INPATIENT AFFILIATION PROVIDER MANUAL

INPATIENT,
PARTIAL HOSPITALIZATION,
ELECTROCONVULSIVE THERAPY
SERVICES

FY2018
FY2019

Allegan County Community Mental Health Services
Community Mental Health of Ottawa County
HealthWest
Kent CMH Authority d/b/a network180
West Michigan Community Mental Health System
PROGRAM SPECIFICATIONS

These services must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as updated. The manual is available at:

A. Inpatient Hospitalization (Adults, Children, and Adolescents)

Services:
- Psychiatric evaluations and reviews, including subsequent care days.
- Coordination of treatment planning, including discharge planning.
- Nursing care.
- Group, individual, and family treatment.
- Ancillary Services – including but not limited to: Lab, Radiology, Psychological Testing, Dietary Evaluation.
- History and Physical.
- Medication.
- Person-Centered treatment.
- Advocacy and linking to community resources as needed.
- Physical, and/or Occupational therapy.
- Language interpreter and/or translation/interpreter services.
- Services delivered will include all services required for an inpatient licensed hospital program.
- Discharge prescriptions.

B. Partial Hospitalization (Adults, Children, and Adolescents)

Services:
- Psychiatric evaluations and reviews, including subsequent care days.
- Coordination of treatment planning, including discharge planning.
- Group, individual, and family treatment.
- Person-centered treatment.
- Medication.
- Advocacy and linking to community resources as needed.
- Physical and/or Occupational therapy.
- Language interpreter and/or translation/interpreter services.
- Services delivered will include all services required for a licensed partial hospitalization program.

C. Electroconvulsive Therapy (ECT) - Inpatient

- Must be provided under contract and will follow the protocol and standards established by the American Psychiatric Association.
- Includes Physician and Anesthesia services.

D. Electroconvulsive Therapy (ECT) - Outpatient

- Must be provided under contract and will follow the protocol and standards established by the American Psychiatric Association.
- Includes facility charge, Physician, and Anesthesia services.
MEDICAL NECESSITY CRITERIA: The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and 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.

DETERMINATION CRITERIA 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 with Federal and State standards for timeliness; and
- Sufficient in amount, scope, and duration of the service(s) to reasonably achieve its/their purpose.

SUPPORTS, SERVICES, AND TREATMENT AUTHORIZED BY THE PIHP/CMHSP 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.
PIHP/CMHSP DECISIONS - Using criteria for medical necessity, a PIHP/CMHSP may:

- Deny services that are:
  - Deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
  - Experimental or investigational in nature; or
  - Services 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, gatekeeping arrangements, protocols, and guidelines.
- A PIHP/CMHSP 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.

LEGAL ISSUES

Adult involuntary admission of a person requiring treatment must meet the criteria specified in Section 401 (1) of the Michigan Mental Health Code, and be screened, evaluated, referred, and approved by the Payor for admission prior to admittance to the Hospital.

Voluntary admission of an eligible person requiring treatment must meet the criteria specified in Chapter 4 Civil Admission and Discharge Procedures: Mental Illness, or Chapter 4A Civil Admission and Discharge Procedures for Emotionally Disturbed Minors of the Michigan Mental Health Code; and be screened, evaluated, referred, and approved for psychiatric inpatient admission by the Payor prior to admittance, in accordance with Section 410 of the Mental Health Code. Other eligible consumers who meet the description in Section 401(2) of the Mental Health Code also may constitute informal or formal voluntary admissions hereunder; said individuals also must be screened, evaluated, and referred for psychiatric inpatient admission by the Payor prior to their admission to the Provider's inpatient unit, pursuant to Section 410 of the Mental Health Code.
INPATIENT PSYCHIATRIC CARE: ADULT

Inpatient psychiatric care may be used to treat a person with a mental illness who requires care in a 24-hour medically structured and supervised facility. The Severity of Illness/Intensity of Service (SI/IS) criteria for admission are based upon the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA: The individual must meet all three outlined below:

1. **Diagnosis:** The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM, or ICD diagnosis (not including V Codes).

2. **Severity of Illness (signs, symptoms, functional impairments, and risk potential):** At least one of the following manifestations is present:

   a. **Severe Psychiatric Signs and Symptoms**
      o Psychiatric symptoms - features of intensive cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) severe enough to cause seriously disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.
      o Disorientation, seriously impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
      o A severe, life-threatening psychiatric syndrome or an atypical or unusually complex psychiatric condition exists that has failed, or is deemed unlikely, to respond to less intensive levels of care, and has resulted in substantial current dysfunction.

   b. **Disruptions of Self-Care and Independent Functioning**
      o The person is unable to attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essentials of daily living due to a psychiatric disorder.
      o There is evidence of serious disabling impairment in interpersonal functioning (e.g., withdrawal from relationships; repeated conflictual interactions with family, employer, co-workers, neighbors) and/or extreme deterioration in the person’s ability to meet current educational/occupational role performance expectations.

   c. **Harm to Self**
      o Suicide: Attempt or ideation is considered serious by the intention, degree of lethality, extent of hopelessness, degree of impulsivity, level of impairment (current intoxication, judgment, psychological symptoms), history of prior attempts, and/or existence of a workable plan.
      o Self-Mutilation and/or Reckless Endangerment: There is evidence of current behavior, or recent history. There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan, and judgment would suggest an inability to maintain control over these ideations.
- Other Self-Injurious Activity: The person has a recent history of drug ingestion with a strong suspicion of overdose. The person may not need detoxification but could require treatment of a substance induced psychiatric disorder.

d. Harm to Others

- Serious assaultive behavior has occurred, and there is a risk of escalation or repetition of this behavior in the near future.
- There is expressed intention to harm others and a plan and/or means to carry it out, and the level of impulse control is non-existent or impaired (due to psychotic symptoms, especially command or verbal hallucinations, intoxication, judgment, or psychological symptoms, such as persecutory delusions and paranoid ideation).
- There has been significant destructive behavior toward property that endangers others.

e. Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care

- The person has experienced severe side effects from using therapeutic psychotropic medications.
- The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment, or reinstitution of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary’s condition or to the nature of the procedures involved.
- There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring, and/or treatment during medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

Special Consideration: Concomitant Substance Abuse - The underlying or existing psychiatric diagnosis must be the primary cause of the beneficiary’s current symptoms or represent the primary reason observation and treatment is necessary in the psychiatric unit or hospital setting.

3. Intensity of Service. The person meets the intensity of service requirements if inpatient services are considered medically necessary for the beneficiary’s treatment/diagnosis, and if the person requires at least one of the following:

- Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.
- Close and continuous skilled medical observation is necessary due to otherwise unmanageable side effects of psychotropic medications.
- Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) is needed to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.
- A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary’s signs and symptoms.
INPATIENT ADMISSION CERTIFICATION CRITERIA: CHILDREN THROUGH AGE 21

Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based on the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA: The individual must meet all three outlined below:

1. **Diagnosis:** The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current DSM, or ICD diagnosis (not including V Codes).

2. **Severity of Illness (signs, symptoms, functional impairments, and risk potential):** At least one of the following manifestations is present:

   a. **Severe Psychiatric Signs and Symptoms**
      - Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.
      - Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
      - Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction.

   b. **Disruptions of Self-Care and Independent Functioning**
      - Beneficiary is unable to maintain adequate nutrition or self care due to a severe psychiatric disorder.
      - The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has been a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance.

   c. **Harm to Self**
      - A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, and impulsivity.
      - There is a specific plan to harm self with clear intent and/or lethal potential.
      - There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment, or a history of prior attempts.
      - There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking, or other self-endangering behavior.
There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan, and judgment would suggest an inability to maintain control over these ideations.

There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.

d. Harm to Others

- Serious assaultive behavior has occurred, and there is a clear risk of escalation or repetition of this behavior in the near future.
- There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired.
- There has been significant destructive behavior toward property which endangers others, such as setting fires.

e. Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care

- The person has experienced severe side effects from using therapeutic psychotropic medications.
- The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment, or re-initiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.
- There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring, and/or treatment during medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

Special Consideration: Concomitant Substance Abuse - The underlying or existing psychiatric diagnosis must be the primary cause of the beneficiary’s current symptoms or represent the primary reason observation and treatment are necessary in the hospital setting.

3. Intensity of Service: The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least one of the following:

- Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.
- Close and continuous skilled medical observation are needed due to otherwise unmanageable side effects of psychotropic medications.
- Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) are needed to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.
- A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary’s signs and symptoms.
INPATIENT PSYCHIATRIC CARE - CONTINUING STAY CRITERIA: ADULTS, ADOLESCENTS, AND CHILDREN

After a beneficiary has been certified for admission to an inpatient psychiatric setting, services must be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in an inpatient setting. Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arrestment of potentially life-threatening self/other harm inclinations, management of adverse biologic reactions to treatment, and/or regulation of complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regimen in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the patient’s problems and dysfunctions.

Continuing treatment in an inpatient setting may be certified when signs, symptoms, behaviors, impairments, harm inclinations, or biologic/medication complications, similar to those which justified the patient’s admission certification, remain present, and continue to be of such a nature and severity that inpatient psychiatric treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the inpatient unit. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

CRITERIA: The individual must meet all three outlined below:

1. Diagnosis: The beneficiary has a validated current version of DSM or ICD mental disorder (excluding V Codes) that remain the principal diagnosis for purposes of care during the period under review

2. Severity of Illness (signs, symptoms, functional impairments, and risk potential): At least one of the following manifestations is present:
   - Persistence/intensification of signs/symptoms, impairments, harm inclinations, or biologic/medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care:
   - Continued severe disturbance of cognition, perception, affect, memory, behavior, or judgment.
   - Continued gravely disabling or incapacitating functional impairments or severely and pervasively impaired personal adjustment.
   - Continued significant self/other harm risk.
   - Use of psychotropic medication at dosage levels necessitating medical supervision, dosage titration of medications requiring skilled observation, or adverse biologic reactions requiring close and continuous observation and monitoring.
   - Emergence of new signs/symptoms, impairments, harm inclinations, or medication complications, meeting admission criteria.

