MCCMH MCO Policy 12-004

Chapter: **UTILIZATION MANAGEMENT**
Title: **SERVICE AUTHORIZATIONS**

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I. ABSTRACT

This policy establishes the standards and procedures of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, to ensure that service authorization requests are processed in an amount, scope, and duration that are medically necessary and consistent with applicable state and federal law, the Michigan Medicaid Provider Manual, and MCCMH's Prepaid Inpatient Health Plan (PIHP) Contract.

II. APPLICATION

This policy shall apply to all directly-operated and contract network providers of MCCMH.

III. POLICY

It is the policy of MCCMH, as an official agency of the County of Macomb, to ensure that medical necessity determination decisions are made by appropriate professionals, based on established criteria, and completed in a timely manner that meets the needs of individuals requesting services.

IV. DEFINITIONS

A. Adequate Notice of Medicaid Adverse Benefit Determination:
A written statement advising individuals of a decision to deny or limit authorization of Medicaid services that were requested. Adequate Notice of Medicaid Adverse Benefit Determination will be provided on the same date the Medicaid Adverse Benefit Determination takes effect.

B. Advance Notice of Adverse Benefit Determination:
A written statement advising individuals of a decision to reduce, suspend, or terminate Medicaid services currently provided. Advance Notice is sent to the individual at least ten (10) days prior to the proposed date when the Medicaid Adverse Benefit Determination is to take effect.

C. Expedited (Urgent) Service Request:
An authorization request where the individual has an urgent or emergent need whereby application of the timeframe for making routine or non-life-threatening care determinations could seriously jeopardize the life, health, or safety of the person served or others, due to the person's psychological state, or would subject the person to adverse health consequences without the care or treatment.

D. Individual Plan of Service (IPOS):
The document that identifies the needs and goals of the individual and the medical necessity, amount, duration, and scope of the services and supports to be provided. This formal written plan must be developed through a person-centered process and accepted by the individual or their legal representative. The IPOS should include all services, including clinical services, support services, natural supports, and services received from other community organizations.

E. Legal Representative:
An adult person's legal guardian or a minor's parent or legal guardian.

F. Medicaid Adverse Benefit Determination:
Any of the following, as it relates to Medicaid enrollees:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an adverse benefit determination.
4. Failure to make a standard authorization decision and provide notice about the decision within seven (7) calendar days from the date of receipt of a standard request for service. (Note: This timeframe may be extended up to an additional fourteen (14) calendar days in certain circumstances.)
5. Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited service authorization. (Note: This timeframe may be extended up to an additional fourteen (14) calendar days in certain circumstances.)
6. The failure to provide services in a timely manner. The State defines timely as being within fourteen (14) calendar days of the start date agreed upon during the person-centered planning and as authorized by MCCMH.
7. Failure of MCCMH to resolve standard appeals and provide notice within thirty (30) calendar days from the date of a request for a standard appeal.
8. Failure of MCCMH to resolve expedited appeals and provide notice within seventy-two (72) hours from the date of a request for an expedited appeal.
9. Failure of MCCMH to resolve grievances and provide notice within ninety (90) calendar days of the date of the request.
10. For a resident of a rural area with only one Managed Care Organization, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network; or
11. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

G. Medical Necessity
Determination that a specific service is medically (clinically) appropriate; necessary to meet needs; consistent with the person's diagnosis, symptomatology, and functional impairments; is the most cost-effective option in the least restrictive environment; and is consistent with clinical standards of care. The medical necessity of a service shall be documented in the individual plan of service (IPOS).

H. Person Served:
Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by MCCMH, including Medicaid beneficiaries, and all other recipients of services.

I. Post-Service Request:
An authorization request for services already provided.

J. Service Authorization Review:
Processing of evaluating a request for services to determine if they meet established criteria for coverage, medical necessity, and benefit eligibility before approving, partially denying, or denying.

K. Standard (Non-Urgent) Service Request:
An authorization request for which application of the time periods for making a decision do not jeopardize the life or health of the person or the person's ability to regain maximum function and would not subject the person to severe plan.

L. Utilization Management:
The process by which MCCMH reviews the use of medical services and resources to ensure they are medically necessary, are performed in the most appropriate care setting, and are at or above quality standards.

