**Purpose**

The Genesee Health System has established a Utilization Management (UM) department with primary responsibilities for implementation of the utilization management duties, on behalf of Region 10 PIHP, as outlined in contract Attachment P 6.7.1.1 with the Michigan Department of Health and Human Services. This document and attachments provides an overview of the UM department and processes to assist providers. Staff is available to answer additional questions by calling UM at (810) 257-1347.

**Overview of Utilization Management Processes**

Genesee Health System Utilization Management prior authorizes medically necessary services through application of criteria outlined in the Michigan Medicaid Provider Manual: Behavioral Health and Intellectual and Developmental Disability Supports and Services. Service authorizations are requested by providers through the GHS Electronic Medical Record (CHIP) vis a`vis development of the individual plan of service, plan addendums, and treatment plans. Prior authorizations are not required to access emergent or non-emergent eligibility screening, or crisis services.

Utilization management processes for mental health services are based on three determinations:

1. Eligibility Determination – a) initial, non-emergent eligibility is determined through the Access screening process; b) initial, emergent eligibility is determined through UM, and after-hour sub-delegation to Common Ground Crisis Intervention Response Team (C.I.R.T.), pre-admission reviews and; c) ongoing eligibility determination through provider clinical reviews and/or UM reviews.
2. Level of Care Determination - established initially and re-evaluated annually, as well as any time there is a significant change in clinical status, based on clinical and demographic information entered in the EMR and updated during person-centered planning.
3. Service Selection Determination – providers utilize established Benefit Plans to determine expected service utilization at the assessed level of care. Services authorized are a) identified through the person centered planning process; b) medically necessary as defined by the Michigan Medicaid Provider Manual; c) based on Best Practice and Evidence Based Practice guidelines; and d) monitored via prospective, concurrent, and retrospective review processes by the UM department.

Utilization management service authorization reviews, denials, and reductions are conducted by health care professionals who have the appropriate clinical expertise to treat the conditions under review. Current UM Department staffs are as follows:

Brian Swiecicki, LBSW – Vice President of Business Operations

John Holiday, BSN RN – Access/QM/UM Director

Michelle Crang, MA, LLP – Manager of Utilization Management

Stefanie Sabin, LMSW – UM Coordinator

Julianne Miller, RN – UM Coordinator

Kara Shelby, LMSW – UM Coordinator

Robin Cunningham, RN-UM Coordinator

Kendra Brown, LMSW **–** UM Coordinator

Rose Bagale, LLP – UM Coordinator

Ellen Bartley-Robertson, PhD, LMSW, CAADC – UM Coordinator

Lisa Merz, RN– UM Coordinator

Krystal Shreve, LMSW-UM Coordinator

Clinical oversight is provided by the Vice President of Clinical Operations, Lauren Tompkins, Ph.D., LP

Mental Health Level of Care and Authorization Process:

Utilization Management utilizes a level of care (LOC) system for adults with serious mental illness and co-occurring disorders, adults with developmental disabilities, and children with serious emotional disorders and co-occurring disorders, and children with developmental disabilities. The initial level of care for adults is determined through the initial biopsychosocial assessment completed at Intake. Level of Care is reviewed and requested at least once a year with every new Individual Plan of Service (IPOS). A request for a change in LOC can be made at any point in time by the primary case holder through CHIP. When requesting, or renewing, a LOC, the primary case holder must type a clinical rationale on the request. The LOC will auto-approve, or pend for UM review, depending on a number of variables. When a LOC request pend for UM review, UM will process as quickly as possible, but no longer than 14 days from the submission date.

Each level of care has a distinct benefit of plan, specific service type and amounts authorized are determined through the person centered planning process and development of the Individual Plan of Service. The benefit plan does not limit access to service types and amounts, authorization requests can be submitted that are not included in the benefit plan for UM review. Please see the level of care descriptor and benefit plan documents in this folder for additional information (attachments 2-8).