3. Intensity of Service:
   - The beneficiary requires close observation and medical supervision due to the severity of signs and symptoms, to control risk behaviors or inclinations, to assure basic needs are met, or to manage biologic/medication complications.
   - The beneficiary is receiving active, timely, treatment delivered according to an individualized plan of care.
o Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations, or biologic/medication complications that necessitated admission to inpatient care.

o The beneficiary is making progress toward treatment goals as evidenced by a measurable reduction in signs/symptoms, impairments, harm inclinations, or biologic/medication complications or, if no progress has been made, there has been a modification of the treatment plan and therapeutic program, and there is a reasonable expectation of a positive response to treatment.

o Discharge and aftercare planning are documented in the beneficiary's record.
**PARTIAL HOSPITALIZATION: ADULTS**

Partial hospitalization services may be used to treat a mentally ill person who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services, and supports are provided for six or more hours per day, five days a week, in a licensed setting. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary’s present treatment needs. The Severity of Illness (SI)/Intensity of Services (IS) criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

**CRITERIA:** The individual must meet all three outlined below:

1. **Diagnosis:** beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD diagnosis (not including V Codes).

2. **Severity of Illness** (signs, symptoms, functional impairments, and risk potential). At least two of the following manifestations are present:

   a. **Psychiatric Signs and Symptoms**
      - Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness), or behavior exists (e.g., intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing, and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation or disorder are not so severe, extreme, or unstable so as to require frequent restraints or to pose a danger to others

   b. **Disruptions of Self-Care and Independent Functioning**
      - The person seriously neglects self-care tasks (hygiene, grooming, etc.) and/or does not sufficiently attend to essential aspects of daily living (does not shop, prepare meals, maintain adequate nutrition, pay bills, complete housekeeping chores, etc.) due to a mental disorder.
      - Beneficiary is able to maintain adequate nutrition, shelter, or other essentials of daily living only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program.
      - The person’s interpersonal functioning is significantly impaired (seriously dysfunctional communication, extreme social withdrawal, etc.).
      - There has been notable recent deterioration in meeting educational/occupational responsibilities and role performance expectations.
c. **Danger to Self**
   - There is modest danger to self reflected in intermittent self-harm ideation, expressed ambivalent inclinations without a plan, non-intentional threats, mild and infrequent self-harm gestures (low lethality/intent), or self-mutilation, passive death wishes, or slightly self-endangering activities.
   - The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity, or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk.

d. **Danger to Others**
   - Where assaultive tendencies exist, there have been no overt actions and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb these inclinations.
   - There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions.
   - There has been minor destructive behavior toward property without endangerment of others.

e. **Drug/Medication Complications**
   - The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the beneficiary’s condition or to the nature of the procedures involved.
   - The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.

3. **Intensity of Service:** The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least **one** of the following:
   - The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care.
   - The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments.
   - Routine medical observation and supervision required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.
PARTIAL HOSPITALIZATION ADMISSION CRITERIA: CHILDREN AND ADOLESCENTS

Partial hospitalization services may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services, and supports are provided for six or more hours per day, five days a week, in a licensed setting. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary’s present treatment needs. The SI/IS criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in either self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments, and/or the estimation or risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA: The individual must meet all three outlined below:

1. **Diagnosis:** The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current DSM or ICD diagnosis (not including V Codes).

2. **Severity of Illness** (signs, symptoms, functional impairments, and risk potential). At least two of the following manifestations are present:

   a. **Psychiatric Signs and Symptoms**
      
      - Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness), or behavior exists (e.g., intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing, and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation is not so severe, extreme, or unstable so as to require frequent restraints or to pose a danger to others.

   b. **Disruption of Self-Care and Independent Functioning**
      
      - The child/adolescent exhibits significant impairments in self-care skills (feeding, dressing, toileting, hygiene/bathing/grooming, etc.) in the ability to attend to age-appropriate responsibilities, or in self-regulation capabilities, due to a mental illness or emotional disturbance.
      - The child/adolescent is able to maintain adequate self-care and self-regulation only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program.
      - There is recent evidence of serious impairment/incapacitation in the child/adolescent’s interpersonal and social functioning (seriously dysfunctional communication, significant social withdrawal and isolation, repeated disruptive, inappropriate, or bizarre behavior in social settings, etc.).
o There is recent evidence of considerable deterioration in functioning within the family and/or significant decline in occupational/educational role performance due to a mental illness or emotional disturbance.

c. **Danger to Self**
   o There is modest danger to self reflected in: non-accidental self-harm gestures or self-mutilation actions which are not life-threatening in either intent or lethal potential; intermittent self-harm ideation; expressed ambivalent inclinations without a plan; non-intentional threats; passive death wishes; or slightly self-endangering activities.
   o The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity, or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control, and the person no longer needs/requires 24-hour supervision to contain self-harm risk.

d. **Danger to Others**
   o Assaultive tendencies exist, and some assaultive behavior may have occurred, but any overt actions have been without any serious or significant injury to others, and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb any serious expression of these inclinations.
   o There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have adequate impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions.
   o There has been minor destructive behavior toward property without endangerment of others.

e. **Drug/Medication Complications**
   o The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the consumer’s condition or to the nature of the procedures involved.
   o The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.

3. **Intensity of Service:** The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least one of the following:

   o The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care.
   o The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive, treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments.
   o Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.
PARTIAL HOSPITALIZATION: CONTINUING STAY CRITERIA FOR ADULTS, ADOLESCENTS, AND CHILDREN

After a beneficiary has been certified for admission to a partial hospitalization program, services will be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in a partial hospitalization setting. Treatment within a partial hospitalization program is directed at resolution or stabilization of acute symptoms, elimination or amelioration of disabling functional impairments, maintenance of self/other safety, and/or regulation of precarious or complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regimen in addressing these concerns, and to determine whether the partial program remains the most appropriate, least restrictive, level of care for treatment of the beneficiary’s problems and dysfunctions.

Continuing treatment in the partial program may be certified when symptoms, impairments, harm inclinations, or medication complications, similar to those which justified the beneficiary’s admission certification, remain present, and continue to be of such a nature and severity that partial hospitalization treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the program. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

CRITERIA: Must meet all three criteria outlined below:

1. **Diagnosis:** The beneficiary has a validated, current DSM or ICD mental disorder (excluding V Codes), which remains the principal diagnosis for purposes of care during the period under review.

2. **Severity of Illness:** (signs, symptoms, functional impairments, and risk potential)
   - Persistence of symptoms, impairments, harm inclinations, or medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care.
   - Emergence of new symptoms, impairments, harm inclinations, or medication complications meeting admission criteria.
   - Progress has been made in ameliorating admission symptoms or impairments, but the treatment goals have not yet been fully achieved and cannot currently be addressed at a lower level of care.

3. **Intensity of Service:**
   - The beneficiary is receiving active, timely, intensive, structured multi-modal treatment delivered according to an individualized plan of care.
   - Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations, or medication complications that necessitated admission to the program
   - The beneficiary is making progress toward treatment goals, or, if no progress has been made, the treatment plan and therapeutic program have been revised accordingly, and there is a reasonable expectation of a positive response to treatment.
   - Discharge criteria and aftercare planning are documented in the beneficiary’s record.
I. AUTHORIZATION
CMHSP has contractual responsibility to "prescreen" all Medicaid covered and indigent persons seeking or being referred for psychiatric care with PROVIDER. CMHSP's obligation is to authorize reimbursement for all individuals enrolled in Medicaid or indigent as defined in this Provider Manual utilizing the Inpatient Affiliation's level of care protocols. Pre-screenings are conducted by clinicians who are credentialed by CMHSP to assess the mental health needs of individuals experiencing psychiatric crises to determine the level of care most appropriate for their assessed treatment need. This service is routinely provided by the CMHSP's Emergency Services clinicians.

A. CMHSP must prescreen all persons enrolled in Medicaid as primary insurance or indigent who present in psychiatric crisis, are referred due to psychiatric crisis, or come to PROVIDER independently seeking psychiatric hospitalization.

B. If the CMHSP determines that inpatient/partial hospitalization is the most appropriate level of care to address the person's psychiatric crisis, PROVIDER will be given an authorization which supports reimbursement for Medicaid beneficiaries or indigent individuals for an identified number of days. Authorized days to cover the stay until the next business day (typically not to exceed three consecutive days).

C. Prior-authorized and approved continued stay review inpatient and partial hospitalization days may be subject to retrospective review by the Lakeshore Regional Entity. Retrospective review is defined as the process of approving or denying payment for inpatient/partial hospitalization care after the individual has been discharged. In the event that documentation does not support level of care and/or is not consistent with information provided during the continued stay review, services may be subject to recoupment.

D. Medicaid funds may only be used for inpatient stays that meet criteria as outlined in the Michigan Medicaid Provider Manual. All other funding sources must be exhausted prior to accessing Medicaid funds.
   i. In circumstances where an individual in foster care placement no longer meets criteria for hospitalization and there is no safe, effective, or appropriate discharge, residence, or alternative level of care available, PROVIDER is responsible for coordinating funding options with the foster care agency.
   ii. In the event that an individual no longer meets inpatient criteria and CMHSP determines there is no safe, effective, or appropriate discharge, residence, or alternative level of care available, CMHSP may not deny payment and PROVIDER will be paid at the rates set forth in this contract.

E. Electroconvulsive Therapy (ECT) requires prior authorization from CMHSP.

II. ADMISSIONS
A. CMHSP will assume the following responsibilities:
   i. Complete Involuntary Commitment Petition/Application with, or prior to, admission.
   ii. Provide identification data such as: service individual’s name, age, marital status, financial information, etc.; and history of circumstances surrounding the present difficulties. *
iii. Provide past medical and psychiatric history, minimally including allergies, alcohol and drug use, current medications, any pertinent medical conditions, and any pertinent past psychiatric history.  *

iv. Summarize the mental status examination completed by a mental health professional and provide a diagnostic impression of psychiatric and medical conditions.  *

v. Provide an initial management/treatment plan stating the individual’s problems, potential problems, and possible interventions.  *

vi. Participate in individual’s deferred treatment process.

vii. Contact the psychiatric unit admission staff to ascertain bed availability and provide a verbal report of the information available on the individual referred by CMHSP. If there is a bed available and the admission staff has accepted the CMHSP referral, the CMHSP staff shall be responsible for making arrangements for transportation of the individual to PROVIDER psychiatric unit.

viii. Maintain all necessary contacts with the Court system regarding involuntary patients, inform PROVIDER regarding those contacts, and complete alternative treatment arrangements when necessary.

*To be completed and received by the inpatient facility prior to or, at least within 24 hours.

