GUIDING PRINCIPLES FOR THE THUMB ALLIANCE PIHP PRACTICE GUIDELINES

The purpose of the Thumb Alliance Practice Guidelines document is to determine eligibility for services and assist in making determinations regarding the continued necessity for care. The services outlined in each of the population specific Practice Guidelines are available to any individual who meets the eligibility criteria for that service, with regard to both medical necessity and benefit plan package. The Thumb Alliance Practice Guidelines are to be utilized by its members in determining medically necessary supports, services, or treatment for those that they serve. These protocols are based upon those guidelines established in the most recent version of the Michigan Medicaid Provider Manual, as well as the Mental Health Code and all Medicaid bulletins. While all of these services contained in the Michigan Medicaid Provider Manual are eligible for Medicaid funding, ACCESS to these services will be determined based on the specific criteria outlined in these practice guideline documents. Least restrictive and more cost effective service(s) will be utilized whenever positive recipient driven outcomes can likely be achieved. Any updates or changes to these documents will be conducted at a minimum of every two years and will be reviewed by the Thumb Alliance Improving Practices Leadership Council (IPLC).

The PIHP's Practice Guidelines provide utilization management criteria and associated outcomes for all levels of care. As such, the Practice Guidelines are a framework for determining what conditions are appropriate for which service (or combination of service components), at what level of intensity, and for how long/how often. The Practice Guidelines: a. identify the clinical variables to be considered in the needs assessment process; b. include level of care guidelines/typical utilization management patterns; and c. describe how the protocols are to be applied in the context of the Person-Centered Planning Process and within the parameters of the Medical Necessity Criteria (the determination that a specific service is clinically appropriate, given the individual's diagnosis, symptomatology, and functional impairments within the most cost-effective and least restrictive environment and is consistent with the clinical standards of care).

The most important characteristic of an effective mental health service delivery system is the appropriate matching of services and supports to recipient need, based upon individual clinical conditions and circumstances, and to the maximum extent possible, personal choice. Thus, the planning climate is largely influenced by clinical conditions, the person centered planning process, and established medical necessity criteria as adopted by MDCH. The relative importance, or weight given to each of these dimensions, will vary according to specific circumstances for individual recipients. That is, there is no single algorithm that will emerge. However, the practice guidelines will provide considerable direction and guidance for both recipients and service providers in reviewing the above mentioned dimensions and making clinical decisions based upon these considerations.

In order to develop an accurate estimation of the severity of a given illness, the required care setting, or intensity of services and supports necessary to safely and appropriately treat the particular disorder, a clinical screening at Access must take place, requiring assessment of diagnosis, functional impairment, duration/history of illness, prior service utilization and clinical stability (risk potential). Together, these variables shall provide sufficient information to determine whether or not the preconditions to qualify for mental health or substance abuse services have been met. The practice guidelines then provide the framework for determining

who is eligible for which service (or combination of service components), at what level of intensity, and for how long. In addition to severity of illness, recipient preferences, and available care settings (service options), least restrictive clinically appropriate environments and medical necessity criteria must always be considered both at Access into services and continuation of services.

When an individual presents with multiple service needs that involve multiple life domains or treatment of an extended duration, the following practice shall be used (in the order stipulated below) to explore potential resources for supports and services:

1. The individual
2. Family, friends, guardian, significant others
3. Resources in the neighborhood and Community
4. Publicly funded supports/services available for all citizens
5. Publicly funded supports/services provided under the auspices of the Michigan Department of Community Health and the Community Mental Health Services Program

It is important to stress that these protocols are not a substitute for a thorough assessment and sound clinical judgment; however, as guidelines, they are part of a practice and utilization management system intended to guide and monitor the appropriateness of care received by individuals of public mental health and substance abuse services. As stated previously, in all situations, eligibility or benefit coverage requires that the selected level of care/intensity be medically necessary. Medical necessity is specifically defined in the following section.

MEDICAL NECESSITY CRITERIA FOR MEDICAID MENTAL, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

1. **Mental health, developmental disabilities, and substance abuse services are supports, 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 or community inclusion and participation, independence, recovery, or productivity

2. **The determination of a medically necessary support, service, or treatment must be:**

   * Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (family, 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 within federal and state standards for timeliness; **AND**

   * Sufficient in **amount** (number of units of service identified in the individual plan or service or treatment plan to be provided), **scope** (parameters within which the service will be provided: who, how, where), and **duration** (length of time it is expected that a service identified in the individual plan of service or treatment plan will be provided) of the service(s) to reasonably achieve its/their purpose.

   * Documented in the individual plan of service.

3. **Supports, services, and treatment authorized by the PIHP 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 practice and standards of practice issued by professionally recognized organizations or government agencies.

4. **Using criteria for Medical Necessity, a PIHP 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**
     --- 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 authorizations for certain services, concurrent utilization reviews, centralized assessment and referral, gate keeping arrangements, protocols and guidelines.

5. **A PIHP may not deny services based solely on present limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.**