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Owner:	*David Lowe: Director, Utilization Management*
Area:	*04. Utilization Management*
Audiences:	*LifeWays Staff, LifeWays' Provider Network*

04-02.16 Inpatient Hospitalization

I. PURPOSE

It is the policy of LifeWays Community Mental Health to ensure appropriate admission and discharge procedures are available to all persons seeking inpatient psychiatric admissions.

II. APPLICATION

A. Inpatient psychiatric hospitalization delivers 24 hour supervised care in a specialized, secure, and intensive medical setting for persons who cannot be adequately and safely be managed in a lower level of care. Such settings provide daily assessments by appropriately credentialed physicians (MD/DO), round the-clock nursing observation and interventions, medical interventions, psychotherapeutic and adjunctive services, diagnostic and laboratory services.

B. Inpatient psychiatric hospitalization must be delivered in an appropriately credentialed psychiatric acute care unit within a psychiatric institution or a psychiatric inpatient unit within a general medical/surgical hospital.

C. All contracted, and subcontracted entities shall develop and implement policies, procedures and practices which reflect the standards set forth, and shall monitor for compliance..

D. **Admission Criteria**:

   A. **Intensity of service:** The consumer must require intensive, comprehensive, 24-hour medically \supervised and coordinated services due to their behavioral health diagnosis(es) in order to qualify for inpatient care.

      i. The need for service at this level may be due to: consumer's and other safety needs; to determine diagnosis; side effects of the treatments; or instability due to medical comorbidities.

      ii. The services delivered must be active treatment, and not simply observational or residential.

      iii. In order to coordinate timely discharge plans, case managers will promote early identification and assessment of post hospital needs.

E. **Severity of illness:** the severity of illness must be sufficient to warrant medical necessity for this level of care, including, but not limited to:

   A. . Threat to self

      i. Suicidal ideation, with sufficient reason to believe the consumer will act on this ideation; or actual suicide attempt; or

ii. Self-harm, or self-destructive behavior (such as eating behaviors including anorexia, bulimia, pica) that poses significant immediate threat to life or bodily integrity.

iii. Disruption of activities of daily living that poses significant and immediate threat to life or bodily integrity (for example, inability to maintain nutrition).

B. Threat to Others

i. Assault ideation with sufficient reason to believe the consumer will act on this ideation.

ii. Assaultive behavior, including physical and verbal behavior.

C. Hallucinations, disordered behavior, or cognitive impairments due to acute psychiatric disorders that lead to behaviors resulting in threats to self or others.

Continued Stay and Discharge Criteria

A. **Continued Stay:** The consumer continues to require active treatment delivered in a medically supervised psychiatric inpatient facility while also meeting the Milliman Clinical Guidelines (MCG) criteria, and that the services being provided are medically necessary, and are expected to:

i. Lead to diagnostic clarity and treatment planning; or

ii. Improve the consumer's mental health.

B. Consumer's medical and psychiatric needs can not be met at a lower level of intensity.

C. The above is all supported by the documentation available in the Consumer record and aligns with the MCG/Indicia managed care tool for inpatient psychiatric treatment which indicates compliance with reviews following each certification.

D. Utilization Managers will complete Continued Stay Reviews at appropriate intervals to determine ongoing need for inpatient level of care. These will be documented in the medical record and include:

i. Diagnosis of Admitting Psychiatrist

ii. Presenting Problems

iii. Current Status of Presenting Problems:

a. Is the individual experiencing any perceptual disturbances and/or suicidal/ homicidal ideation?

b. Please describe their ability to care for self, i.e., hygiene (are they bathing, changing clothing, etc., and determine what is baseline)

c. How is their appetite (quantified by percentages or whether or not it is adequate to baseline/ caloric intake for body weight).

d. Sleep patterns – wakeful, require PRNs, drowsy during the day

e. What is their level of engagement in hospital milieu? Example would include group participation as well as interactions with others.

f. Current medications and titrations. Dosage levels required as well as when taken.

g. Do they require more than 15-minute checks, e.g., 5 minutes, of close observation?

h. How has their behavior been since the last review/last 48 hours; any restraint (including chemical) or seclusion? Anticipated additional number of days necessary.

i. Discharge/aftercare planning that has occurred or is planned.

j. Can step down to Crisis Home/Mobile Crisis Services to be considered?

k. If Substance Use Disorder (SUD), plan for transfer to Substance Use Treatment.