B. PROVIDER will assume the following responsibilities:

i. Accept or deny the individual referred by CMHSP based on bed availability and clinical appropriateness. PROVIDERs shall not distinguish between referrals from CMHSP and other referral sources in the quality of care and access to services.

ii. Emergency access, admission, and all treatment services will be available twenty-four (24) hours daily and seven (7) days a week. Provide a 24-hour contact telephone number for admissions.

iii. Inform authorizing agency (LRE or CMHSP) of all Medicaid/Medicare admissions or when Medicaid is secondary to another third-party insurance during business hours or the next business day.

iv. Coordinate the services provided with CMHSP. Notify Medicaid Health Plan and/or Primary Care Physician regarding medical and mental health issues.

v. Contact CMHSP for coordination of care and to arrange discharge planning and response to treatment updates. PROVIDER and CMHSP staff, functioning as an interdisciplinary treatment team, shall conduct discharge procedures and aftercare planning.

vi. Prepare all transfer materials in the event that the individual is transferred to a medical or State Facility.

vii. Provide complete preliminary discharge information to CMHSP and the Primary Care Physician within forty-eight (48) hours of discharge.

viii. Notify CMHSP of the deferred treatment plan that will be presented to the individual and his/her attorney at the deferred treatment conference.

ix. If the individual and his/her attorney reject the deferred treatment plan, the individual's need for treatment and type of treatment will be determined by the Probate Court. If all parties agree, the deferred treatment plan has the same effect as a Probate Court order for a maximum period of ninety (90) days.

x. Any relocation of individuals involving PROVIDER and another inpatient facility must have the prior authorization of the CMHSP.
III. **REAUTHORIZATION**

LRE and/or CMHSP has responsibility to complete "continued stay reviews" (CSR) for Medicaid covered and indigent individuals hospitalized through the prescreening process. Medicaid Provider Manual criteria for continued stay will be utilized to determine the need for continued hospitalization beyond the number of days authorized at prescreening or authorized by LRE and/or CMHSP following subsequent continued stay reviews completed by LRE or CMHSP staff.

A. PROVIDER will notify CMHSP's designated contact person if PROVIDER decides to discharge the patient prior to the expiration of days authorized at prescreening or from a subsequent continued stay review and if PROVIDER believes the person is ready for discharge.

B. PROVIDER’s assigned continued stay review clinician will contact authorizing agency (LRE or CMHSP) to complete continued stay reviews for patients for whom PROVIDER is seeking inpatient care beyond the days authorized by either the initial prescreening or a subsequent continued stay review.

C. Authorizing agency’s assigned continued stay review clinician will be provided access to the patient and all pertinent PROVIDER clinical records for determining the necessity for continued inpatient care. If access to PROVIDER records is denied, no further inpatient days will be authorized.

D. PROVIDER and/or treating psychiatrist has the right to request a claims reconsideration of the authorizing agency’s continued stay review decision as outlined in Section V.

E. Discharge planning/coordination of care for all Medicaid covered and indigent individuals shall involve CMHSP staff for the purpose of clarifying, coordinating, and implementing aftercare services.

IV. **CONTINUED STAY REVIEW**

A. LRE/CMHSP will:
   i. Conduct continued stay review for inpatient admissions and partial hospitalization to:
      a) Verify that medical necessity criteria are met
      b) Verify that coordination of care/discharge planning is occurring from time of admission
      c) Authorize payment for days of care based on medical necessity criteria as defined in the Medicaid Provider Manual
   ii. Communicate CSR decision to the inpatient provider.

B. PROVIDER will:
   i. Provide clinical information to authorizing agency to determine continued stay appropriateness.
   ii. Report ongoing coordination of care/discharge planning to authorizing agency
   iii. Coordinate with authorizing agency regarding frequency of and schedule for continued stay review.
   iv. Communicate any concerns to the authorizing agency regarding clinical barriers that may impact over or under utilization of service length of stay or discharge.
V. DISPUTE RESOLUTION PROCESS FOR DENIAL OF INPATIENT/PARTIAL HOSPITALIZATION DAYS

A. In circumstances where authorizing agency had denied authorization for payment of continued stay for a current inpatient/partial inpatient placement based on medical necessity, the facility has the option to request an expedited formal review by a physician identified by the authorizing agency.

   i. Should the provider choose to engage in the expedited formal review, a Request for Formal Appeal (RFA) form must be completed and submitted by the facility to the authorizing agency within one business day of denial of authorization.

   ii. If the RFA form is not received within one business day of denial of authorization, it is understood that the facility agrees with the initial determination and does not wish to request a reconsideration of the initial determination.

   iii. Upon receipt of the RFA, authorizing agency will coordinate the physician-to-physician review process.

B. In circumstances where authorizing agency has denied authorization for payment of continued stay based on medical necessity for an individual who has been discharged from the facility:

   i. The facility may submit a RFA form within seven (7) business days of the initial determination to the authorizing agency.

   ii. If the RFA form is not received within seven (7) business days, it is understood that the facility agrees with the initial determination and does not wish to request a reconsideration of the initial determination.

   iii. Upon receipt of the RFA, the authorizing agency will coordinate review of the clinical documentation with the identified physician reviewer.

VI. COORDINATION OF CARE/DISCHARGE PLANNING

A. Coordination of Care/Discharge planning to commence from time of admission. PROVIDER and CMHSP to coordinate all after-care activities.

B. At the time of discharge, PROVIDER will communicate the individual’s discharge information to the authorizing agency within one (1) business day. Discharge information must include:

   i. Discharge date
   ii. Discharge diagnosis(es)
   iii. Medications prescribed at the time of discharge
   iv. Individual’s discharge presentation
   v. Legal Status at time of discharge
   vi. Aftercare plans, including:
       a) Appointment dates
       b) Appointment times
       c) Aftercare provider agencies
       d) Name of aftercare provider/clinician
       e) Living arrangements
       f) Means of transportation
   vii. Challenges/barriers to completing aftercare plan

C. PROVIDER will provide CMHSP with a complete discharge packet within three (3) business days of the date of discharge. The discharge packet shall include the diagnosis and an
interdisciplinary team summary of the individual’s course of treatment, nature of significant family or interpersonal relationship issues, current medications, prognosis, and recommendations.

D. At discharge, PROVIDER shall provide the individual with a minimum of a two (2)-week prescription for medication with one (1) refill. PROVIDER shall be responsible for the prior authorization of all prescribed medications.

E. For indigent patients, PROVIDER agrees to prescribe medications within the authorizing CMHSP’s medication formulary if one is made available to the Provider.
ACCESS TO CLINICAL SERVICES IN THE COMMUNITY MENTAL HEALTH SYSTEM

A. **Allegan County Community Mental Health** - Emergency services are available 24 hours a day, 7 days a week and can be reached through the following phone numbers.
   
   269-673-6617  
   800-795-6617

B. **Community Mental Health of Ottawa County** - Emergency services are available 24 hours a day, 7 days a week and can be reached through the phone numbers listed below.

   Monday through Friday, 8:00 a.m. to 5:00 p.m. 877-588-4357  
   All Other Days and Times 866-512-4357

C. **HealthWest (previously known as CMHS of Muskegon County)** - Emergency services are available 24 hours a day, 7 days a week and can be reached through the phone numbers listed below. Call and ask for the Emergency Services worker on staff that day, or walk in.

   Monday through Friday, 8:00 a.m.-5 00 p.m. 231-720-3200  
   After hours/weekends/holidays 231-722-4357

D. **Kent Community Mental Health Authority d/b/a Network 180** - Emergency services are available 24 hours a day, 7 days a week and can be reached through the phone number: 616-336-3909

E. **West Michigan Community Mental Health System** - Emergency services are available 24 hours a day, 7 days a week and can be reached through the phone numbers listed below.

   Ludington Site 231-845-6294  
   Baldwin Site 231-745-4659  
   Hart Site 231-873-2108

VI. INPATIENT DISCHARGE PACKETS CONTACT

**Lakeshore Regional Entity**  
Utilization Review Team  
FAX: (231) 769-2074  
PHONE: (231) 769-2130

5000 Hakes Avenue  
Norton Shores, MI 49441

**Allegan County Community Mental Health**  
Michell Truax  
P.O. Drawer 130  
Phone: 269-673-6617

Allegan, MI 49010  
Fax: 269-673-2738

**Community Mental Health of Ottawa County**  
Chris Madden  
12265 James Street  
Phone: 616-494-5450

Holland, MI 49424  
Fax: 616-393-5653
HealthWest
Access Center
376 E. Apple Avenue Phone: 231-720-3200
Muskegon, MI 49442 Fax: 231-720-3299

Kent County Community Mental Health Authority d/b/a Network 180
Access Center Medical Records
790 Fuller NE Phone: 616-336-3909
Grand Rapids, MI 49503 Fax: 616-336-2475

For Network180 individuals, discharge packets can be sent directly to the following providers:

**Adults with Mental Illness:**

Cherry Street Health Services
100 Cherry, SE
Grand Rapids, MI 49503
Phone: 616-965-8200
Fax: 616-940-5367

InterAct of Michigan
1131 Ionia, NE
Grand Rapids, MI 49503
Phone: 616-259-7900
Fax: 616-259-7909

Reliance Community Care Partners
2100 Raybrook St., SE, Suite 203
Grand Rapids, MI 49546
Phone: 616-956-9440
Fax: 616-954-1520

Hope Network Behavioral Health
3075 Orchard Vista Drive SE
Grand Rapids, MI 49546
Phone: 616-301-8000
Fax: 616-235-2066

Pine Rest Community
Case Management
339 S. Division
Grand Rapids, MI 49502
Phone: 616-222-4570
Fax: 616-222-4571

**Children/Adolescents:**

Bethany Christian Services
901 Eastern N.E.
Grand Rapids MI 49503
Phone: 616-224-7617
Fax: 616-224-7593

Spectrum Community Services
3353 Lousma Dr. S.E.
Wyoming MI 49548
Phone: 616-241-6258
Fax: 616-241-6470

Wedgwood Christian Services
3300-36th S.E.
Grand Rapids MI 49512
Phone: 616-942-2110
Fax: 616-942-0589

Family Outreach Center
1939 S. Division
Grand Rapids, MI 49507
Phone: 616-247-3815
Fax: 616-245-0450

D.A. Blodgett - St. John’s
805 Leonard, NE
Grand Rapids, MI 49503

Arbor Circle
1115 Ball, NE
Grand Rapids, MI 49505
Easter Seals
4065 Saladin Drive
Grand Rapids, MI 49546
Phone: 616-942-2081
Fax: 616-942-5932

**Adults with Developmental Disabilities:**

Threshholds
4255 Kalamazoo S.E.
Grand Rapids, MI 49508
Phone: 616-455-0960
Fax: 616-455-7324

MOKA
4145 Kalamazoo S.E.
Grand Rapids, MI 49508
Phone: 616-719-4263
Fax: 616-719-4267

Spectrum Community Services
3353 Lousma Dr. S.E.
Wyoming MI 49548
Phone: 616-241-6258
Fax: 616-241-6470

Hope Network Developmental and Community Services
P.O. Box 141
Grand Rapids, MI 49501
Phone: 616-248-5900
Fax: 616-245-4843

West Michigan Community Mental Health
Tracy Bonstell
920 Diana
Ludington, MI 49431
Phone: 231-843-5420
Fax: 231-845-7095
I. **FINANCIAL ELIGIBILITY**

A. A person eligible for Board services is defined as an individual who receives, or is eligible to receive a CMHSP subsidy, or who is eligible for Medicaid services under the Medicaid Provider Manual in the Mental Health and Substance Abuse Section, or who is enrolled in the MI Child program. Access referral and authorization procedures are found in Section B.