Authorization requests will auto-approve, or pend for UM review, based on the LOC and associated benefit plan. Each authorization request requires the clinician to type a clinical rationale for the request. Authorization requests pended for UM review will be reviewed as quickly as possible, but no longer than 14 days from date of submission. If UM denies or limits a request, CHIP will notify the requestor by email with the authorization number as well as notify them when they log into CHIP. Utilization Management will document on the authorization request rationale for the limitation/denial as well as send Notice to the consumer and/or guardian.

* Case Management/Supports Coordination:

Authorization requests for T1017 Targeted Case Management or T1016 Supports Coordination will be automatically divided into quarterly authorization by CHIP when approved. This will allow the case manager/supports coordinator to flex the amount of service provided within the three month authorization based on clinical need. When there is a quarter that requires additional units due to increased, short-term needs, the case manager/supports coordinator may request additional units through CHIP. Requests for additional units will pend for UM review. Documentation of previously billed units will be reviewed in addition to the clinical rationale; previously billed units will also be required to meet medical necessity prior to approval of additional units. When a consumer has increased clinical needs that are long-term, a request for change in level of care should be requested in lieu of requesting additional units.
* CLF-Specialized Residential:

Internal Provider: Initial request are made by the primary case holder by forwarding a completed Residential Request Form to the Residential Placement Committee. The committee will schedule the primary clinician to attend the next weekly scheduled meeting, or if the request is identified as urgent, the placement committee has the flexibility to meet more frequently. For details on this process, please see the Residential Placement Committee attachment located in this manual (attachment 9). On-going requests are made through the person center planning process and Individual Plan of Service with Treatment Plans.

External Provider: Initial request are made directly to UM by faxing the completed Residential Request Form. Utilization Management will review the clinical rationale for the request, plus the clinical record. Utilization Management will notify the primary case holder of the disposition. For details on this process, please see the CLS-Specialized Residential Placement Procedure-External attachments located in this folder (attachments 10). On-going requests are made through the person center planning process and Individual Plan of Service with Treatment Plans.

* Community Living Supports:

Always refer to the current Medicaid Provider Manual for up-to-date information concerning CLS, as there are regular updates. Per the Medicaid Provider Manual dated 1/1/19:

*“Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual’s achievement of goals of community inclusion and participation, independence, or productivity.”*

Coverage includes:

* Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding, and/or training in the following activities:
	+ Meal preparation
	+ Laundry
	+ Routine, seasonal, and heavy household care and maintenance
	+ Activates of daily living
	+ Shopping for food and other necessities of daily living
	+ Money management
	+ Non-medical care (not requiring nurse or physician intervention)
	+ Socialization and relationship building
	+ Transportation from the beneficiary’s residence to community activities, among community activities, and from the community activities back to the beneficiary’s residence (transportation to and from medical appointments is excluded)
	+ Participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts, and events in a park; volunteering; voting, etc.)
	+ Attendance at medical appointments
	+ Acquiring or procuring goods (other than those listed under shopping), and non-medical services
	+ Reminding, observing, and/or monitoring of medication administration
	+ Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting

All CLS requests pend for UM review. Utilization Management will review the CHIP record for assessments and goal/objectives/interventions to support Medicaid standards. Consumers must have Medicaid to receive this service. Please see Community Living Supports and Home Help Services Coordination attachment for additional information (attachment 11).

* County of Financial Responsibility (COFR):

When another county, other than Genesee, is identified as the COFR, UM will request initial authorizations. On-going authorizations are made by the primary case holder to the COFR. The primary case holder is also responsible in providing GHS-UM a copy of the COFR’s authorizations for UM to enter into CHIP. COFRs are identified in CHIP in the consumer header and in red. Only UM can assign or change a COFR in the consumer record. The COFR contact information for authorization requests are documented in the initial authorization comment section by Utilization Management. See COFR Agreement Procedure attachment for additional information (attachment 12).
* Crisis Services:

GHS-Utilization Management, and after-hour sub-delegation to C.I.R.T., is responsible for determining eligibility and medical necessity for crisis services (i.e. inpatient, crisis residential, partial hospitalization, and crisis stabilization) for Genesee County residents who are Medicaid recipients or who are underinsured. Prior authorization is required for these services.