E. **Discharge Criteria:**

i. Intensity and severity criteria are no longer met.

ii. The consumer no longer requires 24 hour medical supervision, and may be served at a lower intensity setting.

iii. Payment will be denied if active treatment ends. For example, intensive treatment is not being delivered; or treatment delivered cannot be expected to improve the consumer's condition

iv. Authorizations will be denied if there is lack of compliance with Continued/concurrent reviews.

F. The assigned Primary Provider will followup minimally within 3 days of discharge and have a face-to-face service within 7 calendar days of referral and schedule the service using the Calendar Appointment in LEO.

G. An individual admitted who is determined to have a primary SUD diagnosis will be referred by the LifeWay's Hospital Liaison for SUD treatment services. The need for referral to LifeWays network services will be evaluated to address co-occurring needs or temporary post-discharge services to ensure transition to SUD services.

H. When Transportation is identified as a need of an individual during discharge planning process, LifeWay's Hospital Liaisons will be responsible for scheduling transportation with the transportation team supervisor.

I. Substance abuse disorder needs and services will be facilitated by providing Substance Abuse treatment information to the unit providing care and having them contact for intake over the phone.

J. If, during the continued stay review, the individual chooses an Out-of-Network Provider for their follow-up appointment, Utilization Management will close the CMH admission within LEO. This is done by the Utilization Manager while also completing the discharge TEDS to close out the individual.

III. STANDARDS

A. Inpatient Psychiatric Care – Continuing Stay Criteria: Adults, Adolescents and Children

1. 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 regime in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the beneficiary's problems and dysfunctions.

2. 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 beneficiary'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.

3. 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.

B. The individual must meet all three criteria outlined in the following table:

1. Diagnosis – The beneficiary has a current version of DSM or ICD mental disorder (excluding V codes) that remains the principal diagnosis for purposes of care during the period under review.
2. Severity of Illness – (signs, symptoms, functional impairments and risk potential)
    a. 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.
    b. Continued severe disturbance of cognition, perception, affect, memory, behavior or judgment.
    c. Continued gravely disabling or incapacitating functional impairments or severely and pervasively impaired personal adjustment.
    d. Continued significant self/other harm risk.
    e. 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.
    f. Emergence of new signs/symptoms, impairments, harm inclinations or medication complications meeting admission criteria.
3. Intensity of Service
    a. 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.
    b. The beneficiary is receiving active, timely, treatment delivered according to an individualized plan of care.
    c. Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or biologic/medication complications that necessitated admission to inpatient care.
    d. 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.

IV. STATE FACILITY PLACEMENTS

Responsibilities of Utilization Management

LifeWays Utilization Management shall serve as the single point of entry to and exit from the State Facility for all consumers served.

LifeWays Utilization Management shall advise on all applications and requests for admission to the State Facility that joint treatment planning will occur between the State Facility and the LifeWays Utilization Management Designee.

A. LifeWays Utilization Management shall evaluate and screen all requests for admittance of its consumers to the State Facility. Once Utilization Management approves for admission, the Utilization Management Designee shall provide the State Facility with the following:

1. Evaluations and recommendations for admission to the State Facility;
2. A report of all known medical issues related to the consumer;
3. The consumer's most recent individual plan of service as applicable; and
4. A list of the consumer's medications, as well as information on any medication tapering plans or history of failed trials of monotherapy. LifeWays shall participate in the development of the Individual Plan of Service (IPOS) for consumers by the State Facility utilizing the Person-Centered Planning (PCP) process. This may be accomplished through coordination between Utilization Management and established and contracted network providers.
5. Utilization Management shall lead in planning for and arranging appropriate community placement services and facilitating the discharge planning of its consumers from the State Facility.
6. Utilization Management is responsible for making determinations on its authorizations, in advance, for consumers as to all admissions of and continued stay at the State Facility, according to the procedures specified in this attachment. Utilization Management shall be responsible for the preparation of an alternative treatment plan and report(s) pertaining to consumers.

