Identify and Using Compliance Tools, Guidelines to Enhance Your Compliance Work"

Presented by:

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Integrated Healthcare Utilization Management "Values" Needed

Under an Accountable Care Organization Model the ***Value*** of Behavioral Health Services will depend upon our ability to:

1. Be Accessible (Fast Access to all Needed Services)
2. Be Efficient (Provide high Quality Services at Lowest Possible Cost)
3. Electronic Health Record capacity to connect with other providers
4. Focus on Episodic Care Needs/Bundled Payments
5. Produce Outcomes!
   - Engaged Clients and Natural Support Network
   - Help Clients Self Manage Their Wellness and Recovery
   - Greatly Reduce Need for Disruptive/ High Cost Services

Utilization Review Vs. Utilization Management

- **Utilization Review** is primarily focused on retrospective review of what has or has not happened in services
- **Utilization Management** is focused on retrospective, concurrent and prospective management of service delivery capacity from intake to discharge and every thing in between

Key Qualitative Based Utilization Management Focus Area to Support UM Plan

- Are we treating the illness we have professionally diagnosed that each client has?
- OR
- Are we carrying inactive active caseload members?... (i.e., Clinical Protocols that require Therapist to Carry Chart for Physicians)

Sample Definition of Treatment

- Define a definition of "treatment" and therefore what is not treatment:

Sample Definition:

"***Behavioral health therapeutic interventions provided by licensed or trained/certified staff either face to face or by payer recognized telephonic/ Telepsychiatry processes that address assessed needs in the areas of symptoms, behaviors, functional deficits, and other deficits/ barriers directly related to or resulting from the diagnosed behavioral health disorder.***"

What Treatment is Not… A Major UM Concern

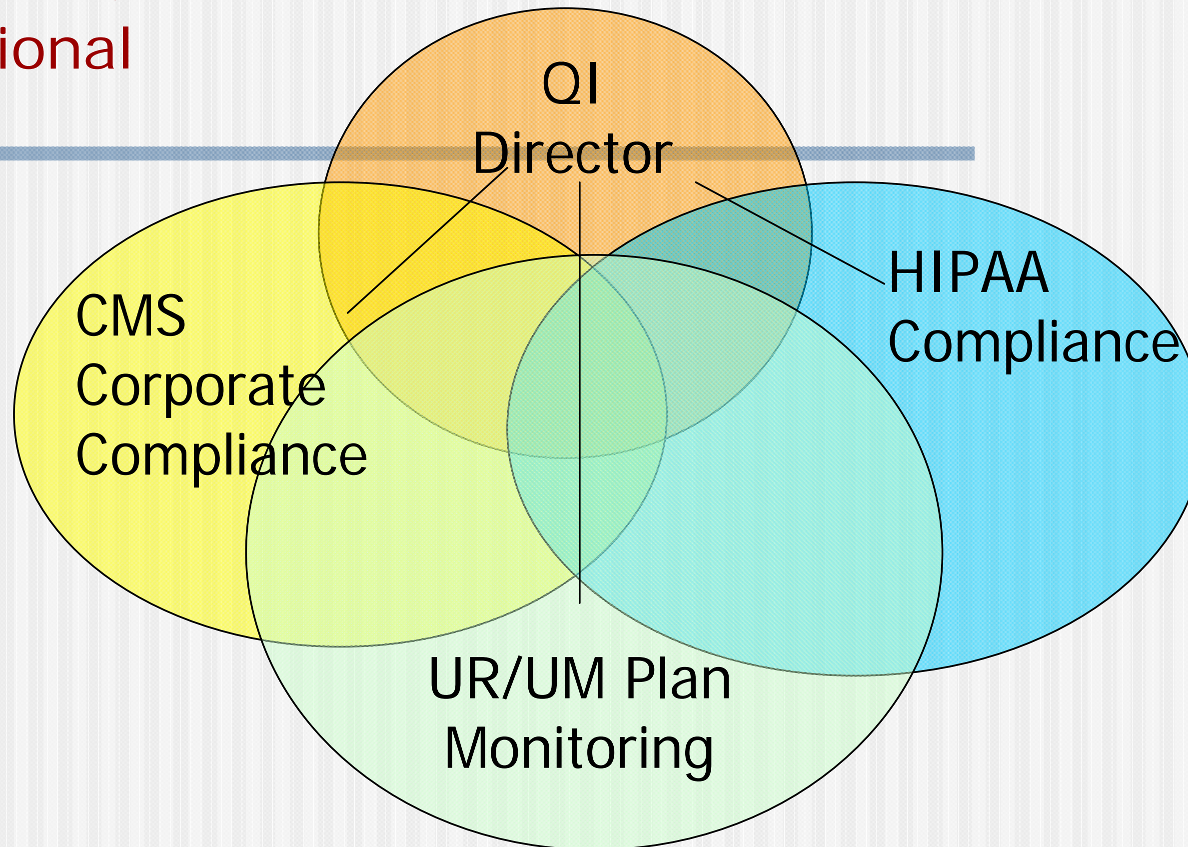
Carrying cases in order to:

