MCCMH MCO Policy 2-022

(was MCCMH Policy 4-03-010)

Chapter: **CLINICAL PRACTICE**
Title: **PMP / SUBSIDIZED LABORATORY SERVICES**

Prior Approval Date: 3/30/06
Current Approval Date: 5/8/08

Approved by: Donald D. Dahlkemper 5/8/08
Executive Director Date

I. Abstract

This policy establishes the standards and procedures of the Macomb County Community Mental Health Board (MCCMH) for determination of eligibility and provider enrollment for consumer participation in subsidized pharmacy and laboratory services.

II. Application

This policy shall apply to all directly-operated and contract network providers which provide and bill the MCCMH Board for subsidized psychiatric medication and related services.

III. Policy

MCCMH will subsidize pharmacy and laboratory services for consumers meeting specified financial eligibility criteria.

IV. Definitions

A. Psychiatric Medication Program (PMP)
A medical assistance service which provides medication for designated MCCMH consumers at no cost to the consumers.

B. Laboratory Subsidized Services
A medical assistance service which provides laboratory tests to analyze blood and urine samples of designated consumers at no cost to them.

V. Standards

A. MCCMH consumers must meet the following eligibility criteria for enrollment in the PMP or subsidized laboratory services:

1. The individual must be a resident of Macomb County.

2. The individual must be a registered MCCMH consumer currently receiving services from a MCCMH directly operated or contracted provider, including MI, DD, and SA agencies.

3. The individual lacks adequate health insurance and has a gross monthly income which results in a zero ability to pay determination, has been denied Medicaid eligibility, or is a child who is enrolled as a MIChild consumer. (See MCO Policy 7-001, "Determination of Financial Liability."

B. Ongoing efforts are to be made to exhaust all available resources such as complimentary drug samples when financial circumstances change, or at least yearly, Pharmaceutical Industry Prescription Drug Patient Assistance Programs or other local community organizations providing free medications on a one time only or limited subsidy such as World Medical Relief, Michigan Emergency Pharmaceutical Program of Senior Citizens, or United Way Community Services.

C. The provider through which medications are being prescribed shall determine whether the consumer is eligible for enrollment into the PMP. When a consumer is transferred from one MCCMH provider to another, the receiving provider must verify continued eligibility.

D. The consumer's eligibility for the PMP subsidy program must be documented every quarter through central or third party resources, e.g., Medifax, DENIS, and industry-sponsored programs, in the consumer's record and entered into the electronic medical record (EMR) system. This includes verifying that the consumer 1) has no available pharmacy or laboratory services benefits through his/her health insurance; 2) has no personal or family financial resources to cover the cost of their prescriptions or laboratory services; 3) is not eligible to receive Medicaid; and 4) has been denied entry into Pharmaceutical Industry Prescription Drug Patient Assistance Programs.

E. The Office of the MCCMH Medical Director shall maintain a list of physicians who are authorized to prescribe medications and order laboratory services under the PMP and the laboratory subsidy service. This listing shall be provided to the participating pharmacies and laboratories.

F. The medication(s) for which subsidy is authorized must be prescribed specifically for the treatment of the consumer's **psychiatric** condition. The subsidy program is not to be used for the treatment of concurrent medical conditions, birth control, general health maintenance, etc.

G. Each designated provider shall use a prescription form specifically for the PMP which bears the name of the provider. Prescriptions provided to consumers newly enrolled in the PMP subsidy program, and to existing PMP consumers requesting new prescriptions, shall primarily be MCCMH formulary generic medications, unless otherwise approved by the MCCMH Medical Director.

H. The laboratory services for which the subsidy is authorized must be related to the consumer's **psychiatric** condition for the purpose of establishing baseline data for periodic monitoring of safety and medication compliance, progress, or lack thereof. The Subsidized Laboratory Services Program Laboratory Tests Order Form, MCCMH #291 (Exhibit A) is to be used when ordering laboratory services.

I. All medications and laboratory work subsidized under these programs must be prescribed by a MCCMH-authorized physician. Exceptions must be authorized by the MCCMH Medical Director.

J. The Medical Director will review and analyze monthly summary reports from the contract pharmacies/laboratories and make periodic utilization reports to monitor cost-effective use of the PMP/laboratory subsidy service. Physician prescribing patterns will be analyzed and profiled and the data will be used for physician education.

VI. Procedures

A. PMP PROCEDURES

1. The designated provider shall assess the consumer's eligibility for the PMP using the MCCMH eligibility criteria.

2. The psychiatrist shall assess the consumer's need for psychotropic medications for psychiatric condition(s) and, if need is indicated, prescribe MCCMH formulary generic psychotropic medications.

