Health Link population to ensure a clear understanding of and consistent application of these procedures system wide.

Expected Outcome: Enrollees/members will receive cost-effective, clinically appropriate, efficient services in the least restrictive setting that meets their needs and that provides measurable outcomes and enrollee/member satisfaction.

References: N/A

KEYWORDS

1. Authorization
2. Behavioral Health Supports and Services
3. Level of Care Utilization System (LOCUS)
4. Medical Necessity
5. Supports Intensity Scale (SIS)
6. UM Guidelines

PROCEDURE

1. All contracted DWMHA Service Providers receive training and technical assistance on the process for entering authorizations in MHWIN with DWMHA’s IT department.
2. All contracted DWMHA Service Providers receive training and technical assistance on the UM Guidelines by the UM Department staff.
   ✓ DWMHA has implemented the UM Guidelines document to serve as the basis for payment approval for all services that do not require prior authorization.
   ✓ The UM Guidelines detail the specific services, frequency per year and HCPCS codes available based on the enrollee/member’s Level of Care Utilization Systems (LOCUS) Score or Supports Intensity Scale (SIS) Level Score.
3. If a contracted DWMHA Service Provider requests units and types of services within the UM Guidelines, no authorization is required for payment. The Service Provider submits the claims to DWMHA claims department for payment.
4. The following issues will cause the authorization to pend for Service Provider service requests:
   ✓ Excess units are requested outside the UM guidelines; or
   ✓ Units requested and level of care do not match; or
   ✓ Type of service requested is not allocated by the UM guidelines; or
✓ Requested Service Dates conflict with previous authorizations i.e. previous dates were already requested by another provider; or
✓ No Locus or SIS score entered in MHWIN.

5. If one or more of issues in #4 occurs, the Service Provider’s request automatically downloads to the DWMHA UM queue in MHWIN and is reviewed within two (2) business days of receipt of the request manually by a UM Reviewer.

6. The DWMHA UM Reviewer staff reviews the UM queue at least twice each business day.

7. A UM Reviewer selects a request for services, evaluates the request and determines reason(s) why the service request was forwarded to the DWMHA UM queue.

8. If the information provided is insufficient to make a determination, the UM Reviewer has two (2) business days from receipt of the service request to document in the Authorization screen, the Authorizing Agent Notes section, in MHWIN, the specific information or changes needed from the Service Provider—See Below.

9. The UM Reviewer clicks the send button to the Service Provider.

10. The Service Provider will receive an email regarding the information needed.

11. The Service Provider is expected to document or change the requested information in the Authorization screen in the Provider Notes section in MHWIN no later than two (2) business days of receipt of the request. See Below.

12. If the contracted Service Provider fails to provide the revisions and/or rationale for additional services outside the UM Guidelines within two (2) business days of receipt of the request, a denial may be issued for part or all of the service request. See the DWMHA Denial policy and procedures for more details about the denial process.
13. The Service Provider then clicks the save button in the authorization screen in MHWIN.
14. If the revised service request is within the UM Guidelines, no authorization is required for payment. The Service Provider submits the claims to DWMHA claims department for payment.
15. If the revised authorization request remains outside of the UM Guidelines, it automatically downloads to the DWMHA UM queue in MHWIN and is reviewed within two (2) business day of receipt of the request manually by a UM Reviewer.
16. Based on the information or changes entered by the Service Provider, the UM Reviewer will determine if authorization should be given for the enrollee/member.
17. If yes, the UM Reviewer clicks the approve button in MHWIN to generate an authorization.
18. If no, the UM Reviewer will either:
   - Document in the authorization screen, the provider note section, in MHWIN the specific clinical or non-clinical information or changes needed and then click the send button to the Service Provider; or
   - Will contact the Service Provider telephonically and discuss the specific information or changes needed; or
   - Consult with a DWMHA physician.
19. If the information requested is not provided within two (2) business days, a determination will be made at that time.
20. The DWMHA UM Reviewers are available from 8:30am to 5pm, Monday-Friday, at DWMHA to address concerns regarding procedures for behavioral health services routinely not requiring authorization for the MI Health Link Population.
21. UM Reviewers will return calls the same day in most cases but always within two (2) calendar day.
22. Staff must identify themselves by name, title and name of organization.
23. Non-contracted Service Providers must complete the Out-Patient Treatment Review (OTR) form (See Exhibit B) and email it to pihpauthorizations@dwmha.com or fax it to 313-833-3670.
24. Daily a UM staff or designee reviews the email address and fax number for completed OTR forms.
25. A DWMHA UM reviewer verifies the member is enrolled in the MI Health Link program for the dates of service requested by the non-contacted by clicking the Eligibility/Insurance in the header of the case in MHWIN. See below:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Member ID:</th>
<th>Status: MH: Open SUD: Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>SSN: 12345676</td>
<td>Current Assignments</td>
</tr>
<tr>
<td>Address</td>
<td>Gender: Male</td>
<td>MCPN: CareLink Network (as of 02/01/2006)</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>MI/DD: SMI</td>
<td>MI Health Link: New Center Community Services, Inc. Eff: 08/01/2015</td>
</tr>
<tr>
<td></td>
<td>CRSP: ICO, HAP MIDWEST HEALTH PLAN, INC.</td>
<td></td>
</tr>
</tbody>
</table>

26. If the enrollee/member is not enrolled in the MI Health Link program, the UM Reviewer will telephonically contact the non-contracted Service Provider and instruct him/her to contact the enrollee/member’s assigned Health Plan.
27. If the enrollee/member is enrolled in the MI Health Link program, the UM Reviewer will scan the completed OTR form to the case in MHWIN.
28. If the enrollee/member is not in MHWIN but is enrolled in the MI Health Link program, the UM Reviewer contacts Wellplace/Access Center via telephone and has the enrollee/member entered in MHWIN.
29. DWMHA is required to authorize services to non-contacted Service Providers for 180 days from the date of the individual’s enrollment in the MI Health Link program.
30. The UM Reviewer may need to contact telephonically the non-contacted Service Provider if the clinical information is not comprehensive and appropriate to meet medical necessity criteria.
31. The UM Reviewer will complete the standardized Out of Network Provider Inquiry Form (See Exhibit C) and then emails the completed form to DWMHA Contract Management’s email at pihpprovidernetwork@dwmha.com within one (1) business day of receipt of the OTR.

32. A DWMHA Contract Management staff will contact telephonically the non-contracted Service Provider and explain the contracting process including how to submit claims.

33. The DWMHA Contract Management staff will send the application to the Service Provider if applicable.

34. The DWMHA Contract Management staff will add contract number in MHWIN and send the request to DWMHA Corporation Counsel Department to secure a single case agreement.

35. Within one (1) business day of entering the contract number in MHWIN, the DWMHA Contract Management staff will email the contract number to the DWMHA UM Department at pihpauthorizations@dwmha.com as the contract number is needed to enter an authorization in MHWIN.

36. If medical necessity is met based on a review of the OTR, the DWMHA UM Reviewer will then enter the contract number, the number of units and the service codes requested by the non-contracted Service Provider in the authorization screen in MHWIN for the requested services for the 180 day transitional period.

37. The UM Reviewer contacts the Service Provider telephonically or via email with the authorization number.

### PROCEDURE MONITORING & STEPS

<table>
<thead>
<tr>
<th>Who monitors this procedure:</th>
<th>DWMHA UM Supervisor or designee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td>Utilization Management</td>
</tr>
<tr>
<td>Frequency of monitoring:</td>
<td>Monthly</td>
</tr>
<tr>
<td>Reporting provided to:</td>
<td>Director of UM</td>
</tr>
<tr>
<td>Regulatory Requirement(s):</td>
<td>NCQA-UM 2,3,5, 6,7 the Medicaid State Contract as of October 1, 2016 and the MI Health Link Three Way Contract as of November 1, 2016</td>
</tr>
</tbody>
</table>

### MONITORING STEPS

1. Secure claims report from DWMHA IT Department identifying providers and enrollees/members that utilization services outside the UM Guidelines.

2. Verify the enrollees/members identified in the claims report have authorizations in MHWIN for services outside the UM Guidelines.

3. Analyze tends for over utilization by providers.
EXHIBIT A:  
To Enter Authorizations In MHWIN:

1. Click the Authorizations link in the Main Menu.
2. The Consumer Authorizations link to the right of the Main Menu.
3. The Consumer search screen will be displayed. Take a moment to read the instructions regarding searching for a Consumer. The most basic search uses the Consumer’s last name and the first two letters of his/her first name.

4. Once you have entered your search criteria, click the button.
5. Click the Authorizations link to the right of the Consumer’s information and the following screen will display:

5. Once you have entered your search criteria, click the button.
6. Alongside the Consumer name, click the Authorizations link and the list screen will appear—see below:
7. Click the **Click here to add Service Authorization** link and the following screen will display:

Field descriptions are as follows:

- **Authorized MCPN/Affiliate**— this will prefill with Detroit Wayne Mental Health Authority Direct Contract.
- **Provider** - enter the provider’s MH-WIN code or click on the to search for and select the provider
- **Consumer**—the person for whom you are adding/requesting services. This is a read only field. Verify it is the correct Consumer before proceeding.
- **Authorization Effective Date, Authorization Expiration Date** —enter the beginning and end dates of the authorization by keying them manually, clicking the **Use Current Date** link or using the date selector icon.
- **Supports Coordinator/Authorizing Agent Notes**—this field may be used by Supports Coordinators, Utilization Management or other approving authority to add additional information.
- **Provider Notes**—notes related to the provider can be added here
- **Continue**—Click on and the following screen will open (clicking will remove data you entered on this screen):
Verify the information in the top portion of this screen is correct e.g. correct Enrollee/member, provider, etc. The lower part of the screen is where you will add detail on the services you are requesting. Complete as follows:

✓ **Service**—the service you are adding/requesting. Click on **lookup** to search for and select the service. Note: if you do not see the service you wish, check with your supervisor.

