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Purpose

Genesee Health System (GHS) has established a Utilization Management (UM) department with primary responsibilities for implementation of utilization management duties, delegated from Region 10 PIHP (R10), as outlined in contract Attachment P 6.7.1.1 with the Michigan Department of Health and Human Services. This document provides a description of the GHS UM program and the annual implementation plan associated with GHS Policy 01-400-93 and R10 Policy #01-04-01, Quality Assessment & Performance Improvement Program, and R10 UM Committee Plan.

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 Region 10 PIHP Access screening process; b) initial, emergent eligibility is determined through UM, GHS Behavioral Urgent Care, and after-hour delegation to Common Ground Crisis Intervention Recovery 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 staff are as follows:

Jennifer McCarty, LMSW, Clinical & Macro – Senior Director, Clinical Performance & Innovations

John Holiday, BSN RN – Director, Quality and Utilization Management

Michelle Crang, MA, LLP-UM Manager

Carrie Corlew-Thayer, LPC, CADC-M – UM Coordinator

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

Julianne Miller, RN – UM Coordinator

Irene Perez, LMSW – UM Coordinator

Kara Shelby, LMSW – UM Coordinator

Kendra Brown, LMSW – UM Coordinator

Krystal Shreve, LMSW – UM Coordinator

Lisa Merz, LMSW – UM Coordinator

Yvonne Williams, RN – UM Coordinator

Ongoing monitoring and evaluation of service utilization trends are used to assist GHS in meeting the mental health needs of the community while improving efficiency and effectiveness of service utilization. Outlier and exception reviews for non-emergent services; concurrent and retrospective reviews of high-intensity, high-cost, and emergent services; and over/under-utilization monitoring are the primary utilization management methods employed. Utilization care management of high-risk and vulnerable individuals is also conducted to assure timely access to needed services, and that individuals are served at the least restrictive treatment setting and level. The UM Department is responsible for the inpatient pre-admission screening review process. Refer to Attachment II – Community Inpatient Psychiatric Service Utilization Review -- for a description of utilization management procedures for these services.

The UM Coordinators complete most of the routine authorization requests that are submitted through CHIP, however, there are certain requests that require an escalated review to the UM Manager:

- Requests for all Environmental Modification and Enhanced Medical Equipment, and Assistive Technology that exceed \$500.00, have an initial review by the coordinator, followed by a final review and decision by the UM Manager.
- Routine respite authorization requests are reviewed and decisions are made by the UM Coordinator, except if the requester has added additional narrative information in the respite assessment that is not already covered by other areas of the assessment, then the UM Manager reviews the additional information to determine if additional hours should be added to the scored assessment.
- Requests for State hospital are assigned to a UM Coordinator to review the CHIP record, meet with the consumer for face to face interview, and to review the hospital records. Once the coordinator completes their assessment, it is reviewed by the UM Manager who makes the final decision to authorize. Once a consumer is approved for State hospitalization, there is a monthly State hospital meeting that reviews all State hospital waitlist, current admissions, recommendation for discharges, and recent discharges. This meeting includes the Senior Director of Clinical Services, directors of adult services, manager of consultative services, the UM State Hospital Coordinators, and UM Manager and director. The purpose of this meeting is to monitor individuals awaiting a State hospital bed, monitoring progress of current admissions, review appropriateness of potential discharges, and discuss needed supports and services for successful community transition.
- The UM Manager reviews provider appeals to denials made by UM Coordinators.

During prescreen review for crisis services, if an individual is being authorized for psychiatric inpatient, the prescreen reviewer (UM Coordinator during regular business hours, C.I.R.T during after-hours) will identify if the individual have recidivated for forward to the UM Manager. For individuals who have recidivated, the UM Manager assigns a UM Coordinator to complete a thorough clinical review that includes:

