Region 10 PIHP UM Redesign Pilot Project Parking Lot
Pilot Project Kiosk and Q/A
Update 10/23/19
Post-Pilot Project Evaluation Report

Questions/Concerns from the Trainings	Response	Disposition	Follow-Up Entity
How will case holders know when their authorizations are running out? Currently, if they run out of authorizations they simply enter more, and the supervisor approves.	There is no need for the PIHP to act on this issue, as there is a section in OASIS that informs the case holders regarding current to-date service utilization; also, there may be a local CMH training opportunity in OASIS navigation and routine monitoring.	Resolved	NA
Regarding time-based service authorizations – Can the case holder request a total amount of units for services that have different HCPCs based on time (e.g. Individual Therapy per 30 minutes, 45 minutes and 60 minutes)?	***This is pending a response from PCE and there is the prospect this may be discussed between the CMHs and PCE***	***Pending***	***CMHs, PCE, R10***
Wraparound Community Team (CT) – What if the CT accepts a case that Region 10 UM determines to be not eligible for Wraparound?	The use of CTs has never emerged as a regional concern as these local administrative entities apply structured review and consensus process to help establish rational parameters around excessive or uninformed authorization requests. CTs may continue as within the person-centered planning process and as informed by SAG COC information, and accordingly, any UM would follow that internal process. Any disagreements should be resolved between the CMHSP and Region 10 UM.	Resolved	NA

LOCUS Score/ACT +1, and Inpatient utilization concern – the current SAG COC model will likely under-assess the needs of an ACT individual because he/she will likely not have any recent hospitalizations due to intensive supports being offered and/or due to LOCUS score being lower due to intensive supports being offered	Region 10 recognizes these concerns and they will be monitored and assessed, moving forward, mindful of what is in the best interests of the individual. These will be opportunities for clinical judgement and rationale to help inform and resolve such concerns. And so, as the case holder selects the overall SAG COC category, he/she can ensure the most appropriate category is assigned, regardless of what category aligns with the LOCUS score and the previous acute/crisis service utilization.	Resolved	NA
Add "No previous service utilization" (for acute/crisis services).	Region 10 will add an item to this section that states "no acute or crisis service utilization in the past 12 months".	Resolved	TBDS, CCO
How should IMH be handled, as this population does not use PECFAS/CAFAS.	Region 10 will exempt IMH case holders from the Pilot activities. It will confer with IMH supervisors and champions to help create service authorizations for this population (birth through age 4 in the in the upcoming months.	Resolved	CCO, TBDS

As Sanilac currently authorizes all services for 12 months, case holders ask what to do for those services on the service grid that have a six-month maximum authorization duration, since these authorizations during the pilot will expire in November, December, or January.	The Pilot will operate with the current SAG services grid durations.	Resolved	NA
Fix the typo, "minimal" in the under-utilization section.	This was not a typo, but it is confusing, and it will be rewritten for greater clarity.	Resolved	TBDS, CCO
Add clinical descriptions to final section.	The vast majority of trainees reported that they prefer the current format. Trainee feedback also indicated that the SAG COC webinar and a few case holder repetitions using tool will help address any significant issues with current cleaner format.	Resolved	NA
Does ABA count as behavior plan?	Yes, and the applicable forms for go-live this fall to will include this in the operational definition.	Resolved	TBDS, PIHP DM Director, CCO
Consider adding extra information on the worksheet, such as definitions and descriptors from the logic document.	The vast majority of trainees reported that they prefer the current format. Trainee feedback also indicated that the SAG COC webinar and a few case holder repetitions using tool will help address any significant issues with current cleaner format.	Resolved	NA
The COC does not take into account psychiatric hospital length of stay and IP per state facility.	The acute/crisis service utilization descriptions will be revised to include these elements.	Resolved	TBDS, CCO