✓ **Standard Unit Type, Rate** – these fields will automatically display a measurement and rate once the step above is completed and a service is selected.

✓ **Override Rate** – select users may be able to adjust the rate by clicking in this box and entering a new amount in the “Unit Rate”.

✓ **Effective Dates**—these dates will pre-fill from the authorization effective and expiration dates entered earlier; end date can be modified.

✓ **From/To, Frequency**—enter a numeric range of services you are requesting for the Consumer along with how often, e.g. from 1 to 2 units (Targeted Case Management) at a weekly frequency.

✓ **Total Units Authorized** – click the **Calculate** button to calculate the total units you are adding.

✓ **Notes** – enter any other information related to this particular service.

✓ If you would like to add more services, click on **Add More Detail Lines** and MH-WIN will create additional sections for entering services.

✓ Click **SAVE** when all of your entries are complete and MH-WIN will process them and return you to the list of Authorizations.
**Exhibit B-Out of Network Out-Patient Treatment Review Form**

*NOTE: This form cannot be used to request ECT, neuropsychological or psychological testing. Please call 313-344-9035 for these services.*

<table>
<thead>
<tr>
<th>MEMBER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ______________________ Date of Birth: _____</td>
</tr>
<tr>
<td>Medicare Id# __________ Medicaid ID# ________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROVIDER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Organization: ___________________________ **DWMHA Contract ID #: ____________________ (if known)</td>
</tr>
<tr>
<td>Provider Organization Address: _____________________ City, State, Zip Code: ____________________</td>
</tr>
<tr>
<td>Tel. #: __________________ Fax #: __________________</td>
</tr>
<tr>
<td>NPI # of Provider: __________________ Tax ID # of Provider: ____________________</td>
</tr>
<tr>
<td>Location of Services provided (if different from above): City, State, Zip Code: ____________________</td>
</tr>
<tr>
<td>Tel. #: __________________ Fax #: __________________</td>
</tr>
<tr>
<td>NPI # of Provider: __________________ Tax ID # of Provider: ____________________</td>
</tr>
<tr>
<td>Name of Individual Provider rendering services: __________________ Professional Licensure/Credentials: ____________</td>
</tr>
<tr>
<td>Name of Individual Provider rendering services: __________________ Professional Licensure/Credentials: ____________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIAGNOSTIC INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Service Requested: □ Mental Health □ Substance Abuse □ Intellectual Development Disability</td>
</tr>
<tr>
<td>Behavioral DX (DSM 5 code and description, its successor or ICD 10):</td>
</tr>
<tr>
<td>Axis I (include All): <em><strong><strong><strong>/</strong></strong></strong></em>__ Axis II: <em><strong><strong><strong>/</strong></strong></strong></em>__ Axis III: _______ Axis IV: _______</td>
</tr>
<tr>
<td>GAF: Current: _______ Highest in past 12 months _______</td>
</tr>
<tr>
<td>Medical Condition or Diagnosis 1. <em><strong><strong><strong>/</strong></strong></strong></em>__ 2. <em><strong><strong><strong>/</strong></strong></strong></em>__ 3. <em><strong><strong><strong>/</strong></strong></strong></em>__</td>
</tr>
<tr>
<td>Summary: ___________________________________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TREATMENT HISTORY: (Please check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Treatment in the Past 12 months, excluding current course of treatment □ Mental Health □ Substance Abuse □ Both □ None □ Unknown</td>
</tr>
<tr>
<td>Treatment Level: □ Outpatient □ Partial/IOP □ Inpatient □ Residential □ Other ____________________</td>
</tr>
<tr>
<td>Locus Score (if applicable): _______ Date of LOCUS Assessment: _______</td>
</tr>
<tr>
<td>SIS Score (if applicable): _______ Date of SIS Assessment: _______</td>
</tr>
<tr>
<td>Outcome: □ Unknown □ Improved □ No Change □ Worse Treatment Compliance (non-medical): □ Unknown □ Poor □ Fair □ Good</td>
</tr>
<tr>
<td>Good</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CURRENT RISK ASSESSMENT: (Please check value for each type of risk)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk to Self: □ None □ Mild, ideations only □ Moderate, ideations w/EITHER plan or history of attempts □ Severe, ideations AND plan, w/either intent or means □ Not Assessed</td>
</tr>
<tr>
<td>Risk to Others: □ None □ Mild, ideations only □ Moderate, ideations w/EITHER plan or history of attempts □ Severe, ideations AND plan, w/either intent or means □ Not Assessed</td>
</tr>
<tr>
<td>Does the member have a behavioral health crisis management or safety plan? □ No □ Unknown □ Yes (Please provide date of plan): ____________________</td>
</tr>
</tbody>
</table>
**CURRENT IMPAIRMENTS:** (Please circle one value for each)

- Mood Disturbance (Depressions or Mania) 0 1 2 3 N/A
- Psychosis/Hallucinate/ Delusions 0 1 2 3 N/A
- Impulsive/Reckless/Aggressive Behavior 0 1 2 3 N/A
- Sleep Disturbance 0 1 2 3 N/A
- Weight Change associated w/ Behavioral Diagnosis 0 1 2 3 N/A
- Substance Abuse/Dependence 0 1 2 3 N/A
- Social Relationship/Martial/Family Problems 0 1 2 3 N/A
- Other (describe) ____________________________ 0 1 2 3 N/A

**SCALE:**

- 0 = none
- 1 = mild/mildly incapacitating
- 2 = moderate/moderately incapacitating
- 3 = severe/severely incapacitating
- NA = not assessed

**MEDICATIONS**  
**0=non-compliant 1=occasional use 2=uses most days 3=taken as prescribed**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose &amp; Frequency</th>
<th>Name of Prescriber</th>
<th>Purpose</th>
<th>Start Date</th>
<th>End Date (if applicable)</th>
<th>Compliance Rating</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**TREATMENT GOALS**

- Behavioral/Cognitive Change
- Mood/Affect Change
- Environmental/Relationship Change
- Insight into Problems
- Other (specify) ____________________________

**TREATMENT HISTORY & REQUEST FOR AUTHORIZATION**

DWMHA Initial Date of Service (In-Take): __________ Start Date: __________ End Date: __________  
CPT Code(s) Requested & Frequency of Each CPT Code: 1) ___________ / ___________ 2) ___________ / ___________ 3) ___________ / ___________

**CARE COORDINATION**

- Mental Health □ Yes □ No □ N/A  
- Substance Use Disorder □ Yes □ No □ N/A  
- Physical Health □ Yes □ No □ N/A  

- Is treatment being coordinated with PCP? □ Yes Name of PCP: ____________________________

- Address: ____________________________________________________________

- No □ If no please give reason: ____________________________________________

**For Out-Patient Eating Disorders:** Please provide documentation the treatment plan includes:

- □ Monitoring of target weight □ Rate of progress □ Member is receiving nutritional counseling by a trained Affiliated Provider

Treating Affiliated Provider’s Signature with credentials: ____________________________________________________________

- Date: __________

*The above signature shall serve as an attestation that the information provided is accurate to best of provider’s knowledge; and services will be rendered as described above.*

Provider Contact Name: ____________________________  Department: ____________________________

Phone # of Provider Contact: ____________________________

**For internal purposes only:**

- Date of receipt: __________ Logged by: ____________________________

- Request for additional information:

  - □ Clinical: ____________________________ Date of request __________ Date of Receipt: __________
  - □ Administrative: ____________________________ Date of request __________ Date of Receipt: __________

*Please fax the completed OTR to (313)833-3670.*

*Questions or concerns please feel free to contact UM – Clinical Specialist at (313)344-9035.*
## EXHIBIT C: OUT OF NETWORK PROVIDER INQUIRY FORM

### Provider

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider ID</th>
</tr>
</thead>
</table>

### Abbreviated / AKA

### Primary Address

<table>
<thead>
<tr>
<th>Facility Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Facility Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Website Address</th>
</tr>
</thead>
</table>

### Primary Contact Person for Contracting

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Title</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Email Address</th>
</tr>
</thead>
</table>

### Provider Classification(s)

**Check all that are applicable for this provider**

- [ ] Outpatient – SUD
- [ ] Outpatient – MI
- [ ] Outpatient – IDD
- [ ] Inpatient – SUD
- [ ] Inpatient – MI
- [ ] Inpatient – IDD

- Other (specify)

### Primary Contact Person for Utilization Management/ Clinical Review

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Title</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Email Address</th>
</tr>
</thead>
</table>

### If the provider is a service location/site of a main provider: specify that main provider below

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

### Notes (if any)

<table>
<thead>
<tr>
<th>25122</th>
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</thead>
</table>

### Name

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Notes (if any)</th>
</tr>
</thead>
</table>
### Federal and State Information and Identifiers

<table>
<thead>
<tr>
<th>Federal ID (EIN)</th>
<th>NPI Number</th>
<th>State License Number</th>
<th>Medicare ID</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Medicaid Provider Type</th>
<th>Medicaid Provider ID</th>
<th>TEDS Lara License Number</th>
<th>Place Of Service</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Capacity</th>
</tr>
</thead>
</table>

### Accreditations

**Check all accreditations that are applicable for this provider**

- AOA
- CARF
- COA
- CQL
- JCAHO

**Check all accreditations that are applicable for this provider**

- OCAL
- NCQA
- SUD Licensed Methadone
UM Review Procedure for Substance Use Disorders

PROCEDURE PURPOSE
To provide procedural and operational guidance to all staff responsible for processing SUD Authorizations.

