PIHP Policy for the COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN	*Policy and Procedure* **Utilization Management and Review Policy**
Department: Utilization Review **Author:**	**Local Policy Number (if used)**
Regional Operations Committee Approval Date **3/5/2018**	**Implementation Date** **7/18/2018**

I. PURPOSE

To establish consistent utilization management and review standards, requirements, structures and activities to be used by Community Mental Health Service Providers (CMHSPs), primary contracted providers, and substance use disorder (SUD) provider systems; and to be monitored by the regional entity of Community Mental Health Partnership of Southeast Michigan (CMHPSM) as the Pre-Paid Inpatient Health Plan (PIHP) and the Substance Abuse Coordinating Agency (CA).

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
12/20/05	2	Revised to meet EQR CAP
6/21/13	3	Revised for new regional entity and language/role clarity
12/10/17	4	Revised to comply with Managed Care Rule of 2017

III. APPLICATION

This policy applies to:

- All regional entity, CMHSP, and primary contracted provider staff responsible for provision of and/or oversight of access system services within the CMHPSM.
- All Staff representing the CA for oversight of access to substance use disorder (SUD) services through the Recovery Oriented System of Care (ROSC) Core Provider network.
- CMHSP staff, SUD Provider staff, and all contractual provider staff responsible for service authorization decisions or adverse actions, and their oversight
- Staff responsible for the development, implementation, and updating of service eligibility, continuing stay, and discharge criteria
- Members of the regional entity Utilization Review Committee and others involved in studying data-based service utilization patterns

IV. POLICY

It is the policy of CMHPSM as the regional entity that utilization management and review standards, requirements, structures and activities will be implemented and practiced in a way that ensures the efficient and effective use of resources. This includes ensuring service decisions are made consistently and based on medical necessity that consumers with comparable needs receive comparable services, and those decisions are made based on medical necessity.

V. DEFINITIONS

Action (also referred to as adverse action) – A benefit/service determination related to Non-Medicaid/General Funds by which the CMHSP determines any of the following covered by Non-Medicaid/General Funds:

- Denial of inpatient psychiatric hospitalization or denial of a requested alternate service if inpatient is denied.
- Denial of services where there are rights to a second opinion.
- Suspension, reduction, or termination of reduction of existing supports/services.

Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

Adverse Benefit Determination (ABD) – A benefit/service determination specific to Medicaid, by which the Pre-Paid In-Patient Health Plan (PIHP)/ Community Mental Health Service Provider (CMHSP) determines any of the following for Medicaid services:

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 part, of a payment for service.
4) The failure to make a service authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard service request.
5) The failure to make an expedited service authorization within 72 hours after receipt of a request for expedited service authorization.
6) The failure to provide services within 14 calendar days of the start date agreed upon during the person centered planning process and as authorized by the PIHP/CMHSP.
7) The failure of a PIHP/CMHSP to resolve standard appeals and provide notice within 30 (44? - MCR says 44) calendar days from the date of a request for a standard appeal. 438.408(b)(1) and (2)
8) The failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal.
9) For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a consumer's request to exercise his or her right under 438.52(b)(2)(ii) to obtain services outside the network.

10) The denial of a consumer's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other consumer financial liabilities.

Concurrent Review - part of a utilization management program in which health care is reviewed as it is provided. Reviewers monitor appropriateness of the care, the setting, and the progress of discharge plans. The ongoing review is directed at keeping costs as low as possible and maintaining effectiveness of care.

Denial – A term used in this policy that includes the definition of an Action or an Adverse Benefit Determination

Medical Necessity – The basis by which service decisions are made for mental health, developmental disabilities, and substance abuse supports and services. Criteria are based on state law/policy and the Medicaid Provider Manual. For the purposes of this policy keys aspects of medical necessity are described below. For a complete definition of medical necessity, see the current version of the Medicaid Provider Manual (Mental Health/Substance Abuse Services Chapter, Section 2.5) and the MI Mental Health Code, Chapter 1, Definitions
Services must be:

- Necessary for screening, assessing, identifying, evaluating; and/or Intended to treat, ameliorate, diminish or stabilize the symptoms; and/or Expected to arrest or delay the progression of a mental illness, developmental disability or substance use disorder
- 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.