Medicare hospitalization information is not electronically available.	Agree - this is not available to PCE (not included in CC360 extract) and so a note should be added regarding this limitation to the logic document.	Resolved	TBDS, CCO
Is the COC logic model sensitive to age changes?	Because there is no way to assess at this point in time, Region 10 will assess when one year's data becomes available.	Resolved	TBDS, CCO
Can a CMH in Region 10 accept another Region 10 CMH's SAG COC if the individual transfers between CMHs?	Yes. Given that in most instances the person is simply relocating to anther residence, the receiving case holder reviews current OASIS documentation and documents that in an updated IPOS/periodic review; that said, another Bio and SAG COC worksheet should be completed if the move was also linked to a significant clinical status change.	Resolved	NA
Does the Pilot apply to individuals who are SUD primary?	*No.*	Resolved	TBDS, CCO
Summer Camp – Lapeer reports H2015 TT for a five-day summer camp program – will this be allowed within the Pilot SAG COC?	Yes, as it was clarified that circumstance involves the provision of active treatment.	Resolved	CCO, Lapeer DM Director
In OASIS the IPOS is automatically routed to the supervisor for review/signature when the case holder signs – this may pose problem for the SER process.	The Pilot was designed assuming the case holder will wait to submit the IPOS to the supervisor until he/she has received the SER UM disposition. Region 10 is only asking supervisors to hold on signing IPOS that *resulted in an SER*. Those IPOS *that did not result in a* SER can be signed immediately upon receipt.	Resolved	NA
Request for vignettes	Based on the training materials, resources, and exercises, vignettes will not be written. Nevertheless, case holders are encouraged to confer with their supervisor to determine what SAG COC is appropriate. Also,	Resolved	CCO

	they may confer with their UM Pilot Implementation work group member (the CMHSP representative on the Region 10 UMC) or send questions / feedback to the CCO.		
One trainee stated that there is a need for LOCUS training because not all SMI case holders are trained.	This has been recognized as an expected, ongoing challenge due to inevitable staff turnover and practitioner-fidelity drift. This has been an ongoing discussion item with the CMHSPs through the Region 10 Improving Practices Leadership Team (IPLT) that meets monthly and periodically monitors each CMHSPs LOCUS Implementation Plan. Currently, each CMHSP must have a go-to supervisor/administrator assigned to ensure LOCUS trainings and as-needed LOCUS fidelity reviews, as offered through the MDHHS' Improving MiPractices. Through a state grant, LOCUS training and fidelity review resources are currently available to all CMHSPs.	Resolved	NA
Individuals served in St. Clair's Medication Only clinic – how will these individuals be handled within this model?	Region 10 has identified that this service population does not need a SAG COC worksheet completed during the pilot. However, given that active CMHSP cases must receive some kind of appropriate case management, this service population will need to have a SAG COC completed for this population when the model rolls out in the fall.	Resolved	TBDS, CCO
What are the timeframes for the presence of items in the clinical assessment section (the "plus 1" section) of the SAG COC?	It is recommended that case holders focus on current symptoms and functional impairment. For ongoing cases, 'current' is basically defined as the status assessed at the last periodic review. If past issues appear critical, the case holder can use that information to inform the overall COC determination. Region 10 also encourages case holders to ensure the LOCUS is up-to-date and valid based on current symptoms, as per fidelity to use of the LOCUS. We are adding a statement to the SAG COC logic documents stressing that a +1 should only be given if the criteria are currently present or have been present within the past three months.	Resolved	NA

Probate Court-ordered treatment, Mental Health Court, assigned Guardianship – do these examples count for multisystem involvement?	Probate Court-ordered treatment and Mental Health Court are good examples of multisystem involvement. For the purposes of the Pilot, Assigned Guardianship may be included, i.e. payor, partial, full plenary; public, private.	Resolved	CCO, Implementation Work Group
Should mental health signs / symptoms be represented in the SAG COC for the IDD Populations?	It may, if the individual is taking a medication for mood. Currently MH diagnosis may be captured in the +1 for chronic medical condition, +1 two or more chronic medical conditions, and may be captured in +1 for psychiatric medication. Any need for change will be monitored and assessed per the Pilot.	Resolved	CCO, TBDS, Pilot Implementation Work Group
Should psychotropic drugs be a +1 in the SAG COC for SED?	Not for now. This prospect will be reassessed at the end of the pilot. A related consideration is prescribed psychostimulants.	Resolved	CCO, TBDS, Pilot Implementation Work Group
Regarding the COC section on previous crisis services utilization, assessing clinical severity for individuals with SED will biased, because psychiatric inpatient and crisis residential are fewer and / or because they receive intensive services in the community, and so they will have little to no such prior service utilization to take into consideration.	Agree. Region 10 will include a statement about lack of beds/hospital access for youth.	Resolved	TBDS
Please add a SIS N/A option to the SAG COC Worksheets.	Agree. Region 10 will update.	Resolved	TBDS
Please fix the Foster care typo in the SAG COC.	Agree. Region 10 will update.	Resolved	TBDS

