Subject: Utilization Management	Accountability: Utilization Management	Effective Date: 3/1/2015	Pages: 4
REQUIRED BY: **BBA Section** 42 CFR 438 Subparts B, C, D, F **PIHP Contract Section** Attachment 6.7.1.1., Part II, 6.8 **NCQA Standard** UM 1 A-D, 2 A-C, 3, 4 A-B, D-F **Other** _____		Last Reviewed Date: 4/27/17	Past Reviewed Dates: 5/26/15
LINE OF BUSINESS: ☐ Specialty Waiver (B/C) ☐ 1115 Waiver ☐ Healthy Michigan Plan ☐ 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: 4/27/17	Past Revised Dates: 5/26/15
Approved : Kevin Hyde 5.10.17 Date:		Required Reviewer: Medical Director Director of UM and ME Chief Clinical Officer	5/9/17

I. Purpose

To establish the standards and guidelines that detail how Southwest Michigan Behavioral Health (SWMBH) and its provider network system comply with the federal laws and Integrated Care Organization (ICO) and Michigan Department of Health and Human Services (MDHHS) Contract requirements pertaining to the Utilization Management (UM) responsibilities of the SWMBH.

II. Policy

It shall be the policy of the SWMBH to have comprehensive UM Program that meets the regulatory requirements of the MDHHS Contract, and Centers for Medicare and Medicaid Services Code of Federal Regulations (CFR) and complies with National Council of Quality Assurance (NCQA) standards. The purpose of the UM Program is to provide a comprehensive integrated process that ensures persons served by the SWMBH and its provider network receive high quality timely, medically necessary and clinically appropriate integrated behavioral healthcare in the most cost effective manner. It shall also be the SWMBH policy that SWMBH does not provide financial incentives, reimbursements or bonuses, to staff or providers, based on customer utilization of covered services.

III. Standards and Guidelines

A. Program Oversight, Governance and Authority

The SWMBH Utilization Management Program shall operate under the oversight of the SWMBH Medical Director, Chief Clinical Officer and Director of Utilization Management and Member Engagement.

B. MI Health Link Utilization Management Committee

The SWMBH shall create and implement a MI Health Link UM Committee (MHL UMC) consisting of both SWMBH clinical and quality staff and external practitioners as needed. The MHL UMC shall serve in a support and advisory capacity to the UM Program.

C. Program Components

The SWMBH's UM Program shall consist of the following four components:

1. Access and Eligibility
2. Service Authorization and Reauthorization
3. Utilization Review (UR)
4. Clinical Protocol

D. Program Structure

The written UM Program description shall describe the program structure, accountability lines, lead staff, involvement of practitioners in its development, implementation of behavioral healthcare practitioners in its implementation and that SWMBH does not provide financial incentives, reimbursements or bonuses, to staff or providers, based on customer utilization of covered services.

E. QAPIP Interface

The UM Program shall operate as a sub-component of the SWMBH Quality Assessment and Performance Improvement Plan (QAPIP). As required by NCQA standards, the UM Program must have a written plan and address mechanisms to address over/under utilization and preservice, concurrent and post service urgent and routine review processes.

F. Annual Program Evaluation

SWMBH shall clearly demonstrate that it has annually evaluated the UM Program, addressed trends, made systemic changes as indicated and has updated the UM Plan to reflect current need, as necessary.

G. Satisfaction with the UM Process

SWMBH through various avenues including stakeholder satisfaction surveys and member services, shall have a mechanism for collecting and tracking feedback regarding satisfaction with the UM Process from members and providers.

H. SWMBH Staff Roles

The UM Program description shall clearly designate the SWMBH practitioners involved in the implementation, supervision, oversight and evaluation of the UM program.

I. Program Information Sources

In implementing the annual UM Program Plan, the SWMBH UM care management reviewers will use the publicly available clinical practice guidelines in conducting their reviews of the various clinical components of the SWMBH plan. These include contractual identified practice guidelines, MDHHS public policy guidelines, technical advisories, nationally recognized medical necessity criteria, Clinical practice guidelines (CPG's) published by The National Institute of Health and Care Excellence (NICE) and the Michigan Quality Improvement Consortium (MQIC).

J. Care Management Review Mechanisms

The SWMBH Annual UM Program Plan shall include care management review mechanisms that addresses all of the regulatory compliant and policy driven functions. SWMBH will assure interrater reliability related to SWMBH policy and criteria annually as identified through the Consistency in Applying Criteria policy.

K. UM Decision-Making Criteria

The SWMBH shall use nationally recognized medical necessity written criteria based upon sound clinical evidence and specific procedures for appropriately applying the criteria to make utilization decisions including application of CPG's published by NICE and the MQIC.

