MCCMH MCO Policy 2-090

Chapter: **CUSTOMER RELATIONS / MEMBER SERVICES**
Title: **SERVICE AUTHORIZATIONS**

Also see MCCMH MCO Policies 2-013, "Access, Eligibility, Admission, Discharge"; 2-014, "Assessment Services"; 4-020, "Medicaid & Non-Medicaid Notice of Adverse Benefit Determination (Advance & Adequate); Notice of Appeal Rights"; 9-170, "Local Dispute Resolution Process (All Consumers)"; 9-171, "Local Appeal Process (Medicaid)"; and 9-180, "Second Opinion Rights."

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Executive Director — Date

I. Abstract

This policy establishes the standards and procedures of the Macomb County Community Mental Health ("MCCMH") Board to ensure that Service Authorization requests are timely processed in an amount, scope and duration that is medically necessary, consistent with applicable State and federal law, the Michigan Medicaid Provider Manual, and the PIHP Contract.

II. Application

This policy shall apply to MCCMH administrative staff, directly-operated and contract network providers of the MCCMH Board, as well as to all consumers of services provided by directly-operated and contract network providers of the MCCMH Board.

III. Policy

MCCMH shall timely process Service Authorizations in an amount, scope and duration that is medically necessary for the Consumer, and as such is otherwise consistent with applicable State and federal law, the Michigan Medicaid Provider Manual, and the PIHP Contract.

In addition, the MCCMH Prepaid Inpatient Health Plan (PIHP) shall ensure the following, with respect to Medicaid Services:

- Service Authorizations will be processed as required by applicable federal regulations;
- Medicaid Enrollees will be provided Adequate 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;
- Authorized Medicaid Services will be commenced within fourteen (14) days of the start date agreed upon during the Person-Centered Planning and as authorized.

IV. Definitions

A. Adequate Notice of Medicaid Adverse Benefit Determination: Written statement advising the Medicaid Enrollee 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. Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP services.

C. Legal Representative: An adult Consumer's legal guardian, a minor Consumer's parent or legal guardian.

D. Medicaid Adverse Benefit Determination: Any of the following, ***as it relates to Medicaid Enrollees, only***:

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;

4. Failure to make a standard Service Authorization decision and provide notice about the decision within fourteen (14) calendar days from the date of receipt of a standard request for service (note: this timeframe may be extended up to an additional 14-calendar days in certain circumstances, as provided in this Section V(G) of this policy).

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 14-calendar days in certain circumstances, as provided in as provided in this Section V(G) of this policy).

6. The failure to provide services in a timely manner, as defined by the State – fourteen (14) calendar days of the start date agreed upon during the Person Centered Planning and as authorized by the PIHP;

7. Failure of the PIHP 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 the PIHP 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 the PIHP 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 MCO, 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.

E. Medicaid Enrollee: A Medicaid beneficiary who is currently enrolled in the MCCMH PIHP.

F. Medicaid Services: Services provided to a Medicaid Enrollee under the authority of the Medicaid State Plan, Habilitation Services and Support waiver, and/or Section 1915(b)(3) of the Social Security Act, or any other relevant waiver, plan or program.

G. Medical Necessity / Medically Necessary: Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment are "Medically Necessary" when they meet the following criteria, or other criteria set forth in the current Michigan Medicaid Provider Manual:

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

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

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

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

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

H. PIHP Contract: The current contract between MCCMH and the Michigan Department of Health and Human Services (MDHHS), wherein MDHHS contracts to obtain the services of the MCCMH PIHP to manage the Concurrent 1915(b)/(c) Programs, the Healthy Michigan Plan and SUD Community Grant Programs, and relevant Waivers in a designated services area and to provide a comprehensive array of specialty mental health and substance abuse services and supports as indicated in the PIHP contract.

I. Plan of Service: A formal written plan, accepted by the Consumer or Legal Representative, for the provision of services which describes the issues/problems to be addressed, the desired outcomes of the service, the activities/interventions designed to facilitate achievement of desired outcomes, the individual(s) or program(s) responsible for implementing the activity/intervention, and the dates upon which service reviews will occur. The Plan of Service may include clinical services, supportive services or both. The Plan of Service may be designed to serve an individual or a family.

J. Service Authorization: PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law.

V. Standards

A. All Service Authorizations will be made in compliance with applicable State and federal law, the Michigan Medicaid Manual, applicable MCCMH policies, including but not limited to MCCMH MCO Policy Nos. 2-001, "Person-Centered Planning Practice Guidelines," and 2-013, "Access, Eligibility, Admission, Discharge," and the Access Center Manual.

B. MCCMH will ensure that Medicaid Services authorized for Medicaid Enrollees are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished, and as otherwise consistent with the PIHP Contract.

