

## LAKESHORE REGIONAL ENTITY SERVICE DESCRIPTION Behavior Treatment Review (BTR)

*This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as updated. The manual is available at:*

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

### 1. Definition or Description of Service

- a. MDHHS requires that any Individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 Federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code.
- b. Any behavior treatment plan that proposes aversive, restrictive or intrusive techniques, or psychoactive medications for behavior control purposes and where the target behavior is not due to an active substantiated psychotic process, must be reviewed and approved by a specially constituted body comprised of at least three individuals, one of whom shall be a fully- or limited-licensed psychologist and one of whom shall be a licensed physician/psychiatrist.
- c. The BTRC shall substantially incorporate the standards in the Behavior Treatment Plan Review Committee Technical Requirement attached to the contract between the PIHP and MDHHS.
- d. A behavior treatment plan, where needed, is developed through the person-centered planning process that involves the Individual. The person-centered planning process should determine whether a comprehensive assessment should be done in order to rule out any physical or environmental cause for the behavior.
- e. This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual and the Behavior Treatment Plan Review Committee Technical Requirement attached to the contract between the PIHP and MDHHS.

### 2. Practice Principles

- a. The PIHP and CMHSP will not tolerate violence perpetrated on the Individuals served by the public mental health system in the name of intervening when Individuals exhibit certain potentially harmful behaviors. If and when interventions are to be used for the purpose of treating, managing, controlling, or extinguishing predictable or continuing behaviors that are seriously aggressive, self-injurious, or that place the Individual or others at risk of harm, Provider agency will develop an individual behavior treatment plan to ameliorate or eliminate the need for the restrictive or intrusive interventions in the future (R.330.7199[2][g]) and that:
  - i. Adheres to any legal psychiatric advance directive that is present for an adult with serious mental illness;
  - ii. Employs positive behavior supports and interventions, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches;
  - iii. Considers other kinds of behavior treatment or interventions that are supported by peer-reviewed literature or practice guidelines in conjunction with behavior supports and interventions, if positive behavior supports and interventions are documented to be unsuccessful; or,
  - iv. As a last resort, when there is documentation that neither positive behavior supports nor other kinds of less restrictive interventions were successful, proposes restrictive or intrusive techniques, described herein, that shall be reviewed and approved by the BTRC.
- b. Acceptable behavioral treatment plans are designed to reduce maladaptive behaviors, to maximize behavioral self-control, or to restore normalized psychological functioning, reality orientation, and emotional adjustment, thus enabling the Individual to function more

appropriately in interpersonal and social relationships. Such reviews shall be completed prior to the Individual's signing and implementation of the plan and as expeditiously as possible.

- c. Providers are encouraged to offer evidence-based and promising practices as part of the Medicaid covered specialty services where applicable. Providers shall assure that these practices are provided by staff who have been appropriately trained in the model(s) and are provided to the population for which the model was intended.
- d. Provider will be in compliance with the principles of person-centered planning as outlined in the MDHHS Mental Health and Person-Centered Planning Policy and Practice Guideline.
- e. MDHHS encourages the use of natural supports to assist in meeting an Individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. The use of natural supports must be documented in the Individual's individual plan of service.

### **3. Credentialing Requirements** *Refer to current Medicaid Provider Manual for updated requirements*

- a. Any behavior treatment plan that proposes aversive, restrictive or intrusive techniques, or psycho-active medications for behavior control purposes and where the target behavior is not due to an active substantiated psychotic process, must be reviewed and approved by a specially constituted body comprised of at least three Individuals, one of whom shall be a fully- or limited-licensed psychologist by the State of Michigan and one of whom shall be a licensed physician/psychiatrist by the State of Michigan. The physician or psychologist must be present during the review and approval process. At least one of the committee members shall not be the developer or implementer of the behavior treatment plans.
- b. Staff implementing the Individual's behavior treatment plan must be trained in how to implement the plan.
- c. Provider will assure that licensed professional staff licensed and/or registered in the State of Michigan to provide services at the level authorized by the Payor. Licensed professionals shall act within the scope of practice defined by their license.
- d. Providers of BTRC services must meet the staff qualifications as defined by the MDHHS Michigan PIHP/CMHSP Provider Qualification per Medicaid Services and HCPCS/CPT Codes.

