MCCMH MCO Policy 10-200

(was MCCMH Policy 2-11-011)

Chapter: **DIRECTLY-OPERATED PROGRAM MANAGEMENT**
Title: **SERVICE PLANNING AND REVIEW**
See also MCCMH MCO Policy 2-010, "Standards for Clinical Services Documentation."

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Approved by: _____ 11/17/10
Executive Director Date

I. Abstract

This policy establishes standards and procedures for assuring that services provided to Macomb County Community Mental Health (MCCMH) Board consumers are provided pursuant to an appropriately developed Plan of Service.

II. Application

This policy shall apply to all directly-operated network providers of the MCCMH Board.

III. Policy

It is the policy of the MCCMH Board that services and supports are delivered based upon a formal written Plan of Service developed with the consumer(s) through a person-centered planning process.

IV. Definitions

A. Clinical Supervision – a process to provide clinical oversight by MCCMH or one of its contracted primary service agencies.

B. Medically Necessary -- adhering to Medical Necessity Criteria For Medicaid Services as established by the MDCH-MCCMH contract (Exhibit A).

C. Plan of Service -- a formal written plan for the provision of services which describes the issues/problems to be addressed, the desired outcomes of service provision, the activities/interventions designed to facilitate achievement of desired outcomes, the individual responsible for implementing the activity/intervention, and the mutually agreed upon time frames for service plan review. The Plan of Service may include clinical services and/or supportive services and may be designed to serve an individual or a family. (See Person-Centered Plan of Service in the MCCMH electronic medical records system, FOCUS.)

D. Clinical Services – those services defined by the Mental Health Code, or by Medicaid as Covered Services for persons with mental health needs, substance use disorders, or co-occurring disorders, or other similar services which are provided consistent with a determination of medical necessity.

E. Supportive Services – those services defined by the Mental Health Code, or by Medicaid as Alternative Covered Service for persons with mental health needs or any of the services defined by Medicaid as Covered Services, for persons with developmental disabilities, or similar types of supports.

F. Preliminary Plan of Service -- a plan of service, developed at the time of the consumer's initial assessment for services or prior to the consumer's discharge from an inpatient psychiatric hospital, which specifies interim planning to address immediate assessment and service needs prior to the development and implementation of a full Plan of Service through a person-centered process.

G. Primary Service Agency -- the agency at which the designated Casemanager, Supports Coordinator or mental health professional responsible for assuring the development of the Plan of Service and his/her clinical supervisor are assigned.

H. Service Review -- a scheduled meeting including the consumer(s), parent or guardian, assigned Casemanager, Supports Coordinator or mental health professional and others as desired or required by the consumer(s) at which the entire Plan of Service is reviewed and revised as needed to ensure that all issues and desired outcomes are being adequately and appropriately addressed. If the Plan of Service requires a revision of the original issues/objectives/interventions and/or if new issues/objectives/interventions are added via amending the formal Plan of Service, the Service Review will serve as the appropriate time/meeting for these activities to occur. (See Person-Centered Plan Service Review in FOCUS.)

V. Standards

A. Based on the initial assessment conducted upon entry into service, a Preliminary Plan of Service is developed which addresses the consumer's immediate specialized assessment needs and immediate service needs insuring that health and safety issues for the consumer are adequately addressed. The Preliminary Plan of Service is developed within seven (7) days of entry into service and continues until a full Plan of Service is developed using a person-centered process, but in no case longer than sixty (60) days.

B. For enrolled MCCMH consumers who are exiting inpatient psychiatric hospitalization, a Preliminary Plan of Service, taking into consideration the discharge recommendations of the inpatient unit is developed prior to the day of discharge. The Preliminary Plan of Service is based upon assessments conducted by hospital treatment staff and addresses the consumer's living arrangement and ability to satisfy necessities of daily living as well as the immediate mental health service needs of the consumer with specific attention to health and safety issues. The Preliminary Plan of Service continues in effect until a full Plan of Service is developed using a person-centered process, but in no case longer than sixty (60) days.