3. Before a non-MCCMH PMP formulary drug for which there is no suitable alternative available is prescribed, a Prior Authorization Request form, MCCMH #304, (Exhibit B) shall be completed and faxed to the MCCMH Medical Director, attaching copies of all prescriptions, current psychiatric evaluation and completed medication review if not available on FOCUS. Criteria for review need to be satisfied prior to submission.

4. The Psychiatrist, or the Nurse, (as delegated by the physician), may dispense complimentary drug samples to PMP eligible consumers as available while waiting assistance through the Pharmaceutical Company Patient Assistance Program.

5. The MCCMH Medical Director shall:

   a. Review the Prior Authorization Request form, MCCMH #304 (Exhibit B), completed by the prescribing MCCMH psychiatrist, using the review criteria, below:

      (1) The use of MCCMH Formulary Drug Products is contraindicated in the patient;

      (2) The patient has failed an appropriate trial of MCCMH Formulary or related agents;

(3) The choices available in the MCCMH Drug Formulary are not suited for the present patient care need and the medication requested is required for patient safety;

(4) The use of a MCCMH Formulary Drug Product may provoke an underlying medical condition (Axis III), which would be detrimental to patient care.

B. LABORATORY TESTING PROGRAM PROCEDURES

1. The designated provider shall determine the consumer's eligibility for the subsidized laboratory services using the MCCMH eligibility criteria.

2. The Psychiatrist shall

   a. Assess the consumer's need for laboratory services to establish baseline data prior to the initiation of medication, monitor safety and medication compliance, progress or lack thereof.

   b. Order laboratory services using the Subsidized Laboratory Services Program Laboratory Tests Order Form MCCMH #291(Exhibit A) indicating the consumer's case no., D.O.B., SS#, physical and behavioral diagnosis code, and the consumer's signature, give the white copy to the consumer, place the yellow copy in the clinical record, and forward the pink copy to the MCCMH Medical Director.

   c. Request prior authorization from the MCCMH Medical Director for laboratory tests not on the approved MCCMH laboratory tests lists, using the Prior Authorization Request Subsidized Laboratory Services Program MCCMH #293 (Exhibit C). Following approval from MCCMH Medical Director, will order the prior approved laboratory tests using the Laboratory Test(s) Order Form Prior Authorized Request MCCMH #294 (Exhibit D).

3. The Psychiatrist/Nurse shall review laboratory test results as soon as received and document review of the laboratory test results by placing his/her signature and the date on the laboratory report. Nurse will have follow-up communication with Psychiatrist on abnormal results and a notation will be made in the Psychiatrist/Nurse's progress notes indicating action taken and follow-up outcome.

4. The MCCMH Medical Director shall

   a. Review and monitor the appropriate use of subsidized laboratory services by physicians.

   b. Request clarification of laboratory services as necessary using the Laboratory Services Utilization Review Request For Clarification, MCCMH #295 (Exhibit E).

c. Receive and approve (or not approve, providing rationale) requests for the prior authorization of laboratory tests not on the MCCMH approved test lists, MCCMH #294 (Exhibit D).

d. Receive and approve (or not approve, providing rationale) requests for the authorization of the use of medications that are not MCCMH formulary generic medications, MCCMH #304 (Exhibit B).

d. Forward a copy of the Diagnostics/Subsidized Laboratory Services Program Laboratory Tests Order Form, MCCMH #291(Exhibit A), received from psychiatrists to the Billing Department.

e. Provide quarterly subsidized laboratory services utilization reports to MCCMH Administration, managers, and physicians.

VII. References / Legal Authority

A. None

VIII. Exhibits

A. Subsidized Laboratory Services Program Laboratory Tests Triplicate Order Form, MCCMH #291

B. Prior Authorization Form, MCCMH #304

C. Prior Authorization Request Subsidized Laboratory Services Program, MCCMH #293

D. Laboratory Test(s) Order Form Prior Authorized, MCCMH #294

E. Laboratory Services Utilization Review Request For Clarification, MCCMH #295

MACOMB COUNTY COMMUNITY MENTAL HEALTH SERVICES
Subsidized Laboratory Services Program
Laboratory Tests Order Form

Patient Name _____ Case #_____

DOB _____ SS#_____

Primary Care Physician _____ Psychiatrist_____

Bill To: Macomb County CMH
22550 Hall Road
Clinton Township, MI 48036
_____

Clinic Name_____
Acct # _____
Address _____
Ph:_____
Fx:_____

Physical Dx Code_____ Behavioral Dx Code_____

Diagnosis codes must be medically appropriate for patient's condition and consistent with documentation in medical record. For your convenience, this is a partial list of Physical Diagnosis Codes which can be found the in ICD-9-CM Book.