### **4. Service Requirements**

- a. Provider must demonstrate the capacity to provide all core requirements as outlined in the MDHHS Medicaid Provider Manual and the Standards for Behavior Treatment Plan Review Committees Technical Requirement attached to the contract between the PIHP and MDHHS.
- b. Provider, utilizing formats acceptable to CMHSP, shall document the progress toward the goals and objectives set forth in the IPOS of the Individual(s) served under this agreement, per CMHSP-required standards. Provider also shall promptly notify the Supports Coordinator/Case Manager, in writing, when it believes that the IPOS or ancillary plan(s) of an Individual is/are in need of revision or modification because of any of the following:
  - i. An Individual has achieved an objective set forth in the IPOS or ancillary plan(s);
  - ii. An Individual has regressed or lost previously attained skills; or,
  - iii. An Individual has failed to progress toward identified objectives despite consistent effort to implement the IPOS.
- c. Provider shall ensure coordination of care occurs between the Individual(s) primary health care physician and Medicaid Health Plan, as appropriate. Coordination of care shall include the full array of primary and acute physical health services, behavioral health care, natural or community supports to provide effective treatment and as specified in an Individual's plan of service.
- d. Provider shall ensure language interpretation, translation services, and hearing interpreter services are provided as needed.

- e. Services must meet all requirements of the Michigan Department of Health and Human Services, Standards for Behavior Treatment Plan Review Committees, Revision FY17.
- f. Services must meet all requirements of the Behavior Treatment Review section of the Michigan Medicaid Provider Manual.
- g. Committee Standards:
  - i. The Committee shall be comprised of at least three Individuals, one of whom shall be a licensed psychologist as defined in Section 2.4, Staff Provider Qualifications, in the Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, with the specified training; and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the Committee as some ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion and with the consent of the Individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.
  - ii. The Committee, and Committee chair, shall be appointed by the agency for a term of not more than two years. Members may be re-appointed to consecutive terms.
  - iii. The Committee shall meet as often as needed.
- h. Expedited Review of Proposed Behavior Treatment Plans
  - i. Each Committee must establish a mechanism for the expedited review of proposed behavior treatment plans in emergent situations. "Expedited" means the plan is reviewed and approved in a short time frame such as 24 or 48 hours.
  - ii. Expedited plan reviews may be requested when, based on data presented by the professional staff (Psychologist, RN, Supports Coordinator, Case Manager), the plan requires immediate implementation. The Committee Chair may receive, review and approve such plans on behalf of the Committee. The Recipient Rights Office must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan. Upon approval, the plan may be implemented. All plans approved in this manner must be subject to full review at the next regular meeting of the Committee.
- i. The Committee shall keep all its meeting minutes, and clearly delineate the actions of the Committee.
- j. A Committee member who has prepared a behavior treatment plan to be reviewed by the Committee shall recuse themselves from the final decision-making.
- k. Functions of the Committee:
  - i. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
  - ii. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques [see definitions in Technical Requirement].
  - iii. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.
  - iv. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the Individual's condition, or when the Individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The committee may require behavior treatment plans that utilize more frequent implementation of intrusive

- or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary.
- v. Assure that inquiry has been made about any known medical, psychological or other factors that the Individual has, which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.
  - vi. As part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP), arrange for an evaluation of the committee's effectiveness by stakeholders, including Individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of the Individuals served.
  - vii. Once a decision to approve a behavior treatment plan has been made by the Committee and written special consent to the plan (see limitations in definition of special consent) has been obtained from the Individual, the legal guardian, the parent with legal custody of a minor or a designated patient advocate, it becomes part of the person's written IPOS. The Individual, legal guardian, parent with legal custody of a minor child, or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-convened, in order to revisit the behavior treatment plan (MCL 330.1712{2}).
  - viii. In addition, the Committee may:
    - (1) Advise and recommend to the agency the need for specific staff or home specific training in positive behavior supports, other evidence based and strength based models, and other Individual-specific non-violent interventions.
    - (2) Advise and recommend to the agency acceptable interventions to be used in emergency or crisis situations when a behavior treatment plan does not exist for an Individual who has never displayed or been predicted to display seriously aggressive, self-injurious or other behaviors that place the Individual or others at risk or harm.
    - (3) At its discretion, review other formally developed behavior treatment plans, including positive behavioral supports and interventions, if such reviews are consistent with the agency's needs and approved in advance by the agency.
    - (4) Advise the agency regarding administrative and other policies affecting behavior treatment and modification practices.
    - (5) Provide specific case consultation as requested by professional staff of the agency.
    - (6) Assist in assuring that other related standards are met, e.g., positive behavioral supports.
    - (7) Serve another service entity (e.g., subcontractor) if agreeable between the involved parties.
  - ix. On a quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each Individual receiving the intervention, as well as:
    - (a) Dates and numbers of interventions used.
    - (b) The settings (e.g., Individual's home or work) where behaviors and interventions occurred.
    - (c) Observations about any events, settings, or factors that may have triggered the behavior.
    - (d) Behaviors that initiated the techniques.
    - (e) Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
    - (f) Description of positive behavioral supports used.
    - (g) Behaviors that resulted in termination of the interventions.
    - (h) Length of time of each intervention.