- Review for higher level of care or alternate treatment, if medically necessary (i.e., intensive case management, ACTP, home-based services, SUD treatment, etc.)
- Consult with the primary case holder/supervisor when additional or other services are potentially necessary to increase stability out of the hospital setting (i.e., increasing the consumer's level of care and case management contacts, adding services such DBT, changing providers if the consumer is not engaged, SUD treatment, etc.)
- Discuss possible discharge planning alternatives with hospitals during continued stay reviews (i.e., step down to Crisis Residential, Partial Hospital, Crisis Stabilization, SUD treatment, etc.)
- Coordinate with GHS hospital liaisons and primary programs for possible alternative discharge planning (i.e., arranging for GHS Intake to meet with the consumer while at the hospital for consumers that have missed multiple follow-up appointments, coordinating an Access screen for SUD treatment, or step down to Crisis Residential, Partial Hospital, or Crisis Stabilization upon discharge to continue treatment and connect with ongoing treatment providers)

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Genesee Health System will continue to work with Region 10 PIHP on implementation of parity for crisis services. Currently, MCG Indicia is utilized for crisis prescreens/crisis screens and concurrent reviews for inpatient and crisis residential services. And Indicia Inter-rater Reliability (IRR) module is utilized every six months for all staff who complete crisis prescreens/crisis screens and concurrent review, more frequently for newly hired staff. Results will be utilized for staff performance improvement.

Secondly, the LOCUS has been integrated with UM reviews to assist decisions concerning level of care and service authorization, which will help increase consistency of decision outcomes, as well as CAFAS and PECFAS.

Levels of Care for Mental Health Specialty Services

Crisis emergent services are not defined as a separate level of care as they are available to all eligible individuals based on medical necessity. Level of care assignments only apply to individuals who are involved in ongoing, non-emergent services in the GHS provider network panel. Service benefits that the individual is eligible to receive are defined in the Medicaid Provider Manual and are determined by the medically necessary services within each level of care. The specific type and amounts of services authorized are determined through the person centered planning process and development of the individual plan of service.

Attachment I – GHS Levels of Care – provides descriptions of each level of care. Associated benefit plans are posted on the www.genhs.org website for reference.

Service Utilization Monitoring

The following is a list of routine utilization reports used to monitor and manage service over/under-utilization.

ACCESS TO SERVICES	Monitoring Frequency
Access: Emergent	
Total pre-screens completed	Monthly
Total denials	Monthly
Total released to a lower level of care	Monthly
Total referred to each crisis level of care (inpatient, crisis residential, partial hospitalization, crisis stabilization)	Monthly
Total pre-booking jail diversions	Monthly

UTILIZATION TRENDS	Monitoring Frequency
Not seen in specified number of days per service type	As Needed
Home-Based Underutilization by Provider	Monthly
Below or above service utilization thresholds by service type and by LOC	Quarterly
Assertive Community Treatment:	
Inpatient Admission within past 60 days prior to the reporting period	Quarterly
Average weekly contacts is less than two service contacts per week during the last 60 days of the reporting period	Quarterly
Total claimed units aggregate and by provider	Monthly
Total number of consumers aggregate and by provider	Monthly
Median Claimed units per consumer	Monthly

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Targeted Case Management/Supports Coordination:	
Two or more crisis service admissions (IPU, CRU, PHP) during the past 365 days	Quarterly
Less than 12 units during the past quarter	Quarterly
Greater than 48 units during the past quarter	Quarterly
Total claimed units aggregate and by provider	Monthly
Total number of consumers aggregate and by provider	Monthly
Median Claimed units per consumer	Monthly
Private Duty Nursing Over-utilization of Monthly Authorized Units	Monthly
Respite:	Monthly
Total claimed units aggregate and by provider	Monthly
Total number of consumers aggregate and by provider	Monthly
Median Claimed units per consumer	Monthly
Applied Behavior Analysis:	Monthly
Weekly average service utilization 25% over/under utilized compared to authorized amount per the Autism Treatment Plan	Quarterly
Family Training less than once per quarter	As needed

FOCUSED SERVICE UTILIZATION MONITORING	Monitoring Frequency
Specialized residential level of care distributions by LOC, CLF/non-CLF settings, level changes per case, vacancy rate	As Needed
Inpatient admission rate	Monthly