B. The CMHSP will determine the financial eligibility of the consumer for CMHSP services, based on the individual's insurance and ability to pay. In some situations, the CMHSP will not have all the necessary financial information at the point of an intake/authorization. The PROVIDER will provide evidence of efforts to establish consumer eligibility and will assist the consumer with completing an application for Medicaid coverage.

C. CMHSP may deny payment for any inpatient or partial hospitalization days of care when there is not **documentation** of the PROVIDER's efforts to establish a consumer's eligibility and/or application for Medicaid coverage. CMHSP may **not** deny payment when the PROVIDER has provided evidence that: (1) an individual’s primary coverage other than Medicaid is found to be invalid; **and** (2) there is no ability to pay; **and** (3) admission meets Medicaid Medical Necessity and the Affiliation’s Service Selection Guidelines.

D. The Medicaid application and information relating to benefits shall be forwarded to the individuals listed below:

**Allegan County Community Mental Health**
Sarah Clark  
P.O. Drawer 130  
Allegan, MI 49010  
269-673-6617

**Community Mental Health of Ottawa County**
For Medicaid applications:  
Lisa Vasche  
12265 James Street  
Holland, MI 49424  
(616) 494-5425  
For Facility Admission Notice:  
Chris Madden  
12265 James Street  
Holland, MI 49424  
(616) 494-5450

**HealthWest**
MaryBeth Tiffany  
376 E. Apple Avenue  
Muskegon, MI 49442  
231-724-3633

**West Michigan Community Mental Health**
Sharon Dostal,  
Reimbursement Department  
920 Diana Street  
Ludington, MI 49431  
231-845-6294

**Kent Community Mental Health Authority d/b/a network180**
Senior Claims Examiner  
Claims Unit  
Kent Community Mental Health Authority d/b/a network180  
3310 Eagle Park NE, Suite 100  
Grand Rapids, MI 49525  
616-336-3909
E. If a consumer has more than one insurance policy, the consumer will be asked to verify which insurance is primary, secondary, etc. If the consumer is unable to verify his/her insurance, a call will be placed to the insurance company(ies) to ensure proper billing.

F. If a consumer has Medicaid along with another insurance, Medicaid is always secondary to the other insurance. Verification of benefits is obtained by calling MediFAX/MPHI.

II. BILLING AND PAYMENT CONDITIONS

A. All claims should be sent to the following addresses:

<table>
<thead>
<tr>
<th>Allegan County Community Mental Health</th>
<th>Community Mental Health of Ottawa County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Clark</td>
<td>Ruth Negelkirk</td>
</tr>
<tr>
<td>P.O. Drawer 130</td>
<td>12265 James Street</td>
</tr>
<tr>
<td>Allegan, MI 49010</td>
<td>Holland, MI 4942616-393-5673</td>
</tr>
<tr>
<td>269-673-6617</td>
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<table>
<thead>
<tr>
<th>HealthWest</th>
<th>West Michigan Community Mental Health</th>
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<tbody>
<tr>
<td>Brandy Carlson</td>
<td>Jane Shelton</td>
</tr>
<tr>
<td>Claims Department</td>
<td>Claims Processing Department</td>
</tr>
<tr>
<td>376 E. Apple Avenue</td>
<td>920 Diana Street</td>
</tr>
<tr>
<td>Muskegon, MI 49442</td>
<td>Ludington, MI 49431</td>
</tr>
<tr>
<td>231-724-1174</td>
<td>231-845-6294</td>
</tr>
</tbody>
</table>

Kent Community Mental Health Authority d/b/a network180

<table>
<thead>
<tr>
<th>Senior Claims Examiner</th>
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</thead>
<tbody>
<tr>
<td>Claims Unit</td>
</tr>
<tr>
<td>3310 Eagle Park NE, Suite 100</td>
</tr>
<tr>
<td>Grand Rapids, MI 49525</td>
</tr>
<tr>
<td>616-336-3909</td>
</tr>
</tbody>
</table>

B. The payment is considered to be an all-inclusive rate as described in Section A. Services not prior authorized will not be reimbursed. The rate will be effective based on the first day of the episode and not the service date. Inpatient stays of less than one (1) day will be paid at the per diem rate, and the code required for the claim is **762-Extended Observation Day**.

C. Valid claims shall be electronically submitted for CMHSP authorized consumers on HIPAA-compliant transactions (837 submissions) within 180 days from the end of the month in which the consumer was discharged. Business to business testing of transactions may be necessary. A clean claim will contain the required consumer data and the ability to pay and reimbursement information. The codes required for the claims are **100-Inpatient** and **912-Partial Hospitalization**. Appropriate documentation of service delivery must also exist in the medical record. **PROVIDERS that are exchanging personal health information with Kent Community Mental Health Authority d/b/a Network 180 will be required to have a Trading Partner Agreement in place.**

D. For individuals with Medicaid and/or other insurance, a claim is filed to the primary insurance according to the procedure of the PROVIDER. Once a payment is received from primary insurance, a contractual allowance (if any) is taken. A claim is then sent to
the secondary insurer, with a copy of the primary explanation of benefits as appropriate. If a rejection is received from the primary insurance, a determination is made based on the reason for denial. Only the amount listed as copay or deductible will be sent to the secondary insurer. There will be 90 days allowed for the submission of claims after Medicaid or indigent status is no longer pending third party approval.

E. “Clean” Claims for authorized services provided by the CMHSP Boards of Allegan, Kent, Muskegon, Ottawa, and West Michigan Community Mental Health will be processed and paid within 30 days of receipt of complete and accurate claims.

F. Payment from the CMHSP is considered payment in full and will not exceed the contracted per diem. The PROVIDER agrees not to bill, charge, collect a deposit from, seek compensation from, seek reimbursement from, surcharge, or have any recourse against a consumer or persons acting on behalf of a consumer, except to the extent the applicable Health Plan specifies a co-payment, coinsurance, consumer fee based on the ability to pay and deductibles.

G. Questions regarding payments and claims status should be directed to the contact person listed for each CMHSP.

H. The PROVIDER will at least annually audit their claims to ensure billing integrity. A Plan of Correction will be required and additional audits will be performed if there are significant findings. The audits and Plans of Correction will be available to CMHSP staff upon request. The PROVIDER is required to prepare a claim adjustment for any claim determined to have been inappropriately billed during the PROVIDER audit.
### III. AUTHORIZATION AND PAYMENT PROCEDURES: Inpatient And Partial Hospitalization Services

<table>
<thead>
<tr>
<th>Benefit Structure</th>
<th>Authorization</th>
<th>Payment</th>
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</thead>
<tbody>
<tr>
<td>Medicare/Medicaid Medicare Deductible and co-insurance amounts covered by Medicaid.</td>
<td>Pre-authorizations are not required, but <strong>notification is required within 15 days of discharge.</strong></td>
<td>Payment is to be made based on Michigan Medicaid Provider Manual rules in effect at the time of the admission.</td>
</tr>
<tr>
<td>Medicare/Medicaid Medicare days expired during the inpatient stay.</td>
<td>No pre-authorization, but <strong>notification is required within 15 days of discharge.</strong> Billing office notifies CMHSP when Medicare days have expired. If medical necessity criteria is met, authorization back to the Medicare expiration will be completed and CSR process will be in place, or a retrospective review will be completed if notification occurs post-discharge.</td>
<td>CMHSP will pay the balance of contracted per diem not covered by insurance up to the contracted amount.</td>
</tr>
<tr>
<td>Commercial Insurance/Medicaid: Commercial Insurance pays percentage of per diem.</td>
<td>No pre-authorization. Provider must request retrospective review after determination that CMHSP has a financial obligation.*</td>
<td>CMHSP will pay the balance of the Third Party Liability (TPL) deductible and co-insurance, if the TPL allowed amount (Provider payment plus contract adjustment) is less than the total contracted per diem rate.</td>
</tr>
<tr>
<td>Commercial Insurance/Medicaid: Commercial Insurance pays for specified number of days, or dollar amount, and Medicaid pays the remainder.</td>
<td>No pre-authorization, but notification is requested. Billing office notifies CMHSP when Commercial insurance is non-existent or commercial insurance days have expired. If medical necessity criteria is met, authorization back to the expiration of the commercial insurance will be completed and CSR process will be in place, or a retrospective review will be completed if notification occurs post-discharge.</td>
<td>CMHSP will pay the balance of contracted per diem not covered by the TPL that meets criteria or the full per diem if the insurance is non-existent.</td>
</tr>
<tr>
<td>Benefit Structure</td>
<td>Authorization</td>
<td>Payment</td>
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</tr>
<tr>
<td>Commercial Insurance with Medicaid or Medicaid eligibility received retroactively.</td>
<td>Retrospective review * following Medicaid eligibility and notification to CMHSP.</td>
<td>CMHSP will pay the balance of the TPL deductible and co-insurance, if the TPL allowed amount (Provider payment plus contract adjustment) is less than the total contracted per diem rate.</td>
</tr>
<tr>
<td>Medicare Insurance Only.</td>
<td>No pre-authorization or retrospective authorizations necessary.</td>
<td>No CMHSP payment.</td>
</tr>
<tr>
<td>Commercial Insurance Only: Days expired during the inpatient stay.</td>
<td>No authorization or CSR process.</td>
<td>CMHSP funds will not be authorized. CMHSP does not supplement insurances.</td>
</tr>
<tr>
<td>Commercial Insurance Only: Policy terminated prior to admission or policy does not have a provision for inpatient mental health benefit AND no ability to pay. (This does not include people who have used up their inpatient days on their policy.)</td>
<td>PROVIDER Billing office notifies CMHSP. PROVIDER staff completes an ability to pay with the consumer. If medical necessity is met, authorization back to the date of admission will be completed, and CSR process will be in place, or a retrospective review will be completed if notification occurs post-discharge.</td>
<td>CMHSP funds will be authorized for approved days of care per review.</td>
</tr>
</tbody>
</table>

* Retrospective reviews will be completed by CMHSP within 30 days of receipt of documentation.

