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Policy Area:	*Utilization Management*
References:	*NCQA UM 2*

Behavioral Health Service Medical Necessity Criteria Policy

POLICY

It is the policy of the Detroit Wayne Mental Health Authority (DWMHA) to use objective and evidenced-based criteria/best practices, when available, taking into consideration the enrollee/member's individual circumstances and the local delivery system when determining the medical appropriateness of behavioral health care services. The DWMHA uses written criteria based on sound clinical evidence to make Utilization Management (UM) decisions, specified procedures for appropriately applying the criteria and to validate the appropriate level of care.

PURPOSE

The purpose of this policy is to ensure that medical necessity determination decisions are conducted using defined criteria and standardized service selection guidelines, and to ensure the criteria used is applied consistently by all staff making UM decisions.

APPLICATION

This policy applies to all DWMHA staff, Access Center staff, Contractual staff, Managers of Comprehensive Provider Network Services (MCPN) staff and 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. American Society of Addiction Medicine (ASAM)
2. Behavioral Health Supports and Services
3. Clinical Appropriateness
4. Evidence Based Practice
5. Indicia
6. Local Coverage Determination (LCD)

7. Level of Care
8. Medical Necessity Criteria
9. National Coverage Determination (NCD)
10. Utilization Management

STANDARDS

1. DWMHA has adopted nationally developed and published Behavioral Health guidelines from MCG which is part of the Hearst Health Network. MCG utilizes clinical editors who analyze and classify more than 100,000 peer reviewed papers and research studies each year. By applying rigorous evidence classification techniques, they select more than 25,000 unique references to formulate into medical necessity clinical guidelines. Nationally recognized quality measures from the Hospital Quality Alliance are also embedded in the guidelines. The clinical editors are supported by a team of data analysts, librarians, and medical copy editors who together have over 115 cumulative years of guideline development experience. In addition, the team coordinates peer reviews by panels that include approximately 100 additional clinicians.
2. The MCG Behavioral Health Medical Necessity Guidelines describe best practice care for the majority of mental health and substance related disorder diagnosis, covering 15 diagnostic groups with graded evidence from published resources. Some of the best known resources include the American Psychiatric Association, the American Association of Pediatrics, the American Society of Addiction Medicine, the National Institute on Alcohol Abuse and Alcoholism and the Local and National Coverage Determination criteria due to their acceptance as the best of evidence-based/best practice and emerging practice for mental health and substance use disorders. This criteria then serves as a decision support tool to help define the most appropriate treatment setting and help assure consistency of care for each individual. DWMHA believes it's criteria should be transparent and available to everyone and be flexible enough to continuously adapt to the changes in mental health and substance use disorder treatment systems.
3. MCG Behavioral Health Criteria, 21st Edition includes the following:
    a. 27 Guidelines that help identify the most effective level of care for specific behavioral health conditions; and
    b. Level of care guidelines that assess an enrollee/member's level of care needs in situations where a diagnosis-specific guideline does not apply, including crisis intervention and observation; and
    c. Therapeutic and Testing Procedures that provide specific criteria for determining when a procedure, treatment or diagnostic test may be indicated; and
    d. Detailed discharge criteria that focus on specific care elements to consider when discharging an enrollee/member to a lower level of care; and
    e. Flexible recovery courses to manage longer behavioral health episodes; and
    f. Alternate care planning to help with select alternative therapies and level of care based on specifics of enrollee/member's case.
    g. MCG also includes key care management tools such as psychosocial, ADL and home safety assessments, teach back, transition of care, Clinical opiate withdrawal scale and medication reconciliation tools.
4. For MI Health Link enrollees/members, the National Coverage Determination (NCD) criteria developed by the Centers for Medicare and Medicaid Services (CMS) is utilized. If no NCD has been issued or an NCD

requires further clarification, a Local Coverage Determination (LCD) is used. LCD's are developed by the Medicare Administrative Contractor for the geographic service area and either supplements or explains when an item or service will be covered if there is no NCD. In addition, the CMS Coverage Manual or other CMS based resources such as the Medicare Program Integrity and Medicare Benefit manuals are used to determine coverage provisions for this population. In coverage situations where there is no NCD or LCD or guidance on coverage in the original Medicare manuals, DWMHA may make its own coverage determination utilizing the MCG criteria or send out to an Independent Review Entity and provide rationale for using an objective evidence based process. Communication will also be sent to the Medicare Administrative Contractor to be addressed.

5. DWMHA has adopted nationally developed and published criteria from the American Society of Addiction Medicine (ASAM) to determine medical necessity and level of care decisions for substance use disorders (SUD). This criteria has become the most widely used and comprehensive of guidelines for placement, continued stay, and transfer/discharge of enrollee/members with addiction and co-occuring conditions. ASAM's criteria provide separate placement criteria for adolescents and adults developed through a multidimensional assessment over five (5) broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety, and security provided and the intensity of treatment services provided. It uses six (6) dimensions including Acute Intoxication and/or Withdrawal Potential, Biomedical Conditions and Complications, Emotional/ Behavioral Conditions, Treatment/ Acceptance/Resistance, Relapse/Continued Use Potential and Recovery Environment to create a holistic assessment of an individual to be used for service planning and treatment across all service and levels of care. Through this strength-based multidimensional assessment, the ASAM criteria addresses the individual's needs and obstacles as well as their strengths, assets, resources and support structure. The website https://ASAM.org , and the attached Level of Care Grid further describe the medical necessity criteria. The ASAM Criteria, Third Edition, is copyrighted and only available in hardcopy but can be purchased by contacting:
American Society of Addiction Medicine 4601 North Park Ave
Upper Arcade Suite 101
Chevy Chase, MD 20815
Telephone: 301-656-3920 Fax: 301-656-3815
Email: email@asam.org
6. Oversight and revision of the criteria is collaborative between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria. The coalition represents major stakeholders in addiction treatment and has been meeting regularly since the development of the first ASAM Patient Placement Criteria in 1991. The coalition addresses feedback and ensures that the Criteria adequately serves and supports medical professionals, employers purchasers and providers of care in both the public and private sectors.
7. The following services must receive a clinical review and application of medical necessity criteria prior to the service being rendered:
    a. Acute inpatient; or
    b. Partial hospitalization; or
    c. Crisis residential.
    d. For the MI Health Link enrollees/members, DWMHA also requires a prior clinical review and application of medical necessity for:
        1. psychological testing;

2. neuropsychological testing;
3. both outpatient and inpatient electroconvulsive treatment (ECT).

