MACOMB COUNTY COMMUNITY MENTAL HEALTH

UTILIZATION MANAGEMENT
PROGRAM DESCRIPTION

Version 1
2025 – 2027
Date of Approval: December 17, 2024

Contents

I. Introduction

Macomb County Community Mental Health (MCCMH) is the Prepaid Inpatient Health Plan (PIHP) and Community Mental Health Services Program (CMHSP) for Macomb County. MCCMH is the third largest Community Mental Health Services Program in the State of Michigan. MCCMH holds a Standard Contract with the Michigan Department of Health and Human Services (MDHHS) for the Medicaid Managed Care Specialty Supports and Services Waiver Programs. MCCMH participated in the Certified Community Behavioral Health Clinic (CCBHC) Expansion Project during its inception and has continued to participate as a CCBHC Demonstration Site. MCCMH is also a Behavioral Health Home and a Substance Use Disorder Health Home. This places MCCMH in a unique position to offer a full array of services and support to individuals seeking services.

Mission

Macomb County Community Mental Health, guided by the values, strengths, and informed choices of the people we serve, provides quality services, which promote recovery, self-sufficiency, and independence.

Values

MCCMH has a phrase that drives its mission to serve its community. The phrase is "Putting People First." The way MCCMH ensures it is putting people first is by embracing the core values of being accountable, collaborative, and respectful in all interactions. MCCMH Core Values are incorporated into all team member functions. MCCMH's Core Values are best implemented into actions when the below statements are true in all interactions:

Collaborative: "I approach all situations with a teamwork and solution focused mindset."
Accountable: "I take ownership and empower others to do the same."
Respectful: "I treat people with dignity while honoring individual differences."

II. Utilization Management Authority and Scope

MCCMH's Utilization Management (UM) process strives to improve health outcomes through quality initiatives by ensuring that individuals receive the right service, in the right amount, for the right duration. MCCMH Utilization Management includes multidirectional input from its Executive Leadership, Quality Improvement Committee, UM Committee, persons served and providers.

The UM activities continuously analyze the effectiveness of services offered and provided to persons served. Services provided by MCCMH include behavioral health, substance use services, ancillary, emergency departments, and non-institutional settings. In addition, UM activities include but are not limited to prior authorization, admission review, concurrent review, retrospective review, discharge planning, quality improvement and continuity of care.

Objectives

MCCMH's UM process focuses on the standardization of utilization management activities. Regardless of where these activities and functions occur, MCCMH retains responsibility to recommend and ensure improvement strategies across its service delivery network, particularly if adverse utilization trends are detected. UM activities engage in continued efforts toward data integrity processes including identification of overlapping services and coding errors.

Utilization Management Affirmative Statement Policy

MCCMH's UM Affirmative Statement encourages appropriate utilization management decisions by supporting MCCMH's position that no financial incentives are provided in decision making.

- MCCMH's policy is that UM decisions are based on appropriateness of care and coverage.
- MCCMH staff members making UM decisions are not rewarded for issuing adverse benefit determinations.
- MCCMH does not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services.
- MCCMH does not penalize or otherwise discourage providers from openly discussing treatment alternatives and medically appropriate care with persons served.

III. Utilization Process Management Process Structure

Oversight

MCCMH's organizational structure enables clear and effective administration and evaluation of the UM Process Description. MCCMH's Chief Executives Officer provides guidance and supervision to the Director of Managed Care Operations. The Director of Managed Care Operations is responsible for the development and implementation of the UM Committee and provides quarterly reports to the Quality Committee.

The Utilization Management (UM) Committee is chaired by the Director of Managed Care Operations (MCO) and conducts ongoing reviews of service utilization, application of medical necessity criteria, reviews and approves the UM Process Description, and compiles an annual UM Evaluation report. UM initiatives are reported to the Quality Committee at least annually.

The UM Committee is comprised of the Chief Medical Officer, Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Clinical Officer, Chief Network Officer, Chief of Quality, Director of Managed Care Operations (MCO), Director of Substance Use Services, Director of Clinical Informatics, MCO psychiatrists, MCO Administrator, Clinical Informatics Coordinator, and practicing providers in the network with the primary responsibility of providing direction, feedback, and/or approval on clinical aspects of health plan functions.

Roles of Committee

- Develop and monitor a regional utilization management plan.
- Set utilization management priorities based on the MCCMH strategic plan and/or contractual policy expectations.
- Recommend policies and practices for access, authorization, and utilization management standards consistent with external requirements and represent best practices.
- Participate in the development of access, authorization, and utilization management monitoring criteria and tools to assure compliance with approved policies and standards.
- Support development of materials and proofs for external quality review activities.
- Establish improvement priorities based on results of external quality review activities.
- Recommend regional medical necessities and level of care criteria.
- Perform utilization management functions sufficient to analyze and make recommendations relating to:
    - Controlling costs
    - Mitigating risk and assuring quality of care
    - Review and monitor utilization patterns
    - Analysis to detect and recommend remediation of over/under or inappropriate utilization.
    - Recommend improvement strategies where adverse utilization trends are detected.
    - Ensure UM coordination and information sharing to address continuity and efficiency of MCCMH processes.

Annual Evaluation

The UM Committee performs a formal evaluation of the MCCMH Utilization Management effectiveness and program activities. The review occurs annually and evaluates the goals, objectives, structure, policies and procedures, organization, and effectiveness of the program for the previous calendar year.