C. MCCMH will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Medicaid Enrollee.

D. MCCMH may place appropriate limits on a service, as follows:

   a. On the basis of criteria applied under the State plan, such as Medical Necessity and other bases described in the Michigan Medicaid Provider Manual, including but not limited to the following, which are permissible when consistent with Medical Necessity:

      i. Deny services: (i) that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care; (ii) that are experimental or investigational in nature; or (iii) for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or

      ii. Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralize assessment and referral, gate-keeping arrangements, protocols, and guidelines. A PIHP 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.

   b. For the purpose of utilization control, provided that –

      i. The services furnished can reasonably achieve their purpose;

      ii. 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 Medicaid Enrollee's ongoing need for such services and supports; and

      iii. Family planning services are provided in a manner that protects and enables the Medicaid Enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20.

E. For the processing of requests for initial and continuing authorizations of Medicaid Services, the MCCMH PIHP shall:

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

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

F. Any decision to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by an individual who has appropriate expertise in addressing the Medicaid Enrollee's medical, behavioral health, or long-term services and supports needs.

G. When a Service Authorization for Medicaid Services is processed (initial request or request for continuation of service delivery) the PIHP shall provide the Medicaid Enrollee with a written service authorization decision within specified timeframes and as expeditiously as the Consumer's health condition requires. The Service Authorization must meet the requirements for either standard authorization or expedited authorization:

1. Standard Authorization:

   a. Timing - Generally: Notice of the authorization decision must be provided as expeditiously as the Consumer's health condition requires, and no later than fourteen (14) calendar days following receipt of a request for service.

   b. Extension: The PIHP may extend the fourteen (14) calendar day timeframe by up to an additional fourteen(14) days if either of the following occur:

      i. The Consumer or provider requests an extension, or
      ii. The PIHP justifies (to MDHHS upon request) a need for additional information and how the extension is in the Consumer's interest.

2. Expedited Authorization:

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

   b. Extension: The PIHP may extend the seventy-two (72) hour timeframe by up to 14 (fourteen) calendar days if either:

      i. The Consumer requests an extension, or
      ii. The PIHP justifies (to MDHHS upon request) a need for additional information and how the extension is in the Consumer's interest.

3. Notice of Extension: When a standard or expedited authorization of services decision is extended, the PIHP must:

   a. Provide the Medicaid Enrollee written notice of the reason for the decision to extend the time frame, and inform the Medicaid Enrollee of the right to file a Grievance if he or she disagrees with that decision; and

b. Issue and carry out the Service Authorization determination as expeditiously as the Medicaid Enrollee's health condition requires, and no later than the date the extension expires.

4. 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.

H. Notice of Medicaid Adverse Benefit Determination:

a. The PIHP must notify the requesting provider (does not need to be in writing), and give the Medicaid Enrollee written notice of:

i. 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 Medicaid Enrollee must be mailed within the applicable "Standard Authorization" or "Expedited Authorization" timeframes described in V(G)(1)-(2), above.

ii. A Service Authorization decision not reached within the relevant timeframe prescribed above (which constitutes a denial of services, and is therefore considered a Medicaid Adverse Benefit Determination). Notice must be mailed to the Medicaid Enrollee no later than the date on the date that the timeframes expired.

b. In either such case, the MCCMH PIHP must provide the Medicaid Enrollee with Adequate Notice of Medicaid Adverse Benefit Determination that meets the requirements described in MCCMH MCO 4-020, "Medicaid & Non-Medicaid Notice of Adverse Benefit Determination (Advance & Adequate) & Appeal Rights".

I. 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.

J. Requests for continued authorization may be submitted for review up to sixty (60) calendar days in advance to ensure that authorization is in place at the start of the new authorization period.

K. All Notices described in this policy shall be transmitted by U.S. mail or conveyed by hand.

L. Authorized Medicaid Services must be commenced in a timely manner, i.e., within fourteen (14) calendar days of the start date agreed upon during the Person-Centered Planning and as authorized by the PIHP**.**

VI. Procedures

A. The MCCMH Access Center and other units performing the utilization review function shall, within the time frames described above for standard and expedited Service Authorization requests:

a. Process all Service Authorization requests (Medicaid and non-Medicaid);

b. If the services in question are Medicaid Services:

i. Provide written notice of the authorization decision to the Consumer; and

ii. Mail Adequate Notice of Medicaid Adverse Benefit Determination, consistent with the requirements outlined in MCO Policy 4-020) 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.

B. 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.

C. Procedures specific to the implementation of this policy and the standards listed above shall be contained in Provider Manuals for each service as relevant to that provider's role in the transmission of Notices of Medicaid Adverse Benefit Determinations.

VII. REFERENCES / LEGAL AUTHORITY

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

B. 42 CFR Part 431

C. 42 CFR Part 438

D. 42 CFR 438.210 - Coverage and authorization of services

E. MCCMH MCO Policy 2-013, "Access, Eligibility, Admission, Discharge"

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

G. MCCMH MCO Policy 4-020, "Medicaid & Non-Medicaid Notice of Adverse Benefit Determinations (Advance and Adequate) & Appeal Rights"

H. MCCMH MCO Policy 9-170, "Local Dispute Resolution Process (All Consumers)"

I. MCCMH MCO Policy 9-171, "Local Appeal Process (Medicaid)"

J. MCCMH MCO Policy 9-180, "Second Opinion Rights"

VIII. EXHIBITS

A. None.