REFERENCES

Michigan Mental Health Code, P.A. 258 of 1974, as amended

Section 6.9.1 of the MDHHS/CMHSP Managed Mental Health Supports and Services Contract

CMS Benefit Policy Manual, Chapter 2 3. Michigan Department of Health and Human Services Medicaid Provider Manual, V.1.1.2020 (in effect, and as as amended) 4. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program (PIHP/ CMHSP contracts 10/1/2019- 9/30/2020 in effect, and as amended)

Michigan Medicaid Provider Manual

Attachments

No Attachments

Approval Signatures

Approver	Date
Ken Berger: Corporate Compliance Officer	pending
Carly Coxon: Customer Services Supervisor	pending
Cindy Keyes: Quality Improvement Specialist	pending
Karen Cascaddan: Executive Director, Governance	pending
Philip Hoffman: Quality Improvement Supervisor	pending

Approver	Date
Gina Costa: Chief Clinical Officer	pending
Michael Cupp: Contracts and Provider Network Management Director	pending
Shannan Clevenger: Chief Operating Officer	pending
David Lowe: Director, Utilization Management	9/1/2021

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Owner:	*Gina Costa: Chief Clinical Officer*
Area:	*05. Clinical Care Services*
Audiences:	*LifeWays Staff, LifeWays' Provider Network*

05-01.07 Referral Process Within the LifeWays Provider Network

I. STANDARDS

A. All individuals under the care of LifeWays and its Provider Network shall have an electronic referral completed prior to transitioning primary case holder or secondary service needs.

II. SCOPE

A. This operating procedure is applicable to LifeWays' internal service provision activities, as well and the LifeWays Provider Network service provision.

III. PROCEDURE

A. The referral form shall be used as the means for requesting a service be added to a consumer's plan of care.

B. The referral form functions as an electronic footprint that allows for electronic referral communication between providers among LifeWays and its provider network.

C. Both the referring staff and the referring staff's supervisor (which may be one in the same) will approve the referral request prior to it being sent to the referral staff of the receiving provider program.

D. If the referring staff supervisor approves the request, the receiving referral staff will approve or deny the referral.

1. The primary case holder will then need to open the provider assignment to the accepting agency.
2. The accepting agency can choose to indicate the staff to be assigned to the case or once the agency is open to the case, the supervisor can assign appropriate staff.

E. The referral form will show as an unsigned document in each referral's staff unsigned document queue until reviewed and signed off.

F. This form shall be located in the consumer's chart in LifeWays Electronic Organizer (LEO).

G. The referral form is located in LEO under the consumer menu, under the link titled "Referral Form."

H. The referral form shall be reviewed and signed within two business days of receipt.

I. Transitions or additions in service shall not be processed until the referral has been accepted.

IV. PROVIDER SPECIFIC REFERRAL STAFF

A. Each provider will have a designated LEO account named 'Referral Staff.'

B. Each provider shall have a gatekeeper that will review referrals and communicate referral needs to their appropriate program supervisor for approval or denial.