- (i) Staff development and training and supervisory guidance to reduce the use of these interventions.
  - (j) Review and modification or development, if needed, of the Individual's behavior plan.
- l. The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's QAPIP or the CMHSP's QIP, and be available for MDHHS review. Physical management and/or involvement of law enforcement, permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported according to the QAPIP standards. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

## **5. Behavior Treatment Plan Standards.**

- a. The person-centered planning process used in the development of an individualized written plan of services will identify when a behavior treatment plan needs to be developed and where there is documentation that functional behavioral assessments have been conducted to rule out physical, medical or environmental causes of the target behavior; and that there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the target behavior.
- b. Behavior treatment plans must be developed through the person-centered planning process and written special consent must be given by the Individual, or his/her guardian on his/her behalf if one has been appointed, or the parent with legal custody of a minor prior to the implementation of the behavior treatment plan that includes intrusive or restrictive interventions.
- c. Behavior treatment plans that propose to use physical management and/or involvement of law enforcement in a non-emergent situation; aversive techniques; or seclusion or restraint in a setting where it is prohibited by law shall be disapproved by the Committee. Utilization of physical management or requesting law enforcement may be evidence of treatment/supports failure. Should use occur more than three (3) times within a thirty (30)-day period, the Individual's written individual plan of service must be revisited through the person-centered planning process and modified accordingly, if needed. MDHHS and DHS Administrative Rules prohibit emergency interventions from inclusion as a component or step in any behavior plan. The plan may note, however, that should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the Individual or others, approved emergency interventions may be implemented.
- d. Behavior treatment plans that propose to use restrictive or intrusive techniques as defined by this policy shall be reviewed and approved (or disapproved) by the Committee.
- e. Plans that are forwarded to the Committee for review shall be accompanied by:
  - i. Results of assessments performed to rule out relevant physical, medical and environmental causes of the challenging behavior.
  - ii. A functional behavioral assessment.
  - iii. Results of inquiries about any medical, psychological or other factors that might put the Individual subjected to intrusive or restrictive techniques at high risk of death, injury or trauma.
  - iv. Evidence of the kinds of positive behavioral supports or interventions including their amount, scope and duration that have been used to ameliorate the behavior and have proved to be unsuccessful.
  - v. Evidence of continued efforts to find other options.
  - vi. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
  - vii. References to the literature should be included on new procedures, and where the intervention has limited or no support in the literature, why the plan is the best option

available. Citing of common procedures that are well researched and utilized within most behavior treatment plans is not required.

- viii. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).
- ix. Monitoring of the behavior treatment plan by the committee or a designee of the committee shall occur as indicated in the individual plan of service.
- f. Provider shall complete services documentation and records that meet the CMHSP's requirements for reimbursement. Provider's services and documentation/records shall comply with the standards of the CMHSP, accreditation bodies, MDHHS, any applicable licensing Department or Agency of the State of Michigan, Medicaid and Medicare regulations and/or any third-party payers.
- g. Provider shall notify the Individual's care manager when the Individual's Plan of Service is in need of revision or modification.
- h. Provider shall ensure language interpretation, translation services, and hearing interpreter services are provided as needed, and at no cost to the Individual. Provider shall be responsive to the particular needs of Individuals with sensory or mobility impairments, and provide necessary accommodations.

## **6. Training Requirements**

- a. See Attachment I: Training Requirements for specific training requirements and frequency of trainings.
- b. Provider will ensure and document that each staff is trained on the Individual's IPOS and ancillary plans, prior to delivery of service.

## **7. Eligibility Criteria/Access Requirements/Authorization Procedures**

- a. Individuals presenting for mental health services will be engaged in a person-centered planning process through which diagnostic information and service eligibility will be determined. Eligibility tools may be used in conjunction with the Person-Centered Planning process to determine and document medical/clinical necessity for the requested service.
- b. Waiver eligibility requires verification of no change in waiver status.
- c. The [Lakeshore Regional Entity Guide to Services](#) provides a summary of service eligibility, access to services, and service authorization. Additional information related to policies, procedures and Provider Manuals may be found by accessing the specific CMHSP websites.