UTILIZATION MANAGEMENT ACTIVITY	Monitoring Frequency
Number of authorizations approved by UM staff	Monthly
Number of authorizations denied by UM staff	Monthly
Number of authorization requests processed by UM staff	Monthly
Number of level of care (LOC) change requests pended for UM review	Monthly
Number of LOC requests Processed by UM	Monthly
Medicaid Adverse Benefit Determination Notice Type and Reason	Quarterly
MDHHS Services Authorization Denial Report	Quarterly

**ATTACHMENT I
LEVEL OF CARE DESCRIPTIONS**

****The following descriptions are to be used as a guideline only and are not intended to be exclusionary or all inclusive***

Adults with Serious Mental Illness and Co-Occurring Disorders**Level 1: Limited Services - Brief Outpatient**

Meets criteria as a seriously mentally ill individual, with or without a co-occurring substance use disorder, but signs and symptoms are generally stable with limited outpatient service support (Medication support only or Outpatient Therapy with Medication support). Individual may require infrequent, low intensity Supports Coordination Assistant or Peer service support but generally mental health needs are met with limited and brief medication or outpatient therapy supports. Functional impairments in self-care, daily living skills, social/interpersonal functioning and/or educational/occupational role may be sporadically evident but there is sufficient self or other support to require little to no assistance in these areas. Risk of harm to self or others is minimal. Services are generally provided in an office based setting and the individual is considered to be generally cooperative with treatment. Frequency of services is determined by consumer need and preferences but typically will occur not more than once weekly, but not less than once quarterly.

Level 2: Limited Services - Supports Coordination

Meets criteria as a seriously mentally ill individual, with or without a co-occurring substance use disorder, with currently mild and relatively stable signs and symptoms. Mild functional impairments in self-care, daily living skills, social/interpersonal functioning and/or educational/occupational role are evident but the individual has the ability to benefit from sustained, offered services and supports to perform and maintain essential activities of daily living. Risk of harm to self or others is low and suicidal or homicidal ideation is only transient, with no recent serious attempts to harm self or others. A combination of office and community based services are appropriate in meeting needs. The individual requires some assistance to link to and coordinate or follow-up with community resources/services/supports, including housing and employment resources, development of social networks, scheduling appointments and meetings, engagement of natural supports, and benefit coordination. Specific outcomes that supports are likely to impact regarding level of functioning and/or remission of presenting symptoms are able to be identified. Frequency of services is determined by consumer need and preferences, but typically will occur not more than once weekly but not less than once quarterly.

Level 3: Specialized Outpatient - Targeted Case Management (Low)

Meets criteria as a seriously mentally ill individual, with or without a co-occurring substance use disorder, with currently mild and relatively stable signs and symptoms. Moderate functional impairments in self-care, daily living skills, social/interpersonal functioning and/or educational/occupational role are evident. The individual has multiple service needs, has a moderately high level of vulnerability, requires access to a continuum of mental health services from the CMHSP, and/or is unable to independently access and sustain involvement with needed services. The individual has an ongoing, consistent need for all components of TCM, including assessment, planning, linkage, advocacy, coordination and monitoring. There is a low to moderate risk of self or other harm and may be transient suicidal or homicidal ideation but no serious recent attempts and no substantial plan of action to harm. Generally requires a multi-disciplinary system of supports and other professional support are usually involved, as well as para-pro-staff support. Contact can occur as often as needed but generally will occur as frequently as once weekly, but not less than monthly. Contacts are largely community based.

Level 4: Specialized Outpatient - Targeted Case Management (High)

Meets criteria as a seriously mentally ill individual, with or without a co-occurring substance use disorder, with currently moderate signs and symptoms. Moderate functional impairments in self-care, daily living skills, social/interpersonal functioning and/or educational/occupational role are evident. The individual has multiple service needs, has a high level of vulnerability, requires access to a continuum of mental health services from the CMHSP, and/or is unable to independently access and sustain involvement with needed services. The individual has an ongoing, consistent need for all components of TCM, including assessment, planning, linkage, advocacy, coordination and monitoring. There may be a moderate risk of self or other harm and may be transient suicidal or homicidal ideation, but no serious recent attempts and no substantial plan of action to harm. Requires a multi-disciplinary system of supports and other professional support are involved, as well as para-pro-staff support. Contacts can occur as often as needed (even daily), but will occur as frequently as once weekly and are largely community based.