REFERENCES

LifeWays Operating Procedure
08-05.02 Electronic Medical Record (EMR) Management

Attachments

No Attachments

Approval Signatures

Approver	Date
Karen Cascaddan: Executive Director, Governance	8/4/2021
Aleksandra Wilanowski: Medical Director	8/4/2021
Maribeth Leonard: Chief Executive Officer	8/3/2021
Mark Weatherwax: Supervisor, Outpatient Services SUD	8/3/2021
Wade Stitt: Director, Access & Crisis Services	7/26/2021
Jessica Tucelli: Supervisor, Clinical Services	7/3/2021
Courtney Sullivan: Supervisor, Integrated Health Clinic Services	7/1/2021
Katelynn Miller: Supervisor, Outpatient Services	6/24/2021
James Horrigan: Crisis Residential Supervisor	6/22/2021
Julie Robert: Access Services Supervisor	6/21/2021
Christina Tindal: Supervisor, Crisis Services	6/21/2021
Angie O'Dowd: Recipient Rights Officer	6/21/2021
Cassandra Watson: Integrated Health Director	6/18/2021
Denae Tracy: Clinical Trainer	6/18/2021
Amy Cosgrove-Bridges: Case Management & Supports Coordination Supervisor	6/18/2021
Jodie Smith: Outpatient Services Director	6/18/2021
Michael Cupp: Contracts and Provider Network Management Director	6/18/2021
Shannan Clevenger: Chief Operating Officer	6/16/2021
David Lowe: Director, Utilization Management	6/15/2021

Approver	Date
Cindy Keyes: Quality Improvement Specialist	6/11/2021
Philip Hoffman: Quality Improvement Supervisor	6/11/2021
Carly Coxon: Customer Services Supervisor	6/10/2021
Ken Berger: Corporate Compliance Officer	6/9/2021
Karen Cascaddan: Executive Director, Governance	6/9/2021
Gina Costa: Chief Clinical Officer	6/9/2021

LEO Assignments Left Open

A HIPAA Horror Story

I want to refer someone for a service

OPTION 1

- I call in-network providers to see if they have availability
- If one does, I send a referral form and open the individual's medical record to them for review

OPTION 2

- 3 providers have this service
- I send a referral to all 3 and open the individual's record to each of them for their review
- **One accepts the referral ☺**

I process the referral and I'm finished... *Right?* **Not Yet!**

There's 1 more important step to keep the

HIPAA PO-PO

from coming after me!

WHAT?

I must close the assignments to the other 2 providers to prevent a HIPAA **Horror Story**

WHY?

I assigned them which gave them access to the recipient's PHI.

They no longer have a right to that PHI.

As always, let's do our best to keep the HIPAA Hippo Happy

New Provider ID Crosswalk:

Old PID	Old Provider Name	New PID	New Provider Name
101700	LifeWays Case Management Hillsdale	102141	Case Management
101701	LifeWays Case Management Jackson	102141	Case Management
100157	LifeWays Medical Services Hillsdale	102146	Psychiatric Services – Med Clinic
100158	LifeWays Medical Services Jackson	102146	Psychiatric Services – Med Clinic
101703	LifeWays Outpatient Hillsdale	102144	Outpatient
101704	LifeWays Outpatient Jackson	102144	Outpatient
	LifeWays Outpatient Hillsdale/Jackson (Panel Type - Peer Services)	102145	Peer Services
101816	LifeWays Integrated Health Services	102146	Psychiatric Services – Med Clinic
101672	LifeWays Crisis Services	102142	Crisis
100154	LifeWays Access Hillsdale	102147	General Administration
100155	LifeWays Access Jackson	102147	General Administration
101257	LifeWays Jail Services	102144	Outpatient (Panel Type – Jail)
102023	LifeWays OBRA	102141	Case Management (OBRA T1017 SE)
102023	LifeWays OBRA	102144	Outpatient (OBRA Assessment H0031 OB)
101672	LifeWays Crisis Services	102143	Mobile Crisis (MCT/ICSS)
101669	SIS Assessment - No change		

Code Modifications:

- T1016 Supports Coordination → T1017 Case Management
- SIS Assessment H0031 HW → H0031 WY
- Family Training (S5111 HM) → S5111 WP – when service provided by a trained parent using the MDHHS endorsed curriculum
- H0031 Assessment is now split between H0031 & 90791, depending on degree level (Case Management is still a bundled code that includes the annual assessment)
    - H0031 Bachelor level **ONLY**
    - 90791 Licensed professional counselor (LPC), Master's social worker, Psychologist, and higher
- Modifier HA – designated Parent Management Training Oregon model (PMTO) → New Modifier Y3