EXPECTED OUTCOME
Enrollees/members will receive cost-effective, clinically appropriate, efficient services in the least restrictive setting that meets their needs. All SUD authorized services will meet medical necessity criteria utilizing the American Society of Addiction Medicine (ASAM) level of care guidelines and medical necessity criteria that validates the level of care.

PROCEDURE
1. All initial requests for Substance Use Disorder (SUD) Services will be authorized through our Access Center staff or Crisis Service Vendor staff. Both entities are available 24 hours /7 days a week to conduct a thorough clinical screening that includes the ASAM criteria and assessment of dimensions of care to objectively determine the appropriate level of care and addresses the stages of addictive and co-occurring substance use and/or mental health disorders.

2. Medically Necessary Substance Use Disorder services will be assessed based on the extent and severity of the six multi-dimensional assessment areas of the ASAM criteria. The ASAM and clinical assessment evaluates the extent and severity of all dimensions, including risk, and level of client functioning, to assist in determine the needed level of care with type and intensity of services:

   ◦ Dimension 1: Acute Intoxication and/or Withdrawal Potential
   ◦ Dimension 2: Biomedical Conditions and Complications
   ◦ Dimension 3: Emotional/Behavioral Conditions and Complications
   ◦ Dimension 4: Treatment/Acceptance/Resistance
   ◦ Dimension 5: Relapse/Continued Use Potential
   ◦ Dimension 6: Recovery Environment

3. The MDHHS Treatment and SUD policies are based on the most recent ASAM Criteria (Third Edition, 2013.) and reflect a continuum of care to assist in determining broad levels of care as defined below:
4. To be eligible for admission to each level of care (Diagnostic Admission Criteria) a person must meet a required diagnosis as indicated by diagnostic criteria as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association. Dimensional Admission Criteria are defined within the ASAM Criteria, Third Edition 2013.

5. Initial Authorizations/Access Center - If a member is determined eligible for services, the Access Center completes a treatment referral to an SUD provider and authorizes a small bundle of services, usually an initial assessment, urine drug screen, and/or withdrawal management days. A more thorough assessment is completed at the provider level that reviews severity and level of functioning, priority areas, and intensity of services needed in each life area. Subsequent authorizations are requested by the SUD provider network and authorized by DWMHA SUD UM Reviewers.

6. Crisis Services Vendor - If a member presents with co-occurring disorders at the emergency room, or crisis screening center, or a request for service results in an SUD disposition such as withdrawal management and/or SUD residential for co-occurring consumers, the Crisis Services Vendor will secure an accepting provider and enter the date of acceptance and/or start date into MH-WIN. The scheduling of an appointment for withdrawal management or residential generates a referral to the provider and initial authorization. If an enrollee/member is determined to require a lower level of care such as Outpatient, Intensive Outpatient, or Recovery Services, he/she is referred to the Access Center.

7. Upon receipt of a request for re-authorization from an SUD provider, the DWMHA reviewers will at a minimum review the following:
   - Service Requested and Associated CPT Code; and
   - Effective Date of Authorization and Requested Date; and
   - ASAM assessment; and
   - SUD Benefit Grid and UM Authorization Guidelines; and
   - Treatment Plan; and
   - Progress towards treatment; and
   - Provider Notes; and
   - Urine Drug Screens; and
8. All contracted DWMHA SUD Service Providers, Access Center and Crisis Services vendor(s) receive training and technical assistance on the process for entering assessments, screenings, and authorizations in MHWIN. All services require prior authorization. Provider staff must adhere to the following time frames for submission of authorizations:

   ◦ The effective date of an authorization cannot precede the authorization request date as these would be considered backdated authorizations and administratively denied. Example: Effective date of authorizations is 5/24, the request needs to be submitted prior to 5/24
   ◦ Re-Authorizations for urgent concurrent requests must be submitted within 72 hours of admission to the organization. (eg withdrawal management)
   ◦ Authorizations pended back, eg. returned to requestor, due to incomplete data or necessary corrections, must be resubmitted within 2 business days. An authorization request can be pended back to the provider only once. If the provider does not respond within the 2 business days, the UM reviewer will render a disposition on the authorization with the available information.
   ◦ All SUD services require prior authorization. An authorization request does not guarantee approval. If not submitted timely, the authorization will be administratively denied.

9. UM staff must adhere to the timeliness of authorizations based on the National Committee for Quality Assurance (NCQA) guidelines:

   ◦ Urgent Concurrent Decisions - Within 24 hours of receipt
   ◦ Urgent Preservice Decisions - Within 72 hours of receipt
   ◦ Non-urgent Preservice Decisions - Within 14 Calendar Days of Receipt
   ◦ Post-Service Decisions - Within 30 days of receipt

10. All contracted DWMHA SUD Service Providers, Access Center and Crisis Services Vendor receive training on the SUD UM Guidelines. The Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program FY 16, Healthy Michigan Program and Substance Abuse Disorder Community Grant Program Contract defines all administrative and treatment requirements for all contractors providing SUD services.

11. The MDHHS PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes further defines Reporting Units and coverage for SUD services, detailing the specific services, units, frequency, and maximum thresholds for billing various funding sources

**PROCEDURE MONITORING & STEPS**

<table>
<thead>
<tr>
<th>Who monitors this procedure:</th>
<th>Clinical Specialist, UM Supervisor or Designee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td>Utilization Management</td>
</tr>
<tr>
<td>Frequency of monitoring:</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>
1. The Clinical Specialist UM Supervisor will generate a Timeliness of Utilization Management Substance Use Disorder Report each quarterly for compliance and monitoring. It will be submitted to the UM Director, SUD Director and Utilization Management Committee.

Attachments: No Attachments

Approval Signatures

<table>
<thead>
<tr>
<th>Approver</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maha Sulaiman</td>
<td>07/2017</td>
</tr>
<tr>
<td>Jennifer Miller: UM Clinical Specialist Supervisor</td>
<td>07/2017</td>
</tr>
</tbody>
</table>
All Calls enter into the Access Center
800-241-4939
313-224-7000
866-870-2599 (TTY)

Access Center Customer Service Specialist (CSS) then requests documentation including face sheet, proof of Wayne County residency, enrollment form, (if applicable) and copy of petition and certification (if applicable).

Access Center CSS receives call from Hospital staff and collects member demographic information and checks current enrollment status.

Access Center CSS verifies eligibility via documentation and completes enrollment process.

Access Center CSS contacts Hospital Staff and informs of enrollment and completes warm transfer to COPE UM Reviewer for assessment and authorization.
# DWMHA ELIBILITY OF SERVICE REVIEW TOOL

<table>
<thead>
<tr>
<th>Enrollee/Member Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Medicaid ID No.:</td>
<td></td>
</tr>
<tr>
<td>Date of Screening for Eligibility:</td>
<td></td>
</tr>
<tr>
<td>Name of Wellplace/Access Center Clinician</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Documentation Found</th>
<th>Documentation Not Found</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Insurance Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Wayne County Residency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Start time of screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Name, address and phone number of caller</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Documentation of call being an Emergency or Crisis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Reason for call/presenting problem identified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Type of Services Request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Contact Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Guardianship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Past Treatment History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. History of Abuse (Sexual/Physical/Emotional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Current living situation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Financial Information including Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Education Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Current Health/Medical Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Referral to ER for Treatment/Clearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Time ER Contacted and Consumer Referred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Medications (name, dose, prescribing physician)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Primary care physician information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Mental Health Symptoms Identified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Substance Use Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Risk (Suicidal/Homicidal) assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Autism Screening Tool Completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. IDD Screening Tool Completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Provisional Disability Designation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Diagnoses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Medical and/or Advance Directives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Diagnoses</td>
<td></td>
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<tr>
<td>29. Medical and/or Psychiatric Advance Directives</td>
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<tr>
<td>30. Eligibility Criteria Met</td>
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<tr>
<td>31. Eligibility Criteria Not Met</td>
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<tr>
<td>32. If Eligibility Criteria Not Met, enrollee/member given community resource referrals</td>
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<tr>
<td>33. If Eligibility Criteria Not Met, Access Center Physician Review Case and Provide Documentation</td>
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<tr>
<td>34. Adequate or Advance Notice Sent to the enrollee/member (using DWMHA standard form)</td>
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</tbody>
</table>
INSTRUCTIONS FOR COMPLETION OF THE ELIGIBILITY OF SERVICE REVIEW TOOL:

The purpose of these reviews are to ensure correct documentation, appropriate level of care decisions and to meet External Quality Review requirements relative to Utilization Management.

- On a quarterly basis, Access Center shall review the following:
  - Ten (10) denial and appeal cases based on all staff making Utilization Management decisions.
  - Ten (10) approved cases for all staff making Utilization Management decisions.

- Reviews should be completed on all levels of care requiring prior authorization, including Acute Inpatient, Partial Hospitalization, State Hospitalization, Crisis Stabilization, Intensive Crisis Residential and/or Child Caring Institutions.