- Provide treatment planning and other documentation support to "medication only" clients
- Providing pseudo services to unengaged clients to support maintenance of benefits or legal conditions
- Avoid closing cases

Refocusing on Treatment

- Develop internal level of care expectations based on assessed needs and client choice (benefit packages)
- Review caseloads to determine if beneficial treatment levels are being provided
- Employ person centered/driven engagement strategies to engage/re-engage individuals with legitimate needs
- Address caseloads accordingly to ensure that your resources are maximized to provide treatment!

Integrated Quality Improvement/ Organizational Structure



Clinical and Support/Admin staff assigned based on size of organization and active caseload

Access & Quality Improvement Department

Access to Care:
- Screening/Triage
- Emergency Services
- Eligibility (Includes Part C)
- Provider Profiling
- Customer Service
- Education
- Referral
- Follow-up

Utilization Management:
- Internal Utilization Review/ Corporate Compliance
- External Authorization/ Re-Authorizations
- Appeals
- Contract Compliance
- Qualitative and Quantitative Auditing

Quality Improvement:
- Quality Management Council
- Office of Consumer Services
- Consumer Satisfaction Surveys
- Clinical Outcomes
- Health Information System

Community Relations:
- Grant Writing
- Public Information and Marketing
- Prev. Community Education

Contract Negotiations:
- Satisfaction
- Clinical Provider Supports
  - Insurance Provider Enrollment
  - Licensure Preparation Support
  - Performance Based Contracting

Support Staff

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Child/Family Department

Assessment:
- Intake
- Crisis Stabilization

Outpatient Therapy:
- IOP
- Individual/ Family/ Group
  - VOCA
  - Detention-based Services
  - Sexual Offender
  - Restoration

Early Intervention:
- Project Daniel
- Transition School

School/Community Based Services:
- Day Treatment
- In-School Outpatient Indiv/ Groups
- SA Prevention Programs
- Behavior Support Services

Home-Based Services:
- In-home Training/Supports
- Individual/ Family/ Group
- Behavior Support Services

Family Supports:
- Parent Support Services
- Early Intervention

Service Coordination:
- Case Management

Residential Services:
- Therapeutic Foster Care
- Respite
- Independent Living

Psychiatric/Medical Services:
- Psychiatry/Medical Doctor
- Nursing

Support Staff

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Adult/Family Department

Assessment:
- Intake
- Crisis Stabilization

Outpatient Therapy:
- IOP
- Individual/ Family/ Group
- Pegasus
- Family Support
  - MESA
  - SA Family Support

Service Coordination:
- Case Management

Community Support:
- Day Program (LRC)
- Supported Living
- Psychosocial Rehab
- Wrap-Around Services
- PACT
- Census Reduction

Residential:
- Group Homes/ ICF
- Respite

Residential Treatment:
- Residential
- Detox
- Halfway House

Psychiatric/Medical Services:
- Psychiatry/ Medical Doctor
- Nursing

Support Staff

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Finance & Support Services Department

Finance:
- Accounts Payable
- Purchasing
- General Ledger

Reimbursement:
- Billing
- Collecting and Posting Payments
- Reporting

Information Technology:
- Tech Support
- CMHC Operating System
- Hardware and Software for Network
- E-mail Communications
- Internet Access
- Information and Management Reports
- Installation and Maintenance of PCs
- Computer Training

Human Resources:
- Center Focused Staff Training
- Payroll
- Recruitment
- Personnel Policies and Files
- Receptionists

Performance Contracting with State

Building/Maintenance:
- Vehicle Fleet Management and Maintenance
- Building and Grounds

Support Staff:
- Agency Program Support
- Operational Policy & Procedure
- Training

Focus Areas for UM Plan

- **Front End** (i.e., Screening/Triage, Eligibility, Emergency Services, Referrals, etc.)
- **Concurrent** (i.e., Urgent/Routine Transfer/Discharge Criteria/Planning, Services for high risk consumers, qualitative review of clinical documentation and treatment planning, etc.)
- **Retrospective** (i.e., Qualitative/ Quantitative Review of Charts and Outcomes/Satisfaction Measures, etc.)