Should adoption be included in the SAG COC foster care item?	Not for now. This prospect will be monitored and reassessed at the end of the Pilot.	Resolved	CCO, TBDS, Pilot Implementation Work Group
Who is going to complete the SAG COC worksheet?	As explained during the training, it will be up to the local CMHSP to decide if the intake worker (assessor) completes it or the receiving case holder. The trainers also emphasized that the worksheet must be completed at some point after the Biopsychosocial assessment and prior to the IPOS.	Resolved	NA
What constitutes as a behavior plan?	A behavior plan is one written by a CMHSP practitioners, and it does not include school behavior plans.	Resolved	NA
SED has a foster care option but IDD youth does not.	This will be added at the end of the pilot.	Resolved	TBDS, CCO
The second section in the COC assessment for IDD Youth (ages 0-4 years) should be revised because not all of the section items apply.	The point made is appreciated and it is under further study and discussion; a workgroup has been convened to develop a draft SAG COC form.	Resolved	TBDS, CCO, CMHSPs
Provide guidance on the two IDD criteria that do not really fit adults.	The point made is appreciated; these items will be retained in the IDD Youth COC and case holder staff have the option of considering per-case whether these apply; these items will not be included in the COC document being developed for 0 – 3.	Resolved	TBDS, CCO
Does the SAG COC occur at the annual or initial assessment?	It is completed at both.	Resolved	NA

Where can I find an ABE Score?	The ABE is a score developed by HSRI. It is derived from the A, B, and E subscale scores, along with the Behavioral and Medical scale scores. Although the ABE Score is not computed automatically within the AAIDD SIS output, all of the above scale scores are noted on the SIS assessment page in OASIS. Following feedback received from select SIS administrators, a regionally coordinated training / guidance document will be disseminated to case holders regarding the SIS ABE score and its calculation.	Resolved	TBDS, CCO
Regarding local requirements to calculate and enter monthly authorization amounts, case holders report they are required to determine the monthly amount for some services (such as CLS and/or skill building) – will this local process be permitted in the future-state model, and will it cause any potential issues?	Region 10 is ok with the concept as long as the CMHs do not place a limit on the total amount of units authorized for this entire time period. R10 encourages the CMHs with PCE to determine if/how PCE can accommodate this.	Resolved	TBDS, PIHP Data Director, CCO, PCE
How will preliminary / interim treatment plans be handled?	Please continue current local processes, unless/until other directives are sent. Region 10 will look to local CMHSP processes to inform this answer.	Resolved	TBDS, CCO, Pilot Implementation Work Group
Psychiatric services without a service goal – at times, psychiatric services are provided prior to a treatment plan being written, and so, how does Region 10 want to handle this?	Any service provided needs to be associated with a goal in a treatment plan and authorized, therefore the current process described does not appear to be in compliance.	Resolved	NA

There is concern that the CLS and TCM services grid maximum amounts are too low - are the data incorrect?	The amounts listed are correct. Reg 10 doublechecked the previous utilization data and confirmed it is aligned with the grid ranges. However, some of the comments within the grid have been updated. Region 10 will monitor SERs related to these services during the pilot and will make any needed revisions to the grid following the pilot. It is important to recall from the training that this is an iterative process.	Resolved	TBDS
Questions/Concerns from the Webinar	**Response**	**Disposition**	**Follow-Up Entity**
Some groups in the Adult Unit are Peer lead and use H2015TT or H0038TT....I don't see those on the chart. How should we handle those?	If the code and modifier does not appear on the grid as a distinct service group, the modifier is included in the service code (for example H2015 on the grid includes H2015TT, as well as any other modifiers, as this is not displayed as a separate service). We recognize this logic may need to be modified prior to go-live this fall. As a service can have multiple modifiers, this can quickly become complex. We welcome input on how to best represent modifiers in the grid.	Resolved	TBDS, CCO
It does not appear that the group therapy authorizations are adequate. TREM and DBT are 12-month groups	DBT group will be addressed using the DBT code, H2019. As TREM does not have a distinct HCPC code, it will be included in the group therapy, 90853.	Resolved	TBDS, CCO
How do you authorize service based on 2 months when we do quarterly at every 3 months?	The 2-month authorization durations are tied to the minimal SAG COC category. This category is only to be used for step-down from services once an individual has met his/her goals and is transitioning out of care. Therefore, a 3-month period would not apply in this instance.	Resolved	TBDS, CCO