- The Access Center must forward all the completed Eligibility of Service Review sheets each quarter to fax: (313) 833-3160. Also an Analysis of all Eligibility of Service UM Reviews for the fiscal year shall be included in the Access Center’s Annual UM Evaluation.
# DWMHA PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL

## Initial Review (PAR Screening)

<table>
<thead>
<tr>
<th>Enrollee/Member Name:</th>
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<tbody>
<tr>
<td>MHWIN ID No.:</td>
<td>Medicaid Number:</td>
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<tr>
<td>Level of Care:</td>
<td>Admit Date:</td>
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</table>

Complete name and credentials of the Crisis Service Vendor UM Staff who completed the initial review (PAR Screening):

<table>
<thead>
<tr>
<th>Documentation</th>
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</thead>
<tbody>
<tr>
<td>1. Date and time of initial call to request the review</td>
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<tr>
<td>2. Date and time of initiation of review (PAR)</td>
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<tr>
<td>3. Complete name, credentials of caller completing the review (PAR)</td>
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<tr>
<td>4. Complete name of facility/location for the caller completing the review (PAR)</td>
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<tr>
<td>5. Phone number of caller completing the review (PAR)</td>
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<tr>
<td>6. Level of Care being requested</td>
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<tr>
<td>7. Living Arrangement prior to admission</td>
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<tr>
<td>8. Education and/or Work status</td>
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<tr>
<td>9. Guardianship</td>
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<tr>
<td>10. Legal Problems</td>
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<tr>
<td>11. Vital Signs</td>
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<tr>
<td>12. Presenting Symptoms/Current Stressors</td>
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<tr>
<td>13. Risk Assessment <em>(Suicide/Homicide/Other Dangerous or Self Aggressive Behavior)</em></td>
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<tr>
<td>15. Past Treatment History</td>
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<tr>
<td>16. Compliance with past outpatient treatment</td>
<td></td>
<td></td>
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<tr>
<td>17. Mental Status</td>
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<td></td>
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<tr>
<td>18. Substance Use Assessment</td>
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<tr>
<td>19. UDS Screening Information</td>
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<tr>
<td>20. ETOH Screening Information</td>
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<tr>
<td>21. Physical/Medical Health History</td>
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<tr>
<td>22. Primary Care Physician information</td>
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<tr>
<td>23. Current Medications <em>(medication name, dose, frequency, complete name of prescriber)</em></td>
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<tr>
<td>24. Compliance with Medications</td>
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<tr>
<td>25. Presence of a Crisis Plan and/or Behavioral Plan</td>
<td>N/A</td>
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<tr>
<td>26. Diagnosis</td>
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<tr>
<td>27. Treatment Plan/Identified Goals</td>
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Revised 12.1.16
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<tbody>
<tr>
<td><strong>28. Discharge Plan</strong></td>
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</tr>
<tr>
<td><strong>29. Estimated Length of Stay (ELOS)</strong></td>
<td></td>
<td></td>
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</tbody>
</table>
| **30. SI/IS criteria identified and documented**  
  *(medical necessity criteria met for level of service)* |   |   |
| **31. Complete Clinical Summary (in clinical note section of criteria authorization screen)* |   |   |
| **32. Consult with Organization’s Supervisor and/or Organization’s Physician** | N/A   |   |
| **33. Number of Days/Units Authorized** | N/A   |   |
| **34. Diversion Information** | N/A   |   |
| **35. Date and Time of PAR Disposition** |   |   |
| **36. Complete name and credentials of Organization’s Staff UM Reviewer and Date**  
  *(can be electronic signature)* |   |   |
| **37. Complete name of staff at hospital/facility to which admission/authorization was given**  
  *(in PAR Disposition)* |   |   |
| **38. Complete name and credentials of the admitting physician**  
  *(in PAR Disposition)* |   |   |
**DWMHA PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL**

**First Continued Stay Review**

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<tr>
<td>2. Name and credentials of caller completing the review</td>
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<tr>
<td>3. Telephone number of caller completing the review</td>
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<tr>
<td>4. Current status of symptoms</td>
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<td>5. Treatment progress to date</td>
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<td>10. Any side effects from medications</td>
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<td>14. Presence of a Crisis Plan and/or Behavioral Plan</td>
<td>N/A</td>
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<tr>
<td>15. SI/IS Criteria Identified</td>
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<td>16. After Care/Discharge Plan <em>(indicate level of care, provider name and date and time of initial appointment with provider)</em></td>
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<td>19. Consult with Organization’s Supervisor and/or Organization’s Physician</td>
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<td>20. Number of days/units authorized</td>
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<tr>
<td>21. Date and time of disposition</td>
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<tr>
<td>22. Complete name and credentials of Organization’s UM staff reviewer</td>
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</table>
## DWMHA PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL

### Second Continued Stay Review

<table>
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<tr>
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<tbody>
<tr>
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<td>Name of UM Staff Reviewer:</td>
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<tr>
<td>Admit Date:</td>
<td>Discharge Date:</td>
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<td>3. Telephone number of caller completing the review</td>
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<tr>
<td>4. Current status of symptoms</td>
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<tr>
<td>5. Treatment progress to date</td>
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<td>6. Baseline functioning</td>
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<td>19. Consult with Organization’s Supervisor and/or Organization’s Physician</td>
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Revised 12.1.16
DWMHA PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL

<table>
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<tbody>
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<tr>
<td>Admit Date:</td>
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<tr>
<td></td>
<td>Documentation</td>
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<tr>
<td>1. Date and time of concurrent review was initiated</td>
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<tr>
<td>22. Complete name and credentials of Organization’s UM staff reviewer</td>
<td></td>
</tr>
</tbody>
</table>

Signature, title and credential of Staff Auditor (person who completed the case audit)  
Date of the case audit

Revised 12.1.16
For any areas where the documentation was not found or was not complete or not accurate please indicate the nature of the deficiency and any corrective action given to the Organization’s UM staff reviewer:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

INSTRUCTIONS FOR COMPLETION OF PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL:

The purpose of these reviews are to ensure correct documentation, appropriate level of care decisions and to meet External Quality Review requirements relative to Utilization Management.

- On a quarterly basis, the Crisis Service Vendor and the MCPNs shall review the following:
  - All (100%) denial and appeal cases based on all staff making Utilization Management decisions.
  - Crisis Service Vendor and Carelink - ten (10) approved cases (PAR Screenings) for all staff making Utilization Management decisions.
  - Consumer Link, Community Living Services and Integrated Care Alliance- five (5) approved request for service cases on all staff making Utilization Management decisions.

- Reviews should be completed on all levels of care requiring prior authorization, including Acute Inpatient, Partial Hospitalization, State Hospitalization, Crisis Stabilization, Intensive Crisis Residential and/or Child Caring Institutions.

- The Crisis Service Vendor and the MCPNs must forward all the completed Prior Authorized Service UM Chart Review sheets each quarter to fax: (313) 833-3160.

- An Analysis of all Prior Authorized Service UM Chart Reviews for the fiscal year shall be included in the Crisis Service Vendor and the MCPNs' Annual UM Evaluation.
### General Documentation Note

*Note: Questions with asterisks (*) must have a response.*

1. The Ability to Pay/Fee Agreement (including insurance information) is current, signed and dated.
   - Not Met/Partial/Met N/A

2. * The annual consent for treatment is current, signed and dated.
   - Not Met/Partial/Met N/A

3. * The individual's signature indicates the Consumer Handbook was offered annually.
   - Not Met/Partial/Met N/A

4. * If the consumer has a legal guardian, there are current court papers in the file.
   - Not Met/Partial/Met N/A

5. Advanced Directive and Self-Determination were offered and explained. (Adults only)
   - Not Met/Partial/Met N/A

6. There is evidence that the consumer and family were informed of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) process for recipients under 21.
   - Not Met/Partial/Met N/A

7. * Recipient Rights, Person-Centered Planning and Confidentiality Notification forms are signed by the consumer, parent of minor children, or guardian/legal representative when services were initiated and annually.
   - Not Met/Partial/Met N/A

### Assessments

1. * Level of care is based on comprehensive assessment.
   - Not Met/Partial/Met N/A

2. If the consumer is a child or adolescent, the appropriate assessment scale (DECA-I, DECA-T, DECA-C, PECFAS or CAFAS) is present as required.
   - Not Met/Partial/Met N/A
3. Natural Supports are assessed.
Not Met/Partial/Met  N/A

4. Health and safety needs, risk/at-risk behaviors are assessed.
Not Met/Partial/Met  N/A

5. Substance use, risk, and patterns are assessed.
Not Met/Partial/Met  N/A

7. There is evidence of a Diagnostic Formulation/Summary which supports the diagnosis given.
Not Met/Partial/Met  N/A

**Implementation of Person-Centered Planning**

1. * Services and supports identified in the individual plan of service assist the individual in pursuing outcomes consistent with their preferences and goals.
Not Met/Partial/Met  N/A

2. Family-driven and youth-guided supports and services are provided for minor children.
Not Met/Partial/Met  N/A

3. * Individuals are provided with on-going opportunities to provide feedback on how they feel about services, supports and/or treatment they are receiving, and their progress towards attaining valued outcomes.
Not Met/Partial/Met  N/A

4. The person-centered planning process is used to modify the individual plan of service in response to changes in the individual’s preferences or needs.
Not Met/Partial/Met  N/A

5. * The person-centered planning process builds upon the individual's capacity to engage in activities that promote community life.
Not Met/Partial/Met  N/A

6. * Person-centered planning addressed and incorporated natural supports.
Not Met/Partial/Met  N/A

7. * Person-centered planning addresses and incorporates health and safety.
Not Met/Partial/Met  N/A
8. Pre-planning meetings occur before a person-centered planning meeting, according to the individual’s desires and needs.

Not Met/Partial/Met  N/A

9. Individuals are provided an opportunity to develop a Crisis Plan.

Not Met/Partial/Met  N/A

10. The individual is offered the option of Independent Facilitation.

Not Met/Partial/Met  N/A

### Plan of Service and Documentation Requirements

1. * The individual plan of service identifies the roles and responsibilities of the individual, the Supports Coordinator or Case Manager, the allies, and providers in implementing the plan.

Not Met/Partial/Met  N/A

2. * Specific services, supports and treatment provided were identified in the plan of service, including the amount, scope, and duration of services.

Not Met/Partial/Met  N/A


Not Met/Partial/Met  N/A

4. Individuals are provided a copy of their individual plan of service within fifteen business days after the planning meeting.