THE TREATMENT LOOP

AUTHORITY | PROVIDER

Pre-Intake Diagnosis Additional Assessments (if needed)

Intake Assessment Service Plan

Discharge Criteria

Eligibility Determined

Intervention Plan

Intervention

On-going Informal Assessment

Three Options:

1. Adjustments to Service &/or Intervention Plans

2. Continued Need for Services

3. DC Services no longer needed

Document Individual's Response (+ or -)

Formal Plans Review

Adapted from the Texas Medicaid Rehab Manual by
Ron Lewis, MS, MPA
Center for Health Care Services, San Antonio, Tx.

UM Plan Summary

Assumptions

- Management of service utilization is necessary to assure optimal use of MH resources on behalf of clients.
- Utilization Management can provide a decision support system for managing service utilization
- Programs and service modalities have discreet functions linked to client outcome
- Medical/clinical necessity criteria, levels of care, and practice standards are valid and reliable mechanisms for systems management.
- If a client is receiving the appropriate level of care and service modalities the result will be improved client outcomes.

UM Plan Summary

Goal

- To ensure highest quality mental health services to all persons served by MHS at the most appropriate level of care, in the most appropriate setting, in the least restrictive environment, by the most appropriate provider and in the most cost effective manner possible.

Objectives

1. Facilitate access to and availability of needed services
2. Facilitate service coordination and continuity of care
3. Implement a set of review criteria, protocols, and clinical policy guidelines
4. Provide timely review of service utilization
5. Monitor utilization trends and recommend changes in practice patterns/resource deployment
6. Contribute to performance improvement/quality assurance

UM Plan Summary

Overview of Utilization Management

- The Utilization Management Program's mission is to provide a decision support system for clinicians and managers. The Utilization Management Program will provide feedback on service utilization to clinicians and managers on behalf of clients. The UM Program will monitor and report on system wide service utilization patterns. The UM Program will also provide concurrent utilization review of individual client service needs.

UM Plan Summary

Authority and Responsibility

- It will be the responsibility of Utilization Management to assist administrators to manage service utilization. Utilization Management will provide oversight of service utilization for all MH/SU programs and clinicians. Utilization Management will assist MH/SU staff to manage client care from the point of entry into services to discharge. All reviews of service allocation to individual clients will be subject to the same care standards and medical necessity criteria. All MH/SU staff will be expected to follow the same utilization management and utilization review procedures. Utilization Management staff will be empowered to make decisions about individual client service plans and authorize or deny services.

UM Plan Summary

- **Chart Review Sampling Requirements/Procedures Authorized:**

- **Level I Review:** 100% reviews shall be conducted on all admission, continuing stay, and discharges, as outlined in Administrative Policies

- **Level II Review:**
- **Substance Abuse Services:**
  1. A service data report is generated to identify all admissions, continuing stay, and discharges within each quarter.
  2. The UM Chairperson receives the list and calculates the number of files to be reviewed as determined by funding and/or licensure requirements.
  3. A minimum sample of 15% of these records must be selected for review. DUI samples shall consist of at least 15%, but no less than five and no more than 20 cases. The cases for review will be selected on a random basis.
  4. The reviews are conducted and feedback provided as outlined in Administrative Policies

- **Mental Health:**
  1. A service data report is generated to identify all admissions, continuing stay, and discharges within each quarter.
  2. The Support Team Manager receives the list and calculates the number of files to be reviewed as determined by funding and/or licensure requirements.
  3. A minimum sample of 10% of all Medicaid files will be reviewed quarterly. The cases for review will be selected on a random basis.
  4. The reviews are conducted and feedback provided as outlined in Administrative Policies

UM Plan Summary

- **Authority and Responsibility Lead to Sanctions to Close Accountability Loop:**
- **SANCTIONS:** Staff are expected to maintain clinical records in accordance with all applicable laws, rules, regulations, and policies. When clinical records are found to be in non-compliance, Management will work with staff to develop corrective plans of action to address deficiencies. Management will monitor the progress toward completing corrective plans of action and will continue to review files to make sure that the problem has been corrected within the time frames agreed upon in the corrective plan. Staff who fail to follow-through with the corrective plan of action will be subject to disciplinary action, up to, and including, termination. Failure to follow through with recommendations made at any review level will result in disciplinary action, up to, and including, termination.

