Department of Community Health

CHILDREN'S WAIVER PROGRAM

TECHNICAL ASSISTANCE MANUAL

Appendix Items 15a-19a

Revised Edition - May 2004

A P P E N D I C E S

** These items will be forthcoming.*

Children's Waiver Program
Review Summary
_____CMHSP
Date

Introduction

The purpose of this site visit is to review and provide technical assistance to the CMHSP and/or contract agency regarding the Children's Waiver Program (CWP). It is intended to ensure the following: eligibility requirements, freedom of choice provision, service providers' qualifications, administrative procedures*, and a safe and appropriate plan of service for children served by the (CWP). Reviewing the implementation of policies and procedures, clinical records, personnel records, and interviews with staff and families/guardians completes this process. Site visits are conducted in children's homes to assess customer service, person-centered planning/family centered practice, the child's health and safety, and consumer satisfaction. Site reviews also provide an opportunity to evaluate staff training and competence. This report summarizes the results of the Michigan Department of Community Health (MDCH) site review.

# of Clinical records reviewed	# of face-to-face interviews	# of phone interviews	# of personal home visits

* It is understood that an agency may not currently have written agency policy for the CWP, but refer to the MDCH CWP guidelines. Although it is not required, it is recommended agencies develop their own implementation policy to correspond with the MDCH CWP policy and to assist their staff with the implementation of the program areas listed below.

Eligibility

Note: yes/no indicates whether or not the standard was met

Clinical Record Evidence	Yes	No	Comment
E-1 Original Waiver certification form and annual re-certification is completed, current and signed by CMHSP provider and by CRT Chairperson.			
E-2 Child currently meets eligibility criteria and is at risk for ICF/MR placement without waiver services.			
E-3 Assigned Category of Care is circled and appropriate to child's condition.			
E-4 FIA 49-A Medical Examination Report form is completed annually and a copy forwarded to MDCH.			

Freedom of Choice

Note: yes/no indicates whether or not the standard was met

Clinical Record Evidence	Yes	No	Comment
F-1 Parent has signed freedom of choice statement (Section 3) on initial Waiver Certification form.			
F-2 Parent concurs with comprehensive plan of service (IPOS).			
F-3 Parent was offered written, formal opportunity to express level of satisfaction with program.			

Home visits	Yes	No	Comment
H-1 Copy of IPOS is in the home and parent concurs with IPOS.			
H-2 Parent was offered formal opportunity to express level of satisfaction with program.			

Provider Qualifications

Note: yes/no indicates whether or not the standard was met

Home visits	Yes	No	Comment
H-3 Staff is knowledgeable about the individual health and safety issues of the child, as indicated in the IPOS.			
H-4 Protocols for managing individual health and safety issues are identified in the IPOS and implemented by staff.			
H-5 Staff have been trained in how to manage individual health and safety issues, as indicated in the IPOS.			

Provider Qualifications

Note: yes/no indicates whether or not the standard was met

Clinical Record Evidence	Yes	No	Comment
Q-1 Service providers are employees of CMHSP, on contract with CMHSP or hired through Choice Voucher System or Medicaid enrolled PDN providers.			
Q-2 Clinical service providers have been credentialed by CMHSP/Provider organization.			
Q-3 Case manager meets QMRP requirements.			
Q-4 Community Living Support (CLS) staff and Respite staff have received requisite education/training appropriate to child's needs, as indicated in the IPOS.			
Q-5 Provider assures staff are provided adequate supervision as identified in the IPOS/assessments to assure child's health and safety.			
Q-6 Provider assures paid parent caregivers meet provider qualification as listed in Q 1-4.			
Q-7 Provider assures staffing meets child's needs (i.e., level, frequency) as designated in the IPOS.			

Other Administrative Procedures

Note: yes/no indicates whether or not the standard was met

Clinical Record Evidence	Yes	No	Comment
A-1 CMHSP has a documented process for determining Category of Care.			
A-2 CMHSP has a documented process for review and approval of locally authorized services, durable medical equipment, and room air-conditioners.			
A-3 CMHSP has a documented process for review, recommendation and submission to CRT for MDCH required authorization.			
A-4 CMHSP has documentation informing parent in understandable/readable formats of: Recipient Rights, Complaint Resolution, and the State Medicaid Fair Hearings process.			
A-5 Contracts between CMHSP and service providers contain clear Performance Standards.			
A-6 CMHSP has formal process to facilitate the Choice Voucher option.			
A-7 Payments to parents are within program parameters.			
A-8 CMHSP has Prior Authorization documentation for services.			

Plan of Service

Note: yes/no indicates whether or not the standard was met

Clinical Record Evidence	Yes	No	Comment:
P-1 I POS is developed through a person-centered plan/family centered process.			
P-2The IPOS including a treatment plan is in the home and implemented by staff within 7 days from start of service.			
P-3 Current assessments of all identified service needs are included in the PCP/IPOS.			
P-4IPOS addresses all needs identified by assessments and team.			
P-5 IPOS identifies measures of expected out-come for each Intervention.			
P-6 Services are provided according to IPOS and are within the Category of Care determination.			
P-7 Services are appropriate to child's reported condition.			.
P-8 Physician prescriptions are obtained and in the child's chart for waiver durable medical equipment, supplies, and home modifications.			
P-9 Physician prescriptions are obtained and in child's file for OT and PT services, stating the diagnosis, date of prescription, specific service or item being provided, expected start date of the order, and the amount and length of time the service is needed.			.

Clinical Record Evidence	Yes	No	Comment:
P-10 CLS costs are identified (e.g., CLS worksheet), and isin child's chart.			
P-11 Evidence exists that supports services and supplies are the most appropriate, cost-effective alternative to meet the child's needs			
P-12 Evidence exists that community resources/natural supports have been exhausted.			
P-13 Evidence exists of denial of benefit from private insurance, Medicaid, CSHCS, etc.			
P-14 IPOS is reviewed and revised as needed, at least annually.			
P-15 Budget and billings reflects only those services and frequencies of services as identified in the IPOS>			

Consultative Comments and Recommendations:
The agency is encouraged to address the following concerns:

Reviewer's signature: _____

_____

Clinical Review Chair/Program Director's signature: _____, Date: _____

cc: CMHSP Director, MDCH Division Of Quality Management & Planning, MDCH Contract Manager

PHP REVIEW PROTOCOLS

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CATEGORY	DIMENSIONS/INDICATORS/*EVIDENCE*	SOURCE OF INFORMATION
A. CONSUMER INVOLVEMENT **Attach. P 6.8.2.3. Consumerism Practice Guideline** **Attach. P 6.8.2.1. Inclusion Best Practice Guideline**	A.1. Consumers (people who have received on-going or long-term public mental health services and supports) are involved throughout the delivery system. *Evidence = ways consumers are enlisted in designing, communicating, implementing and overseeing the PHP delivery system: advisory groups, consumer council, limited term focus group, other one-time-only forums, and committees reviewing aggregate consumer satisfaction information. Note: This is involvement beyond Board membership.*	AFP Administrative policies/records: Announcements, minutes, agendas, sign-in sheets Administrative staff interview Consumer interview *Reviewers: provide consultation regarding ways to involve consumers at the exit conference.*
	A.2. PHP promotes the efforts and achievements of consumers through special recognition of consumers. *Evidence = press releases, award banquet/dinners, volunteer award, certificates for achievement*	DCH Division of Consumer Relations Administrative records and policies: Announcements, agendas, minutes, newspaper articles Administrative staff interview
	A.3. Consumers, former consumers, family members and advocates must be invited to participate in evaluating implementation of the guideline. *Evidence = ways former consumers, family members and advocates are enlisted in designing, communicating, implementing and overseeing the PHP delivery system: advisory/monitoring groups, consumer council, limited term focus group, one-time-only forums, committees reviewing aggregate consumer satisfaction. Note: This is involvement beyond Board membership.*	*Reviewers: provide consultation regarding ways to recognize consumers at the exit conference.* Administrative records: Announcements, agendas, minutes of activities within last 12 months Consumer/family interview *Reviewers: provide consultation at exit regarding ways that families, consumers, and advocates can have input.*

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B. SERVICES **Sec 2.0 Supports and Services** **Chapter III, Coverages & requirements** **1. General**	B.1.1 The entire DD, MI, and SA service arrays, including alternative services, are available to consumers who need them. *Evidence = list/description of services available; a variety of services from the arrays are being utilized; waiting lists for specific services or types of services; services are available and accessible to people who live in rural counties (e.g., alternatives, or sub-contracts with another PHP); information packages mention service arrays*	Sub-element data Administrative records Individual records Individual Plan of Service documents Consumer/family interview: Access to needed services Offered alternative services in lieu of covered services
Chapt. III, General Info	B.1.2. Qualifications of non-professionals are consistent with the needs described in person-centered plans. *Evidence = identification of needed qualifications in plan, and actual qualifications of non-professionals as indicated in personnel records*	Administrative records Personnel records Position descriptions Individual records
Chapter III, Coverages and Limitations **Section 2**	B.1.3. Non-professionals are appropriately supervised. *Evidence = Personnel records, individual's plan, job description (who non-professional reports to, who signs time sheet), supervisor's monitoring, training provided by supervisor*	Administrative records (personnel) Individual records
B. SERVICES, continued **2. Peer-delivered and Operated Services** **Contract Part One** **18.0 Entire Agreement** **Contract Part Two**	B.2. Consumer-run programs are consistent with Medicaid Policy Bulletin *NOTE: drop-in centers must be controlled by consumers, not by CMH or provider staff in order to be in compliance with this requirement.* B.2.1. Evidence that services or supports are delivered to existing or prospective primary	Administrative records Consumer/family interview

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Section 2.0 Supports and Services **Chapter III, Coverages and Limitations** **AFP 3.5 Service Array** **Attach. P 6.8.2.3. Consumerism Practice Guideline**	consumers. B.2.2. Evidence that services or supports are alternatives or in addition to existing Medicaid covered PHP services such as PSR Clubhouse, ACT teams, etc.(Presence of other programs). B.2.3. Evidence that if the service or support is to be delivered in the same site or facility as a PSR Clubhouse, day program, etc., that the services or support are: - occurring at times outside of the "ordered day" or socialization component of the clubhouse; occurring at times outside of the day program schedule; publicized and made available to persons other than clubhouse members or day program participants; those in which consumers have exclusive decision-making authority over the planning and implementation of the service and support (i.e., professional staff are involved only as consultants at the request of consumers and not part of the actual service delivery). B.2.4. In the case of self-help organizations or activities, the group must consist of consumers who have control of the purpose and content of the discussion and evidence of PHP direct financial or in-kind support (e.g., donation of building space, phones, travel expenses, etc.) in addition to formal or informal referral agreements. *Evidence = consumers are actually running the organization; schedule of activities*.	
B. SERVICES, continued **3.0 Home-Based Services** **Chapter III, Coverages and Limitations** **Section 4 Home-Based Services.**	B.3.1.Enrolled by DCH. B.3.2. Eligibility/Target pop: Family unit with multiple service needs. *Evidence = plan of services contain assessment and goals.* B.3.3. Structure/Org:	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview

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Chapter III, Section 4, p. 2	1.Home-based program has a centralized structure (identifiable service unit of an organization). 2.Mechanism for service coordination and integration has been defined & utilized. B.3.4.Staffing: 1. Worker to family ratio does not exceed 1:15. *Evidence = from interview with administrative & clinical staff.* 2. Program is supervised by QMHP and Child Mental Health professional. *Evidence = documentation in personnel file.* 3. Staff is child mental health professional. *Evidence = documentation of qualifications in personnel file, and/or staff development/training records.* 4. Staff for individual with D.D., must be QMRP and child mental health professional. *Evidence = documentation of qualifications in personnel file, and/or staff development/training records.* 5. Home-based assistants must be trained prior to beginning work with the beneficiary and family. *Evidence = documentation in individual's record; training files.* 6. Infant MH Home-based staff are trained in infant mental health intervention prior to beginning work with child and family. *Evidence = in training files.*	

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B. SERVICES, cont. **Chapter III, Coverages and Limitations** **Section 4 Home-Based Services.** **Chapter III, Coverages and Limitations** **Section 4, p. 2.**	B.3.5. Presence in Individual Plan: 1. Services provided by home based service assistants must be clearly identified in IPOS. 2. Services must be based on family-focused plan of service. *Evidence = entire family is mentioned in assessment, treatment plan, and progress notes*. 3. Home based services are provided in the family home or community settings which all citizens use. *Evidence = documentation in individual record, family interview*.	Individual records Clinical staff interview Consumer/family interview
B. SERVICES , cont. **4.0 Assertive Community Treatment** **Chapter III, Coverages and Limitations** **Section 5. ACT**	B.4.1. Program is enrolled by DCH. B.4.2. Eligibility/Target Pop: Persons with serious psychiatric disorders with: • difficulty managing medications without ongoing support. • psychotic/affective symptoms despite medication compliance. • socially disruptive behavior presenting high risk for arrest & inappropriate incarceration • who are frequent users of inpatient hospital services, emergency services, or crisis residential. *Evidence = record review: assessments*. B.4.3.1. Structure/Organization: ACT services are provided by all members of a mobile, multi-interdisciplinary team. *Evidence = staff interviews, minutes, progress notes; all team members see all consumers unless there is a clinical reason to do otherwise*.	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview
B. SERVICES , cont.	B.4.3.2. Case management services are interwoven	DCH records

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4.0 Assertive Community Treatment - continued **Chapter III, Coverages and Limitations** **Section 5. ACT** .	with treatment and rehabilitation services and are provided by all members of the team. *Evidence = documentation in individual records*. B.4.3.3. ACT services and interventions must be consistent with medical necessity of the individual beneficiary with goal of maximizing independence. B.4.3.4. ACT services are available 24 hours a day, 7 days a week, including crisis response coverage (psychiatric availability) and rapid response to decompensation. NOTE: if Access Service is used for after-hours calls, referral procedures should be in place to link ACT consumer with on-call ACT team member(s). B.4.3.5. ACT team meetings are held daily. B.4.3.6. Physician meets with team on a frequent basis. B.4.3.7. ACT meetings cover: a. plans for deploying activities of the team; b. discussion of urgent or emergent situations; c. progress updates, clinical, medical needs as well as psychosocial interventions and supports. B.4.3.8. Utilization reviews are completed every 3-6 months. *Evidence = team meeting minutes*, *utilization reviews*.	Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview
B. SERVICES, cont. **4.0 Assertive Community Treatment, cont.** **Chapter III, Coverages and Limitations** **Section 5**	B.4.4.Staffing: B.4.4.1.Team composition is sufficient in number to provide an intensive array of services on a 24-hour/7days a week basis (including capability of multiple daily contacts); and team size is based on a staff (excluding psychiatrist and clerical staff) to consumer ratio of not more than 1:10. B.4.4.2. Team must include: a) one physician (MD or DO) assigned to the team;	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview

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	b) one Health Care professional with extensive experience with the target population and is licensed, certified, or registered by State or National organization to provide health care services, and is qualified to provide programmatic and administrative supervision; c)one RN licensed by the state of Michigan; d)other professional staff licensed, certified or registered by the state of Michigan or national organizations to provided health care services; e) non-professionals supervised by one of the above and documented in the clinical record. *Evidence = documentation in personnel records of licensure and/or certification, or registration; documentation of regular meetings with team physician and that the physician serves all caseload of the team members; team meetings*.	
B. SERVICES, cont. **4.0 Assertive Community Treatment, cont**. Chapter III, Coverages and Limitations Section 5	B.4.5.Presence in Individual Plan: B.4.5.1.ACT team case manages and coordinates all services received by individual, including medical, clinical, and psychosocial, as well as seeing that basic needs (i.e., food, housing, self-care, employment) are being met. *Evidence = coordination is documented in the individual's plan of service; and community living needs are being addressed in planning*. B.4.5.2. Level of ACT is appropriate to person's needs and intended to maximize independence. *Evidence = documentation in plan; interview with consumer*. B.4.5.3. Continuity of care is supported by flexible on-going approach and titrated contacts with a goal of maximizing independence.	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview

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	Evidence = consumer interview; case record shows evidence of titration of services appropriate to individual's condition and supporting independence. B.4.5.4. Discharge is based on criteria including stability, community tenure, preference of consumer. *Evidence = documentation in plan*. B.4.5.5. Majority of ACT services are provided according to the beneficiary's preference and clinical appropriateness in the beneficiary's home or other community locations rather than the team office. *Evidence = progress notes, consumer interview* .	
B. SERVICES, cont. **5.0 Psychosocial Rehabilitation Programs** **Chapter III, Coverages and Limitations** **Section 6**	B.5.1. Program is <u>enrolled</u> by DCH. B.5.2. <u>Eligibility:</u> Individuals must have SMI with identified psycho-social rehabilitation goals and the ability to participate in and benefit from PSR program. B.5.3. <u>Structure/Org:</u> B.5.3.1. Members have access during weekend, evening and/ or holiday hours. B.5.3.2. Must have schedule that identifies when program components occur. *Evidence for 1 & 2 = activity logs, sign-in sheets, staff and consumer interviews*. B.5.3.3. Must have ordered day; vocational & educational support; member supports (outreach, self help groups, sustaining personal entitlements, help locating community resources, and basic necessities); social opportunities that build personal, community and social competencies. B.5.3.4. Members influence & shape program operations.	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview

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	Evidence = policy meeting minutes; interviews with consumers. B.5.3.5. Staff & members work side by side. *Evidence = observation and consumer interview*.	
B. SERVICES, cont. **5.0 Psychosocial Rehabilitation Programs, cont.** **Chapter III, Coverages and Limitations** **Section 6**	B.5.4.Staffing: B.5.4.1. FTE manager who is professionally licensed, certified, or registered by State or national organization to provide health care services. B.5.4.2. Non-professional staff work under documented supervision of professional. *Evidence = personnel files, performance appraisals, time sheets signed by supervisor.* B.5.5 Presence in the Plan B.5.5.1. Services reflect individual's needs and identified PSR goals. B.5.5.2. Member establishes own schedule. *Evidence = Work assignment board; morning meeting minutes; consumer interview; PSR unit sign in sheets.* B.5.5.3. Member receives support towards recovery from fellow members and staff. *Evidence = documentation in individual's plans*.	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview
B. SERVICES, cont. **6.0 Crisis Residential** **Chapter III, Coverages and Limitations** **Section 7**	B.6.1. Program is enrolled by DCH and provided in DCIS licensed and certified settings. B.6.2.Eligibility: Person meets psychiatric inpatient criteria or is at risk of admission, and who can be served appropriately outside the hospital. *Evidence = documentation in individual's record*.	
B. SERVICES, cont.	B.6.3.1. Structure/Organization: Services include: psychiatric supervision;	DCH records Administrative records

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6. 0 Crisis Residential, cont. **Chapter III, Coverages and Limitations** **Section 7**	therapeutic support services; medication management; stabilization and education; behavioral services; milieu services; & nursing services. *Evidence = all services are provided as documented in record review; discussion with supervisor*. B.6.3.2. Nursing services for children must be available through regular consultation. *Evidence = services are provided as documented in record.* B.6.3.3. <6 beds - on-site nursing must be provided at least 1 hr/day with 24 hour on-call availability. OR 7-16 beds - on-site nursing must be provided 8 hrs/day, 7 days a week, with 24 hour on-call availability. B.6.4.1. Staffing: Services provided under supervision of psychiatrist and under immediate supervision of a professional with BA and 2 years experience. B.6.4.2. Non-degree holding staff must have at least one year of satisfactory work experience providing services to persons with mental illness or they must have successfully completed DCH approved training program. *Evidence = documentation in personnel files*.	Administrative staff interview Individual records Clinical staff interview
B. SERVICES, cont. **6. 0 Crisis Residential, cont.** **Chapter III, Coverages and Limitations** **Section 7**	B.6.5 Individual Plan of Service: B.6.5.1. Plan must be developed within 48 hours of admission. B.6.5.2. Plan must contain clearly stated goals and measurable objectives structured to resolve the crisis. (Children's plan of service must address the child's need in context with the family's needs and	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview

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	in consultation with school district staff.) B.6.5.3. Discharge plan identifies aftercare/ follow-up services with the identification and role of case manager documented. B.6.5.4. Signed by beneficiary, parent or guardian, psychiatrist and any other professionals involved in treatment planning. B.6.5.5. The assigned case manager must be involved in the course of treatment, as soon as possible. B.6.5.6. If the crisis period exceeds 14 days, the interdisciplinary team develops a subsequent plan based on comprehensive assessments.	
B. SERVICES, cont. **7.0 Mental Health Case Management** **Chapter III, Coverages and Limitations Section 8**	B.7.1. Case management program must be enrolled by DCH. B.7.2. <u>Eligibility:</u> B.7.2.1. Persons who have mental illness and are functionally limited. B.7.2.2. Persons who have multiple service needs. B.7.2.3. Persons who have high level of vulnerability. B.7.2.4. Persons who require access to a continuum of mental health services.. B.7.2.5. Persons who have demonstrated inability to independently access and sustain involvement with services. *Evidence = documentation in record, consumer interviews*. B.7.3. <u>Structure/Organization</u> B.7.3.1. Provider must have capacity to perform a face-to-face assessment and produce a written report. B.7.3.2. Persons must have choice of case management providers.	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview

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	B.7.3.3. Program provides core element of case management: assessment, linking/coordination, monitoring. *Evidence = documentation in case record.* B.7.3.4. Providers must document initial and ongoing training for case managers related to core requirements. B.7.4.1. Staffing: Primary case manager must be a professional who possesses a bachelor's degree in human services or a registered nurse. *Evidence = documentation in personnel file; training records.*	
B. SERVICES, cont. **8.0 Day Program Settings or Sites** **Chapter III, Coverages and Limitations Section 2**	B.8.1. Site must be enrolled by DCH. B.8.2. Structure/Organization: B.8.2.1. Services are provided in settings other than person's home or specialized residential setting. B.8.2.2. Program has schedule which delineates the services and supports offered. B.8.3. Staffing B.8.3.1. Services are delivered by or under the supervision of professional staff licensed, certified, or registered by a state or national organization to provide health related services within scope of practice. B.8.3.2. "under supervision" is appropriately documented. *Evidence =documentation in personnel file and individual record.* B.8.4. Presence in Plan: An individual schedule identifies supports and services provided based on desired outcomes and/or goals defined through a person-centered planning process.	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview

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	Evidence = documentation in individual records.	
B. SERVICES, cont. **9. 0 Personal Care** Chapter III, Coverages and Limitations, Section 9	B.9.1.Structure/Organization: B.9.1.1. Provided in licensed, specialized residential care facilities to assist beneficiaries with activities of daily living. *Evidence = DCIS license displayed; Equivalency to 3803's justification; documentation in clinical record.* B.9.1.2. Providers must meet DCH specialized mental health residential contract requirements. *Evidence = license is displayed; training record.* B.9.2. Staffing: Supervision of personal care must be provided by RN, physician, or case manager. *Evidence = documentation in clinical record; personnel files.* B.9.3. Presence in Plan: B.9.3.1. Provided in accordance with the IPOS. *Evidence = documentation in clinical record* B.9.3.2. Ordered by a physician or Medicaid designated case manager; reviewed and approved at least once a year. *Evidence = 3803s are signed by physician or Medicaid case manager.* B.9.3.3. Documentation of the delivery of personal care services is consistent with how the individual plan of service specifies those services that are to be provided.	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview
B. SERVICES, cont. **10.0 Inpatient Psychiatric Hospital Admissions & Partial Hospitalization Services**	B.10.1 Structure/Organization: B.10.1.1. Available 24 hours a day, 7 days a week. *Evidence = discussion with staff and consumers regarding how the after-hours system is structured.* B.10.1.2. Presence of severity of illness and clinical	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview

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Chapter III, Coverages and Limitations, Sections 10 and 11. **Mental Health Code 1409 & 1705** **42 CFR 441.153**	criteria for pre-screening. B.10.1.3. PHP coordinates care with Substance Abuse treatment providers when appropriate. B.10.1.4. PHP provides or refers to alternative services. B.10.1.5. Notice of rights to a second opinion is provided to individuals denied hospitalization. B.10.1.6. PHP communicates with treating and/or referring providers. B.10.1.7. PHP communicates with primary care physician or health plan with consumer/ guardian authorization. *Evidence = prescreen form for items 2 through 7; evidence of second opinion.* B.10.1.8. MSA- 4486 completed by PHP for beneficiaries under age 21. B.10.1.9. Hospital area PHP conducts pre-admission reviews and consults with designated county/catchment area to determine appropriate disposition for admission, authorization/approval. B.10.1.10. PHP for beneficiary's county of residency must prior authorize the admission for psychiatric inpatient care. B.10.1.11. Aftercare services planning is completed in conjunction with hospital personnel.	
B. SERVICES, cont. **11.0 Intensive Crisis Stabilization Services** **Chapter III, Coverages and Limitations Section 12**	B.11.1. Program is <u>enrolled</u> by DCH. B.11.2. <u>Eligibility</u>: B.11.2.1. Persons assessed to meet criteria for psychiatric hospital admission, but who with intense interventions , can be stabilized and served in their usual community environments. B.11.2.2. Persons leaving inpatient psychiatric services if crisis stabilization services will result in shortened inpatient stay.	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview

PHP REVIEW PROTOCOLS

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	B.11.2.3. Persons with a diagnosis of mental illness or mental illness with a co-occurring substance abuse disorder or a developmental disability. *Evidence = documentation in plan (e.g.,assess.).* B.11.3. Structure/Organization: Crisis stabilization services are delivered by a treatment team under psychiatric supervision (direct on-site supervision is not required, but psychiatrist must be available by phone at all times). B.11.4. Staffing: B.11.4.1. Professionals providing intensive crisis stabilization services must be licensed practitioners of the healing arts. B.11.4.2. Nursing services/consultation must be available. B.11.4.3. Trained paraprofessional may assist the professional team if they have one year experience providing services to persons with serious mental illness or if they have completed a CMH approved training program. *Evidence = personnel records, training records.*	
B. SERVICES, cont. **11.0 Intensive Crisis Stabilization Services, cont.** **Chapter III, Coverages and Limitations** **Section 12**	B.11.5. Presence in Plan: B.11.5.1. Intensive crisis stabilization services treatment plan must be developed within 48 hours. B.11.5.2. Plan must contain clearly stated goals and measurable objectives and identification of services and activities to resolve the crisis. B.11.5.3. Plans for follow-up services after crisis is resolved with role of case manager identified. B.11.5.4. Assigned case manager must be involved in treatment for those beneficiaries receiving case management services. B.11.5.5. For children's intensive crisis stabilization services the plan must address the child's needs in	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview

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	context with the family's needs; consider the child's educational needs; and be developed in context with the child's school district staff. *Evidence = presence in child's plan.*	
B. SERVICES, cont. **12.0 Children's Waiver** **Chapter III, Coverages and Limitations** **Section 14**	B.12.1. Eligibility B.12.1.1. Meets Mental Health Code definition of DD, and at risk of ICF/MR placement. B.12.1.2. Under age 18 (unless enrolled and over 18 prior to 10/1/96). B.12.1.3. Resides with birth/adoptive parents, and/or legal guardian; or foster care with a permanency plan to return home within 1 month of placement. B.12.2. Structure/Organization: B.12.2.1. Waiver services are provided in family home and in community. B.12.2.2. Category of Care Decision Guide is used to determine the amount of publicly funded hourly care.. B.12.2.3. CMHSP is responsible for assessment, application and referral of potential waiver candidates sending to DCH along with completed CWP prescreen. B.12.2.4. CMHSP is responsible for coordination of child's waiver services. B.12.2.5. CMHSP must maintain a record of all specialty services and other services (CLS) costs for audit purposes. B.12.2.6. CMHSP approves and issues prior authorization letters for waiver services and private duty nursing authorized to all service providers. B.12.2.7. CMHSP submitted requests for all durable equipment and home modifications to DCH for approval.	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview

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	B.12.2.8. At least one Children's Waiver service is provided to each enrollee per month.	
B. SERVICES, cont. **12. Children's Waiver, cont.** **Chapter III, Coverages and Limitations** **Section 14**	B.12.3. Documentation exists that service providers are employees of CMHSP; on contract with the CMHSP; hired through the Choice Waiver system; or are Medicaid enrolled private duty nursing providers. B.12.3.1. Staffing - Hourly care provided under the supervision of professional staff licensed, certified, or registered by state or national organization. B.12.3.2. Plan supervised by a QMHP. B.12.3.3. Hourly care staff must be trained in the following: plan of service implementation, first aid, infection control, emergency procedures, and recipient rights. *Evidence = personnel records, training records*. B.12.3.4. Parents may not act as paid staff for their child. (Under very limited circumstances, a parent or stepparent who possesses appropriate licensure/certification, special skills, documented training, and is considered a qualified provider, may function and be paid as a provider.) B.12.3.5. Reimbursement for parents and stepparents may not exceed 248 hours during 30 consecutive days and CLS provided by parents may not be used more than twice in a 12-month period. B.12.4. Presence in Plan: B.12.4.1. Covered services with measurable outcomes and methodology in place for tracking are specified in IPOS. B.12.4.2. All necessary assessments are current (within 12 months or within 6 months of annual waiver certification). B.12.4.3. Evidence that planning took place with family, needs, desires and goals were discussed.	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview

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	B.12.4.4. Evidence of active treatment must be present in IPOS. *Evidence = in plan of aggressive, ongoing, outcome-based program.*	
B. SERVICES, cont. **13.0 Habilitation Supports Waiver for Persons With Developmental Disabilities** **Chapter III, Coverages and Limitations Section 13**	B.13.1. Eligibility: B.13.1.1. Persons must have a developmental disability as defined by the Developmental Disabilities Assistance and Bill of Rights Act. B.13.1.2. Persons assessed to require the level of service or supports provided in an ICF/MR as evidenced by a QMRP's certification. B.13.1.3. Persons must reside in a community-based setting. B.13.1.4. Persons must be certified as current enrollees and be re-certified annually. *Evidence = certification forms, annual recertifications, assessment*. B.13.2. Structure/Organization: CMHSP maintains documentation of : B.13.2.1. Total annual Medicaid expenditures for supports and services do not exceed the total amount that would have been spent for the care of the consumers in an ICF/MR setting. B.13.2.2. Current information showing all CMHSP waiver sites. Licensed settings must be authorized to provide DD programs and certified (AFC only) if the setting is providing specialized mental health services to persons with a developmental disability. B.13.2.3. The cost of room and board is excluded from the CMHSP's HSW utilization/cost accounts. B.13.3.1. Staffing All services, including supports coordination, are provided under the supervision of a physician or other licensed practitioner of the healing arts.	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview

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	Evidence = documentation in personnel records.	
B. SERVICES, cont. **13.0 Habilitation Supports Waiver for Persons With Developmental Disabilities, cont.** **Chapter III, Coverages and Limitations Section 13**	B.13.4. Presence in the Plan: Services and supports provided were specified in the individual plan of service. B.13.4.1. Documentation that HSW support and services provided are necessary to prevent institutionalization. *Evidence = plan*. B.13.4.3. Family training. Is identified as appropriate to meet the individual's needs. B.13.4.4. Individual had the opportunity to choose between HSW supports and services, and institutional services. *Evidence = plan*. B.13.4.5. Individual was informed of right to request alternative providers, or service site if proposed not acceptable. *Evidence = in plan*. B.13.4.6. Documentation that services are not available under IDEA or the Rehabilitation Act. B.13.4.7. Documentation that services and supports focus on habilitation rather than exclusively custodial care. B.13.4.8. At least one HSW service is provided to each enrollee per month.	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview
B. SERVICES, cont. **14. 0 Alternative services** **Contract 2.0 Supports and Services**	B.14.1. Eligibility: Persons with developmental disability or mental illness as defined by the Mental Health Code. B.14.2. Structure/Organization: B.14.2.1. PHP provides assessments and evaluations as needed. B.14.2.2. Staffing: All services, including supports coordination, are	DCH records Administrative records Administrative staff interview Individual records Clinical staff interview Consumer/family interview

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	provided under the supervision of a physician or other health care professionals. *Evidence = documentation in personnel records.* B.14.3. Presence in the Plan: B.14.3.1. Services to be provided, including amount, scope, provider, and duration of services. B.14.3.2. State plan services for which these services are an alternative. B.14.3.3. Services monitoring schedule. *Evidence = documentation in plan..*	
B. SERVICES, continued **15. Jail Diversion Program** **Attach. P 6.8.4.1. Jail Diversion Practice Guideline**	B.15.1. Presence of Jail Diversion Program Persons with serious mental illness, serious emotional disturbance, or developmental disability who have committed misdemeanors and non-violent felonies are diverted to services as an alternative to being charged and incarcerated in a county or municipal jail. *Evidence = presence of program, people using services.* B.15.2. PHP has made an effort to establish working relationships with representative staff of law enforcement agencies. *Evidence= written interagency agreement, and/or correspondence indicating attempts to communicate with law enforcement; minutes from meetings in which PHP participates*. B.15.3. PHP makes cross-training opportunities available to staff of local law enforcement agencies. *Evidence - training curriculum, agenda, announcements, minutes of sessions* B.15.4. PHP collects data and maintains a data base on jail diversion programs and uses the information to monitor and evaluate the program. *Evidence = data base; reports on information with*	Administrative records Administrative staff interviews

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	recommendations for improvement.	
B. SERVICES, continued **16. Substance Abuse Access and Treatment** **Contract 2.0 Supports and Services** **Attachment P.3.2.1 Medical Necessity Criteria** **Attachment P.6.8.2.5 substance Abuse Practice Guideline** **AFP** **Chapter III, Section Three-Covered Services** **Chapter III, Section Fifteen - Substance Abuse Services**	B.16.1. The PHP ensures that the required continuum of substance abuse rehabilitative services are available. *Evidence = customer services and other informational brochures describing available services; documented utilization of services.* B.16.2. The PHP has sufficient capacity to meet demands for substance abuse services. *Evidence= needs assessment; assessment of current capacity; presence or lack of waiting lists for specific services.* B.16.3. The PHP meets the time and distance requirements for access to substance abuse services. *Evidence= compliance with requirement that services be available within 30 miles or thirty minutes in urban areas, and available within 60 miles or 60 minutes in rural areas.* B.16.4. The PHP meets the requirements to provide 24 hour a day, 7 day a week access to substance abuse screening assessment and referral services. *Evidence = presence of screening function during and outside of regular business hours; screening assessment times and dates indicate compliance with the requirement.*	DCH Records AFP Administrative records Administrative staff interview Individual records Clinical staff interview Consumer interview
B. SERVICES, continued **16. Substance Abuse Access and Treatment** **Contract 2.0 Supports and Services** **Attachment P.3.2.1 Medical Necessity Criteria** **Attachment P.6.8.2.5 substance Abuse Practice Guideline**	B.16.5. The PHP has effective methods for assuring that substance abuse treatment is based on the development of an individualized treatment plan. *Evidence = presence of individualized treatment plan in provider records; PHP policy on substance abuse individualized treatment; PHP processes and procedures for evaluating provider compliance;*	DCH Records AFP Administrative records Administrative staff interview Individual records Clinical staff interview Consumer interview

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AFP **Chapter III, Section Three-Covered Services** **Chapter III, Section Fifteen - Substance Abuse Services**	*and documentation that supports the PHP's implementation of their policies and procedures.* B.16.6. The PHP has a process for ensuring that substance abuse treatment providers make clinical decisions consistent with the Medical Necessity Criteria for Medicaid Mental Health and Substance Abuse Services requirements as attached to the contract. *Evidence = PHP administrative policy and procedure; PHP process for assessing provider compliance; clinical treatment records at provider level indicate adherence to requirements.*	
C. IMPLEMENTATION OF PCP **Sec. 4.5.1 & Attach. 4.5.1.1, PCP Best Practice Guideline** **Attach. 3.11.3, Consumerism Best Practice Guideline** **MHC 712** **Chapt III, Provider Assurances & Provider Requirements** **Attach.4.7.4.1 Grievances and Appeals Technical Requirement** **MDCH Administrative Hearings Policy and Procedures dated 9/1/99.** **Technical Requirements in 42CFR on Grievance and Appeals**	C.1. PHP has policy or practice guideline delineating how PCP is implemented which is consistent with DCH's. C.1.1. Process for informing consumers of their rights to PCP. C.1.2. The individual is provided with options of choosing external facilitation of their meeting, unless the individual is receiving short term outpatient therapy only, medication only, or is incarcerated. C.1.3. Individual plans of service are developed within 7days of commencement of services. C.1.4. Individuals were provided timely Adequate Notice consistent with DCH format. C.1.5. Staff are trained in the philosophy and methods of pers	Administrative policies/records Administrative Staff interview Individual record review Clinical staff interview Consumer/family interview

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	on-centered planning. C.1.6. Preplanning meetings occur before a person-centered planning meeting is originated. C.2. Person-centered planning addressed: C.2.1. Individual's dreams, desires, and/or goals. C.2.2. Individual's strengths, not weaknesses. *Evidence = plan, assessments, progress notes are written from strengths-based perspective.* C.2.3. Specific services and supports to be provided, including the amount, scope, and duration of services. *Evidence = plan documents date(s)services or supports are to begin and specifies the scope, duration, intensity, frequency of face to face monitoring contacts and who will provide each authorized service or support; documentation supports that the use of alternative services were discussed.*	
C. IMPLEMENTATION OF PCP, cont. **Sec. 4.5.1 & Attach. 4.5.1.1, PCP Best Practice Guideline** **Attach. 3.11.3, Consumerism Best Practice**	C.2.4. Natural Supports. *Evidence = plan or pre-planning documents discussion about family, friends or others (community at large, neighbors, church, etc.) who do now, or could be asked in the future, to support*	Administrative policies/records Administrative Staff interview Individual record review Clinical staff interview

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Guideline **MHC 712** **Chapt III, Provider Assurances & Provider Requirements**	*the person in achieving desired outcomes*). C.2.5. Health and Safety. *Evidence = health and/or safety issues identified and addressed. If issues identified, what accommodation and supports needed to meet individual's needs. Was opportunity for crisis plan provided?* C.2.6. Conflict resolution. *Evidence = plan documents who can be contacted if dissatisfaction or concerns arise regarding services or service provision.* C.2.7. Accommodations for sensory and/or communication handicaps if needed. *Evidence = plan documents use of interpreter, communication device, and/or person who knows consumer best*. C.2.8. Accommodations for cultural diversity. *Evidence = plan documents use of translator/inter-pretor, translated documents as needed for language differences and proficiencies?* C.2.9. Inclusion of consumer in community. *Evidence = plan documents paid or volunteer work/activities in which the individual is or wants to be engaged and what accommodations will be made for this to occur.*	Consumer/family interview
C. IMPLEMENTATION OF PCP, cont. **Contract Part II: Statement of Work Section 3.4.1.** **Attach. P 3.4.1.1. Person-Centered Planning Best Practice Guideline** **Attach. P 6.8.2.3. Consumerism Practice Guideline**	C.2.10. Individuals have ongoing opportunities to express their needs and desires, preferences, and meaningful choices. *Evidence = plan documents that individual's preferences were identified in selection of services, supports and staff and individuals with court appointed guardians were given opportunities to make decisions in areas not delegated to guardian.* C.2.11. Family-focused supports and services (for	Administrative policies/records Administrative staff interview Individual record review Clinical staff interview Consumer/family interview