Not Met/Partial/Met  N/A

5. Individuals are provided timely ADEQUATE Notice of Action.

Not Met/Partial/Met  N/A

6. Individuals are provided timely ADVANCE Notice of Action.

Not Met/Partial/Met  N/A

### Behavior Treatment Plan

1. If the individual has a behavior treatment plan, it is developed through a person-centered planning process.

Not Met/Partial/Met  N/A
2. There is evidence of written "special consent" before the behavior treatment plan is implemented.
Not Met/Partial/Met N/A

3. There is evidence in the clinical record to verify that all staff has been duly trained on each behavioral intervention identified in the plan.
Not Met/Partial/Met N/A

4. There is evidence that the Behavior Treatment Plan has been followed and outcomes are documented.
Not Met/Partial/Met N/A

### Coordination of Care

1. There is evidence of the Behavioral Health provider coordinating treatment with the Primary Care Physician.
Not Met/Partial/Met N/A

2. There is evidence that the Behavioral Health provider received information from the Primary Care Physician. Enter "YES" or "NO" in the text box.
Text Field N/A

3. There is evidence of the Behavioral Health provider coordinating services with natural and other community supports.
Not Met/Partial/Met N/A

4. There is evidence that the Behavioral Health provider received requested information and or communication from the consumer's natural / community supports. Enter "YES" or "NO" in the text field.
Text Field N/A

5. There is evidence of the Behavioral Health provider coordinating treatment with the Substance Use Disorder provider.
Not Met/Partial/Met N/A

6. There is evidence that the Behavioral Health provider received information from the SUD Provider. Enter "YES" or "NO" in the text box.
Text Field N/A
7. If the individual has not visited a Primary Care Physician for more than 12 months, there is evidence of a basic health care screening, including height, weight, BMI and blood pressure.

Not Met/Partial/Met  N/A

8. There is evidence that the psychiatrist or Primary Care provider ordered a diabetic screening that includes an HbA1C or fasting blood sugar (FBS), BMI, blood pressure, and LDL cholesterol for consumers prescribed an atypical antipsychotic medication. Indicate "Met", "Not Met" or "Partial" in the text box, if applicable (see reference below).

Text Field  N/A

<table>
<thead>
<tr>
<th>Targeted Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Case Manager/Supports Coordinator completed an initial written comprehensive assessment, updates it as needed, and no less than annually. The assessment addresses the needs/wants and identifies barriers as well as supports to overcome the barriers.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td>2. The case record contains sufficient information to document the provision of case management services. The record contains the nature of the service, the date and location of the contacts between the Case Manager/Supports Coordinator and the beneficiary, and whether the contacts were face-to-face.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td>3. The Case Manager/Supports Coordinator determines if the services and supports have been delivered and if they are adequate to meet the needs/wants of the beneficiary.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td>4. There is documentation that the Case Manager/Supports Coordinator &quot;regularly&quot; reviews the consumer's health status noting any issues, visits to the emergency room and hospitalizations and the Case Manager/Supports Coordinator ensures that the Critical and Sentinel Events have been reported per the Provider's Incidence Reporting Procedure and the Authority's policy.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
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<thead>
<tr>
<th>Personal Care in Licensed Residential Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The assessment of the individual's need for personal care services uses a format that captures the required elements.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td>2. Personal care services are authorized by a physician or other health-care professional.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
</tbody>
</table>
### Additional Mental Health Services (b)(3)’s

1. If the consumer receives Environmental Modifications or equipment, there is evidence of prior authorization in accordance with the provider’s process. This includes the physician’s prescription for modifications or assistive technology purchased within the year.

   Not Met/Partial/Met  N/A

2. Progress notes demonstrate appropriate implementation of the plan for Community Living Supports: Used to increase/maintain personal self-sufficiency, facilitating an individual’s achievement of his/her goals of community inclusion and participation, independence or productivity.

   Not Met/Partial/Met  N/A

3. Enhanced Pharmacy: There is documentation of physician ordered, non-prescription "medicine chest" items as specified in the IPOS.

   Not Met/Partial/Met  N/A

4. IPOS identifies Family Support and Training necessary to assist the individual in achieving goals. Family Support and Training is Family-focused training services provided to families of persons with SMI, SED or DD for the purpose of assisting the family in relating to and caring for and/or living with disabilities.

   Not Met/Partial/Met  N/A

5. Housing Assistance: There is documentation of assistance with short-term interim, or one-time-only expenses for beneficiaries transitioning from restrictive settings into more independent, integrated living arrangements while in the process of securing other benefits (e.g., SSI).

   Not Met/Partial/Met  N/A

6. There is documentation in the clinical record that Peer Support services/programs provides the individual with opportunities to learn and share coping skills and strategies, move into more active assistance and away from passive patient roles and identities and to build and/or enhance self-esteem and self-confidence. These may be Peer Delivered or Operated Services.

   Not Met/Partial/Met  N/A

7. Peer Specialist Services: There is documentation in the clinical record indicating that the individual received support, mentoring and assistance in achieving community inclusion, participation, independence, recovery, resiliency, and/or productivity.

   Not Met/Partial/Met  N/A
8. *Skill Building Assistance:* There is evidence in the clinical record of activities assisting the beneficiary with increasing his/her economic self-sufficiency and/or to engage in meaningful activities such as school, work and/or volunteering.

Not Met/Partial/Met  N/A

9. *Supported Integrated Employment:* There is documentation in the clinical record that job development along with initial and on-going support services was provided to assist beneficiaries to obtain and maintain paid employment that would otherwise be unachievable without such supports.

Not Met/Partial/Met  N/A

**Implementation of Arrangements that Support Self-Determination**

1. The individual budget and the arrangements that support self-determination are included as part of the person-centered planning process.

Not Met/Partial/Met  N/A

2. The individual participating in arrangements that support self-determination has a Self-Determination Agreement that complies with the requirements.

Not Met/Partial/Met  N/A

3. Individuals participating in self-determination shall have assistance to select, employ, and direct his/her support personnel, and to select and retain the chosen qualified provider entities.

Not Met/Partial/Met  N/A

4. There is evidence that within prudent purchaser constraints, an individual is able to access any willing and qualified provider.

Not Met/Partial/Met  N/A

5. Fiscal Intermediary Services: There is documented evidence that assistance for the adult beneficiary, or a representative identified in the beneficiary’s individual plan of service, is provided to meet the beneficiary’s goals of community participation and integration, independence or productivity.

Not Met/Partial/Met  N/A

**Medication/Psychiatric**

1. All medications, (such as OTC and those prescribed by external physicians), are documented and updated as necessary.

Not Met/Partial/Met  N/A
2. Medication Consents for all program-prescribed medications are current, include dosage (if outside therapeutic range), documentation of the right to withdraw consent verbally, are signed by consumer/guardian and prescribing physician.

Not Met/Partial/Met  N/A

3. Evidence of drug-specific patient education is provided to individuals prior to administering each new drug.

Not Met/Partial/Met  N/A

4. The Physician/Medical Professional's handwriting is legible.

Not Met/Partial/Met  N/A

5. Laboratory results (ordered by Program physician) are reviewed, signed off by a physician and available in the chart.

Not Met/Partial/Met  N/A

6. Quarterly Tardive Dyskinesia testing dates and results are documented by program physician.

Not Met/Partial/Met  N/A

7. A copy of RX or Medical Orders are in the file (if prescribed by program physician).

Not Met/Partial/Met  N/A

<table>
<thead>
<tr>
<th>Community Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is evidence that the consumer’s choice for gainful employment, to volunteer, pursue education/training opportunities or unpaid internships has been discussed and encouraged during the pre-planning meeting.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td>2. There is evidence the consumer is being supported to pursue his/her unique path to competitively paid work options or career goals.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td>3. There is evidence that the employed consumer is earning at least minimum wage.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td>4. There is evidence the consumer who resides in General Specialized or Specialized Adult Foster Care Homes, Nursing Homes, State Hospital, Nursing Homes or other restrictive residential setting were informed of the full array of housing options, including Permanent Supported Housing (PSH).</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
</tbody>
</table>
5. There is evidence that the consumer was offered a choice of living options based on their individual needs and desires.
Not Met/Partial/Met  N/A

6. There is evidence that the Access to Community Living Guidelines form is in the consumer’s case record.
Not Met/Partial/Met  N/A

**Autism Program Requirements**

1. There is evidence the individual, parent or guardian was informed of their right to choose among various Autism Spectrum Disorder Providers.
Not Met/Partial/Met  N/A

2. The comprehensive diagnostic evaluation and psychological assessment were uploaded within 14 calendar days of the assessment appointment.
Not Met/Partial/Met  N/A

3. There is evidence that the ABA Assessment (ABLS, VB-MAPP, AFLS) was uploaded to MHWIN within seven (7) calendar days of the assessment appointment.
Not Met/Partial/Met  N/A

4. There is evidence that as part of the IPOS, there is a comprehensive individualized ABA behavioral plan of care that includes specific targeted behaviors for improvement, along with measurable, achievable, and realistic goals.
Not Met/Partial/Met  N/A

5. There is evidence risk factors have been identified for the child/family, a description of how the risks may be minimized and the backup plan for each identified risk.
Not Met/Partial/Met  N/A

6. There is evidence the Beneficiary's ongoing determination level of service (which occurs every six months) has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with the ABLLS-R or VB- MAPP.
Not Met/Partial/Met  N/A

7. There is evidence that the IPOS Service Reviews are completed on a quarterly basis (every 90 days) while the individual was enrolled in the ASD Benefit.
Not Met/Partial/Met  N/A
8. There is evidence that the Individual Plan of Service had been updated within 365 days of the last plan of service.
Not Met/Partial/Met  N/A

9. There is evidence that the ABA Provider and Supports Coordinator communicate on a monthly basis.
Not Met/Partial/Met  N/A

10. When more than three appointments in one month were missed, there is documentation of multiple attempts (weekly) to keep families engaged.
Not Met/Partial/Met  N/A

11. The average hours of ABA services during a quarter were within the suggested range for the intensity of services (+/- 25%).
Not Met/Partial/Met  N/A

12. The number of ABA hours of direction/observation during a quarter were equal to or greater than 10% of the total ABA Direct service provided.
Not Met/Partial/Met  N/A

MI Health Link Required Documentation

1. The DCH-3927 "Consent to Share Your Health Information" form is complete. The DCH-3927 contains the appropriate client and/or guardian signature(s) and is uploaded to the MHWIN Consumer’s Chart “All Scanned and Uploaded Documentation” section.
Not Met/Partial/Met  N/A

2. There is evidence that a current Bio-Psycho-Social Assessment (obtained at Clinically Responsible Service Provider) was submitted into the Care Bridge within 14 days of receipt of the referral. The Assessment must address medical necessity for the treatment planned.
Not Met/Partial/Met  N/A

3. There is evidence that the appropriate assessments (LOCUS, SIS, or ASAM) were completed and submitted to the Care Bridge within 14 days of receipt of the referral.
Not Met/Partial/Met  N/A

4. If the 14-day requirement for the Level II Assessment was not met, there is documentation in the case record regarding the barrier(s) to timely completion and submission.
Not Met/Partial/Met  N/A
5. There is evidence of communication and collaboration with the Integrated Care Team (ICT), including contact with the Health Plan Care Coordinator.