UM Plan Clinical Tools

Clinical (Medical) Necessity Criteria

(Services recommended in the treatment plan must meet all of the following criteria)

1. Treatment must be no more and no less than the client requires based on diagnosis/symptoms/behaviors/skills/abilities/functioning
2. Treatment is safe and effective according to national standards
3. Treatment is in the least restrictive setting
4. Treatment is cost effective

Source: UM Plan for DuPage County Mental Health

UM Plan Clinical Tools

Levels of Care/Benefit Design:

- Level of care guidelines will be used to determine the kind and intensity of services necessary to achieve treatment benefits. Level of care guidelines provide a framework for determining who is eligible for which services at what level of intensity and for how long.
- Utilization Management will provide clinicians with a decision support tool to assist them in assigning clients to the appropriate level of care.
- The same decision support tool will be incorporated into treatment planning and used for all utilization review.
- If possible, the decision support tool will be used for both program evaluation (client outcomes) and utilization management.
- Utilization Management will investigate whether these outcome measures are useful for level of care assignments and make recommendations.

Internal Benefit Design/Levels of Care Provide the Required Framework for UM Plans and to Create Capacity for New Clients to Receive Treatment

1. Development of internal levels of care/benefit package designs to support appropriate utilization levels for all consumers
2. Core Elements of Benefit Design/LOC Model:
   1. Admission Criteria (as objective as possible using Diagnostic Profiles, DLA-20/LOCUS scores, etc.)
   2. Continue Stay Criteria
   3. Transition/Discharge Criteria
   4. Service Array and Frequency to be Provided
   5. Projected Service Duration within each level

Same Day Access/Treatment Plan Model Using Benefit Design/Level of Care Criteria

Level of Functioning 3:	**Service**	**Amount**	**Add-Ons**
Indicators of Level: GAF 41 – 50 **and** Moderate Levels in at least 5 of the 10 Client/Family/Guardian Expression of Needs/Preferences Recovery Indicators **Recommended Length of Services:** • **6 to 18 Months** **(Descriptors)** • Prior history of hospitalizations within past 2 years • No imminent dangerousness to self or others • Moderate structure and supports in his/her life • Everyday functioning is impaired • Potential for compliance fair to good • However, the person is tenuous and feels unstable because of situational loss or an occurrence • No crisis management needed **Discharge Criteria:** • Stable on meds • Self administers meds • Means of obtaining meds when discharged • Community integration • Community support • No substance abuse • Medical needs addressed • Minimal symptoms • Client is goal directed • Employed or otherwise consistently engaged (volunteer, etc.) • Client has a good understanding of illness • Family or significant other understand the illness	1. **Diagnosis/Assessment** 2. **Crisis Interventions** 3. **Partial Hospitalization** 4. **Counseling/Psychotherapy**: **5. Community Support Program (CSP)** • Ongoing assessment of needs • Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent • Facilitation of further development of daily living skills, if identified by the individual and/or parent or guardian • Coordination of the ISP, Including: a. Services identified in the ISP; b. assistance with accessing natural support systems in the community; and c. Linkages to formal community services/systems • Symptom monitoring • Coordination and/or assistance in crisis management and stabilization as needed • Advocacy and outreach • As appropriate to the care provided to individuals, and when, appropriate, to the family, education and training specific to the individual's assessed needs, abilities and readiness to learn • Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist in an individual in eliminating barriers to seeking or maintaining education and employment • Activities that increase the individual's capacity to positively impact his/her own environment **6. Medication/Somatic Services**	1. Maximum of 2 contacts per episode of need 2. As needed, no maximum 3. Up to 20 days per episode of need 4. Up to 15 sessions per episode of need 5. Up to a maximum of 4 hr/wk per episode of need 6. Psychiatric Evaluation completed at first contact within 4 weeks of admission. Minimum of 1 contact a month with MD, RN and/or other qualified provider if medications are required	• Supported Employment – at least 1 visit per month • Consumer operated services • Peer support • Social and recreational support • Hotline Services • Mental Health Education and Referral