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Mental Health Code Section 712 **Chapter III, Coverages and Limitations Program Requirements, page 1** **Attach. P 6.3.2.1. PHP Grievance and Appeal Technical Requirement** **Technical Requirements in 42CFR on Grievance and Appeals**	minor children). *Evidence = plan is centered on children's needs with focus on the family as a support. Family signed plan and were involved with child in the process.* C.2.12. Meaningful activities. *Evidence = plan documents meaningful activities that will assist in achieving desired outcomes.* C.2.13. The individual is provided an opportunity to develop a crisis plan. C.2.14. Frequency that the individual plan of service will be formally reviewed (no less than annually) for effectiveness. *Evidence = plan clearly identifies how frequently the plan will be reviewed and documents individual's opinion regarding review frequency; documentation that individual was informed of their ability to request a meeting when needed or desired.* C.2.15. Individuals are provided with ongoing opportunities to provide feedback on how they feel about services, supports and/or treatment they are receiving, an their progress towards attaining valued outcomes.	
C. IMPLEMENTATION OF PCP, cont. **Contract Part II: Statement of Work Section 3.4.1.** **Attach. P 3.4.1.1. Person-Centered Planning Best Practice Guideline** **Attach. P 6.8.2.3. Consumerism Practice Guideline**	C.3. Individuals are provided a copy of their individual plan of service within fifteen business days afer the planning meeting. C.4. The PHP has a process for assuring subcontractors' implementation of and compliance with person-centered planning requirements. *Evidence= Contract is inclusive of person-centered training, implementation of person-centered planning process, use of standardized formats, crisis planning, consumer satisfaction, and PHP*	Administrative policies/records Administrative staff interview Individual record review Clinical staff interview Consumer/family interview

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Mental Health Code Section 712 **Chapter III, Coverages and Limitations Program Requirements, page 1** **Attach. P 6.3.2.1. PHP Grievance and Appeal Technical Requirement** **Technical Requirements in 42CFR on Grievance and Appeals**	*monitoring (oversight) and performance improvement activities.* C.5. Reviews of the effectiveness of the individual plan of service are completed at the intervals identified in the plan and include a review of the individuals satisfaction with services and/or treatment and a review of progress made towards achieving desired outcomes.	
D. ADMINISTRATIVE SERVICE FUNCTIONS **1. <u>Customer Services</u>** **Contract: Part II Statement of Work Section 6.3** **BBA-438.10f 6 viii E ix** **Attach. P 6.8.2.3. Consumerism Practice Guideline** **BBA-438.10b1-2,3.** **BBA-438.10f6i-xii.** **BBA-438.10c2-3,5i-ii,d1i-ii-2.** **BBA-438.10c3,5i,438.10f(a)(v),6viiiE**	D.1.1. Customer services is an identifiable function at the PHP. *Evidence = Office, or minimally 1-2 staff assigned and budget* D.1.2. PHP has available informational brochures for consumers and families. *Evidence =Explanation of managed care, enrollees understanding of requirements and benefits* *Evidence=Recipient rights, grievance and appeals, PCP and service array (including MI, DD, and SA services); booklet with names, location, telephone numbers of and non-English languages spoken by providers, those not taking new patients.* D.1.2.1 Brochures are available in alternative formats for people with sensory disabilities (large print or audio), or who are non-English reading or have limited reading proficiency. *Evidence = whether the PHP made available written information in each prevalent non-English language in the service area; including a toll-free number that enrollees can use to file a grievance or an appeal by phone.* D.1.2.2. Oral interpretation services are available in any language, free of charge, for both potential and	Administrative records, materials Consumer/family interview

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BBA-438.10gi(v) **BBA-438.10c4,5i-ii.** **BBA-438.10 (5),(d)ii**	actual enrollees. *Evidence = community needs assessment; presence of brochures; "I Speak Cards".* D.1.2.3. Person-first language is used in documents.	
D. ADMINISTRATIVE SERVICE FUNCTIONS **1. <u>Customer Services</u>, cont.** **Contract: Part II Statement of Work Section 6.3** **Attach. P 6.8.2.3 Consumerism Practice Guideline** **Attach. P 6.8.2.1 Inclusion Practice Guideline** **BBA-438.10c3,5i** **BBA-438.206 (6)c2** **BBA-438.10c4,5i-ii.**	D.1.3.1. PHP method for outreach and ensuring adequate access. *Evidence = outreach to underserved populations in the community, community needs assessment*. D.1.3.2. Culturally responsive. *Evidence = brochures, PSAs in alternative formats, and/or outreach to cultural groups/communities, have written materials available in prevalent non-English language, each PHP participates in efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.; programs have the ability to respond to culturally diverse populations by having referral agreements with cultural groups, access to translators, etc.; oral interpretation services are available in any language, free of charge, to potential enrollees and enrollees; information to potential enrollees about basic features of managed care, which enrollees are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily; benefits covered, service area, cost sharing, names, locations and telephone of providers, and identification of those not accepting new patients and those that have non-English services, also information on primary care physicians, specialists and hospitals.*	Administrative materials Administrative policies Administrative staff interview Consumer/family interview

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D. ADMINISTRATIVE SERVICE FUNCTIONS, cont **Customer Services, cont.** **Contract: Part II Statement of Work** **Section 6.3** **Attach. P 6.8.2.3 Consumerism Practice Guideline** **Attach. P 6.8.2.1 Inclusion Practice Guideline** BBA-438.10e2iA-C, iiA-E. *BBA-438.10f5.*	D.1.3.3. Inclusion of consumers in development and provision of members services (e.g., helping to develop brochures). *Evidence = how consumers are recruited, ways in which they are involved, and how many are involved*. D.1.3.4. Accommodations for disabilities. *Evidence = outreach activities; brochures , newspaper articles, materials used in community (language formats - including Braille); uses Person-first language; ramps to and automatic doors on the buildings; TDD; access to interpreter; audio tapes describing services.* D.1.3.5. The PHP makes a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt of or issuance of the termination notice to each enrollee who received their primary care from or was seen on a regular basis by the terminated provider.	Administrative records/materials Consumer/family interview
D. ADMINISTRATIVE SERVICE FUNCTIONS, cont **2. Local Complaint Resolution Process** **Contract: Part II Statement of Work** **Section 6.3** **Attach. P 6.3.2.1** **AFP Section 3.6**	D.2.1. There is a local complaint resolution process assessed as substantially compliant by the DCH Office of Recipient Rights. D.2.2. Grievance/complaint records and reports demonstrate adherence to the approved process**.**	DCH records Administrative records Administrative interview Individual records
D. ADMINISTRATIVE SERVICE FUNCTIONS, cont **3. Consumer Grievances and Appeals**	D.3.1. There are methods for informing consumers, in understandable/readable formats, of Sections 159, 409 and 705 rights to hearings, second opinions and Medicaid Fair Hearings processes. D.3.2. PHP must provide the following information	Administrative policies or pamphlets Administrative staff interview Consumer/family interview

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Contract: Part II Statement of Work Section 6.3 **Attach. P 6.3.2.1** **AFP Section 3.6** **BBA-438.10f 6iv** **CFR Subpart A,** **Section 438.10(f)1** **(i-vii).**	to all its enrollees. (iv) Information on grievances and fair hearing procedures, and for PHP enrollees, the information specified in section 438.10(g)(1). D.3.3. Each PHP must provide instructional materials in a manner and format that may be easily understood (language proficiency, identified prevalent non-English languages, oral interpreters free of charge) about the grievance system to all providers and subcontractors at the time they enter into a contract. *Evidence = brochures, fliers, hospital pre-screening documents, consumer service denial or reduction records/notices (maintained by records mgt., customer services, Access or other PHP or provider staff for all service areas (MI, DD, and SA)).* D.3.4 Process/procedure used to acknowledge receipt of each consumer's grievance and/or appeal. D.3.5 Evidence of timely and correct adherence to the Adequate Notice Process, and use of a form consistent with DCH format.	
D. ADMINISTRATIVE SERVICE FUNCTIONS, cont **3. <u>Consumer Grievances and Appeals</u>** **Contract: Part II Statement of Work Section 6.3** **Attach. P 6.3.2.1** **AFP Section 3.6** ***BBA-438.206(2)*** ***BBA-438.210a-e.*** ***BBA-438.410***	D.3.6. Each PHP must establish and maintain an expedited review process for appeals when the PHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. D.3.7. Records/reports of grievances and/or appeals from Medicaid recipients demonstrate adherence to the grievance and appeal processes as described in the technical requirement and	Administrative policies Informational pamphlets Administrative staff interview Consumer/family interview

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BBA- 438.424 **42 CFR, Subpart A, Section 438.10(g)(1)** **42 CFR, Subpart F, Parts 400 et al.** **42 CFR, Subpart D, Sections 438. 206(b) (3), 438.228** **MDCH Administrative Hearings Policy and Procedures (MDCH Administrative Tribunal Office) dated 9/1/99.**	associated CFR grievance and appeals requirements. Evidence = grievance and appeal logs, grievance and appeal outcomes. D.3.8. Techniques used to recognize trends, evaluate and improve the effectiveness of the grievance and appeals process. *Evidence = PHP or provider grievance and appeals tracking logs, QI and consumer satisfaction survey documents and reports, individual person-centered plans or records.*	
4. <u>Provider Networks</u> **Contract Part II: Statement of Work Section 6.4** **Attach. P6.4.1.1** **Chapter III, Coverages and Limitations, Section 1** **AFP Section 3.8** **BBA-438.206b/i,ii,iii,IV,V,2** **BBA-438.206(b)1-5** BBA-438.206,6	D.4.1. There is a process for procurement, including development of an RFP, an evaluation plan, and criteria for selection. *Evidence = DCH checklist, or other standardized checklist, RFPs.* D.4.2. The PHP maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. D.4.2.1. PHPs with urban areas have qualified Native American Providers that offer speciality mental health and substance abuse services to Native American populations. D.4.3. There is a process for and evidence of continual re-evaluation of the provider network. *Evidence = provider contract language, CQI plan, monitoring reports*. D.4.4. Process for and evidence of certification of provider network**.** D.4.5.1 The PHP demonstrates that its providers are credentialed as required by §438.214. D.4.5.2. The PHP demonstrates that its providers provide timely access to care and services. D.4.5.3. The PHP demonstrates that its providers	**AFP** **Administrative policies and procedures** **Administrative staff interview** **DCH records** **Administrative records**

PHP REVIEW PROTOCOLS

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	are available 24/7 when medically necessary.	
4. <u>Provider Network s, cont.</u> **Contract Part II: Statement of Work** **Section 6.4** **Attach. P6.4.1.1** **Chapter III, Coverages and Limitations, Section 1** **AFP Section 3.8** **BBA-438.206b/i,ii,iii,IV,V,2** **BBA-438.206(b)1-5** **BBA-438.206,6** ***BBA-438.608** ***BBA-438.206b6** ***BBA-438.610** ***BBA-438.810**	D.4.5.4. The PHP assures provider compliance with the requirements associated with limited English proficiency, cultural competence, and accommodation of physical and communication limitations. *Evidence = PHP administrative process for monitoring contractual providers compliance with LEP requirements. Reports, meeting minutes, review activities, etc., that demonstrate the PHPs review activities. Documentation of actions taken to improve contractual providers compliance to LEP requirements as a result of the monitoring activities.* D.4.5.5. Policy regarding program integrity requirements. D.4.5.6. PHP has to have a specific requirement relating to the development and implementation of a policy that meets the requirements in sec.438.610 D.4.5.7 Conflict of Interest: PHP has developed and implemented a policy that meets the requirements of section 438.810 D.4.6. There is a single point of responsibility within the PHP for overseeing contract development and execution. D.4.7. There is a single point of responsibility within the PHP for ongoing contract and network management. D.4.8. The PHP has adopted common policies and procedures concerning assessment and service provision for individuals with co-occurring mental health and substance abuse disorders.	AFP Administrative policies and procedures Administrative staff interview DCH records Administrative records

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D. ADMINISTRATIVE SERVICE FUNCTIONS **5. <u>Quality Improvement</u>** **Contract Part II: Statement of Work** **Section 6.7** **Attach. P 6.7.1.1** **AFP Section 3.9** BBA-438.240a,b,c,d **BBA-438.240(b)1,(d)1-2**	D.5.1.PHP has written description of its QAPIP: D.5.1.1. Structure, objectives, scope. D.5.1.2. Specific activities. D.5.2. PHP has systematic process of Quality Assessment and Improvement. D.5.2.1. Process for monitoring and evaluating care. D.5.2.2. Process for making improvements on an ongoing basis. D.5.2.3. Example of how it works. *Evidence=documentation in administrative records, examples of specific process improvement studies or projects with evidence of outcomes.* D.5.3. The PHP has an ongoing quality assessment and performance improvement program for the services it furnished to its enrollees. D.5.4. The PHP conducts required performance improvement projects. D.5.4.1. The PHP submits accurate performance measurement data. D.5.4.2. The PHP has mechanisms in place to detect both underutilization and overutilization of services. D.5.4.3. The PHP has mechanisms in place to assess the quality and appropriateness of care furnished to enrollees with special health care needs. D.5.5.1. Annually, the PHP measures and reports to the State its performance, using standard measures required by the State**.** D.5.5.2. Annually, the PHP submits to the State, data specified by the State, that enables the State to measure the PHP's performance.	DCH records Administrative records Administrative staff interview
D. ADMINISTRATIVE SERVICE FUNCTIONS	D.5.6. Oversight of QIP is done by a Governing	AFP

PHP REVIEW PROTOCOLS

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5. <u>Quality Improvement</u>, cont. **Contract Part II: Statement of Work** **Section 6.7** **Attach. P 6.7.1.1** **AFP Section 3.9** **BBA-438.206,6,2** **BBA-438.10(g)1(i-vii)** **BBA-438.100c/438.102(a)1(iv)**	Body. *Evidence = agendas, minutes, activities summaries*. D.5.7. QIP is supervised by senior executive. D.5.8. Medical Director has defined role. *Evidence = job description of medical director and executive director.* D.5.9. The QIP contains written procedures regarding personnel, qualifications, selection, management, credentialling and re-credentialing. *Evidence = presence in QI plan*. D.5.9.1. Staff members receive initial and continuing education and staff development activities which include person-centered planning; Abuse and Neglect; Behavior Management (Applied Behavioral Sciences); Crisis Management*;* cultural diversity, language proficiency; grievance and appeal; and recipient rights. *Evidence = training agendas, sign-in logs of participants***.**	Administrative records Administrative staff interview Clinical staff interview
D. ADMINISTRATIVE SERVICE FUNCTIONS **5. <u>Quality Improvement</u>, cont.** **Contract Part II: Statement of Work** **Section 6.7** **Attach. P 6.7.1.1** **AFP Section 3.9**	D.5.10. A Consumer Satisfaction process is in place. *Evidence = established mechanisms (survey, focus group) for obtaining assessment of member experiences with services at least once a year; (e.g. survey instrument) that it is conducted regularly (dates of administration, procedures, results); how the information from the feedback is used to make changes for individuals, as well as systemic actions taken*. D.5.10.1. The PHP's quality improvement system actively seeks feedback from individuals receiving services concerning their satisfaction with the person-centered planning process; their	Administrative policies & records Administrative staff interview Individual records Clinical staff interview Consumer/family interview

PHP REVIEW PROTOCOLS

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	opportunities to express desires and preferences; and their ability to make choices. *Evidence = sign-in logs and/or minutes of meetings, reports (annual,QI).* D.5.10.2.Consumers are involved in the review of aggregate consumer feedback. *Evidence = action taken by the PHP.* D.5.10.3. Process for sharing the aggregated feedback with the PHP Director, governing body, providers, and recipients. D.5.11.1. PHP has written description of, or policy for, or manual about its Utilization Management Program (i.e., how does PHP uniformly make service authorization or reduction decisions?) D.5.11.2. UM Program has written mechanism to identify and correct under- and over- utilization D.5.11.3 UM Program has written prospective, concurrent, and retrospective procedures.	
D. ADMINISTRATIVE SERVICE FUNCTIONS **5. <u>Quality Improvement</u>, cont.** **Contract Part II: Statement of Work** **Section 6.7 and 6.8** **Attach. P 6.7.1.1** **AFP Section 3.9**	D.5.11.4 For persons with developmental disabilities, there is a written mechanism for regular and ongoing review of their needs and circumstances, and the services being delivered. *Evidence=needs match services, and any criteria used for decisions about service type, frequency or scope are applied uniformly.* D.5.12.Policy and Procedure for the review, analysis, reporting and follow-up of consumer deaths and sentinel events. *Evidence = record review.* D.5.13. The PHP has a specially constituted body that meets the composition requirements, in place for review of: D.5.13.1. Use of aversives; D.5.13.2. Generalized use of token economies;	Administrative procedures Individual records

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BBA-438.206,2	D.5.13.3. Use of psychoactive meds for the purpose of behavior control; D.5.13.4. Use of restraints, including situations that could be inappropriately implemented as seclusion. *Evidence = policies or procedures.* *D*.5.14. The PHP has an administrative policy and procedure which addresses cultural competency and including those with limited English proficiency. D.5.15. Cultural considerations. Each PHP promotes the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	
6.* Health and Safety** ***Attachment P 3.4.1.1 ***BBA-438.208 (c)1,2,3,4***	D.6.1. Organizational process for addressing health issues. *Evidence = written procedures.* *Evidence = health issues being discussed during planning.* *Evidence = Follow-up w/issues which need to be addressed.* *Evidence = monitoring reports (e.g. copies of lab results).* D.6.2. Organizational process for monitoring medications. *Evidence = written procedures.* D.6..3. Organizational process for addressing safety issues. D.6.3.1. At risk behaviors/activities in home/community. D.6.3.2. Safety of setting (home/work) and neighborhood. D.6.3.3. Emergency response capacity (e.g., fire,disaster, medical emergency).	Administrative policies/records Administrative staff interview Individual record review Clinical staff interview Consumer/family interview

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	D.6.3.4. Infection control practices.	
7. <u>Performance Indicators</u> **Contract: Part II Statement of Work** **Section 6.5** **Attachment P. 6.5.1.1** **BBA-438.604a-b** **BBA-438.606**	D.7.1 Demonstration of how data submitted to DCH per the reporting requirements is collected and calculated. D.7.2 Quality Improvement data submitted to DCH is updated annually. D.7.3. Submitted data is certified by one of the following: (1) The PHP's Chief Executive Officer; (2) The PHP's Chief Financial Officer; or (3) An individual who has delegated authority to sign for, and who reports directly to, the PHP's Chief Executive Officer or Chief Financial Officer.	DCH records Administrative records Information Systems source documents Administrative staff interviews Individual records
D. ADMINISTRATIVE SERVICE FUNCTIONS **8. Limited English Proficiency** **Contract: Part II Statement of Work** **Section 6.3.3, 6.4** **Office of Civil Rights Policy guideline on Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency** **BBA-438.10(5)(d)ii {assessing}** **BBA-438.10c4,5i-ii**	D.8.1. PHP has an administrative policy and procedure in place for identifying and assessing the language needs of the program and the individuals to be served. *Evidence=administrative policy and procedure.* D.8.1.2. The PHP makes oral interpretation services available free of charge to each enrollee. (This applies to all non-English languages, not just those that the State identifies as prevalent.) D.8.1.3. The PHP notifies enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services. D.8.1.4. Written material is available in alternative formats and in an appropriate manner takes into consideration the special needs of those who are visually limited or have limited reading proficiency. D.8.2. PHP has developed and implemented a comprehensive written policy that ensures meaningful communication with LEP individuals. *Evidence=administrative policy on consumer*	Administrative policies/records Administrative staff interview Individual record review Consumer/family interview

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	records; clinical records identify the language needs of each LEP consumer.	
D. ADMINISTRATIVE SERVICE FUNCTIONS **8. Limited English Proficiency** **Contract: Part II Statement of Work** **Section 6.3.3, 6.4** **Office of Civil Rights Policy guideline on Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency** **BBA-438.206,2** ***BBA-438.10(c),1-5x(d)1-2 (policy)**	D.8.3. Cultural considerations-the PHP promotes the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. D.8.3.1. The PHP has established a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout their service region. D.8.3.2. The PHP developed written information in each prevalent non-English language. *Evidence = presence of written materials in languages other than English; documentation that shows LEP individuals have utilized free language assistance; and confirmation from interviewed LEP consumers.* D.8.3.3. The PHP made its written information available in the prevalent non-English languages in its particular service area. D.8.3.4. The PHP made oral interpretation services available free of charge to each enrollee. (This applies to all non-English languages, not just those that the State identifies as prevalent.) D.8.3.5. The PHP notified enrollees: D.8.3.5.1. that oral interpretation is available for any language and written information is available in prevalent languages. D.8.3.5.2. how to access those services.	Administrative policies and procedures Administrative records Administrative staff interview
D. ADMINISTRATIVE SERVICE FUNCTIONS **8. Limited English Proficiency**	D.8.3.6 Written material must use easily understood language and format and be available in alternative formats and in an appropriate manner that takes into	Administrative policies and procedures Administrative records

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Contract: Part II Statement of Work **Section 6.3.3, 6.4** **Office of Civil Rights Policy guideline on Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency** **BBA-438.10c4,5i-ii**	consideration the special needs of those who are visually limited or have limited reading proficiency. D.8.3.7. All enrollees must be informed that information is available in alternative formats and how to access those formats. D.8.4. PHP has capacity to provide a range of oral language options appropriate to each individual's needs. *Evidence = consumer records identify the language services provided each LEP consumer. PHP demonstrates through contracts and/or documentation of language services that they have the capacity for translating oral and written materials as required in the LEP guideline.*	Administrative staff interview Consumer record review Consumer/family interview
D. ADMINISTRATIVE SERVICE FUNCTIONS **8. Limited English Proficiency** **Contract: Part II Statement of Work** **Section 6.3.3, 6.4** **Office of Civil Rights Policy guideline on Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency**	D.8.5. PHP has a process for ensuring that directly employed and contractually employed staff are trained on LEP requirements. *Evidence = PHP administrative policy concerning staff LEP training. Review of staff training records and training curriculum. Discussions with staff.* D.8.6. PHP has a demonstrated process for annually monitoring its compliance with LEP requirements. *Evidence = PHP administrative process for monitoring their own compliance with LEP requirements. Reports, meeting minutes, etc., that demonstrate the PHP's internal review. Documentation of actions taken to improve compliance to LEP requirements as a result of the monitoring activities.*	Administrative policies and procedures Administrative records Administrative staff interview Staff training records

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D. ADMINISTRATIVE SERVICE FUNCTIONS **8. Limited English Proficiency** **Contract: Part II Statement of Work** **Section 6.3.3, 6.4** **Office of Civil Rights Policy guideline on Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency** ***BBA-438.204 g***	D.8.8. There is a process for providing written materials in other languages as outlined in the LEP guideline. *Evidence = information materials about the PHP, and information required to be provided to individuals by statute, administrative rules or Federal requirement are available in other languages as identified in the LEP guidelines.* D.8.9. Formal agreements must be in place when PHPs utilize community volunteers as translators. *Evidence = formal agreements with community volunteers used as translators, if volunteers are used.* D.8.10. Language assistance must be available 24 hours per day, seven days per week. *Evidence = contract with agency providing translation services, agreements with any agencies providing volunteer translators, documentation that services have been utilized at various days of the week and times.* D.8.11. The PHP must provide the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients.	Administrative policies and procedures Administrative records Administrative staff interview Consumer/family interview Consumer record review Demographic data Interagency agreement
D. ADMINISTRATIVE SERVICE FUNCTIONS **8. Limited English Proficiency** **Contract: Part II Statement of Work** **Section 6.3.3, 6.4**	D.8.12. Telephone interpreters are only used as a last resort and are only to be used when the language is one not usually encountered in the community. *Evidence = agreements or contracts for translator services, records of individuals with LEP who utilized translator services.*	Administrative policies and procedures Administrative records Administrative staff interview Consumer/family interview Consumer record review

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Office of Civil Rights Policy guideline on Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency	D.8.13. The PHP has a process for ensuring that persons used as interpreters have competency in both English and those languages they translate to or from. *Evidence = PHP administrative policy and procedure for verifying translator competency. Documentation that process was utilized to verify interpreter competency.*	
D. ADMINISTRATIVE SERVICE FUNCTIONS **9. Cultural Competence** **Sections BBA-438.204(b)3,(d), 438.206(b)1iii,6; 438.206(c)1i-vi,2 details cultural competence requirements.**	D.9.1. The PHP has a written Cultural Competency Plan. *Evidence = administrative policy and procedure.* **D.9.2. The PHP promotes the delivery of services in a culturally competent manner to all individuals, including those with limited English proficiency and diverse cultural and ethnic backgrounds.**	Administrative policies and procedures Administrative staff interview
D. ADMINISTRATIVE SERVICE FUNCTIONS **9. Cultural Competence** **Sections BBA-438.204(b)3,(d), 438.206(b)1iii,6; 438.206(c)1i-vi,2 details cultural competence requirements**	D.9.3. The PHP identifies and assesses the cultural needs and language needs of potential and active consumers. *Evidence = administrative policy and procedure, cultural and language needs assessment.* D.9.4. The PHP identifies how access to services is facilitated for persons with diverse cultural backgrounds and/or limited English proficiency. *Evidence = administrative policy and procedure, service penetration rates, administrative and consumer records document cultural outreach efforts.* D.9.5. The PHP identifies standards for the recruitment and hiring of culturally competent staff members.	Cultural Competence Plan Demographic data Consumer records

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	Evidence = staff cultural competence standards, administrative recruitment activities, pre-employment evaluation of applicant's cultural competence. D.9.6. identifies how ongoing staff training needs in cultural competence will be assessed and met. *Evidence = staff training needs assessment, staff training schedule, staff training curriculum outline.* D.9.7. The PHP maintains evidence that staff members receive cultural competence training. *Evidence = staff training curriculum outline, in-service training attendance logs.*	
D. ADMINISTRATIVE SERVICE FUNCTIONS **9. Cultural Competence** **Sections BBA-438.204(b)3,(d), 438.206(b)1iii,6; 438.206(c)1i-vi,2 details cultural competence requirements**	D.9.8. The PHP has a process for ensuring that contractual providers comply with all applicable requirements concerning the provision of culturally competent services. *Evidence = PHP's administrative process for monitoring contractual providers compliance; reports, meeting minutes, etc. that demonstrate the PHP's external review of contractual providers; completed assessments of provider organization's compliance; corrective action plans to ensure contractual provider's compliance.* D.9.9. The PHP has a process for annually assessing its compliance with the cultural competence plan. *Evidence = PHP administrative process for monitoring their compliance with cultural competence requirements; reports, meeting minutes, etc. that demonstrate the PHP's internal review; documentation of efforts to improve PHP compliance as a result of the monitoring activities.*	Administrative records Administrative staff interview Provider contracts

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E. COORDINATION **Sec. 4.9.1** **Contract: Part II Statement of Work** **Sections 6.4.4, 6.4.5 and 6.8.3**	E. 1. Health Care Plans *Evidence =Signed joint coordination/collaboration agreements; individual records document attempts by the PHP to communicate information with the Health Plans.*	Administrative procedures & records Administrative staff interview Individual records Clinical staff interview
E. COORDINATION, cont **Contract: Part II Statement of Work** **Sections 6.4.4, 6.4.5 and 6.8.3** BBA-438.208(b)(4)	E. 2. Local Community Agency Collaboration: E.2.1. Multipurpose Collaborative Bodies * E.2.2. Schools/ISDs * E.2.3. Jobs Commission E.2.4. FIA* E.2.5. Substance Abuse *Must have signed agreements at a minimum *Evidence = arrangements, agreements, memoranda of understanding, participation in meetings, reports and referrals in individual records*. E.3. Primary care providers. E.3.1. Documentation at a minimum addresses coordination of care between the PHP and the QHP for people who are case managed and/or are using psychotropic medications. *Evidence = set of policies and procedures which document coordination.* *Evidence = documentation in individual records*. E.3.2. The PHP ensures that each individual's privacy is protected in accordance with privacy requirements in 45 CFR parts 160 and 164 subparts A and E, if applicable.	Administrative records Administrative staff interview Individual records
F. CMHSP BOARD OF DIRECTORS MEMBERSHIP	F.1 CMHSP Board composition meets the requirements identified in the Mental Health Code.	AFP

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Mental Health Code Section 330.1212	*Evidence = list of all Board members and their designations.*	Administrative Policies
G. RECORD KEEPING **Sec. 4.11** **Chapter I, Medicaid manual** **Record keeping**	G.1. Record Retention G.1.1. Minimum of 7 years. G.1.2. Includes written orders of other providers. G.2. Client information. G.2.1. name. G.2.2. Medicaid identification number. G.2.3. Medical record number. G.2.4. Address (+zip code). G.2.5. Birth date. G.2.6. Telephone number. G.3. Clinical records. G.3.1. Specific findings or results of diagnostic or therapeutic procedures. G.3.2. Test methodology. G.3.3. Record of prescribed treatments, tests, therapies, drugs. G.3.4. Strength, dosage and quantity of drug. G.3.5. Diagnosis, symptom, condition. G.3.6. Histories, plan of care, progress notes, consultation reports. G.3.7. Begin and end time of service delivered. G.3.8. Prescribing/referring physician.	Clinical records (DCH and Independent Medicaid evaluation reviews)

Rec'd by DCH:

DCH CHILDREN'S WAIVER PROGRAM
PRIOR REVIEW AND APPROVAL REQUEST
EQUIPMENT/HOME MODIFICATIONS

DCH USE ONLY
PRIOR APPROVAL CODE

NOTE: APPROVAL REFERS TO SERVICE APPROPRIATENESS AND DOES NOT GUARANTEE MEDICAID PAYMENT

DATE OF REQUEST:	PROVIDER'S CASE NO. : (IF APPLICABLE)	
CHILD'S NAME (Last, First, Middle Initial):	DOB:	MEDICAID I.D. NUMBER:
ADDRESS:	Parent(s) name:	
SUPPORTS COORDINATOR'S NAME:		TELEPHONE NUMBER:
RMHA:	TYPE:	
RMHA FINANCIAL REPRESENTATIVE'S NAME:		TELEPHONE NUMBER:

LINE NO.	DESCRIPTION OF SERVICES (INCLUDE BRAND NAME/MODEL NUMBER IF APPLICABLE)	QUANTITY	CHARGE	Waiver Approval Code
01				
02				
03				

Indicate any other services (related to this need/Waiver Procedure Code) approved during the past 3 years (please attach another sheet if needed):

THE FOLLOWING ITEMS ARE REQUIRED FOR A COMPLETED EQUIPMENT REQUEST PACKET:

Original Physician's Prescription Y N Narrative Justification of Need by Appropriate Professional Y N Medicaid/CSHCS Denial Y N

Copy of Habilitation Program Related to This Request Y N Three Similar Bids Y N Denial of Request by Private Insurance Y N

_____ _____

Supports Coordinator's Signature Date

_____ _____

RMHA Financial Representative's Signature Date

DCH USE ONLY

ENROLLED WAIVER PARTICIPANT 9 ENROLLEMENT CURRENT (ALL REQUIRED RE/CERTIFICATION DOCUMENTATION UP-TO-DATE) 9

Approved as:	Denied (see remarks)	Remarks: Approved services must be delivered by _____ & Billed before _____
Presented 9	9	
Amended 9	No Action Taken 9	
		_____ Clinical Review Team Chair or Designee Date _____

Michigan Department of Community Health
Mental Health Services to Children and Families
Children's Medicaid Waiver Program
PRAR Review Form

CHILD'S NAME: _____ CMHSP: _____

ITEM REQUESTED: _____ CRT RVW Date: _____

CRT MEMBERS PRESENT: _____

	Selection Criteria	Substantiated	
		Yes	No
1	Is the POS essential to prevent the person/child being placed outside their natural home (institution)?		
2	Is the identified service/support essential to success of the plan?		
3	Is there either scientific or historical documentation that the proposed service/support will achieve the requisite outcome?		
4	Is the prescribed treatment essential to the successful outcome described in the POS?		
5	Has the treatment been prescribed by a licensed physician or licensed independent health care practitioner?		
6	Is the treatment being directly supervised by the appropriate clinical discipline?		
7	Is the requested equipment of environmental modification essential to a successful outcome of the prescribed treatment?		
8	Is this the most cost-effective intervention that will achieve the desired outcome?		
Comments			

CRT DECISION: _____

should be identified during an assessment of service needs. These factors have implications for service planning, and should be considered when determining the actual number of hours (within the range) to authorize.

Decision Guide For Establishing Maximum Amount of Private Duty Nursing To Be Authorized on a Daily Basis

FAMILY SITUATION / RESOURCE CONSIDERATIONS		INTENSITY OF CARE Average Number of Hours Per Day		
		LOW	MEDIUM	HIGH
Factor I – Availability of Care Givers Living in the Home	2 or more caregivers; both work or are in school F/T or P/T	4-8	6-12	10-16
	2 or more caregivers; 1 works or is in school F/T or P/T	4-6	4-10	10-14
	2 or more caregivers; neither works or is in school at least P/T	1-4	4-8	6-12
	1 caregiver; works or is in school F/T or P/T	4-8	6-12	10-16
	1 caregiver; does not work or is not a student	1-4	6-10	8-14
Factor II – Health Status of Care Giver(s)	Significant Health issues	Add 2 hours if Factor I <= 8	Add 2 hours if Factor I <= 12	Add 2 hours if Factor I <= 14
	Some health issues	Add 1 hour if Factor I <= 7	Add 1 hour if Factor I <= 9	Add 1 hour if Factor I <= 13
Factor III – School *	Beneficiary attends school 35 or more hours per week, on average	Maximum of 6 hours per day	Maximum of 8 hours per day	Maximum of 12 hours per day

* Factor III limits the maximum number of hours which can be authorized for a beneficiary:

- Of any age in a center-based school program for more than 25 hours per week; or
- Age six and older for whom there is no medical justification for a homebound school program.

In both cases, the lesser of the maximum 'allowable' for Factors I and II, or the maximum specified for Factor III applies.

When using the Decision Guide, the following definitions apply:

- 'Caregiver': legally responsible person (e.g., birth parents, adoptive parents, spouses); paid foster parents; guardian or other adults who are not legally responsible or paid to provide care, but who choose to participate in providing care.
- 'Full-time (F/T)': working at least 30 hours per week for wages/salary, or attending school at least 30 hours per week.
- 'Part-time (P/T)': working at least 15 hours per week for wages/salary, or attending school at least 15 hours per week.
- 'Significant' health issues: one or more primary caregiver(s) has a health or emotional condition that prevents the caregiver from providing care to the beneficiary (e.g., beneficiary weighs 70

pounds and has no mobility and the primary caregiver just had back surgery and is in a full-body cast).

- 'Some' health issues: one or more primary car giver(s) has a health or emotional condition, as documented by the caregiver's treating physician, that interferes with, but does not prevent, provision of care (e.g., care giver has lupus, alcoholism, depression, back pain when lifting, lifting restrictions, etc.).
- 'School' attendance: The average number of hours of school attendance per week is used to determine the maximum number of hours that can be authorized for the individual of school age. The average number of hours is determined by adding the number of hours in school, plus transportation time. During planned breaks of at least 5 consecutive school days (e.g. spring break, summer vacation), additional hours can be authorized within the parameters of Factors I and II.

  The Local School District (LSD) or Intermediate School District (ISD) is responsible for providing such 'health and related services' as necessary for the student to participate in his education program. Unless medically contraindicated, individuals of school age should attend school. Factor III applies when determining the maximum number of hours to be authorized for an individual of school age. The Medicaid PDN benefit cannot be used to replace the LSD's or ISD's responsibility for services (either during transportation to/from school or during participation in the school program).

2.4 Exception Process

Because each beneficiary and his family are unique and because special circumstances arise, it is important to maintain an exception process to ensure the beneficiary's safety and quality of care. PDN services that exceed the beneficiary's benefit limitation as established by the Decision Guide must be prior authorized by the appropriate Medicaid case management program. Limited authority to exceed the published PDN benefit limitations may be granted on a time-limited basis as detailed below.

The beneficiary or his primary care giver must initiate the request for an exception. The applicable Medicaid case management program's representative is responsible for facilitating the request and documenting the necessity for an exception. Factors underlying the need for additional PDN must be identified in the beneficiary's POC, which must include strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception;
- Current lack of natural supports required for the provision of the needed level of support; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care; and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition.

Exceptions are time-limited and must reflect the increased identified needs of the beneficiary. Consideration for an exception are limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

A temporary alteration in the beneficiary's care needs following a hospitalization, resulting in one or both of the following:	**The temporary inability of the primary caregiver(s) to provide the required care, as the result of one of the following:** ('Inability' is defined as the caregiver is either unable to provide care, or is prevented from providing care.)
▪ A temporary increase in the intensity of required assessments, judgments, and interventions. ▪ A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs. The total number of additional PDN hours cannot exceed two hours per day, for a maximum of six months.	▪ An acute illness or injury of the primary caregiver(s). The total number of additional PDN hours cannot exceed two hours per day for the duration of the caregiver's inability, not to exceed six months. In the event there is only one caregiver living in the home and that caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. ▪ The death of the primary caregiver(s) or an immediate family member. 'Immediate family member' is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days. ▪ The home environment has been determined to be unstable, as evidenced by FIA protective or preventive services involvement. The written POC and community-based care coordination activities must include strategies directed toward stabilizing service supports and/or the family situation. The maximum number of hours varies by the beneficiary's Intensity of Care category: High = maximum of 18 hours per day; Medium = maximum of 14 hours per day; Low = maximum of 10 hours per day. The length of time for this exception is three months or the time needed to stabilize service supports and/or family situation, whichever is less. A one-time extension of up to three months may be made if there is documented progress toward achieving the stabilized home environment.

