MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Office Of Substance Use
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June 28, 2021

To: All Direct and Contracted Providers of MCCMH
RE: Executive Directive - Services No Longer Requiring Prior Authorization
From: Dave Pankotai, CEO

Effective July 1, 2021, prior authorization/reauthorization for services provided July 1, 2021 and forward will not be needed to provide the services listed below:

Mental Health Provider Services

- Skill Building (H2014 and pre-vocational for HSW T2015)
- Supported Employment (H2023)
- Psychotherapy (90785, 90832, 90833, 90834, 90836, 90837, 90838)
- Group Therapy (90853), family therapy (90846, 90847, 90849) & Didactics (H2027)
- Assessments by a Non-physician (H0001, H0031, 90791)
- Treatment Planning (H0032)
- Family Training (S5111)
- Medication Administration (96372, 99211, 99506, H0020)
- All Peer Services (H0023, H0038, H0046)
- Medication Reviews (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215)
- Psychiatric Evaluations (90791, 90792)

Substance Use Provider Services

- Psychotherapy (90785, 90832, 90833, 90834, 90836, 90837, 90838)
- Group Therapy (90853), family therapy (90846, 90847, 90849) & Didactics (H2027)
- Assessments by a Non-physician (H0001, H0031, 90791)
- Treatment Planning (H0032)
- Medication Administration (96372, 99211, 99506, H0020)
- All Peer Services (H0023, H0038,)
- Medication Reviews (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215)
- Psychiatric Evaluations (90791, 90792)
- Early Intervention (H0022)
- Urinalysis (H0003)
- Buprenorphine (H0033)
- Naltrexone (J2315)
- Initial Blood Lab (H0047)
- Case Management (H0050)

These services are in addition to Psychiatric, E&M codes, that already had the prior authorization removed. It is important to note that removing the prior authorization is **not** a free pass to provide an unlimited amount of service. The amount, scope, frequency, and duration of services must be determined by medical necessity and through the person-centered/Individualized Treatment planning process. All the standards/rules listed in the Attachment to this memo must continue to be followed.

MCCMH is working to remove possible barriers to services and has not identified over-utilization of services in these areas, at this time. In place of the prior authorizations, MCCMH will begin using a retrospective review process for the utilization review of the services listed above. Retrospective reviews take many forms:

- Annual Site Visits
- Claim Verification Activities
- Claims Data Review
- Compliance Inquiries
- Targeted or Focused Reviews can be triggered at any time for any reason

Providers are encouraged to review the information in the attachment below closely. Please also review the accompanying document titles: **How to Enter a Service Activity Log Using a Service Code That Does Not Require Prior Authorization** and **How to Enter a Claim Using Direct Data Entry for a Service Code that Does Not Require Prior Authorization.**

Attachment

All services/claims pass through the multiple layers of claims edits and must meet the medical necessity criteria described in Michigan's Medicaid Provider Manual and in the Supplemental Medicaid Bulletins List located at:
http://www.michigan.gov/mdhhs/0,5885,7-339--87572--,00.html
http://www.michigan.gov/documents/mdch/SUPPLEMENTAL_BULLETIN_LIST-12-29-2006_182075_7.pdf
The Center for Medicare and Medicaid Services and MDHHS have specified broad evidence-based tests of medical necessity. MCCMH has adopted the following medical necessity definition to guide the provision of services. The service must be:

- Necessary to meet the basic needs/health of the person;
- Necessary for screening and assessing the presence of behavioral health and substance use disorders;
- Consistent with the person's diagnosis, symptomatology, and functional impairments and/or required to evaluate a disorder that is inferred or suspected;
- Rendered in the most cost effective and least restrictive manner that weighs safety and effectiveness;
- Sufficient in scope, frequency, and duration to be effective;
- Provided for reasons other than the convenience of the person his/her caretaker or provider;
- Reasonable and necessary for the diagnosis or treatment of illness or injury or to improve, diminish or stabilize the symptoms and improve/stabilize the functioning of a person;
- Expected to arrest or delay the progression and to forestall or delay relapse;
- Reasonable to reduce significant disability;
- Assistive in attaining or maintaining a sufficient level of functioning to enable the individual to live in his or her community.