The annual UM Evaluation includes:

- Synopsis of the specific actions taken to improve utilization management and the results in terms of measurable outcomes;
- Trending of utilization data;
- Trending and evaluation of UM approvals, denials and appeals to make revision recommendations to the Authorization List;
- Assessment of member and provider complaints, specific to UM processes;
- Assessment of the organizational structure, functions, policies and procedures;
- An objective and clear discussion of any planned revisions to the UM Program Description;
- Staffing and other resources allocated to support the program; and
- Identification of program limitations and recommendations for the upcoming year.

MCCMH monitors several key performance indicators in the annual evaluations performed by the UM Committee that are focused on monitoring and improving UM processes.

Goals

MCCMH is committed to focus on forward planning for UM activities for the 2024-2025 Fiscal year.

1. Annually and based upon the established schedule, review Authorization Decision Guidelines for all populations served, obtaining input from various committees.
2. Monitor Over/Under Utilization of Services to decrease the gap between authorization and utilization by population, provider, and level of care.
3. Continue work on UM procedures, policies, and protocols to address NCQA standards. Implement feedback from the NCQA site review to ensure compliance for the next review period.
4. Assure fair and consistent UM/review decisions based on MCG, American Society of Addiction Medicine (ASAM), and other pertinent medical necessity criteria by monitoring the application of the applied criteria and service authorizations for behavioral health services (including substance use disorders) using a standard inter rater reliability process system wide.
5. Monitor the effectiveness of processes that promote utilization management procedures established from accrediting and regulatory agencies.

IV. Standards and Philosophy

Utilization Management is the process of monitoring the provision of service to persons served enrolled in one of MCCMH programs. MCCMH UM ensures adherence to statutory, regulatory and contractual obligations. Furthermore, utilization management activities are designed to be consistent and supportive of assuring achievement of MCCMH's mission, vision, and guiding principles.

MCCMH's UM policies provide a description of processes, procedures and criteria necessary to ensure cost-effectiveness, achieving the best outcome for persons served using the resources provided.

Various MCCMH management information systems support UM functions for reporting purposes. The functionalities and maintenance of such systems include but are not limited to:

1. Utilization of electronic health information systems and incorporation/integration of behavioral health and physical health data.
2. Real-time access to aggregate and case level information, which is complete, accurate, and timely.
3. Reporting services which are automated, routine, and inclusive of the system's logic.
4. Reporting formats which are readily available, graphically presented, easy to understand and present actionable information aligned to MCCMH objectives and standards.
5. Collection of uniform behavioral health and physical health data elements and utilization of functional assessment tools that provider input to levels of care and means to provide data to MCCMH to manage over/under utilization of services provided.

Access to MCCMH Services

MCCMH is the public provider of mental health, substance use, and developmental disability treatment services in Macomb County. Access to services begins with a phone call to the customer service line and the completion of a telephonic screening. The screening's purpose is not to determine eligibility but to understand the needs of individuals requesting services. MCCMH's Managed Care Operations (MCO) department connects the individual with resources intended to meet their needs. This means that they may be linked within the MCCMH provider network or linked externally. MCO and New Oakland Family Centers complete pre-screenings for hospitalization, partial hospitalization, intensive crisis stabilization, and crisis residential.

An individual may access MCCMH Behavioral Health Services through any of the following pathways:

- Requesting services directly from MCO.
- Face-to-face assessment by a local Community Mental Health Service Program (CMHSP).

- Crisis behavioral health services through the local CMHSP, inpatient hospitals, and mobile crisis teams.
- Requesting services from a local substance use disorder provider who, depending on the level of medically necessary care, subsequently collaborates with MCO for screening and authorization.

Service Standards

- Ensuring a welcoming, responsive access system available 8am-5pm Monday through Friday, MCO Case Managers are responsible for managing all requests with prompt, consistent screenings for services.

- An after-hours recording prompts callers to be directed to an after-hours decision tree. Callers are prompted to call back during regular business hours. Voicemail messages are responded to the next business day. Hospital providers and certain priority populations are given an option to reach an appropriate professional 24-hours per day. During business hours, outbound communications related to UM issues are handled by telephone, fax, or e-mail. Customer Service staff input data to start cases in the UM documentation system. MCCMH also provides interpreter and TTY services to members, at no cost to them.

Interpreter and Translation Services

MCCMH persons served can obtain translation services, plan information and materials for deaf, blind or in a language other than Spanish or English by calling MCCMH Customer Services. Services can be set up for telephonic translation services, as well as accompanying a person to a health-related office visit. Persons served who are blind can receive all materials in Braille, in audio form, or in large print.

Appropriate Professionals

UM Staff Members' Assigned Activities and Professional Qualifications:

- Chief Medical Officer (CMO):
    - Must have a valid Michigan License to practice as a physician, and Michigan controlled substance license. Additionally, they must have a valid and current Drug Enforcement Authority Registration. Board certification by the American Board of Psychiatry and Neurology as an adult psychiatrist is required;
    - Responsible for setting UM behavioral healthcare policies;
    - Provides on going oversight of the UM Program;
    - Reviews and updates the behavioral health medical necessity criteria;
    - Reviews UM behavioral healthcare cases including appeal cases;
    - Maintain accurate records of all communications and interventions in clinical software system, FOCUS;

- Serves as a liaison to the medical community on all issues designed to improve the quality of behavioral health services to enrollee/members;
- Functions as a liaison with local, state, and national psychiatric and medical organizations for the purpose of information gathering, networking to keep the Board of Directors and staff aware of trends in psychiatric and medical practice, research, training, and issues;
- Provides oversight of MCCMH contracted behavioral health psychiatrists;
- Collaborates with Director of MCO to set UM department yearly goals;
- Assists with the development of quality improvement processes and ensure accreditation and regulatory requirements are met;
- Conducts analysis of internal and external reports to evaluate UM outcomes and performance;
- Reviews and provides oversight to the annual UM Program Evaluation.