PRIVATE DUTY NURSING

INSTRUCTION FOR THE THIN CLIENT DATABASE

MAY 2004

TABLE OF CONTENTS

SECTION ONE: ENTERING A PRIOR AUTHORIZATION REQUEST

This revised manual is designed to walk you through the process step-by-step, screen-by-screen. This design was based on your feedback about what would be most helpful for you.

As always, if you are experiencing difficulty with entering prior authorizations into the system, please contact Delainie Cornwell at (517) 241-5768 or e-mail at cornwelld@michigan.gov.

General Rules and Hints:

1. To move between fields (the boxes where you enter information), use the mouse or the TAB or Arrow keys. Do not use ENTER or RETURN. Pressing ENTER or RETURN is the same as submitting or saving.

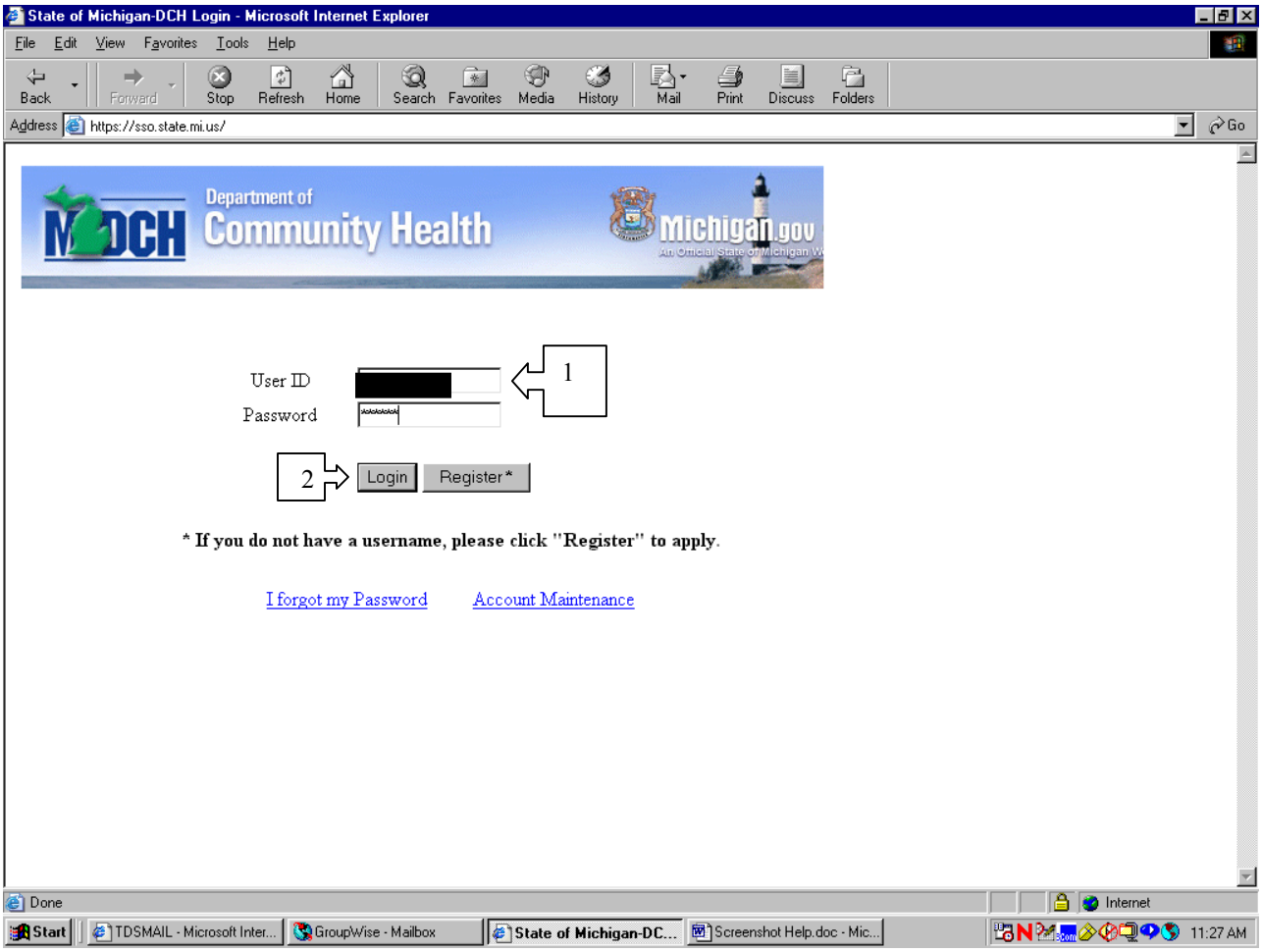
2. Pressing the SUBMIT will SAVE your information.

3. If the child is going to receive services for the RN and LPN, choose the procedure code that best represents the majority of services provided.

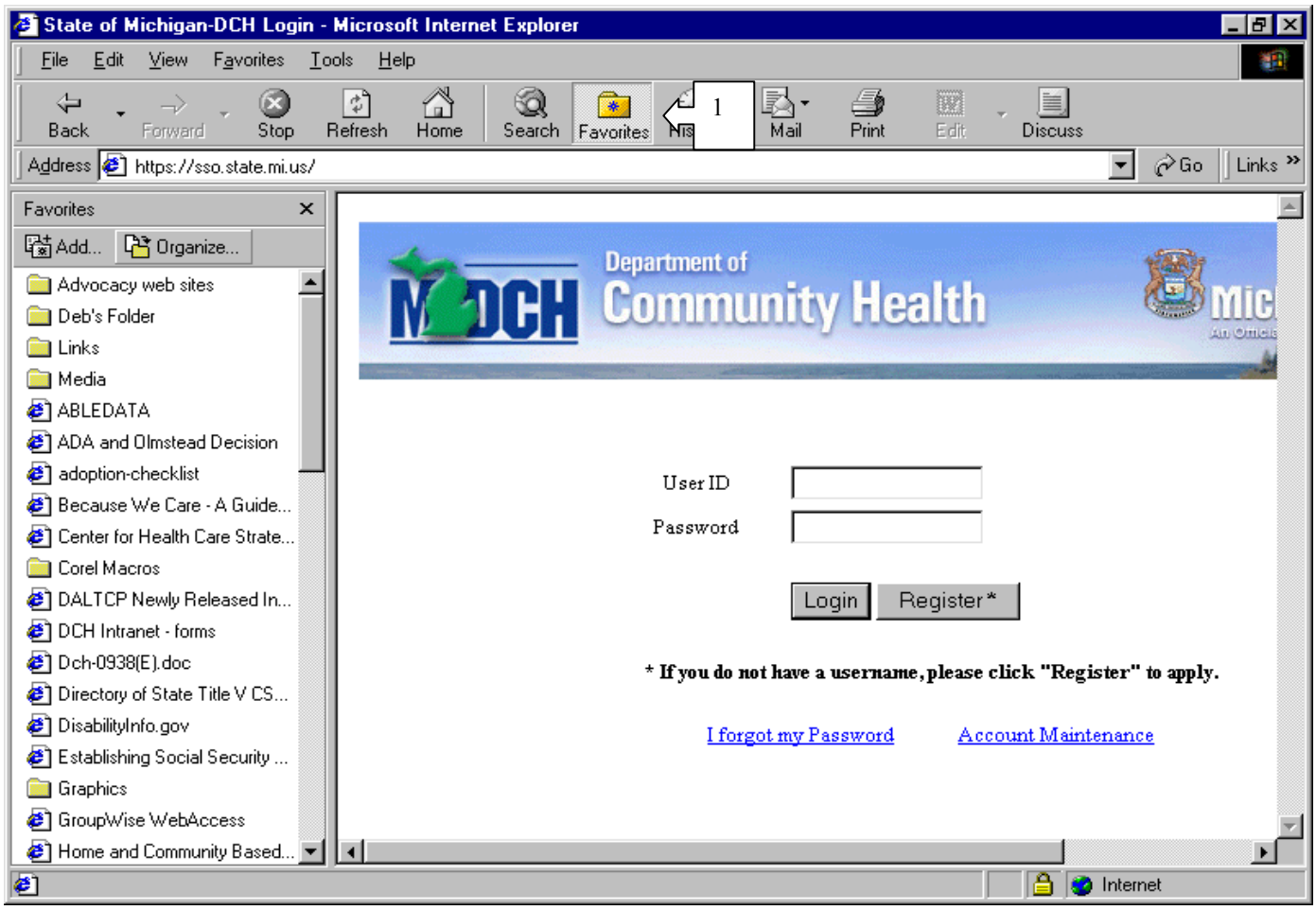
LOGGING IN TO THE THIN CLIENT SYSTEM

Go to https://sso.state.mi.us/

If you are already registered, follow the directions below. If you are new to the system, select REGISTER and follow those directions. The next page will tell you how to bookmark this site so you can access it quickly in the future without having to key in the address each time.



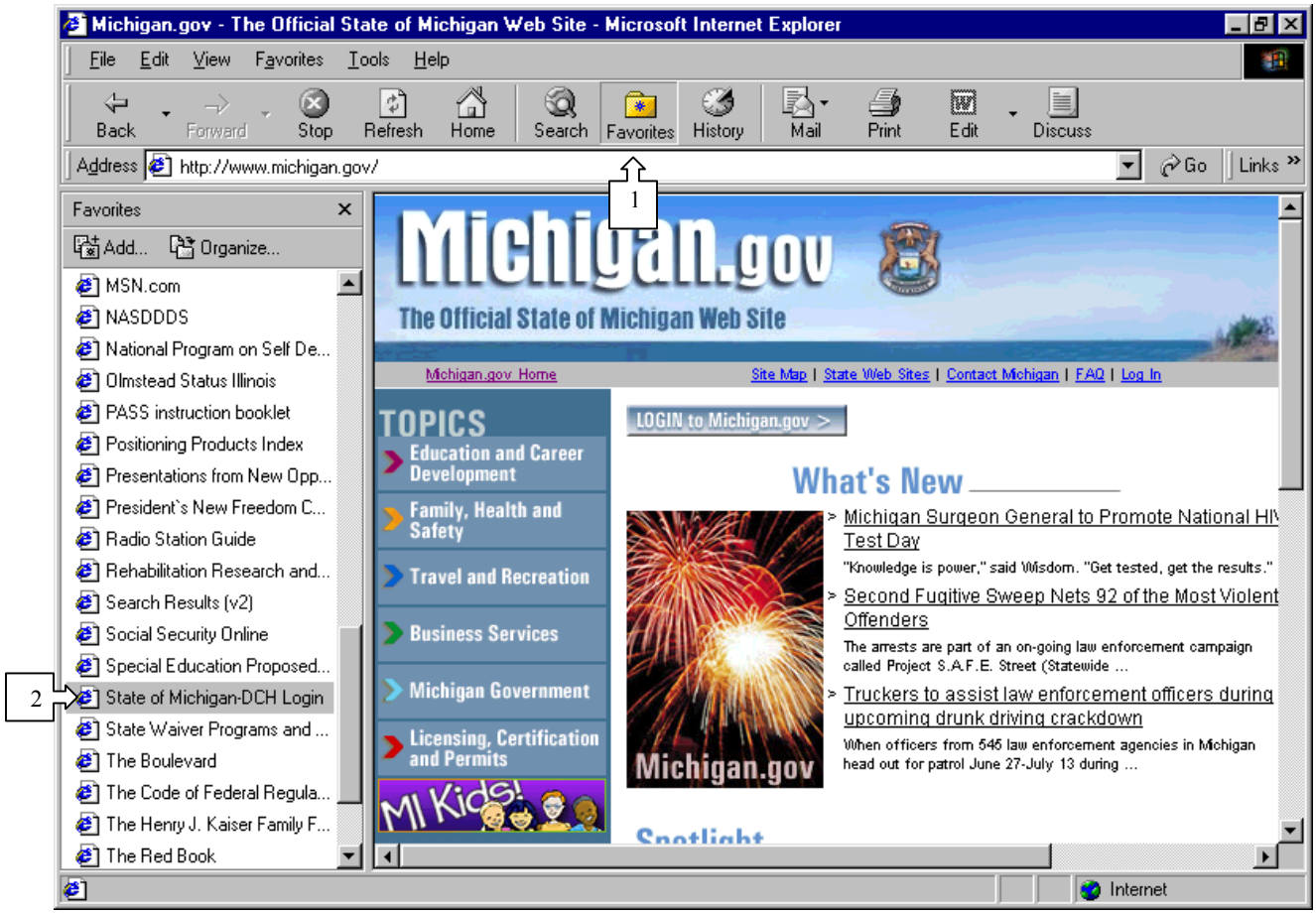
1. Enter your User ID and password.
2. Click Login.



1. Click on "Favorites" (either the folder if you have it on your Toolbar or the word "Favorites" above). Either of these will do exactly the same thing. You don't have to click on both of them.

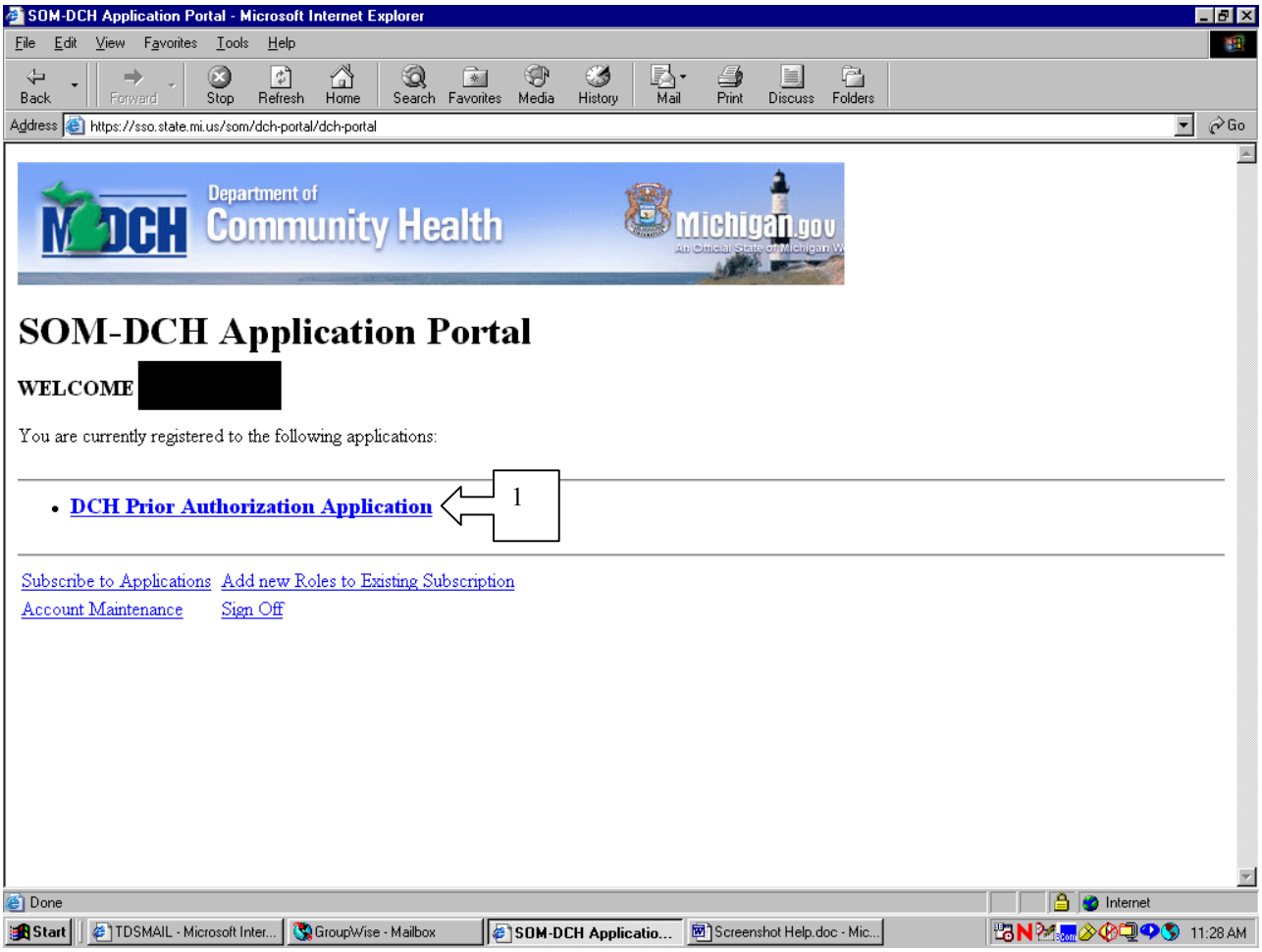
2. Click on Add to place this website address in your "Favorites" folder.

The next time you go on-line and want to get directly to the Thin Client sign-on, you would click on "Favorites" to get your drop-down list and select the site from the list.

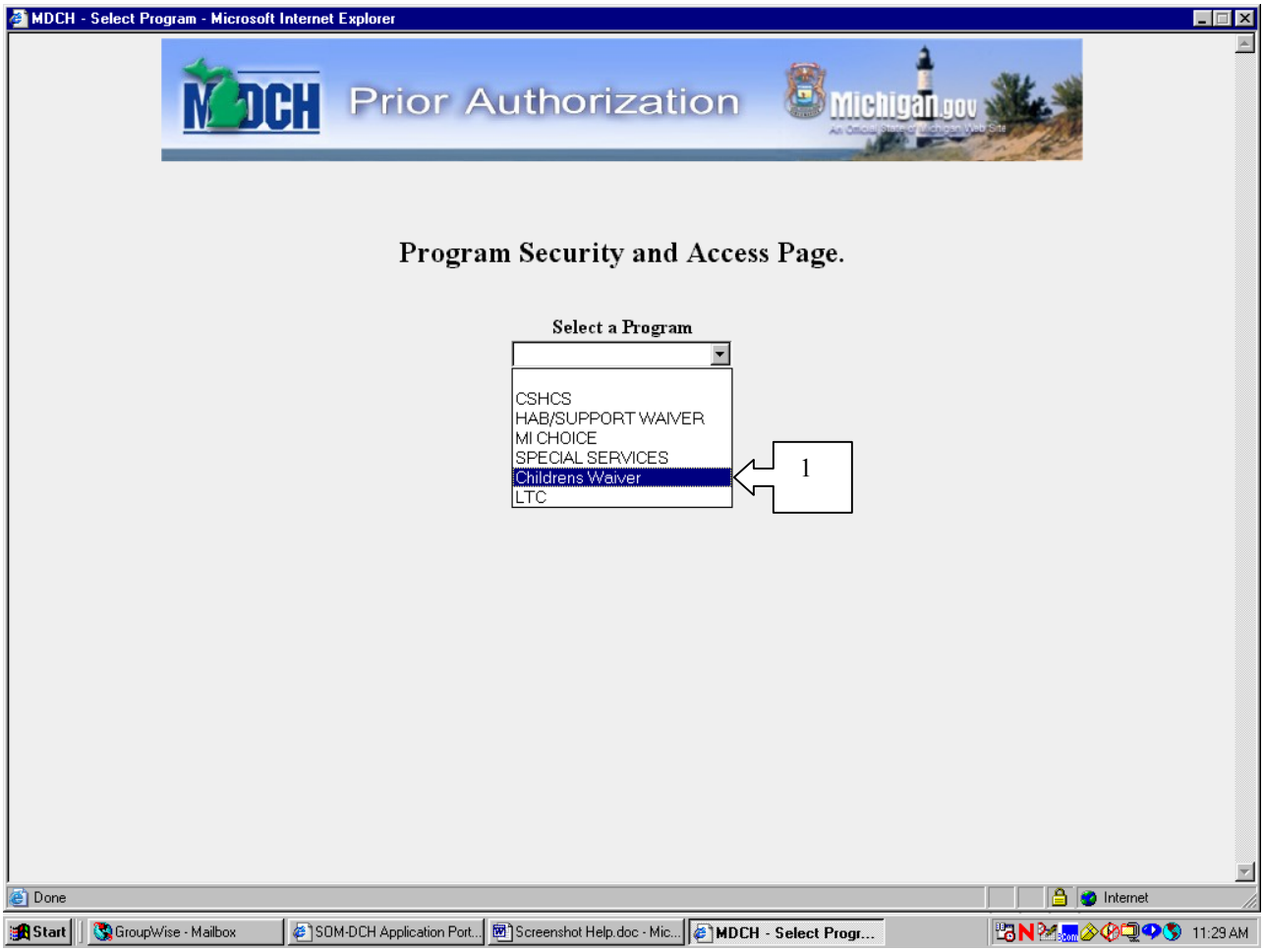


1. Click on "Favorites". A column should appear on the left if you select the folder from your Tool Bar or will appear directly underneath the word "Favorites" in a list if you select that route.

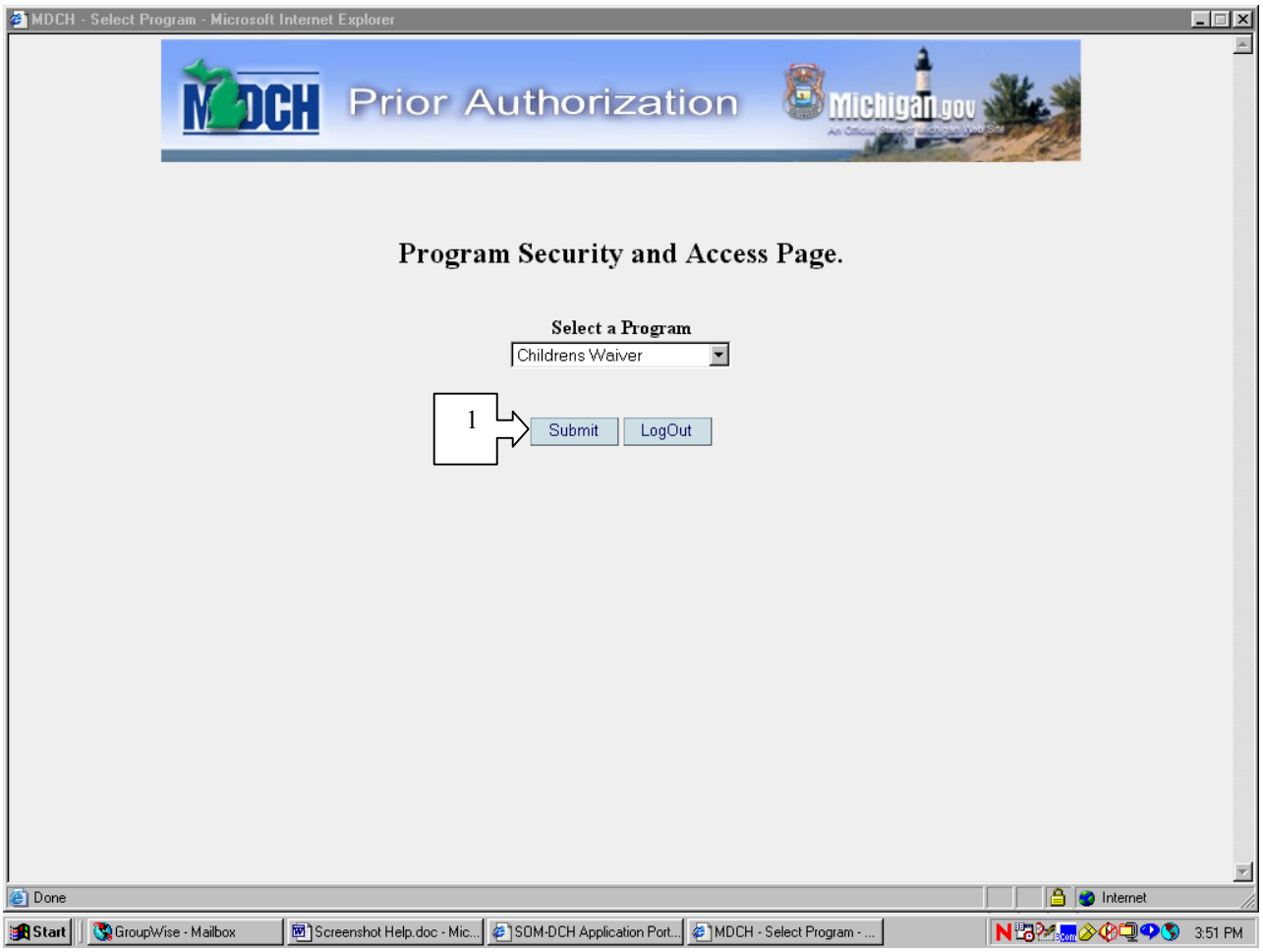
2. Find the site you want to go to and click on it. It will take you to the sign-on page so you can enter your user name and password. Then proceed to the next page to continue the process of entering a PA.



1. Click on DCH Prior Authorization Application.



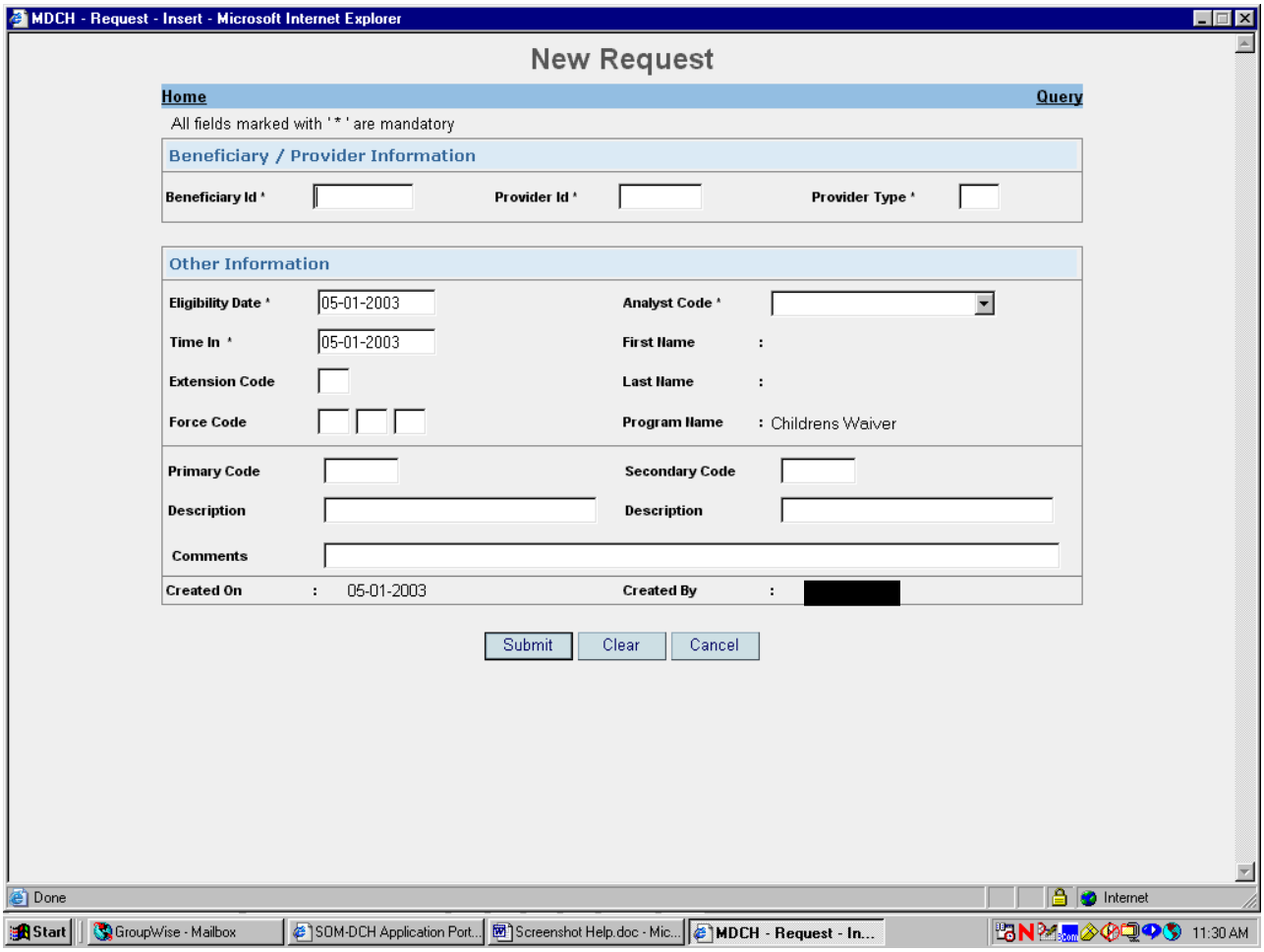
1. Select the program for the beneficiary you want to obtain PA for. You should either select Children's Waiver or Habilitation Supports Waiver.



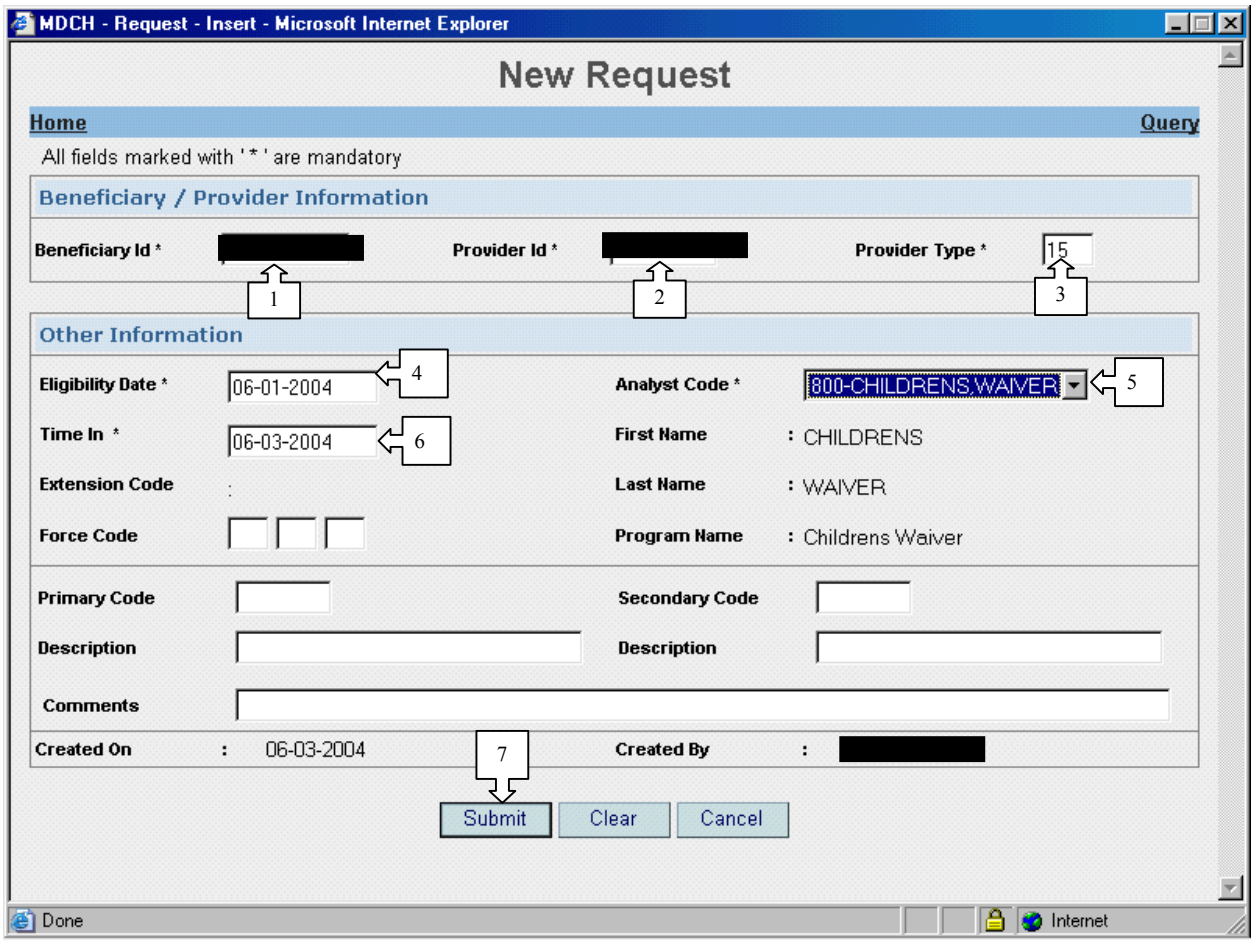
1. Click Submit to select the program you chose.

THIS IS YOUR HOME SCREEN.

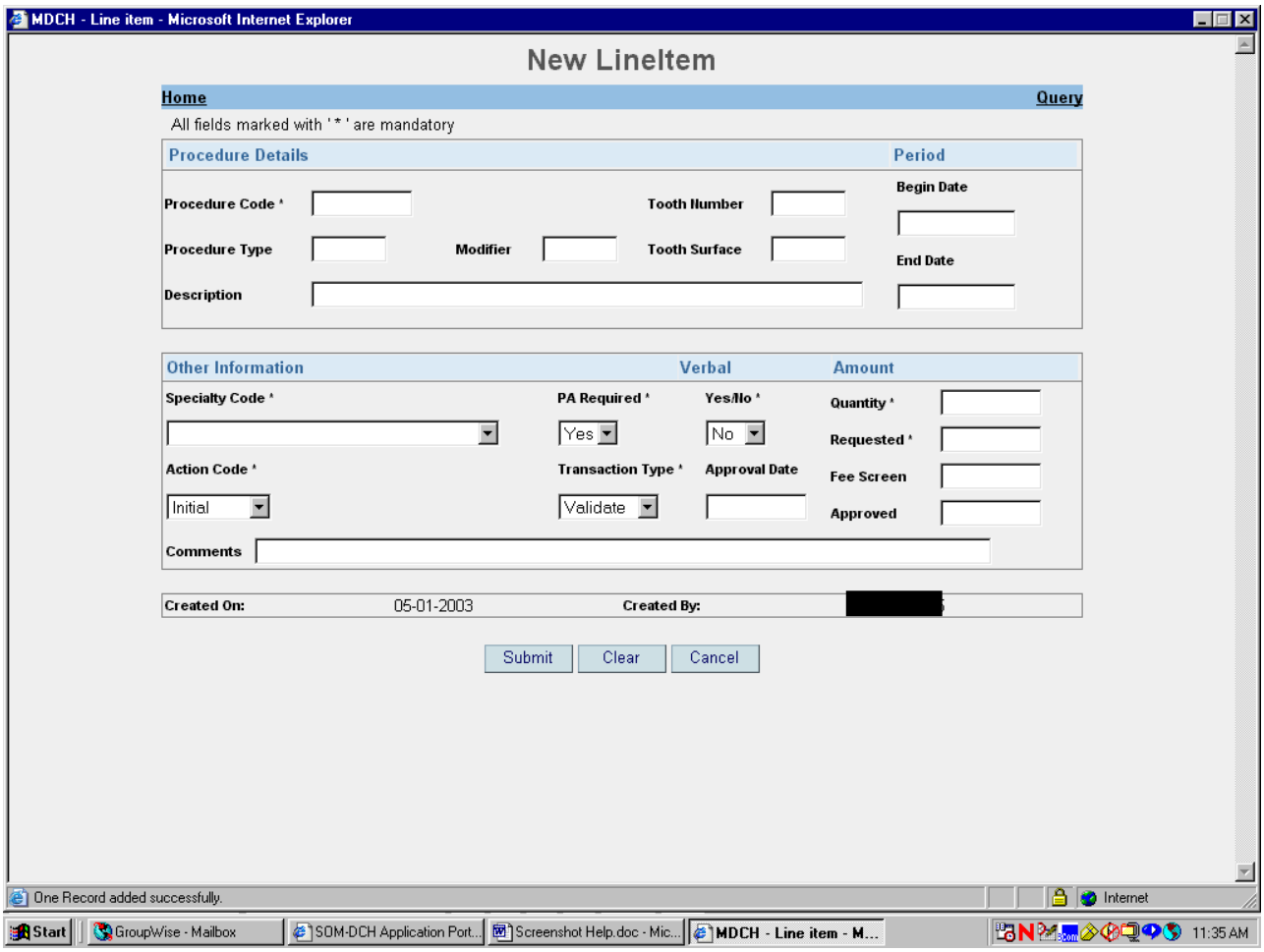
1. To add a PA, click on REQUEST under the Add column.



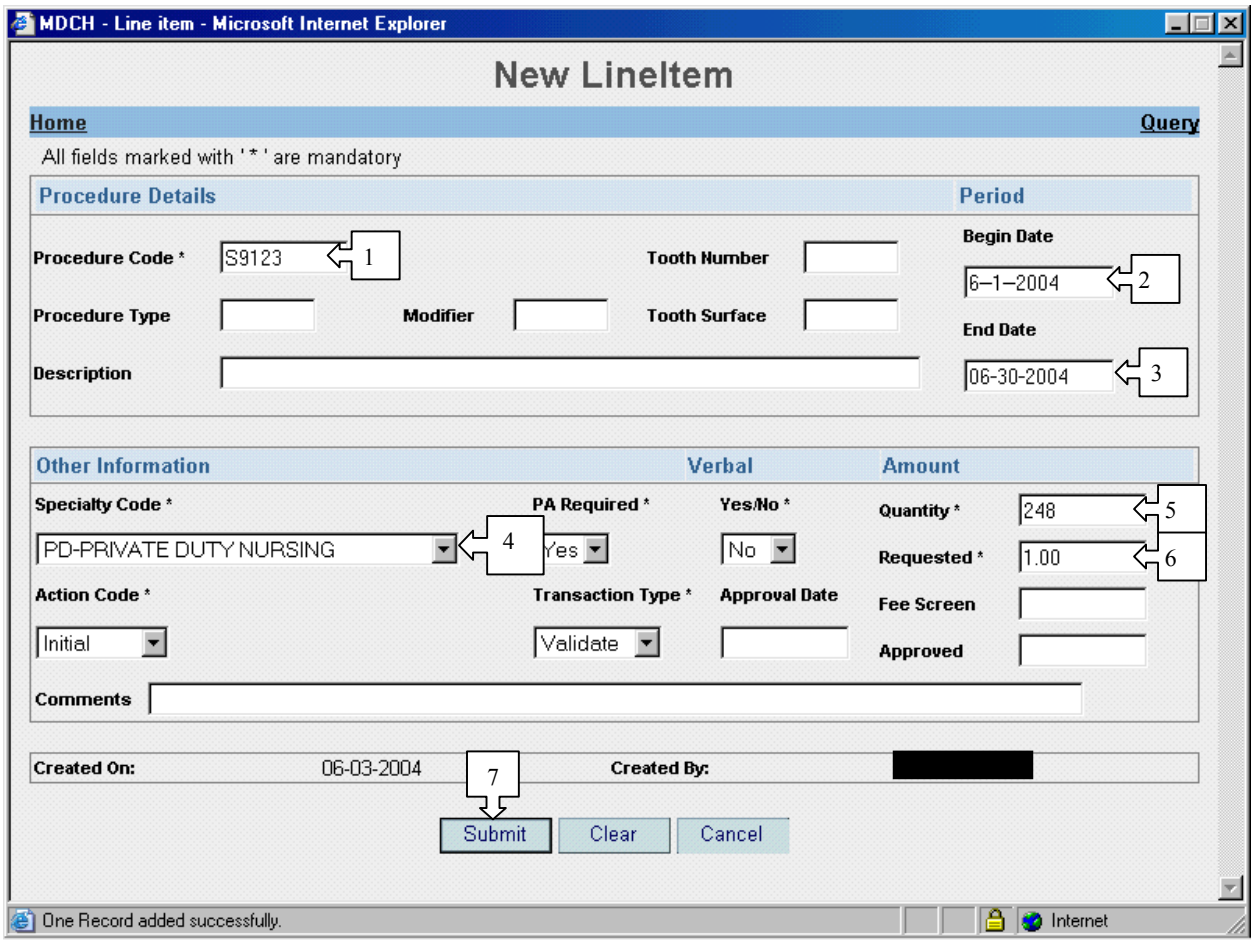
1. When adding a new PA, you will now be at a blank "New Request" screen.