In the assessment for a I/DD child, will we be able to put a child with no PECFAS/CAFAS in Home-Based services?	Homebased services are included on the IDD youth grid – so yes, you can request this service without a PECFAS/CAFAS being completed.	Resolved	TBDS, CCO
Will we have access to a breakdown to a breakdown - per category before we go live?	All CMHs currently have access to the service grid and can view the services authorization ranges for each SAG COC category.	Resolved	TBDS, CCO
What does 2X mean on last column?	The last column is "max units for remaining duration". "2x" referred to the units for the remaining duration were the same as the first 6 month. As this is confusing, we have revised the grid to reflect the actual number of units.	Resolved	TBDS, CCO
What if a currently authorized service is much higher than the grid and it is denied? Then what?	Upon completion of the IPOS, the case holder will complete a Service Exception Request and submit this to Reg 10 UM for review. If UM approves the request, the service will be provided. If UM determines that service amount is not medically necessary, the case holder will serve notice and appeal paperwork. The consumer can file an appeal if they disagree with the UM decision. If an appeal is filed, services will be provided until the appeal is resolved. If no appeal is requested, the IPOS will be amended and/or rewritten (based on local process).	Resolved	TBDS, CCO
If authorizing over limit and it is not approved, does the auth revert to the max or is there no service authorized?	If UM determines the service is medically necessary, but the amount was not, UM would provide a partial denial. If UM determined the service is not medically necessary, this would result in a denial. In both cases the CMH has to follow the notice and appeal process.	Resolved	TBDS, CCO

If I use up the authorizations, do I do indirect code if needing to see the individual?	No. The proper code should always be used to report the service provided. It is the case holder's responsibility to monitor the utilization of authorization to ensure a service is not provided without an auth. The case holder is expected to proactively request additional authorizations if they are running low before the anticipated next IPOS review date.	Resolved	TBDS, CCO
Remaining duration still doesn't make sense	Remaining duration simply refers to the number of months left within a 12-month period. If the service has an auth duration of 12 months, remaining duration will always be 0. If the service has an auth duration of 6 months, the remaining duration would be 6 months.	Resolved	TBDS, CCO
So, for 6-month duration, do we have to re-request every 6 months? Or - we can just put them in if it is the max remaining duration amount?	For service authorizations with a six-month duration, a new authorization request is needed prior to the end of the first six-month period.	Resolved	TBDS, CCO
Are we to do the SAG COC form for only admits to CMH? Or denial at intake as well?	The SAG COC worksheet is only required for individuals that are referred for ongoing CMH services following the biopsychosocial assessment. If someone is determined to be ineligible for CMH services and referred out, another SAG COC is not required.	Resolved	TBDS, CCO
What do we do if someone is currently in more than one program that uses the same code, therefore will use up the max authorizations more quickly? Just complete a SER?	Request all the units of the service code that are needed, for both programs. If the total amount of units used in both programs exceeds the max amount for the selected SAG COC category, a SER does need to be completed.	Resolved	TBDS, CCO

Questions/Concerns Post-Webinar	Response	Disposition	Follow-Up Entity
At the webinar, the minimum SAG COC category was described as a "step-down" due to the duration being 2 months. In theory then, should we not have anyone at intake falling into this minimum category? What happens if we do?	Individuals that fall into the SAG COC minimum category at intake should be referred out to a mild/moderate provider in the community.	Resolved	TBDS, CCO
As far as the durations, If we do an IPOS for 12 months duration, but the codes on the grid say the max duration is 6 months, do we only put in authorizations for the 6 months and at their review if still needed, then add up to the remaining max units for the other 6 months?	Yes, another authorization request would need to be entered just prior to the first six-month period expiring.	Resolved	TBDS, CCO