Level of Functioning 4:	Service	Amount	Add-Ons	Average Cost
Indicators of Level: GAF 31 – 40 **and** High Priority Levels in at least 5 of the 10 Client/Family/Guardian Expression of Needs/Preferences Recovery Indicators **Recommended Length of Services:** • **1 to 3 years** **(Descriptors)** • History of hospitalizations in past 2 years • Co-occurring medical or substance abuse • No imminent dangerousness to self or others • Limited structure and limited supports • Compliance is fair to poor • Occasional crisis management needed **Transition Criteria:** Reduced LON when criteria are met. ** **Dual Diagnosis - Axis I and an Axis II Personality Disorder would be served under LOF 4**	**1. Diagnosis/Assessment** **2. Crisis Interventions** **3. Partial Hospitalization** **4. Counseling/Psychotherapy**: **5. Community Support Program (Intensive CSP)** • Ongoing assessment of needs • Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent • Facilitation of further development of daily living skills, if identified by the individual and/or parent or guardian • Coordination of the ISP, Including: a. Services identified in the ISP; b. assistance with accessing natural support systems in the community; and c. Linkages to formal community services/systems • Symptom monitoring • Coordination and/or assistance in crisis management and stabilization as needed • Advocacy and outreach • As appropriate to the care provided to individuals, and when, appropriate, to the family, education and training specific to the individual's assessed needs, abilities and readiness to learn • Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist in an individual in eliminating barriers to seeking or maintaining education and employment • Activities that increase the individual's capacity to positively impact his/her own environment **6. Medication/Somatic Services**	1. Maximum of 4 contacts per episode of need 2. As needed, no maximum 3. Up to 40 days per episode of need 4. Up to 20 sessions per episode of need **5.** Minimum of 6 hrs/wk and up to 24 hrs/wk. Up to 30 hrs/wk for Dually Diagnosed or medically unstable 6. Psychiatric Evaluation completed at first contact within 4 weeks of admission. Minimum of 1 contact a month with MD, RN and/or other qualified provider if medications are required	• Supported Employment - at least 2 visits per month • Supported Housing – At least 2 visits per month • Consumer operated services • Peer support • Social and recreational support • Hotline Services • Mental Health Education and Referral	

Level of Functioning 5:	Service	Amount	Add-Ons	Average Cost
Indicators of Level: GAF 21 – 30 **and** High Priority Levels in at least 5 of the 10 Client/Family/Guardian Expression of Needs/Preferences Recovery Indicators **Recommended Length of Services:** • **2 to 5 years** **(Descriptors)** ▪ Potential for harm to self or others if not managed well ▪ Recent hospitalizations, or ▪ Co-occurring medical or substance abuse which could be life threatening ▪ Compliance is poor ▪ Frequent crisis management needed ▪ If not with ACT or intensive programming on a weekly basis, the client is at risk ▪ Intractable symptoms ▪ No supports or very limited ▪ Structureless without BGC ▪ High use of psychiatric emergency services during the past 18 months ▪ Primary DSM-IV on Axis I of: Schizophrenia; Major Depressive Disorders; Bipolar Disorders; Other Psychotic Disorders; or Schizoaffective Disorder **Transition Criteria:** • Reduced LON when criteria are met. • Admission for Psychiatric Inpatient Treatment for six months with no imminent discharge date • Placed in a nursing home with no imminent discharge date • Incarceration with no imminent release date	**Assertive Community Treatment (ACT)** • Diagnosis/Assessment • Crisis Intervention • Medication/Somatic Services • Counseling/Psychotherapy • CSP Services	Staff must offer an average of three face to face contacts per week per consumer and average of one contact per week to persons providing support for the consumer. The frequency of contacts with an individual consumer at any one time will depend on the needs and preferences of the individual consumer. The team must have the capacity to increase intensity rapidly to meet the needs of a consumer, as well as the capacity to decrease intensity.	▪ Supported Housing - at least 4 visits per month ▪ Supported Employment ▪ Respite or close family supervision ▪ Substance abuse services ▪ Services for families and other members of the consumer's social network.	