8. The MCG Behavioral Health Medical Necessity Criteria and DWMHA's procedures for application is reviewed at least annually. MCG annual updates are based on the most current research, relevant quality standards and evidence-based/best practice, and emerging practice models of care. As noted above, in the event there are changes to the National Coverage Determination Criteria or the Local Coverage criteria (LCD/NCD criteria), these changes are reviewed as they occur or at a minimum, annually.
9. Any updates to the MCG, ASAM or LCD/NCD criteria will be reviewed and shared with the applicable clinicians and/or committees or professional work groups as applicable:
    a. Practice Collaboratives such as with the Manager of Comprehensive Provider Network's (MCPN's) for Intellectual/Developmental Disabilities (I/DD), Serious Mental Illness (SMI), and Serious Emotional Disturbance (SED); and
    b. Quarterly Tri-County Medical Director meetings; and
    c. Bi-monthly MCPN/Provider partnership meetings; and
    d. DWMHA Improving Practices Leadership Team (IPLT) Meetings.
10. Once approved by the Chief Medical Officer, and reviewed by the applicable practitioner/provider groups in #9, DWMHA requires the Access Center, MCPN's, and screening entities using MCG Indicia software to have at least one machine installed with the online version of the MCG Behavioral Health guidelines and make it accessible to all clinical practitioners during hours of operation. DWMHA makes the most current version of the personal computer (PC) software of the Behavioral Health Medical Necessity Guidelines available for download at the time of initial distribution through various means such as: secured Google drive, or removable media such as a flash drive or DVD thus allowing access to the criteria in the event of a mass or individual internet outage or for contracted practitioners/providers without internet access. Notification is emailed, mailed, or faxed to all contracted practitioners/providers using Indicia advising them when the criteria or updates to the criteria are available.
11. Since the MCG Behavioral Health Medical Necessity Guidelines are proprietary, access to the entire criteria is limited to the DWMHA provider network. Specific criteria related to an individual case is available by request to non-contracted providers/practitioners and enrollee/members as noted in #28 below. A log in and password can be obtained from the MCPNs or the DWMHA UM Department. The URL to the Behavioral Health MCG Medical Necessity criteria is https:/cgi.careguidelines.com/login-careweb.htm DWMHA mails the criteria to practitioners without Internet access.
12. All staff making utilization management decisions receive formal initial and annual training on the criteria. However, additional training is provided whenever updates occur. Staff are also able to access MCG web seminars on a variety of behavioral health utilization management and quality assurance topics on demand. (See MCG training)
13. The determination of a medically necessary support, service or treatment must be:
    a. Based on information provided by the enrollee/member, the enrollee/member’s family, and/or other individuals (e.g., friends, personal assistants/aides) who know the individual; and
    b. Based on clinical information from the enrollee/member’s health care professionals with relevant qualifications who have evaluated the member; and
    c. For enrollee/;members with mental illness or intellectual developmental disabilities, based on person centered planning; and for members with substance use disorders, based on individualized treatment

planning; and

d. Made by appropriately educated, trained and licensed mental health, substance abuse and/or intellectual and/or developmental disabilities professionals such as a Qualified Mental Health Professional (QMHP) and/or a Qualified Intellectual Disability Professional (QIDP).

14. Medical necessity review is a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the enrollee/member's circumstances, relative to appropriate clinical criteria and DWMHA's policies.
15. Decisions about the following require medical necessity review:
    a. Covered medical benefits defined by DWMHA's certificate of coverage or summary of benefits; or
    b. Preexisting conditions, when the enrollee/member has creditable coverage and if there exists a policy to deny preexisting care or services; or
    c. Care or services whose coverage depends on specific circumstances; or
    d. Out-of-Network services when they may be covered in clinically appropriate situations; or
    e. Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program; or
    f. Experimental or investigational requests, unless the requested services or procedures are specifically excluded from the benefits plan and deemed never medically necessary under any circumstance in DWMHA's policies,then medical necessity review is not required.
16. Decisions about the following do not require medical necessity review:
    a. Services in the enrollee/member's benefits plan that are limited by number, duration or frequency; or
    b. Extension of treatments beyond the specific limitations and restrictions imposed by the enrollee/member's benefits plan; or
    c. Care that does not depend on any circumstances.
17. DWMHA believes that all treatment decisions made in alignment with the MCG Behavioral Health Criteria must be first and foremost clinically based. Care must be patient-centered and take into account the enrollee/member's needs, clinical and environmental factors, and personal values. The MCG Behavioral Health Criteria do not replace clinical judgment, and every treatment decision must allow for the consideration of the unique situation of the individual. In this way, the Criteria promote advocacy for the enrollee/member and enhance the collaboration between DWMHA and providers to achieve optimal, patient-centered outcomes. They also promote consistent communication and coordination of care from one treatment setting to the next.
18. For urgent pre-service and concurrent adverse determination notices when an enrollee/member is hospitalized, the UM staff will inform the hospital UM department staff of its decision, with the understanding that they will inform the attending/treating practitioner. Written notification of the adverse determination is addressed to both the hospital UM department and the attending/treating practitioner.
19. Using the medical necessity criteria, appropriate professionals identified in #15 below may deny services that are:
    a. Deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
    b. Experimental or investigational in nature; or

c. For which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services.