V. STANDARDS

A. All service authorizations shall comply with applicable state and federal law, the Michigan Medicaid Provider Manual, and applicable MCCMH policies.

B. MCCMH uses formalized utilization management criteria to make utilization management decisions. MCCMH's utilization management criteria are available on its website at www.mccmh.net and can be requested by contacting MCCMH at 855-996-2264.

C. Mental health, intellectual/developmental disabilities, and substance use supports, services, and treatment may be deemed medically necessary 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 person served to attain or maintain a sufficient level of functioning to achieve their goals of community inclusion and participation, independence, recovery, or productivity.

D. When applying medical necessity criteria, MCCMH has a process for incorporating consideration of the local delivery system.

1. Consider whether the available services in the local delivery system are capable of meeting the individual's documented needs and assess whether the requested service can meet those needs.

2. Consider clinically appropriate available alternatives and whether they can meet the individual's needs under the applicable criteria.

3. If the requested service is not available within the local delivery system, evaluate alternatives and consider a higher level of care only when the individual's documented needs and applicable criteria support it.

E. All denials based on medical necessity shall be made by appropriate professionals, including board-certified physicians or doctoral-level clinical psychologists.

F. Treating physicians and providers are given contact information if they would like to discuss a medical necessity denial with a physician when the determination is provided telephonically.

G. When enrollees or their authorized representatives request services from an out-of-network provider/practitioner, MCCMH will make an authorization and/or non-authorization determination on a case-by-case basis.

H. MCCMH expects that an out-of-network provider/practitioner make an effort to secure prospective authorization before services are initiated and agrees to enter a single case agreement with MCCMH.

I. MCCMH shall ensure that services authorized are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished, and as otherwise consistent with MCCMH's PIHP Contract.

J. Medicaid enrollees shall be provided an appropriate Notice of Medicaid Adverse Benefit Determination in any case where a service authorization request is denied, or a Medicaid Service is authorized in an amount, duration, or scope that is less than requested.

K. MCCMH shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition.

L. Consistent with the criteria applied under the State plan, MCCMH may place appropriate limitations on services rendered.

1. Services may be denied when:

a. They are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

b. They are experimental or investigational in nature; and/or

c. There exists another appropriate, efficacious, less restrictive, and cost-effective service, setting or support that otherwise satisfies the standards for medically necessary services.

2. MCCMH uses various methods to determine amount, scope, and duration of services, including but not limited to prior authorization for certain services, concurrent utilization reviews, and centralized assessments and referrals.

3. MCCMH may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

4. For the purpose of utilization control, limitations on services may occur provided that:

a. The services furnished can reasonably achieve their purpose;

b. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the individual's ongoing need for such services and supports; and

c. Family planning services are provided in a manner that protects and enables the individual freedom to choose the method of family planning to be used consistent with 42 CFR 441.20.

M. For the processing of requests for initial and continuing authorizations, MCCMH shall:

1. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

2. Consult with the requesting provider for medical services when appropriate.

N. The requesting provider is responsible for verifying that persons served are actively enrolled in the appropriate Medicaid waiver and/or program before requesting services requiring such enrollment. The Michigan Department of Health and Human Services (MDHHS) CPT Code Chart may be referenced as guidance to ensure services are requested, authorized, and billed in accordance with current coverage and reporting requirements.

O. When a service authorization is processed, MCCMH shall provide the individual with a written service authorization decision within specified timeframes and as expeditiously as the person's health condition requires. The service authorization must meet the requirements for either a standard authorization or expedited authorization:

1. Standard Authorization:
    a. Notice of the authorization decision must be provided as expeditiously as the person's health condition requires, and no later than seven (7) calendar days following receipt of a request for service.
    b. MCCMH may extend the seven (7) calendar day timeframe by up to an additional fourteen (14) days if either of the following occur:
        i. The person served or provider requests an extension, or
        ii. MCCMH justifies (to MDHHS upon request) a need for additional information and how the extension is in the person's interest.