1. Enter the Beneficiary Medicaid ID # (8 digits-include any zeros).
2. Enter Provider ID# (7 digits, usually starting with 43 or 44).
3. Enter Provider Type:
    a) 15 for agency.
    b) 10 for independent nurse.
4. Eligibility date must be the first day of the month, unless the beneficiary doesn't become eligible until a later date in the month. For example, if a child enrolls in CWP on 5/15/03, the eligibility date for May would be 5/15. Subsequent months would have an eligibility date of 6/1. 7/1, etc.
5. Select the correct program from the drop down list. You will only see the program(s) for which you are authorized. If you need authorization for a second program and do not see it on your drop down list, call for technical assistance.
6. Leave the Time In on the date that has been filled in automatically. Don't change it.
7. Click SUBMIT to save the information.



You will now be on a blank New Line Item screen and you'll see a message on the gray bar that says you added one record successfully (that record was the Request screen you just completed and submitted).



1. Enter S9123 for RN or S9124 for LPN as procedure code.

2. Enter date the PDN services will start for that month. The system will automatically fill in the hyphens so you only need to key in mmddyyyy (e.g. 05012003)

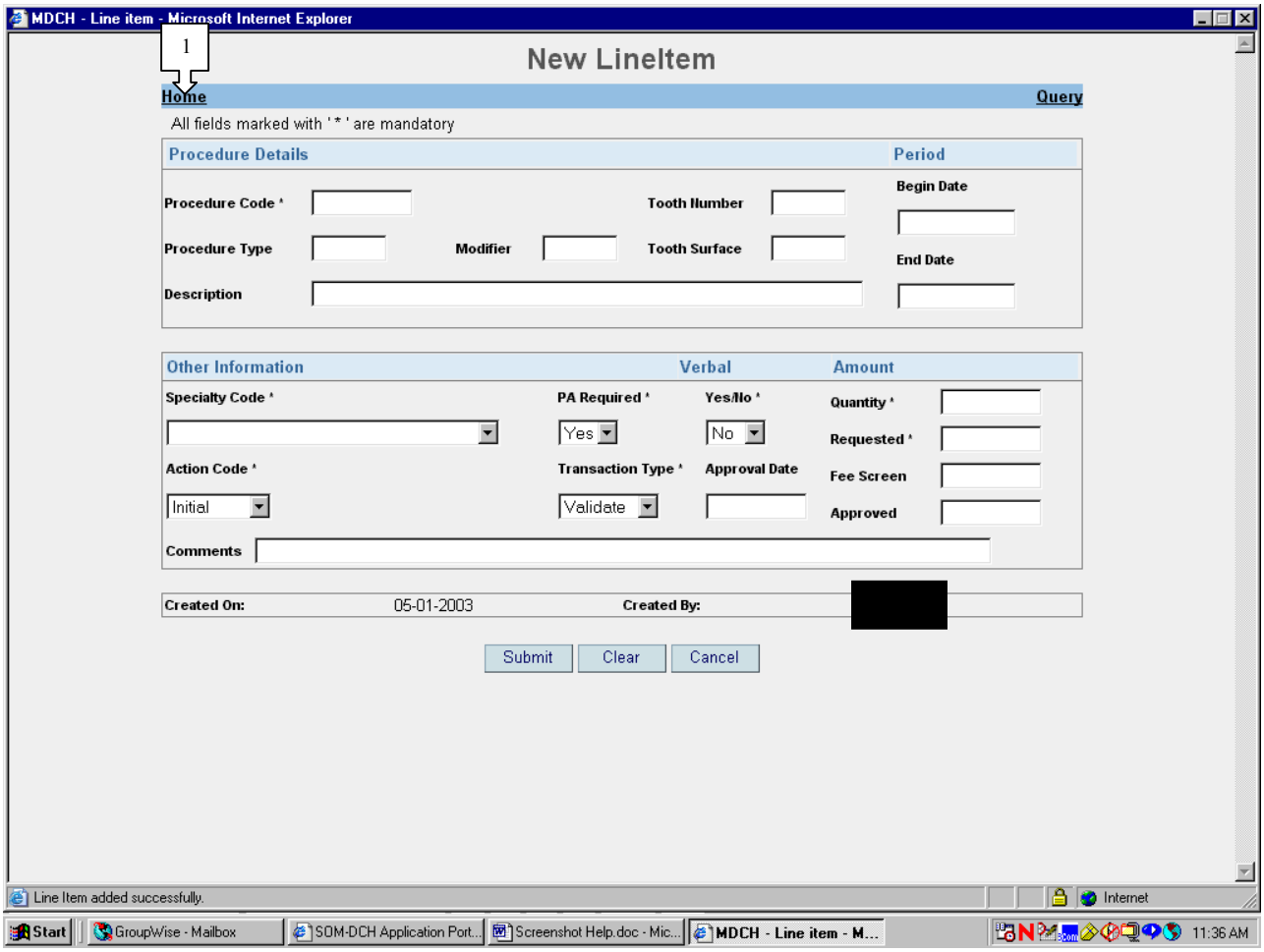
3. Enter last date that PDN services will be authorized for that month. It should be the last date of the month unless the beneficiary will lose eligibility for PDN services before the end of the month. As an example, if a beneficiary will turn 21 during the month, they can only receive PDN authorization until their birthday. If a child enrolled in CWP will age off on his/her 18th birthday, the end date for a CWP authorization would be the day before their birthday.

4. Select PD-Private Duty Nursing from the drop-down list. NOTE: The list isn't in alphabetical order, so you'll find PD toward the end of the list.

5. Enter quantity in number of <u>hours</u> of PDN authorized for that provider for that month.

6. Request amount is always enter as 1.00

7. Click on SUBMIT to save the line item information you just entered.

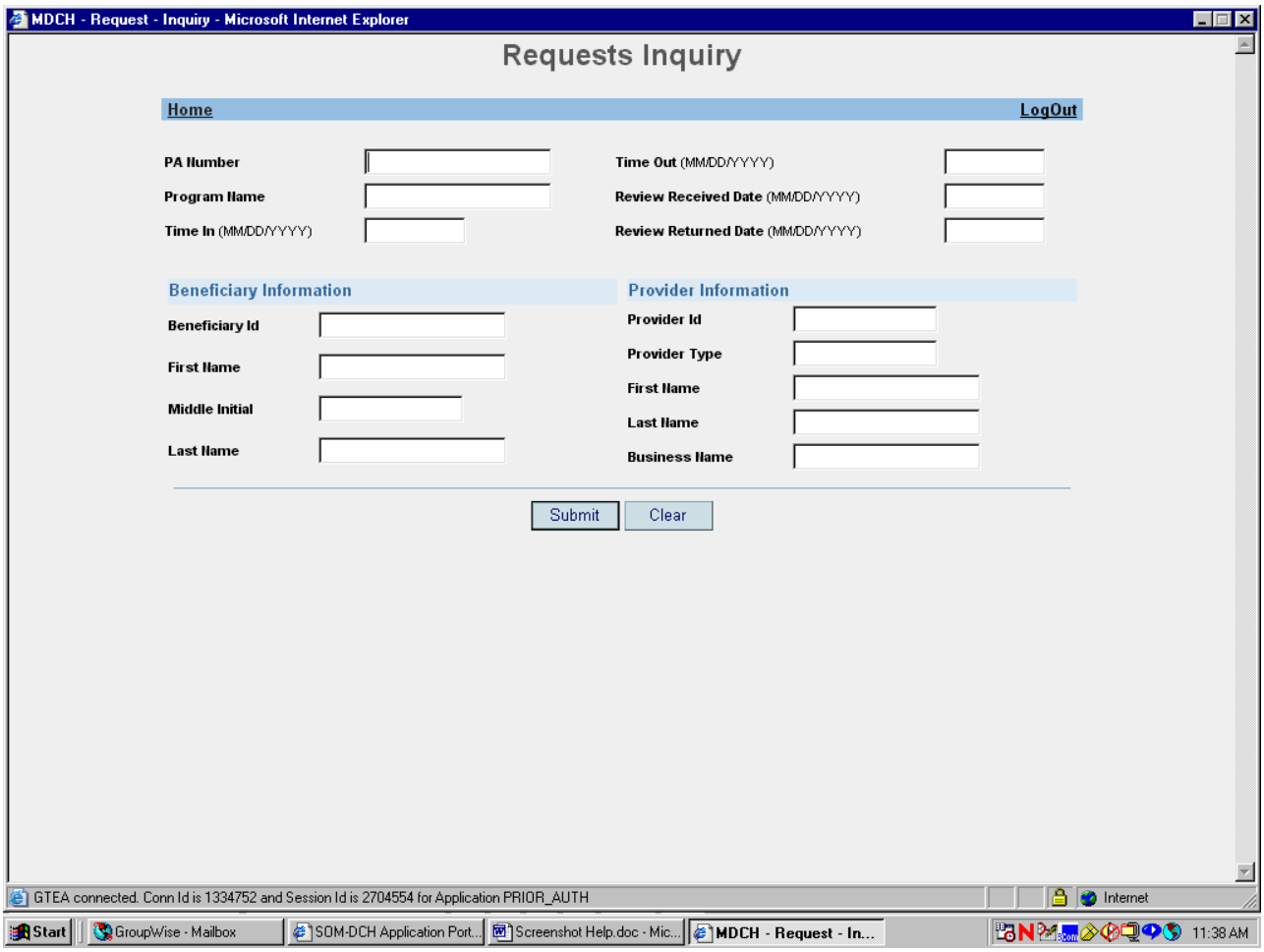


You will see another blank New Line Item screen. Do **not** fill out this screen a second time.

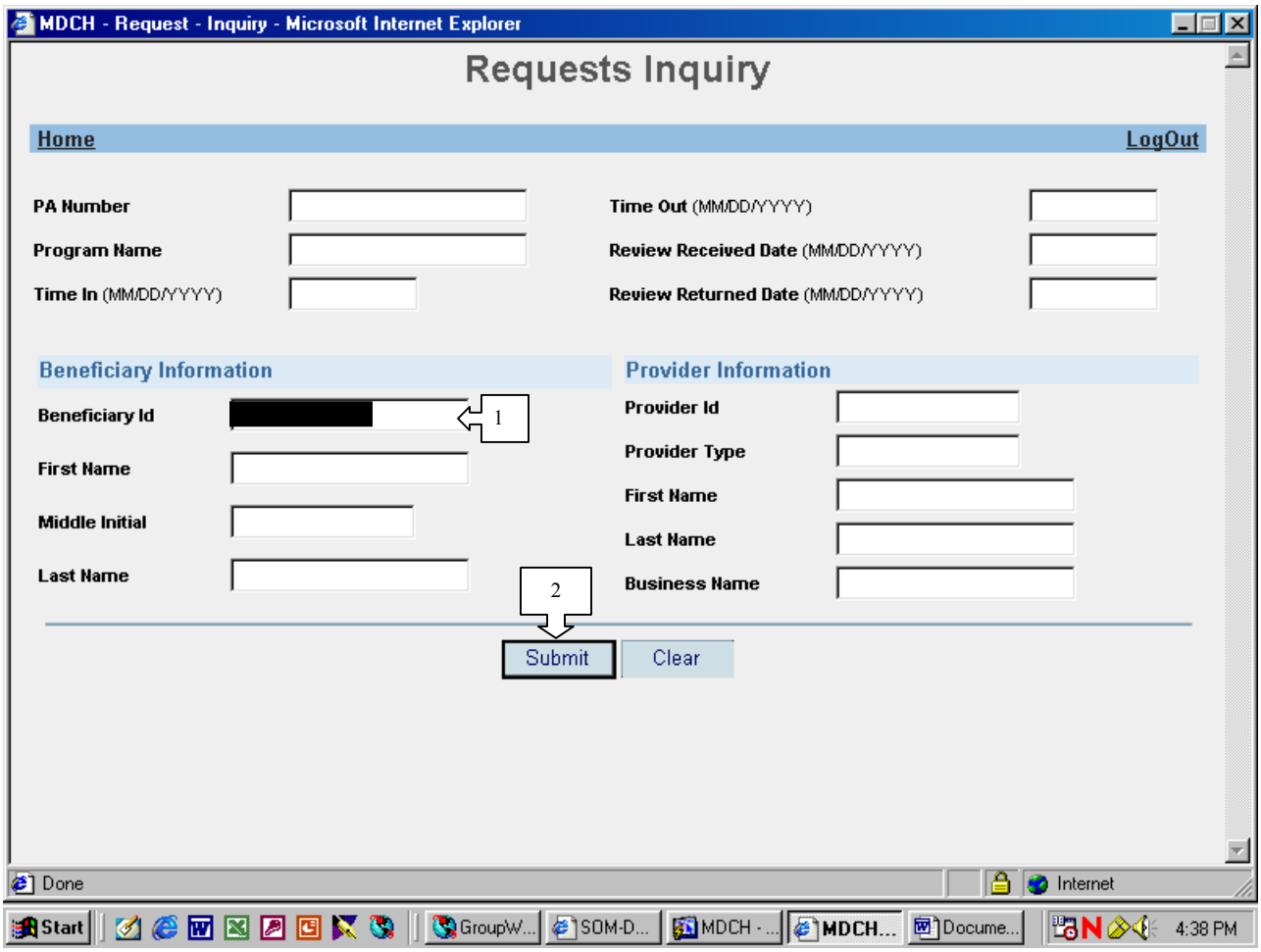
1. Click on HOME.

You are now back at your Home screen.

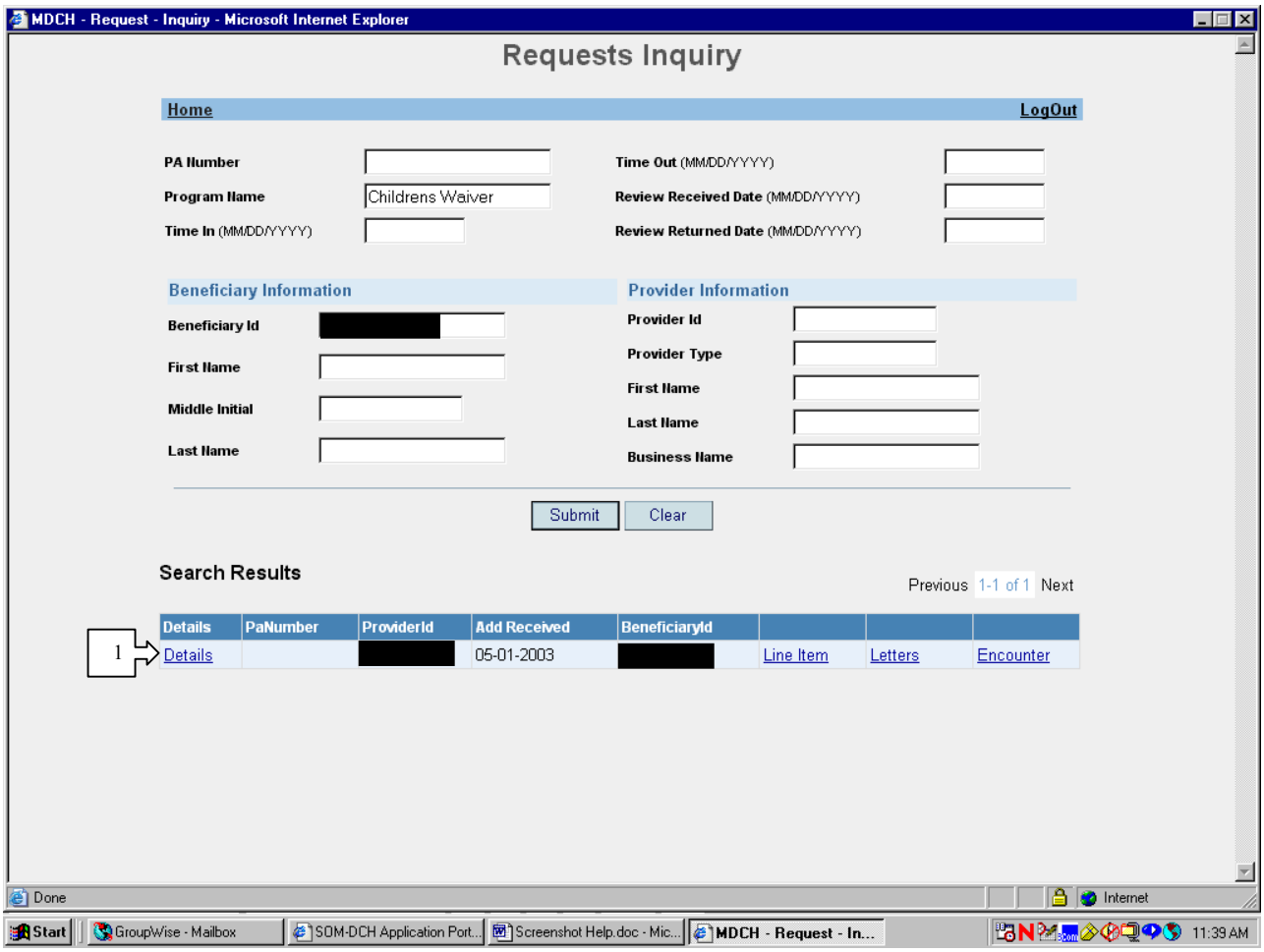
1. To complete the request you just entered, click on REQUEST under the Find/Update column.



This is the Find screen and it is blank until you tell the system what to look for.

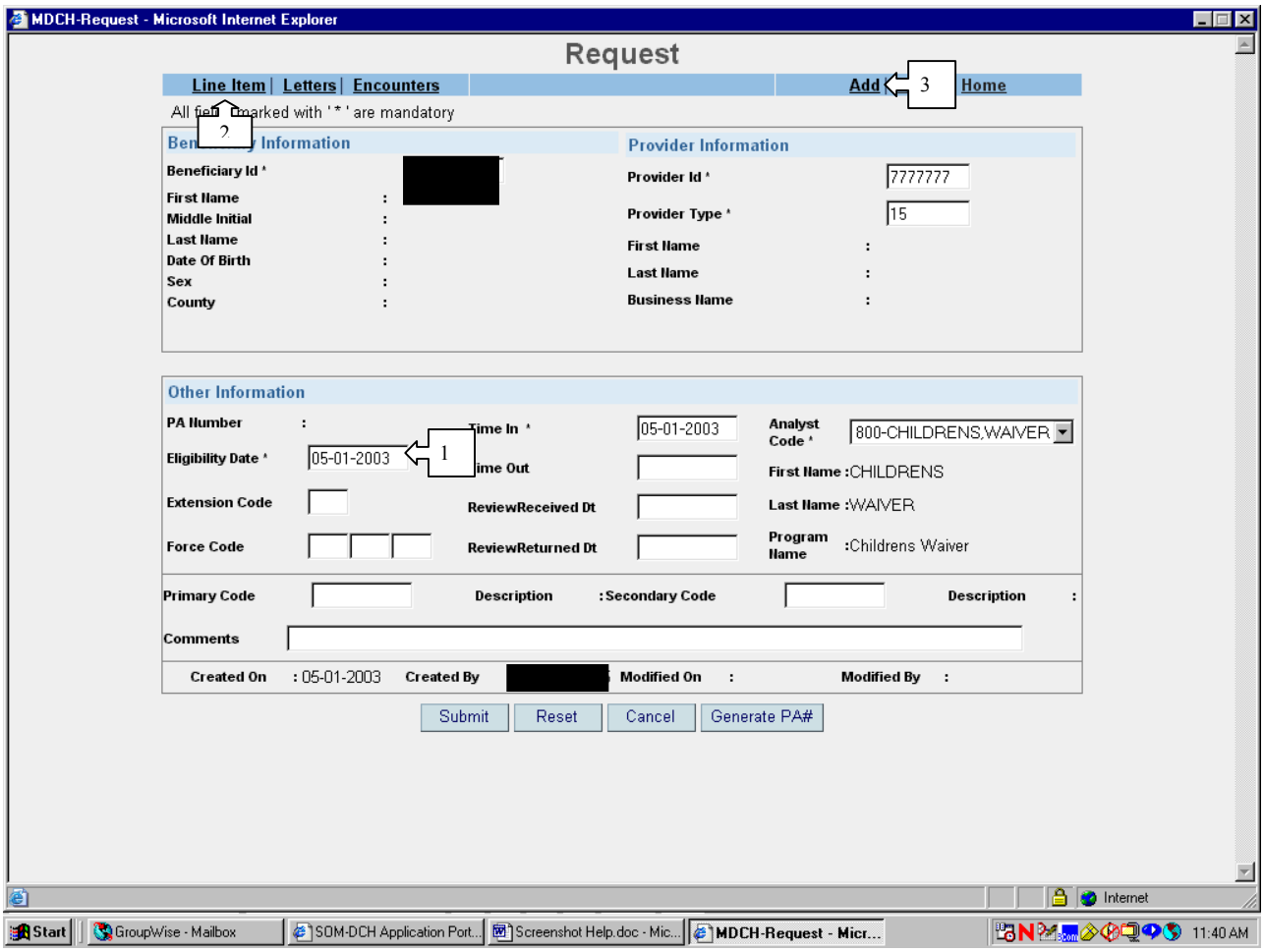


1. Enter the beneficiary's Medicaid ID#.
2. Click on SUBMIT.



At the bottom of the screen, the search results will appear as a list. Find the request you want to validate by scrolling through the list. The requests are listed on rows. Your action keys are in columns on each row and are in blue underlined font. DETAILS is the left column and will take you to the Request screen. LINE ITEM will take you to a list of line items. LETTERS will take you to a letter template screen. Do not worry about ENCOUNTERS at this time.

1. Click on DETAILS in the left column of the request you want to validate.

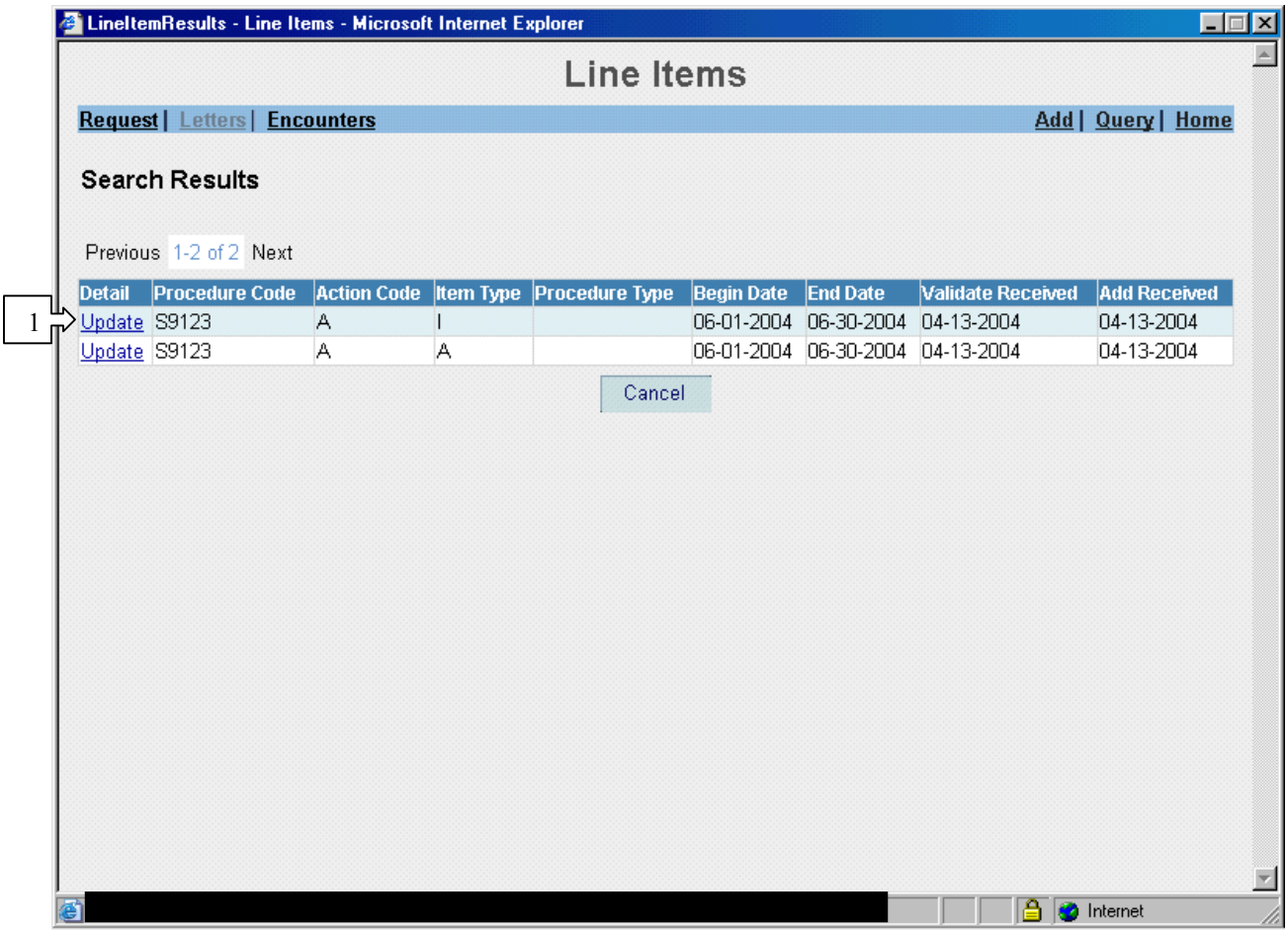


You will be taken to the Request screen

1. Look at the date to make sure that the eligibility date is for the month you want to authorize. If it is, go to step 2. If not, go back to your HOME screen by clicking the HOME button in the right upper corner (see arrow #3). Repeat the Find Request function to locate the beneficiary's records again.

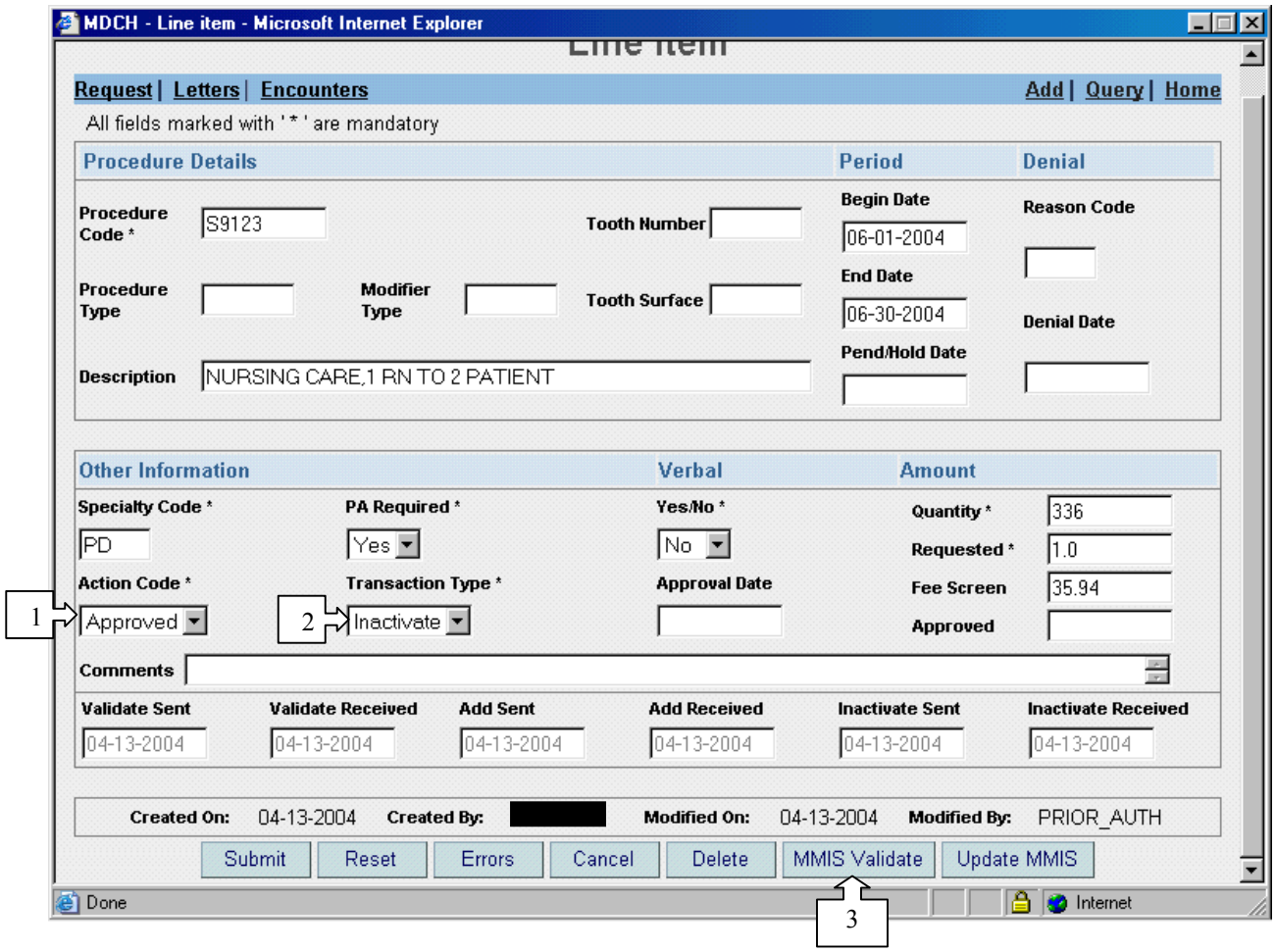
2. Click on LINE ITEM.

3. Click ADD.



If you've entered everything correctly to this point, you will only see one line listed. NOTE: If you have more than one line, stop and call for technical assistance. You cannot delete a line, but it can be done by central office. Call for technical assistance. If you only see one request, proceed to step 1.

1. Click on UPDATE.



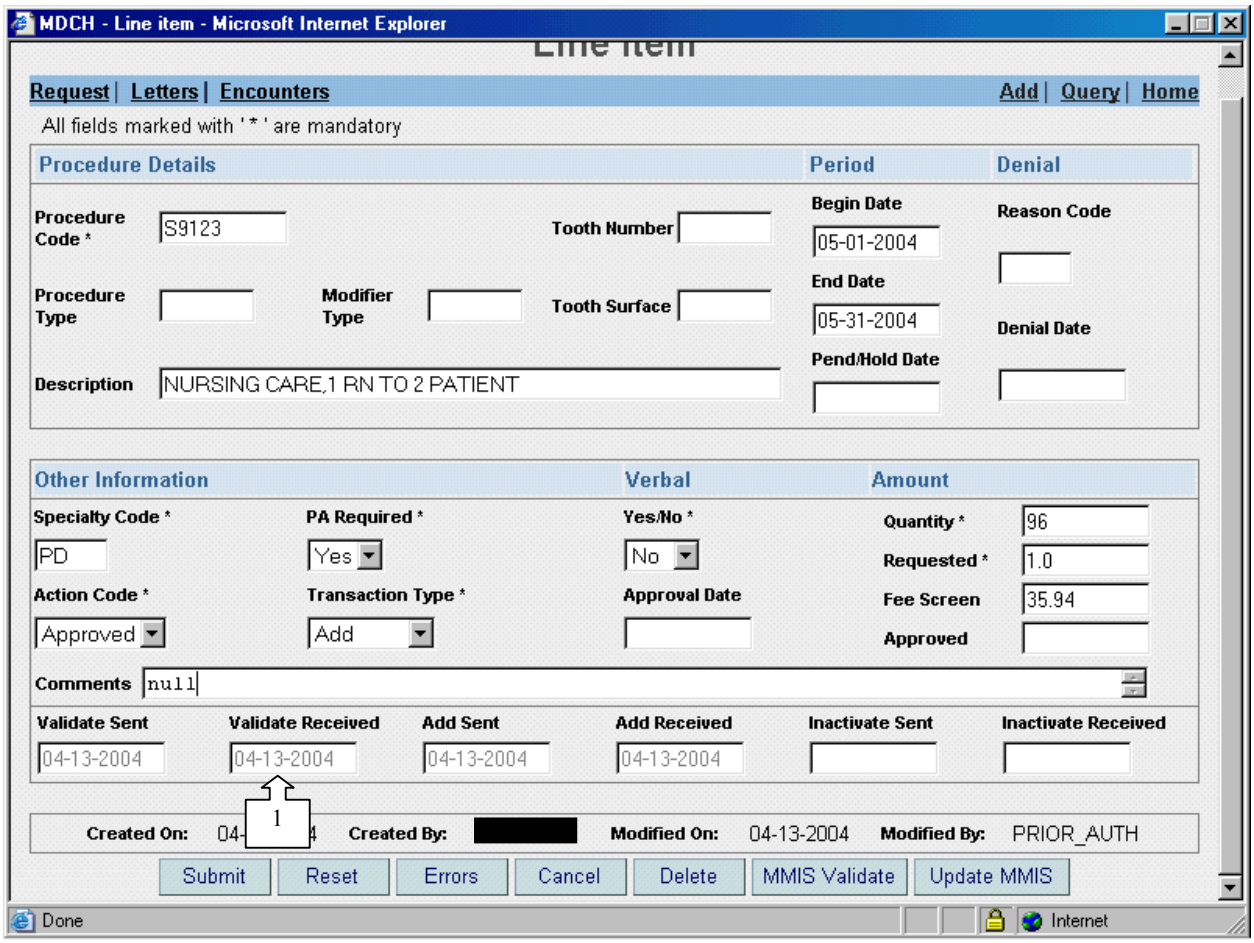
You should see the Line Item screen you have already filled in. Check that the information is correct, especially the quantity. If you need to change any information, change it and click SUBMIT to save it.

1. Default setting in Action Code is Initial. Leave it as is.

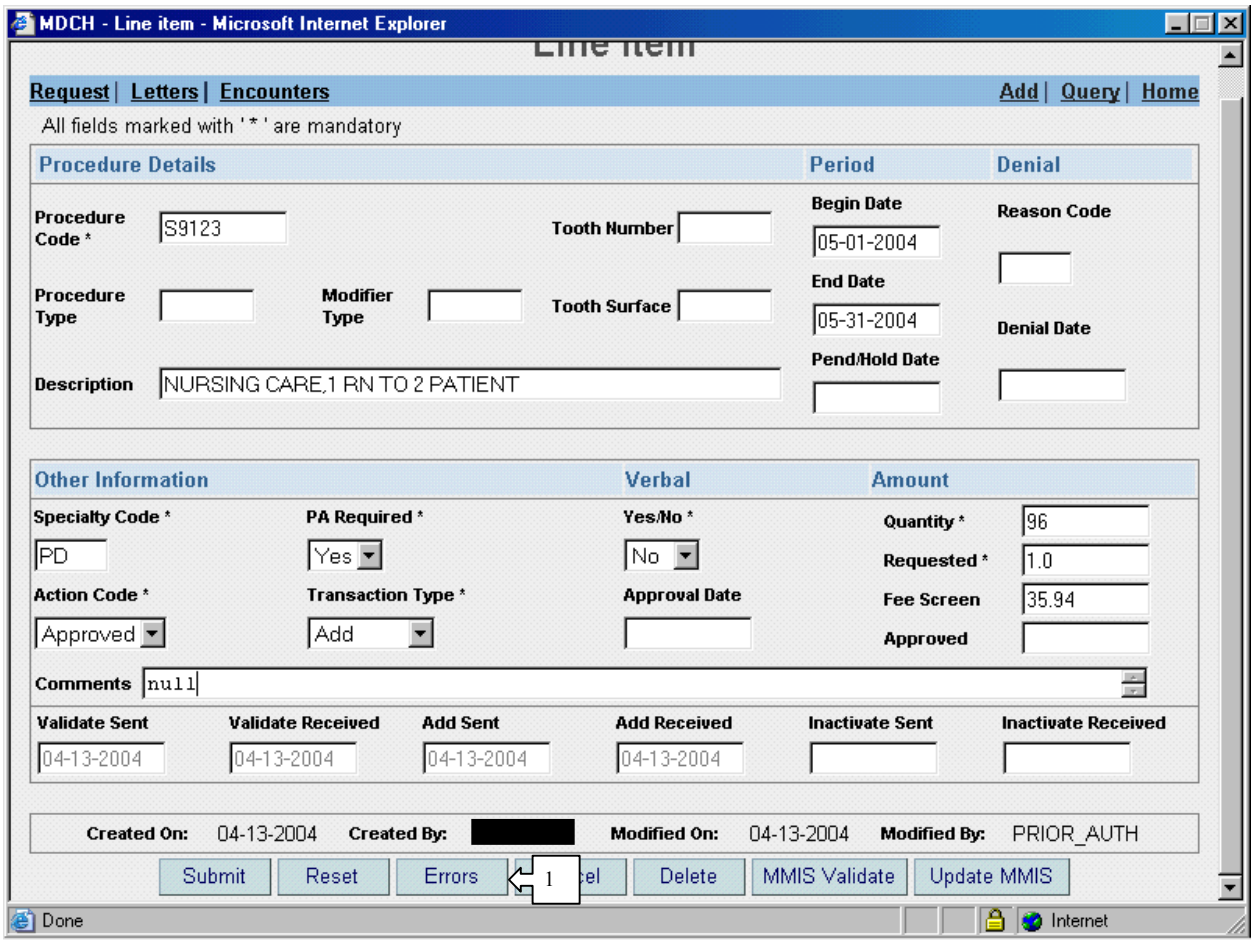
2. Default setting in Transaction Type is Validate. Do not change it yet.

