Medical Necessity

Why is it important and what role do providers play?

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Objectives

- Review the definition of Medical Necessity
- Provide an overview on the Utilization Review (UR) process
- Understand importance of provider input/documentation

Medical Necessity

Michigan Medicaid Provider Manual (MPM)

- Determination that a specific service is
  - medically (clinically) appropriate
  - necessary to meet needs
  - consistent with the person's diagnosis, symptomatology and functional impairments
  - is the most cost-effective option in the least restrictive environment
  - is consistent with clinical standards of care.
- Medical necessity of a service shall be documented in the individual plan of service

Determination Criteria

THE DETERMINATION OF A MEDICALLY NECESSARY SUPPORT, SERVICE OR TREATMENT MUST BE:

- ***BASED ON INFORMATION PROVIDED BY THE BENEFICIARY, BENEFICIARY'S FAMILY, AND/OR OTHER INDIVIDUALS (E.G., FRIENDS, PERSONAL ASSISTANTS/AIDES) WHO KNOW THE BENEFICIARY***

- **BASED ON CLINICAL INFORMATION FROM THE BENEFICIARY'S PRIMARY CARE PHYSICIAN OR HEALTH CARE PROFESSIONALS WITH RELEVANT QUALIFICATIONS WHO HAVE EVALUATED THE BENEFICIARY (APPROPRIATELY TRAINED MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, OR SUBSTANCE ABUSE PROFESSIONALS WITH SUFFICIENT CLINICAL EXPERIENCE);**

- **FOR BENEFICIARIES WITH MENTAL ILLNESS OR DEVELOPMENTAL DISABILITIES, BASED ON PERSON CENTERED PLANNING, AND FOR BENEFICIARIES WITH SUBSTANCE USE DISORDERS, INDIVIDUALIZED TREATMENT PLANNING;**

- **MADE WITHIN FEDERAL AND STATE STANDARDS FOR TIMELINESS;**

- **AND SUFFICIENT IN AMOUNT, SCOPE AND DURATION OF THE SERVICE(S) TO REASONABLY ACHIEVE ITS/THEIR PURPOSE.**

Key Components

Diagnosis

- What is the ICD-10 (DSM-V) diagnosis?

Symptoms and Severity

- What are the clinically ***significant functional impairments** associated with the diagnosis that are being targeted?

Treatment Plan

- What goal-oriented interventions are being provided to alleviate symptoms and improve functioning?

Continuity of Care

- Interventions must be part of a coordinated treatment plan.

Ok.....can you synthesize that information down?

A Medical Necessity Determination or statement helps establish whether a specific medical treatment, service, or intervention is needed for an individual based on their medical condition, clinical need, and expected benefit.

Assessing Clinical Need for Behavioral Health Services

Functional Impairment

- Assess the impact of the condition on daily living
  - Performance of Major Life Activities (PMLA)
  - Review participation in meaningful daytime activity (work, volunteer, social opportunities)
  - Review any current paid supports, unpaid supports

Safety and Risk

- Evaluate current risk of harm to self or others
  - Standardized assessments (CSSR-S, PHQ-9, etc.)
  - Mental Status Exam
  - Feedback from individual, natural supports, other service providers

Treatment Progress

- Evaluate response to treatment ongoing
  - Review for acquisition of skills, achievement of IPOS goals
  - Regular progress updates will either support continued medical necessity or give clues that transition into other services and supports is more appropriate based on current clinical factors

Utilization Review

*A **PROCESS** THAT EVALUATES THE APPROPRIATENESS, NECESSITY, AND EFFICIENCY OF SERVICES PROVIDED TO ENSURE PATIENTS RECEIVE THE RIGHT CARE AT THE RIGHT TIME, WHILE MANAGING COSTS AND IMPROVING QUALITY.*

- UR is NOT delegated solely to the UM team.