Level 5: Specialized Outpatient - Assertive Community Treatment (ACT)

Meets criteria as a seriously mentally ill individual with or without a co-occurring substance use disorder. Requires intensive, community based supports, and without ACT, would require more restrictive services and/or settings. Individual has significant impairment of self-care and independent functioning and difficulty managing medications without ongoing support or experience symptoms despite medication treatment adherence. Individual is often at high risk of arrest, incarceration, inpatient, or other crisis service use, but with ACT can remain safely in the community with intensive, 24/7 supports requiring a multi-disciplinary team. Service intensity requirements are up to several times daily as needed, but no less than several times weekly. Risk to self or others is not immediate, but assessment of risk potential is consistently and frequently done.

Level 6: Specialized Residential Treatment

Meets criteria as a seriously mentally ill individual, with or without a co-occurring substance use disorder. Signs and symptoms of mental illness are substantial and prominent, resulting in serious neglect of self-care and/or insufficient attention to essential aspects of daily living. Interpersonal functioning is significantly impaired. Ability to maintain adequate nutrition, shelter, and other essentials of daily living is dependent on structures and/or prompts available in residential environment. Crisis response is available 24/7. Active treatment and service delivery are expected to occur on a daily basis, and support staff are available around the clock. Individual does not present any substantial or immediate risk of harm to self or others, although may display transient, intermittent ideation or mild, infrequent self-harm with no serious threat of harm. Individuals require and are involved with a multi-disciplinary team of professionals and targeted case management (Low or High level) supports. Frequency of contact is up to several times per week, but no less than twice per month.

Adults with Intellectual/Developmental Disabilities**Level 1: Limited Services - Basic Support**

- Meets criteria as an intellectual/developmentally disabled individual.
- Housing needs are met in the family home, General AFC, or independent housing.
- There are established entitlements, sufficient natural supports to meet daily living needs, and otherwise individual requires and desires only basic support services.
- With basic supports, there is minimal risk of harm to self or others.
- When engaged in vocational/educational/community activity, it is often community based with minimal supports being required or if in a classroom setting, requires minimal supports.
- Professional support services needs (i.e. supports coordination, medical and other clinic based) are met with 1-10 hours of supports per month.

Level 2: Enhanced Support Services

- Meets criteria as an intellectual/developmentally disabled individual.
- Individual has medical necessity for and desires to be involved in additional support and specialty services beyond basic supports.
- Housing, entitlements, natural supports, and other coordination and linking needs may not otherwise be met without Supports Coordination.
- Residential needs are met through the family home with supports (e.g. CLS, Respite), AFC Specialized Residential Contract, or Semi-independent placement with weekly supports.
- Vocational/educational/community inclusion needs are met through supported employment, community living support, skill building, and other support services.
- Risk of harm to self or others is low with supports in place.
- Professional support service needs (i.e., Supports Coordination or Targeted Case Management, BTPRC, Medical and other clinic services) are met with 11-20 hours of support per month.

Level 3: Specialized Support Services and HSW

- Meets criteria as an intellectual/developmentally disabled individual.
- Residential needs are met via Specialized Residential contract group home (Level 3-4), family home with CLS and/or Respite supports, semi-independent living arrangements with multiple weekly supports.
- Vocational/educational/community inclusion support needs are met through supported employment, pre-vocational training, Community Living Supports, Skill Building, and other support services.
- Risk of harm to self or others with supports in place is low.
- Professional Support Service needs are met through Supports Coordination, Targeted Case Management, BTPRC, Medical, and other clinic services of 21-30 hours per month.
- HSW services are offered at this level for adult consumers who are determined eligible for the waiver by MDHHS.

Level 4: Intensive Residential and Support Services

- Meets criteria as an intellectual/developmentally disabled individual.
- Residential needs are met via Specialized Residential contract group home with 24-hour awake staff.
- Risk of harm to self or others is minimized with this intensive level of support.
- Vocational/educational/community inclusion support needs are generally provided with continual supports.
- Professional Support Service needs (i.e., Supports Coordination or Targeted Case Management, BTPRC, Medical or other clinic services) of 31+ hours of support per month.