NOTE: CMHSP may deny payment for any inpatient or partial hospitalization days of care when there is no documentation of the PROVIDER’s efforts to establish a consumer’s eligibility and/or application for Medicaid coverage. CMHSP may not deny payment when the PROVIDER has provided evidence that: (1) an individual’s primary coverage other than Medicaid is found to be invalid; (2) there is no ability to pay; and (3) admission meets Medicaid Medical Necessity and the Affiliation’s Service Selection Guidelines.
IV. CMHSP’S PROCESS FOR RESPONDING TO A CMHSP-DENIED CLAIM

A. Any claims to be resubmitted must be resubmitted within **120 days** of the date of the Denied Claims Report for CMHSP process. If a PROVIDER error was made in billing, the PROVIDER will make the necessary correction(s) and resubmit the claim. If after checking for errors the PROVIDER believes that the claim was rejected due to an error in the CMHSP claims processing system, the PROVIDER will submit the reason for the appeal in writing to CMHSP, along with any copies of backup evidence. The PROVIDER should send this information to CMHSP to the attention of the following individual:

<table>
<thead>
<tr>
<th>ALLEGAN</th>
<th>Michell Truax</th>
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<tr>
<td></td>
<td>Allegan County Community Mental Health</td>
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<td></td>
<td>P.O. Drawer 130</td>
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<td>Allegan, MI 49010</td>
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<tr>
<th>HEALTHWEST</th>
<th>Brandy Carlson, Mental Health Comptroller</th>
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<td>HealthWest</td>
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<td></td>
<td>376 E. Apple Avenue</td>
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<td>Muskegon, MI 49442</td>
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<tr>
<th>OTTAWA</th>
<th>Mental Health Financial Manager</th>
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<tr>
<td></td>
<td>CMH of Ottawa County</td>
</tr>
<tr>
<td></td>
<td>12265 James Street</td>
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<td></td>
<td>Holland, MI 49424</td>
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<table>
<thead>
<tr>
<th>NETWORK180</th>
<th>Claims Appeal Department</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Attn: Theresa Jennings, Financial Supervisor</td>
</tr>
<tr>
<td></td>
<td>Kent Community Health Authority d/b/a network180</td>
</tr>
<tr>
<td></td>
<td>3310 Eagle Park NE, Suite 100</td>
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<tr>
<td></td>
<td>Grand Rapids, MI 49525</td>
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<tr>
<th>WEST MICHIGAN</th>
<th>Jane Shelton</th>
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<td>Claims Processing Department</td>
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<td></td>
<td>West Michigan Community Mental Health</td>
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<td>920 Diana Street</td>
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<td></td>
<td>Ludington, MI 49431</td>
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</table>

B. CMHSP may deny payment based on denial of admission, denial of continued stay, and retrospective review. In these cases, the initial request for CMHSP authorization for payment of an admission, additional days during a continued stay review, or a retrospective review (defined as the process of approving payment for inpatient care after the individual has been discharged) may be denied by the CMHSP Board’s Gatekeeping staff, e.g., master’s level clinician. In cases of denial, the CMHSP staff must clearly identify in writing the utilization management criteria used for making the decision.
decision and the alternative service offered. If CMHSP denies payment based on any one of these reasons, the facility may submit a Request for Claims Reconsideration Form C060P. (See form at the end of this section.) CMHSP then sends a decision to the inpatient facility.

C. Within **seven (7) business** days of the CMHSP or PIHP decision to deny a claim, the inpatient facility may then file an appeal of that decision through the process detailed below.

1. Facility will complete the Request for Claims Reconsideration Form (C060P). (See form at the end of this section.)
   a. Complete all fields and fax the completed form to **Inpatient Appeals**.
      
      **Allegan County CMH:** 269-673-2738
      **HealthWest:** 231-724-4545
      **CMH of Ottawa County:** 616-393-5653
      **Kent CMH Authority d/b/a Network 180:** 616-336-8830
      **West Michigan CMH:** 231-845-7095
   b. For clinically-based appeals, clearly identify the symptoms and functioning documentation for Medical Necessity and Clinical Appropriateness to support the service being requested as defined by the service eligibility criteria for inpatient/partial hospitalization care. (Part III)
   c. The facility may request an expedited review for denied urgent care, e.g., admissions denials or denied continued stay days, by checking the section on the bottom of the form. An expedited review is defined as a request to change a denial for urgent care in which the typical time frame for reviews seriously jeopardizes the life or health or ability of the consumer to regain maximum function. It must be supported by information cited in Part III.

2. CMHSP will document the review of the request for reconsideration by completing the Reconsideration Decision Form (C010P). (See form at the end of this section.)
   a. A CMHSP Master’s level staff person not involved in the prior adverse decision is appointed to review the appeal. They have the authority to approve services for which there are explicit criteria, however, in the case of clinical issues, they do not have the authority to deny.
   b. For appeals of clinical issues, e.g., admissions denials or denied continued stay days, a same specialty practitioner must do the review (a practitioner with similar credentials and licensure as those who typically
treat the condition or health problem in question in the appeal), for example, a child psychiatrist reviewing a child case appeal.

c. The reviewing psychiatrist will review the request and may contact the requesting facility psychiatrist. The reviewing psychiatrist will document his/her findings in the Summary of Peer Contact section of the form (Part IV), and fax the form to the inpatient facility.

d. Within **thirty (30) days** of receipt of the facility request, a decision on an appeal for a retrospective review will be completed by CMHSP.

e. Within **forty-eight (48) hours** of receipt of the facility request, a decision on an expedited request for continued stay days will be completed by CMHSP.

f. Within **three (3) business days, excluding Sundays and legal holidays**, a denial of admissions that is not a retrospective review will be completed by CMHSP.
QUALITY INDICATORS

1. **Access to Services (Rate of Denials)**
   On a monthly basis, the member CMHSP will submit data to the LRE specific to access to inpatient services. By population type (child/adolescent and adult), the following information will be provided:
   a. Number of inquiries made to inpatient setting for an open bed
   b. Number of individuals denied services due to the inpatient setting being full
   c. Number of individuals denied an open bed
   d. Summary of reasons for denial of services.

2. **Hours of Physical Restraint use**
   On an annual basis, the inpatient setting will submit data to the LRE (due to LRE by October 31 for the previous fiscal year) a summary of this HBIPS Core Measure data.

3. **Hours of Seclusion use**
   On an annual basis, the inpatient setting will submit data to the LRE (due to LRE by October 31 for the previous fiscal year) a summary of this HBIPS Core Measure data.

4. **Rate of Readmission**
   On a quarterly basis, the member CMHSP will submit data to the LRE specific to the rate of readmission for inpatient settings based on the MMBPIS definitions and criteria. This data will be aggregate to the inpatient setting from which the original discharge occurred.
PROVIDER OBLIGATIONS TO RECIPIENT RIGHTS PROTECTION
(LICENSED PSYCHIATRIC HOSPITAL/UNIT)

The responsibilities of the Provider in relationship to the Rights of the Recipients served under the authority granted by this contract include the following:

1. The Provider agrees that recipients under contract will be protected from recipient rights violations while receiving inpatient or partial hospitalization services, in compliance with Chapter 7 and 7a of the Mental Health Code and with other Federal and State laws and regulations applicable to its services.

2. The Provider agrees to annually provide copies of their Recipient Rights policies and procedures for review by the Payor’s Recipient Rights Officer. At a minimum, the Provider agrees to submit all policies and procedures required by the Michigan Mental Health Code, MCLA 330.1752 and the additional policies listed below as follows:
   a. Recipient Rights complaint and appeal processes.
   b. Informed consent to treatment and services.
   c. Family Planning.
   d. Fingerprinting, photographing, audio taping, one-way glass.
   e. Abuse and neglect.
   f. Confidentiality and disclosure.
   g. Treatment by spiritual means.
   h. Qualifications and training for recipient rights staff.
   i. Change in type of treatment.
   j. Medication procedures.
   k. Use of psychotropic drugs.
   l. Use of restraint.
   m. Right to be treated with dignity and respect.
   n. Least restrictive setting.
   o. Services suited to condition.
   p. Right to entertainment material, information, and news.
   q. Comprehensive examinations.
   r. Property and funds.
   s. Freedom of movement.
   t. Resident labor.
   u. Communication and visits.
   v. Use of seclusion.
   w. Individual Plan of Service.
   x. Person-Centered Planning.
   y. Grievance and Appeal.
3. The Provider agrees that all of its employees will receive training in Recipient Rights protection within 30 days of hire and at least every three (3) years thereafter if requested by the Payor’s Recipient Rights Officer, but minimally upon substantive revisions to Federal and/or State law, rules, or regulations.

4. The Provider will monitor the safety and welfare of recipients while they are under its service supervision pursuant to the contract and provide immediate comfort and protection to and assure immediate medical treatment for a recipient who has suffered physical injury.

5. The Provider agrees that its Recipient Rights Advisor and Alternate will receive the education, training, and experience necessary to fulfill its responsibilities and have successfully completed the following DCH-ORR training within ninety (90) days of hire: Basic Skills I and II Training and Developing Effective Training.

6. The Provider agrees to immediately notify the Payor’s Office of Recipient Rights of all incidents of apparent or suspected abuse, neglect, serious injury, or death of a recipient while receiving services. The Provider agrees to comply with reporting requirements in regard to death, serious injury, suspected abuse or neglect, and all other alleged rights violations concerning a recipient while they are under the contractor’s service supervision, as well as legally mandated reporting to CIS Licensing, Protective Services (Adults & Children), law enforcement, and other public agencies as applicable.

7. The Provider agrees to furnish to the Payor’s Office of Recipient Rights, immediately upon receipt, copies of any and all recipient rights complaints or any allegation of suspected or apparent recipient rights violation and subsequently, upon completion, copies of all acknowledgement letters, Investigative Reports, Intervention Letters, Summary Reports, including documentation of remedial action or other corrective action taken in response to complaints. The Provider agrees to the jurisdiction for all Appeals of Recipient Rights complaints made by or on behalf of recipients served by the Payor by the Payor’s Recipient Rights Advisory Committee and agrees to comply with any recommendations resulting from appeals. The Provider agrees to forward, upon receipt, any and all appeal requests to the Payor’s Office of Recipient Rights. The Provider can appoint their own Appeals Committee, and they will need to adhere to MHC 330.1774.