20. Physicians may not deny services based solely on pre-set limits of the cost, amount, scope and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis applying clinical appropriateness.
21. A denial of service can only be made by a physician (DO or MD) or certified addiction medicine specialist physician.
22. Staff performing pre-admission reviews and/or utilization management functions pertaining to prior authorized services including initial/continuous reviews, appeals, and denials, must be credentialed and re-credentialed. The credentialing process defined by the DWMHA ensures that staff making UM decisions meet at least Michigan Department of Health and Human Services (MDHHS) licensing, training and scope of practice, as well as contractual and Michigan Medicaid Provider Manual requirements.
23. Only highly qualified clinicians (MD, DO, PhD, PsyD, LPC, LMSW, LMFT, LLP, MSN, Psychology BA, Nurse Practitioner (NP) and BSN) who have demonstrated experience in the specialty areas in which they are making decisions may initiate and carry out UM review functions.
24. Clinicians authorizing Substance Use Disorder services are required to have:
    a. A minimum of a Bachelor's degree in Social Work, Psychology, Sociology, or related human services area; and
    b. A minimum of three (3) years working in a human services organization; and
    c. A certification as a Certified Addiction Drug Counselor (CADC);or a certification as a Certified Advanced Addiction Drug Counselor (CAADC). If not certified, have an active development plan of a duration no longer than three (3) years approved by Michigan Certification for Addiction Professionals (MCBAP); or
    d. Be certified as a Qualified Mental Health Professional (QMHP) with a CADC or CAADC or a development plan approved by the Michigan Certification for Addiction Professionals (MCBAP).
25. Due to a potential conflict of interest, practitioners may not provide direct services; including crisis intervention, for the persons they are screening for pre-admission (pre-service), concurrent and/or retrospective (post- service) reviews or appeal reviews.
26. A UM Reviewer must also be credentialed and re-credentialed as a Qualified Mental Health Professional (QMHP) or Qualified Intellectual Disability Professional (QIDP) if authorizing those populations in order to be certified to complete the UM review functions.
27. When applying the criteria, UM Reviewers shall consider the characteristics of the local delivery system that are available to the member, such as the availability of alternative levels of care; highly specialized services, recommended services within the estimated length of stay and the benefit plan coverage options.
28. When applying the medical necessity criteria, UM Reviewers shall ensure that treatment is provided at the most appropriate, least restrictive level of care necessary to provide safe and effective treatment and meets the enrollee/member’s individual needs. Consideration is given to at least the following individual characteristics when applying the medical necessity criteria: age, comorbidities, complications, progress of treatment, psychosocial situations, available services in the local delivery system and home environment, as applicable.
29. DWMHA shall provide its medical necessity criteria to the Access Center, the Crisis Service Vendor,

Screening Entities, MCPNs, Practitioners/Providers, ICOs, enrollees/members and other stakeholders upon request free of charge. Criteria can be requested to be provided by email, fax, mail, in person or by telephone. A log will be kept of any instances of request. The medical necessity criteria and clinical protocols are compliant with contractual and regulatory requirements of font (at least 12 point type size) and available in alternative mediums such as larger font (at least 16 point font), Braille, or audio format.

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 Quality Assessment Performance Improvement Program (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. An Inter-Rater Reliability case review test is conducted by all DWMHA, Crisis Service Vendor and MCPN staff making UM decisions to ensure consistent application of medical necessity criteria and appropriate level of care decisions.
4. Annually, the DWMHA UM Director or his/her designee identifies applicable vignettes from the Inter-Rater Reliability Indicia MCG module to assess Inter-Rater Reliability system wide based on the types of review the UM staff performs.
    a. All DWMHA, Crisis Service Vendor and MCPN staff performing UM functions must review the vignettes and select the appropriate level of care by applying the MCG and NCD or LCD Utilization Management Criteria.
    b. The MCG module immediately generates a compliance report which includes the test scores for each staff person and an item response analysis and detailed assessment report that pinpoints any areas the staff need additional training in.
    c. It is the expectation of DWMHA that staff meet or exceed a score of 90%.
    d. In the event that a staff person does not meet or exceed the 90% threshold, a corrective action plan which may include such activities as face-to-face supervision, coaching and/or education and re-training is implemented with the expectation that the staff person pass at the next Inter-Rater Reliability case review test.
5. One additional re-test will be given within thirty (30) days of the initial Inter-Rater Reliability care review test.
    a. It is the expectation of DWMHA that the staff person meet or exceed a score of 90%.
    b. In the event that the staff person does not meet or exceed the 90% threshold for a second time, he/she will be subject to a transfer to a role outside the UM Department or termination.
6. The results of the Inter-Rater Reliability case review tests 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 utilization management functions shall be trained at least annually on the MCG and LCD or NCD Utilization Management Criteria.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWMHA 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 2016-2018
2. MDHHS and DWMHA Contract, October 1, 2016.
3. Michigan Medicaid Provider Manual, Version Dated April 1, 2017
4. Contract for Medicare and 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. Behavioral Health Utilization Management Review Policy
3. Denial of Service Policy
4. Inter Rater Reliability Policy
5. Customer Service Member Appeal Policy
6. Standard of Conduct Policy
7. Utilization Management/Provider Appeal 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

Yes

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

ASAM Levels of Care for SUD attachment to

Med Necessity.pdf
Procedure Training Opportunities and Use of MCG Behavioral Health Guidelines revised 1.25.2018.docx
UM Review Procedure for Substance Use Disorders.pdf
Use of MCG Indicia for Case Management Software and Behavioral Health Guidelines Supporting Medical Necessity.pdf

Approval Signatures

Approver	Date
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Dana Lasenby: Deputy Chief Operating Officer [AS]	05/2017
Allison Smith: Project Manager, PMP	05/2017
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Muddasar Tawakkul: Director of Compliance/Purchasing [AS]	04/2017
Tracey Lee: Director Claims Management [AS]	04/2017
Bessie Tetteh: CIO	03/2017
Kip Kliber: Director, Recipient Rights	03/2017
Darlene Owens: Director, Substance Use Disorders, Initiatives	03/2017
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Levels of Care: Adolescents and Adults

Though the intensity of treatment is often split into "levels" of care, these levels connect to each other, acting more like "benchmarks" along a single spectrum. Patients can move between levels, depending on their unique needs. ASAM also uses separate criteria and levels of care benchmarks for adult patients and adolescent patients. This is because adolescents can be in different stages of emotional, mental, physical, and social development than adults. For this reason, certain adolescent services, such as withdrawal management, are bundled together with the rest of their treatment, whereas adults are able to enter into withdrawal management treatment separately.