Children with Serious Emotional Disturbance and Co-occurring Disorders or Intellectual/Developmental Disabilities**Level 1: Limited Services - Basic Support**

- Meets criteria as a child with a serious emotional disturbance or intellectual/developmental disability
- Natural supports provide for basic needs, such as housing.
- Minimal risk of harm to self or others with natural supports in place.
- Needs met by primary outpatient programs such as Medication services, Respite, or Outpatient Therapy, but may need some Supports Coordination contacts for period support.
- 20 or fewer service support contact needed per year.

Level 2: Enhanced Support Services

- Meets criteria as a child with a serious emotional disturbance or intellectual/developmental disability.
- Child has needs that require ongoing (bi-monthly to quarterly) support and coordination.
- Child is not enrolled in the HSW or Child Waiver programs.
- The child or family is able to identify specific outcomes that supports (supports coordination) are likely to impact regarding improved level of functioning and/or remission of presenting symptoms.
- Minimal immediate risk of self-harm or harm to others.

Level 3: Specialized Support Services

- Meets criteria as a child with a serious emotional disturbance or intellectual/developmental disability.
- May require up to three (3) times weekly case management support, weekly CLS support and/or skill building assistance, monthly psychiatric monitoring, and other clinic services.
- May be HSW or Child Waiver enrolled.

Level 4: Intensive Residential and Support Services

- Meets criteria as a child with a serious emotional disturbance or intellectual/developmental disability.
- Has medical necessity for home-based, MST, or wrap-around services.
- May be HSW or Child Waiver enrolled.
- Symptom severity does not pose immediate risk of harm, but risk would be substantially greater if specialty supports were not in place.
- Requires multi-disciplinary supports, including intensive case management or (HSW) supports coordination.
- Contact as often as needed, typically from two (2) hours per week to daily.

Level AUT: Serious Emotion Disorder or Intellectual/Developmental Disability

- Available to Medicaid recipients under 21 years old
- For new cases, coming through Access, that has rule out Autism Spectrum Disorder and positive brief screen, such as M-CHAT or SCQ screening tool
- Temporary level of care while further diagnostic evaluations are completed for Autism Spectrum Disorders.
- All level 4 services that are medically necessary are available, as medically necessary, during the interim of further evaluation.

**ATTACHMENT II
COMMUNITY INPATIENT PSYCHIATRIC SERVICES UTILIZATION REVIEW**

Overview

Genesee Health System Utilization Management (GHS UM), delegated by Region 10 PIHP, requires pre-admission screening and prior-authorization for inpatient mental health services. The provider is responsible for contacting GHS Utilization Management (UM) prior to admission, either by fax (*the preferred method*) or phone, and will submit all required information contained on the GHS Inpatient Pre-Admission Review Request form. Utilization Management, and after-hour delegation to Common Ground Crisis Intervention Response Team (C.I.R.T.), staff who are licensed mental health professionals complete a review of eligibility and medical necessity and communicate the disposition to the provider within three hours or less of receipt of the IPAR request. It is the goal of GHS to complete the IPAR in the most expeditious manner. Continuing stay reviews are completed at intervals set by GHS UM for ongoing authorization. Retrospective reviews will be conducted as well to assure that services provided were medically necessary, were delivered at the lowest level of care necessary, and that standards of care were adhered to. Providers should diligently adhere to review timelines and processes as outlined in this manual.

How to Contact GHS – Utilization Management	
Pre-admission screen FAX	810-496-4932
Pre-admission screen phone	810-496-4931
UM Phone – Regular Business Hours	810-257-1325
UM FAX – General Use	810-257-1347
Mail	Genesee Health System Utilization Management 421 W. Fifth Ave Flint, MI 48503

Pre-admission Review (IPAR) for Inpatient Psychiatric Care Admissions**Purpose**

The purpose of an Inpatient Pre-Admission Review (IPAR) Request form is to determine eligibility and medical necessity for inpatient psychiatric services, ensuring that the least restrictive medically necessary level of care is accessed by beneficiaries in an expeditious manner. The IPAR and authorization requirements are regulated by federal and state codes.