L. Service Authorizations

The SWMBH shall have UM review criteria that reviews utilization management decisions being made across its network for consistency and alignment with its clinical practice guidelines. In this

regard, the UM Care Management Review team shall ensure, through its sampling reviews of the UM program, that all regulatory, statutory and policy requirements are met. Service determinations resulting in denials are made by appropriately licensed and credentialed staff limited to the SWMBH Chief Medical Officer, contracted board certified psychiatrists or the consulting psychologist as a fully licensed psychologist. SWMBH does not provide financial incentives, reimbursements or bonuses, to staff or providers, based on customer utilization of covered services.

M. Level of care decisions

Level-of-care UM decisions shall base on the SWMBH policy (developed from the MDHHS Specialty Services Contract, Michigan Mental Health Code, Medicaid Provider Manual, Medicare and NCQA regulations), nationally recognized Medical Necessity Criteria, ASAM Level of Care Criteria, Supports Intensity Scale (SIS), Level of Care Utilization System (LOCUS) and SWMBH, Clinical Practice Guidelines. Level of care decisions shall only be made by qualified staff with the expertise to make decisions and are reviewed, as appropriate, through supervisory, peer case and random SWMBH UM review mechanisms. Service determinations resulting in denials are made by appropriately licensed and credentialed staff limited to the SWMBH Chief Medical Officer, contracted board certified psychiatrists or the fully licensed consulting psychologist. In instances of potential conflict of interest, SWMBH shall utilize board certified consultants to make medical necessity denial and appeal decisions. SWMBH does not provide financial incentives, reimbursements or bonuses, to staff or providers, based on customer utilization of covered services.

N. Authorization and Denial review criteria/procedures

The SWMBH UM Care Managers shall consistently apply medical necessity criteria, Utilizing the policy driven criteria, reviewers will review service authorization decisions rendered by UM Care Managers and service denial decisions rendered by the SWMBH Medical Director, contracted board certified psychiatrists or the fully licensed consulting psychologist. SWMBH does not provide financial incentives, reimbursements or bonuses, to staff or providers, based on customer utilization of covered services. Reviewers do not have a reporting relationship to SWMBH staff making medical necessity or level of care determinations.

O. Practitioner Access to UM Decision Criteria

The SWMBH ensures its customers and practitioners have access to all the utilization decision criteria used by the network and have received information or training on the use of the criteria and how to access it, as requested. Mechanisms to access criteria are identified in provider and member handbooks.

P. Access to UM Staff to Discuss UM Issues

Organizational providers, practitioners and customers have access to staff to discuss UM criteria via the toll free UM or Member Services and/or Michigan Relay 711 phone numbers. Information regarding how to access a UM reviewer is identified in provider and member handbooks. UM reviewers are available Mon-Fri 8AM to 8PM to discuss and process routine UM issues. UM reviewers are also available after hours, holidays and weekends to process pre-service or concurrent urgent requests. Providers and members have 24 hour availability to electronic submit requests and/or leave a voicemail. Additionally, interpreter services are made available to members at no cost and critical documents as identified per BBA/Social Security safe harbor thresholds.

Q. Appropriate UM Professionals

As identified via ICO/MDHHS contracts and NCQA standards, SWMBH shall ensure that only qualified licensed professionals assess the clinical information used to support and oversee all UM decisions.

R. SWMBH Review Case Selection

Specific cases for UM Review are identified by the SWMBH in accordance with the annual guidelines set forth in the UM Plan. In this regard, the SWMBH may choose specific cases for review according to the UM Plan and may include random or targeted samples and cases of over and underutilization. In order to realize administrative efficiencies, the SWMBH will complete 100% of MI Health Link UM Reviews required by policy, contract and UM Plan.

S. UM Program Monitoring Results and Reporting

1. Results of UM Reviews will be aggregated in a common format and compared across the SWMBH region for improvement of service delivery and cost effectiveness and to address over and underutilization. Those will include recommended organizational level of care changes.
2. The MHL UMC will review all aggregated data on UM and service authorization trends on a regular basis. The efficacy of services, the quality of the services and supports as well as their cost-effectiveness will be assessed and decisions regarding improvements and needed changes in the system(s) will be discussed and reviewed.
3. UM reports shall be provided monthly to the ICO per contract specifications.

T. Policies for Appeals

SWMBH shall maintain policies for service recipient appeals of UM decisions. These policies shall be maintained in the SWMBH Provider Policy Manual, and posted on the SWMBH web site. SWMBH shall ensure there is a full and fair process for resolving service member disputes and responding to the person's request to reconsider a decision they find unacceptable regarding their care and services. The SWMBH appeal process shall address the regulatory and contractually mandated appeal and appeal related processes.

U. Delegation

SWMBH shall comply with delegation requirements set forth in the applicable ICO contract.

IV. Definitions

A. See definitions section of policy manual/folder

V. References

A. None

VI. Attachments

A. None