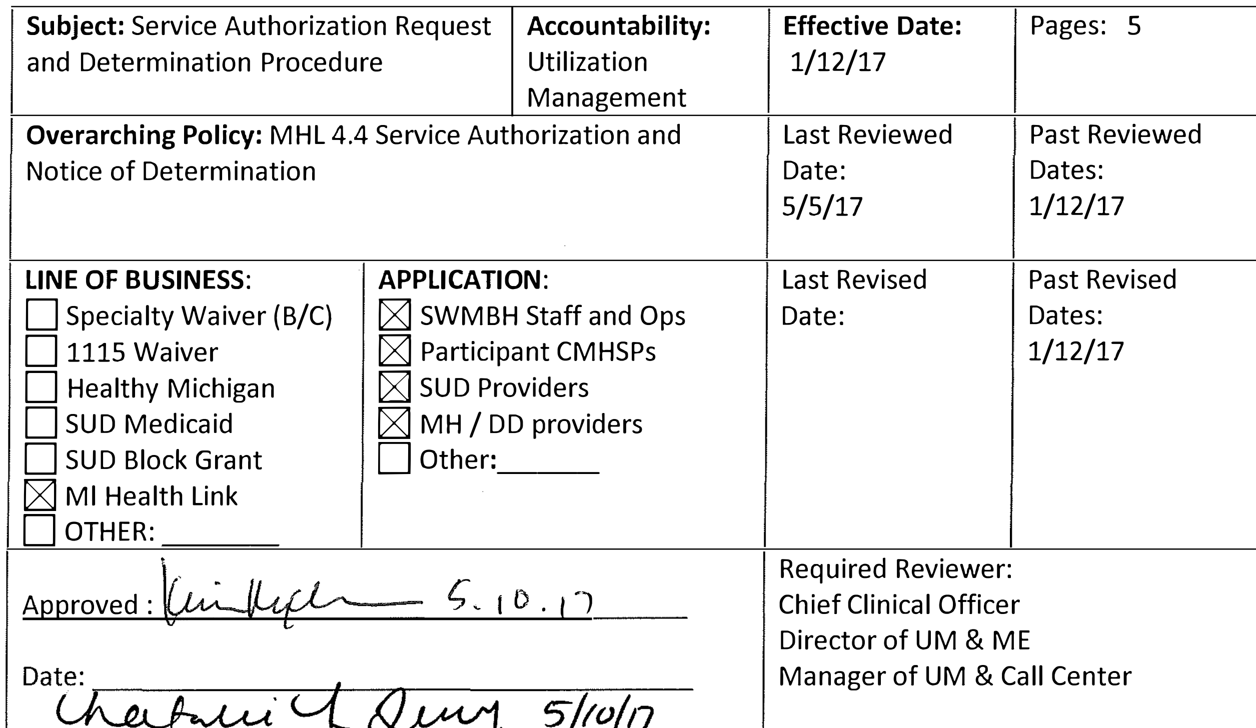
SWMBH MI Health Link Operating Procedure 4.4.1



Subject: Service Authorization Request and Determination Procedure	**Accountability:** Utilization Management	**Effective Date:** 1/12/17	Pages: 5
Overarching Policy: MHL 4.4 Service Authorization and Notice of Determination		Last Reviewed Date: 5/5/17	Past Reviewed Dates: 1/12/17
LINE OF BUSINESS: ☐ Specialty Waiver (B/C) ☐ 1115 Waiver ☐ Healthy Michigan ☐ SUD Medicaid ☐ SUD Block Grant ☒ MI Health Link ☐ OTHER: ________	**APPLICATION:** ☒ SWMBH Staff and Ops ☒ Participant CMHSPs ☒ SUD Providers ☒ MH / DD providers ☐ Other:_______	Last Revised Date:	Past Revised Dates: 1/12/17
Approved: [signature] 5.10.17 Date: [signature] 5/10/17		Required Reviewer: Chief Clinical Officer Director of UM & ME Manager of UM & Call Center	

I. Purpose

To identify the parameters and criteria for a low intensity community based behavioral health outpatient treatment available to all persons meeting the standard without further preservice/prospective review. As well as to describe a clear method for requesting further authorization of MI Health Link (MHL), Behavioral Health Medicare covered service(s), and the process for completing an authorization determination for those requests.

II. Scope

This MI Health Link service authorization request and determination procedure applies to all preservice/prospective, concurrent and post service/retrospective authorization requests and shall apply when:

- Southwest Michigan Behavioral Health (SWMBH) is identified as the reviewing entity to make the authorization determination **and**
- The authorization is being requested for a Medicare covered outpatient service for a MI Health Link Member **and**
- The service authorization that is being requested is for the treatment of a behavioral health condition.