3. Click on MMIS VALIDATE.

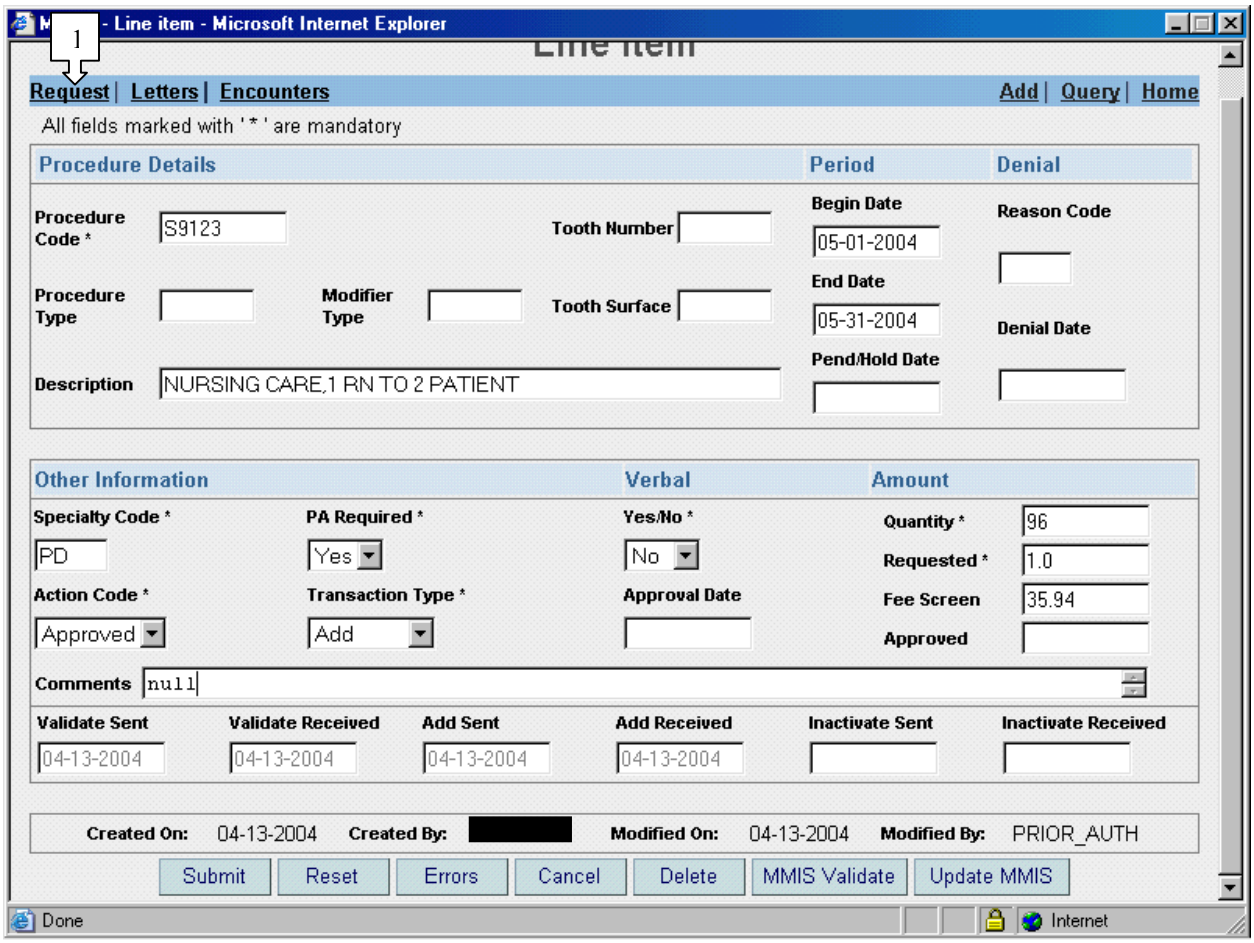
NOTE: The description, "NURSING CARE, 1 RN TO 2 PATIENT" is incorrect for the procedure code listed. However, procedure codes S9123 and S9124 should be used even though the description does not accurately represent the procedure code.



1. If you have successfully validated this request, you will get a pop up message that your request has validated successfully. Click OK and keep going. When you leave this screen & return again, you will see today's date filled in the Validate Sent and Validate Received boxes. You don't have to fill in any dates here; it will fill in automatically.

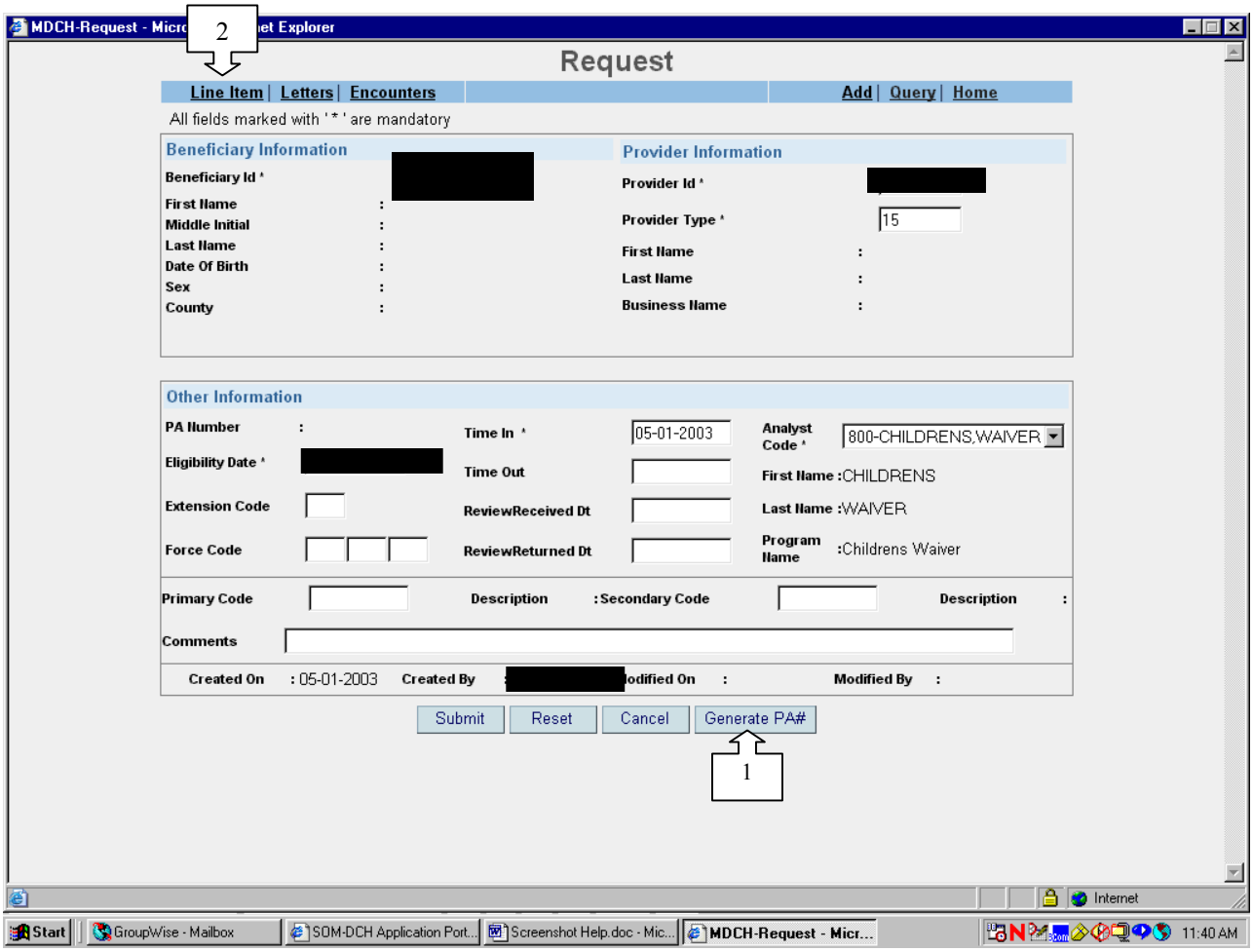


1. If you did not validate successfully, there will be an Error message at the bottom of the page. You will also see that the Validate Received box is still blank. That means you sent it, but the system can't receive it until you fix the errors. Click on Error button to see what the problem is. If you can fix it, go back and make the changes, SUBMIT to save and MMIS VALIDATE again.



If you did validate successfully, you now want to get a PA# assigned so you can update your authorization to MMIS.

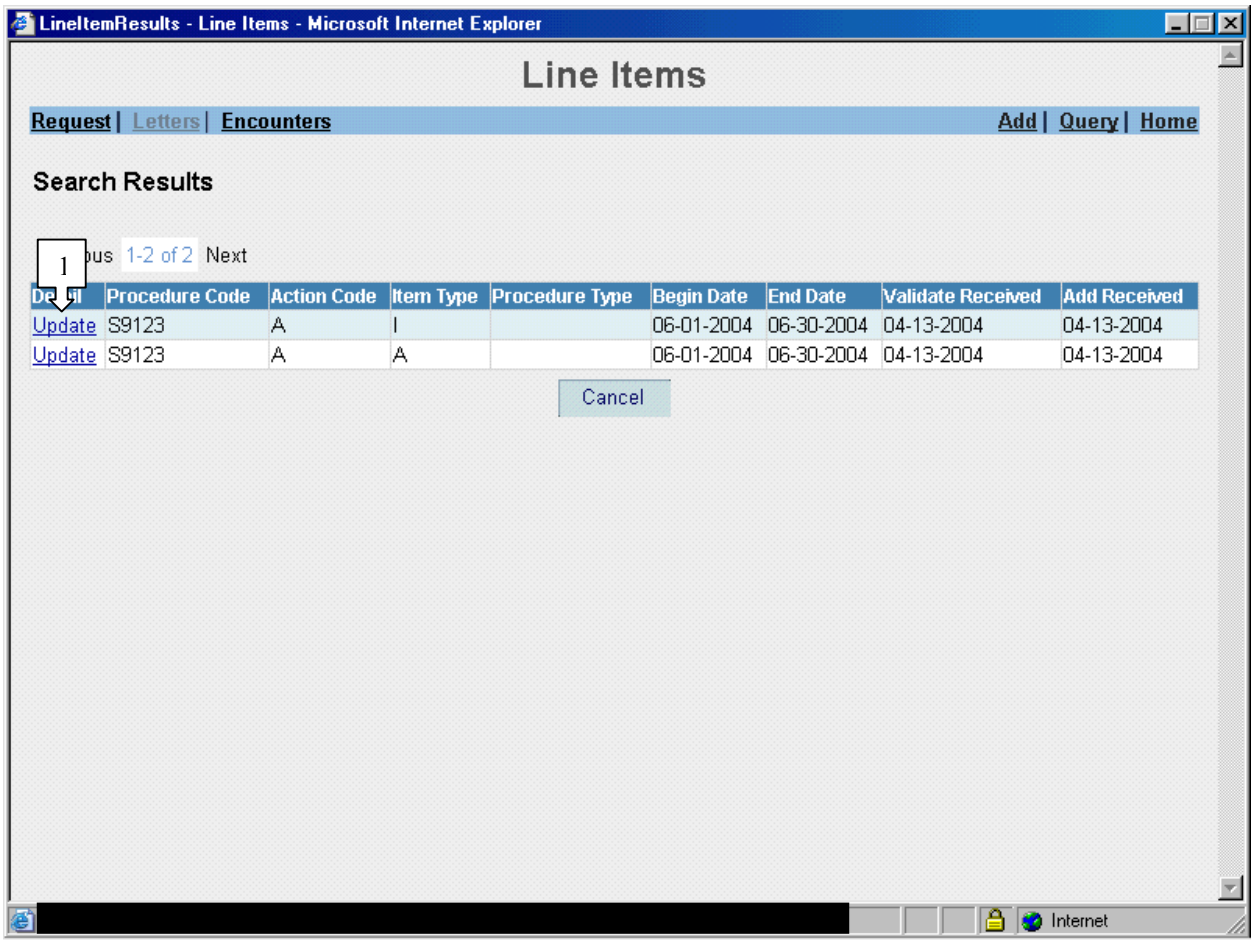
1. Click on REQUEST so you can generate a PA#. Do not proceed to this step if you have not successfully validated the Line Item.



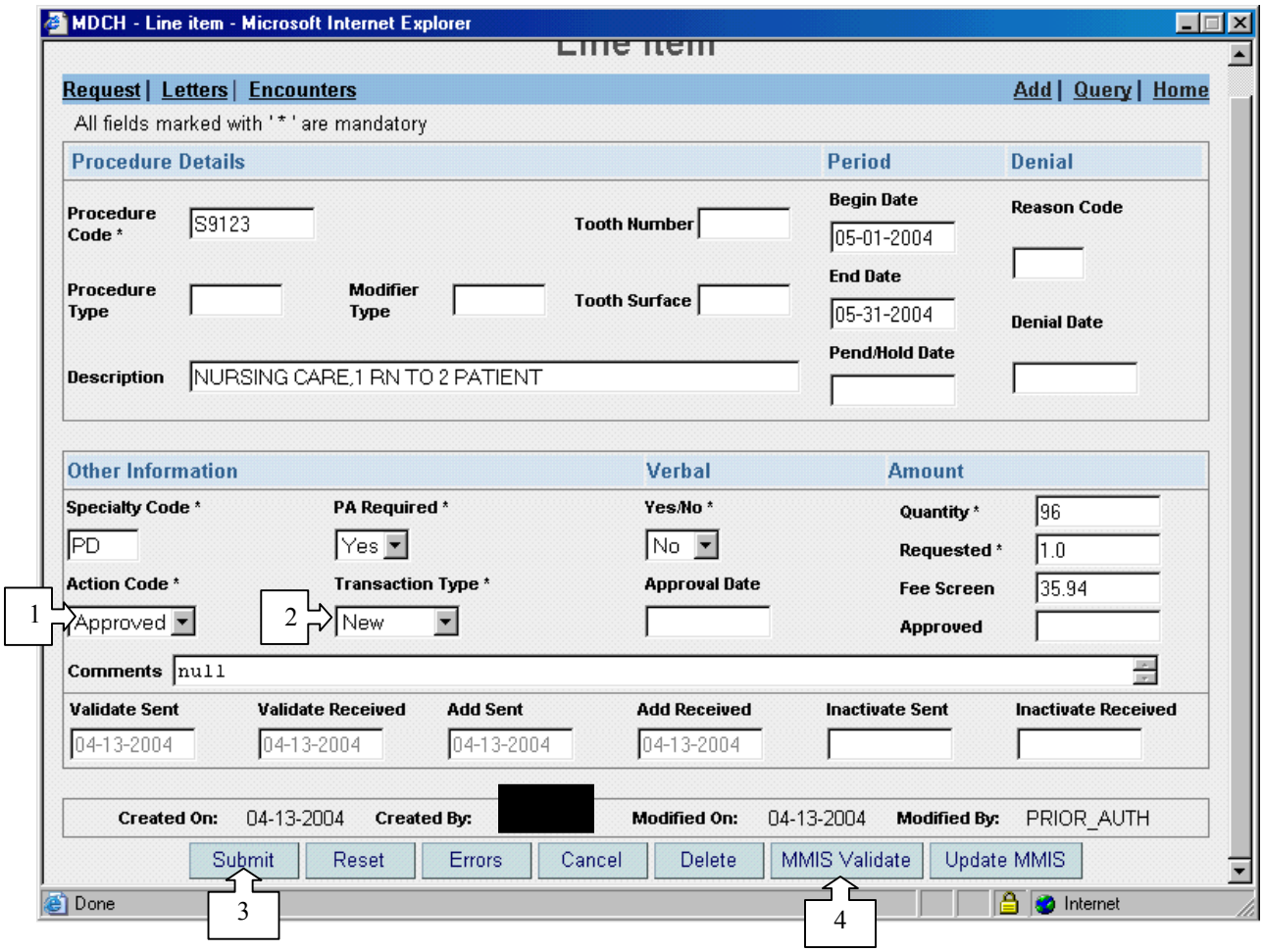
1. Click on GENERATE PA#. A 12 digit number will automatically fill in the PA Number box.

NOTE: The PA# that you will give the provider for their billing purposes is the last 9 digits. The fist 3 digits will drop off on the letter when the system fills in the letter.

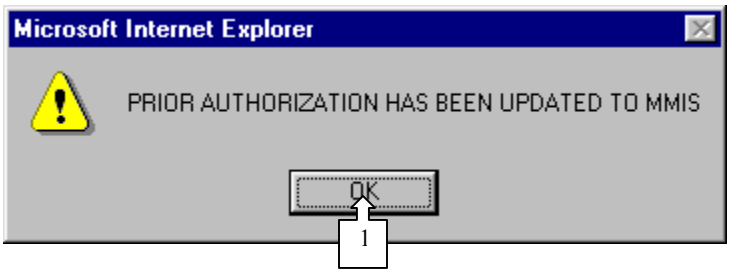
2. Now that you have your PA#, you have to go back to the Line Item one more time. Click on LINE ITEM .



1. Click on UPDATE.



1. Click on the arrow to change the Action Code to Approved from the drop-down list.
2. Click on the arrow to change the Transaction Type to New from the drop down list.
3. Click on SUBMIT to save your changes.
4. Click on UPDATE MMIS.



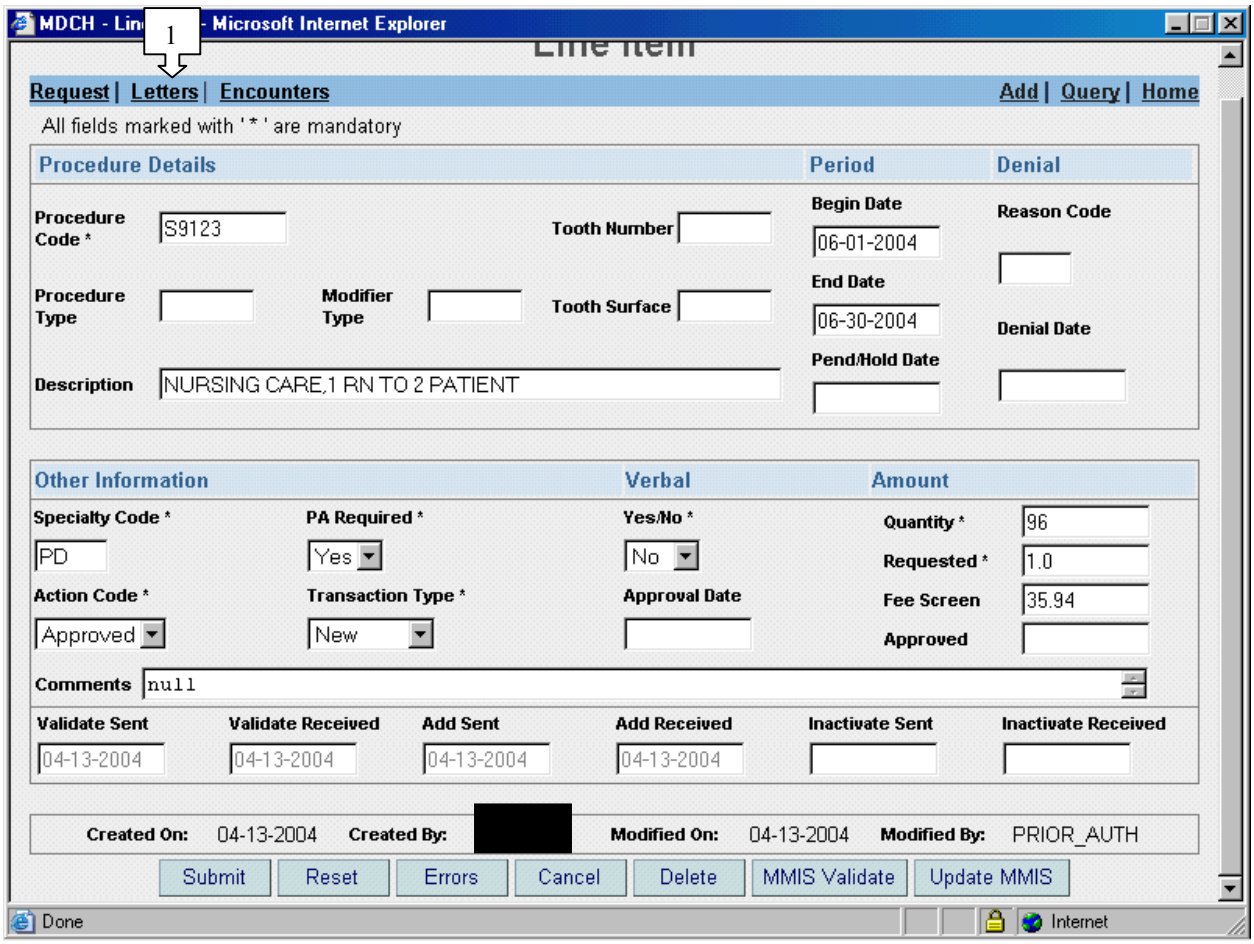
1. If you have updated successfully, you will get a pop up message saying your prior authorization has been updated to MMIS. Click OK.

Good Job! You're ready to do the letter. Go to next Section, CREATING A LETTER.

If you get an error message, click on the Error button. See if you can fix the error. If you require technical assistance please contact Delainie Cornwell at (517) 241-5768 or e-mail to cornwelld@michigan.gov

SECTION TWO: CREATING A LETTER

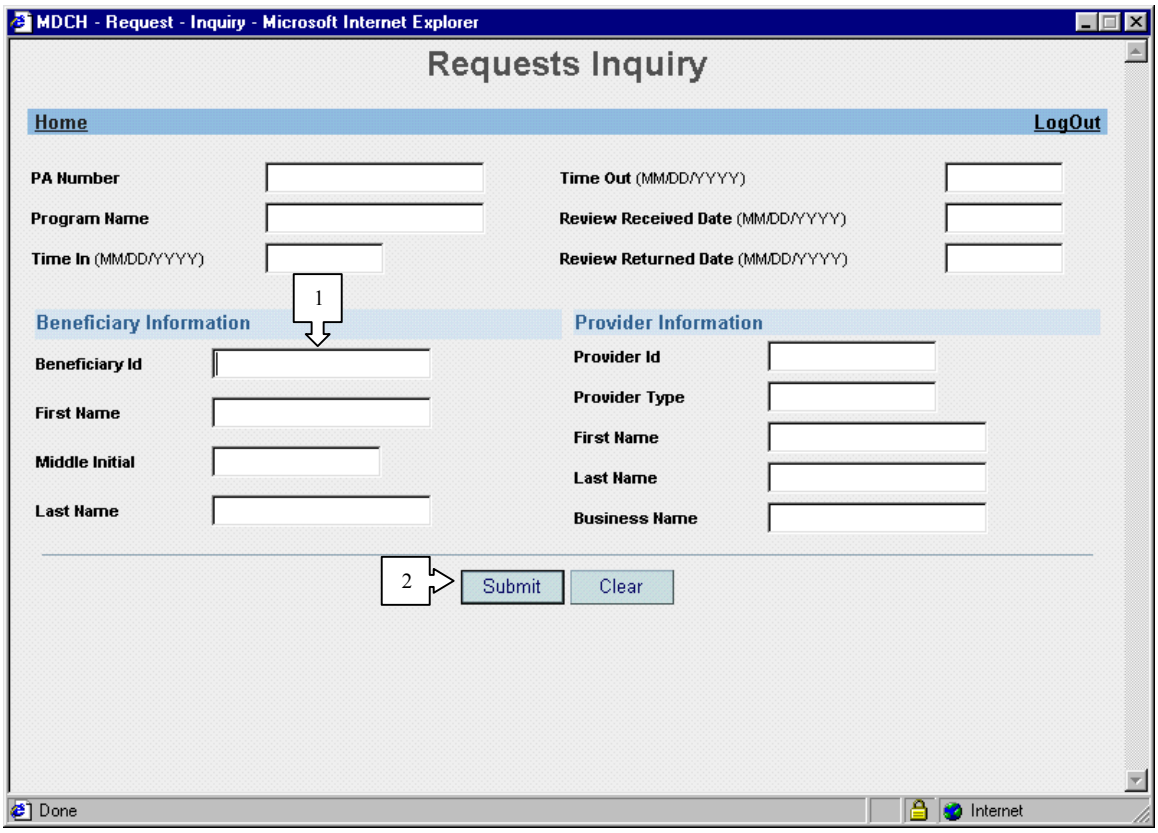
Once you have completed a prior authorization and have updated it successfully to the system, you are looking at the line item screen.



1. If you are at this Line Item screen and have successfully updated to MMIS, you can immediately create a letter from this screen. Click on LETTERS on the blue bar, left top of screen. It will take you to a screen found in this manual on page 35. The next three pages of instructions are if you are starting at the HOME screen instead of the Line Item screen.

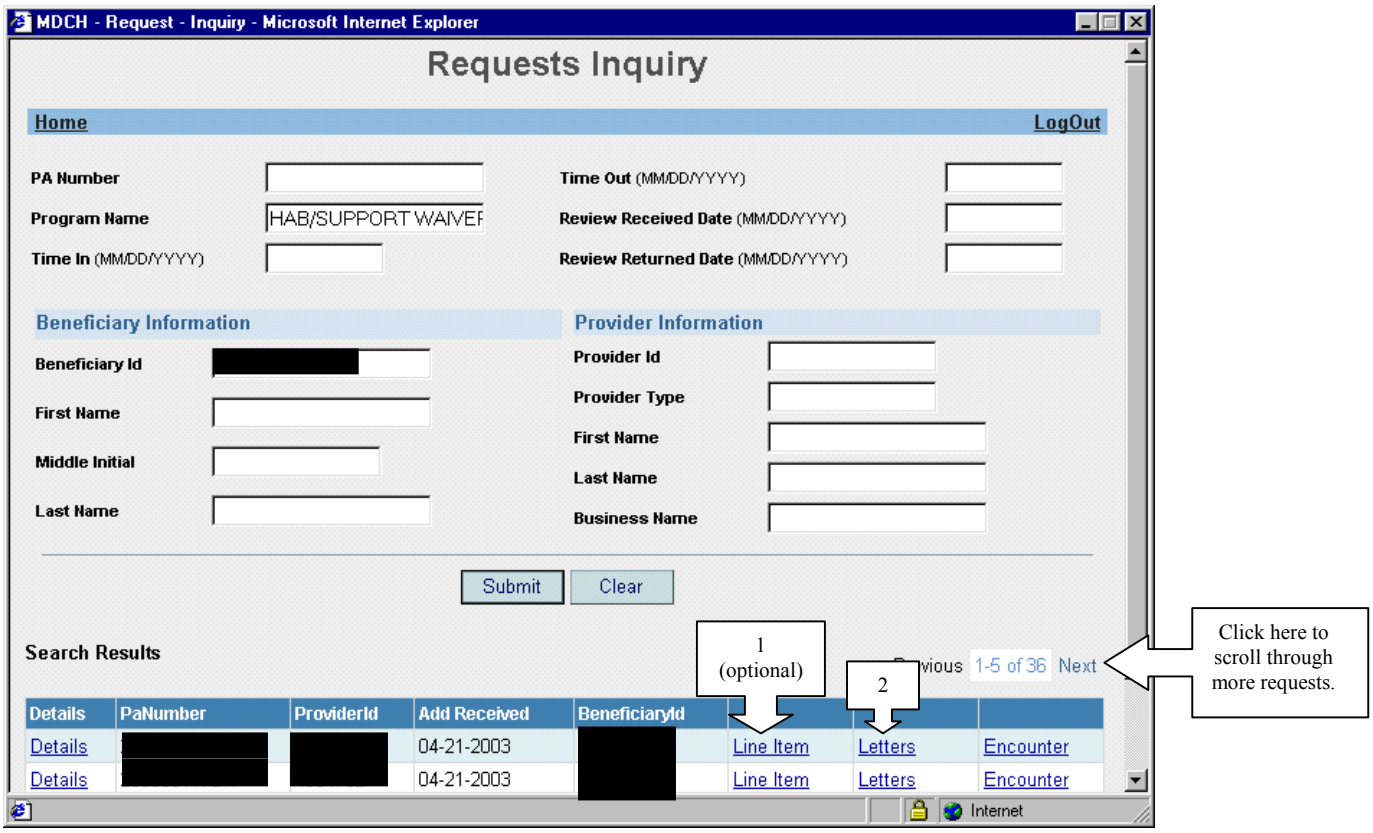
If you are unsure, you can always go back to your home screen (below) and start from there.

1. Click on REQUEST in the Find/Update column.



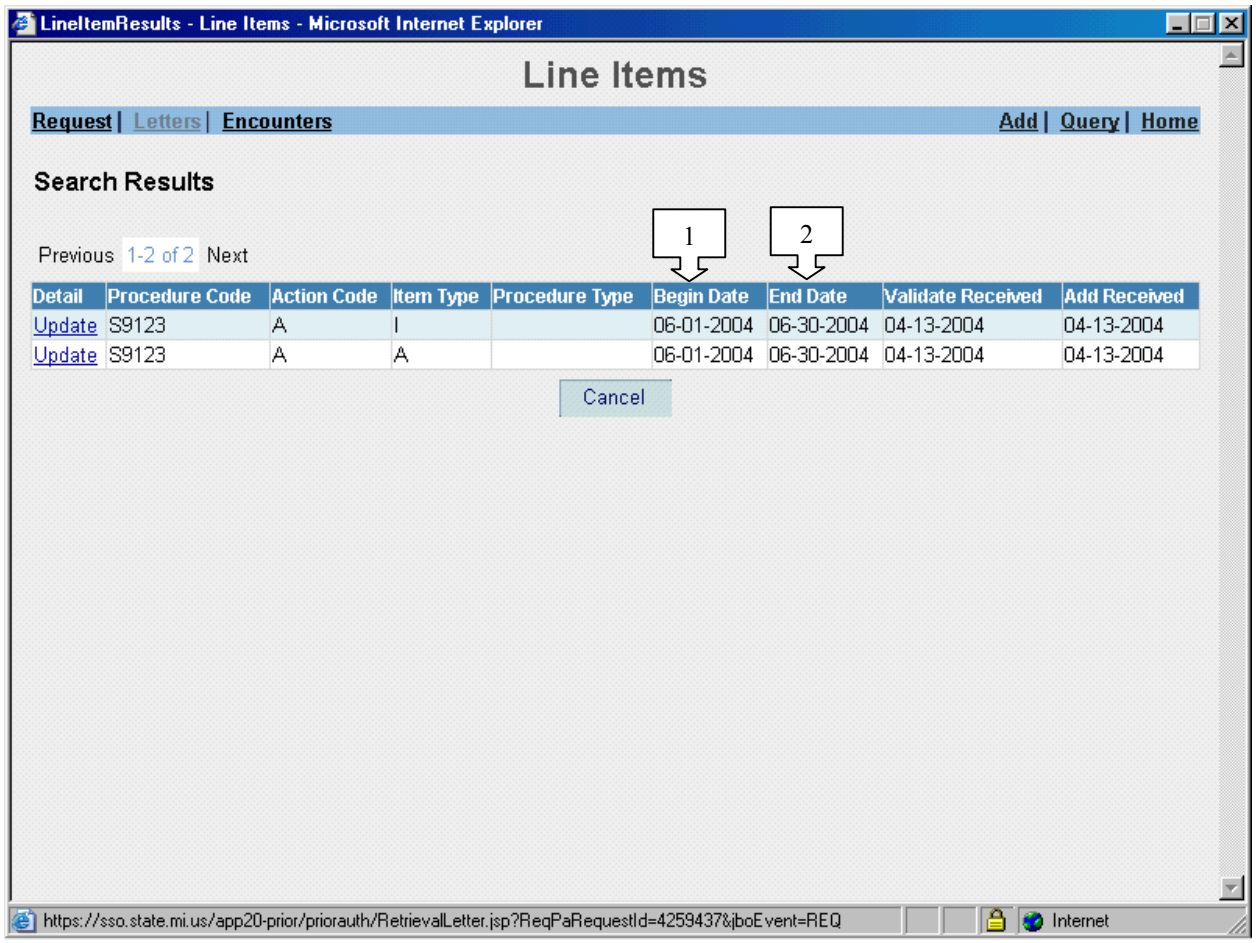
1. Enter the Beneficiary Medicaid ID number (8 digits)
2. Click SUBMIT.

At the bottom of the screen, you will see a list of search results. You may have one or many. Look at the list to find the PA for which you want to generate a letter. If it is not in the first five listed, click on "Next" on the right side of the screen just above the table of search results. That would display the next five requests and so on, until you find the one you want.



1. If you are unsure which PA you need, click on LINE ITEMS and proceed to the next page. This step is only necessary if you're unsure which PA # you want to do a letter for. Skip to Step 2 if you know you're on the right PA#.

2. If you know which PA you need, click on "Letters" and proceed to page 35 in this manual.

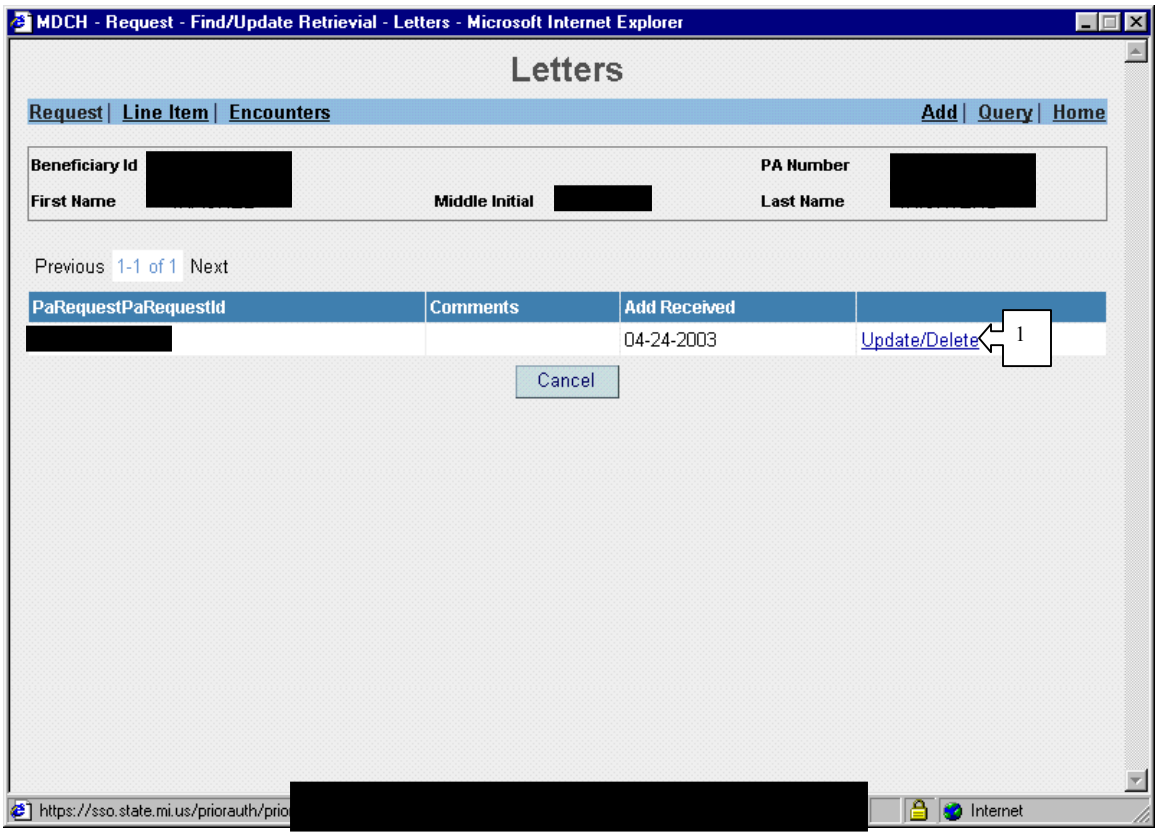


1. Check the Begin Date & End Date to make sure you have the correct month. It is just a way to double check that you are in the correct month and have the correct record. It is not a required step, just another method of checking for accuracy.

2. Click on QUERY and go back to find your request by entering the beneficiary ID # again. You will see the search results again and can proceed to the correct letter from there.

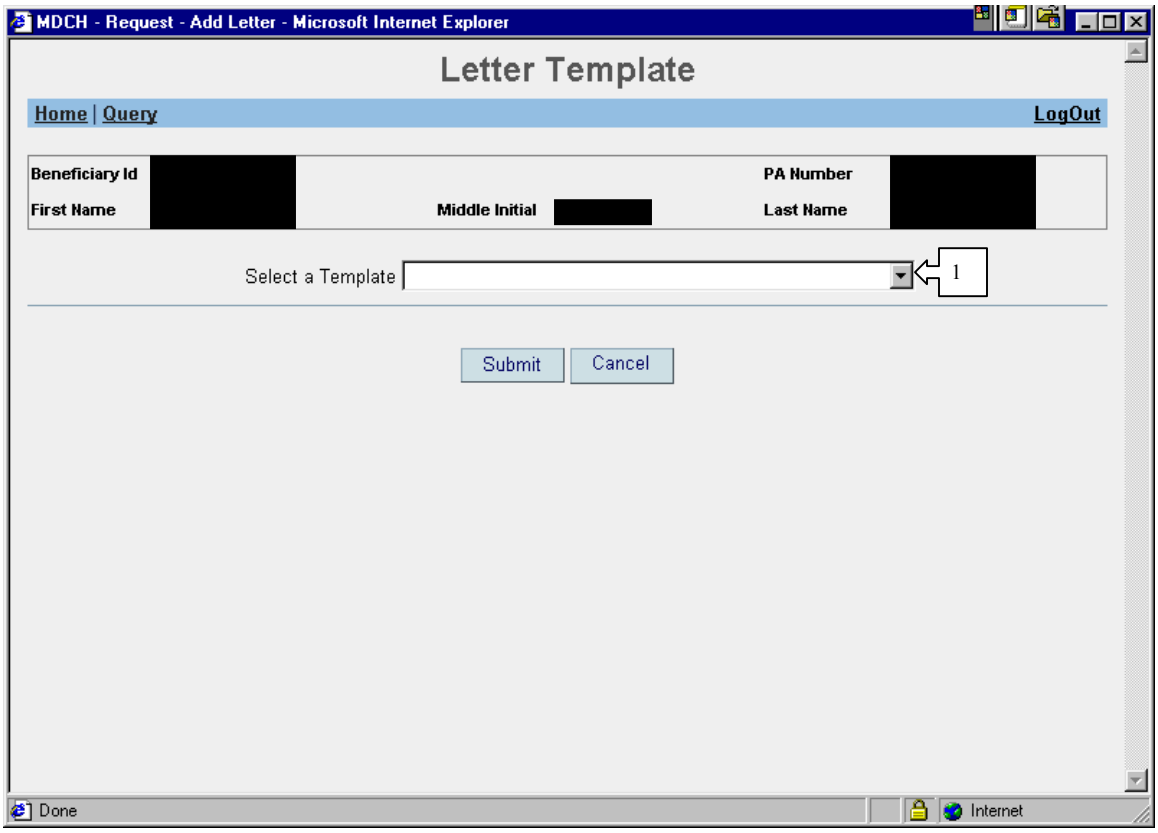
If this letter will be for a new PA that you entered, you will see this screen. It is telling you that there is no letter created yet for that PA#. If you are creating a new letter, complete Step #1 below. If you are changing a letter you had previously created, turn to the next page for the correct screen.