Not Met/Partial/Met  N/A

<table>
<thead>
<tr>
<th>Habilitation Supports Waiver Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> There is evidence of Eligibility: The Habilitation Supports Waiver Eligibility Certification is current, completed and signed by CMHSP Provider and by Clinical Review Team (CRT) Chairperson. If appropriate, the annual HSW Recertification Worksheet is current, completed and signed by CMHSP Provider and by PHIP Designee.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td><strong>2.</strong> There is evidence that the annual Waiver Services Consent under the Habilitation Supports Waiver Eligibility Certification Section 3 is current.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td><strong>3.</strong> If the enrollee receives Environmental Modifications or Equipment, the CMHSP has implemented prior authorizations in accordance with their process with physician’s prescription within the last year.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td><strong>4.</strong> There is documentation that the selected Environmental Modifications or Equipment is the most cost-effective and fully functional option that meets the consumer’s needs which comply with the CMHSP’s process/policy.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td><strong>5.</strong> There is documentation that the individual and/or guardian were informed of their right to choose among various providers and that the Consumer Handbook/Consumer Directory of Services was reviewed with the consumer and/or guardian. This evidence of choice of providers may appear in the Initial Pre Plan or IPOS.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td><strong>6.</strong> The clinical record reflects that the individual and/or guardian was informed of their right to choose among various Waiver Services. Evidence may be found in the Pre Plan and/or IPOS.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td><strong>7.</strong> The IPOS for individuals enrolled in the HSW is updated within 365 days of their last IPOS.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
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</tbody>
</table>
8. There is evidence that the member received at least one active habilitative treatment service as identified in the Individual Plan of Service (i.e., CLS, Out-of-Home Non-vocational habilitation and Prevocational or supported Employment).
Not Met/Partial/Met  N/A

9. For individuals receiving Private Duty Nursing (PDN), there is evidence of a minimum of one HSW service per month (i.e., CLS, Out-of-Home Non-vocational habilitation and Prevocational or supported Employment).
Not Met/Partial/Met  N/A

10. There is documentation of an annual physical examination.
Not Met/Partial/Met  N/A

<table>
<thead>
<tr>
<th>Children’s Home And Community-Based Services Waiver (CWP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is evidence that the initial Children’s Waiver Certification is current, completed and signed by CMHSP Provider and by Clinical Review Team (CRT) Chairperson.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td>2. There is evidence that the annual Children's Waiver Re-certification is current, completed and signed by CMHSP Provider.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td>3. There is evidence that the Assigned Category of Care/Intensity of Care is circled and appropriate to child’s condition, as evidenced by both 1.) The Category of Care/Intensity of Care designated on the Waiver Certification and 2.) The corresponding narrative.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td>4. There is evidence that the child resides with his/her birth or legally adoptive parent(s) or with a relative who has been named the legal guardian of that child under the laws of the State of Michigan (provided that the relative is not paid to provide foster care for that child).</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
</tr>
<tr>
<td>5. There is evidence that an annual medical examination was completed, as evidenced by the completion of the DHS 49-A Medical Examination Report form, and information was entered into the WSA for MDHHS review and approval.</td>
</tr>
<tr>
<td>Not Met/Partial/Met  N/A</td>
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<tr>
<td>6. There is evidence that at least one habilitative CWP service is provided to this Waiver consumer per month.</td>
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<td>14.</td>
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</table>

### Implementation of Arrangements that Support the Choice Voucher System for Children

1. There is evidence that information about accessing the Choice Voucher System for Children was provided and explained to parent, adoptive parent or legal guardian.
2. If the family is participating in arrangements that support the Choice Voucher System, there is a Choice Voucher Agreement that complies with the requirements.

3. There is evidence that if the family is participating in arrangements that support the Choice Voucher System, there is assistance to select, employ, and direct their support personnel, as well as, to select and retain chosen qualified provider entities.

4. If there is a Choice Voucher Agreement present, the voluntary and involuntary termination clauses meet the requirements of the Choice Voucher System Policy and Practice Guideline.
The Detroit Wayne Mental Health Authority (DWMHA) has developed standardized self-monitoring tools to be utilized throughout the system. The implementation of this self-monitoring plan is a component of the Continuous Quality Improvement (CQI) process. The CQI is designed to provide an organized, documented process for assuring that eligible Wayne County residents are receiving the medically necessary and appropriate services for mental health issues, substance disorders and/or developmental disabilities. In addition, these services must conform to accepted standards of care while achieving the consumers’ desired outcomes.

The goal of the self-monitoring plan is to support a CQI process. This involves ongoing monitoring efforts to improve services through continuous and consistent evaluation and change thus resulting in a process/procedure that creates program refinements.

The CQI process is iterative.

Four main principles of quality improvement include:

1. **Focus on the client**: Services should be designed to meet the needs and expectations of consumers. An important measure of quality is the extent to which customer needs and expectations are met.

2. **Understanding work and system processes**: Providers need to understand the service system and its key processes in order to improve them. Using process-engineering tools provides simple visual images of these processes and systems.

3. **Teamwork**: Because work is accomplished through processes and systems in which different people fulfill different functions, it is essential to involve stakeholders in the improvement process. This brings their insights to the understanding of changes that need to be made and to the effective implementation of the appropriate process. It also ensures ownership of the improvement processes and systems.

4. **Focus on the use of data**: Data is needed to analyze processes, identify problems and measure performance. Changes can then be tested and the resulting data analyzed to verify that the changes have actually led to improvements.
Monitoring and contractual responsibilities:
DWMHA contracts with Managers of Comprehensive Provider Networks (MCPN) who then contract with service providers to manage and deliver a full array of supports and services to consumers within Wayne County. For the Dual Eligible project, DWMHA will retain the monitoring function that is delegated to the MCPNs in this plan except for Specialized Residential Service providers which shall remain a monitoring function of the MCPNs.

Delegation:
Delegation is a formal process by which a Prepaid Inpatient Health Plan (PIHP) gives another organization the authority to perform certain functions on its behalf, such as, but not limited to, customer services, utilization management or quality improvement. Although DWMHA can delegate the authority to perform a function, the ultimate responsibility, for assuring the quality and appropriateness of care rests with DWMHA. DWMHA must ensure all contractual obligations between the Michigan Department of Health and Human Services (MDHHS) and all other regulatory bodies are met. It is DWMHA’s responsibility to ensure that the MCPN delivers the provision of Medicaid services consistent with the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the Center for Medicare and Medicaid (CMS) Medicaid & State Operations Manuals, Michigan’s Medicaid State Plan, and the Michigan Medicaid Provider Manual and Mental Health-Substance Abuse requirements.

This monitoring plan is geared to improve quality, measure our performance in the delivery of service and ensure compliance with required standards. The plan requires the involvement, skills, expertise and input from the service providers, MCPNs and DWMHA staff. This approach is a partnership between DWMHA, the MCPNs, providers, professionals and consumers.

Goals, Objectives and Strategies:
Improving the quality and consistency of services is an important part of improving the provision of services to Wayne County consumers. DWMHA’s goals are to ensure providers maintain high standards and offer reliable supports and services within all programs.

To accomplish this goal, DWMHA needs to achieve the following three objectives.

Objective 1: Continuously improve the overall standards of clinical care.
Objective 2: Reduce unacceptable variation in clinical practice.
Objective 3: Ensure the best use of resources so that consumers receive the greatest benefits.

Strategies to meet the above objectives require that supports and services be:
- Appropriate to the consumer needs
- Effective by utilizing the best practices based on available clinical evidence
- Efficient and cost effective to maximize mental health gains for the maximum number of consumers.
Implementation of a Multilevel Approach:

This multi-level monitoring approach begins at the service provider level and cascades up to DWMHA’s Quality Improvement Team.

Standardized Tools:
Standardized monitoring tools were developed to promote inter-rater reliability, sound and cost-effective self-regulation and data driven outcomes. Mental health professionals will be able to assess the care they provide against established standards.

Standardized tools are necessary to ensure:
- Actions and/or process requirements are not open to different interpretations
- The process is made easier to understand
- Non-value added steps are eliminated
- An increase in effectiveness and efficiency
- The process can be benchmarked to determine if it is proficient or that new performance goals are needed
- DWMHA and MCPN staff can collect evidence relying on process conformity to increase validity and reliability in findings.

Review Process:

Similar to the process described during the test quarter, the MCPN and DWMHA Monitors will validate the provider outcomes.

**Level I:** The beginning of the process occurs at the provider level with the clinician delivering the service and documenting it in the clinical record. Staff is expected to self-regulate their clinical activities under the direction of the supervisor.