III. Procedural Steps

A. **Initial Outpatient Mental Health Service Authorization**

1. Member Not Open To Mental Health Services at Time of Enrollment

   a. An appropriately trained Southwest Michigan Behavioral Health (SWMBH) staff telephonically completes a Level of Care Utilization System (LOCUS) screening tool, in which the level of care score indicates Level I or Level II and/or composite score of 14 or less, SWMBH adopted Beacon Health options medical necessity criteria for outpatient mental health services and/or medication management services are met, and the member is agreeable to the determined level of care, SWMBH will

coordinate with a network community based outpatient provider of the member's choice and schedules a face to face assessment and/or psychiatric evaluation.

b. SWMBH provides verbal approval of the service or services and enters authorizations for the provider into the Managed Care Information System (MCIS) in which they referred the member to.

   a. One (1) assessment **and**
   b. Twelve (12) outpatient therapy sessions **and/or**
   c. One (1) psychiatric evaluation **and**
   d. Six (6) medication management reviews.

c. Authorizations entered into the MCIS will reflect the number of service authorizations available through the initial benefit package and will not exceed a duration of 365 days.

d. For any service requests exceeding the LOCUS Level of Care I or II, SWMBH adopted Beacon Health Options medical necessity criteria for outpatient mental health services and/or medication management, senior clinical staff including the Medical Director, are available for consultation and will make the clinical determination.

e. For authorization requests exceeding the outpatient therapy service protocol, please refer to the Service Authorization Policy.

2. <u>Member Open to Mental Health Services Prior to MI Health Link Enrollment</u>

   a. Upon a provider's identification of an existing member who has become enrolled in the MI Health Link program, the provider will immediately notify SWMBH and provide SWMBH with a valid/signed SWMBH Release of Information between the provider/organization, SWMBH, and the Integrated Care Organization (ICO) (Meridian or Aetna).

   b. In the event the identified member has completed a Psychosocial Assessment, or an alternative tool that addresses the same domains identified in the corresponding Level II Assessment, within the 12 months prior to enrollment in the MI Health link Program, SWMBH will adopt said assessment tool as the Level II Assessment under the MI Health Link 3 way contract if it is deemed complete, accurate and appropriate for the enrollees current status.

   c. If the provider's Psychosocial Assessment/Assessment tool is adopted as the Level II Assessment, the provider can request authorizations via telephone, fax, secure email, or through Smartcare 4.0, if applicable. Authorizations can be requested from the date of member becoming enrolled in the MI Health Link program. The end date of the request can be no longer than 364 days from the date of the adopted Level II Assessment. Any units of service requested above the initial benefit package (1 assessment, 12 outpatient therapy sessions, 1 psychiatric evaluation, 6 medication reviews) must be included in the corresponding plan of care and clinical documentation must support medical necessity in accordance with SWMBH's Clinical Documentation Policy.

   d. In the event the member has not had an assessment within 12 months prior to enrollment in the MI Health Link program, which meets criteria to be adopted as the Level II assessment, the provider must also provide contact information for the member, in efforts to have a Level II assessment completed by SWMBH.

   e. SWMBH will make the appropriate attempts to contact the member to complete a telephonic Level II Assessment. In the event that the member refuses to complete the Level II assessment, is unable to be reached to complete the Level II screening, or due to other uncontrollable circumstances in which the Level II was unable to be completed, SWMBH may require additional documentation from the provider to support the current level of care.

f. Upon determination of level of care and medical necessity criteria for the services requested, SWMBH may authorize the Medicare covered services requested, up to 364 days, in accordance with the goals and objectives indicated in the member's plan of care.

B. **Initial Outpatient Substance Abuse Service Authorization**

1. <u>Member Not Currently Open to Services at Time of Enrollment</u>

   a. An appropriately trained Southwest Michigan Behavioral Health (SWMBH) staff completes a American Society of Addiction Medicine (ASAM) screening, in in which the level of care score indicates criteria is met for Level I (Outpatient Services, SWMBH adopted Beacon Health Options medical necessity criteria for outpatient substance abuse services, and the member is agreeable to the determined level of care, SWMBH will coordinate with a network community based outpatient provider of members choice and schedules a face to face assessment.

   b. SWMBH provides verbal approval of the service or services and enters authorizations for the provider into the MCIS in which they referred the member to.

      a. One (1) assessment **and**

      b. Twelve (12) outpatient therapy sessions

   c. Authorizations entered into the MCIS will reflect the number of service authorizations available through the initial benefit package and will not exceed a duration of 365 days.

   d. Upon SWMBH's receipt of the release, a provider record will be created for the provider organization serving the client (if one does not already exist), and the authorizations entered at the time of the ASAM screening will be released to the provider.