Benchmark Levels of Care for Adolescents and Adults

Level of Care	Adolescent Title	Adult Title	Description
0.5	Early Intervention		Assessment and education
OTP (Level 1)	*Not specified for adolescents	Opioid Treatment Program	Daily or several times weekly opioid medication and counseling available
1	Outpatient Services		Adult: Less than 9 hours of service per week Adolescent: Less than 6 hours of service per week
2.1	Intensive Outpatient Services		Adult: More than 9 hours of service per week Adolescent: More than 6 hours of service per week
2.5	Partial Hospitalization Services		20 or more hours of service per week
3.1	Clinically Managed Low-intensity Residential Services		24-hour structure with available personnel, at least 5 hours of clinical service per week
3.3	*Not available because all adolescent levels attend to cognitive/ other impairments	Clinically Managed Population-specific High-intensity Residential Services	24-hour care with trained counselors, less intense environment and treatment for those with cognitive and other impairments
3.5	Clinically Managed Medium-intensity Residential Services	Clinically Managed High-intensity Residential Services	24-hour care with trained counselors
3.7	Medically Monitored High-intensity Inpatient Services	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability, 16 hour per day counselor availability
4	Medically Managed Intensive Inpatient Services		24-hour nursing care and daily physician care, counseling available

Benchmark Withdrawal Management Levels of Care for Adults

Level of Withdrawal Management for Adults	Level	Description
Ambulatory Withdrawal Management without Extended On-site Monitoring (Outpatient Withdrawal Management)	1-WM	Mild withdrawal
Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management)	2-WM	Moderate withdrawal
Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)	3.2-WM	Moderate withdrawal requiring 24-hour support
Medically Monitored Inpatient Withdrawal Management	3.7-WM	Severe withdrawal requiring 24-hour nursing care, physician visits as needed
Medically Managed Intensive Inpatient Withdrawal Management	4-WM	Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits

The following information cannot be used as a distillation of the full principles, concepts and processes within *The ASAM Criteria*. Many elements of a clinical decision are extremely abbreviated here and many parts of the decision-making process have been excluded for ease of patient understanding. This is not a clinical document.

Example Chart for Adult Levels of Care

Level of Care	Dimension 1	Dimension 2	Dimension 3	Dimension 4	Dimension 5	Dimension 6
Level 0.5	No withdrawal risk	None, or stable	None, or stable	Willing to explore how use affects personal goals	Needs understanding or skills to change current use or high-risk behavior	Environment increases risk of use
OTP - Level 1	Physiological dependence needing OTP	None, or manageable	None, or manageable	Ready to change, but not ready for total abstinence	At risk of continued use without OTP	Supportive environment, patient has coping skills
Level 1	No significant withdrawal, minimal risk of severe withdrawal	None, or stable	None, or stable	Ready for recovery, needs strategies to strengthen readiness	Able to maintain abstinence or control use with minimal support	Supportive environment, patient has coping skills
Level 2.1	Minimal risk of severe withdrawal	None, or not distracting	Mild severity	Variable treatment engagement, requires structured program	High likelihood of relapse without close monitoring and support	Unsupportive environment, patient has coping skills
Level 2.5	Moderate risk of severe withdrawal	None, or not distracting	Mild to moderate severity	Poor treatment engagement, needs near-daily structured program	High likelihood of relapse without near-daily monitoring and support	Unsupportive environment, cope with structure and support
Level 3.1	No withdrawal risk, or minimal or stable withdrawal	None, or stable	None or minimal	Open to recovery, needs structured environment	Understands relapse, needs structure	Dangerous environment, 24-hour structure needed
Level 3.3	Minimal risk of severe withdrawal, manageable withdrawal	None, or stable	Mild to moderate	Needs interventions to engage and stay in treatment	Needs intervention to prevent relapse	Dangerous environment, 24-structure needed
Level 3.5	Minimal severe withdrawal risk, manageable withdrawal	None, or stable	24-hour setting for stabilization	Has significant difficulty with treatment, with negative consequences	Needs skills to prevent continued use	Dangerous environment, highly structured 24-hour setting needed
Level 3.7	High withdrawal risk, manageable withdrawal risk	Requires 24-hour medical monitoring	Moderate severity, requires 24-hour structured setting	Low interest in treatment, needs motivational strategies in 24-hour structured setting	Challenges controlling use at less intensive care levels	Dangerous environment
Level 4	High withdrawal risk requiring full hospital resources	Requires 24-hour medical and nursing care, requiring hospital resources	Severe or unstable challenges	Challenges here do not grant admission	Challenges here do not grant admission	Challenges here do not grant admission

The following information cannot be used as a distillation of the full principles, concepts and processes within *The ASAM Criteria*. Many elements of a clinical decision are extremely abbreviated here and many parts of the decision-making process have been excluded for ease of patient understanding. This is not a clinical document.