1. Click on the ADD button on the blue bar, top right. Skip the next page of this instruction manual since it is for doing changes to an existing letter.

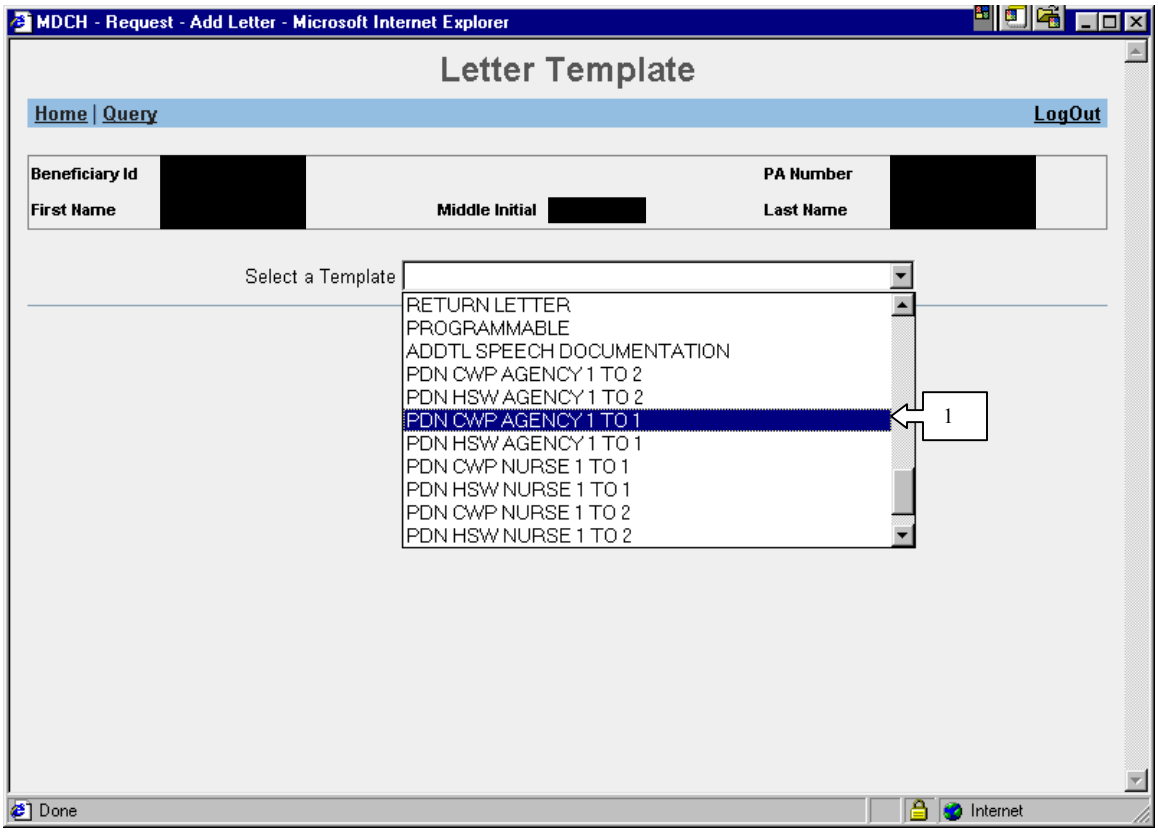


This is the screen you will see if you had already created a letter and now need to revise it. For example, if you inactivated a line and added a line to change hours authorized, you would then be revising a PA letter.

1. Click on UPDATE/DELETE.

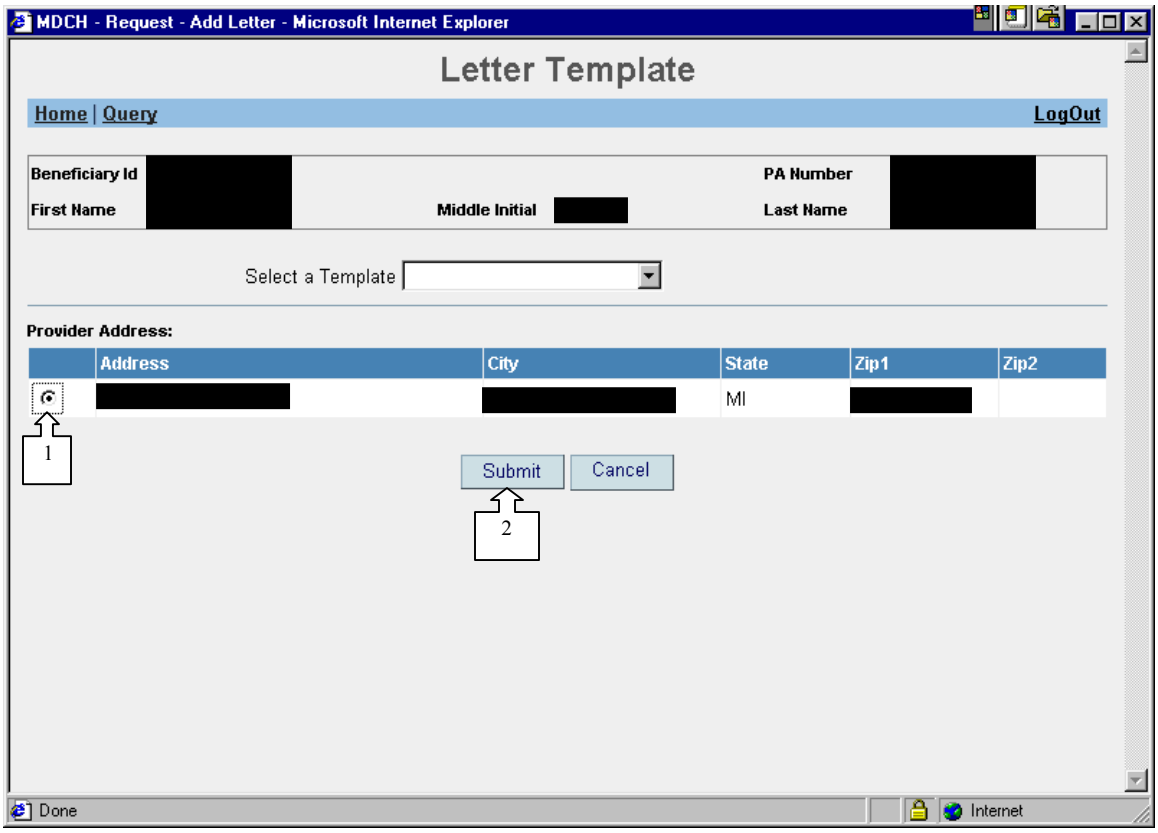


1. Click on the arrow to get the drop-down list in the "Select a Template" box.



1. Select the correct letter template.

All of the PDN letters are grouped together and begin with PDN. The next letters indicate the program (either CWP for Children's Waiver or HSW for Habilitation Supports Waiver) in which the child is enrolled. Next is either agency (for a provider type 15) or nurse (for a provider type 10). Finally, the staff to child ratio is either 1:1 (one nurse serving one child) or 1:2 (one nurse serving two children at the same time).

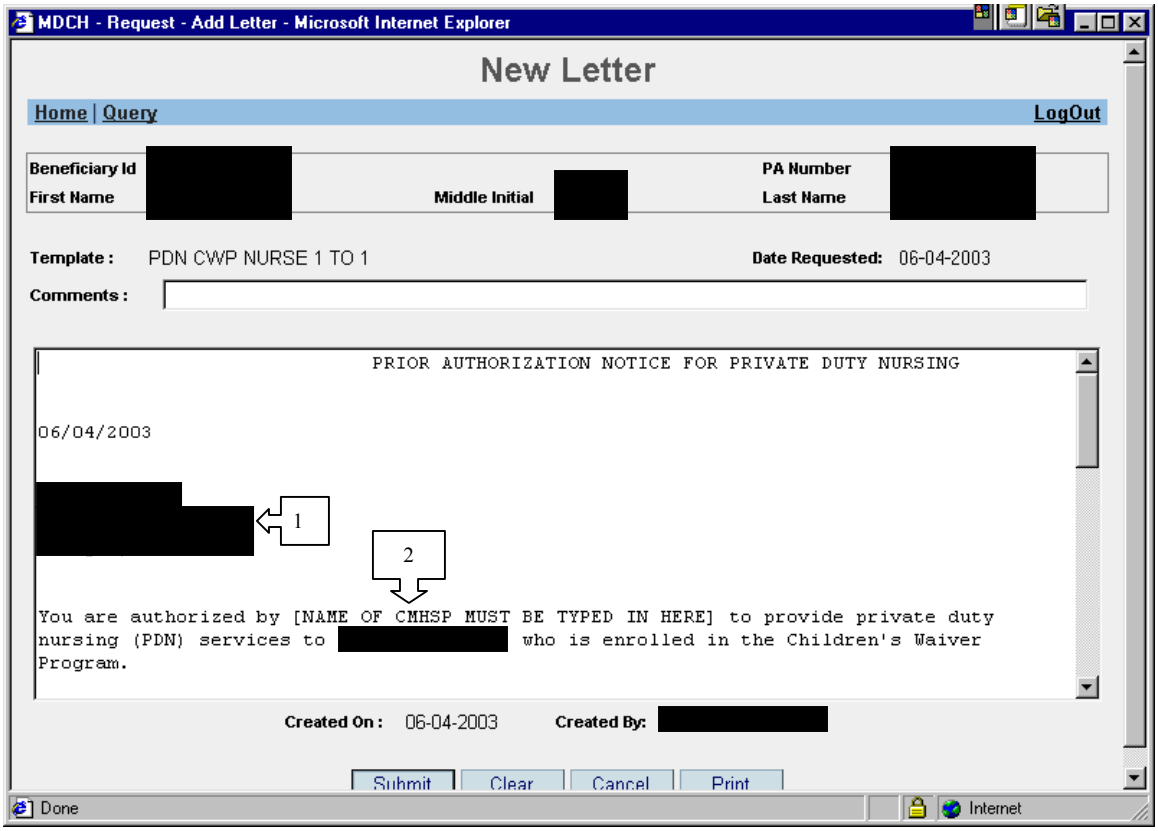


1. If there is more than one address from which to choose, select the correct provider address by pointing your mouse to the circle to the left of the address and clicking. That will place a black dot inside the circle. If there is only one choice, place your mouse over the circle and click to place a block dot inside the circle.

   NOTE: If this is not the address you are sending the letter to, just select it and change it manually in the letter itself. If there are several different addresses listed (not uncommon with large agencies), be sure to select the correct address from the list.

2. Click on SUBMIT.

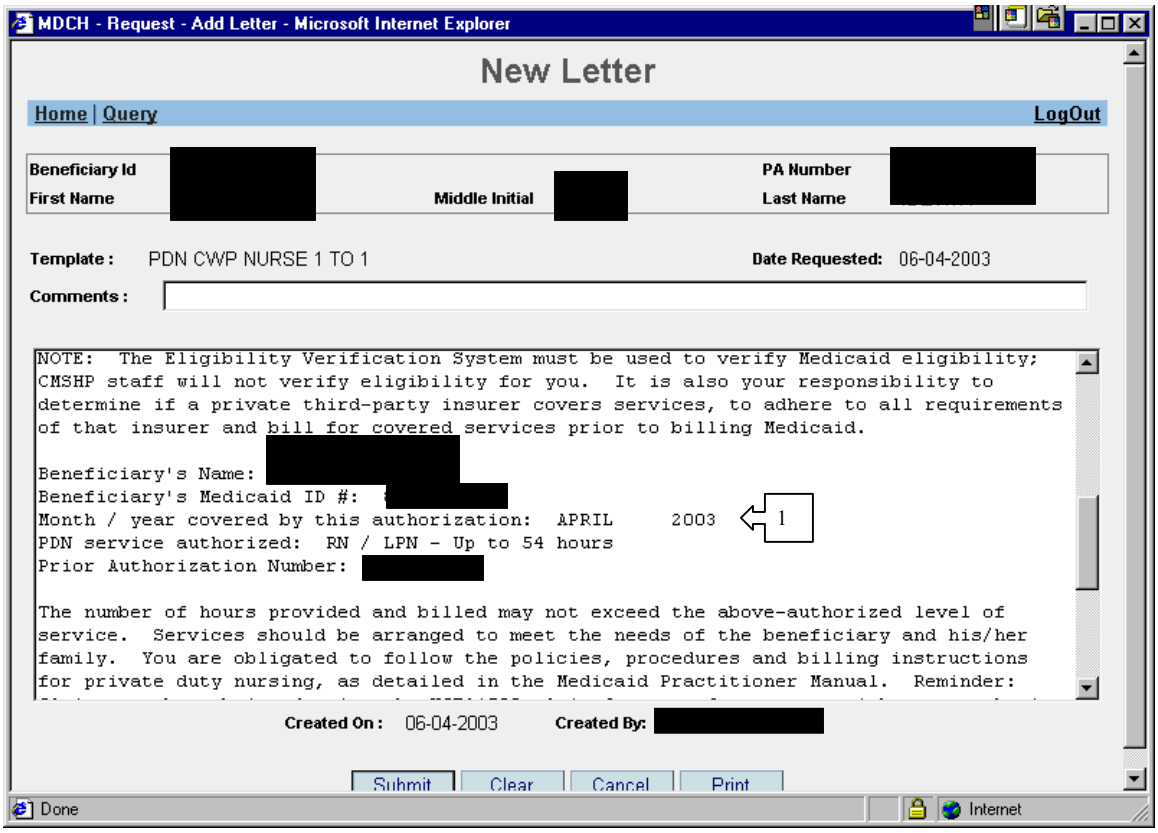
This screen appears with your letter. **NOTE**: The scroll bar to the right of the letter must be used to view the letter in segments. You will see the entire letter on this and the next two pages of this manual.



1. Check the name of the provider and mailing address that have been filled in. Make any changes as appropriate.

2. In the first sentence, you must delete the brackets and instructions contained inside them that directs you to type the name of your agency. Key in the name of your agency that is authorizing the PDN services.

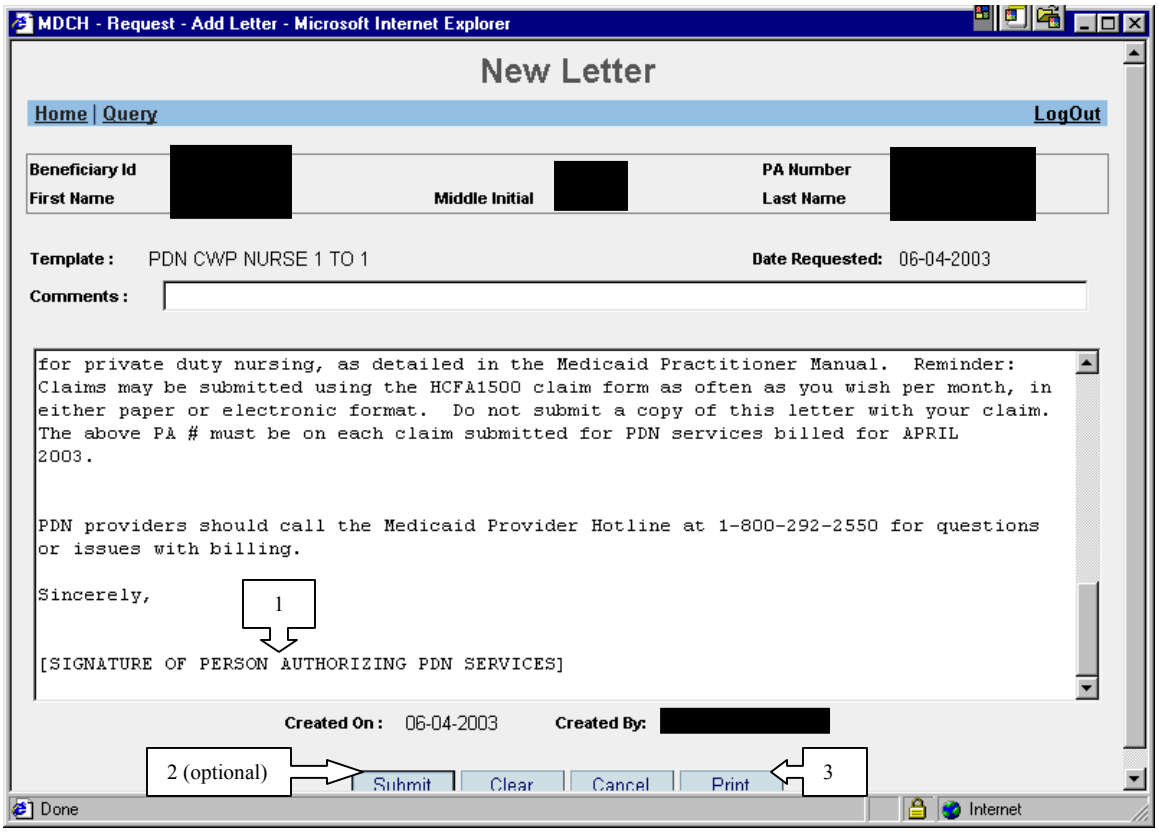
This is the middle portion of the letter.



1. Check to be sure the information filled in is correct. If not, you can change it by keying in the correct information.

NOTE: If you are changing an existing letter, you must change the date and the number of hours authorized. The system will not automatically do that for you.

This is the lower portion of the PA letter.



1. Delete the brackets and instructions contained inside. Key in the name of the person who is signing the authorization letter.

2. Select SUBMIT to save the letter. The system will ask you if you want to print. Click OK to print the letter.

3. There is a step-saver here if you want to use it. This is the ONLY place in the PA system where you can click one button and have it do two functions. If you click on PRINT, that will both save (same as clicking on the "Submit" button) and send it to print.

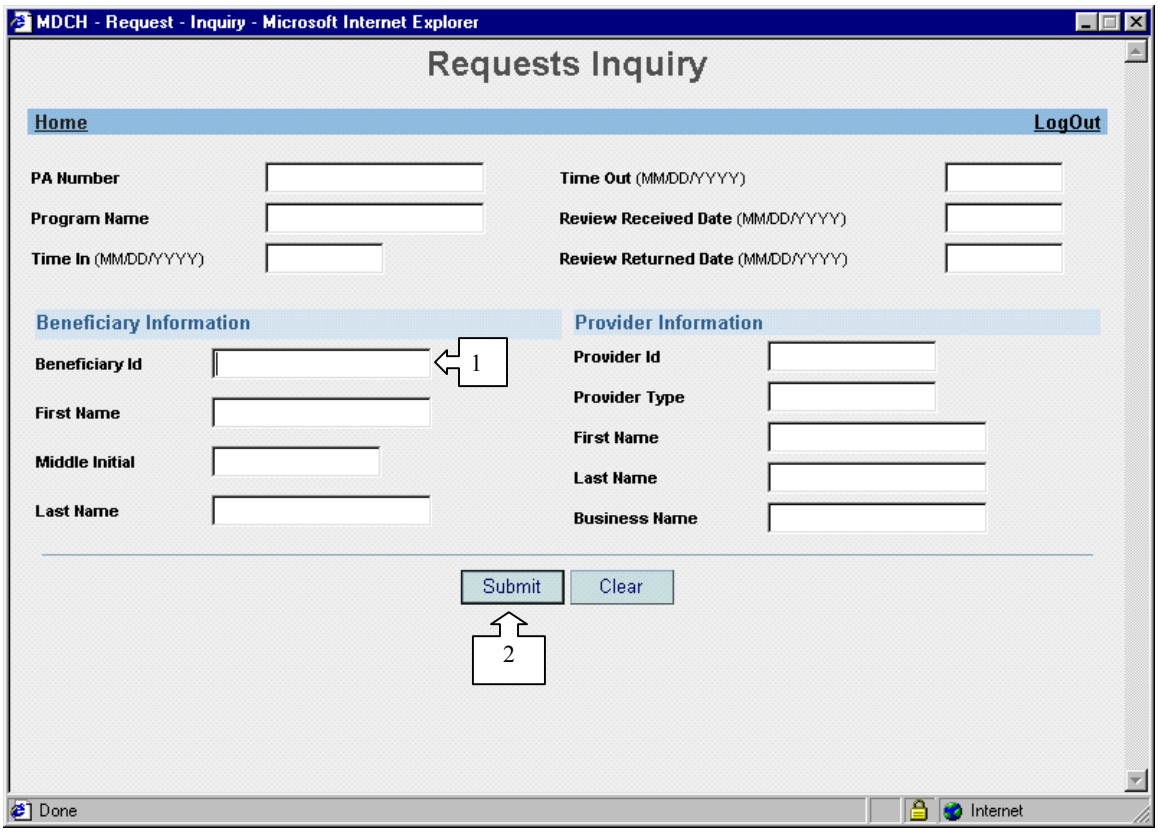
You have now successfully printed a letter to send to the provider.

SECTION THREE: CHANGING THE AMOUNT OF HOURS AUTHORIZED

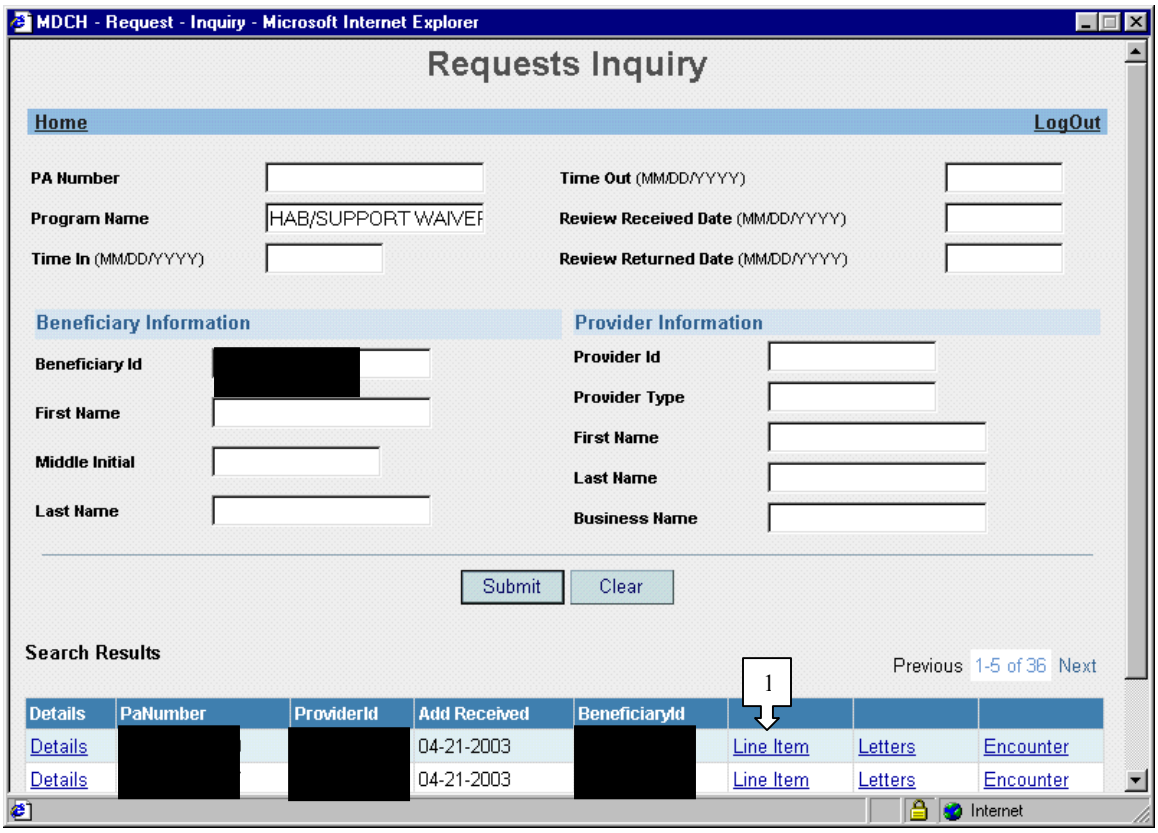
Occasionally, you will need to revise the number of hours authorized for a particular provider for a month. This is usually because there are multiple providers for whom hours have been authorized and one provider is unable to meet the obligation, resulting in another provider picking up the extra hours to assure full coverage. This process does NOT change the PA#, only the number of hours authorized for a month.

Example: Provider A was authorized for 100 hours and Provider B was authorized for 50 hours, totaling 150 hours for June 2003. Provider A had a family emergency and could not provide 25 hours of PDN services. The authorizing agency must increase the authorization for Provider B to 75 hours. While it is not mandatory to change the hours authorized to Provider A since a provider may only bill Medicaid for the number of hours of PDN service, you may want to do so, just for clarity to both providers that the total hours authorized for the month of June continues to be 150 hours.

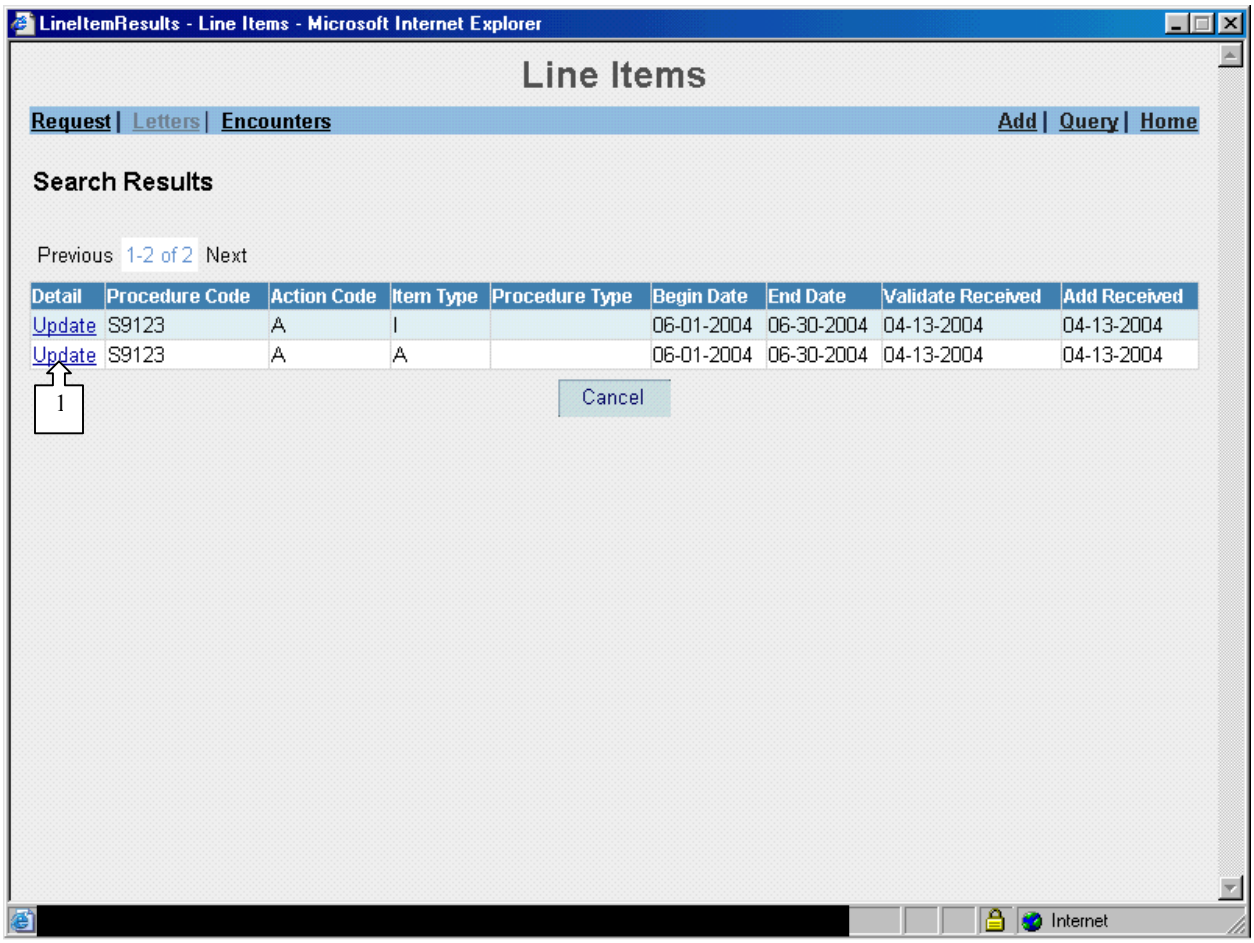
1. At your home page, click on REQUEST in the Find/Update column.



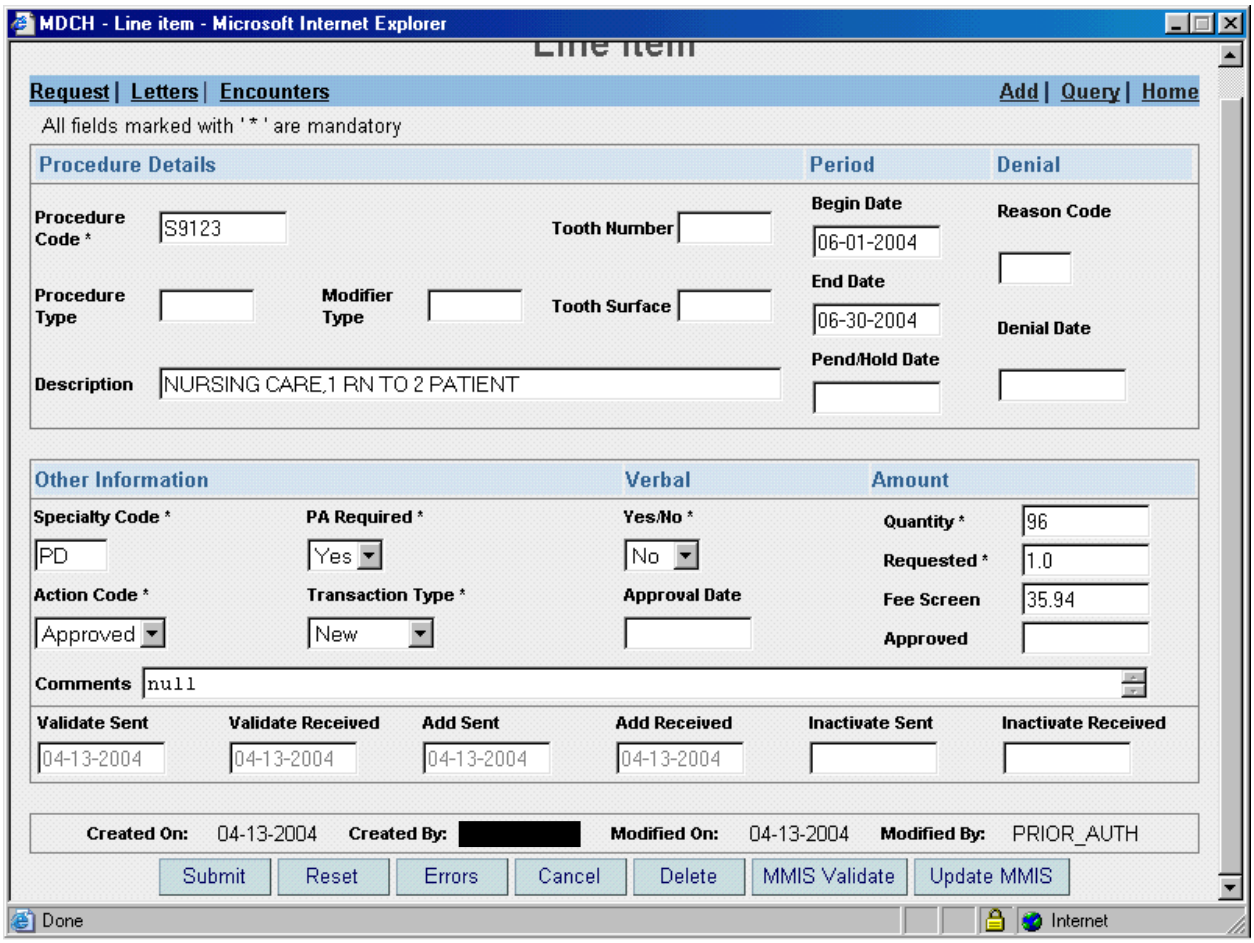
1. Enter the Beneficiary ID#.
2. Click on SUBMIT.



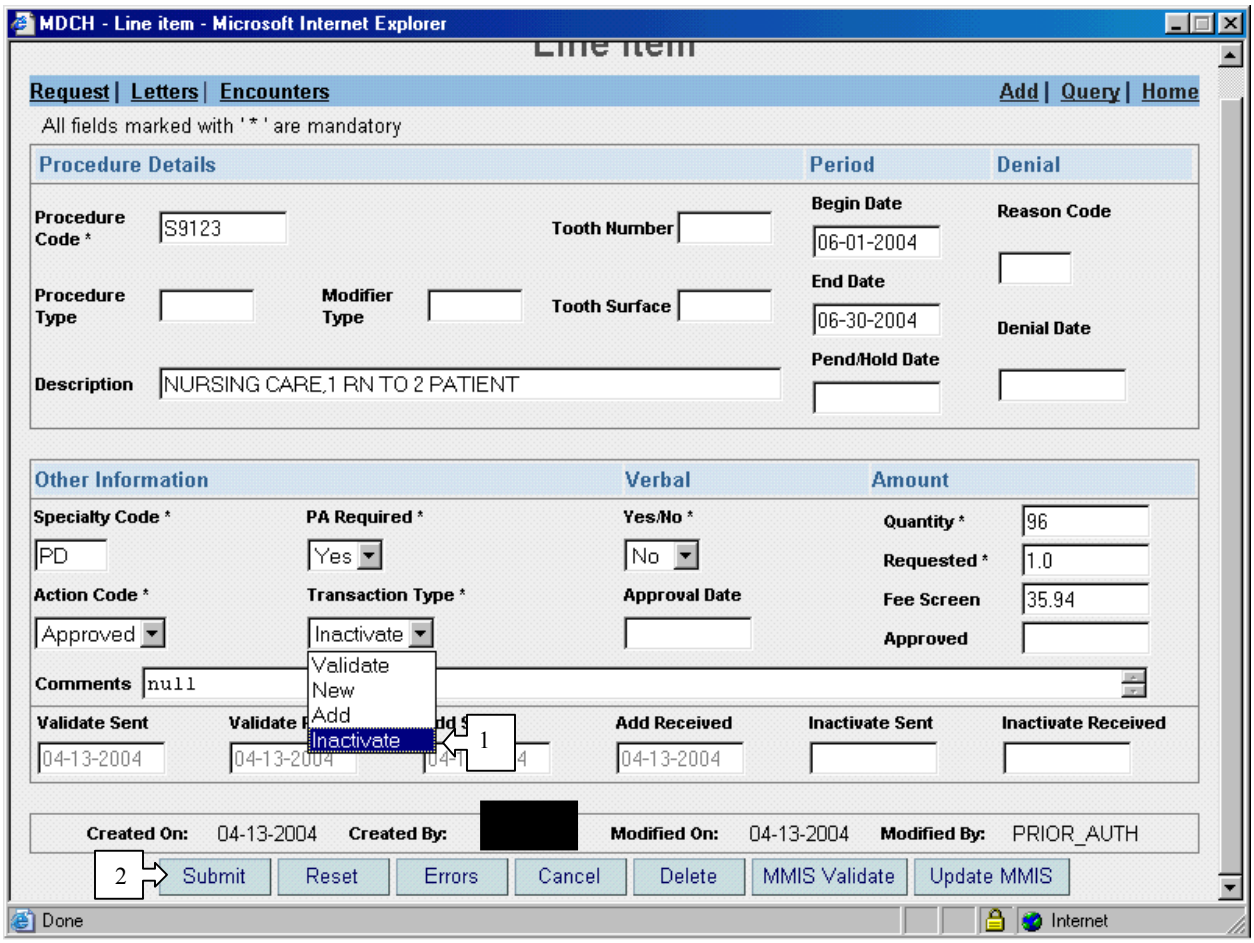
1. Locate the row with the PA# for which you need to change the line item. Click on LINE ITEM. If you are unsure which row you need, just look at the PA# you issued for the hours that you now want to change. The PA# is in the column just to the right of the DETAILS column.