- **Managed Care Operations Psychiatrist:**
  - Must have a valid Michigan License to practice as a physician, and Michigan controlled substance license. Board certification by the American Board of Psychiatry and Neurology as an adult psychiatrist is preferred but not required
  - Must have completed a Psychiatric Residency approved by Accreditation Council for Graduate Medical Education (ACGME)
  - Reviews UM behavioral healthcare cases including denial and appeal cases
  - Maintains accurate records of all communications and interventions in electronic medical record system (FOCUS).
  - Conducts first level review of concurrent and post-service appeals
  - Participates on the UM committee
  - Participates on various internal and external committees
  - Participates in peer reviews

- **Director of Managed Care Operations:**
  - Master's degree in Social Work, Counseling, Psychology, or Doctorate in Psychology or a directly related mental health field from an accredited college or university.
  - Licensed Master Social Worker (LMSW), Licensed Professional Counselor (LPC), or Licensed Psychologist (LP). Responsible for the development and continual updating of all UM processes, policies and procedures.
  - Chair of UM committee.
  - Provides supervision and implements development plans for all MCO staff.
  - Oversees the on-going utilization review activities to monitor usage of services across all covered populations
  - Participates in multidisciplinary case reviews, to recommend/develop alternative treatment plans for complicated cases.

- Conducts analyses of internal and external reports to ensure compliance with contract, accreditation and regulatory requirements.
- Performs analysis of internal and external reports to evaluate UM outcomes.
- Collaborates with other departments and agencies.
- Establishes annual UM goals.
- Represents MCCMH in collaborative meetings or presentations with MDHHS, board associations, and contracted entities.
- Responsible for all UM reporting requirements.
- Provides oversight of outcomes of delegated entities.

- **Managed Care Operations Clinical Supervisor:**
  - Master's degree in Social Work, Counseling, Psychology or Doctorate in Psychology or a directly related mental health field from an accredited college or university.
  - Licensed Master Social Worker (LMSW), Licensed Professional Counselor (LPC), or Licensed Psychologist (LP).
  - Provides day to day supervision of assigned MCO staff, participates in staff training, monitors for consistent application of UM criteria by MCO staff for each level and type of UM decision.
  - Monitors documentation for accuracy and is available to UM staff on site or by electronic communication.
  - Applies clinical experience, health plan benefit structure and claims payment knowledge to pre– and post-service reviews.
  - Leverages clinical knowledge, business rules, regulatory guidelines and policies and procedures to determine clinical appropriateness.
  - Accountable for timely and comprehensive review of clinical data with concise documentation, decisions, and rationale.
  - Completes case documentation according to regulatory standards and clinical procedures.
  - Conducts/supervises prospective reviews for service authorizations as identified by MCCMH.
  - Conducts/supervises concurrent clinical case reviews as needed.
  - Conducts/supervises retrospective reviews of service provision to ensure services were provided in the appropriate amount, scope, and duration to reasonably achieve goals as outlined in the individualized plan of service (IPOS).
  - Analyzes data and management reports. Provides recommendations for improvement plans and recognition for exemplary practices.

- **Managed Care Operations Therapist:**
  - Master's degree in Social Work, Counseling, Psychology or Doctorate in Psychology or a directly related mental health field from an accredited college or university.

- Licensed Master Social Worker (LMSW), Limited Licensed Master of Social Work (LLMSW), Licensed Professional Counselor (LPC), Limited License Professional Counselor (LLPC), Temporary Limited Licensed Psychologist (TLLP), or Licensed Psychologist (LP).

- Leverages clinical knowledge, business rules, regulatory guidelines and policies and procedures to determine clinical appropriateness.
- Accountable for timely and comprehensive review of clinical data with concise documentation, decisions, and rationale..
- Maintains accurate records of all communications regarding the authorization process in MCCMH's electronic medical record (FOCUS).
- Reviews pre- and post-service behavioral health requests for benefits and/or medical necessity.
- Refers cases as appropriate to physician for review.
- Reviews clinical information for psychiatric hospitalization concurrent reviews, extending the length of stay for inpatient admissions as appropriate.
- Prepares denial letters.
- Understands and reviews Michigan County of Financial Responsibility (COFR) guidelines and refers any possible COFR individuals to the Managed Care Operations Administrator for follow up.

- **Managed Care Operations Case Manager**
  - Bachelor's degree in Social Work, Counseling, Psychology, or a directly related mental health field from an accredited college or university.
  - Ensures adequate, accurate and timely screenings.
  - Screens for Medicaid specialty services and support, and appropriate level of care by utilizing clinical level of care tools (LOCUS, MichiCANS, and ASAM).
  - Completes all documentation accurately and completely within the appropriate timeframes.
  - Sets intake appointments with provider agencies and other community agencies.
  - Adheres to established Quality Improvement Key Performance Indicators.
  - Understands MCCMH provider agencies and informs appropriate and available choice of agency and services to those eligible for MCCMH services.
  - Maintains knowledge of multiple community resources and communicates them to individuals in need and/or who do not meet criteria for MCCMH services.
  - Monitors the treatment compliance of Macomb County individuals placed on an Assisted Outpatient Treatment (AOT) court order.