Example Chart for Adolescent Levels of Care

Level of Care	Dimension 1	Dimension 2	Dimension 3	Dimension 4	Dimension 5	Dimension 6
Level 0.5	No withdrawal risk	None, or stable	None, or very stable	Willing to explore how use affects personal goals	Needs understanding or skills to change current use or high-risk behavior	Environment includes people with high-risk behaviors
Level 1	No withdrawal risk	None, or stable	No risk of harm	Willing to engage in treatment, needs motivating and monitoring strategies	Able to maintain abstinence or control use with minimal support	Environment supportive with limited assistance
Level 2.1	Minimal withdrawal, or at risk of withdrawal	None, or stable, not distracting	Low risk of harm, safe between sessions	Needs close monitoring and support several times a week	High risk of relapse, needs close monitoring and support	Needs close monitoring and support
Level 2.5	Mild withdrawal, or at risk of withdrawal	None, or stable, not distracting	Low risk of harm, safe overnight	Requires near-daily structured program to promote progress	High risk of relapse, needs near-daily monitoring and support	Needs near-daily monitoring and support
Level 3.1	Withdrawal or risk of withdrawal managed at another level	None, or stable, receiving medical monitoring	Need stable living environment	Open to recovery, needs limited 24-hour supervision	Understands relapse potential, needs supervision	Needs alternative secure housing placement or support
Level 3.5	Mild to moderate withdrawal, or at risk, not requiring frequent management/monitoring	None, or stable, receiving medical monitoring	Medium-intensity 24-hour monitoring or treatment	Needs intensive motivating strategies in 24-hour structured program	Needs 24-hour structured program	Needs residential treatment to promote recovery
Level 3.7	Moderate to severe withdrawal, or at risk	Requires 24-hour medical monitoring	High-intensity 24-hour monitoring or treatment	Needs motivating strategies in 24-hour medically monitored program	Needs high-intensity 24-hour interventions	Needs residential treatment to promote recovery
Level 4	Severe withdrawal, or at risk, requiring intensive active medical management	Requires 24-hour medical and nursing care, requiring hospital resources	Severe risk of harm	Challenges here do not grant admission	Challenges here do not grant admission	Challenges here do not grant admission

	Procedure Title: Training Opportunities and Use of MCG Evidenced Based Behavioral Health Guidelines, including Indicia
	Procedure Origination Date: February 7, 2017
	Procedure Revision Date: January 26, 2018
	Procedure Owner: Jennifer Miller
	Department: Utilization Management
	Line of Business: ALL
	Regulatory Requirements: NCQA UM 1, UM2, MDHHS, CMS
	Associated Policy: Behavioral Health Medical Necessity Criteria Policy

OVERVIEW

Procedure Purpose: To provide all users procedural and operational guidance to access, review and utilize the MCG Behavioral Health (BH) Care Guidelines, including the educational opportunities available from MCG regarding the BH guidelines and other available MCG training.

A separate procedure will address the Use of the software solution called Indicia for Case Management. Indicia allows you to apply the BH Guidelines to a consumer specific treatment episode and apply clinical criteria that supports medically necessary services and track an episode of care. DWMHA will utilize Indicia for **inpatient hospitalizations, partial hospital, and intensive crisis residential services**.

The Behavioral Health Guidelines replace previously published medical necessity criteria and describe best practices for mental health and substance related disorders, covering 15 diagnostic groups. The Guidelines include Level of Care Guidelines for both Adults and Children and Adolescents including inpatient, residential, partial hospital, intensive outpatient, outpatient, crisis intervention, and Observation. In addition to the Levels of Care described above, therapeutic and testing procedure criteria are available for treatment modalities such as applied behavioral analysis, Assertive Community Treatment, Bright Light Therapy, and Electroconvulsive therapy. Although not in DWMHA's Lines of business, there are Guidelines for Home Care and Recovery Facilities. Benchmarking Data are also available within the BH Guidelines.

Expected Outcome: DWMHA staff, Crisis Screening Entities, Managers of Comprehensive Provider Networks (MCPNS) and DWMHA staff will understand how to access the MCG Behavioral Health Guidelines and reference them to assist in managing a consumer's care. Although, the behavioral health guidelines cover many levels of care, the Indicia software will be used as a decision support tool to substantiate inpatient hospitalizations, partial hospitalizations and intensive crisis residential services. Indicia will also be used to assess appropriateness of some therapeutic or testing procedures for the MI Health Link population.

References:

A summary of the guideline development policies and procedures is included in the Methodology Information section on the home page of the Behavioral Health Care guidelines and is available to all users.

Click on BHG (Behavioral Health Guidelines) at **https://cgi.careguidelines.com/login-careweb.htm** for the Static Web Guidelines. This site offers MCG research based Guidelines in a read-only electronic encyclopedia format. Information can be reviewed, copied and pasted to other destinations, and is used during the first step in the MCG training plan. Only one account is required as the same username and password can be used simultaneously by many users.

URL: http://cgi.careguidelines.com/login-careweb.htm Contact DWMHA for universal user ID and passwords

Neither MCG nor its employees accept any funding or remuneration from outside sources to support or influence guideline development. All participants in the guideline development and outside review processes complete conflict of Interest statements. Any identified conflicts are addressed.

KEYWORDS

1. **Behavioral Healthcare Guidelines**
2. **Indicia for Case Management –**
3. **Training**

PROCEDURE

1. Users can receive training and an overview of the Behavioral Health guidelines from MCG in a variety of ways described below. The available trainings will benefit all levels of users. The static BH guidelines (also referred to the encyclopedic version) are available at the link listed above and will also be made available to Crisis Screening Entities, MCPNs, and Access Center in a CD-ROM format or other removable media format such as a flash drive. Although the guidelines are web-based, DWMHA makes the most recent version of the Behavioral Health guidelines available for installation on a personal computer or server to be available as a backup in the event of an internet outage or system failure.
2. Front end users that will enter member data in Indicia for hospitalizations and other levels of care, will receive additional training for use of the interactive software, Indicia. The Behavioral Health guidelines can be accessed within the Indicia software or in the stand-alone static version.

TRAINING OPPORTUNITIES

The following are learning opportunities for users of the static MCG Behavioral Health Guidelines and also the software Indicia for Case Management. The primary methods for receiving training on the BH guidelines are listed below:

A. **Standard Web Seminars** - Web seminars (MCG EScholar Webinar Training) are open to all licensed clients. Offered on a recurring basis, they provide instructor-led basic training on core fundamentals for all MCG clinical content solutions. These sessions are didactic in their approach, are up to two hours in duration. Register through the mcg.com website and/or online

at**: https://www training mcg com**. Note: You must list DWMHA as Company Name in the online registration.