Has there been any changes to content? (I see the "2x" for the CLS in SED Severe was removed, but that was the only example we had discussed at webinar.)	The latest version includes all of the following changes: i. Change "2X" to be actual value of units associated with remaining duration ii. Update Respite Camp to be a 12 month duration for levels Moderate, Serious, Severe iii. Added Respite Camp to I/DD Adult and I/DD Child service grids (with same recommended thresholds as SED) iv. Removed Private Duty Nursing from both the I/DD Adult and I/DD Child service grids as these services are always provided per a physician's order v. Added column heading to denote which service grid is being viewed/printed (i.e. MIA Service Grid vs. SED Service Grid) vi. Added functionality to include column headings and page numbers on every page when printed vii. Changed the orientation of the print to landscape and legal-size paper	Resolved	TBDS, CCO
St. Clair CMH is doing 90-day authorizations, but for the grid amounts that are 6, 10, or 12 months, should they be calculating the 3-month amount, and if they are projecting needing more units, do the SER immediately? Or wait until the end of the time frame listed in the grid?	A big part of the Pilot is to generate authorization requests as per within the Pilot, and accordingly there is no 90-day interval for the CMHSPs to work with.	Resolved	TBDS, CCO
If the IPOS was done after 5/28/19 but the initial intake was completed before this	Yes, please complete the form. In the training, we presented the flow of relevant tasks as follows: Intake > SAG COC Selection > PCP/IPOS > (service grid) > Auth Request.	Resolved	TBDS, CCO

date, would the case holder need to complete the forms?	And it was noted that the most critical task in connection to the 5/28 launch date is SAG COC Selection, because that is the task that helps inform the IPOS and Auth Request		
If the authorizations requested fall with-in the guidelines / grid, does a SAG COC need to be done?	Yes, you may recall from the training the flow of tasks noted on page 12, and that the completed SAG COC worksheet (Overall Assessment) informs what point along the continuum (minimal, moderate, serious, severe) you would refer to on the service authorization grid.	Resolved	TBDS, CCO
Regarding COFR, do we complete the SAG COC if the case is a COFR and the other county is actually doing the authorizations requested? When we accept a consumer from another county, let's say the person belongs to Gen. Co. we do an IPOS the requested authorizations are sent to them to review approve, modify or deny. The COFR is actually finalizing the requested Authorizations and approval into services.	Yes, in that example we would not include in the Pilot.	Resolved	TBDS, CCO
Questions/Concerns Pilot Week 1 – Week 8	**Response**	**Disposition**	**Follow-Up Entity**
I have had about three IPOSs in the last week and a half. One was able to meet the grid units and the other two did not. Skill building is the reason for both of my issues as the grid does not allow for enough units in	Some training and education to staff has been provided per-case. UM typically has requested additional information to help to understand why the particular amount / scope / duration are being requested, and as it relates to the Medicaid Manual criteria: *Skills training and development that assist the beneficiary to increase economic self-sufficiency and / or to engage in meaningful activities such as school, work and / or volunteering. Assistance may be provided in the person's*	Resolved	TBDS, CCO

this area. All other units have met well. The hardest part I have had is knowing what specifically they are wanting in our brief summary. I have tried to make it to the point and then they have been returned for further information.	*residence or community.* So far, the review process generally assumes that a more severe clinical condition warrants more intensive services, given what is presently known per CMH data analyses identifying typical service utilization patterns. That said, post-Pilot analysis of such service exception requests may help us further understand typical higher-intensity service needs and utilization patterns.		
I find it stressful, yet all my requests have been approved. I find this process tedious, but maybe it will get easier as they move forward. In the cases where they have requested further information, the individuals who contacted me were very kind and easy to talk to. Shannon and Debbie in our office have been great through the process, patient and helpful.	We appreciate the frustrations and the positive feedback.	Resolved	TBDS, CCO
I like the way you can select the severity and population to minimize the choices on the grid. It is way too big to read otherwise.	We appreciate the positive feedback.	Resolved	TBDS, CCO
I am concerned about the case management authorizations. I feel they are too limited for the less severe categories because it is never just one	Ii is important to understand that the authorization request pertains to a a total amount of units for X time period (6 months, or 12 months) and that the amount of units used can (and will) fluctuate month to month.	Resolved	TBDS, CCO