8. The Provider agrees to provide the Payor’s Office of Recipient Rights unimpeded access to the Provider’s premises, staff, records, and recipients of services under contract. The Payor acknowledges that the Provider’s Recipient Rights Office will maintain immediate jurisdiction over the recipient rights protection system for recipients receiving inpatient or partial hospitalization services, but that the Payor’s Office of Recipient Rights will retain final jurisdiction for monitoring and coordinating rights protection. The Provider acknowledges that this may be accomplished through coordination with another CMHSP’s Recipient Rights Office. The Provider agrees to implement corrective action in a timely manner for any and all deficiencies found as a result of monitoring activities conducted by the Payor or by another CMHSP Office of Recipient Rights.

9. The Provider will implement appropriate remedial action in consideration of the recommendations of either the Provider or Payor’s Office of Recipient Rights.
resulting from Recipient Rights investigation and appeal processes, whether allegations are substantiated or not substantiated. The Provider also agrees to implement corrective actions resulting from monitoring or other prevention activities as recommended by the Payor’s Office of Recipient Rights. The Provider understands that the Payor reserves the right to take contract action for failure to remedy violations or correct deficiencies appropriately.

10. To maintain the confidentiality of information regarding recipients in compliance with Sections 748 and 750 of the MHC.

11. The Provider agrees to assure that appropriate action is taken to ensure protection for complainants and Recipient Rights staff if evidence of harassment or retaliation occurs regarding an alleged recipient rights violation or recipient rights complaint.
GRIEVANCE AND APPEAL TECHNICAL REQUIREMENT
PIHP GRIEVANCE SYSTEM FOR MEDICAID BENEFICIARIES

January, 2016

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I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with Medicaid Beneficiary Grievance System requirements for grievances and appeals contained in Part 11, 6.3.2 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services (MDHHS). These requirements are applicable to all PIHPs, Community Mental Health Services Programs (CMHSPs) and their provider networks.

Although this technical advisory specifically addresses the federal Grievance System processes required for Medicaid beneficiaries, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

The term "Grievance system," as used in the federal regulations refers to the overall system for Medicaid beneficiary grievances and appeals, required in the Medicaid managed care context. Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, as defined in this document, and those challenging anything else. A challenge to an action is called an appeal. Any other type of complaint is considered a grievance.

The Due Process Clause of the U.S. Constitution guarantees that Medicaid beneficiaries must receive "due process" whenever benefits are denied, reduced or terminated. Due Process includes: (1) prior written notice of the adverse action (2) a fair hearing before an impartial decision maker (3) continued benefits pending a final decision and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements.

Consumers of mental health services who are Medicaid beneficiaries eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care. Grievance and appeal process requirements for Medicaid beneficiaries were significantly expanded through federal regulations implementing the Balanced Budget Act (BBA) of 1997.

Medicaid beneficiaries have rights and dispute resolution protections under federal authority of the Social Security Act, including:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- Local appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Beneficiaries, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, (hereafter referred to as the 'Code") Chapters 7,7A, 4 and 4A, including:
II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

**Action:** A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP.
- Failure of the PIHP to act within **45 calendar days** from the date of a request for a standard appeal.
- Failure of the PIHP to act within **three (3) working days** from the date of a request for an expedited appeal.
- Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

**Note:** The term "action" is also referred to as an "adverse action" in this document.

**Additional Mental Health Services:** Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, under the authority of Section 1915(b)(3) of the Social Security Act. Also referred to as "B3" waiver services.

**Adequate Notice of Action:** Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid services requested. Notice is provided to the Medicaid beneficiary on the same date the action takes effect, or at the time of the signing of the individual plan of services/supports.

**Advance Notice of Action:** Written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services currently provided. Notice to be provided/mailed to the Medicaid beneficiary at least **12 calendar days prior** to the proposed date the action is to take effect.
**Appeal:** Request for a review of an 'action" as defined above.

**Authorization of Services:** The processing of requests for initial and continuing service delivery.

**Beneficiary:** An individual who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through a PIHP/CMHSP.

**Consumer:** Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

**Expedited Appeal:** The expeditious review of an action, requested by a beneficiary or the beneficiary's provider, when the time necessary for the normal appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. If the beneficiary requests the expedited review, the PIHP determines if the request is warranted. If the beneficiary's provider makes the request, or supports the beneficiary's request, the PIHP **must grant** the request.

**Fair Hearing:** Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing".

**Grievance:** Medicaid Beneficiary's expression of dissatisfaction about PIHP/CMHSP service issues, other than an action. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the beneficiary.

**Grievance Process:** Impartial local level review of a Medicaid Beneficiary's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues other than an action.

**Grievance System:** Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

**Local Appeal Process:** Impartial local level PIHP review of a Medicaid beneficiary's appeal of an action presided over by individuals not involved with decision-making or previous level of review.

**Medicaid Services:** Services provided to a beneficiary under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

**Notice of Disposition:** Written statement of the PIHP decision for each local appeal and/or grievance, provided to the beneficiary.
Recipient Rights Complaint: Written or verbal statement by a consumer, or anyone acting on behalf of the consumer, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

111. GRIEVANCE SYSTEM GENERAL REQUIREMENTS

Federal regulation (42 CFR 438.228) requires the state to ensure through its contracts with PIHPs, that each PIHP has an overall grievance system in place for Medicaid beneficiaries that complies with Subpart F of Part 438.

The grievance system must provide Medicaid beneficiaries:

- A local PIHP appeal process for challenging an "action" taken by the PIHP or one of its agents.
- Access to the state level fair hearing process for an appeal of an "action".
- A local PIHP grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an 'action'.
- The right to concurrently file a PIHP level appeal of an action, and request a State fair hearing on an action, and file a PIHP level grievance regarding other service complaints.
- The right to request a State fair hearing before exhausting the PIHP level appeal of an 'action'.
- The right to request, and have, Medicaid benefits continued while a local PIHP appeal and/or state fair hearing is pending.
- The right to have a provider, acting on the beneficiary's behalf and with the beneficiary's written consent, file an appeal to the PIHP. The provider may file a grievance or request for a state fair hearing on behalf of the beneficiary only if the State permits the provider to act as the beneficiary's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the beneficiary’s behalf with the beneficiary’s written consent to do so.

IV. SERVICE AUTHORIZATION DECISIONS

When a Medicaid service authorization is processed (initial request or continuation of service delivery) the PIHP must provide the beneficiary written service authorization decision within specified timeframes and as expeditiously as the beneficiary's health condition requires. The service authorization must meet the requirements for either standard authorization or expedited authorization:

- **Standard Authorization:** Notice of the authorization decision must be provided as expeditiously as the beneficiary's health condition requires, and no later than 14 calendar days following receipt of a request for service.

If the beneficiary or provider requests an extension OR if the PIHP justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the 14 calendar day time period by up to 14 additional calendar days.
**Expedited authorization:** In cases in which a provider indicates, or the PIHP determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, the PIHP must make an expedited authorization decision and provide notice of the decision as expeditiously as the beneficiary's health condition requires, and **no later than three (3) working days** after receipt of the request for service.

If the beneficiary requests an extension, or if the PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the three (3) working day time period by up to **14 calendar days**.

When a **standard or expedited** authorization of services decision is extended, the PIHP must give the beneficiary written notice of the reason for the decision to extend the timeframe, and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision. The PIHP must issue and carry out its determination as expeditiously as the enrollee's beneficiary's health condition requires and no later than the date the extension expires.

### V. NOTICE OF ACTION

A Notice of Action must be provided to a Medicaid beneficiary when a service authorization decision constitutes an "action" by authorizing a service in amount, duration or scope other than requested or less than currently authorized, or the service authorization is not made timely. In these situations, the PIHP **must** provide a notice of action containing additional information to inform the beneficiary of the basis for the action the PIHP has taken, or intends to take and the process available to appeal the decision.

**PIHP Notice of Action requirements include:**

- The notice of action to the beneficiary must be written and meet language format needs of the individual to understand the content (i.e. the format meets the needs of those with limited English proficiency and or limited reading proficiency).
- The requesting provider, in addition to the beneficiary, must be provided notice of any decision by the PIHP to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice of action to the provider is not required to be in writing.
- **If** the beneficiary or representative requests a local appeal or a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the appeal.
- **If** the beneficiary's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.
- **If** the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units),
any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an action, and requires a written notice of action.

The notice of action must be either Adequate or Advance:

- **Adequate notice:** is a written notice provided to the beneficiary at the time of EACH action. The individual plan of service, developed through a person-centered planning process and finalized with the beneficiary, must include, or have attached, the adequate notice provisions.

- **Advance notice:** is a written notice required when an action is being taken to reduce, suspend or terminate services that the beneficiary is currently receiving. The advance notice must be mailed **12 calendar days** before the intended action takes effect.

The content of both adequate and advance notices must include an explanation of:

What action the PIHP has taken or intends to take,

- The reason(s) for the action and the policy relied upon to make your determination,
- 42 CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures,
- The beneficiary's or provider's right to file a PIHP appeal, and instructions for doing so,
- The beneficiary's right to request a State fair hearing, and instructions for doing so,
- The circumstances under which expedited resolution can be requested, and instructions for doing so,
- An explanation that the beneficiary may represent himself or use legal counsel, a relative, a friend or other spokesman.

The content of an advance notice must also include an explanation of:

The circumstances under which services will be continued pending resolution of the appeal,

- How to request that benefits be continued, and
- The circumstances under which the beneficiary may be required to pay the costs of these services.

**NOTE:** Examples of adequate and advance notices containing required content are in Exhibits A and B at the end of this document.

**There are limited exceptions to the advance notice requirement.** The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, **IF**:

- The PIHP has factual information confirming the death of the beneficiary.
The PIHP receives a clear written statement signed by the beneficiary that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.

The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.

The beneficiary's whereabouts are unknown and the post office returns PIHP mail directed to him/her indicating no forwarding address.

The PIHP establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.

A change in the level of medical care is prescribed by the beneficiary's physician

The date of the action will occur in less than **10 calendar days.**

The Notice of Action must be mailed within the following timeframes:

- **At least 12 calendar days before** the date of an action to terminate suspend or reduce previously authorized Medicaid covered services(s) (Advance)
- **At the time of the decision** to deny payment for a service (Adequate)
- **Within 14 calendar days** of the request for a standard service authorization decision to deny or limit services (Adequate).
- **Within 3 working days** of the request for an expedited service authorization decision to deny or limit services (Adequate).