2. <u>Member Open to Substance Abuse Services Prior to MI Health Link Enrollment</u>

   a. Upon a provider's identification of an existing member who has become enrolled in the MI Health Link program, the provider will immediately notify SWMBH and provide SWMBH with a valid/signed SWMBH Release of Information between the provider/organization, SWMBH, and the ICO (Meridian or Aetna).

   b. In the event the identified member has completed an ASAM, within the 12 months prior to enrollment in the MI Health link Program, SWMBH will adopt said ASAM as the Level II Assessment under the MI Health Link 3 way contract if it is deemed complete, accurate and appropriate for the enrollees current status.

   c. If the provider's ASAM is adopted as the Level II Assessment, the provider can request authorizations via telephone, fax, secure email, or through Smartcare 4.0, if applicable. Authorizations can be requested from the date of member becoming enrolled in the MI Health Link program. The end date of the request can be no longer than 364 days from the date of the adopted Level II Assessment. Any units of service requested above the initial benefit package must be included in the corresponding treatment plan and clinical documentation must support medical necessity.

   d. In the event the member has not had an ASAM within 12 months prior to enrollment in the MI Health Link program, meeting criteria to be adopted as the Level II assessment, the provider must also provide contact information for the member, in efforts to have a Level II assessment completed by SWMBH.

   e. SWMBH will make the appropriate attempts to contact the member to complete a telephonic ASAM/Level II Assessment. In the event that the member refuses to complete the Level II assessment, is unable to be reached to complete the Level II screening, or due to other uncontrollable circumstances in which the Level II was unable to be completed, SWMBH may require additional documentation from the provider to support the current level of care.

a. Upon determination of level of care and medical necessity criteria for the services requested, SWMBH may authorize the Medicare covered services requested, up to 364 days from the Level II Assessment date, in accordance with the goals and objectives indicated in the member's plan of care.

C. **Continued Outpatient Service Authorization**

1. Within the initial authorization timeframe
    a. Upon the member's admission to treatment, and in accordance with the required documentation for authorization requests as indicated in SWMBH's Clinical Documentation Policy, additional units may be requested. If there is an identified need for units above the benefit package, the requesting provider must enter the authorization request in the MCIS based on the plan of care, minus the previously approved number of units authorized.
    b. The end date of the authorization requested must coincide with the end date of the previously authorized units. In the event the provider requests units beyond that date, the authorization may be partially administratively denied.
2. Beyond the initial authorization timeframe
    a. Upon the expiration of authorizations approved during the initial authorization, providers may submit authorizations requests based on, and accompanied by, a new plan of care through the MCIS.
    b. In the event the annual Level II has not yet been completed, SWMBH will make the necessary attempts to complete the annual Level II screening with the member, and may pend the authorizations requested for up to 14 calendar days to secure the Level II assessment completion.
    c. In the event SWMBH is able to complete the annual LOCUS or ASAM with the member within the timeframe that the authorization(s) have been pended, and the member has a LOCUS level of care score of Level I or II or and/or a composite score of fourteen or less, or continues to score in Level I of the ASAM tool, and the applicable medical necessity criteria is met, authorizations requested will be processed and approved as deemed appropriate.
    d. In the event SWMBH is not able to complete the annual Level II, due to being unable to reach the member for the screening, member refuses, etc., SWMBH will retrieve from the provider's MCIS, or request from the provider, additional clinical information to determine if the service(s) being requested remain medically necessary.

IV. Definitions

A. Medically Necessary Services: Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y. Per Medicaid, 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 most integrated setting, and is consistent with clinical standards of care. Medical necessity includes, but is not limited to, those supports and services designed to assist the person to attain or maintain a sufficient level of functioning to enable the person to live in his or her community

B. ASAM (American Society of Addiction Medicine) Patient Placement Criteria**:** A set of criteria designed to assist clinicians in providing outcome-orientated and results-based care in the

treatment of addiction. ASAM criteria provides guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

C. LOCUS (Level of Care Utilization System): A Nationally recognized and widely used instrument for determining the appropriate level of service intensity for persons with behavioral health disorders.

V. References

A. 2017 MBHO Accreditation Standards: Section 4 Utilization Management

VI. Attachments

A. SWMBH MI Health Link Operating Policy: 12.3 Clinical Documentation
B. Beacon Health Options Medical Necessity Criteria