hour per month for the entire year or even six months and the pilot isn't tracking it for that long. I believe it will change throughout the year and more authorizations will be needed. For example, my moderate person who I may have trouble seeing one month for even 30 minutes because of his symptoms, may then have a crisis where I need to spend a couple hours with him at one visit. Going out in the community even with a moderate person can take more than an hour. We go to forensic center, Caro, Immigration center in Detroit, other counties, SSI hearings, court hearings, etc. They stay moderate because we are available when they need us.	That said, we may need to look at the amount of TCM and SC for the moderate level and bump it up if this is a trend (that the need is higher than what the grid currently allows for this service…)		
I had to complete the forms for an IPOS of an ACT consumer residing in a Specialized Residential placement since typically an ACT consumer does not qualify for both ACT and Specialized Residential. The UM design committee had numerous questions about the consumer and services she	We appreciate the positive feedback.	Resolved	TBDS, CCO

receives. They got in touch with me by phone and email. There were questions that they were not able to answer about this situation as they had not come across a SAG COC/SER form like this to date but they were quick to respond. The current services were approved with no additional work needed.			
For the IDD adult form, it requires a SIS score. Not all of our consumers have a SIS score completed and if not, the timeline to have it completed does not fall in line with the form deadline. Without that score, the form isn't completed. I am unsure how to proceed in those situations.	There is now an option for "No SIS Score available" and so we encourage you to access that form's updated version.	Resolved	TBDS, CCO
Nice that clinical judgement is taken into consideration when possible "overrides" need to happen on the SAG COC categories. Forms are fairly self-explanatory and easy to complete. Grid is fairly easily understood.	We appreciate the positive feedback.	Resolved	TBDS, CCO
Something that I would find helpful is to have examples of	This is the challenge of using a homegrown clinical tool, given that good case examples are empirically derived from the standardization process	Resolved	TBDS, CCO

the various categories we are expected to score in Step 2 – there has been some discrepancy as to whether to give a +1 to someone – to ensure score is the most accurate score as possible.	for the tool so it has acceptable "inter rater reliability" vs. having a clinical that is relevant yet flexible for the clinician. So far, we believe the definitions included (footnoted material) in the logic document should be sufficient, but we will also revisit this concern at the end of the Pilot.		
Clubhouse has significant concerns that if their services were limited by the grid it would affect their standing with Clubhouse International Standards: *1. Membership is voluntary and without time limits.* *2. Clubhouse has control over its acceptance of new members. Membership is open to anyone with a history of mental illness, unless that person poses a significant and current threat to the general safety of the clubhouse community.* *3. Members choose the way they utilize the clubhouse, and the staff with whom they work. There are no agreements, contracts, schedules, or rules intended to*	We appreciate your placing additional attention and priority onto this evidence-based practice, and we will use your feedback to revise the service grid.	Resolved	TBDS, CCO

enforce participation of its members. *4. All members have equal access to every clubhouse opportunity with no differentiation based on diagnosis or level of functioning.* *Also, under the Subheading of Functions of the House:* *31. The clubhouse director, members, staff, and other appropriate persons participate in a comprehensive 2 or 3 week training program in the clubhouse model at a certified training base.* *32. The clubhouse has recreational and social programs during evenings and on weekends. Holidays are celebrated on the actual day they are observed.* *Please let me know what may be able to be done to avoid impacting our ability to adhere to these standards.*			
There is concern that (SCCCMHA contract) providers are not being considered as partners in change. We can offer a perspective that may	Your feedback and concerns are valid. Presently, we are arranging a PCE/CMHSP feedback to cover essential MIX features and next-steps with implementing future-state. Implementation timeframes have been moved back to allow for more time to include all stakeholders, and we	Resolved	TBDS, CCO