1. Click on UPDATE for the line item you need to change.

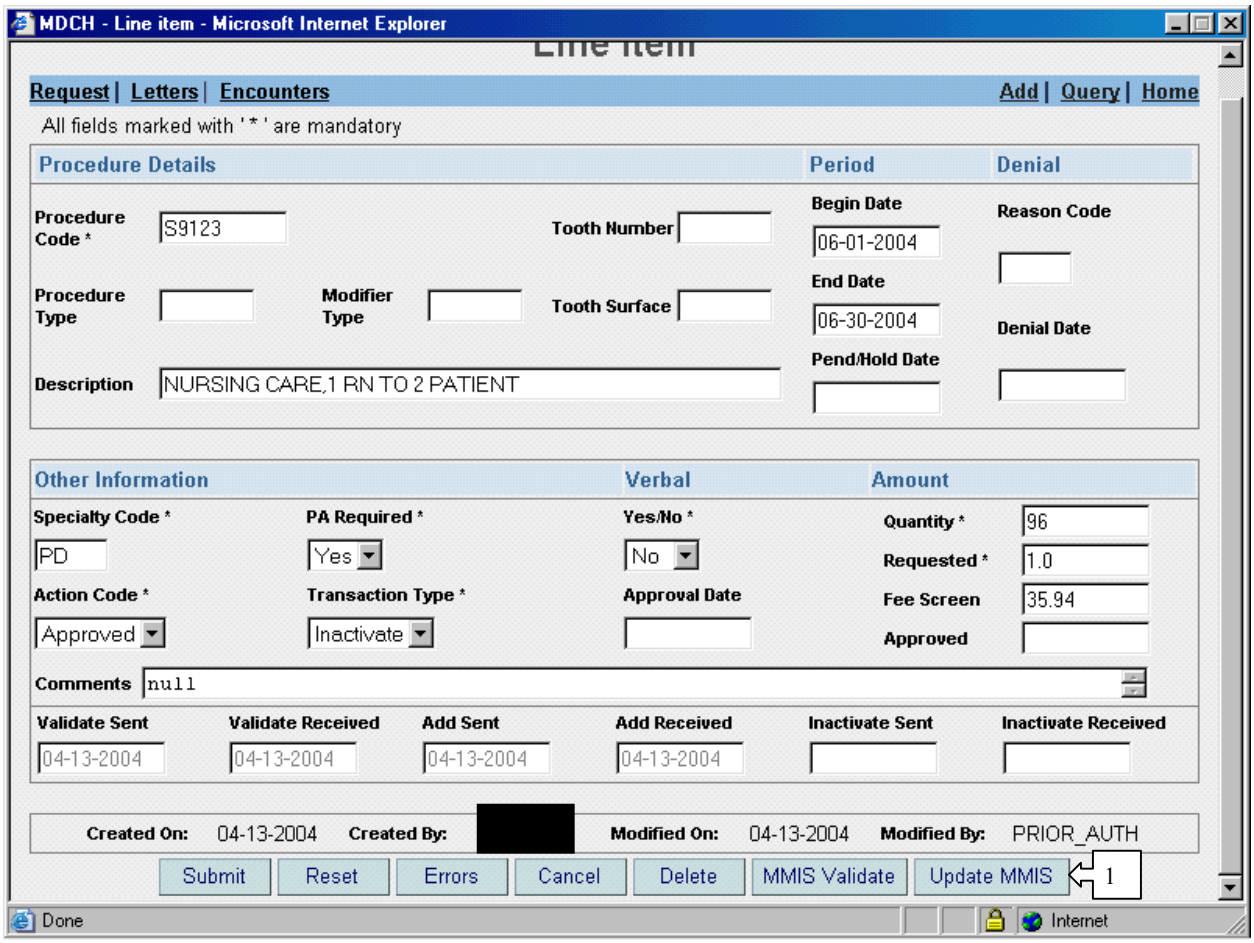


This is the Line Item you had previously approved.



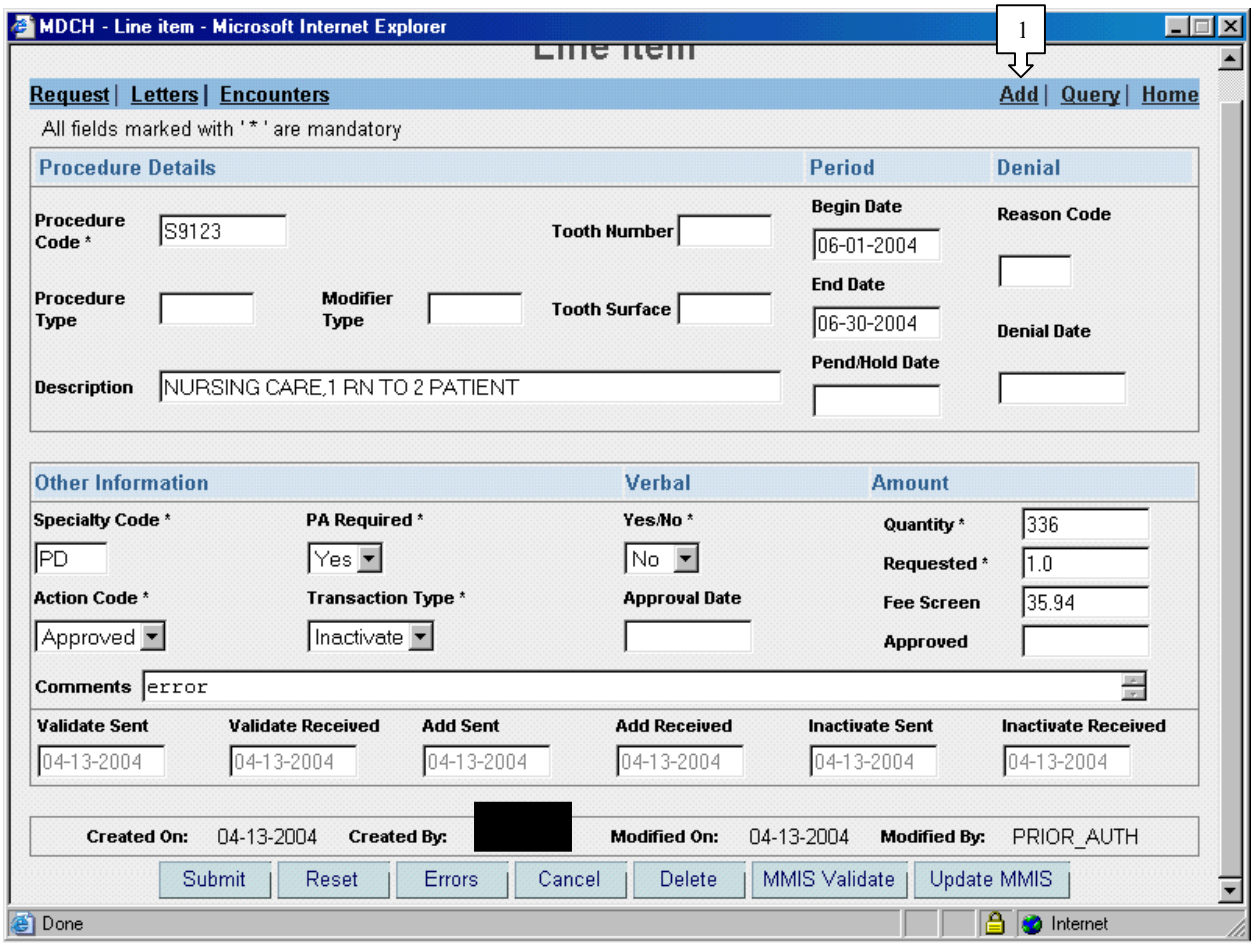
1. Click on the arrow on the Transaction Type to get the drop down list. Select INACTIVATE.

2. Click on SUBMIT to save the change.



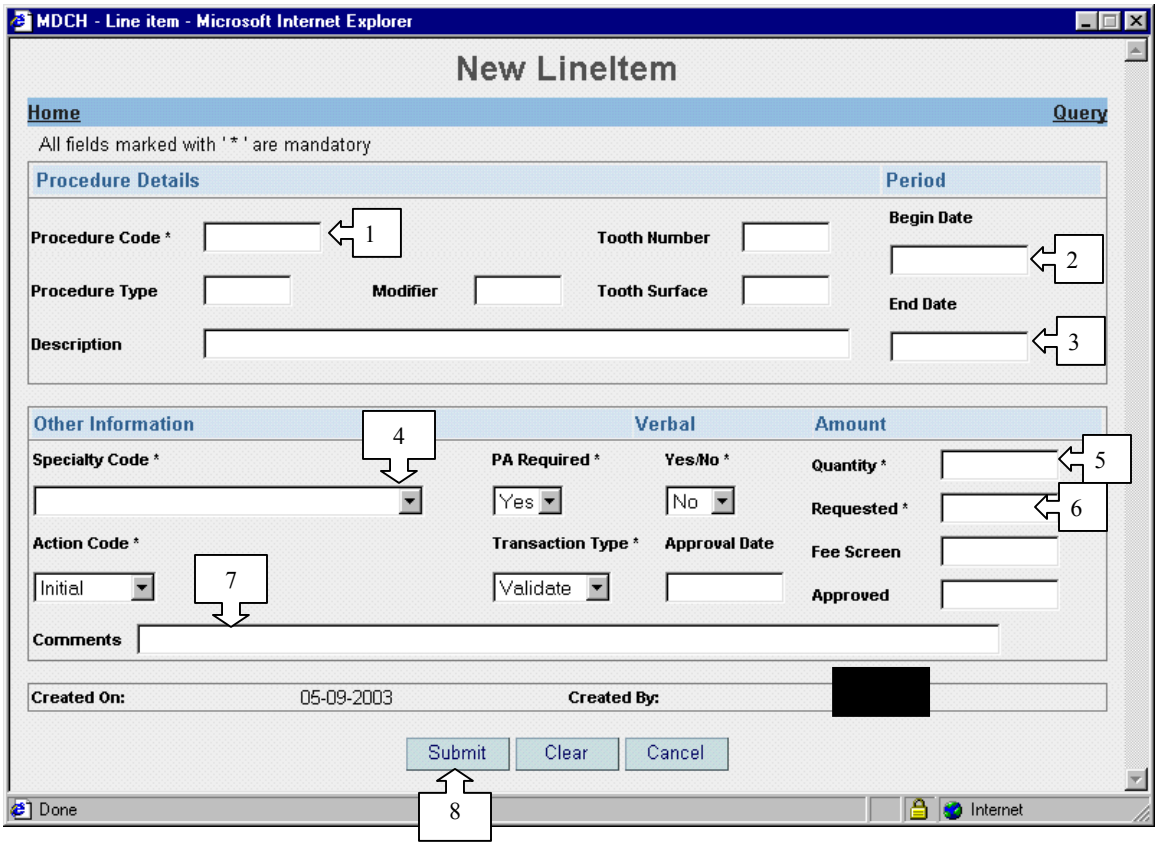
1. Click on UPDATE MMIS to send the inactivate command to MMIS. Today's date will be filled in the "Inactivate Sent" and 'Inactivate Received" fields once you exit out of this screen.

You should receive a message that says the record was successfully updated to MMIS. Click OK.

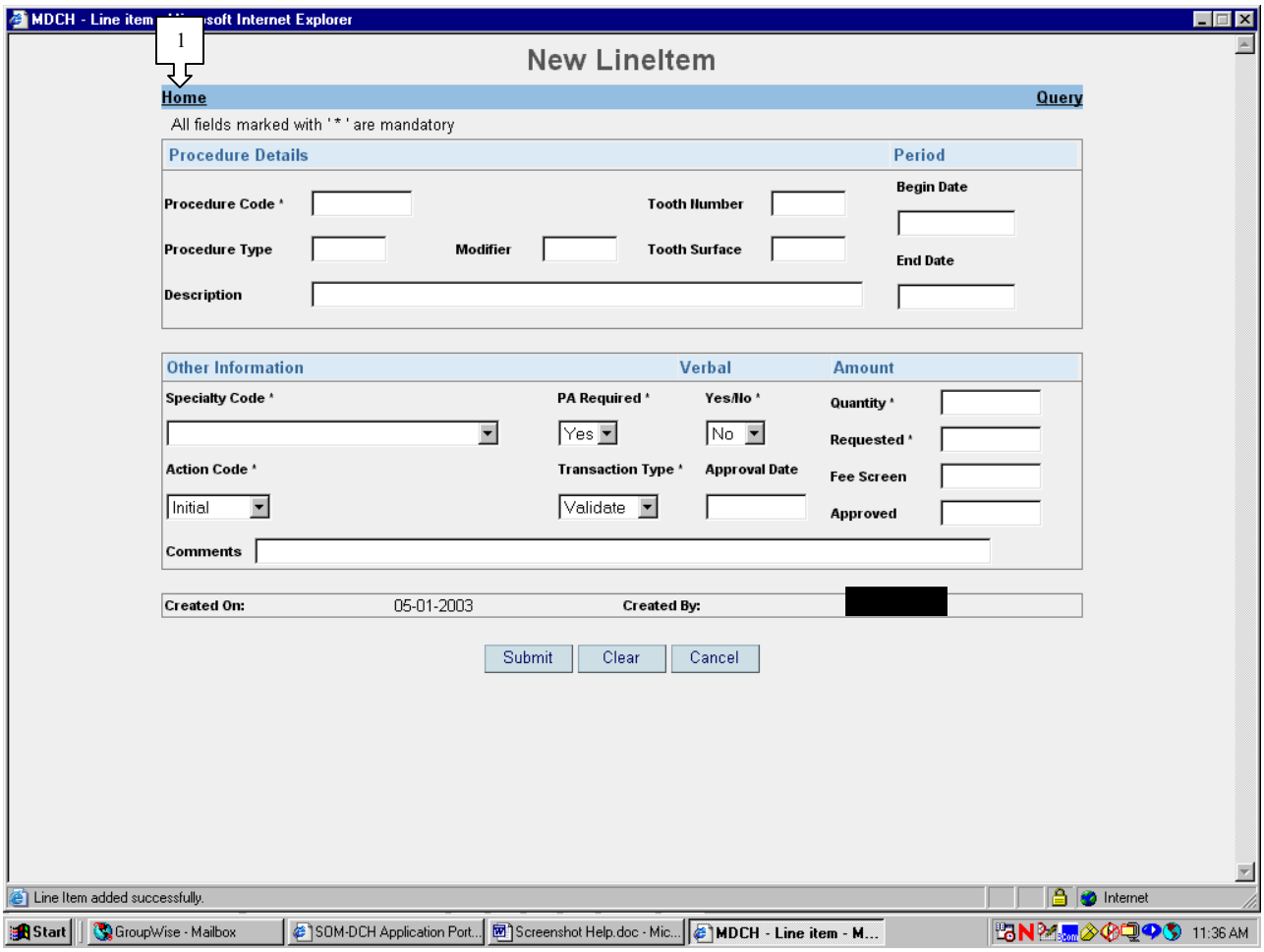


1. Click on ADD to take you to a blank New Line Item Screen.

You will now be on a New Line Item screen



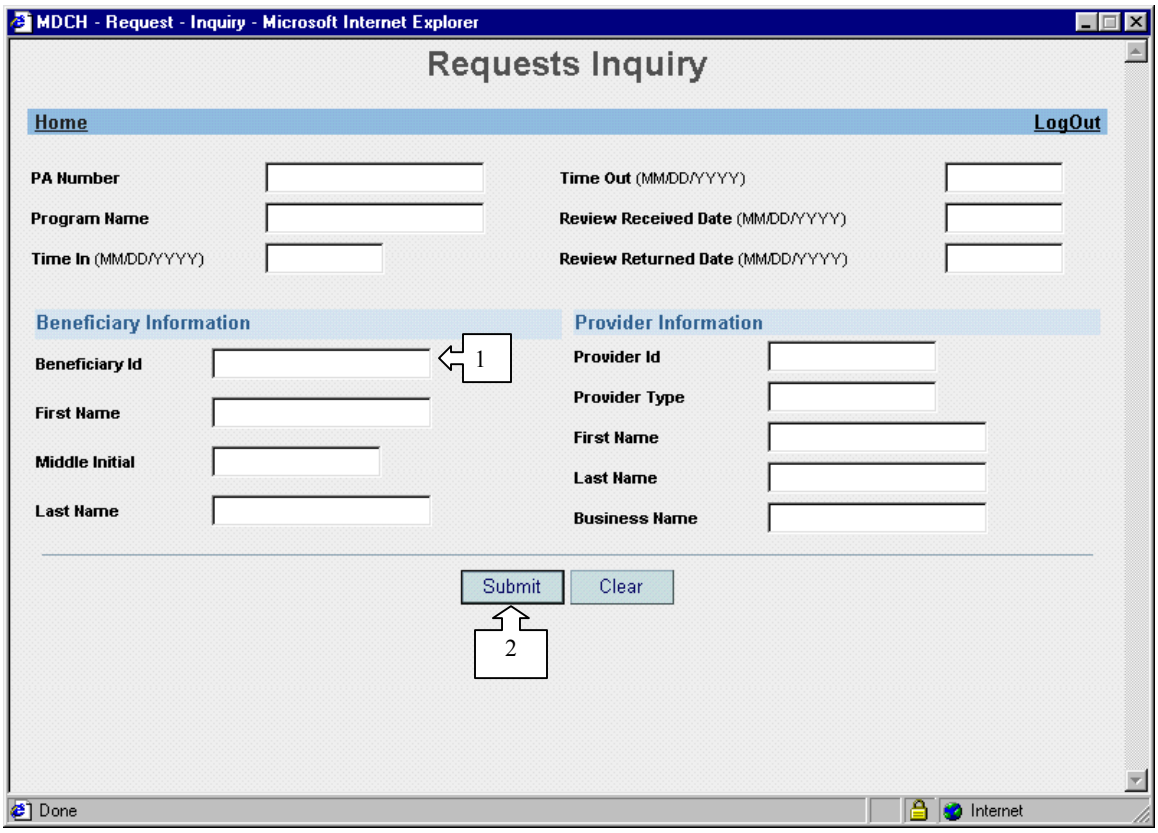
1. Enter Procedure Codes S9123 for RN or S9124 for LPN.
2. Enter Begin Date.
3. Enter End Date.
4. Select PD from the drop down list under Specialty Code.
5. Enter the new hours to be authorized in Quantity field (in hours).
6. Enter 1.0 in the Requested field.
7. Enter a reason for the change in line item in the Comments field.
8. Click on SUBMIT to save the information. It will take you to a new blank Line Item screen.



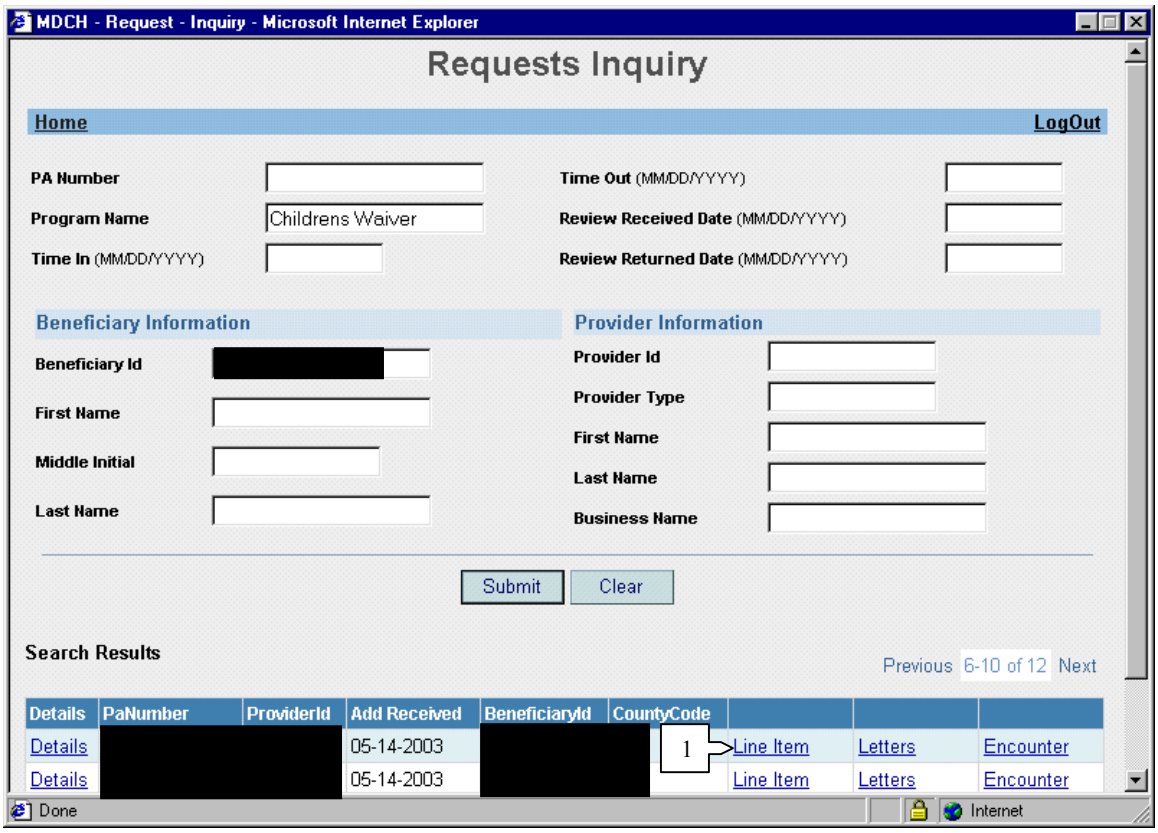
You will see another blank New Line Item screen. Do **not** fill out this screen a second time.

1. Click on HOME.

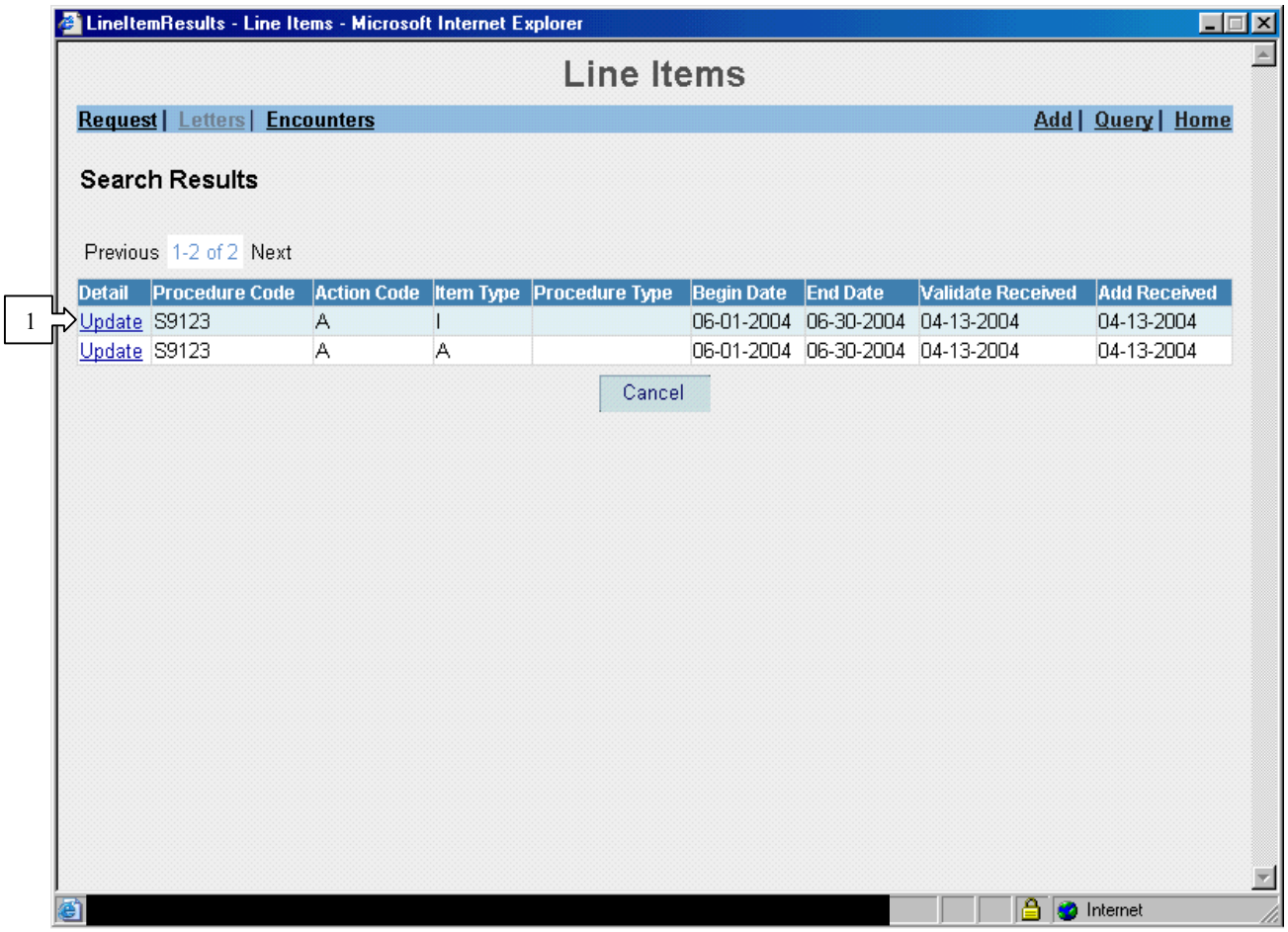
1. You now have to go back to that line item you just added to validate it, so you must find it again. Click on REQUEST under the Find/Update column.



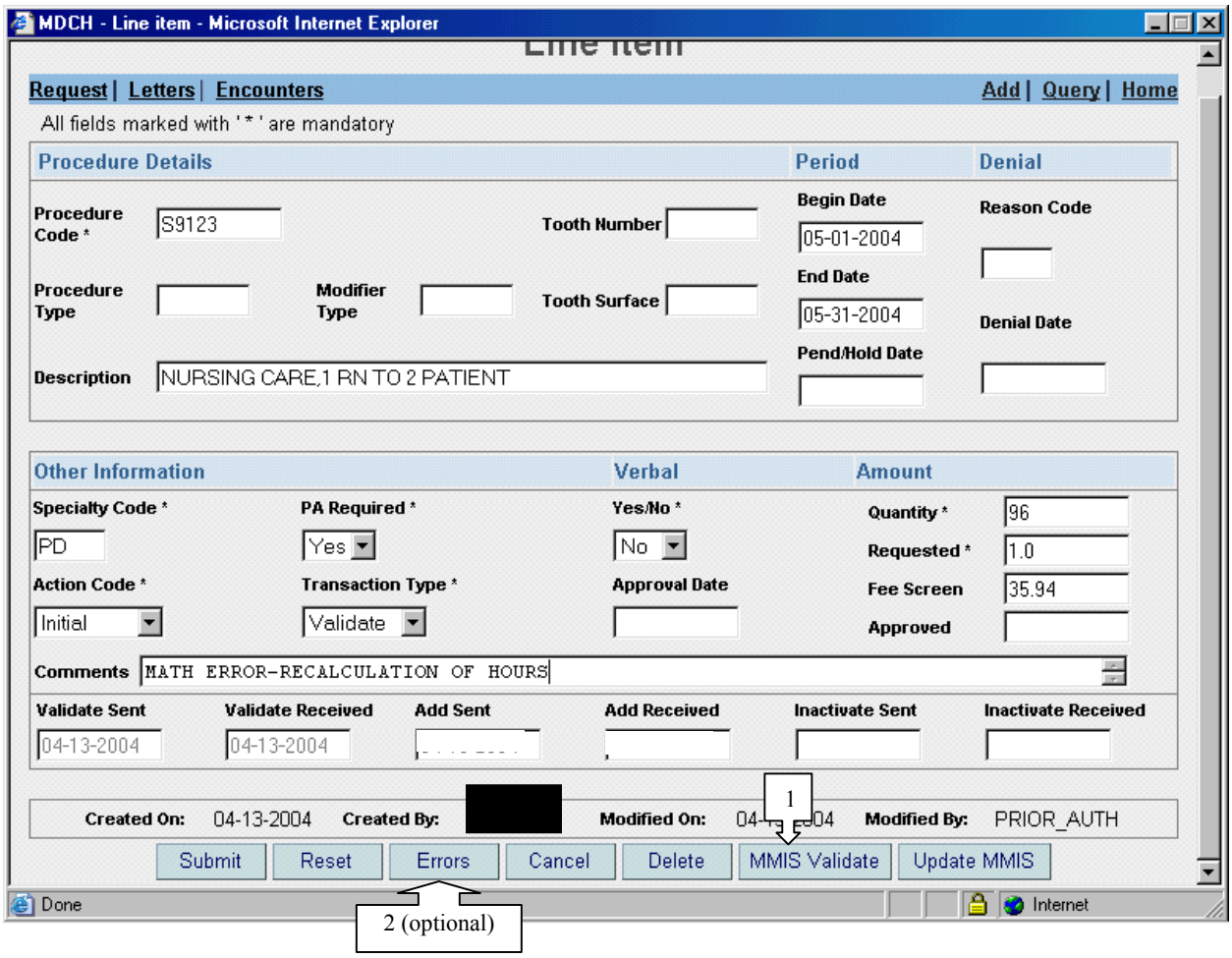
1. Enter the beneficiary Medicaid ID#.
2. Click on SUBMIT.



1. Select the LINE ITEM for the PA# in which you made the line item change.

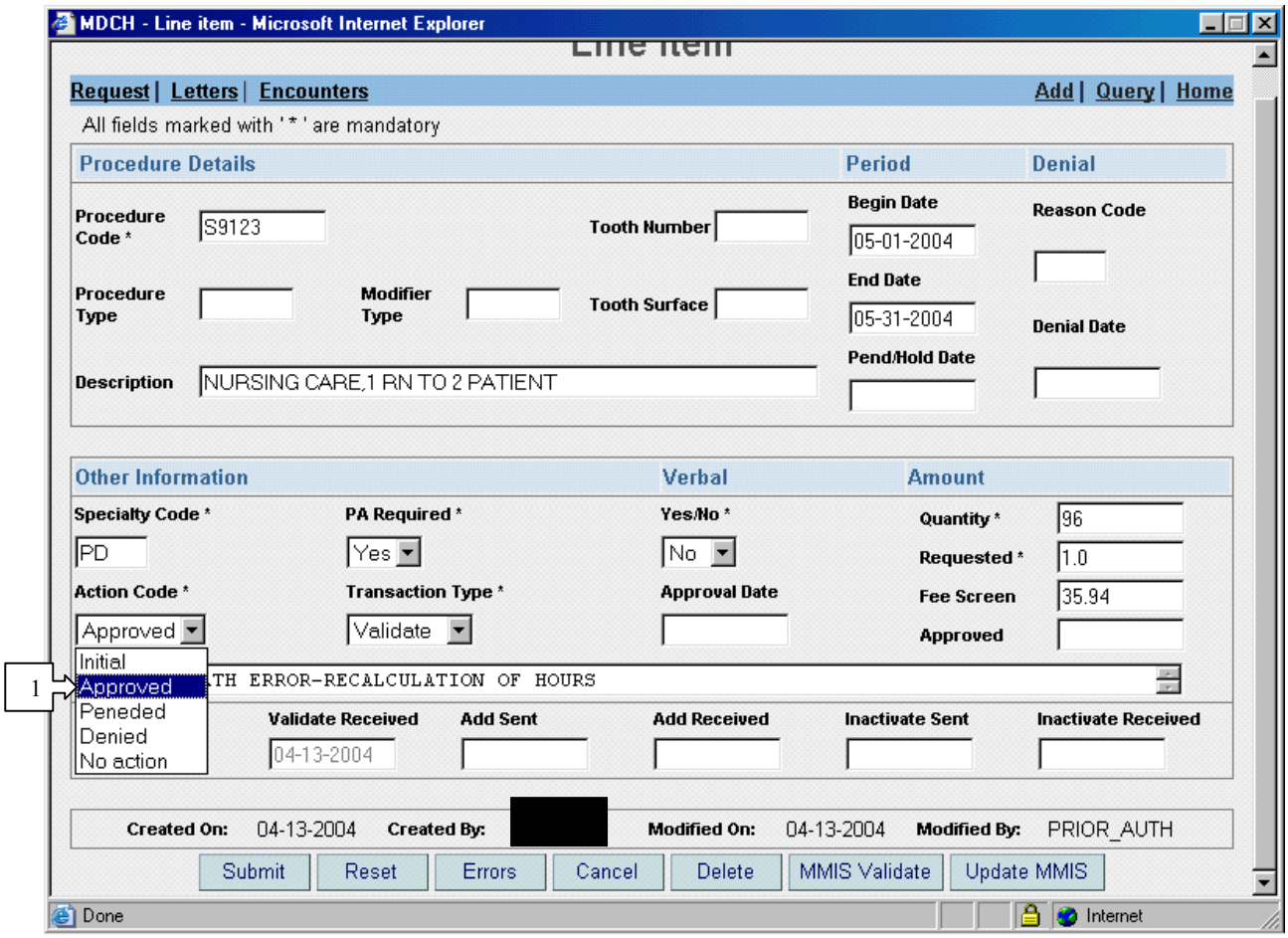


1. Click on UPDATE next to the Line Item you need to validate. You can tell because there is an "I" in the Action Code column for "Initial" and a "V" in the Item Type column for "Validate". You'll also note that there is no date filled in yet under the Validate Received or Add Received fields because you have not validated or updated that line item yet.

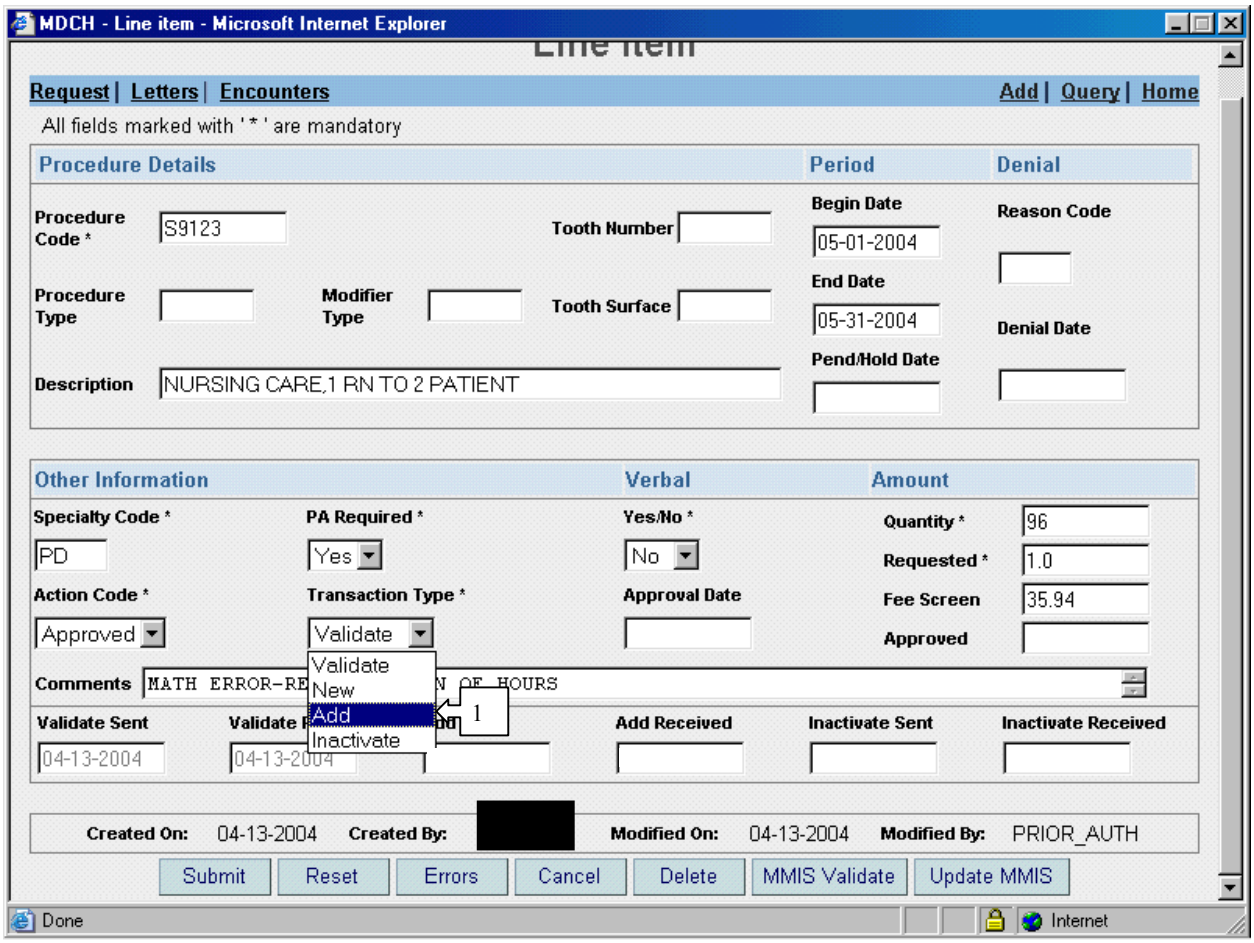


1. Click on MMIS VALIDATE. You should receive a message that you have successfully validated the record. Click OK.

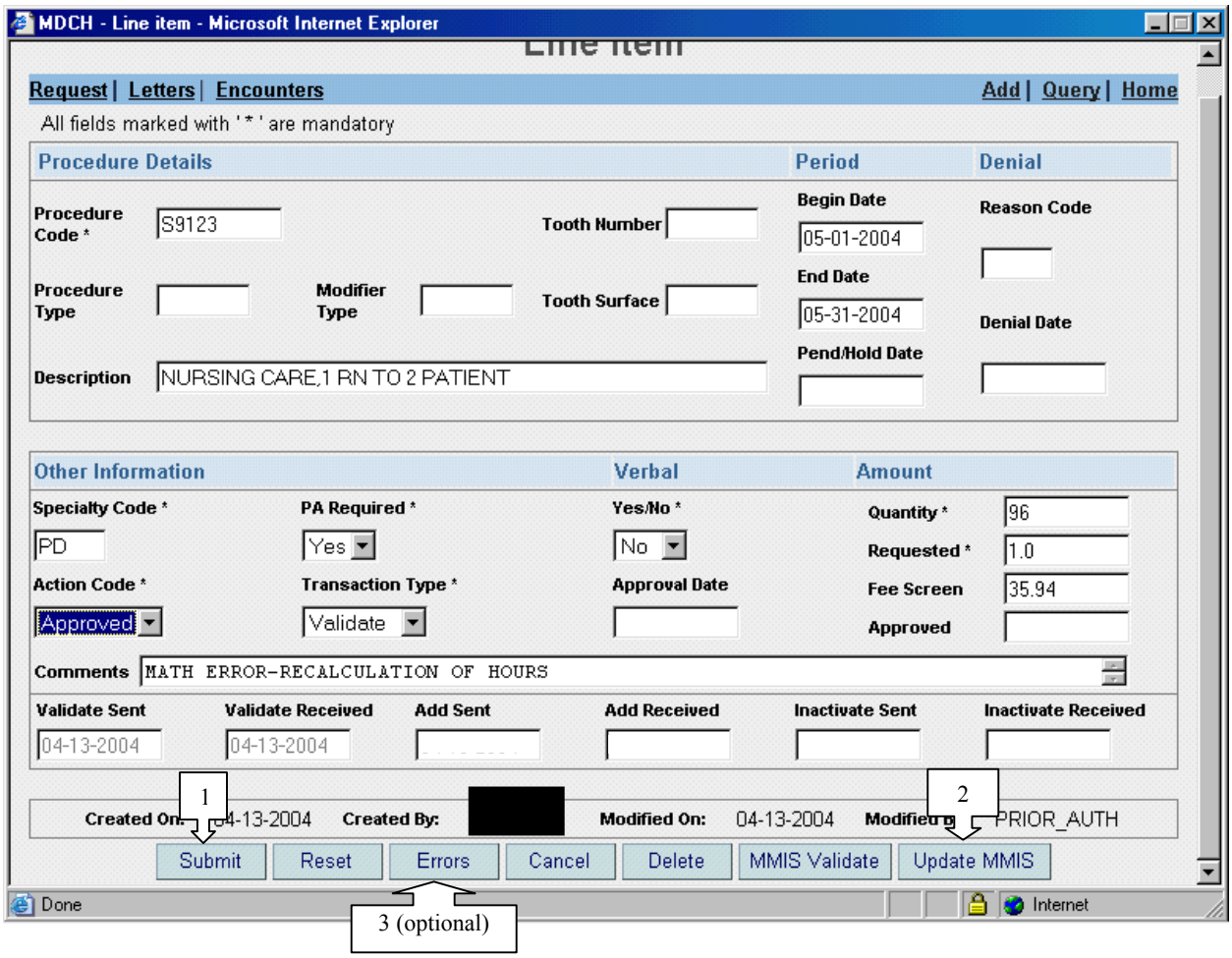
2. If you receive an error message, check ERROR to see what the error is. Try to fix it if you can. If you can't, please call for technical assistance.