Service determinations must be:

- Based on information provided by the individual, his/her family, and/or other individuals who know the individual and clinical information from the individual's primary care physician/health care professionals
- Based person centered planning or individualized treatment planning and documented in the plan
- Made by appropriately trained professionals with sufficient clinical experience;
- Accessible to the individual, and responsive to any cultural, sensory, or mobility needs
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Provided in the least restrictive, most integrated setting.
- Consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

For substance use/abuse services, ASAM (American Society of Addiction Medicine) Placement Criteria shall also be used when determining the medical necessity of

placement, continued stay and transfer/discharge of individuals with addiction and co-occurring conditions.

Primary Contracted/Core Provider – a provider contracted by the CMHSP to provide primary community mental health services that would otherwise be directly operated by a CMHSP.

Prospective Review - (also known as **Preauthorization**) the prior assessment by a payer or payer's agent that proposed services are appropriate for a particular individual, or that the individual and the categories of service are covered by a benefits plan. Preauthorization The approval of or concurrence with the individual plan of service proposed by a CMHSP professional before the provision of service. Under some plans, preauthorization by the carrier is required before certain services can be provided

Recovery Oriented System of Care (ROSC) – is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

Retrospective Review - a post-treatment assessment of service utilization on a case-by-case or aggregate basis after the services have been performed. A retrospective review can include a review of whether payment of services will be authorized/reimbursed when a provider requests retrospective payment of an inpatient psychiatric hospital stay.

Utilization Management (UM) - Procedures and clinical decisions intended to ensure that the services provided to a specific consumer at a given time are appropriate, medically necessary, and cost effective.

Utilization Review (UR) - Analysis of the patterns of service authorization decisions and service usage in order to determine the means for increasing the value of services provided that include minimizing cost and maximizing effectiveness/appropriateness.

VI. STANDARDS

A. Utilization management decisions will be conducted as a delegated function by the regional entity to the CMHSPs, ROSC Core Providers, and primary contracted providers, and occur as close as possible to local provision of services.

B. The basis by which service determinations are made is founded on state and regional entity policy and will be in compliance with medical necessity and all state/federal rules. The regional entity will include this basis in its delegation of UM functions to CMHSPs, primary contractual providers, and ROSC Core Providers. Any relevant updates to standards on service determinations will be

communicated by the regional entity and implemented locally by the CMHSPs, primary contractual providers, and ROSC Core Providers.

C. The CMHSPs, primary contractual providers, and ROSC Core Providers are delegated by the regional entity to be responsible for local implementation, evaluation and updating of service-specific entry, continuing stay and discharge criteria.

D. The regional entity shall have auditing and monitoring mechanisms in place to ensure utilization management standards and delegated functions are met by the CMHSPs, primary contractual providers, and ROSC Core Providers. The regional entity shall also enact and oversee any corrective action for areas of non-compliance.

E. Decisions regarding the type, frequency, intensity and duration of services to authorize or deny must be:

1. Accurate and consistent with medical necessity criteria,
2. Consistent with Medicaid Provider Manual eligibility, entry, continuing stays and discharge criteria as applicable, and state law/policy as defined by MDHHS.
3. Consistent with formal assessments of need and consumers' desired outcomes,
4. Conducted with an effort to obtain all necessary information including pertinent clinical information and consultation with treating physicians/ clinicians as appropriate.
5. Adjusted appropriately as consumers' needs, status, and/or service requests change,
6. Timely,
7. Provided to the consumer in writing, including reasons for the decision that are clearly documented
8. As applicable, shared with affected service providers in writing as to the specific nature of the decision and its reasons, (refer to the Provider Appeals Policy) if there are any concerns with decisions made,
9. Documented in the clinical case record as to the specific nature of the services authorized or denied and its reasons and
10. Accompanied by the appropriate notice to consumers regarding their appeal rights with a copy of the notice placed in the consumer's clinical case record. (refer to the Consumer Grievance & Appeals Policy)

F. The above utilization management / service authorization decisions and their associated procedures are required at numerous points during the course of service provision:

1. The completion of the Initial Assessment or Pre-Screen to assess initial CMH eligibility and medical necessity
2. The completion of the Initial Individual Plan of Service through the Person-Centered Planning Process

3. The consumer requires or requests a more intensive or less intensive level of a current service
4. The consumer requires or requests the addition of a new service
5. The consumer requires or requests the termination of a current service
6. The expiration of a service authorization
7. The completion of the annual review of need/periodic review or other assessment including assessment of ongoing CMH eligibility and medical necessity of supports and services
8. The completion of the annual Individual Plan of Service through the Person- Centered Planning Process
9. Review of services that may be denied, suspended, reduced, or terminated

G. Utilization management decisions (both service authorization and denials) will be made by staff with appropriate clinical competencies as defined at minimum by state policy and will possess the required competencies and clinical expertise to treat the conditions relevant to the decisions being reviewed. Where necessary, review decisions are supervised by qualified medical professionals.