 GHS Utilization Management, and C.I.R.T., will directly determine eligibility and medical necessity for crisis services, with availability 24 hours per day, 7 days per week. If an individual appears to require psychiatric hospitalization, they must present to a hospital emergency department; in Genesee County, Hurley and McLaren emergency departments are preferred. The emergency department will assess the individual and contact GHS Utilization Management for inpatient or other crisis service authorization.

GHS Network providers wishing to directly make a referral to crisis residential, partial hospital, or crisis stabilization services may do so without referral to the hospital emergency department by calling GHS Utilization Management for a pre-admission review at (810) 496-4931. Please note, this number is not for consumers to contact. Consumers can independently access crisis services when they present to an emergency department or by calling the GHS 24 hour Crisis Line (810) 257-3740. Only staff who qualify as Mental Health Professional (i.e. physician, psychologist, licensed master’s social worker, licensed or limited licensed professional counselor, licensed marriage and family therapist, or registered professional nurse) can complete a prescreen with Utilization management.

Concurrent reviews are completed by the provider with GHS UM. Inpatient providers complete reviews by calling UM Monday-Friday between 12:30pm-4:30pm. Crisis Residential and Crisis Stabilization programs complete their electronically through CHIP (see attachments 13 CRU Concurrent and Retrospective Review and 14 Crisis Stabilization Continuing Stay Review for further details).

* General Fund Medication Formulary:

GHS has a limited medication formulary for active consumers who have no prescription coverage. Medications are dispensed by Genoa Pharmacy located at GHS main facility at 420 W. Fifth Ave, 1st floor. Please see attached General Fund Medication Procedure for details (attachment 15).
* Habilitation Supports Waiver (HSW):

The Habilitation Supports Waiver (HSW) is a special supports and service array for Medicaid beneficiaries who are developmentally disabled and who would require an institutional level of care if not enrolled in the HSW. For details on the referral process, please see the Habilitation Supports Waiver Process attachment in this manual (attachment 16).
* Respite:

Respite services are to give an unpaid caregiver a break from providing care to the consumer. All respites requests are reviewed by Utilization Management. A Respite Assessment is to be completed in CHIP prior to requesting an authorization. See Respite Services attachment in this manual for detailed information concerning this service and the process in making a request or requesting a change (attachment 17).
* State Inpatient Admission and Discharge:

Utilization Management is responsible to review requests for State Hospitalization. Requests are made directly to UM from the community inpatient facility. Please see State Inpatient Facility Admission Procedure attachment for details (attachment 18). The UM State Hospital Liaison is also responsible for coordinating discharge, please see attached States Facility Discharge-Clinical Monitoring Guidelines for details on the discharge processes and required post-discharge clinical monitoring (attachment 19).

* Provider Appeal

Any adverse UM decisions are subject to appeal through the provider reconsideration process:
* The provider completes the Provider Reconsideration Form, located on the internet:
[www.genhs.org](http://www.genhs.org), located “For Providers”>”Forms”>”Handout and Administrative” (attachment 20. Provider Reconsideration Form) and will submit copies of any additional supporting documentation that is not directly entered into CHIP.
* UM staff, other than the one who original made the decision, will review the CHIP record and approve or deny based on medical necessity.
* UM staff will consult with the UM Manager as needed.
* UM staff will send a letter of notification of the decision (and notify via phone when appropriate) to the provider.
* UM has up to 30 days to complete this review.
* If a provider disagrees with the reconsideration disposition, the provider may write a letter to the UM Manager, requesting a review. UM Manager will send a final disposition in writing to the provider.