1. Change the Action Code to APPROVED from the drop down list.



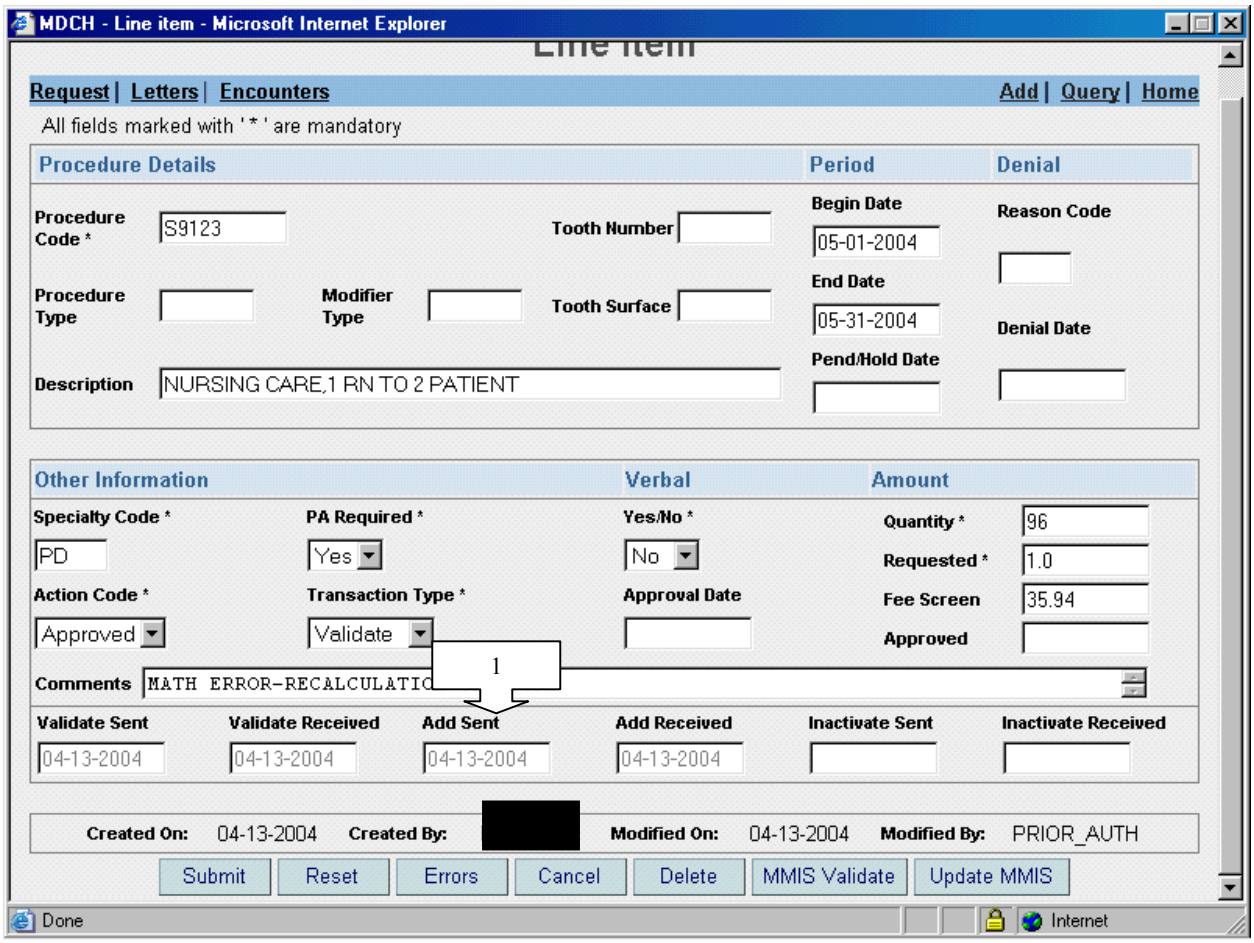
1. Change the Transaction Type to ADD from the drop down list.



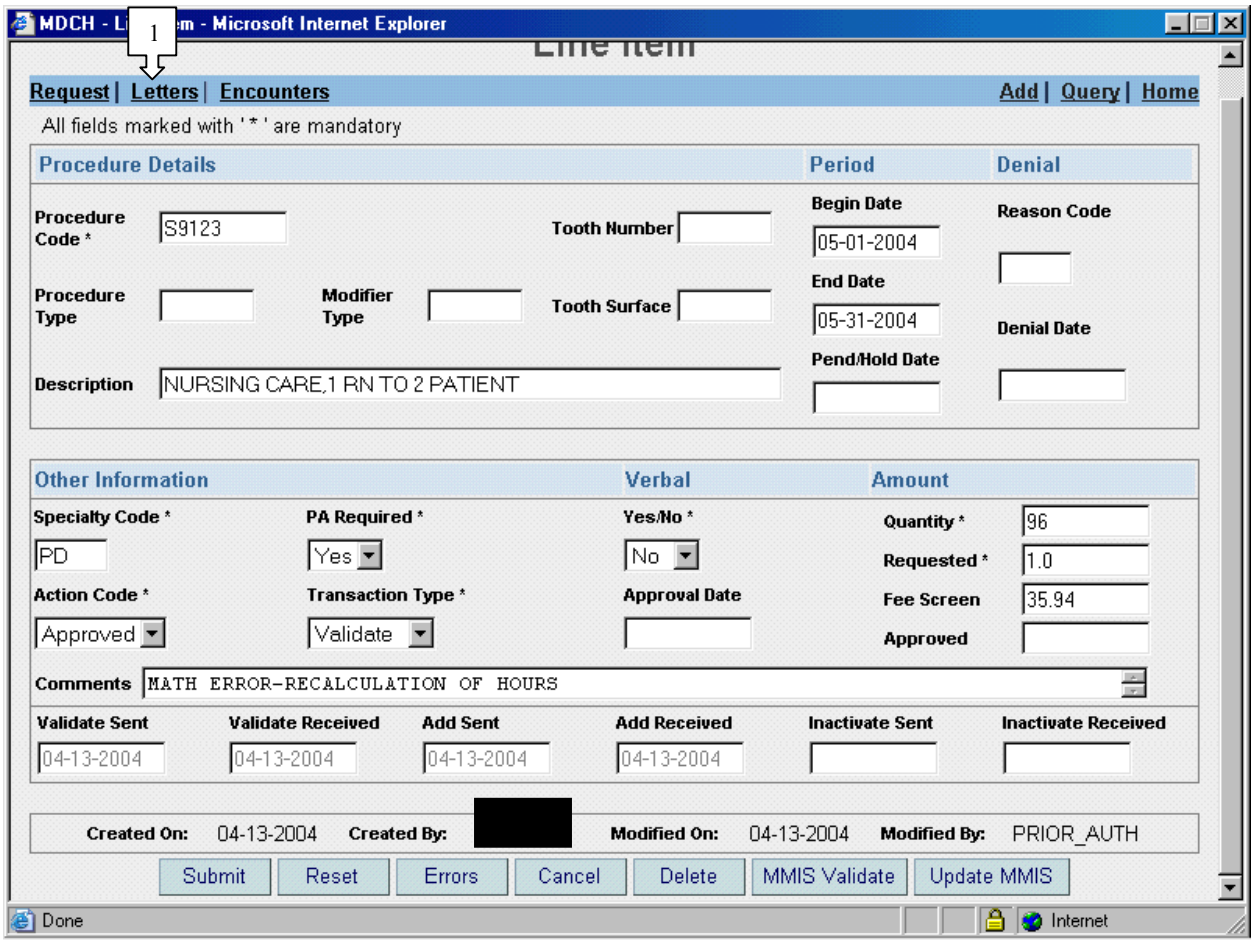
1. Click on SUBMIT to save your changes.

2. Click on UPDATE MMIS to send the change to MMIS. If you have updated successfully, you will receive a message.

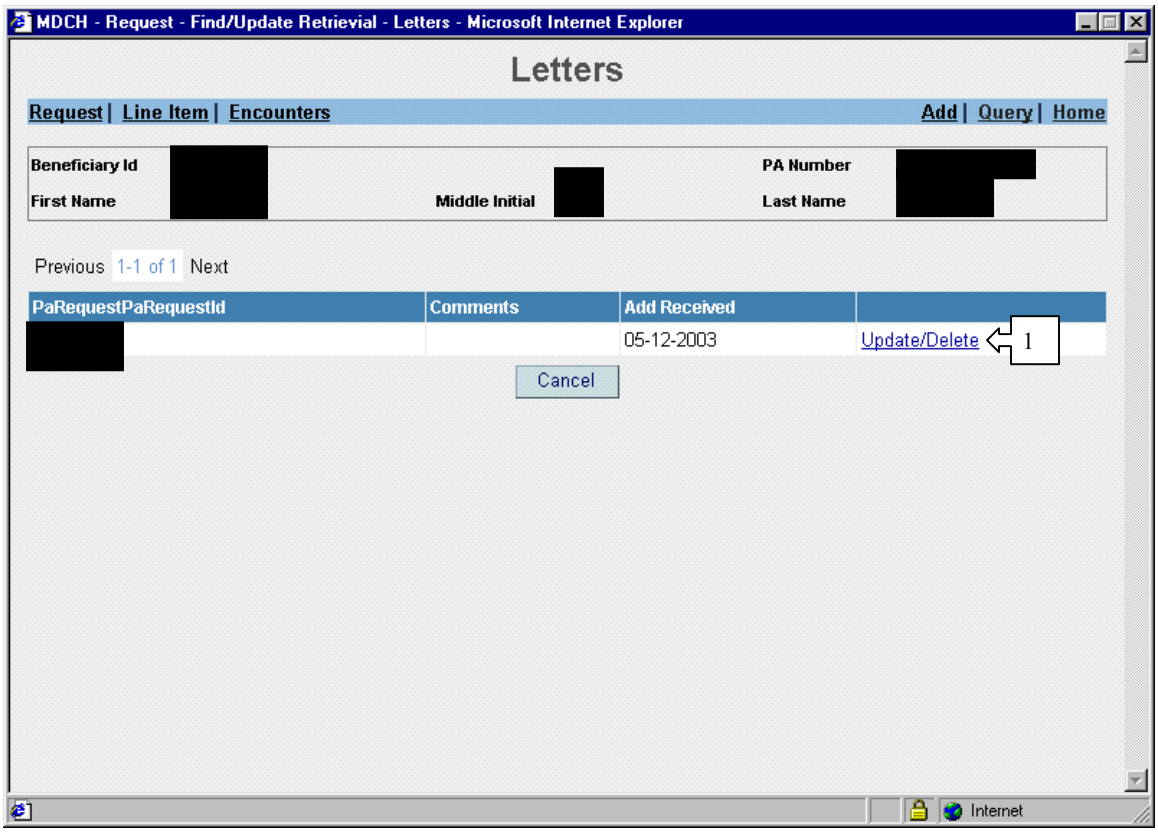
If you get an error message, click on ERROR to view your error. See if you can fix it but if you get stuck, please call for technical assistance.



1. Notice that there should be a date in the ADD SENT & ADD RECEIVED fields. This tells you that your PA has been successfully received at MMIS. That means your provider may now bill against that PA# with the new hours.

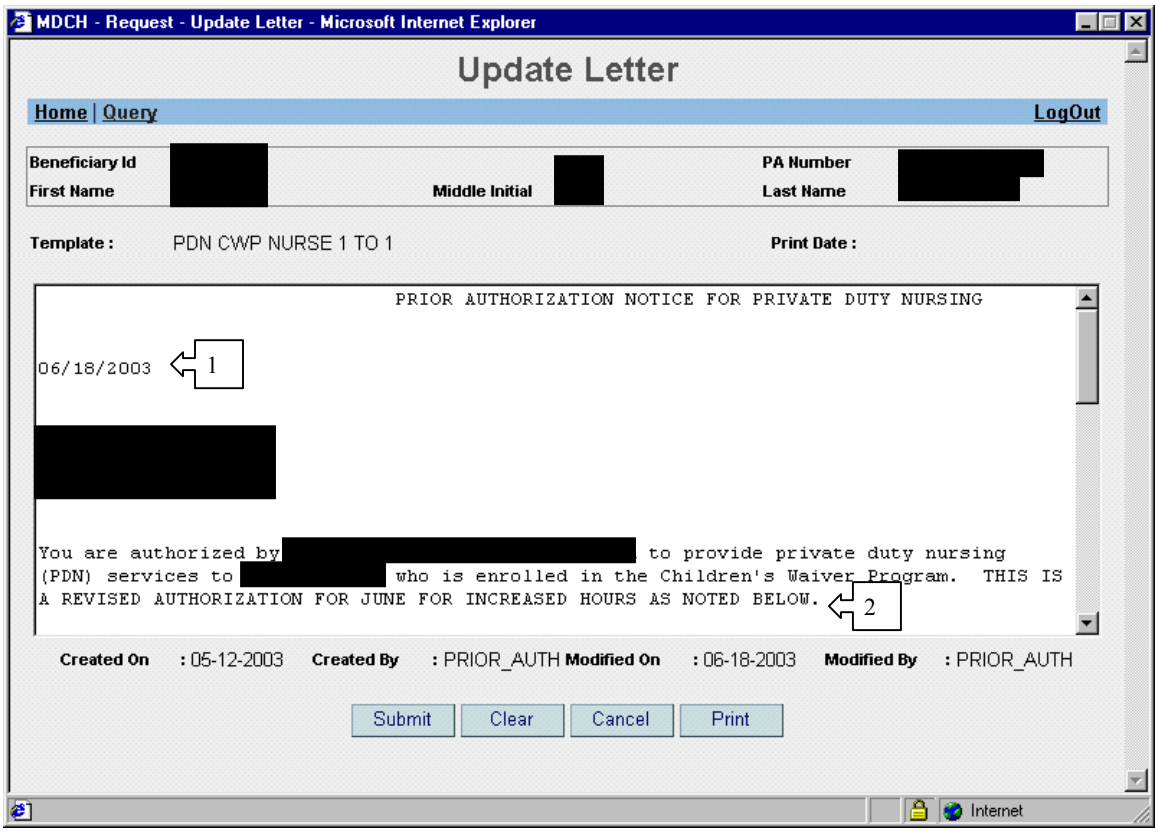


1. If you want to print a letter now, click on LETTERS.



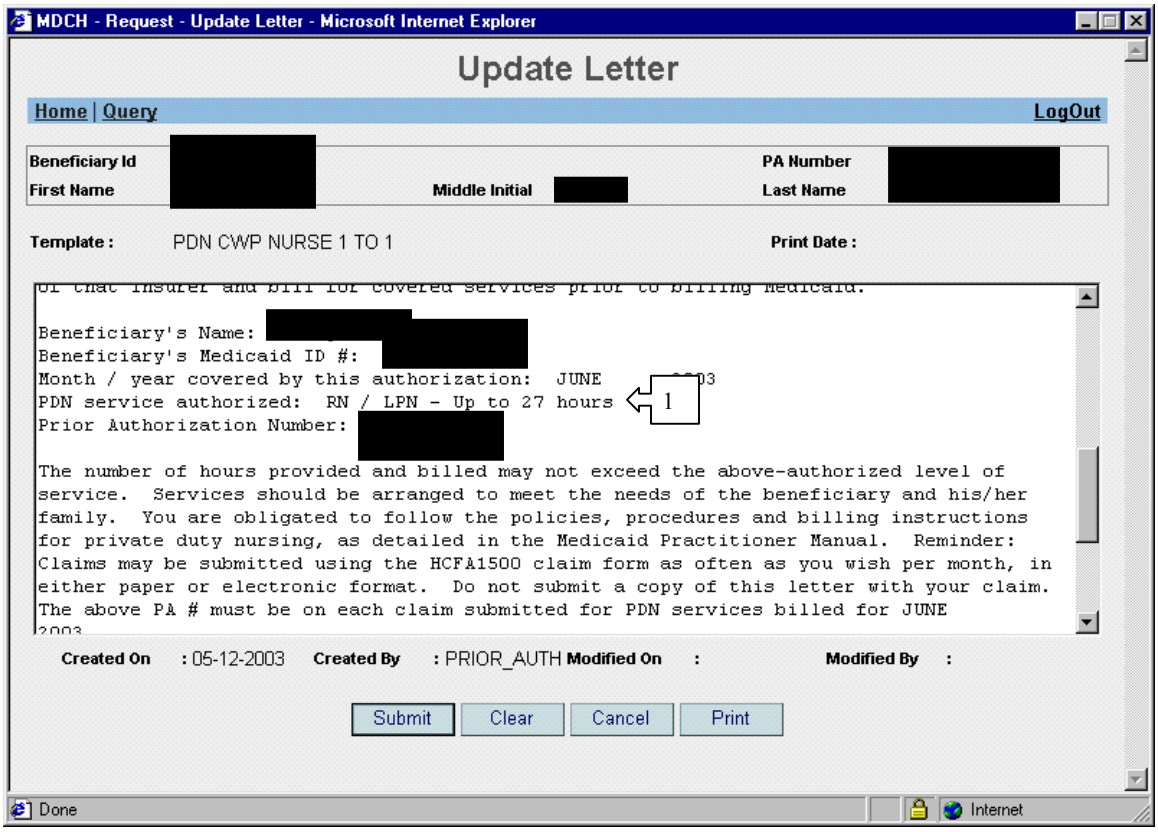
1. To change a letter you have previously issued, click on UPDATE/DELETE.

.

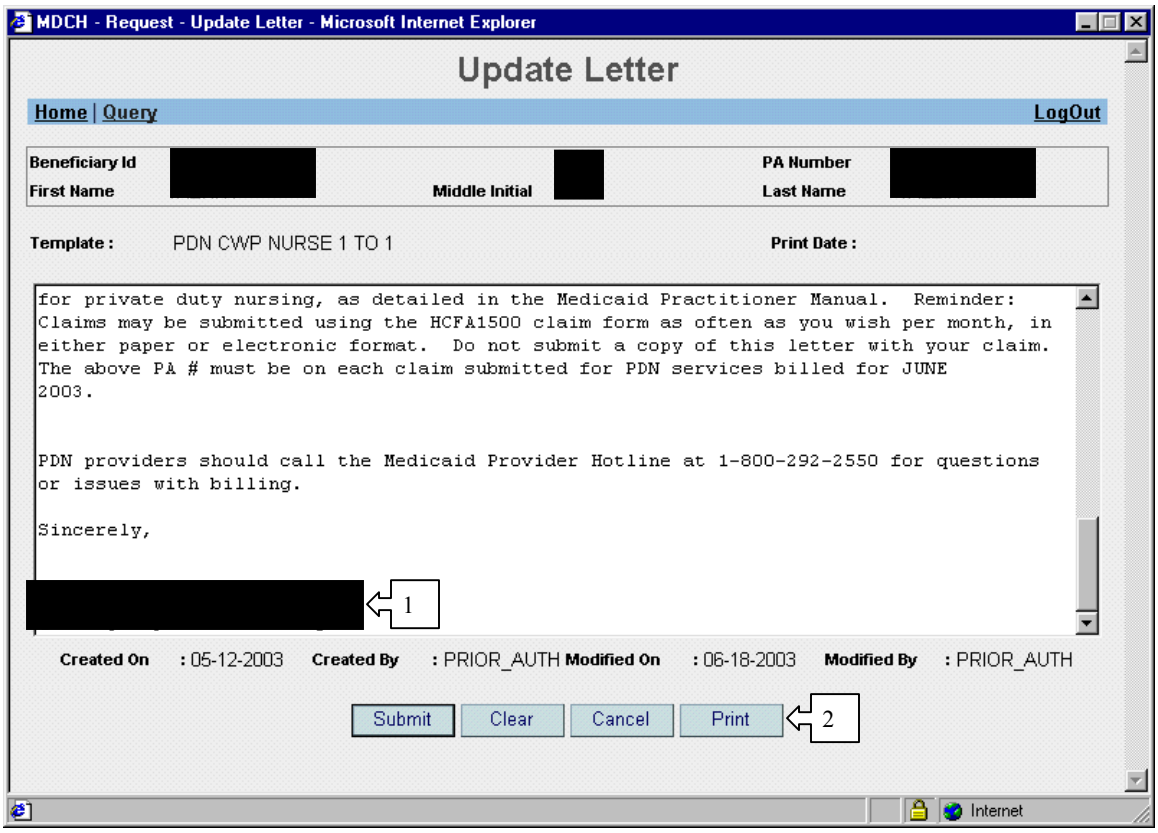


1. Change the date to today's date.

2. In the first paragraph of the letter, add a statement to alert the provider that this is a revised PA with new hours. NOTE: The PA# does not change; it is the same number you originally issued. The only change is the line item with new hours.

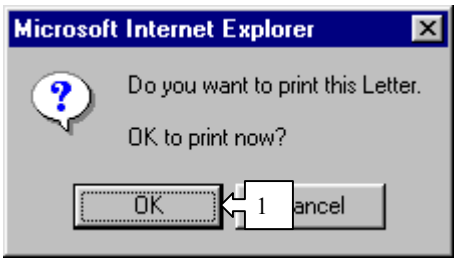


1. You will need to manually change the number of hours authorized because the letter still has the old hours in it.



1. If the person signing this revised letter is different than the original signature, change the name/title. Otherwise, you are ready to print the letter.

2. Click on PRINT to save & print the letter.



1. You will see this box pop up on top of the letter. Click OK. You have successfully printed a letter to advise the provider of a change in authorized hours.

SECTION FOUR: THE JULIAN CALENDAR

Julian Date Calendar (non-leap year)												
Day of Month	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	--	88	119	149	180	210	241	272	302	333	363
30	30	--	89	120	150	181	211	242	273	303	334	364
31	31	--	90	--	151	--	212	243	--	304	--	365

Trivia: A Julian Calendar is the calendar introduced by Julias Caesar in Rom in 46 B.C., eventually replaced by the Gregorian calendar.

Julian Date Calendar (leap year)												
Day of Month	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
1	1	32	61	92	122	153	183	214	245	275	306	336
2	2	33	62	93	123	154	184	215	246	276	307	337
3	3	34	63	94	124	155	185	216	247	277	308	338
4	4	35	64	95	125	156	186	217	248	278	309	339
5	5	36	65	96	126	157	187	218	249	279	310	340
6	6	37	66	97	127	158	188	219	250	280	311	341
7	7	38	67	98	128	159	189	220	251	281	312	342
8	8	39	68	99	129	160	190	221	252	282	313	343
9	9	40	69	100	130	161	191	222	253	283	314	344
10	10	41	70	101	131	162	192	223	254	284	315	345
11	11	42	71	102	132	163	193	224	255	285	316	346
12	12	43	72	103	133	164	194	225	256	286	317	347
13	13	44	73	104	134	165	195	226	257	287	318	348
14	14	45	74	105	135	166	196	227	258	288	319	349
15	15	46	75	106	136	167	197	228	259	289	320	350
16	16	47	76	107	137	168	198	229	260	290	321	351
17	17	48	77	108	138	169	199	230	261	291	322	352
18	18	49	78	109	139	170	200	231	262	292	323	353
19	19	50	79	110	140	171	201	232	263	293	324	354
20	20	51	80	111	141	172	202	233	264	294	325	355
21	21	52	81	112	142	173	203	234	265	295	326	356
22	22	53	82	113	143	174	204	235	266	296	327	357
23	23	54	83	114	144	175	205	236	267	297	328	358
24	24	55	84	115	145	176	206	237	268	298	329	359
25	25	56	85	116	146	177	207	238	269	299	330	360
26	26	57	86	117	147	178	208	239	270	300	331	361
27	27	58	87	118	148	179	209	240	271	301	332	362
28	28	59	88	119	149	180	210	241	272	302	333	363
29	29	60	89	120	150	181	211	242	273	303	334	364
30	30	--	90	121	151	182	212	243	274	304	335	365
31	31	--	91	--	152	--	213	244	--	305	--	366

CHILDREN'S WAIVER SERVICES COST SUMMARY - PART I

CHILD'S NAME _____ DATE OF BIRTH _____ MEDICAID ID # _____

CMHSP _____ (circle one) INTENSITY OF CARE: HIGH MEDIUM LOW

Case Manager _____ **OR** CATEGORY OF CARE 1 2 3 4

Please check one: ☐ Initial Budget (list month and year services are to begin) _____/1/_____ ☐ Annual Budget 10/1/_____

☐ Quarterly Budget (for Category I or "Yes" Enhanced) If quarterly, indicate the beginning month of that quarter ☐1/1/____ ☐4/1/____ ☐7/1/____

		Frequency In Billing Unit			Net Cost to Medicaid						
Service	**Providers**: Identify each discrete level of staff that will deliver services.	First month	Second Month	Third Month	Net Billable Units This Quarter	Cost Per Billing Unit	Total Cost This Quarter	(Less) Reimbursements from Non-MA Sources	Source	Projected Net Cost to MA This Quarter	Estimated Full Year Net Cost to MA
Targeted Case Management-billed per month (Frequency may not exceed 1 per month) This includes the following services that can no longer be billed separately: Assessments IPOS Planning Periodic Treatment Reviews											
Family Training (Previously Didactic Skill Training)											
Clinic Services											
Specialty Services Recreation Therapist Massage Therapist Music Therapist Art Therapist											

CHILDREN'S WAIVER SERVICES COST SUMMARY - PART I

CHILD'S NAME _____ DATE OF BIRTH _____ MEDICAID ID # _____

CMHSP _____ (circle one) INTENSITY OF CARE: HIGH MEDIUM LOW

Case Manager _____ **OR** CATEGORY OF CARE 1 2 3 4

Please check one: ☐ Initial Budget (list month and year services are to begin) _____/1/_____ ☐ Annual Budget 10/1/_____

☐ Quarterly Budget (for Category I or "Yes" Enhanced) If quarterly, indicate the beginning month of that quarter ☐ 1/1/___ ☐ 4/1/___ ☐ 7/1/___

		Frequency In Hours/Visits			Net Cost to Medicaid						
Service	**Providers**: Identify each discrete level of staff who will deliver services.	First month	Second Month	Third Month	Net Billable Hours/Session This Quarter	Cost Hour/Visit	Total Cost This Quarter	(Less) Reimbursements from Non-MA Sources	Source	Projected Net Cost to MA This Quarter	Estimated Full Year Net Cost to MA
Community Living Supports Skills related to: ADL's, Safety Skills, Mobility, Sensory Motor, etc.											
Respite Regular – billed per 15 minutes, but can be listed in hours for budget reporting Vacation Respite (per diem)											
Private Duty Nursing Implementation of IPOS by Hourly Care Staff LPN/RN											
Non-Family Training (previously Psychological/Behavioral) LLP/MSW/QMRP Monitoring, Supervision, Coaching											
Additional Clinic Services											

CHILDREN'S WAIVER SERVICES COST SUMMARY - PART II

CHILD'S NAME _____ DATE OF BIRTH _____ MEDICAID ID # _____

CMHSP _____ (circle one) INTENSITY OF CARE: HIGH MEDIUM LOW

Case Manager_____ **OR** CATEGORY OF CARE 1 2 3 4

Please check one: ☐ Initial Budget (list month and year services are to begin) _____/1/_____ ☐ Annual Budget 10/1/_____

☐ Quarterly Budget (for Category I or "Yes" Enhanced) If quarterly, indicate the beginning month of that quarter ☐ 1/1/____ ☐ 4/1/____ ☐ 7/1/____

***Specialized Medical Equipment, Supplies, and Environmental Accessibility Adaptation**	Purchase Price	Monthly Rental Cost	Total Cost This Quarter	(Less) Reimbursements From Non-MA Sources	Source	Projected Net Cost to MA This Quarter	Estimated Full Year Net Cost to MA
TOTAL							

* **Please Note**: List only those items that have received prior approval at the local level or by DCH.

Signatures

Case Manager/QMRP _____ **Date** _____

DCH CWP Director _____ **Date** _____

Michigan Medicaid
CMHSP Children's Waiver Services Database
Effective 10-1-03

CPT/ HCPCS	Description	Status	Fee Screen	Parameters
90782	INJECTION, SC/IM	A	$2.47	
90788	INJECTION OF ANTIBIOTIC	A	$2.69	
90801	PSY DX INTERVIEW	A	$89.72	
90802	INTERACTIVE PSY DX INTERVIEW	A	$95.33	
90804	PSYCHOTHERAPY, 20-30 MIN	A	$39.70	
90805	PSYCHOTHERAPY, 20-30 MIN W/ E&M	A	$44.64	
90806	PSYCHOTHERAPY, 45-50 MIN	A	$59.44	
90807	PSYCHOTHERAPY, 45-50 MIN W/ E&M	A	$64.15	
90808	PSYCHOTHERAPY, 75-80 MIN	A	$87.93	
90809	PSYCHOTHERAPY, 75-80, W/ E&M	A	$92.64	
90810	INTERACTIVE PSYCHOTHERAPY, 20-30 MIN	A	$42.84	
90811	INTERACTIVE PSYCHOTHERAPY, 20-30, W/ E&M	A	$48.00	
90812	INTERACTIVE PSYCHOTHERAPY, 45-50 MIN	A	$63.25	
90813	INTERACTIVE PSYCHOTHERAPY, 45-50 MIN W/ E&M	A	$68.41	
90814	INTERACTIVE PSYCHOTHERAPY, 75-80 MIN	A	$92.41	
90815	INTERACTIVE PSYCHOTHERAPY, 75-80 W/ E&M	A	$96.00	
90846	FAMILY PSYCHOTHERAPY W/O PATIENT	A	$58.32	
90847	FAMILY PSYCHOTHERAPY W/ PATIENT	A	$69.98	
90853	GROUP PSYCHOTHERAPY	A	$21.31	
90862	MEDICATION MANAGEMENT	A	$31.63	
92506	SPEECH/HEARING EVALUATION	A	$58.77	MAXIMUM OF 8 SESSIONS PER MONTH
92507	SPEECH/HEARING THERAPY	A	$46.65	MAXIMUM OF 8 SESSIONS PER MONTH
92508	SPEECH/HEARING THERAPY	A	$45.76	MAXIMUM OF 8 SESSIONS PER MONTH
92526	TREATMENT OF SWALLOWING DYSFUNCTION	A	$47.55	MAXIMUM OF 8 SESSIONS PER MONTH
96100	PSYCHOLOGICAL TESTING, PER HOUR	A	$40.82	
96105	ASSESSMENT OF APHASIA, PER HOUR	A	$40.82	
96110	DEVELOPMENTAL TEST, LIMITED	A	$12.07	
96111	DEVELOPMENTAL TEST, EXTENDED, PER HOUR	A	$40.82	
96115	NEUROBEHAVIORAL STATUS EXAM, PER HOUR	A	$40.82	
96117	NEUROPSYCH TEST BATTERY, PER HOUR	A	$40.82	
97001	PT EVALUATION	A	$41.72	
97002	PT RE-EVALUATION	A	$22.21	
97003	OT EVALUATION	A	$43.51	
97004	OT RE-EVALUATION	A	$29.38	
97110	THERAPEUTIC EXERCISES, EACH 15 MIN	A	$16.37	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
97112	NEUROMUSCULAR REEDUCATION	A	$17.05	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
97113	AQUATIC THERAPY	A	$17.94	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
97116	GAIT TRAINING THERAPY	A	$14.13	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
97124	MASSAGE THERAPY	A	$12.79	LIMIT OF 4 SESSIONS PER MONTH PER TYPE OF SPECIALTY SERVICES.
97140	MANUAL THERAPY, EACH 15 MIN	A	$15.25	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.

Michigan Medicaid
CMHSP Children's Waiver Services Database
Effective 10-1-03

CPT/ HCPCS	Description	Status	Fee Screen	Parameters
97150	GROUP THERAPY PROCEDURE(S)	A	$10.99	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
97520	PROSTHETIC TRAINING, EACH 15 MIN	A	$15.25	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
97530	THERAPEUTIC ACTIVITIES, EACH 15 MIN	A	$20.41	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
97532	DEVELOPMENT OF COGNITIVE SKILLS, EACH 15 MIN	A	$13.91	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
97533	SENSORY INTEGRATIVE TECHNIQUES, EACH 15 MIN	A	$14.80	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
97535	SELF-CARE/ HOME MANAGEMENT TRAINING, EACH 15 MIN	A	$18.39	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
97537	COMMUNITY/ WORK REINTEGRATION TRAINING, EACH 15 MIN	A	$14.80	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
97542	WHEELCHAIR MANAGEMENT/PROPULSION TRAINING, EACH 15 MIN	A	$15.25	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
97802	MEDICAL NUTRITION THERAPY, EACH 15 MIN	A	$10.32	
97803	MEDICAL NUTRITION THERAPY RE-ASSESMENT, EACH 15 MIN	A	$10.32	
97804	MEDICAL NUTRITION THERAPY, GROUP, EACH 30 MIN	A	$4.04	
99506	HOME VISIT FOR IM INJECTIONS	A	$5.87	
E1340	REPAIR OR NONROUTINE SERVICE FOR DME, PER 15 MIN	P	$0.01	PRIOR AUTHORIZATION REQUIRED
E1399	DME, MISCELLANEOUS	M	$0.01	LIMIT OF ONE SINGLE ROOM AIR CONDITIONER EVERY 5 YEARS WITH A MAXIMUM COST OF $400. USE THE REMARKS FIELD TO IDENTIFY THE ITEM.
G0176	ACTIVITY THERAPY, PER SESSION (45 MINS OR MORE)	A	$69.31	LIMIT OF 4 SESSIONS PER MONTH PER TYPE OF SPECIALTY SERVICES.
H0018	BEHAVIORAL HEALTH; SHORT-TERM RESIDENTIAL	A	$211.00	
H0034	MEDICATION TRAINING AND SUPPORT, PER 15 MIN	A	$10.32	
H2000	COMPREHENSIVE MULTIDISCIPLINARY EVALUATION	A	$192.00	MAXIMUM OF 5 SESSIONS PER MONTH PER BENEFICIARY.
H2015	COMP COMM SUPP SVC, 15 MIN	A	$3.77	
M0064	MONITORING OR CHANGING DRUG PRESCRIPTIONS	A	$14.13	
S0215	NON-EMERGENCY TRANSPORTATION; MILEAGE, PER MILE	A	$0.32	
S5111	HOME CARE TRAINING, FAMILY; PER SESSION	A	$66.02	
S5116	HOME CARE TRAINING, FAMILY; PER SESSION	A	$64.68	
S5151	UNSKILLED RESPITE CARE, NOT HOSPICE; PER DIEM	A	$356.40	MAXIMUM OF 14 DAYS PER YEAR FOR VACATION RESPITE
S5151/ TT	UNSKILLED RESPITE CARE, NOT HOSPICE; PER DIEM	A	$267.36	
S5165	HOME MODIFICATIONS, PER SERVICE	P	$0.01	PRIOR AUTHORIZATION REQUIRED
S5199	PERSONAL CARE ITEM, NOS, EACH	A	$100.00	LIMIT OF 5 ITEMS PER QUARTER WITH A MAXIMUM COST OF $100. USE REMARKS FIELD TO IDENTIFY THE ITEM(S)
S8990	PT OR MANIP FOR MAINT	A	$65.48	MAXIMUM OF 8 SESSIONS PER MONTH FOR COMBINED PT & OT PROCEDURE CODES.
S9445	PATIENT EDUCATION, NOC, INDIVIDUAL, PER SESSION	A	$25.02	
S9446	PATIENT EDUCATION, NOC, GROUP, PER SESSION	A	$12.50	
S9470	NUTRITIONAL COUNSELING, DIETITIAN VISIT	A	$25.50	
S9484	CRISIS INTERVENTION MENTAL HEALTH SVC, PER HOUR	A	$46.26	
T1001	NURSING ASSESSMENT/ EVALUATION	A	$48.09	
T1002	RN SERVICES, UP TO 15 MIN	A	$10.32	

Michigan Medicaid
CMHSP Children's Waiver Services Database
Effective 10-1-03

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T1005	RESPITE CARE SVC, UP TO 15 MIN	A	$3.71	
T1005/ TD	RESPITE CARE SVC, UP TO 15 MIN	A	$7.99	
T1005/ TE	RESPITE CARE SVC, UP TO 15 MIN	A	$6.79	
T1999	MISCELLANEOUS THERAPEUTIC ITEMS & SUPPLIES, NOC	A	$25.00	ONLY ADAPTIVE TOYS CAN BILLED UNDER THIS CODE. LIMIT OF ONE ADAPTIVE TOY PER QUARTER WITH A MAXIMUM COST OF $25.00. USE TIHE REMARKS FIELD TO IDENTIFY TH E ITEM.
T2023	SUPPORTED EMPLOY, PER 15 MIN	A	$303.72	THE DATE OF SERVICE SHOULD BE THE LAST DAY OF THE MONTH THAT THE CASE MANAGEMENT SERVICE WAS PROVIDED.
T2028	SPECIALIZED SUPPLY, NOT OTHERWISE SPECIFIED, WAIVER	A	$100.00	LIMIT OF 5 ALLERGY CONTROL SUPPLIES PER QUARTER WITH A MAXIMUM COST OF $100. USE THE REMARKS FIELD TO IDENTIFY THE ITEM(S).
T2029	SPECIALIZED MEDICAL EQUIPMENT, NOT OTHERWISE SPECIFIED, WAIVER	A	$250.00	LIMIT OF 5 ENVIRONMENTAL SAFETY & CONTROL DEVICES PER QUARTER WITH A MAXIMUM COST OF $250. USE THE REMARKS FIELD TO IDENTIFY THE ITEM(S).
T2039	VEHICLE MOD WAIVER/ SERVICE	A	$5,500.00	MAXIMUM COST FOR VAN LIFTS & TIE-DOWNS IS $5,500, ONCE EVERY 5 YEARS. PRIOR AUTHORIZATION IS REQUIRED IF THE COST EXCEEDS $5,500 OR WHEN REPLACEMENT IS NEEDED BEFORE 5 YEARS. ALL OTHER VEHICLE MODIFICATIONS REQUIRE PRIOR AUTHORIZATION.