V70.0	*Gen. Medical Exam (Adult)*	**242.90**	*Hyperthyroid*
V20.2	*Gen Medical Exam (Child)*	**276.9**	*Electrolyte Imbalance*
244.9	*Hypothyroid*	**251.2**	*Hypoglycemia*
573.3	*Hepatit*is	**V22.1**	*Pregnancy*
790.6	Hyperglycemia	**593.9**	*Renal Disease*
401.1	Hypertension	**246.9**	*Thyroid Disorder*

Test Requested

899	__*TSH*	**294**	__*BUN*
10231	__*Comprehensive Metobolic Panel* *	**822**	__*AST*
10165	__*Basic Metobolic Panel* *	**823**	__*ALT*
10256	__*Hepatic Function Panel* *	**593**	__*LDH*
7020	__*Thyroid Panel (T_3, T_4)* *	**287**	__*Bilirubin, Total*
34392	___*Electrolytes Panel* *	**375**	__*Creatinine*
7600	__*Lipid Panel* *_____	**896**	__*Triglycerides (Cholesterol)*
29424	__*10 Drug Screen w/o confirmation* *	**571**	__*Iron*
6399	__*CBC with differential and platelet*	**613**	__*Lithium*
793	__*Reticulocytes*	**916**	__*Valproic Acid*
5463	__*Urinalysis, including micro*	**329**	__*Tegretol (Carbamazepine)*
859	__*T_3 Total*	**396**	__*Pregnancy Test - Urine*
867	__*T_4 Total*	**8435**	__*Pregnancy Test - HCG Serum*
483	__*Glucose, Serum (Fasting Blood Sugar)*		

NOTE: All Other Tests Not On This List Need Prior Authorization: Please submit a completed Prior Authorization Form (MCCMH #294) To The Medical Director at Fax No.: (586) 465-8320

I understand that I am receiving subsidy for laboratory tests based on my claim that I do not have insurance nor financial resources for these procedures.

_____
Client Signature Date

MCO 2-022 - Exhibit A MCCMH #291-1 (Rev 1/08)

WHITE - CONSUMER COPY YELLOW - CHART COPY PINK - MEDICAL DIRECTOR'S COPY

Subsidized Laboratory Services Program
Panels and Components Laboratory Tests
Quest Diagnostics, Inc.

10231 Comprehensive Metabolic Panel

Carbon Dioxide	Sodium	Potassium	Chloride
Albumin	Alkaline Phosphatase	ALT (SGPT	AST (SGOT)
Bilirubin, Total	BUN (Urea Nitrogen)	Creatinine	Glucose
Calcium	Globulin		
Total Protein			

10165 Basic Metabolic Panel

Carbon Dioxide	Sodium	Potassium	
BUN (Urea Nitrogen)	Creatinine	Chloride	
Calcium	Glucose		

0256 Hepatic Function Panel

Alkaline Phosphatase	ALT (SGPT)	AST (SGOT)	Bilirubin, Direct
Bilirubin, Total	Albumin	Indirect Bili	Total Protein

7020 Thyroid Panel

T3 Uptake	T4, Total	T4, Free, Calculated

34392 Electrolyte Panel

Carbon Dioxide	Sodium	Potassium	Chloride

29424 Drug Screen: 10 Drug w/o confirmation

Amphetamines	Barbiturates	Benzodiazepines	Cocaine
Methadone	Methaqualone	Opiates	Phencyclidine (PCP)
Propoxyphene	THC	PH	Creatinine

7600 Lipid Panel

Cholesterol, Total	HDL-Cholesterol	Triglycerides	LDL

MACOMB COUNTY COMMUNITY MENTAL HEALTH

Prior Authorization Request
Phone: (586) 465-8323
Fax: (586) 465-8320

Instructions:
This form is to be used by designated MCCMH physicians to obtain coverage for a MCCMH non-formulary drug for which there is no suitable alternative available. Please complete this form and fax to Medical Director at (586) 465-8320, attaching copies of all prescriptions, current psychiatric evaluation and medication review if not available on FOCUS. If you have any questions regarding this process, please contact the office of the Medical Director (585) 465-8323.