Responsibility

Providers are responsible for requesting and obtaining prior authorization from GHS for all voluntary and involuntary admissions for which GHS is the payer. Genesee Health System UM, and C.I.R.T., is responsible for providing pre-admission reviews 24 hours per day, 7 days per week. Genesee Health System is also responsible for assisting providers to link and coordinate referrals to lower level of care alternatives to inpatient psychiatric services. Genesee Health System UM does not verify recipient insurance at the time of the pre-screen review; providers are responsible for verifying insurances and county of residency.

Requirements

All inpatient psychiatric care must be certified and prior authorized by GHS- UM, or CIRT, in order to be reimbursed by GHS.

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Medical necessity criteria for inpatient psychiatric services, as published in the most current version of the Michigan Medicaid Provider Manual (http://mi.gov/mdhhs/0,1607,7-132-2945_5100-87572--,00.html), is required to be met at the time of admission, as established through the Pre-admission Review process. A primary substantiated diagnosis of mental illness is required, as well as sufficient severity and intensity of symptoms to warrant the inpatient level of care. If medical necessity criteria are met, a prior-authorization number will be assigned and the review will be certified.

The following information contained on the IPAR form is required:

- Admission Type (Voluntary or Involuntary)
- Patient Name
- Patient Date of Birth
- Patient Address
- Patient County of Residency
- Social Security Number
- Patient Home Phone
- Patient Gender
- Patient Medicaid, Healthy Michigan, or MI Child ID#
- AKA or other names used if known
- Guardian Name and Address
- Primary Care Physician Name and Phone
- Presenting Problem
- Mental Health Treatment History
- Substance Use History
- Blood Alcohol and/or Urinalysis Results when available
- Risk Factors
- Overall Risk Rating
- Current Impairments
- Preliminary or Rule-out Dx
- Recommended Disposition
- Referring hospital contact information

Providers should always use the most current version of the IPAR form which can be located on the www.genhs.org web site under the 'Provider' section and then 'Utilization Management'. The IPAR is to be completed by the provider and faxed to GHS Utilization Management at 810-496-4932 to initiate the review. An alternative, but less preferred, method of submission is for providers to contact UM and C.I.R.T. by phone at 810-496-4931 to obtain prior authorization; callers may be placed into voicemail. The voicemail is continuously monitored and calls are returned in the order they are received. Providers who opt to complete a pre-screen telephonically must be prepared to provide all of the information contained on the IPAR form, and must remain on the call while data is gathered and electronically entered by staff.

Pre-admission reviews will be processed in the order in which they are received, and completed in as expeditious a manner as possible, typically within 15 to 60 minutes from time of faxed receipt of a complete IPAR form, but within no more than three (3) hours from time of receipt. Once a pre-admission determination is made, UM (or C.I.R.T.) will contact the provider by phone to discuss the disposition, and a fax will be sent to the provider documenting the disposition. Utilization Management, and C.I.R.T., will provide assistance in linking to alternative lower service level of care or community referral option(s) as appropriate. Initial authorization for inpatient care will be for one (1) day. Psychiatric hospitals located within Genesee County will fax the completed bottom portion of the disposition form to UM at 810-496-4932 within one (1) business day, providing UM with a valid DSM-V mental health diagnosis from the psychiatric

evaluation, and the expected length of stay. Concurrent reviews will begin when the consumer exceeds the expected length of stay, or six (6) days from admission, whichever occurs first. In-county psychiatric hospitals are monitored via auditing as needed, subject to denials if documentation does not support medical necessity. Out-of-county inpatient admissions will have concurrent reviews starting the next business day via the provider calling UM's general number, 810-257-1325, between the hours of 12:30 p.m. and 4:30 p.m.