Current available sessions applicable to DWMHA offered and repeated on a **monthly** basis include: **BH Guidelines and Inter-Rater Reliability Module, Summary of Changes: Indicia 9.0 and 21st Edition Content**

B. **On Demand Training (Learning Management System (LMS)) -** includes a series of self-paced modules that deliver comprehensive basic training on MCG content and software solutions. There are some knowledge checks (questions/answers) following some of the modules. Current offerings applicable to DWMHA: **Introduction to MCG** and **Behavioral Health Care**. Each user will receive an email after their LMS account has been created.

DWMHA must be notified of each new user in order for MCG to create a LMS user account. First name, Last Name, Email address, Office phone, Supervisor's email address are required.

The URL for the Learning Management System is: ***https//learn.mcg.com***

The username can only contain alphanumeric lowercase characters (letters and numbers), underscore (_), hyphen (-), period (.) or at symbol (@). Once registered the system will generate a password and email the user. Example: bjones@dwmha.com

The BH Care Training Plan consists of the following modules:

- Introduction to MCG –
- Behavioral Health Care Introduction
- General Recovery Care
- Getting Started
- Summary of Changes
- Physician Lead Webinars

In addition to the topics listed above, The Learning Management System also has Job Aids that can be accessed under the **My Learning** Icon in the LMS system. The job aides can be accessed within the above modules. The LMS system will also be used to test users in vignettes to ensure Inter-Rater Reliability. (IRR) The LMS system has a comprehensive IRR module within the LMS system including on-line tutorials.

C. **Physician Leader Webinars** - These web seminars are designed for medical directors and other clinicians who use MCG solutions. As a licensed client of MCG, DWMHA staff and subcontractors are free to attend any/all of the Physician Leader Webinar series. However, the applicability of each session topic may vary for you and your staff, as each month focuses on a unique topic. MCG physician editors and education staff are available to answer questions about the use of the guidelines in daily medical management processes.

DWMHA license is for Indicia for Case Management & Behavioral Health Care as well as the Interrater Reliability module.

Register online at: **https://www mcg com/client resources/education training/physician** leader-webinar/

D. Customized Web-based and Customized On-site Training and Train-the Trainer training are available on request.

E. Training will be provided annually for all staff performing UM functions. Any enhancements or product development including updated guidelines will be addressed at this time. MCG updates the guidelines in February of each year and training will be held no later than 60-90 days after the release. Additionally, all staff performing UM functions, will be required to complete Inter-Rater Reliability case reviews, via the MCG module on an annual basis to ensure consistent application of medical necessity criteria and appropriate level of care decisions. Staff not achieving a satisfactory score will be required to complete a corrective action plan which may include additional training.

PROCEDURE MONITORING & STEPS

Who monitors this procedure:	UM Clinical Specialist Supervisor
Department:	Utilization Management
Frequency of monitoring:	Ongoing
Reporting provided to:	Director, UM, UMC
Regulatory Requirements(s):	NCQA UM 1, UM2, MDHHS, CMS

COMMENTS: Course completion and pre and post test scores will be monitored as applicable.

Origination:	*07/2017*
Last Approved:	*07/2017*
Last Revised:	*07/2017*
Next Review:	*07/2018*
Owner:	*Jennifer Miller: UM Clinical Specialist Supervisor*
Policy Area:	*Utilization Management*
References:	

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:

- Early Intervention- Level 0.5
- Outpatient - Level 1
- Intensive Outpatient -Level 2.1
- Partial Hospital Level 2.5
- Clinically Managed Low Intensity Residential Services Level 3.1
- Clinically Managed Population Specific High Intensity Residential Level 3.3
- Clinically Managed High Intensity Residential Services (Adult) 3.5
- Clinically Managed High Intensity Residential Services (Adolescent) 3.5
- Medically Monitored Intensive Inpatient (Adult) 3.7
- Medically Monitored Intensive Inpatient (Adolescent) 3.7
- Medically Managed Intensive Inpatient Services Level 4
- Opioid Treatment Services

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

- Planning for My Future Recovery Plan(for Recovery Services)(if applicable); and
- Evidence of Coordination of Care (Medication Assisted Treatment (if applicable); and
- Clinical Institute Withdrawal Assessment for Alcohol (CIWA) or Clinical Opiate Withdrawal Scale (COWS) (if applicable); and
- Medication Automated Prescribing System (MAPS); and
- Medical Marijuana Card.

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

Who monitors this procedure:	Clinical Specialist, UM Supervisor or Designee
Department:	Utilization Management
Frequency of monitoring:	Quarterly

Reporting provided to:	Director of Utilization Management
Regulatory Requirements: Medicaid Managed Specialty Supports and Services Program FY 16 Contract	

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

Approver	Date
Maha Sulaiman	07/2017
Jennifer Miller: UM Clinical Specialist Supervisor	07/2017

Origination:	*03/2017*
Last Approved:	*07/2017*
Last Revised:	*07/2017*
Next Review:	*07/2018*
Owner:	*Jennifer Miller: UM Clinical Specialist Supervisor*
Policy Area:	*Utilization Management*
References:	*NCQA UM 2*

Use of MCG Indicia for Case Management Software and Behavioral Health Guidelines Supporting Medical Necessity

PROCEDURE PURPOSE

Indicia for Case Management is a tool that will be used for real time screening and prior to authorization of the following services:

1. Inpatient hospitalization
2. Partial hospitalization
3. Intensive Crisis Residential

This procedure will provide operational guidance to utilize the MCG Behavioral Health Care Guidelines and the interactive software tool, Indicia for Case Management. Indicia allows you to apply the BH Guidelines to a consumer specific treatment episode and apply clinical criteria that supports medically necessary services. Users will search for a guideline, select an appropriate guideline, determine appropriateness of admission, apply and track a recovery course, concluding with entry of a discharge date.