improve the process. Also as integral partners in the service system. It is important that we be participants in the change process. We are recommending that a meeting be scheduled to discuss the pilot program and how it may impact our system. We realize that this is an evolving process and we want to be involved.	also want to defer to existing CMHSP contract management systems and processes to provide appropriate follow-up.		
I/DD Infant Toddler – are any revisions needed to the model? See my email from June 13th	No immediate changes are needed. Continued monitoring of pilot data will occur. After the Pilot analysis is completed, we plan to schedule a meeting with interested IMH champions to identify potential revisions.	Resolved	TBDS, CCO
Questions/Concerns Pilot Week 9 – 14	**Response**		**Follow-Up Entity**
How should we handle the OT assessments as far as having the requests in before the assessment takes place? We were in the habit of asking for the particular code after the assessment was completed and we knew which was appropriate. Can we still do this, or does the auth need to be in prior to the assessment being billed? Given that there are three codes, can one of	***This issue involves clinical as well as technical issues. We have outreached PCE to see if it's possible to have a 'parent code' that clinicians could use to request the evaluation authorization and then the system figures out which code was the appropriate match.***	***Pending***	***TBDS, CCO***

each be requested and the others deleted after we've used the appropriate one? This would look like a request for 3 assessments so that's above the allotted amount (OT services can vary. At this point, it is authorized as needed, and sometimes more is needed, and sometimes it is not).			
Med Reviews 1 every 3 months (there are many instances monthly M/Rs are necessary)?!	We appreciate this point as a real concern. This will be assessed and recommendations will be made post-Pilot, and accordingly the current process will stay in place for now. We appreciate the point that since M/Rs are always per a physician's order and are issued with rationale per the M/R note, over-utilization would appear to be an unlike concern.	Resolved	TBDS, CCO
What's the service amount allotted to PMTO?	This was referred for consultation. It was recognized that PMTO providers are trained and certified in the model and have specific service codes, with modifiers. We are in favor of adding it to the grid. We will likely need to add units to the family service as it currently only allows for 24 sessions in six months and no additional services in the following six months, and it is recognized that not all families complete PMTO within six months.	Resolved	TBDS, CCO
It appears that the development of the SAGs has not accounted for the few important sub-populations (e.g. severely impacted I/DD, adults with dementia / Alzheimer's, and kids who are more seriously impacted by	This has been referred to executive team for decision with consultation. So far, it is worth noting that a well-identified sub-population may be feasibly considered; the SMI/Alzheimer's subgroup has been identified, and the need to identify any remaining subgroups will be assessed during first-year implementation.	Resolved	TBDS, CCO

SED – SED Waiver kids) should/could have been segregated into their own category.			
There is no therapeutic camp code T2036 for I/DD children.	This was been included.	Resolved	TBDS, CCO
SAG COC only reflects trauma diagnoses and not trauma history; it should reflect all trauma	This was extensively discussed months leading into the Pilot, and it was decided that the spectrum of trauma-related diagnoses was necessary to provide the most meaningful data point as well as sufficient in terms of also addressing history.	Resolved	TBDS, CCO
What about PSP who use S5111 and there are only 2/month – do we need to do an SER for every PSP on a kid's case? It seems that more S5111 should be allowed.	This was referred for consultation and further discussion to provide clarification. Per the HCPC chart: *S5111 HM-Parent-to-parent support provided by a trained Parent Support Partner using the MDHHS endorsed curriculum (can report encounter after completion of initial 3 days of core training but must continue certification process).* Currently in the grid, this is included in the family training code, which for most SAG COC categories is up to 24 sessions in the first six months. This may be another example of our need to tweak the grid by doing a code break-out per the modifier.	Resolved	TBDS, CCO
What if we need to do an amendment due to accepted/denied SER and we don't have any S5111 or T1016 available to bill for amendment?	***This was been referred to PCE and we are awaiting response to see whether this functionality is possible.***	***Pending***	***TBDS, CCO***
Will CMHs be able to authorize shorter durations than those defined in the region model?	This was referred to executive team for decision with consultation. R10 agrees, that over-utilization of services such as CLS is a concern, and that the CMHs have a legitimate need to internally control for it, per-case.	Resolved	TBDS, CCO

	R10 is ok with CMHs dosing out monthly increments, but they will need to do so by setting up and oprating their own internal systems.		
Is the service grid referring to H2015 and H2015TT as being different codes?	The service grid sees any H2015 as one code. This may be another example of our need to tweak the grid by doing a code break-out per the modifier.	Resolved	TBDS, CCO
Med injection and accompanying RN services should be expanded to accommodate best-practices regarding dosage and frequency	This has been discussed and the SAG authorization grid will be expanded accordingly to a maximum of 52 units annually	Resolved	CCO, TBDS