Review Criteria:
The following criteria are used in reviewing medication requests:
1. The use of MCCMH Formulary Drug Products is contraindicated in the patient.
2. The patient has failed an appropriate trial of MCCMH Formulary or related agents.
3. The choices available in the MCCMH Drug Formulary are not suited for the present patient care need and the medication requested is required for patient safety.
4. The use of a MCCMH Formulary Drug Product may provoke an underlying medical condition (Axis III), which would be detrimental to patient care.

Medication Request Information (please complete each section of this form prior to transmittal):

Consumer Name:	Physician's Name:
Please check as applicable ☐ Medicaid client ☐Medicare client ☐ Other Insurance ☐ Indigent client	
Consumer ID #:	Physician NPI #:
Consumer DOB:	Physician Area Code and Telephone Number (required): ( )
Diagnosis: Axis I:	Physician Area Code and Fax Number (required): ( )
Axis II:	
Axis III:	
Medication Requested:	
Dose:	Dosage Form:(e.g. Oral, Injection)
Strength:	Length of Treatment **(be specific):**
Reason for Medication Request (**be specific, give detail**):	
Other Medications Tried and/or Failed (dose, dosage form, duration):	
Other Pertinent History:	
Physician Signature:	Date:
Received: / / ☐ Approved	☐ Not Approved
Comment:	
Medical Director:	Date:

(Norma Josef, M.D.)

Prior Authorization Request, MCCMH #304 (rev. 12/17/07), MCCMH MCO Policy 2-022, Ex. B

MACOMB COUNTY COMMUNITY MENTAL HEALTH

PRIOR AUTHORIZATION REQUEST

Subsidized Laboratory Services Program

Date: _____

TO: Norma Josef, M.D., MEDICAL DIRECTOR, MCCMH

From: _____,MD
Physician Name (Please PRINT)

Program / Services Unit: _____
Ph #: _____
Fax #: _____

Consumer Name: _____ Case #: _____ DOB: _____

LABORATORY TESTS	CODE NO.	RATIONALE

Consumer Diagnosis:

Axis I _____

Axis II _____

Axis III _____

Physician Signature: _____

Please FAX to: Norma Josef, M.D., Medical Director, MCCMH FAX#: (586) 465-8320

☐ Approved P.A. No.: _____ ☐ Not Approved

Comment: _____

_____

_____

_____

_____

_____
(Name of Medical Director, credentials, date)

MCO 2-022 - Exhibit C MCCMH #293 (3/06)

MACOMB COUNTY COMMUNITY MENTAL HEALTH

Subsidized Laboratory Services Program

P.A. No.: _____

LABORATORY TEST(s) ORDER FORM
PRIOR AUTHORIZED

Consumer Name _____ Case #_____

DOB _____ SS#_____

Primary Care Physician _____ Psychiatrist_____

Bill To: Macomb County CMH
22550 Hall Road
Clinton Township, MI 48036

Clinic Name_____
Acct #:_____
Address:_____
Ph:_____
Fx:_____

Physical Dx Code_____ Behavioral Dx Code_____

Diagnosis codes must be medically appropriate for patient's condition and consistent with documentation in medical record. For your convenience, this is a partial list of Physical Diagnosis Codes which can be found in the ICD-9-CM Book.

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573.3	*Hepatit*is	**V22.2**	*Pregnancy*
790.6	Hyperglycemia	**593.9**	*Renal Disease*
401.1	Hypertension	**246.9**	*Thyroid Disorder*

Tests Requested

The following laboratory tests have received prior approval:

CODE NO. LABORATORY TESTS ORDERED

_____
_____
_____
_____
_____

NOTE: THIS FORM IS TO BE USED ONLY AFTER APPROVAL OF TEST(S) USING MCCMH FORM #293 "PRIOR AUTHORIZATION REQUEST"

Original copy: Consumer to take to participating Quest Laboratories

MCO 2-022 - Exhibit D MCCMH #294 (4/04)

MACOMB COUNTY COMMUNITY MENTAL HEALTH

LABORATORY SERVICES UTILIZATION REVIEW
CLARIFICATION REQUEST

Date:_____

To:_____ Program/Services Unit:_____

Consumer:_____ Case #:_____

RE: Laboratory Tests Ordered:

1 _____ Date:_____

2. _____ Date:_____

3. _____ Date:_____

In reviewing the above laboratory tests ordered for your patient, it has been determined that clarification is needed for their use.

PLEASE CLARIFY THE FOLLOWING:_____

PHYSICIAN RESPONSE

Please PRINT clearly. You may write on back if needed.

_____
Physician Signature/Date

Please send your response by _____ Mail or Fax to: *Name of Medical Director, credentials*
22550 Hall Road
Clinton Township, MI 48036
Tel: (586) 465-8323
Fax: (586) 465-8320