MCCMH MCO Policy 2-020

(was MCCMH Policy 2-11-012)

Chapter: **CLINICAL PRACTICE**
Title: **SPECIALIZED HEALTH CARE SERVICES**

Prior Approval Date: 5/19/10
Current Approval Date: 08/22/18

Approved by: BOARD ACTION

Executive Director — Date: 08/22/18

I. Abstract

This policy establishes the standards of the Macomb County Community Mental Health Board (MCCMH) regarding referral of MCCMH consumers to specialized health care services when those service needs are identified during the provision of services.

II. Application

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

III. Policy

It is the policy of the MCCMH Board to provide or facilitate access to specialized health care services for consumers when prescribed by a psychiatrist or authorized or recommended by a nurse, treatment staff member, or client services manager.

IV. Definitions

A. None.

V. Standards

A. During the provision of service, specialized health care needs may be identified by the psychiatrist, nurse, client services manager, treatment staff, primary care physician, or other external provider. These needs may include (but are not limited to) medical, dental, optical, physical therapy, occupational therapy, speech, hearing and language, psychological testing, neurological evaluation, or laboratory tests.

1. Services requiring physician prescription or referral include physical therapy, occupational therapy, speech therapy, psychological testing, neurological evaluation, and laboratory tests.

2. Services not requiring physician prescription or referral include physical examination, dental, optical, and hearing screening.

B. For those services requiring a physician prescription, certificate of medical necessity or referral, the psychiatrist shall document in the clinical record his/her recommendation and will complete a provider's form requesting the services (see example Specialized Residential Services Request for Medical, Surgical, Dental Services, Exhibit A); completion includes a brief description of the requested service and the need for the service (see example form, Exhibit A). A copy of the request shall be retained in the clinical record as documentation of the request.

C. For those services not requiring physician prescription or referral, the nurse, treatment staff member, or client services manager may authorize the referral and complete the provider's form requesting the services. A copy of the request shall be retained in the clinical record as documentation of the request.

D. The nurse, treatment staff member, or client services manager shall provide follow-up on the referral to ensure that arrangements for access to prescribed/referred services are completed and assist the consumer in accessing sources of funding and transportation where needed. (Service coordination between MCCMH behavioral health and substance abuse providers and external providers shall follow the provisions of MCCMH MCO Policy 2-042, "Service Referrals, Recommendations, Coordination of Care, and Follow-Up.")

E. The nurse, treatment staff member, or client services manager shall ensure that reports of assessments, evaluations, laboratory test results, etc., done by community providers are available for psychiatrist review when completed – either directly entered or scanned in the electronic medical record.

F. The psychiatrist shall review laboratory test results and consultation reports and document his/her impressions and comments in the clinical record.

VI. Procedures

A. Procedures shall be contained in Provider manuals.

VII. References / Legal Authority

A. MCL 330.1206(1)(d)

VIII. Exhibits

A. Specialized Services Request for Medical, Surgical, Dental Services, (example).

MACOMB COUNTY COMMUNITY MENTAL HEALTH
REQUEST FOR MEDICAL, SURGICAL, DENTAL SERVICES

Consumer Name | Date of Request | Case No.

Provider Name

Address

Consumer has: □ Medicare □ Medicaid □ No insurance / Estimated cost $_____

□ Other insurance, specify_____

Requested Service (describe briefly): _____

Prospective Service Provider

Name: _____

Address: _____

Telephone: _____ Prospective Service Date: _____

_____
Requestor Signature

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□ Service approved, if under $100.00 □ Approval pending (if over $100.00 requires administrative approval)

□ Disapproved □ Telephone approval

Comments: _____

_____

_____

_____ _____
Reviewer Signature Date

Specialized Services Request for Medical, Surgical, Dental Services (8/02), Exhibit A, MCCMH MCO Policy 2-042