CMHC Benefit Package Design – Level of Care Criteria
Child & Adolescent Services

Integrates Recovery, Outcomes, Systems Finance, Compliance, and Advocacy Initiatives

Level of Care # 3	Service	Amount	Add-Ons	Average Cost
	Recommended Length of Services: 1 to 3 Years			
Indicators of Level: • DSM-IV Axis I Diagnosis. (V-codes excluded), And • CGAF 41 – 50, and/or	**1. Diagnosis/Assessment**	• Maximum of 2 contacts per episode of need	• Mental Health Education & Referral	
	2. Crisis Interventions	• As needed, no maximum	• Hotline Services	
	3. Counseling/Psychotherapy:	• Individual/Group: Up to 12 sessions per episode of need • Family: Up to 12 Sessions per episode of need	• AA/NA Support Groups	
	4. Medication/Somatic Services	• Psychiatric Evaluation completed at first contact within 10 days of referral. • Minimum of 1 contact a month with Medical Staff until stable	•	
Additional Service Eligibility: • Client/family willingness to participate in services	**5. Behavior Management Services (BMS)**	•	•	
	6. Comprehensive Community Support Services (CCSS):	• Up to a maximum of 4 hr/wk.	• Peer support	
	7. Summer Life Skills Develop Program	• Full summer program	•	

Possible Descriptors:
- Possible history of hospitalizations
- No imminent dangerousness to self or others
- Moderate structure and supports in his/her life
- Everyday functioning is impaired
- Potential for compliance fair to good
- However, the person is tenuous and feels unstable because of situational loss or an occurrence
- No acute stabilization needed

Discharge Criteria:
- Stable on meds
- Family/Self administers meds
- Means of obtaining meds when discharged
- Medical needs addressed
- Minimal symptoms
- Client is goal directed
- Enrolled in school or employed
- Family/Client has a good understanding of illness
- Family provides structure and support

Sample Level of Care Model

Level II

Goal: *Maintain active integration at home, community and work.*

Definition: Recovery services are provided to individuals with chronic mental health needs and who need ongoing treatment but who are stable in the community when provided with ongoing but low intensity supports. Interventions may include case management, psychiatry, counseling, vocational, and psychosocial. On-call and crisis services should be made available.

Admission Criteria:

1. **Diagnostic criteria:** Axis I or II psychiatric disorder as defined in the DSM IV
2. **Risk of Harm:** Moderate to serious risk of harm (See rating scales)
3. **Functional Status:** Moderate to serious impairment (See rating scales)
4. **Medical, Addictive and Psychiatric Co-Morbidity:** No co-morbidity to Severe co-morbidity. (See rating scales)
5. **Engagement:** Positive engagement to limited engagement (See rating scales)

Continued Stay Criteria:

1. **Diagnostic criteria:** Axis I or II psychiatric disorder as defined in the DSM IV.
2. **Risk of Harm:** Moderate to serious risk of harm. See rating scales) Psychiatric and behavioral symptoms still exist and continued low intensity supports are beneficial.
3. **Functional Status:** Documented progress toward treatment outcomes. Symptomatology is still present to a degree that make transfer to a less intensive level of care unfeasible at this time.
4. **Co-morbidity:** No co-morbidity to severe co-morbidity (See rating scales)
5. **Engagement:** Positive engagement to limited engagement. (See rating scales)

Discharge Criteria:

1. Psychiatric and behavioral symptoms have improved, and a less intensive level of care is appropriate.
2. Client's risk of injury to self or others has increased and a higher level of care is needed.
3. Psychiatric and behavioral symptoms have worsened, and a higher level of care is needed.

Estimated length of stay: 6 months to 3 years

Service Utilization:

CPST	2-9 hours per month	Not to exceed 108 hours per year
Ind. Counseling	1-2 hours per month	Not to exceed 12 hours per year
Group Counseling	1-8 hours per month	Not to exceed 40 hours per year
Psychiatry	0-1.25 hours per month	Not to exceed 5 per year

Continued authorization: Must be approved after three years

Level of Care-Benefit Package Design

- Purpose is to establish Group Practice Clinical Guidelines to Facilitate Integration of all services into one service plan
- Provide an awareness to consumers at entry to services the types of services and duration of services the practice has found most helpful to meet their treatment needs so that the consumer will know and the staff will know what services are needed to complete that level of care
- Moves consumers to a more recovery/ resiliency based service planning and service delivery approach
- Facilitates being able to use centralized scheduling using the actual service plan of each consumer

UM Plan Clinical Tools

Other Samples of Level of Care Guidelines

1. **Level of Care Utilization System for Psychiatric and Addition Services** (LOCUS) Adult Version 2000 developed by the American Association of Community Psychiatrists
2. **Child and Adolescent Level of Care Utilization System** (CALOCUS) Version 1.5 developed by the American Academy of Child and Adolescent Psychiatry and American Association of Community Psychiatrists
3. **Vermont Clinical Guidelines** developed by the Behavioral Health Network of Vermont and available through the National Council of Community Behavioral Healthcare in Rockville, MD
4. **Other appropriate Level of Care or Clinical Practice Guidelines** can be used to provide clinical tools for staff to help ensure that appropriate utilization, intensity, frequency and duration of services is provided within Medical Necessity criteria.