If the PIHP is unable to complete either a standard or expedited service authorization to deny or limit services within the timeframe requirement, the timeframe may be **extended up to an additional 14 calendar days.**

If the PIHP extends the timeframe, it must:

- Give the beneficiary written notice, no later than the date the current timeframe expires, of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision; and
- Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

**VI. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT**

The PIHP **must** continue Medicaid services previously authorized while the PIHP appeal and/or State fair hearing are pending if:

- The Beneficiary specifically requests to have the services continued, and
- The Beneficiary or provider files the appeal timely; and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and
• The services were ordered by an authorized provider, and
• The original period covered by the original authorization has not expired.

When the PIHP continues or reinstates the beneficiary's services while the appeal is pending, the services must be continued until one of the following occurs:

• The beneficiary withdraws the appeal.
• **Twelve calendar** days pass after the PIHP mails the notice of disposition providing the resolution of the appeal against the beneficiary, **unless** the beneficiary, within the **12 day** timeframe, has requested a State fair hearing with continuation of services until a State fair hearing decision is reached.
• A State fair hearing office issues a hearing decision adverse to the beneficiary. The time period or service limits of the previously authorized service has been met.

If the PIHP, or the MDHHS fair hearing administrative law judge **reverses a decision** to deny authorization of services, and the beneficiary **received the disputed services** while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations.

If the PIHP, or the MDHHS fair hearing administrative law judge **reverses a decision** to deny, limit, or delay services that were **not furnished** while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires.

**VII. STATE FAIR HEARING APPEAL PROCESS**

Federal regulations provide a Medicaid beneficiary the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by the local agency or its agent.

• A Medicaid beneficiary has the right to request a fair hearing when the PIHP or its contractor takes an "action", or a grievance request is not acted upon within **60 calendar days**. The beneficiary does not have to exhaust local appeals before he/she can request a fair hearing.
• The agency must issue a written notice of action to the affected beneficiary. (See section VI above for Notice information.)
• The agency may not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.
• Beneficiaries are given **90 calendar days** from the date of the notice to file a request for a fair hearing.
• If the beneficiary, or representative, requests a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing by the administrative law judge.
• If the beneficiary's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the action.
• The parties to the state fair hearing include the PIHP, the beneficiary and his or her representative, or the representative of a deceased beneficiary's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.
• Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at: www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid Fair Hearings http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html

VIII. LOCAL APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an action. PIHP appeals, like those for fair hearings, are initiated by an "action". The beneficiary may request a local appeal under the following conditions:

• The beneficiary has 45 calendar days from the date of the notice of action to request a local appeal.
• An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary requests expedited resolution. The beneficiary may file an appeal with the PIHP organizational unit approved and administratively responsible for facilitating local appeals.
• If the beneficiary, or representative, requests a local appeal not more than 12 calendar days from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing.

When a beneficiary requests a local appeal, the PIHP is required to:

• Give beneficiaries reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
• Acknowledge receipt of each appeal.
• Maintain a log of all requests for appeal to allow reporting to the PIHP Quality Improvement Program. Ensure that the individuals who make the decisions on appeal were not involved in the previous level review or decision-making.
• Ensure that the individual(s) who make the decisions on appeal are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease when the appeal is of a denial based on lack of medical necessity or involves other clinical issues.
• Provide the beneficiary, or representative with:
  o Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;
Opportunity, before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents or records considered during the appeals process;

Opportunity to include as parties to the appeal the beneficiary and his or her representative or the legal representative of a deceased beneficiary's estate;

Information regarding the right to a fair hearing and the process to be used to request the hearing.

**Notice of Disposition requirements:**

- The PIHP must provide written notice of the disposition of the appeal, and must also make reasonable efforts to provide oral notice of an expedited resolution. The content of a notice of disposition must include an explanation of the results of the resolution and the date it was completed.

- When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition must also include:
  - The right to request a state fair hearing, and how to do so;
  - The right to request to receive benefits while the state fair hearing is pending, if requested within 12 days of the PIHP mailing the notice of disposition, and how to make the request; and
  - That the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action.

The **Notice of Disposition** must be provided within the following timeframes:

- **Standard Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed **45 calendar days** from the day the PIHP receives the appeal.

- **Expedited Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties no longer than **three (3) working days** after the PIHP receives the request for expedited resolution of the appeal. An expedited resolution is required when the PIHP determines (for a request from the beneficiary) or the provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

- The PIHP may extend the notice of disposition timeframe by up to **14 calendar days** if the beneficiary requests an extension, or if the PIHP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the beneficiary's interest.

- If the PIHP denies a request for expedited resolution of an appeal, it must:
  - Transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the PIHP receives the appeal;
o Make reasonable efforts to give the beneficiary prompt oral notice of the denial, and
o Give the beneficiary follow up written notice within two (2) calendar days.

IX. LOCAL GRIEVANCE PROCESS

Federal regulations provide Medicaid beneficiaries the right to a local grievance process for issues that are not "actions".

Beneficiary grievances:
- Shall be filed with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of the grievance.
- May be filed at any time by the beneficiary, guardian, or parent of a minor child or his/her legal representative.
- **Do not** have access to the state fair hearing process unless, the PIHP fails to respond to the grievance **within 60 calendar days**. This constitutes an 'action", and can be appealed for fair hearing to the MDHHS Administrative Tribunal.

**For each grievance filed by a beneficiary, the PIHP is required to:**
- Give the beneficiary reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability
- Acknowledge receipt of the grievance;
- Log the grievance for reporting to the PIHP/CMHSP Quality Improvement Program.
- Ensure that the individual(s) who make the decisions on the grievance were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on the grievance are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease if the grievance:
  o Involves clinical issues, or
  o Involves the denial of an expedited resolution of an appeal (of an action).
- Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination.
- Provide the beneficiary a written notice of disposition not to exceed 60 calendar days from the day PIHP received the grievance/complaint. The content of the notice of disposition must include:
  o The results of the grievance process
  o The date the grievance process was concluded.
  o The beneficiary's right to request a fair hearing if the notice of disposition is more than 60 days from the date of the request for a grievance and
  o How to access the fair hearing process.

X. RECORDKEEPING REQUIREMENTS
The PIHP is required to maintain Grievance System records of beneficiary appeals and grievances for review by State staff as part of the State quality strategy.

PIHP Grievance System records should contain sufficient information to accurately reflect:

- The process in place to track requests for Medicaid services denied by the PIHP or any of its providers.
- The volume of denied claims for services in the most recent year.

**XI. RECIPIENT RIGHTS COMPLAINT PROCESS**

Medicaid beneficiaries, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services contract, Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process.
EXHIBIT A ADEQUATE NOTICE OF ACTION (SAMPLE FORM)

ADEQUATE ACTION NOTICE

Date
Name
Address
City, State, Zip

RE: Beneficiary's Name:

Beneficiary's Medicaid ID Number:

Dear

Following a review of the mental health services for which you have applied, it has been determined that the following service(s) shall not be authorized.

<table>
<thead>
<tr>
<th>Service(s)</th>
<th>Effective Date</th>
</tr>
</thead>
</table>

The reason for this action is <reason and related policy citation> . The legal basis for this decision is <provide policy relied upon> and 42 CFR 440.230(d).

If you do not agree with this action, you may request a Michigan Administrative Hearing System fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the "Request for Hearing" form and mail to:

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 30763
LANSING, MI 48909-
ADEQUATE ACTION NOTICE
Page 2

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

If you do not agree with this action, you may request a local appeal, either orally or in writing, with your Prepaid Inpatient Health Plan (PIHP) within 45 calendar days of the date of this notice by contacting:

<Name of PIHP office/individual responsible for local appeal process>
<Address>
<City, State ZIP>
<Phone Number - Voice>
<Phone Number - FAX>

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your PIHP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Michigan Administrative Hearing System, toll free, at 877-833-0870 or the PIHP if you have further questions.

Enclosures:
   Hearing Request Form
   Return Envelope
EXHIBIT B ADVANCE NOTICE OF ACTION (SAMPLE FORM)

ADVANCE ACTION NOTICE

Date

Name
Address
City, State, Zip

RE: Beneficiary's Name:
Beneficiary's Medicaid ID Number:

Dear

Following a review of mental health services and supports that you are currently receiving, it has been determined that the following service(s) shall be <reduced, terminated or suspended> effective <date>.

<table>
<thead>
<tr>
<th>Service(s)</th>
<th>Effective Date</th>
</tr>
</thead>
</table>

The reason for this action is <reason and related policy citation>. The legal basis for this decision is <provide policy relied upon> and 42 CFR 440.230(d).

If you do not agree with this action, you may request a Michigan Administrative Hearing System fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the enclosed "Request for Hearing" form and mail to:

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 30763
LANSING, MICHIGAN 48909-

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

ADVANCE ACTION NOTICE
You will continue to receive the affected services until the hearing decision is rendered if your request for a fair hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a fair hearing you may be required to repay the benefits. This may occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.
- You or the person you asked to represent you does not attend the hearing.

If you do not agree with this action, you may also request a local appeal, either orally or in writing, with your Prepaid Inpatient Health Plan (PIHP) within 45 calendar days of the date of this notice by contacting:

<Name of PIHP office/individual responsible for local appeal process>
<Address>
<City, State ZIP>
<Phone Number - Voice>
<Phone Number - FAX>

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your PIHP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Michigan Administrative Hearing System, toll free, at 877-833-0870 or the PIHP if you have further questions.

Enclosures:
- Hearing Request Form
- Return Envelope
Introduction

A. Summary/Background

The purpose of the community mental health system is to support adults and children with developmental disabilities, adults with serious mental illness and co-occurring disorders (including co-occurring substance abuse disorders), and children with serious emotional disturbance to live successfully in their communities—achieving community inclusion and participation, independence, and productivity. Person-centered planning (PCP) enables individuals to achieve their personally defined outcomes. As described below, PCP for minors (family-driven and youth-guided practice) accommodates the entire family.

Person-centered planning is a way for individuals to plan their lives with the support and input from those who care about them. The process is used for planning the life that the individual aspires to have—taking the individual’s goals, hopes, strengths, and preferences and weaving them in plans for a life with meaning. PCP is used anytime an individual’s goals, desires, circumstances, preferences, or needs change.