In addition, medically necessary services should be based upon the following:

- Responsive to the needs of multicultural populations and furnished in a culturally relevant manner.
- Delivered in a timely manner, with immediate response in emergencies in a location that is accessible to the person.
- Provided in the appropriate level of care.
- Provided in sufficient amount, duration, and scope to reasonably achieve their purpose

And the determination of a medically necessary support, service or treatment must be:

- Based on information provided by the person, their family, and/or other individuals (e.g., friends, personal assistants/ aides) who know the person; and
- Based on clinical information from the person's health care professionals with relevant qualifications who have evaluated the person; and
- For people with mental illness and/or intellectual developmental disabilities, based on person centered planning; and for people with substance use disorders, based on individualized treatment planning; and,

- Made by appropriately educated, trained, and licensed mental health, substance use and/or intellectual and/or developmental disabilities professionals

FOCUS claims edits include, but are not limited to:

- A covered service defined the Person's applicable benefit plan;
- The Person meeting "eligibility" criteria for the benefit plan (e.g., Medicaid) on the date of service delivery;
- Service must be in the provider's contracted benefit array;
- An allowable diagnostic code must be included with the claim;
- Overlapping claim edits;
- The daily threshold (DT) listed on the PIHP/CMHSP Encounter Reporting Costing Per Code and Code Chart (as periodically updated) must not be exceeded. This information can be found at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

Qualitative rules include, but are not limited to:

- The Person meeting MCCMH's medical necessity criteria for the covered service on the date of service delivery;
- The Person having an assessed need completed by a qualified credentialed practitioner, with supporting evidence contained in the medical record;
- The Person having the covered service documented in the individual's Person-Centered Plan/Individualized Treatment Plan, as a service that was medically necessary that was contained in the Person's medical record;
- Documentation in the medical record that details what covered services were provided to the individual on the date of the encounter;
- Documentation in the medical record that the covered service was provided by an appropriately credentialed practitioner, qualified to render the covered service;
- Documentation in the medical and/or administrative records that the provider organization maximized all applicable first- and third-party payments due via the submitted claims encounter into MCCMH, and,
- Assurance that the claim encounter was submitted timely and in accordance with MCCMH claims payment protocols

Administrative rules in this area include, but are not limited to:

- Claims must be submitted within 60 days of the date of service
- Coordination of Benefit rules must be followed
- LOCUS, ASAM, and/or any other level of care assessment must support the need for the services provided

Operational rules in this area required providers who manually enter claims into FOCUS ('direct data entry' or 'DDE') to start the entry process by an authorization. While services

that do not require an authorization can be included on a DDE claim along with other services that are associated with an authorization, the DDE process requires the consumer have an authorization for at least one service at that location in the period being billed. If a provider submits claims electronically, by uploading an 837-claim file to FOCUS, this is not an issue. **Common errors** found during the retrospective review process that can lead to recoupment include, but are not limited to:

- Billing for medically unnecessary services
- Billing for services not rendered
- Billing for undocumented services - This is the most common reason for recoupment of funds. Every provider should ensure they have internal checks & balances in place to ensure documentation supporting that services were provided as billed exists prior to claims being submitted to MCCMH.
- The documentation of a service does not support the service and/or the time billed
- Characterizing non-covered services or costs in a way that secures reimbursement
- Not seeking payment from beneficiaries who may have other primary payment sources
- Errors made in billing due to ignorance of federal and state laws (ignorance of the law is not accepted as a valid defense)
- Delivering and billing for a service beyond what was necessary to treat the person effectively
- Delivering and billing a service that is clearly not helping the person
- Billing for a clinical service delivered by an “unqualified” provider

Please note that when identifying a pattern of claims’ issues MCCMH may, at its sole discretion, utilize an extrapolation methodology to reconcile claims as permitted and detailed in Medicaid policy.