- **MCCMH Due Process Coordinator:**
    - Reviews clinical documentation to determine completeness of information submitted.
    - Requests additional information as needed to assist with review of appeals.
    - Coordinates case review with MCCMH physician on clinical cases that do not meet the medical necessity criteria.
    - Prepares appeals for independent medical review and other state and federal government reviews.
    - Responds to inquiries regarding status, process, and outcome of UM appeals.
    - Communicates either verbally or in writing regarding the outcome of UM appeals.
    - Interfaces with other MCCMH departments to resolve UM appeals issues.
    - Completes appropriate documentation in clinical systems (FOCUS) in compliance with regulatory and accreditation standards.
    - Participates on committees or special projects as needed.
    - Manages the data gathering and analysis of reports regarding UM appeal activity and preparation for appeal audits.

v. Clinical Criteria for UM Decisions

Determination of Medical Necessity Criteria

MCCMH has adopted behavioral health guidelines from MCG, part of the Hearst Health Network. MCG utilizes clinical editors who analyze and classify medical necessity guidelines that support MCCMH UM. The MCG Behavioral Health guidelines are available through a secure website at the following URL, http://cgi.careguidelines.com/login-careweb.htm.

MCG Behavioral Health Care criteria include:

- Behavioral health guidelines which identify the most effective level of care for specific behavioral health conditions;
- Level of care guidelines that assess a person's level of care needs in situations where a diagnosis-specific guideline does not apply.
- Five (5) levels of care covering inpatient, residential, partial hospitalization, intensive outpatient, and outpatient.
- Therapeutic and testing procedures that provide specific criteria for determining when a procedure, treatment, or diagnostic test may be indicated.
- Detailed discharge criteria focus on specific care elements to consider when discharging patients to a lower level of care.
- Flexible recovery courses manage longer behavioral health episodes with recovery courses listed in care days for in-patient treatments and stages for out-patient treatments.
- Alternative care planning helps to select effective alternative therapies and levels of care based on the specifics of a person's case.

Clinical Information

Clinical information used by MCCMH to make utilization determinations includes, but is not limited to:

1. Individual Plan of Service (IPOS)
2. Office and hospital records
3. Clinical assessment
4. Diagnostic testing results
5. Progress notes
6. Person's served psychosocial history
7. Information from consultations with the treating practitioner
8. Evaluations from other health care practitioners and providers
9. A printed copy of criteria related to the request information regarding benefits for services or procedures
10. Information regarding the local delivery system

MCCMH does not routinely request copies of all medical records to conduct utilization reviews. During utilization review, copies of the pertinent sections of medical records are only required when a difficulty develops in determining whether the health care is medically necessary or appropriate, experimental, or investigational.

Criteria Review, Approval and Distribution

MCCMH uses various internal and external UM decision-making tools when reviewing criteria for authorizations. A component of prospective, concurrent, and retrospective review is the use of criteria and evidence-based guidelines, such as MCG guidelines. Utilization data is examined to identify outcomes, determine patterns of possible over- and/or under- utilization, and to ensure continuity of care.

MCCMH uses the following documents to make benefit coverage determinations:

- Evidence of Coverage
- Summary of Benefits and Coverage
- Medicaid Provider Manual
- LOCUS
- MichiCANS
- DECA
- ASAM
- MCCMH Policies and Procedures

Licensed physicians oversee UM decisions to ensure consistent medical necessity decision making. Efforts are made to obtain all necessary clinical information to render a decision. The rationale for all utilization review decisions is clearly documented and available to the MCCMH provider and the person served.

Standards in Decision Making Process

- MCCMH staff and delegates that perform utilization review do not observe, participate, and are not present during a person's served physical or mental examination, treatment, procedures, or therapy unless approved by the provider and person served.
- Physicians, doctors, and other health care providers employed by or under contract with MCCMH to perform utilization review are appropriately trained, qualified, and currently licensed. Personnel conducting utilization review hold unrestricted licenses, an administrative license, or are otherwise authorized to provide health care services by a licensing agency in the United States.

- Staff are not permitted to receive compensation, nor is it a condition of employment or the evaluation process to base performance ratings on:

    - Volume of adverse determinations.

    - Reductions or limits on length of stay, benefits, services or charges.

    - The number or frequency of telephone contacts with providers or persons served.

- Quality of care is not adversely impacted by financial and reimbursement-related processes and decisions.

- Utilization review determinations are made in a manner that takes special circumstances of the case into account that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include an individual with a disability, acute condition, or life-threatening illness.

Medical Necessity Determinations

Requests for services are reviewed for medical necessity. Medical necessity is defined as mental health, developmental disabilities, and substance use services when they meet the following criteria, or other criteria as set forth in the current version of the Michigan Medicaid Provider Manual and applicable MCCMH policies:

1. Necessary for screening and assessing the presence of a mental illness, developmental disability, or substance use disorder;

2. Required to identify and evaluate a mental illness, developmental disability, or substance use disorder;

3. Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, developmental disability, or substance use disorder;

4. Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

5. Designed to assist the beneficiary to attain or maintain a sufficient level of functioning to achieve their goals of community inclusion and participation, independence, recovery, or productivity.

Note: MCCMH is part of Michigan's CCBHC Demonstration Project under which services to individuals who meet the criteria for mild to moderate mental health issues may be able to receive services.

Documentation submitted by requesting practitioners and organizational providers must support the following requirements for medical necessity:

- Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;
- Provided in compliance with all applicable laws, policies, and procedures.
- Provided at the appropriate levels of care for a person's behavioral health conditions.
- Consistent with health care practice guidelines and standards endorsed by professionally recognized health care organizations or governmental agencies.
- Consistent with the person's diagnoses.
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
- Not experimental or investigational.
- Not primarily for the convenience of the person served, practitioner, or organizational provider.
- Not more costly than an alternative service at least likely to produce equivalent diagnostic or therapeutic results as to the treatment of the person's injury or disease.

