COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN/PIHP	*Policy and Procedure* *Timeliness of Service Provision and Documentation*
Department: Clinical Performance Team **Author:**	**Local Policy Number (if used)**
Approval Date **7/24/17**	**Implementation Date** **8/1/17**

I. PURPOSE

To establish standards of timeliness for the provision of care, treatment, and services, and the documentation of those services, to ensure the continuity of care.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
2014	1	Revised to reflect the new regional entity.
May 2017	2	3-year review

III. APPLICATION

This policy applies to all staff, students and contractual organizations within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

All programs and services provided directly by the CMHPSM or through contractual agreements with service providers are obligated to follow these guidelines.

IV. POLICY

The provision and documentation of all care, treatment, and services shall be done in a timely manner. Service provision and documentation should occur in compliance with Michigan Department of Community Health (MDCH), and applicable accreditation standards.

V. DEFINITIONS

Adverse Benefit Determination: (1) A denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized or previously provided covered service; (3) The denial, in whole or in part, of payment for a covered service; (4) The failure to make an authorization decision and provide notice about the decision, within standard time frames; (5) The failure to provide authorized services within the standard timeframe; or (6)The failure of the CMHSP or the CMHPSM to act within the timeframes required for disposition of grievances.

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for

mental health, intellectual/developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports for people with mental health, intellectual/developmental disabilities, and substance use disorder needs.

VI. STANDARDS

A. Program/Service Specific Standards

1. Habilitation Waiver Certifications must be completed every 12 months. The Individual Plan of Service (IPOS) for individuals enrolled in the Habilitation Services Waiver must be updated within 365 days of their last IPOS.

2. Physician prescriptions (orders) must be obtained prior to the services of Occupational Therapy and Physical Therapy, as outlined in the Medicaid Provider Manual.

B. Intake/Initial Assessments

1. Initial requests for services, phone call screens or walk-ins, must be documented in the electronic health record within 1 business day of the contact.

2. The initial assessment screen must be completed within 1 business day of the contact.

3. The initial assessment process, which includes documentation of the initial assessment and initial authorization for services, must be completed within 14 calendar days of the initial request for services. The initial assessment documentation must be completed within 2 business days of the assessment, as long as that documentation does not exceed the aforementioned 14 calendar days.

4. Once the assessment is completed and a service was authorized, the assigned staff must provide service to the consumer within 14 calendar days, unless the consumer or legal guardian has requested a later start date. If a request for a later start date has occurred, staff will ensure this request is documented in the consumer's clinical record.

5. Documentation of the initial meeting with the assigned staff must occur within 1 business day of the contact.

C. Assessments/Re-assessments

1. An annual assessment of need/re-assessment must occur prior to a new annual. Documentation of an annual assessment/re-assessment must be completed within 2 business days of the completion of the assessment.

2. All specialty service (Occupational Therapy, Speech and Language Therapy, Nursing, Psychology, Physical Therapy) assessment documentation must be completed within 2 business days of the completion of the assessment process.

3. Psychiatric assessment documentation must be completed within 2 business days of the completion of the assessment.

D. Progress Notes

1. Progress notes completed by clinical staff (management, hospital and jail liaisons, case managers, supports coordinators, therapists, psychiatrists, psychologists, nurses, occupational therapists, physical therapists, and speech and language therapists) must be completed within 1 business day of the care, treatment, or service.

2. Progress notes and other documentation for Community Living Support/Personal Care services provided in a Specialized Residential group home, for Skill Building services, for Supported Employment services, and for Community Living Support services must be completed by staff that provided the service by the end of their shift.
   ***Exceptions are for Supported Employment Enclaves, Supported Employment Work crews, or for Skill Building services whereby the activities are scheduled for a work week. For those exceptions, the staff providing the service must complete documentation of the service provision no less than weekly, unless otherwise specified in the Individual Plan of Service (IPOS) or other contractual agreement.

3. Progress notes and other documentation for respite services must be completed by staff that provided the service within 24 hours from the date of the service.

E. Person Centered Planning (PCP) process

1. The periodic reviews and the annual reviews of the IPOS must be completed and signed, by the assigned staff, in the electronic health record within 14 calendar days of a contact.

2. The Pre-plan must be completed and signed, by the assigned staff, in the electronic health record within 1 business day of the contact. The Pre-plan meeting cannot occur on the same day as the Person Centered Planning meeting (the exception is the Single-Service Plan of Service.)

3. The Pre-plan must occur prior to the Person Centered Planning meeting. Ideally, staff should start the planning process 30 days before the expiration date of the current IPOS, but not later than 14 days, to assure consumers have enough time to choose an independent facilitator and to arrange the Person Centered Planning meeting.

4. All consumers must have a current IPOS that is completed annually. An IPOS cannot exceed beyond 365 days. If a new IPOS cannot begin by the expiration date of the current IPOS due to consumer emergency or other consumer barriers, a new short term or engagement plan of service shall be developed. A short term/engagement plan of service shall not exceed 3 months. The start date of the short term/engagement plan of service will be the day after the current IPOS.

5. Any IPOS for consumers enrolled in a specific waiver program (Children's Waiver Program, Children's SED Waiver or the Habilitation Supports Waiver cannot exceed 365 days, therefore a new IPOS must begin at the point the previous IPOS has expired.

6. The IPOS documentation must be completed and a copy sent to the consumer within 15 business days after the effective date of the IPOS. Staff will note in the electronic record whether the consumer was provided with a copy of the IPOS by mail or hand delivered. Documentation must be completed within 1 business day of the date the IPOS was hand-delivered or mailed to the consumer.

7. Provision of care, treatment, and services authorized in IPOS must occur within 14 calendar days of the start date of the authorization for a service, unless the consumer or legal guardian has requested a later start date. If a request for a later start date has occurred, staff will ensure this request is documented in the consumer's clinical record.