- The UM team reviews a subset of authorizations. To prepare:
  - Ensure pre-reviews were requested/completed as required (Self-determination arrangements)
  - Documentation needs to align- psychosocial assessment, standardized assessments, progress notes, provider notes related to services like CLS/Supported Employment/Respite, etc. The level of care needs to be consistent across all of these documents
  - Documentation should explain the “why” for prior utilization concerns (over/under)
  - The Michigan Medicaid Provider Manual and MDHHS Code Reporting chart will always dictate the boundaries in which services will be reviewed
  - **Medicaid is payor of last resort**

- Any UR review needs has to ensure services provided are helping the individual work toward the goals identified in the IPOS by targeting the functional impairments noted to be a barrier to achieving the goals outlined in the plan

Documentation Best Practices

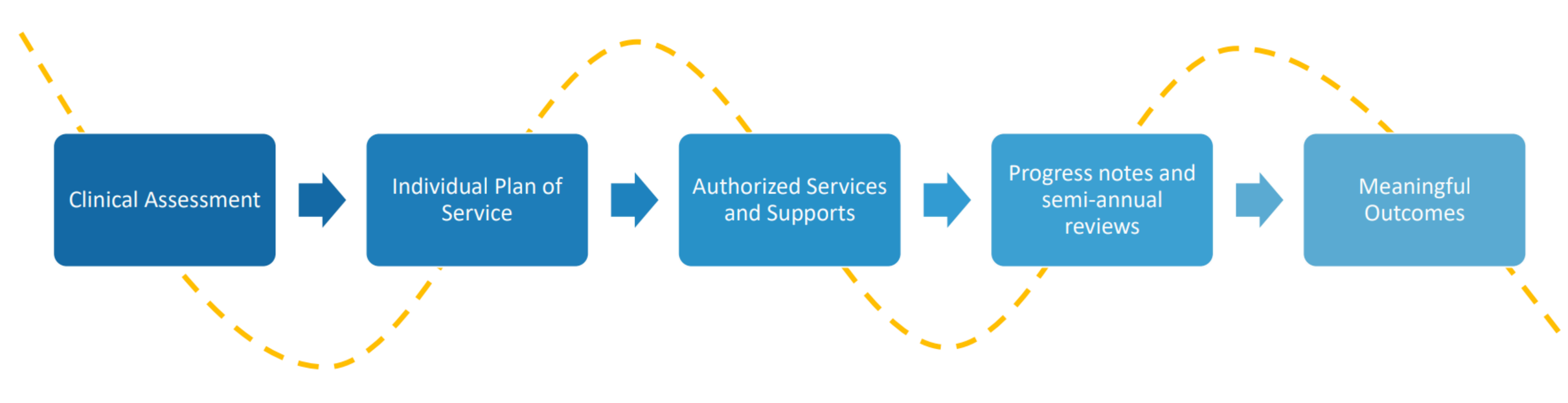
- Improve care of the individual/justifies need for treatment
- Coordinate services
- Furnish sufficient services
- Comply with regulations/protects against Medicaid audits
- Support claims billed
- Reduce improper payments/supports appropriate reimbursement

Centers for Medicare and Medicaid (CMS)

Progress notes

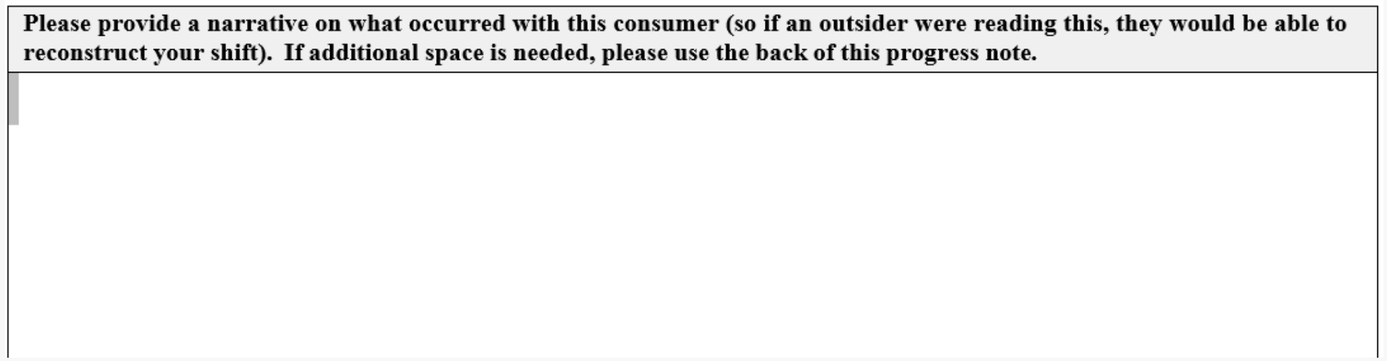
- Update on progress toward IPOS goals/objectives
- Document any utilization issues and “why”
- Document any relevant risk assessment issues
- Discuss any outside referrals/transition planning in progress
- **Progress notes evidence continued need for care**