MCCMH reserves the right to review all services to determine whether they are medically necessary.

Prospective Review

Prospective review is the process in which clinical information and requests are reviewed to determine medical necessity before rendering services. Review determinations are based on the

medical information obtained at the time of the review. Prospective review allows for a person's eligibility and benefit determination, the evaluation of proposed treatment, determination of medical necessity, and level of care assessment prior to the delivery of service. Prospective screening for medical necessity and appropriateness of specified services is performed by a master's level clinician and if needed, reviewed by a physician.

Concurrent Review

Concurrent review is the process of ongoing review of hospitalizations, through communication with the hospital physicians and other healthcare professionals. This communication process takes place by telephonic review and electronic review to approve appropriate, medically necessary care for continued medical treatment. Review determinations are based on the medical information obtained at the time of the review. The frequency of continued stay review is based upon diagnosis, guidelines, or change in the person's health condition status.

Standards for Review

MCCMH uses MCG, the Michigan Medicaid Provider Manual and other Health Plan developed guidelines to assist in UM decision making. These criteria are evidence-based, scientifically valid, outcome-focused, and comply with the requirements in Michigan Insurance Code §4201.153. MCCMH recognizes that evidence-based medicine may not always be available for a particular health care service provided. In those cases, generally accepted standards of medical practice recognized in the medical community are used for decision making.

Inter-rater reliability testing is performed annually to ensure criteria are consistently applied by staff.

UM criteria are reviewed and recommended for approval by the UM Committee, with informational presentation to the Quality Committee. These criteria are subject to ongoing review by physician reviewers, to include selected specialists. The criteria are used by MCO Therapists as medical necessity screening tools to provide authorization of services. Only a physician or doctorate level psychologist may deny services.

Post-Service Review

Post-service review is a process consisting of obtaining medical information to determine medical necessity as it relates to services that have been provided when there has been no notification or request for review during the pre-service or concurrent process or when clinical information was not available at the time services were being rendered. Medical records may be required for the post-service review process. Review determinations are based solely on the medical information available.

Ongoing Implementation and Monitoring

The ongoing monitoring of UM activities is completed by the UM Committee. UM monitoring is done through utilization and claim analysis and evaluation of reports. UM monitoring metrics, outcomes, and activities are reported to the UM Committee and Quality Committee.

Adverse Determinations

Any case that does not meet criteria for medical necessity is referred to a physician for review. Only a physician or qualified clinical consultant may issue an adverse determination based on medical necessity. The qualified reviewer consults with the physician for clinical information, as appropriate. There is a mechanism in place for the attending physician to contact the clinical reviewer to discuss the adverse determination.

Coordination and Continuity of Care

The MCCMH Utilization Management plan is designed to maximize timely local access to services for individuals served while providing an outlier management process to reduce over and underutilization (financial risk) for each network providers and the substance use disorder provider network. The Utilization Management Plan endorses two core functions.

1. Outlier Management identified inflated cost, elevated risk service outliers or those with need under-utilizing services.
2. The Outlier Management process provides real-time service authorization determination and applicable appeal determination for identified service outliers. The policies and procedures meet accreditation standards for Behavioral Health services (Specialty Behavioral Health Medicaid and SUD Medicaid and Community Grant). Service authorization determinations are delivered real-time via a managed care information system or a telephonic review process (prospective, concurrent, and retrospective reviews). Outlier Management and level of care guideline methodology is based upon service utilization across the region. The model is flexible and consistent based upon utilization and funding methodology. Oversight and monitoring of delegated specialty behavioral health UM functions.

The Utilization Review process uses monthly review of outlier management reports and annual review with specialized audit tools that monitor contractual, statutory, and regulatory requirements. The reports and internal standardized utilization protocols speak to ensuring intensity of service matching level of care with services and typical service utilization as well as any additional external audit findings. Should any performance area be below the established benchmark standard, the Utilization Review process requires that a Corrective Action Plan be submitted to address any performance deficits. MCCMH Quality staff monitor the implementation of the Corrective Action Plans.

The outlier management process and subsequent reports to manage it, including over and underutilization and uniformity of benefit, are based on accurate and timely assessment data and scores of agreed tools and service determination transactions being presented to the UM Committee for review and implementation of level of care guidelines and development.

VI. Timeliness of UM Decisions

MCCMH Policy 12-004, "Service Authorization Policy" specifies that all service authorizations shall be made in compliance with applicable state and federal law, the Michigan Medicaid Provider Manual, and applicable MCCMH policies and procedures.

Standard Authorization

Notice of the authorization decision must be provided no later than fourteen (14) calendar days following receipt of a request for service. MCCMH may extend the fourteen (14) calendar day timeframe by up to an additional fourteen (14) days if either of the following occur:

- The person served or provider requests an extension, or
- MCCMH justifies (to MDHHS upon request) a need for additional information and how the extension is in the person's best interest.

Expedited Authorization

In cases in which a provider indicates or MCCMH determines that following the standard timeframe could seriously jeopardize the person's health and safety, MCCMH must make an expedited authorization decision and provide notice of the decision no later than seventy-two (72) hours after receipt of the request for service. MCCMH may extend the seventy-two (72) hour timeframe by up to fourteen (14) calendar days if either:

- The person requests an extension, or
- MCCMH justifies (to MDHHS upon request) a need for additional information and how the extension is in the person's best interest.