8. Staff implementing the IPOS must be in-serviced within 30 days of its effective date. Documentation must occur within 1 business day of the in-service.

9. A periodic review of the IPOS must be completed at the frequency identified in the IPOS and/or as was requested by the consumer. A periodic review must occur no later than 6 months from that start date of the IPOS. A periodic review may occur prior to this date when a significant event occurs or to amend the IPOS If a periodic review results in revision of an IPOS, completion of the revised IPOS must occur within 14 calendar days of the periodic review.

F. Utilization management:

1. All service authorization decisions related to an IPOS, (annual IPOS, periodic review, or other IPOS revision) must be completed within the 14-day timeframe from when the relevant IPOS review was completed with the consumer/family.

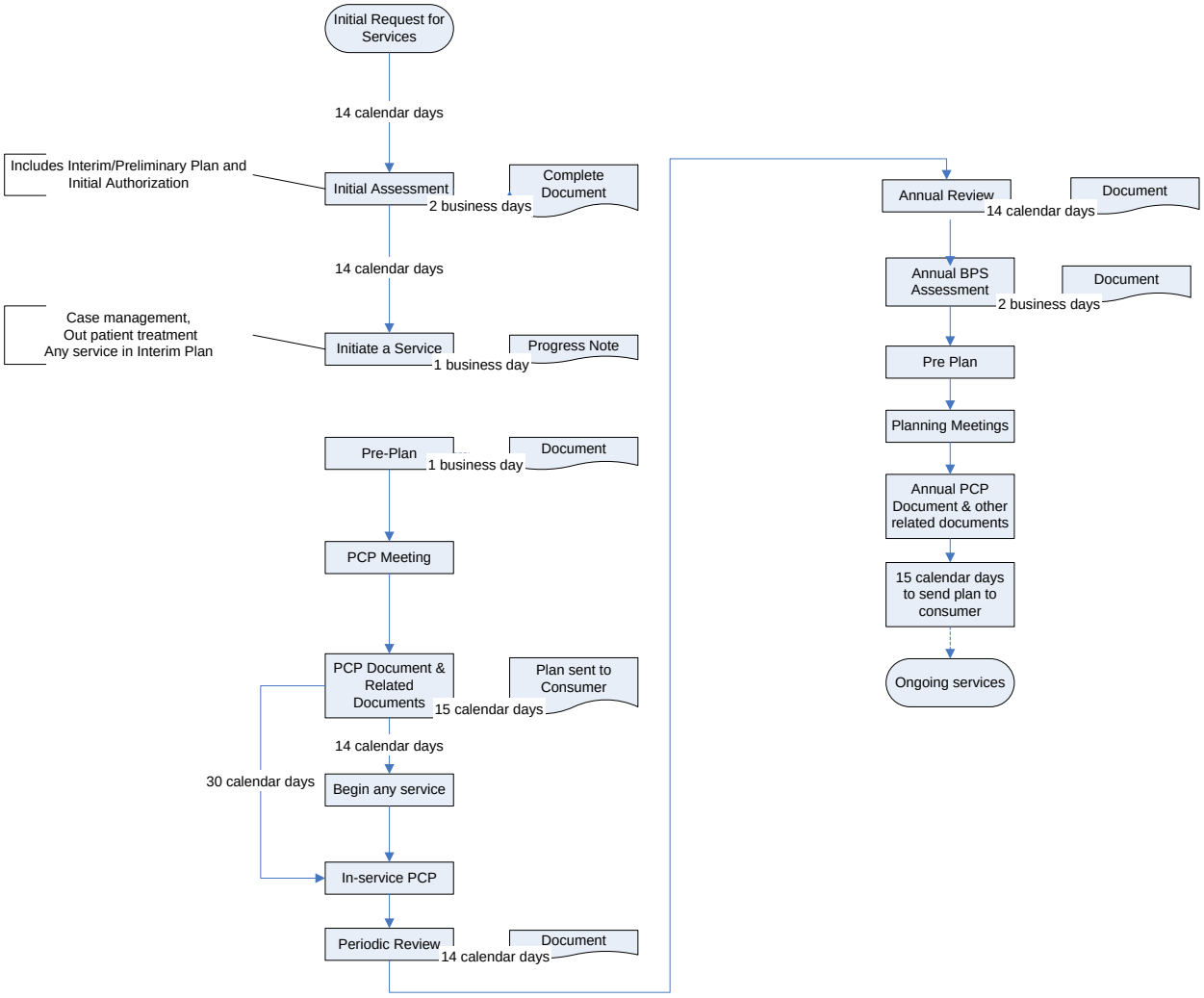
2. If a service authorization decision related to an IPOS exceeds the 14-day time frame, the proper notice of an adverse benefit determination will be provided to the consumer/legal representative
3. Any adverse benefit determinations will follow state and federal requirements, as outlined in the CMHPSM Consumer Appeals Policy

VII. EXHIBITS

Flowchart

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
42 CFR Parts 400 et al. (Balanced Budget Act)	X	438.208 (B) (C)
Michigan Mental Health Code Act 258 of 1974	X	330.1409 (1-7), 330.1700(g), 330.1707 (1-5), 330.1712 (1-3)
Joint Commission Standards	X	
MDHHS PIHP Contract	X	
MDHHS CMHSP Contract	X	
CMHPSM Consumer Grievance and Appeal Policy	X	
OBRA Operations Manual-MDCH	X	
Deficit Reduction Act	X	
Patient Protection and Affordable Care Act	X	



*GRIEVANCE AND APPEAL TIMEFRAMES CAN OCCUR ANY TIME IN THE PLAN OF SERVICE CYCLE.