There are two URLs or web addresses for Indicia. One is for Test /Training and is initially used for set-up, testing and training. One is for Production / Live and is used for documenting real cases after Go LIVE**.** The initial name and user passwords are set-up by your system administrator. The web addresses are as follows:

Test URL:	https://dwmhaicmtest.carewebqi.com
Prod URL:	https://dwmhaicm.carewebqi.com

EXPECTED OUTCOME

Front end users including DWMHA, Screening Entities, the MCPNs, and any other contractor or subcontractor authorizing the above services will understand how to access Case Management for Indicia and apply the MCG Behavioral Health Guidelines to assist in managing a consumer encounter/episode of care.

In addition to the above Levels of Care, DWMHA requires MI Health Link consumers to receive prior authorization and substantiate medical necessity for psychological testing, neuropsychological testing and electroconvulsive therapy (both inpatient and outpatient). These therapeutic and testing procedures are within the Behavioral Health Guidelines of Indicia. DWMHA MI Health Link reviewers will utilize Indicia to assist them

in determining appropriateness of requests for authorization of these services.

PROCEDURE

1. A summary of the guideline development policies and procedures is included in the Methodology Information section on the home page of the Behavioral Health Care guidelines and is available to all users. Click on BHG (Behavioral Health Guidelines) at **http://cgi.careguidelines.com/login-careweb.htm. Contact DWMHA for user IDs and passwords.**
2. Please reference the procedure Tr**aining Opportunities and use of MCG Behavioral Health Guidelines Supporting Medical Necessity** for a full description of available training for both users of the static guidelines and Indicia software.
3. In addition to resources referenced in the Training procedure there are Job Aides for use of the Behavioral Health Care Guidelines and for use of Indicia in the On Demand Training System at **http://learn.careguidelines.com/client,** Under the Resource Library, in the Learning Management System, the following Job Aides are available for Behavioral Health Care. They are also an attachment to this procedure. Those in **bold print** will assist Indicia Users.
    a. Introduction to MCG
    b. Introduction to Behavioral Health Care
    c. MCG- Searching the Care Guidelines Software
    d. **Applying the Level of Care Guidelines**
    e. **Applying the Admission Content**
    f. Diagnosis Based-Managing the Inpatient Level of Care: Extended Stay
    g. **Diagnosed Based – Managing the Inpatient Level of Care: Optimal Recovery Course**
    h. **Applying the Treatment Course for Non-inpatient Levels of Care**
    i. Behavioral Health Levels of Care
    j. Discharge Planning Resources
    k. Utilizing Care Management Tools
    l. **Behavioral Health Care - The Basics**
4. For users entering consumers and encounters in Indicia for Case Management the key steps are included in the Behavioral Health Care - the Basics Job Aide and Include:
    a. Determining Appropriateness of Admission (Entering Clinical Indications for Admission),
    b. Charting the Optimal Recovery Course, via continued stay reviews, and
    c. Entering the discharge date when treatment has been completed

PROCEDURE MONITORING & STEPS

Note: The steps explained below may vary slightly based on development of the API interface.

1. All Users of the MCG Indicia for Case Management software, including DWMHA Staff, Crisis Screening Entities, MCPNs and other subcontractors approving authorization for levels of care described) will receive training and an overview of the Behavioral Health guidelines and use of Indicia to enter client specific encounters into Indicia.

2. DWMHA requires the above users and organizations to have at least one machine installed with the offline version of the MCG Behavioral Health Guidelines and make it accessible to all clinical practitioners during hours of operation. The guidelines can then be accessed if there is a mass internet or provider outage.
3. The Indicia software allows organizations to personalize their workflow. Some of the following Options are available for completion: Clinical Indications for Admission, Alternatives to Admission, Hospitalization and Treatment, Optimal Recovery Course, Goal Length of Stay and Extended Stay (Inpatient Only) Care Planning, and Discharge Criteria,
    a. DWMHA has designed a unique work flow and requires at a minimum completion of:
        1. Clinical Indications for Admission
        2. Optimal Recovery Course Milestones
        3. Entry of the discharge date
    b. Users will document cases in the Production/Live URL: **https://dwmhaicm.carewebqi.com**. (There is a HELP button in the upper right hand header/ corner of the MCG home screen that is a comprehensive user manual for Using Indicia for Case Management)
4. Screening Entities will log into Indicia and shall complete the following steps.
    a. Select Case Management from the Area list.
    b. Find: Select the Patient tab. > Select Search Patient. > Enter the patient information. The Medical Record Number (MRN) in Indicia will be the MH-WIN number in Indicia. Cases are uploaded to the system through Bulk Data Load every 36 hours. Select the appropriate client based on MRN and/or Date of Birth.
    c. In the event you are unable to locate your patient, Select the Patient tab. > Select New Patient. > Complete the information. > The only fields required are Medical Record Number, First name and Last Name. Select Save.
    d. Create New Encounter: Select the New Encounter tab. > Complete the information. > Screening entities will use the MH _WIN or MCPN REQUEST FOR SERVICE ID from the PAR screen as the ENCOUNTER ID which is auto generated. When the PAR is completed. Encounter IDs will need to be manually entered into Indicia until an API interface is developed. Additionally, the Admit Date is required for the Encounter. Select Save
    e. Add a Guideline: Select the Add Guideline tab. > Select to Current Encounter. > Search for and select a guideline. It is preferred to select a diagnosis specific guideline and the Level of Care. (Either inpatient, partial hospital, or intensive crisis residential).
    f. Document the Encounter for Inpatient, Partial or Crisis Residential.
        1. Document **Clinical Indications for Admission or Procedure**
        2. Select Clinical Indications or Procedure from the Careflow pane.
        3. Compare the patient's status to the list of criteria and select indications that apply to your case.
        4. Check to see the guideline requirements have been met using the status bar.
        5. Document Indication and/or general notes for the encounter (if applicable).
        6. Select Save.
5. Navigational Tip: When reviewing the steps below, Care Date = Your Review Date (date you spoke with

hospital or treating facility, or reviewed information submitted by treating facility); Goal Days are best interpreted or defined as evidence based recovery milestones, or clinical benchmarks that should be achieved prior to discharge.