UM Plan Clinical Tools Needed

Standards of Care/Best Practices:

- How will the MHC ensure that Units/Programs and staff attain service delivery consistent with "Standards of Care" for each level of care?
- Also, how will MHC ensure that services within each level of care are consistent with best practice protocols (i.e., Practice standards for many MH services are listed in the DHS Program Book).

UM Plan Clinical Tools Needed

Entry Into Care

- What are the Access to Care standards for consumers per level of acuity (**Emergent, Urgent and Routine**)?
- Who will assign the initial Level of Care for the consumer entering services?
- What clinical tool(s) will they use to make the assignment?
- Who will authorize initial services?

UM Plan Clinical Tools Needed

Utilization Management Procedures:

- "The provider shall have a written utilization review (UR) plan and ongoing activities to assess:

1. The appropriateness of Medicaid community mental health services
2. Intensity/level of services, and
3. Continued services for the client.
4. Such services may be subject to utilization management parameters established by the public payer.

UM Plan Clinical Tools Needed

Utilization Management Procedures (Cont'd):

- Describe in the written Plan the methods and procedures for performing and recording individual case reviews by persons not involved in providing services to the clients whose records are reviewed
- Need to define the authority and functions of the individual case review designated unit, which may be:

1. A representative committee, chaired by a QMHP, and including QMHPs, MHPs, and RSAs; or
2. A QMHP

UM Plan Clinical Tools Needed

Utilization Management Procedures (Cont'd):

- How will the MHC ensure that appropriate utilization reviews are provided by UM Program?
- Will the reviews be retrospective or concurrent and how will result affect each six-month treatment plan review/revision?
- Need procedures in Plan describing the method for selecting cases for quarterly case review and the procedures for reviewing 10 per cent of the clients served under annually
- Need procedures in Plan to ensure that the review includes and summarizes the client's progress over the previous 90 days

UM Plan Clinical Tools Needed

Utilization Management Procedures (Cont'd):

- Need Policies and Procedures for documenting and reporting individual case review findings, determinations and recommendations to the supervising QMHP and, if applicable, the billing department
- Need provisions in the Plan for ensuring confidentiality of individual case reviews, determinations, results and/or recommendations in accordance with the Confidentiality Act

MTM Services

UM Plan Clinical Tools Needed

Monitoring Client Care

- What treatment milestones that will be used to monitor consumers' care and progress (i.e., Treatment Plan Reviews or Annual Updates)?
- Who will monitor consumer services delivered and progress attained?
- What procedures will be used for utilization review of individual client's use of available funds, medication expenditures or other community based resources.

UM Plan Clinical Tools Needed

UM Information Sources and Documentation Requirements

- What data elements/fields or information will be used to monitor/measure outlier management process?
- What forms/written process will be used to document utilization reviews and inform staff and clinical managers of findings?
- How will information regarding findings be conveyed to appropriate staff?
- Need procedures in Plan for following up on case review recommendations.

UM Plan Clinical Tools Needed

Review Levels and Appeal Process:

- Need procedures in Plan for appeal by clients and staff affected by the UM decisions with which they disagree

First Appeal Level of Review Findings: (Sample of typical Level One Appeal protocol)

- The first level of appeal occurs only when the provider and/or consumer are not satisfied with the result of utilization review process regarding Medical Necessity determination for appropriateness for continued service intensity, frequency and/or duration. The first level of appeal is processed in a manner to ensure independent review of the relevant issues of the appeal by a UM Review Panel. Requests for first appeals can be made either concurrently or retrospectively but not both. Concurrent first level of appeal can be made verbally followed by a written notification by fax or writing. All retrospective first level of appeal must be made in writing.