C. The person-centered pre-planning meeting to develop the full Plan of Service is to be held within 30 business days of the Preliminary Plan. As part of the pre-planning meeting, all individuals that the consumer desires or requires to be part of the planning process, including family members, friends, and professionals, shall be identified. The preparation of the full Plan of Service, with signatures of the Clinician and Supervisor, is to be completed within three business days of the person-centered planning meeting for submission to the consumer and to the Access Center along with the services authorization request. Signatures shall be affixed within 24 hours.

D. Each individual or family Plan of Service is designed to respond to needs and preferences of the individual or family framed within the context of the consumer's diagnoses and levels of functioning.

E. The Plan of Service is an annually developed record of planning for the provision of services and supports and is reviewed and revised at intervals necessary to respond to the changing needs and preferences of the consumer(s). At the time of development of the annual Plan and at the time of each subsequent Service Review, a mutually agreed upon time frame for the next scheduled Service Review will be determined, if appropriate.

F. Service Reviews are conducted, at a minimum, prior to requesting authorization for continued services, but at least every six months. Service Reviews may also be conducted at more frequent intervals as prearranged at the time of the development of the annual Plan of Service, at any time of significant change in the consumer's needs, or upon request of the consumer and/or parent/guardian.

G. Revisions or additions to the Plan of Service arising from the Service Review meeting do not require reauthorization so long as they fall within the currently authorized service array and authorization period. All other service changes will require reauthorization.

H. Clinical services include only those behavioral health services which are subject to medical necessity criteria and will be provided by MCCMH either directly or through its contracted provider panel.

I. Supportive services include all services and supports not subject to medical necessity criteria which are necessary to assist and support the consumer in reaching his/her desired outcomes including those which are provided by or accessed through sources other than MCCMH. MCCMH functions as provider of last resort for those services and supports which cannot be otherwise satisfied.

J. Each consumer of MCCMH services has an assigned Client Services Manager, Supports Coordinator or other mental health professional who is responsible for assuring that the Plan of Service is developed, reviewed and revised as required, signed by the Clinician, Client Services Manager, or Supports Coordinator and the Supervisor, and that services are provided in accordance with the Plan of Service. Professional staff signatures on clinical records and documents shall be affixed within 24 hours of completion.

K. Person-Centered Planning Practice Guidelines (MCCMH MCO Policy 2-001) are utilized in the development, review and revision of each Plan of Service. The consumer(s) take(s) an active role in the process of planning his/her own services. Documentation of the consumer's activity in this regard appears in the clinical record.

L. The Plan of Service shall include:

1. A summary of the consumer's strengths and abilities and those resources/sources of support which are available to the consumer;

2. Statements of issues to be addressed through the provision of service;

3. A description of outcomes desired as a consequence of addressing these issues. Outcomes are stated from the consumer's perspective;

4. Objectives to be accomplished in reaching the outcome, stated in behaviorally specific terms;

5. Descriptions of activities/interventions designed to assist the consumer in achieving his/her desired outcomes. Descriptions shall identify the services, supports and treatments that the consumer requested, as well as the

services, supports, and treatments committed by MCCMH to honor the consumer's request;

6. Designation of the individual responsible for providing each activity/intervention;

7. A timeline for when the individual can reasonably expect each of the designated services and supports to begin, and, in the case of recurring services or supports, how frequently, for what duration, and over what period of time;

8. How the designated mental health services and supports will be coordinated with the consumer's natural support systems and the services and supports provided by other public and private organizations;

9. A plan addressing anticipated health and safety issues as needed; areas of possible need may include any of the following:

    a. Food
    b. Shelter
    c. Clothing
    d. Physical health care
    e. Employment
    f. Education
    g. Legal services
    h. Transportation
    i. Recreation

10. Any restrictions or limitations of the individual's rights. Such restrictions, limitations, or any intrusive behavior treatment techniques shall be reviewed and approved according to the provisions of MCCMH MCO Policy 8-008, "Behavior Treatment Plan Review Committee." Any restriction or limitation shall be justified, time-limited, and clearly documented in the plan of service. Documentation shall be included that describes attempts that have been made to avoid such restrictions as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future.