When a standard or expedited authorization of services decision is extended, MCCMH must:

1. Make reasonable efforts to give the individual prompt oral notice of the delay;

2. Within two calendar days, provide written notice of the reason for the decision to extend the timeframe, and inform them of their right to file a grievance if they disagree with that decision;

3. Issue and carry out the service authorization determination as expeditiously as possible and no later than the date the extension expires.

When more information is needed to make coverage or appeal decisions, MCCMH shall request the needed clinical documentation and document at least one attempt to obtain it. If, after the documented attempt, MCCMH does not receive any additional information, MCCMH shall make the best decision it can based on the available information within the required timeframes. In its sole

discretion, MCCMH may extend a previous existing authorization for up to thirty (30) days while it gathers needed information on which to base the authorization.

MCCMH must notify the requesting provider and give the person served written notice of:

1. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Notice to the person served must be sent within the applicable standard or expedited authorization timeframes described above.

2. A service authorization decision not reached within the relevant timeframe prescribed above constitutes a denial of services and is therefore considered an Adverse Benefit Determination. Notice must be mailed to the Medicaid enrollee no later than the date on the date that the period expired.

3. In such cases, MCCMH must provide the Medicaid enrollee with Adequate Notice of Medicaid Adverse Benefit Determination that meets the requirements described in MCCMH MCO 4-004, Due Process System.

Compensation to individuals or entities that conduct utilization management activities shall not be structured to provide incentives for them to deny, limit, or discontinue medically necessary services to any Medicaid enrollee.

Requests for continued authorization may be submitted for review up to sixty (60) calendar days, and no later than fourteen (14) calendar days, in advance to ensure that authorization is in place at the start of the new authorization period.

VII. Policy on Appeals

MCCMH has well-established and readily available appeal mechanisms for both providers and members. The appeal process is included in the denial notification letters distributed to providers and members and is also discussed with the physician during telephonic notification. The MCCMH MCO Policy Manual and Member Handbook delineate appeal processes. Appeal processes and descriptions are outlined in MCCMH Policy 4-004, “Due Process System.” Well publicized and accessible appeal mechanisms are available for both the providers and individuals receiving services. Notification of denials should include a copy of how to file an appeal.

The MCCMH Ombudsman assists persons served with informal concerns and filing grievances. When the Ombudsman receives a grievance, if the person requests someone else to represent them in the process, the Ombudsman will request that this be in writing. The Ombudsman sends a written acknowledgement of the grievance. Once a grievance is resolved, the MCCMH Ombudsman sends written notice of the resolution containing the results of the grievance, the closing date of the grievance, and information on how to access a State Fair Hearing.

Timeliness of the Appeal Process

Upon receipt of a notice of Adverse Benefit Determination persons served have the right to appeal the Adverse Benefit Determination through the Local Dispute Resolution (LDR) Process, if the following conditions are satisfied:

1. The person served or their representative requests the LDR within 30-calendar days from the date on the notice of Adverse Benefit Determination.
2. The person served or their representative requests the LDR either in writing or orally followed and confirmed by a written, signed request for appeal.

Appeal Reviewers

MCCMH ensures that the individuals who make the decision on appeals:

1. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual
2. Consider all comments, documents, records and other information submitted by the person served or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
3. When deciding an appeal that involves either clinical issues or a denial based on lack of medical necessity, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the person served's condition or disease.
4. Appeal Reviewers must provide the person served a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing and inform the person served or their representative of the limited time available for this sufficiently in advanced of the resolution timeframe for appeals (standard/expedited, as applicable).
5. Appeal Reviewers must provide the person served or their representative the case file, including medical records and any other document or records considered, relied upon, or generated by or at the direction of the PIHP in connection with the appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals (standard/expedited as applicable)
6. Appeal Reviewer must provide an opportunity to include as parties to the appeal the person served and their representative or the legal representation of a deceased person's estate.
7. Appeal Reviewers must provide the Medicaid Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.

Practitioners for Review of Denials

Staff performing UM reviews and/or UM functions such as initial, concurrent and post-service reviews, denials and appeals must be credentialed and re-credentialed. The credentialing process defined by MCCMH supports our commitment to ensure that each person, directly or indirectly or contractually engaged, meets at least MDHHS licensing, training and scope of practice, CMS, contractual and Medicaid Provider Manual requirements.

Qualified clinicians who have demonstrated experience in the specialty areas in which they are making decisions may initiate and carry out UM reviews and duties. Clinicians authorizing SUD services must have certification as a Certified Addiction Drug Counselor (CADC) or a Certified Advanced Addiction Drug Counselor (CAADC) or have an approved development plan by the Michigan Certification for Addiction Professionals (MCBAP) or be certified as a Qualified Mental Health Professional (QMHP). A clinician must be credentialed and re-credentialed as Qualified Mental Health Professional (QMHP), Qualified Intellectual Disability Professional (QIDP) and/or a Child Mental Health Professional (CMHP), if authorizing those populations to be certified to complete the pre-admission review (PAR) or Utilization Management (UM) staff functions. Due to a conflict of interest, these practitioners may not provide direct services, including crisis intervention, for the enrollee/member they are screening for pre-admission review.

Notification of Appeal Decision

MCCMH must acknowledge receipt of each request for appeal in writing and maintain a record of appeals for review by the State as a part of its quality strategy and to allow reporting to the MCO/PIHP Quality Improvement Program.