UM Plan Clinical Tools Needed

***Level Two Appeal**:* (Sample of typical Level Two Appeal protocol)

- A second appeal is available to the client and/or clinician in the appeals process. It occurs only when the provider and/or consumer are not satisfied with the result of the first level of appeal. Second level of appeals is processed in a manner to ensure independent review by a psychiatrist of the relevant issues of the appeal.
- Requests for second appeals can be made either concurrently or retrospectively but not both. Concurrent second level of appeal can be made verbally followed by a written notification by fax or writing. All retrospective second level of appeal must be made in writing.

Service Delivery

LPHA authorizes initial services

UM

Change services/ level of care

Utilization monitoring for service pattern variance (outliers)

UM Decides on Services

Physician Review

UR for clinical appropriateness/ change in level of care

Service Approved

Level 2 Review Requested by Clinician & Manager

Service Not Approved

NO

Level 1 Review initated by UM. Are services appropriate?

Service Approved

Appeal for Peer Review by Manager or Client

Service Not Approved

Yes

Continue services/ level of care

Source: DuPage County Mental Health, Wheaton, Illinois

MHS Utilization Management Flow Chart

SERVICE DELIVERY

CONTINUED FROM REFERRAL PROCESS

UTILIZATION MONITORING PROCESS

UM

CONSUMER NEARS SERVICE LIMIT

INTERNAL UM FOR CHANGE IN LEVELS AND CLINICAL APPROPRIATENESS

CLINICIANS

HAS DISCHARGE CRITERIA BEEN MET?

NO

YES

CLOSE FROM PROGRAM/ REFER

GET EXTERNAL AUTH

YES

NO

CLINICAL APPEAL?

YES

GET EXTERNAL AUTH

NO

REFER TO DIFFERENT LEVEL OF CARE ?

YES

NO

DISCHARGE/REFER OUT

"Advocacy" Model

Presented By:
David Lloyd, Founder

Source: Mercy Behavioral Health

Third Party/Managed Care Utilization Management Plan Components:

2. Internal utilization management processes and support staff to help ensure:
   a. Pre-Certification, authorizations and re-authorizations are obtained
   b. Referrals are made to only clinicians credentialed on the appropriate third party panels
   c. Appropriate front desk co-pay collections
   d. Timely/Accurate claim submission to support payment for services provided

UR/UM Plan Clinical Tools Needed

Entry Into Care

1. What are the Access to Care standards for consumers per level of acuity that are required by the third party payers (**Emergent = within one hour, Urgent = within 24 hours and Routine = within 7 to 10 days**)?
2. Who will:
   - Determine the type of Third Party Insurance a client has
   - Obtain initial authorization prior to service delivery and
   - Refer the client to a clinician that is credentialed on the right insurance company panel?
   - Confirm if an additional authorization is needed to continue services after the initial intake/assessment
3. What clinical tool(s)/Reports will they use to make the assignment (i.e., Access data base of all third party payers and the clinicians credentialed on each panel, etc.)?

UR/UM Plan Clinical Tools Needed

Re-Authorizations During Service

1. Who will:
   - Confirm the number of sessions that have been delivered against the current authorization from payer
   - Obtain re-authorization prior to the end of the current authorization if additional services are clinically needed, and
   - Engage in appeals process with payer if re-authorization is denied?
2. What clinical tool(s)/Reports will they need/use to monitor current authorization levels and confirm need for re-authorizations (i.e., Number of remaining session in current authorization are recorded in centralized scheduler, etc.)?

Roles of Support Staff In Third Party Billing

1. Centralized Scheduling is needed to ensure referral is made to clinician on the appropriate insurance panel
   - Ability to know at all times the availability of clinical staff that are credential on third party panels will be critical to timely acceptance of new referrals
2. Re-think Front Desk functions/needs
   - Collection of Co-Pays prior to Service
   - Confirmation of Insurance via copy of Insurance cards prior to service

Roles of Clinical and Financial Staff In Third Party Billing

1. Completion and submission of all required clinical documentation by direct care staff will be needed to support authorizations after Intake (if required) and re-authorizations
2. Filing timely and accurate claims will be critical
3. Monitoring level of unreimbursed third party care – determine reasons for non payment and correct issues

Revenue Cycle Management

- A greater understanding of cash flows and management of billing practices will be needed in the new environment
  - How long is your billing process?
    - Are you billing weekly?
    - Can you process third party claims daily?
  - What is your percent of denials?
  - What is your performance standard on reconciliation of billing errors?
  - What percent of co-pays and self pay amounts are you collecting daily
    - Do you establish a daily collection figure for your front desk?

Questions and Feedback

- Questions?
- Feedback?
- Next Steps?