11. The date(s) upon which the plan and any of its subcomponents will be formally reviewed to assess the consumer's progress toward achieving the desired outcomes, and to determine the need for possible modification or revision;

12. A clear summary or statement that reflects the consumer's involvement with the development or updating of this Plan of Service and/or acknowledgment of the Person-Centered Planning process; and

13. Identification of an informal process and contacts through which the recipient may resolve problems with service planning and provision.

M. At a minimum, the Plan of Service is formally agreed to (via signature or witnessing of verbal agreement) by the consumer, the consumer's guardian, if any, , or the parent who has legal custody of a minor consumer, as applicable, the assigned Casemanager, Supports Coordinator or mental health professional, and the responsible Clinical Supervisor. Each subsequent revision of the Plan of Service requires formal agreement as described herein.

N. The Plan of Service with original signatures is kept in the consumer's clinical file at the Primary Service Agency. Copies of the Plan of Service are provided to the consumer, his or her guardian, if any, or the parent who has legal custody of a minor consumer, and to any additional service providers by whom portions of the plan's services will be provided or monitored. The consumer may choose to share the Plan of Service with additional members of his/her family and community support system.

O. Implementation of a plan without agreement of the consumer, his or her guardian, if any, or parent who has legal custody of a minor consumer may only occur when an individual has been adjudicated pursuant to Michigan Mental Health Code sections 469a (court order for treatment program as alternative to hospitalization), 472a, or 473 (court order for involuntary mental health treatment or for continuing order for involuntary mental health treatment), 515, 518, or 519 (court order for an individual with a developmental disability to be admitted to or discharged from a center; court order for a program of care and treatment other than admission to a center for individual with a developmental disability).

P. The plan shall not contain privileged information or communications. To the degree that the consumer desires to share the Plan of Service with others, the consumer's wishes are respected with regard to the inclusion or exclusion of information which he/she considers sensitive or privileged.

VI. Procedures

A. Procedures shall be contained in Provider manuals.

VII. References / Legal Authority

A. MCL 330.1712

B. 2009 MDCH Administrative Rules, R 330.7199, "Written Plan of Services"

C. MDCH-MCCMH Managed Specialty Supports and Services Contract, Attachments 3.4.1.1, "Person-Centered Planning Practice Guideline"

D. Commission on Accreditation of Rehabilitation Facilities (CARF) 2010 Standards Manual, §1.K., "Rights of Persons Served," 2.C., "Individual Plan"

E. MCCMH MCO Policy 2-001, “Person-Centered Planning Practice Guidelines”

F. MCCMH MCO Policy 2-010, “Standards for Clinical Services Documentation”

G. MCCMH MCO Policy 8-008, “Behavior Treatment Plan Review Committee”

VIII. Exhibits

A. Medical Necessity Criteria for Medicaid Mental Health and Substance Abuse Services, Michigan Department of Community Health Medicaid Provider Manual, Mental Health/Substance Abuse, October 1, 2010, pages 12-14

Medicaid Provider Manual
Mental Health/Substance Abuse
Date: October 1, 2010 Pages 12-14
Michigan Department of Community Health

MEDICAL NECESSITY CRITERIA FOR MEDICAID MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- □ Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- □ Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- □ Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- □ Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- □ Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- □ Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- □ Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- □ For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- □ Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- □ Made within federal and state standards for timeliness; and

- □ Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

- □ Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- □ Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and

- □ Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

- □ Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and

- □ Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- □ Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- □ Deny services that are:

    - o deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

    - o experimental or investigational in nature; or

    - o 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; and/or

- □ Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.