**Level II:** The service provider’s Quality Improvement staff is responsible for evaluating their program’s use of self-monitoring tools.

**Level III:** The MCPN is required to review 100% of their contracted service providers including the specialized residential homes during the fiscal year.

The MCPN will report their monitoring results to the providers. This data is critical to implementing a systematic process for improvement.

The MCPN is required to submit data findings from review outcomes to the Authority on a monthly basis.

**Level IV:** DWMHA Performance Monitoring staff will be responsible for validating the information submitted by MCPNs and providers. On a monthly basis DWMHA Monitoring staff will generate aggregated reports of their assigned MCPNs and providers.
Steps of the Review Process:

**Step I: Clinician and Clinical Supervisor:**

Clinicians will deliver the services, document the findings in the case record, review case record documentation based on clinical record requirements and consult with the supervisor in areas of concern.

Training and technical assistance can be provided through a number of venues: peer reviews, increased supervision, technical assistance, in-service training, and practice-specific conferences. To ensure skills are updated the service provider organization should create an organizational learning culture that encourages staff to continually update their skills through such arenas as University or VCE offered trainings and other educational forums.

**Step II: Provider Quality Improvement Supervisor:**

The service provider’s Quality Improvement (QI) staff is responsible for evaluating provider compliance using self-monitoring tools.

On a monthly basis it is recommended that providers analyze data on completed case reviews. The findings should be reviewed with the supervisor(s) who will then review with staff and if needed, will implement corrective action.

Each quarter all providers will review at least 100% of the randomly selected case records provided by DWMHA. At the end of each quarter, the QI supervisor will complete a Combined Report of the Case Record Review tools from the randomly selected case records. The findings shall be used to assess program compliance and plan continuous quality improvement activities. The QI supervisor will aggregate the scores from the standardized review tool to assess trends, areas of weaknesses and strengths. The results will be shared with supervisors, clinical staff and MCPNs as part of the continuous quality improvement process. It is the responsibility of the QI supervisor and staff to implement a plan to achieve and maintain 95% compliance.

At this level, the reviewers are able to determine the employee or supervisor’s level of understanding, skill set and strengths. If problems are found, the QI supervisor should take the lead to provide direction, guidance and technical assistance. It is imperative that problem areas are addressed and corrected. Evidence of these corrections should be demonstrated in the clinical record progress notes and/or a revised IPOS, as appropriate.
Step III: MCPN Quality Director:

The MCPN is still required to review 100% of their contracted service providers including Specialized Residential homes during the fiscal year. DWMHA expects the MCPN to ensure all dimensions of the programs are being fully implemented and that there is a process for providing continuous quality improvement. The MCPN’s Quality Improvement staff must ensure quality outcomes as evidenced by compliance scores of no less than 95%.

MCPN monitoring will continue to occur through currently established venues:

a. Review of the MH-WIN data
b. Review of the randomly selected clinical records
c. Site visits.

Step III involves the MCPN implementing a CQI process through on-going evaluations using standardized review protocols and guidelines to analyze the findings. If problems are identified, the provider and MCPN are to work to understand the problem and develop a hypothesis about the changes needed to correct the problem.

MCPNs are expected to validate a sample of the case records submitted by each provider. The Authority will determine the sample size to be reviewed. On a monthly basis, using the Case Record Review Tool in MHWIN, the MCPN will validate the provider records. On a quarterly basis, the MCPN shall compile reports using the Combined Report Tool in MHWIN by provider of the validated Case Record Review tools. For all providers whose total score on the Combined Report falls below 95%, a written plan of correction will be implemented and monitored by the MCPNs and DWMHA staff.

Step IV: Authority

The sample size for DWMHA Performance Monitor to review will be determined by the Performance Monitor Administrator.

On a monthly basis, DWMHA Performance Monitoring staff will review and validate the MCPN and provider Case Record Reviews and Combined Reports in MH-WIN. For the Dual Eligible providers, DWMHA Performance Monitoring staff will annually review and validate the provider Case Record Reviews. The Performance Monitoring staff will submit:

a. Monthly reports to the Performance Monitoring Administrator on the first working day of the month following the end of a month. Monthly reports shall include:
   i. Updates on the outcomes of the Provider Plans of Correction.
   ii. Results of continuous monitoring from desk audits, internal Agency reporting and on-site reviews.
b. Quarterly reports will be submitted to the Performance Monitoring Administrator on the first working day of the month following the end of a quarter. The quarterly reports are:
   i. Quarterly narrative reports along with bar charts displaying the overall MCPN/provider performance to include significant findings: improvements/deficiencies and plans of correction for providers below the 95% compliance threshold.
   ii. Recommendations for technical assistance that DWMHA can offer to the providers as a group to ensure compliance to the standards of care to continue to be a “high performing PHIP”.

Inter-DWMHA Review of the MCPN Process for Continuous Improvement

DWMHA Performance Monitoring staff will work in conjunction with staff from other DWMHA units such as Utilization Management in monitoring identified standards. These units will include but are not limited to the following:

1. Contract Management
2. The Office of Recipient Rights
3. Customer Services
4. Evidence-Based Medicine
5. Children’s Initiative

Coordinating with the various units will improve our ability to monitor health and welfare issues by way of recipient complaints, sentinel events, Medicaid Fair Hearing requests as well as monitoring the use of restrictive or aversive behavioral interventions.

The results of DWMHA Reviews will be incorporated in the annual Quality Assurance Performance Indicator Program evaluation and will be distributed to the Providers, MCPNs, Integrated Care Organizations and other stakeholders. This evaluation will also be available on the website at [www.DWMHA.com](http://www.DWMHA.com).
<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Makes Decision</th>
<th>Fax/Phone Notification</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent pre-service review</td>
<td>Within 14 calendar days of receipt of the request. If additional information is needed, DWMHA, Crisis Service Vendor or MCPN must contact the provider within 2 business day of receipt of the request. The provider then has 2 business days to provide the needed information. A denial may be issued if the provider fails to secure the needed information within 2 business day of receipt of the DWMHA, Crisis Service Vendor or MCPN request.</td>
<td>Within 3 hours of determination but no later than within 14 calendar days of the receipt of the request.</td>
<td>Within 14 calendar days of receipt of the request.</td>
</tr>
<tr>
<td>Urgent pre-service review</td>
<td>Within 72 hours of receipt of the request. If service denied and oral notification given within 3 hours of determination, have up to 24 hours after oral notification.</td>
<td>Within 3 hours of determination but no later than 72 hours of receipt of the request.</td>
<td>Within 72 hours of receipt of the request.</td>
</tr>
<tr>
<td>Urgent concurrent review</td>
<td>Within 24 hours of receipt of the request, if all information received and request for service is made prior to 24 hours before expiration of the current authorization period or number of treatments. If service denied &amp; oral notification given within 3 hours of the determination, have up to 24 hours after the oral notification.</td>
<td>Within 3 hours of determination but no later than within 24 hours of receipt of the request.</td>
<td>Within 24 hours of receipt of the request.</td>
</tr>
<tr>
<td></td>
<td>Within 72 hours if additional information had to be requested &amp; information requested within 24 hours of receipt of request or if request for service is not made prior to 24 hours before expiration of the current authorization period or number of treatments.</td>
<td>Within 3 hours of determination but no later than within 72 hours of receipt of the request.</td>
<td>Within 72 hours of receipt of the request.</td>
</tr>
<tr>
<td>Post-service review</td>
<td>Within 30 calendar days of receipt of the request. If service denied &amp; oral notification given within 3 hours of the determination, have up to 24 hours after the oral notification.</td>
<td>N/A</td>
<td>Within 30 calendar days of the request.</td>
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</table>

**Nonurgent:** A request for care or services for which application of the time periods for making a decision does not jeopardize the life or health of the enrollee/member or the enrollee/member’s ability to regain maximum function and would not subject the member to severe pain.

**Urgent pre-service:** A request for care or services where application of the time frame for making routine or non-life threatening care determinations could seriously jeopardize the life, health or safety of the enrollee/member or others, due to the enrollee/member’s psychological state or in the opinion of the practitioner would subject the enrollee/member to adverse health consequences without the care or treatment.

**Urgent concurrent:** A request for coverage of care or services made while an enrollee/member is in the process of receiving the requested care or services, even if there was not previous approval for the care.

**Post-service:** A request for coverage of care or services that have already been received.

In a situation beyond DWMHA, MCPN, Crisis Service Vendor’s control such as in the case of waiting for an evaluation by a specialist, the pre-service non-urgent and post-service timeframes may be extended once for up to 15 calendar days. If DWMHA, MCPN, or the Crisis Service Vendor requests the extension they must do it within 15 days of a pre-service request or 30 calendar days of a post-service request and must notify the member in writing within these timeframes of the need for an extension.

Revised 6.1.17
<table>
<thead>
<tr>
<th>ITEM</th>
<th>DESCRIPTION</th>
<th>CODE</th>
<th>HCPCS</th>
<th>COVERAGE</th>
<th>UNIT</th>
<th>PAYMENT</th>
<th>CODE</th>
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<th>COVERAGE</th>
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<th>CODE</th>
<th>HCPCS</th>
<th>COVERAGE</th>
<th>UNIT</th>
<th>PAYMENT</th>
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<tbody>
<tr>
<td>SUPPORTS INTENSITY SCALE (SIS) MI Health Link Population</td>
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</tbody>
</table>
**PHYSICIAN REVIEW**

### REFERRAL INFORMATION

<table>
<thead>
<tr>
<th>DWMHA Physician:</th>
<th>Member:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Date:</td>
<td>Medicare ID:</td>
</tr>
<tr>
<td>DWMHA UM Staff:</td>
<td>Medicaid IID:</td>
</tr>
<tr>
<td>Provider:</td>
<td>ICO:</td>
</tr>
<tr>
<td>Provider Phone:</td>
<td>Admission Date:</td>
</tr>
<tr>
<td>Attending Physician:</td>
<td>Last Authorized Date:</td>
</tr>
<tr>
<td>Attending Physician Phone:</td>
<td>Discharge Date:</td>
</tr>
</tbody>
</table>

**Materials Reviewed:** (include all medical documentation and information considered during the review, reference to any medical literature/research data used, health plan or other recognized criteria referred to, any prior determination, reports, etc.)