Standard Appeal Resolution

The PIHP must resolve the appeal and provide Notice of Resolution of Appeal to the affected parties as expeditiously as the person served's health condition requires, not later than 30-calendar days from the day the PIHP receives the request for appeal.

Expedited Appeal Resolution

1. The PIHP determines (when the appeal request come directly from the person served without the support of their provider) or the provider indicated (in making a request on the person served's behalf or supporting the person served's request) that the time for a standard resolution could seriously jeopardize the person served's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
2. The PHIP may not take punitive action against a provider who requests an expedited resolution or supports a person served's appeal.
3. If a request for expedited resolution if denied, the PIHP must:
    a. Transfer the appeal to the time for standard resolution
    b. Make reasonable efforts to give the person served prompt oral notice of denial.
    c. Within two calendar days, give the person served written notice of the reason for the decision and inform the Medicaid Enrollee of the right to file a Medicaid Fair Hearing request if they disagree with the decision.
    d. Resolve the appeal as expeditiously as the person served's health condition requires.

e. If a request for expedited resolution is granted, the PIHP must resolve the appeal and provide Notice of Resolution of Appeal to the affected parties no later than 72-hours after the PIHP received the request for expedited resolution.

Extension of Timeframes

1. The PIHP may extend the standard or expedited timeframe for reaching resolution and providing notice by up to 14-calendar days if the person served requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the person's interest.
2. If the PIHP extends resolution/notice timeframes not at the request of the person, it must complete all of the following:
    a. Make reasonable efforts to give the person served prompt oral notice of the delay
    b. Within two (2) calendar days, give the person written notice of the reason for the decision to extend the timeframe and inform the Medicaid Enrollee of the right to file a Medicaid Fair Hearing if they disagree with the decision
    c. Resolve the appeal as expeditiously as the person's health condition requires and not later than the date the extension expires.

Notice of Resolution of Appeal

1. The PIHP must provide persons served or their representatives with written Notice of Appeal Resolution and must also make reason efforts to provide oral notice in the case of an expedited resolution.
2. The notice must meet the requirements of 42 CFR 438.10 (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency). (Refer to MCCMH MCO 4- 010, "Provision and Distribution of Information to Consumers").
3. The Notice of Appeal Resolution must include the results of the appeal and the date it was completed.
4. When the appeal is not resolved wholly in favor of the Medicaid Enrollee, the Notice of Resolution of Appeal must also include notice of the Medicaid Enrollee's: (i) right to request a State Fair Hearing, and instructions on how they can do so; (ii) right to request to receive continuation of Medicaid benefits while the State Fair Hearing is pending, and instructions on how to timely and properly make the request; and (iii) potential liability in the amount of the cost of those continued Medicaid benefits, if the hearing decision upholds the PIHP's Medicaid Adverse Benefit Determination.
    a. In any case where MCCMH fails to adhere to the notice and timing requirements for resolution of appeals, the Medicaid Enrollee will be

deemed to have exhausted the Local Appeal Process, and the Medicaid Enrollee will be permitted to initiate a State Fair Hearing.

Continuation / Reinstatement of Medicaid Services Pending Appeal

1. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered/requested by an authorized provider, the PIHP MUST continue the Medicaid Enrollee's benefits if all of the following occur:
    a. The Medicaid Enrollee files the request for appeal timely (within 30-calendar days from the date on the Medicaid Adverse Benefit Determination Notice);
    b. The Medicaid Enrollee files the request for continuation of benefits on or before the latter of (i) 10 calendar days from the date of the notice of Medicaid Adverse Benefit Determination, or (ii) the intended effective date of the proposed Medicaid Adverse Benefit Determination; and
    c. The period covered by the original authorization has not expired

Duration of Continued or Reinstated Benefits

1. If benefits are continued or reinstated at the Medicaid Enrollee's request while the Appeal or State Fair Hearing is pending, they must be continued until one of following occurs:
    a. The Medicaid Enrollee withdraws the appeal or request for State Fair Hearing;
    b. The Medicaid enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after PHIP sends the Medicaid Enrollee notice of an adverse resolution to the Medicaid Enrollee's appeal
        NOTE: This means that for a Medicaid Enrollee to receive continuation of Medicaid benefits pending a State Fair Hearing, the Medicaid Beneficiary must request the State Fair Hearing and request continuation of benefits within 10-calendar days after the PIHP sends notice of adverse resolution to the Medicaid Enrollee's Appeal.
    c. A State Fair Hearing office issues a decision adverse to the Medicaid Enrollee.
2. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Medicaid Adverse Benefit Determination, the PIHP may, consistent with the state's usual policy on recoveries and as specified in the PIHP's contract, recover the cost of services furnished to the Medicaid Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements.

3. If the Medicaid Enrollee's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action
4. If the PIHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the Medicaid Enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations
5. If the PIHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the Medicaid Enrollee's health condition requires, but no later than 72-hours from the date it receives notice reversing the determination.

Documentation of Appeal Requests

When a request for an appeal is received by MCCMH, the Due Process Coordinator enters the information into the Local Appeal Request Form and a Notice of Receipt of Appeal Form is completed in FOCUS which documents the date and time of request and auto-fills in the Appeals Log. All documentation is then reviewed in FOCUS by the Appeals Committee. The Appeals committee, which includes an individual who is of the same or similar specialty of the appropriate professional who made the original denial decision, decides within the appropriate timeframe and enters the decision into FOCUS. The date of determination is timestamped on the chart note documenting the determination of the Appeal Committee. The Due Process Coordinator manually enters the determination date into the Appeals Sheet which auto-populates the Appeals Log in FOCUS.