H. Utilization management decisions shall not be made by case managers or supports coordinators. Case managers, supports coordinators, and other professional staff responsible for treatment planning will assess need and make treatment recommendations per their function in the development of Individualized Plans of Service, including requesting services, and as a way to inform the utilization management process. This information will be reviewed at minimum by qualified UM staff or supervisors or who will make the relevant service authorization decisions.

I. Each local CMHSP, primary contractual provider, and ROSC Core Provider will have a written internal process to oversee and review compliance with utilization management practices, including, eligibility, medical necessity, service authorization, service denial, and service verification.

J. Each local CMHSP primary contractual provider, and ROSC Core Provider will have a local UM/UR review processes to monitor the accuracy of service decisions.

K. The Utilization Review Committee for the regional entity will provide the following functions:

- Evaluate the success of utilization management processes used in the affiliation and ensure the accuracy, appropriateness and consistency of utilization management decisions.
- Coordinate ongoing utilization review activities and projects of the affiliation
- Conduct UM/UR studies on behalf of the affiliation or local CMHSP/core provider as requested by the local CMHSP/core provider or regional entity.

- Report findings/results of committee activities/ studies to the regional entity, including any areas of trending, performance improvement projects, or compliance that requires follow-up or oversight by the regional entity
- Make recommendations and suggestions to the regional entity on local or regional performance improvements related to UM/UR functions
- Serve as a reporting body to the regional entity. Where compliance issues or trends arise during committee work, the committee will report issues/trends to the regional entity for CMHPSM action or oversight; the responsibility of monitoring CMHSP/core provider compliance with UM/UR standards and auditing UM/UR functions delegated to CMHSPs/core provider will remain in the jurisdiction of the CMHSPM as the regional entity.
- Any activity the regional entity would delegate or assign to the Utilization Review Committee as a regional entity function, or on behalf of the regional entity will be determined and assigned by the CMHPSM.

L. In <u>evaluating</u> the success of utilization management processes and to ensure the accuracy, appropriateness and consistency of utilization management decisions, priority should be given to:
   a. high cost services,
   b. highly utilized services,
   c. services associated with a high number of consumer grievances and appeals,
   d. services for which there are large differences in cost per case and/or cost per unit among individual affiliates,
   e. services which are under and/or over utilized and,
   f. PIHP studies/assignments priorities.

M. Consideration should be given to the following utilization review methods in evaluating the effectiveness of UM decisions:
   - Analyzing aggregated case record review data reflecting the degree to which consumers meet service eligibility criteria
   - Analyzing aggregated case record review data to determine the degree to which consumers meet entry criteria for a specific service
   - Analyzing aggregated case record review data to determine the degree to which frequency and intensity of services are consistent with medical necessity criteria
   - Data collection and analysis of cost per unit or cost per case for a service or program type
   - Data collection of average length of stay for a specified service
   - Data collection and analysis of consumer and provider satisfaction with the Utilization Management/ Utilization Review process
   - Studies of under and over-utilization of services
   - Studies of inpatient admissions per capita
   - Studies of utilization of alternatives to high cost care

VII. EXHIBITS

None

VIII. REFERENCES

Medicaid and CHIP Managed Care Final Rule, April 2016 42 CFR 431, 42 CFR 433, 42 CFR 438 42 CFR 440, 42 CFR 457, 42 CFR 495 (Replaces Balanced Budget Act of 1998 (42 CFR 438; 438.210, 438.240)		
Michigan Mental Health Code, Act 258 of 1974 (most recently revised November 2017)		
MDHHS Medicaid Provider Manual (current version)		
The Joint Commission Behavioral Health Standards		
CMHPSM Consumer Grievance and Appeal Policy		
CMHPSM Service Verification Policy		
MDHHS CMHSP Managed Mental Health Supports and Services Contract (current version)		
MDHHS PIHP Medicaid Managed Specialty Supports and Services Contract (current version)		

IX. PROCEDURES

None