Golden Thread



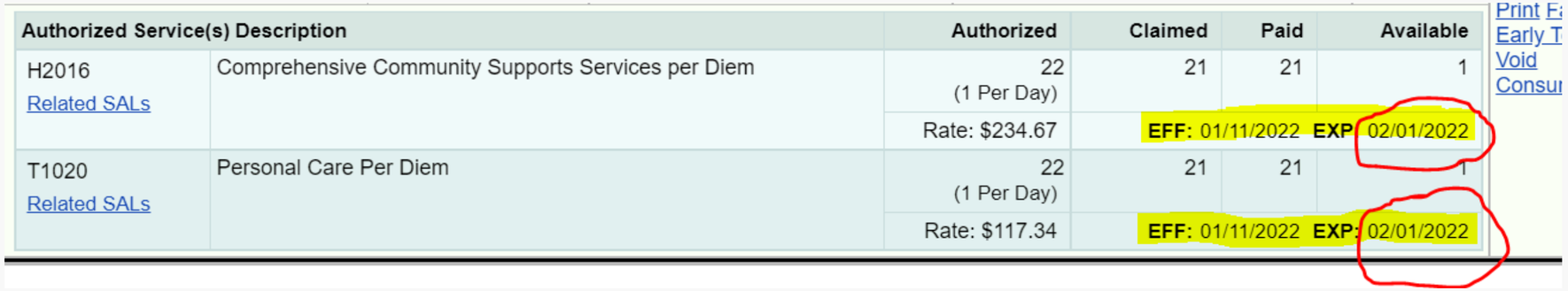
Avoid These Documentation Pitfalls

- Vague descriptions (e.g., “Client doing better”, “took individual to the store”, “helped cook meals”)
- Copy-pasting progress notes
- Not tying progress (or lack of) back to treatment goals
- Inaccurate start/stop times
- Adding Home Help time (DHHS) into CMHCM claim submissions



How Do Providers Support Medical Necessity?

- **Communicate with CMHCM treatment team (authorization is ending soon, support needs have changed in any way, reason services are not being provided as authorized)**
- Provide clear documentation on supports provided to the individual. This helps not just to document services provided as authorized but also to assist with determination of supports needed ongoing
- Ensure all staff are adequately trained on the Individual Plan of Service (IPOS). Ask questions if anything is unclear
- Ensure there is an active authorization in place BEFORE providing services



Authorized Service(s)	Description	Authorized	Claimed	Paid	Available
H2016 Related SALs	Comprehensive Community Supports Services per Diem	22 (1 Per Day)	21	21	1
		Rate: $234.67	EFF: 01/11/2022 EXP: 02/01/2022		
T1020 Related SALs	Personal Care Per Diem	22 (1 Per Day)	21	21	1
		Rate: $117.34	EFF: 01/11/2022 EXP: 02/01/2022		

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Corporate Compliance/Office Inspector General

The Office of Inspector General (OIG) is the criminal justice agency within the Michigan Department of Health and Human Services (MDHHS) providing program integrity services. OIG agents provide investigation and advisory services to ensure appropriate and efficient use of available public resources in the State of Michigan.

- **The Integrity Division conducts investigations into alleged Medicaid fraud, waste and abuse and receives referrals from the public, beneficiaries, providers and other government and/or state law enforcement and regulatory agencies.**

Examples of health services provider fraud, waste and abuse:
Billing for medical services not actually performed.
Billing for unnecessary services.
Billing for more expensive services than actually performed.
Billing for services separately that should legitimately be one billing.
Billing more than once for the same medical service.
Dispensing generic drugs but billing for brand-name drugs.
Billing for supplies/medication not dispensed.
Giving or accepting something of value (e.g., cash, gifts, services) in return for medical services and/or patient referrals (i.e., kickbacks).

- CMHCM Corporate Compliance Officer: Renee Raushi , COO rraushi@cmhcm.org

Resources

- CMHCM > Providers
  - Policies, forms, trainings, HCBS resources
- CMHCM Provider Network Team
- Medicaid Provider Manual
  - https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

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