6. MCPNs, DWMHA (MI Health Link staff, other subcontractors approving continuing stays) once electronically notified of admission shall:
    a. Document the **Recovery Course** Note: If the Admit Date has been changed, the Edit button can be selected and this can be modified if different than the date entered by screeners.
    b. Select **Optimal/General Recovery Course** from the Careflow pane.
    c. Select Level of Care
    d. Select Add Care Date. The Care Date is the date you are reviewing the case. The first Care Date defaults to Goal Day 1 and can automatically be completed by reviewer (Select all Recovery Milestones, or check the box Clinical Indications met) as Clinical Indications for Admission have been met by the Screening Entity
    e. For each subsequent day reviewer conducts a review, Add a Care Date. Care Date (review dates) intervals are determined by reviewers based on what is clinically appropriate. You can document more than one Guideline Day (Goal Day) on the same Care/Review Date. You will need to select the Add a Care Day button to add another Care Day for the same date as the system automatically moves the date forward to the next calendar day. Example: If a patient is admitted, 5/3 and on 5/6 you review the case, your first care date is 5/3 and is Goal Day 1, Go to Care Date Calendar and enter 5/6 for the second review/Care Date, depending on patient's progress you can enter Goal Day 2, and what milestones are met, if **bolded** milestones are met you can add the same care date/ review date and chart milestones for Goal Day 3 on the same date using the calendar.
    If a member progresses beyond the subsequent review date and their progress can be documented on the next date, eg Goal Day 1 = meets clinical indications , Goal Day 2 and member has progressed beyond the recovery milestone, this day is skipped and goal day is selected and member's progress is documented under Goal Day 3. If the milestones for the selected Goal Day are not met, add a variance, and follow the steps below. The yellow sticky notes next to each recovery milestone as well as the notes section at the bottom of the patient's encounter allow for clarifying member's progress and status, add a variance, and follow the steps below. Note: It is not necessary to chart each and every Goal Day but the clinical progress of the patient should be clear.
    f. Review the patient's status against the applicable bolded Recovery Milestones and select Recovery Milestones and Care Elements met.
    g. Document indication and/or general notes for the encounter (if applicable).
    h. Select Recovery Course Overview to view the full Recovery Course
    If the patient does not meet or exceeds the Recovery Milestones on a given care date, **add a variance. Variance** Categories: Medically Necessary (attributed to patient); Potentially Avoidable (Attributed to health care system); Positive (Optimal); and Does Not Apply.UM reviewers should consult with supervising clinicians as needed on those cases where there is a variance identified. Consulting with supervising clinician should also be done by UM reviewer when a medically necessary level of care does not exist (e.g. rural locations). DWMHA supervisor can consider extra-contractual benefits or authorizing a higher level of care as needed to meet individual enrollee/ member needs.
    i. Select Save, Enter Next Review date (if applicable).

j. Repeat the process to enter subsequent care days. Again, you do not have to chart reviews on a daily interval, but the patient's treatment course should be documented clearly.

k. Exit or Discharge an Encounter

l. Exit encounter to leave the encounter status as open to allow continued documentation.

m. Note: To exit an encounter, select a new patient, select a new area, or log out. There is no Exit Encounter button.

n. If determining Clinical Indications for a Procedure, Select the procedure. Add to Careflow. Click on Indications met. You may enter a note and/or select no indications apply.

o. Enter discharges in Indicia within 72 hours of discharge. Discharge: Select the Discharge link for the Encounter. > Enter the discharge date. > Enter discharge disposition. > Include discharge medications, aftercare appointment, time, date, and location if known. Note if the phone number and address of consumer is different than what is in file. Select Save.

p. The Edit Alert choice next to the Discharge Button in the upper right hand corner can be used to flag cases that are 1) Readmission Risk 2) extended Stay Risk, and 3) Potentially Ready for Discharge. You can use these at discharge or during a treatment episode.

Who monitors this procedure:	UM Clinical Specialist Supervisor
Department:	Utilization Management
Frequency of monitoring:	Ongoing and Quarterly to UM Committee
Reporting provided to:	Director, UM, UM Committee
Regulatory Requirements:	NCQA UM 1, UM2, MDHHS, CMS

MONITORING STEPS:

1. All staff utilizing Indicia for Case Management will be required to review this procedure and complete one of three methods of training prior to Going Live in Indicia.
   a. Attend customized live training with an MCG facilitated instructor or web ex facilitated by an MCG Instructor.
   b. View standard web seminars that pertains to the Fundamentals of MCG Content of Behavioral Health Guidelines and Introduction to Indicia. These are available for registration via https://training.mcg.com. Currently, the same training is offered monthly or bi-monthly and facilitated by an MCG instructor and requires preregistration.
   c. Receive live training on the job from a trained supervisor..
2. There is a comprehensive Learning Management system that can be accessed via http://learncareguidelines.com./client The module offers a basic training self-paced module on the Behavioral Health Care Guidelines..
3. DWMHA has purchased Inter-Rater Reliability (IRR) software from MCG that will be installed after the Go Live date and is described further in the Inter-Rater Reliability policy. The IRR module is accessed via the Learning Management system. All users will be required to complete case studies demonstrating inter-rater reliability.
4. Additional training requirements can be found in the procedure, Training **Opportunities and Use of MCG Behavioral Health Guidelines.**

Attachments:

Job Aides (1).pdf

Approval Signatures

Approver	Date
Maha Sulaiman	07/2017
Jennifer Miller: UM Clinical Specialist Supervisor	07/2017