Other County of Residency

Genesee Health System UM, or C.I.R.T. will complete a courtesy pre-screen for inpatient service authorization requests for individuals presenting in a local emergency department who reside in a county other than Genesee, and where GHS is not otherwise financially responsible. Genesee Health System UM, or C.I.R.T., will contact the CMHSP/PIHP of the county of residence to provide service recommendations and the emergency department contact information to coordinate. Genesee Health System UM, or C.I.R.T., will also provide the CMHSP/PIHP contact information to the local emergency department. If an out-of-county emergency department contacts UM for inpatient service authorization for an individual with a county of residency other than Genesee, and GHS is not otherwise the county of financial responsibility, the emergency department will be directed to the CMHSP/PIHP county of residency.

Continued Stay Reviews**Purpose**

The purpose of the continued stay review is to evaluate ongoing medical necessity for inpatient care and the need to extend authorization. The UM reviewer will evaluate the services that have already been provided and the continued inpatient treatment plan, as well as the appropriateness of lower level of care service options.

Responsibility

Providers are responsible for submitting requests for continued stay reviews in a timely and complete manner. Utilization Management is responsible for receiving and reviewing all submitted information at the time of the scheduled review.

Requirements

Continued stay reviews will be completed at intervals determined by GHS UM. Review intervals may be as often as daily, but will be at intervals not to exceed six (6) consecutive inpatient days or the expected length of stay for the inpatient episode of care, whichever is less. In all cases, reviews will be scheduled to occur prior to the current authorization expiration date.

Continued stay reviews are conducted by phone with UM staff during normal business hours. The provider is responsible for contacting UM during normal business hours, on or before the scheduled review date, to complete the review. If the authorization expiration date falls during a weekend or holiday, then a continuing stay review will be completed on the next business day; the consumer will need to meet medical necessity for inpatient services for approval.

The following information will be made available to UM by the provider and will be considered during the review:

- Psychiatric evaluation and diagnosis
- Current acuity or risk assessment
- Functional assessment
- Appropriateness and effectiveness of service
- Quality of care
- Length of stay
- Discharge plan progress

The UM continued stay review will result in one of the following outcomes:

- 1) The continued stay is certified and the authorization is extended until the next concurrent review date, as determined and scheduled by UM.
- 2) The review is pended for GHS physician review due to identified issues in services, discharge plan progress, or quality of care, which may result in a GHS physician initiation of consultation with the provider physician.
- 3) The continued stay is denied and no further authorization is approved.

Discharge Notification

Notification of discharge from the inpatient unit will be submitted to UM within 24 hours of discharge, via fax, to 810-257-1347, and will include the following required information:

- Date of discharge
- Mental health after-care appointment information:
 - › Program name
 - › Program contact person
 - › Appointment date and time
 - › Service type

It is the responsibility of the provider to send required discharge information to the receiving after-care provider.

Late Submission Reviews

Exceptions may be made to the regular admission and continued stay review timelines as outlined in this document. Reasons for exception may include an emergent inpatient admission where a prior certification may have resulted in a compromise to the care of the individual, or late determination of payer responsibility and eligibility. Requests for late submission reviews will be made by the provider by calling GHS UM at 810-257-1325 during regular business hours.

Utilization Review Appeals

Genesee Health System UM offers providers an appeal option for all adverse determinations. Providers will be sent written notice of an adverse action, including the reason for the action, within one (1) business day of the determination. The written notice will include provider appeal rights and procedures. Appeal reviews will be conducted by the Director of Quality & Utilization Management, or designee, who is neither the individual nor the subordinate of the individual who made the original determination, and has no conflicts of interest with the patient, attending physician, or facility under review.

Providers requesting an appeal will complete the 'Provider Reconsideration' form, which can be located on the www.genhs.org web site under the 'Provider' section and then 'Utilization Management', and submit hard-copies of all supporting documentation by mail to:

**Genesee Health System
Utilization Management - Appeal
421 W. Fifth Ave
Flint, MI 48503**

An expedited appeal can be requested for medical necessity review of urgent care cases when the provider has received a non-certification action from GHS UM. The appeal request can be made by phone, fax, or mail and must be received by UM within two (2) days of receipt of notification of the adverse action. When an appeal request is received by UM after this period of time, it will be processed as a standard appeal. Expedited appeals will be processed within three (3) days, and standard appeals will be processed within 30 days of request receipt by UM.