Illinois Department Human Services/Division of Mental Health
UTILIZATION MANAGEMENT PROGRAM
(FY14)

Introduction

This document provides an overview of the Illinois Department of Human Services/Division of Mental Health (DHS/DMH) Utilization Management Program (UM Program). The primary focus of this UM Program is to ensure quality services and compliance with Rule 132 standards. Specifically, this is the vehicle through which DHS/DMH ensures that individuals being served receive

- the services best suited to support their recovery needs and preferences,
- cost effective services in the most appropriate treatment setting, and
- services consistent with medical necessity criteria and evidence-based practices.

By implementing the UM Program, DHS/DMH strives to achieve a balance between the needs, preferences, and well-being of persons in need of mental health services, demonstrated medical necessity, and the resources available to serve their needs. The DHS/DMH UM Program has been developed in collaboration with the Department of Healthcare and Family Services, the State Medicaid agency.

Guiding Principles of Utilization Management

In developing the UM Program, DHS/DMH acknowledges the following principles:

- **Utilization Management is a dynamic, quality improvement process** As additional data, new research, and other new information becomes available, the UM Program will evolve and change.
- **Utilization Management must be based on data**. The UM Program must use data to identify patterns of utilization, work with clinicians to determine if the patterns and variations are desirable or not, and work with providers to make needed improvements.
- **Individuals accessing services should have a consistent threshold of medical necessity statewide**. The UM Program must operate in concert with the definition of Medical Necessity and additional guidance provided by DHS/DMH to ensure all individuals accessing services have consistent and equitable access to services.
- **Utilization Management should strive to minimize administrative costs where possible**. The UM Program will seek to limit authorization activities to services with a demonstrated need for Utilization Review.
- **Authorization must be clinically focused and conducted by qualified staff**. Where authorization is determined to be necessary, it must be based on clinical information and reviewed by staff at the independent license level (LPHA).

- **Utilization Management should primarily focus on outliers**. Patterns of underutilization and overutilization should be identified, with clinical review and management protocols focused on outliers to ensure that service utilization patterns are appropriate to the recovery needs of the individuals being served.

UM Program Components

The DHS/DMH Utilization Program has the following components:

1. **Medical Necessity Guidance**. Consistent with Rule 132, DHS/DMH is providing enhanced Medical Necessity Guidance as a component of the State of Illinois Community Mental Health Services Definition and Reimbursement Guide for the following Rule 132 services:
    a. Assertive Community Treatment (ACT) – adult only
    b. Community Support Team (CST) – adult and youth versions
    c. Psychosocial Rehabilitation (PSR) – adult only
    d. Community Support Group (CSG) – adult and youth versions
    e. Therapy Counseling (TC) – adult and youth versions
    f. Community Support Individual (CSI) – adult and youth versions

    This guidance should be used by providers in making consistent treatment decisions with consumers. This guidance is to be used for each consumer, regardless of whether or not DHS/DMH or its designee externally authorizes the service. Provider adherence to this guidance may be subject to post payment review.

2. **Limited External Authorization**. Authorization for payment by DHS/DMH or its designee will be required for specific services, based on a review of service utilization patterns for the previous fiscal year. Exhibit 1 identifies the services that continue to require authorization as well as those services for which authorization thresholds will be phased in during FY2011. This includes both the type of authorization and the circumstances under which authorization is necessary.

    A. Initial and Continuing Authorizations for ACT and CST. At this time, DHS/DMH will continue to require both admission and continuing service authorization for ACT and CST.

    B. Authorization Thresholds. Rather than requiring admission authorization and periodic reauthorization thereafter for all services, DHS/DMH is minimizing

administrative burden on providers by applying clinical review thresholds.

1. For the services with authorization thresholds, DHS/DMH will be phasing in clinical review and authorization when the number of services received by an individual exceeds at least the 75th percentile, as compared to all users of that service statewide from analysis of FY09 utilization data. In other words, authorization will only be required on outliers. This means that at least 75% of existing consumers are not expected to require authorization for their services because their utilization, based on historical patterns, will not exceed the clinical review threshold.
2. Authorizations for these services will be based on the current fiscal year. For clients already receiving a service prior to the beginning of the fiscal year, only those services provided on or after the first day of the new fiscal year will be included in computing when the person would meet the threshold for authorization.

C. Appeals. Consistent with Rule 132, if DHS/DMH, or its designee, and the provider are unable to concur on authorization decisions, the provider may initiate an appeal. Instructions regarding the appeal process will be included in the notification of authorization denial.

3. **Service Definition Fidelity Review**. DHS/DMH will continue its process of service definition fidelity review to ensure that consumers are receiving the services as defined in the Medicaid State Plan, Rule 132, and evidence based practices as applicable. This will be accomplished by the continuation of periodic focused reviews on services (e.g. PSR, ACT, CST), as well as through the incorporation of service fidelity elements in the service authorization process where applicable.

4. **Post Payment Review**. DHS/DMH conducts post payment review at least annually with each provider. This process ensures that the services provided and the claims submitted for payment are documented and billed in compliance with applicable federal and Illinois rules and regulations. Applicable items reviewed in and results from the post payment review will support the UM Program and contribute to the UM Program's ongoing

Quality Improvement efforts. Outlier patterns in utilization may be used to inform additional Post Payment Review focus.

5. **Ongoing Data Reporting and Analysis**. DHS/DMH will continue to report and analyze utilization patterns, post payment review results, authorization impacts, and other quantitative and qualitative aspects of service delivery. These data will be used to inform provider technical assistance efforts, training, and future UM Program modifications.

Exemptions from the UM Program

1. Individual Care Grant (ICG) Services (Rule 135): Eligibility determinations and authorization processes for services governed by Rule 135 and funded through the ICG service line remain unchanged. Further information on this process can be obtained from the ICG manual at: http://www.illinoismentalhealthcollaborative.com/provider/prv_fy11_manual.htm

2. Screening, Assessment and Support Services (SASS): Rule 132 Services provided to children or youth during their SASS eligibility period will not be included in the UM Program review or used for setting the thresholds for UM program authorization.

EXHIBIT 1 – Service Authorization Matrix

The following table summarizes the services for which authorization is required at admission and/or at subsequent clinical review thresholds.

Thresholds are the same for adults and children/adolescents and are calculated by provider and consumer per fiscal year. This means that any services provided prior to the beginning of the fiscal year are not included when calculating thresholds for services. Providers are required to obtain authorization prior to receiving reimbursement for services delivered to consumers beyond the specified thresholds. Authorization for reimbursement will be made based upon the medical necessity of the consumers.

For purposes of determining clinical review thresholds, PSR and CSG utilization will be managed as a combined benefit. Clinical review and continuing service authorization will be required whenever an individual's combined utilization of PSR and CSG exceeds 800 units per fiscal year, with recognition that an individual may use one or both of these services during the year.

Service	Admission Authorization Required?	Continuing Service Authorization Required?
ACT	Yes	Yes
CST	Yes	Yes
PSR	Not for first 800 units (combined PSR and CSG) each fiscal year	Yes, for services beyond 800 units (combined PSR and CSG) each fiscal year
CSG		
Therapy Counseling	Not for first 40 units each fiscal year	Yes, for services beyond 40 units each fiscal year