Through the PCP process, an individual and those who support him or her:

a. Focus on the individual’s life goals, interests, desires, preferences, strengths and abilities as the foundation for the planning process.

b. Identify outcomes based on the individual’s life goals, interests, strengths, abilities, desires and preferences.

c. Make plans for the individual to work toward and achieve identified outcomes.

d. Determine the services and supports the individual needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system.
e. Develop an Individual Plan of Service (IPOS) that directs the provision of supports and services to be provided through the community mental health services program (CMHSP).

Meaningful PCP is at the heart of supporting individual choice and control. Person-centered planning focuses on the goals, interests, desires and preferences of the individual, while still exploring and addressing an individual’s needs within an array of established life domains (including, but not limited to those listed in the Michigan Mental Health Code (the Code): the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation). As appropriate for the individual, the PCP process may involve other MDHHS policies and initiatives including, but limited to, Recovery, Self-Determination, Culture of Gentleness, Positive Behavior Supports, Treatment of Substance Abuse or other Co-Occurring Disorders, and Transition Planning.

PCP focuses on services and supports necessary (including medically necessary services and supports funded by the CMHSP) for the individual to work toward and achieve their personal goals rather than being limited to authorizing the individual to receive existing programs.

For children, the concepts of person-centered planning are incorporated into a family-driven, youth-guided approach (see the MDHHS Family-Driven and Youth-Guided Policy and Practice Guideline). A family-driven, youth-guided approach recognizes the importance of family in the lives of children and that supports and services impact the entire family. In the case of minor children, the child/family is the focus of planning and family members are integral to success of the planning process. As the child ages, services and supports should become more youth-guided especially during transition into adulthood. When the individual reaches adulthood, his or her needs and goals become primary.

There are a few circumstances where the involvement of a minor’s family may be not appropriate:

a. The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, guardian or person in loco parentis within the restrictions stated in the Mental Health Code;

b. The minor is emancipated; or

c. The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process as stated in the Code. Justification of the
exclusion of parents shall be documented in the clinical record.

B. Michigan Mental Health Code—Definition

PCP, as defined by the Code, “means a process for planning and supporting the individual receiving services that builds upon the individual’s capacity to engage in activities that promote community life and that honors the individual’s preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.” MCL 330.1700(g).

The Code also requires use of PCP for development of an Individual Plan of Service:

“(1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient’s need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.” MCL 330.1712.

C. PCP Values and Principles

Person-centered planning is a highly individualized process designed to respond to the expressed needs/desires of the individual.

- Every individual is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community.

- Every individual has strengths, can express preferences, and can make choices.
• The individual’s choices and preferences are honored and considered, if not always implemented.

• Every individual contributes to his or her community, and has the ability to choose how supports and services enable him or her to meaningfully participate and contribute.

• Through the person-centered planning process, an individual maximizes independence, creates community connections, and works towards achieving his or her chosen outcomes.

• An individual’s cultural background is recognized and valued in the person-centered planning process.

D. Implementation of Person-Centered Planning

While the Code requires that PCP be used to develop an Individual Plan of Service (IPOS) that includes community mental health services and supports, the purpose of person-centered planning is a process for an individual to define the life that he or she wants and what components need to be in place for the individual to have, work toward or achieve that life. Depending on the individual, community mental health services and supports may play a small or large role in supporting him or her in having the life he or she wants. When an individual is in a crisis situation, that situation should be stabilized before the PCP process is used to plan the life he or she desires to have.

Individuals are going to be at different points in the process of achieving the life to which they aspire and the PCP process should be individualized to meet the needs of the individual for whom planning is done, e.g. meeting an individual where he or she is. Some people may be just beginning to define the life they want and initially the PCP process may be lengthy as the individual’s goals, hopes, strengths, and preferences are defined and documented and a plan for achieving them is developed. Once this initial work is completed, it does not need to be redone unless so desired by the individual. Once an IPOS is developed, subsequent use of the planning process, discussions, meetings, and reviews will work from the existing IPOS to amend or update it as circumstances and preferences change. The extent that the IPOS is updated will be determined by the needs and desires of the individual. If and when necessary, the IPOS can be completely redeveloped. The emphasis in using PCP should be on meeting the needs and desires of the individual when he or she has them.
II. Essential Elements for Person-Centered Planning

The following characteristics are essential to the successful use of the PCP process with an individual and his/her allies.

1. **Person-Directed.** The individual directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.

2. **Person-Centered.** The planning process focuses on the individual, not the system or the individual’s family, guardian, or friends. The individual’s goals, interests, desires, and preferences are identified with an optimistic view of the future and plans for a satisfying life. The planning process is used whenever the individual wants or needs it, rather than viewed as an annual event.

3. **Outcome-Based.** Outcomes in pursuit of the individual’s preferences and goals are identified as well as services and supports that enable the individual to achieve his or her goals, plans, and desires and any training needed for the providers of those services and supports. The way for measuring progress toward achievement of outcomes is identified.

4. **Information, Support and Accommodations.** As needed, the individual receives comprehensive and unbiased information on the array of mental health services, community resources, and available providers. Support and accommodations to assist the individual to participate in the process are provided.

5. **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process. See Section III below.

6. **Pre-Planning.** The purpose of pre-planning is for the individual to gather all of the information and resources (e.g. people, agencies) necessary for effective person-centered planning and set the agenda for the process. Each individual (except for those individuals who receive short-term outpatient therapy only, medication only, or those who are incarcerated) is entitled to use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person’s needs, is used anytime the PCP process is used.

The following items are addressed through pre-planning with sufficient time to take all necessary/preferred actions (i.e. invite desired participants):
a. When and where the meeting will be held,
b. Who will be invited (including whether the individual has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support),
c. What will be discussed and not discussed,
d. What accommodations the individual may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication),
e. Who will facilitate the meeting,
f. Who will record what is discussed at the meeting.

7. **Wellness and Well-Being.** Issues of wellness, well-being, health and primary care coordination or integration, supports needed for an individual to continue to live independently as he or she desires, and other concerns specific to the individual’s personal health goals or support needed for the individual to live the way they want to live are discussed and plans to address them are developed. If so desired by the individual, these issues can be addressed outside of the PCP meeting.

8. **Participation of Allies.** Through the pre-planning process, the individual selects allies (friends, family members and others) to support him or her through the person-centered planning process. Pre-planning and planning help the individual explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

**III. Independent (External) Facilitation**

In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator of the person-centered planning process, unless the individual is receiving short-term outpatient therapy or medication only. The CMHSP must make available a choice of at least two independent facilitators to individuals interested in using independent facilitation. The facilitator is chosen by the individual and serves as the individual’s guide (and for some individuals, their voice) throughout the process, making sure that his or her hopes, interests, desires, preferences and concerns are heard and addressed. The facilitator helps the individual with the pre-planning activities and co-leads any PCP meeting(s) with the individual.
The independent facilitator must not have any other role within the CMHSP. The independent facilitator must personally know or get to know the individual who is the focus of the planning including what he or she likes and dislikes as well as personal preferences, goals, modes of communication, and who supports or is important to the individual. The Medicaid Provider Manual (MPM) permits independent facilitation to be provided to Medicaid beneficiaries as one aspect of the coverage called “Treatment Planning” MPM MH&SAA Chapter, Section 3.25. If the independent facilitator is paid for the provision of these activities, the PIHP may report the service under the code H0032. It is advisable that the CMHSP support independent facilitators in obtaining training in PCP, regardless of whether the independent facilitator is paid or unpaid.

IV. Individual Plan of Service

The Code establishes the right for all individuals to develop individual plans of services (IPOS) through a person-centered planning process regardless of disability or residential setting. However, an IPOS needs to be more than the services and supports authorized by the community mental health system; it must include all of the components described below. The PCP process must be used at any time the individual wants or needs to use the process. The agenda for each PCP meeting should be set by the individual through the pre-planning process, not by agency or by the fields or categories in a form or an electronic medical record.

Once an individual has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the individual’s needs, changes in the individual’s condition as determined through the PCP process or changes in the individual’s preferences for support). Assessment may be used to inform the PCP process, but is not a substitute for the process.

The individual and his or her case manager or supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. An individual or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually through the PCP process to review progress toward goals and objectives and to assess beneficiary satisfaction. Reviews will work from the existing plan to amend or update it as circumstances, needs, preferences or goals change or to develop a completely new plan if so desired by the individual. Use of the PCP process in the review of the plan incorporates all of the Essential Elements as desired by the individual.
The individual decides who will take notes or minutes about what is discussed during the person-centered planning process. In addition, documentation maintained by the CMHSP within the Individual Plan of Service must include:

1. A description of the individual’s strengths, abilities, goals, plans, hopes, interests, preferences and natural supports;
2. The outcomes identified by the individual and how progress toward achieving those outcomes will be measured;
3. The services and supports needed by the individual to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS)), community resources, and natural supports;
4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.
5. The estimated/prospective cost of services and supports authorized by the community mental health system.
6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.
7. Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

The individual must be provided with a written copy of his or her plan within 15 business days of conclusion of the PCP process. This timeframe gives the case manager/supports coordinator a sufficient amount of time to complete the documentation described above.

V. Organizational Standards

The following characteristics are essential for organizations responsible for providing supports and services through PCP:

- **Individual Awareness and Knowledge**—The organization provides accessible and easily understood information, support and when necessary, training, to individuals using services and supports and those who assist them so that they are aware of their right to PCP, the essential elements of PCP, the benefits of this approach and the support available to help them succeed (including, but not limited, pre-planning and independent facilitation).
- **Person-Centered Culture**—The organization provides leadership, policy direction, and activities for implementing person-centered planning at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.
• **Training**—The organization has a process to identify and train staff at all levels on the philosophy of PCP. Staff who are directly involved in PCP are provided with additional training.

• **Roles and Responsibilities**—As an individualized process, PCP allows each individual to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.

• **Quality Management**—The QA/QM System includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful person-centered planning. The best practices for supporting individuals through PCP are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and standards are in place to assure support the individual directs the PCP process and ensures that PCP is consistently done well.

**VI. Dispute Resolution**

Individuals who have a dispute about the PCP process or the IPOS that results from the process have the rights to grievance, appeals and recipient rights as set forth in detail in the Contract Attachment 6.4.1.1 Grievance and Appeal Technical Requirement/PIHP Grievance System for Medicaid Beneficiaries. As described in this Contract Attachment, some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as a denial, reduction, suspension or termination of services). Other options are available to all recipients of Michigan mental health services and supports. Supports Coordinators, Case Managers and Customer Services at PIHP/CMHSPs must be prepared to help people understand and negotiate dispute resolution processes.