**Telephone Calls/Communication:** (include all telephone calls and other communications conducted or received from onset of review to completion between DWMHA physician and any other party regarding this case. Be sure to document findings issued verbally to the referring entity.)

<table>
<thead>
<tr>
<th>Date</th>
<th>Time/Zone</th>
<th>Person/Means of Contact</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Case Summary:**

**Findings/Opinions:** (include level of care reviewed, citation of specific criteria used, findings/opinions, rationale and alternative level of care; when appropriate. Must include 2-3 clinical reasons for findings of “no medical necessity”.)

Reasons for Denial **(drop down box)**
- Not a danger to self
- Not a danger to others
- Appears to be at baseline functioning
- Mental status is appropriate at this time
- No Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care at this time
### Approve Days
- Yes
- No

### Offered Provider Appeal:
- Yes
- No. Explain: i.e. documented review only.
- Not addressed per Member's instructions.
- N/A

### Advised Provider of Opinion:
- Yes
- No. Explain: i.e. documented review only.
- Not addressed per Member's instructions.
- N/A

### Quality of Care Issues:
- Yes. Describe:
- No. Explain: i.e. documented review only.
- Not addressed per Member's instructions.
- N/A

<table>
<thead>
<tr>
<th>Name and Credentials of DWMHA Physician Reviewer</th>
<th>Date</th>
</tr>
</thead>
</table>
# INDEPENDENT REVIEW ORGANIZATION REFERRAL REVIEW REQUEST FORM

<table>
<thead>
<tr>
<th>Case Priority:</th>
<th>Expedited</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee/Member Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrollee/Member’s Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOB:</td>
<td>Telephone Number:</td>
<td></td>
</tr>
<tr>
<td>Provider Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treating Physician Name and Credentials:</td>
<td>Telephone Number:</td>
<td></td>
</tr>
<tr>
<td>Name of Person responsible for filing the request:</td>
<td>Telephone Number:</td>
<td></td>
</tr>
<tr>
<td>Level and Type of Services in Dispute:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dates of Services in Dispute:</td>
<td></td>
<td></td>
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<tr>
<td>Type of Services Currently Authorized (if applicable):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dates of Services Currently Authorized (if applicable):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason for the IRO referral:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chronology of Care: (This should be a brief overview of the timeline of events in this case.)

| DWMHA Contact Person: DWMHA UM Appeal Coordinator | Telephone Number: 313-344-9099 ext. 3328  
Fax Number: 313-833-3670 |
IRO Physician Reviewer Documentation Form

Member’s Name:
Member’s Date of Birth:
Hospital Physician Name and Credentials:

Specific Question(s) to be answered:
Based on standards of care, your medical experience and evidence based literature:

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Reviewer’s Decision and Principal Reason(s) for Decision:

Deny services

Uphold denial of services

Overturn the denial of services

Modify the denial of services

Clinical Rational for Decision:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Evidence based References: (Provide a minimum of two (2) and a maximum of five (5) peer review CURRENT (within 3 years) medical references to support your opinion in this review.
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Page | 1
I certify that I have experience providing direct clinical care to patients within the past three (3) years that represent the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review; and have current, relevant experience and/or knowledge to render a determination for this case under review.

Physician Signature and Credentials: ________________________________
Date: _______________ Case tracking ____________________

When you complete the case, FAX your review to: 248-305-7093 Attention: Melody
MEMBER INFORMATION
Name: __________________________ Date of Birth: ______________ Medicare Id# __________________ Medicaid ID# ________________

PROVIDER INFORMATION
(For non-participating/non contracted providers)
Provider Organization: ________________________________________________ **DWMHA Contract ID #: _____________________________ (if known)
Provider Organization Address: __________________________ City, State, Zip Code: ______________ Tel.: ______________ Fax #: ______________
NPI # of Provider: __________________________ Tax ID # of Provider: __________________________
Location of Services provided (if different from above):
City, State, Zip Code: ____________________________________________________________________
Tel.: __________________________ Fax #: __________________________ NPI # of Provider: __________________________ Tax ID # of Provider: __________________________
• Name of Individual Provider rendering services: ____________________________ Professional Licensure/Credentials: ______________
• Name of Individual Provider rendering services: ____________________________ Professional Licensure/Credentials: ______________

DIAGNOSTIC INFORMATION
Type of Service Requested: □ Mental Health □ Substance Abuse □ Intellectual Development Disability
Behavioral DX (DSM 5 code and description, its successor or ICD 10):
Axis I (include All): __________/__________ Axis II: __________/__________ Axis III __________/__________ Axis IV: __________/__________
GAF: Current: __________ Highest in past 12 months __________
Medical Condition or Diagnosis 1. __________/__________ 2. __________/__________ 3. __________/__________
Summary: ___________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

TREATMENT HISTORY: (Please check all that apply)
Previous Treatment in the Past 12 months, excluding current course of treatment □ Mental Health □ Substance Abuse □ Both □ None □ Unknown
Treatment Level: □ Outpatient □ Partial/IOP □ Inpatient □ Residential □ Other____________________________________________
Locus Score (if applicable): __________________________ Date of LOCUS Assessment: __________________________
SIS Score (if applicable): __________________________ Date of SIS Assessment: __________________________
Outcome: □ Unknown □ Improved □ No Change □ Worse Treatment Compliance (non-medical): □ Unknown □ Poor □ Fair □ Good

CURRENT RISK ASSESSMENT: (Please check value for each type of risk)
Risk to Self: □ None □ Mild, ideations only □ Moderate, ideations w/EITHER plan or history of attempts □ Severe, ideations AND plan, w/either intent or means □ Not Assessed
Risk to Others: □ None □ Mild, ideations only □ Moderate, ideations w/EITHER plan or history of attempts □ Severe, ideations AND plan, w/either intent or means □ Not Assessed
Does the member have a behavioral health crisis management or safety plan? □ No □ Unknown □ Yes (Please provide date of plan): ____________
## CURRENT IMPAIRMENTS:
(Please circle one value for each)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Impairment</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>mild/mildly incapacitating</td>
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<tr>
<td>2</td>
<td>moderate/moderately incapacitating</td>
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<tr>
<td>3</td>
<td>severe/severely incapacitating</td>
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<tr>
<td>NA</td>
<td>not assessed</td>
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</tbody>
</table>

- **Mood Disturbance (Depressions or Mania)**: 0 1 2 3 N/A
- **Psychosis/Hallucinate/ Delusions**: 0 1 2 3 N/A
- **Impulsive/Reckless/Aggressive Behavior**: 0 1 2 3 N/A
- **Sleep Disturbance**: 0 1 2 3 N/A
- **Weight Change associated w/ Behavioral Diagnosis**: 0 1 2 3 N/A
- **Substance Abuse/Dependence**: 0 1 2 3 N/A
- **Social Relationship/Martial/Family Problems**: 0 1 2 3 N/A
- **Impulsive/Reckless/Aggressive Behavior**: 0 1 2 3 N/A
- **Activities of Daily Living Problems**: 0 1 2 3 N/A
- **Lack of Motivation/Pleasure**: 0 1 2 3 N/A
- **Gain/Loss of ___ pounds in the past 3 months**: N/A
- **Legal Problems**: 0 1 2 3 N/A
- **Gain/Loss of ___ pounds in the past 3 months**: N/A

## MEDICATIONS

**0=non-compliant  1=occasional use  2=uses most days  3=taken as prescribed**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose &amp; Frequency</th>
<th>Name of Prescriber</th>
<th>Purpose</th>
<th>Start Date</th>
<th>End Date (if applicable)</th>
<th>Compliance Rating</th>
</tr>
</thead>
</table>

**See Above**

## TREATMENT GOALS

- Behavioral/Cognitive Change
- Mood/Affect Change
- Environmental/Relationship Change
- Insight into Problems
- Other (specify)

## TREATMENT HISTORY & REQUEST FOR AUTHORIZATION

- DWMHA Initial Date of Service (In-Take): __________ Start Date: __________ End Date: __________
- CPT Code(s) Requested & Frequency of Each CPT Code: 1) ____________/ ____________ 2) ___________/ ____________ 3) ____________/ ____________

## CARE COORDINATION

- Mental Health: Yes ☐ No ☐ N/A
- Substance Use Disorder: Yes ☐ No ☐ N/A
- Physical Health: Yes ☐ No ☐ N/A
- Is treatment being coordinated with PCP? Yes ☐ No ☐ N/A
- Name of PCP: ___________________________ Address: ___________________________
- No ☐ If no please give reason: ___________________________

For Out-Patient Eating Disorders: Please provide documentation the treatment plan includes:
- Monitoring of target weight
- Rate of progress
- Member is receiving nutritional counseling by a trained Affiliated Provider

- Treating Affiliated Provider’s Signature with credentials: ___________________________ Date: ___________________________

*The above signature shall serve as an attestation that the information provided is accurate to best of provider’s knowledge; and services will be rendered as described above.

## For internal purposes only:

- Date of receipt: ___________________________ Logged by: ___________________________
- Request for additional information:
  - Clinical: ___________________________ Date of request: ________ Date of Receipt: ________
  - Administrative: ___________________________ Date of request: ________ Date of Receipt: ________

Please fax the completed OTR to (313)344-9035.

Questions or concerns please feel free to contact UM – Clinical Specialist at (313)344-9035.