2. Expedited Authorization:
    a. In cases in which a provider indicates or MCCMH determines that following the standard timeframe could seriously jeopardize the person's life; health; or ability to attain, maintain, or regain maximum function. MCCMH must make an expedited authorization decision and provide notice of the decision as expeditiously as the person's health condition requires, and no later than seventy-two (72) hours after receipt of the request for service.

    b. MCCMH may extend the seventy-two (72) hour timeframe by up to fourteen (14) calendar days if either:
        i. The person requests an extension, or
        ii. MCCMH justifies (to MDHHS upon request) a need for additional information and how the extension is in the person's interest.

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

1. Make reasonable efforts to give the person served 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; and

3. Issue and carry out the service authorization determination as expeditiously as the person's health condition requires and no later than the date the extension expires.

Q. When additional information is needed to make coverage or appeal decisions, MCCMH shall request the needed clinical documentation and document a minimum of one attempt to obtain the necessary information. If, after the documented attempt, MCCMH does not receive any additional information, MCCMH will make the best decision it can based on the available information within the required timeframes. In its sole discretion, MCCMH may extend a previously existing authorization for up to thirty (30) days while it gathers the information needed to base the authorization.

R. For all covered outpatient drug authorization decisions, MCCMH shall provide notice to the Medicaid enrollee as described in Section 1927(d)(5)(A) of the Social Security Act.

S. 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 timeframe expired.

3. In such cases, MCCMH must provide the Medicaid enrollee with a Notice of Medicaid Adverse Benefit Determination that meets the requirements described in MCCMH MCO 4-020, "Medicaid and Non-Medicaid Notice of Adverse Benefit Determination."

4. In such cases, MCCMH offers the requesting provider the opportunity to discuss medical necessity denials with a UM physician reviewer. The requesting provider initiates this discussion by sending an email to UMInformation@mccmh.net. This is detailed in the written Adverse Benefit Determination notice.

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

U. 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.

VI. PROCEDURES

A. The MCCMH Managed Care Operations Division (MCO) and other units performing the utilization review function shall:

1. Process all service authorization requests (Medicaid and non-Medicaid);

2. If the services are Medicaid Services:
    a. Provide electronic notification of the authorization decision to the primary clinical provider; and
    b. Send Adequate Notice of Medicaid Adverse Benefit Determination in any case where a service authorization request is denied, or services are authorized in an amount, duration, or scope that is less than requested to the person served.

B. MCCMH utilizes written Utilization Management (UM) decision making criteria that are objective and based on clinical evidence to determine the medical necessity and clinical appropriateness of service authorizations. The following UM criteria are used as appropriate by MCCMH in making medical necessity decisions:

1. The American Society of Addiction Medicine (ASAM) Criteria
2. Devereaux Early Childhood Assessment (DECA)
3. Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS)
4. MCG Care Guidelines
5. Michigan Child and Adolescent Needs and Strengths (MichiCANS)
6. Michigan Medicaid Provider Manual
7. Michigan Mental Health Code
8. MCCMH Policies and Procedures

C. All authorized services must begin within fourteen (14) calendar days of a non-emergent assessment with a professional or the agreed upon start date in the person-centered plan.

D. MCCMH ensures that staff, including physicians involved in the decision-making process, do not benefit financially from denying treatment or encourage decisions that result in under-utilization of care or services to persons served.

VII. REFERENCES / LEGAL AUTHORITY

A. Michigan Department of Health and Human Services Medicaid Provider Manual, in effect and as amended.

B. MDHHS-MCCMH Managed Specialty Supports and Services Contract (the PIHP Contract)

C. 42 CFR Part 431

D. 42 CFR Part 438

E. 42 CFR 438.210 - Coverage and Authorization of Services

F. 42 CFR 441.20

G. U.S. Congress. (1934) United States Code: Social Security Act, 42 U.S.C. Section 301-1940.

H. MCCMH MCO Policy 12-001, "Access, Eligibility, Admission, Discharge"

I. MCCMH MCO Policy 2-014, "Assessment Services"

J. MCCMH MCO Policy 4-020, "Medicaid & Non-Medicaid Notice of Adverse Benefit Determinations"

K. MCCMH MCO Policy 9-170, "Local Appeals"

L. MCCMH MCO Policy 4-005, "Second Opinion Rights"

VIII. EXHIBITS

None.