VIII. System Controls

MCCMH maintains identification and authentication safeguards to secure data stored in its electronic information technology systems and procedures to ensure the integrity of the data.
MCCMH conducts ongoing security monitoring of its systems through virus scanners, firewalls, system and software logs, version controls, and multi-factor authentication.

System Control Access

FOCUS access is limited to individuals authorized to upload, review, modify, or disclose behavioral health information in performance of their assigned duties. Unauthorized access, changes to, and release of information is prevented by password-protected electronic systems. MCCMH maintains user requirements including but not limited to: The use of strong passwords using different passwords for different accounts, prohibiting the sharing or writing down of passwords, updating passwords periodically Reviewing, modifying, or revoking access privileges

when an employee experiences a change in circumstances such as being transferred or terminated from current role. For more information on MCCMH's system management, refer to MCCMH Policy 10-031, "Expectation of Privacy." Security permissions for denial and appeal logs are limited to MCCMH's FOCUS access team sets up permissions based upon an individual's designated role and electronic permissions.

UM Denial and Appeal System Controls Oversight

Denial and appeal information is securely stored in MCCMH's FOCUS electronic medical record (EMR) system. Such information includes but is not limited to: Documentation related to requests for services; Level of care determinations and benefit eligibility; Notification to members and providers on the approval or denial of the requested benefit; This information is automatically stamped on time and date within the FOCUS system. Any modifications to the document, including the selected reason and the date/time stamp of the modification, are tracked within FOCUS.

The date of the denial and/or appeal determination, as listed on the written notification, is defined as the date on which MCCMH generates and sends the decision letter to the member and provider. Denial and appeal documentation related to requests for appeals; When an appeal is requested by a member or a member's authorized representative, the necessary information is entered into FOCUS and an acknowledgement letter is generated and sent within five (5) calendar days for standard appeal requests and within twenty-four (24) hours for expedited appeal requests. All entered information is automatically time/date stamped within FOCUS. FOCUS tracks any modifications made to a document, the selected reason for modification, and the date/time stamp of the modification.

Systems Control Monitoring

Denial and Appeal Logs are tools used to monitor and determine that timeliness and appropriate professionals' criteria are met. Access to the confidential denial and appeal logs is limited to designated MCCMH staff that includes members of the Appeals Committee, the Due Process Coordinator and select UM staff. Individuals given access are assigned in FOCUS to a user group that defines the level of permission granted (such as ability to view the log, enter into the logs, or modify the logs.) Once the user groups are determined, those user groups are added to the appropriate functions. After initial review of the information generated, the designated staff will add the following fields to the log as it pertains to their involvement:

Denial Log

- Department from which the denial was generated from
- Provider name
- Level of service
- Type of denial

- Type of review
- Date and time adverse action was made by the appropriate professional (physician/doctoral level psychologist)
- Date and time verbal notification was given to provider of adverse action decision

Appeal Log

- Department from which the appeal was generated from
- Member initials
- Date appeal request was received from member
- Type of appeal request
- Method of appeal request
- Service provider
- Category of appeal
- Disposition date and time type of decision rendered
- Verbal notification to member of appeal decision date and time

The logs automatically track entries by electronically stamping the User ID, date, and time. When modifications are made, FOCUS tracks the following: Time and date the information was added; Time and date of any changes; The assigned staff who made the changes; and Reason(s) for changes made.

Ongoing Monitoring

MCCMH conducts a monthly audit of modified files to ensure consistency in adherence to required standards. The audit reviews:

- The Denial and Appeal Logs
- The Consumer Access Log
- Cases from the Denial and Appeal Logs are compared to the user activities listed on the Consumer Access report for modifications made, including deletions.

Any modifications and rationales for change must be documented/recorded on the Denial and Appeal Audit tools. The appropriateness of modifications will be assessed. Any modifications that do not meet the appropriate modifications identified in this procedure will be addressed with a corrective action plan and monitored quarterly until improvement is found for at least three (3) consecutive quarters. Team members found in violation of this procedure may be subject to disciplinary action, consistent with MCCMH's policies.

Security of Information

MCCMH team members must take all necessary precautions to secure MCCMH equipment, data, files, and other materials to prevent unauthorized access, destruction, or tampering.

Team members may not compromise the confidentiality or security of data, protected health information (PHI), personally identifiable information, or other sensitive information due to remote computer access.

All team members must comply with the policies and guidelines of proper use of information technology found in MCCMH's policies. Any breaches of secure or confidential information must be reported immediately to MCCMH's IT and Compliance Departments. MCCMH performs testing of its system's automatic alerts or flags annually and a real time review of the system's alerts and flags is monitored.

IX. Delegation of UM Function

MCCMH maintains executed pre-delegation agreements for the delegated UM functions of initial authorization of inpatient hospitalization, partial hospitalization, crisis residential, and intensive crisis stabilization to New Oakland Family Centers. New Oakland has appropriately degreed and credentialed staff to perform initial delegated functions.

For individuals who require on-going service reviews MCCMH's MCO Therapists review the request and determine if the requested services are medically necessary. If the request is approved, the MCO Therapist processes the authorizations. All denials based on medical necessity are reviewed and processed by the consulting agreement with PREST who provide credentialed MD, DO, or PhD professionals.

PREST is an accredited consultant as an Independent Review Organization by the URAC. PREST provides MCCMH with utilization review and Peer to Peer reviews when medically necessary. MCCMH reviews and monitors monthly PREST denials by the Managed Care Operations Director/Administrator.