Section: Utilization Management	Policy Name: **Utilization Management**	Policy Number: **04.02**
Owner: **Director of Utilization Management**	Reviewed By: **Elizabeth Guisinger, LPC, CAADC** **Michael Redinger, MD**	Total Pages: **6**
Required By: ☒ **BBA** ☒ **MDHHS** ☒ **Other (please specify):** **See References**	Final Approval By: Beth Guisinger (Jul 18, 2025 15:58 EDT)	Date Approved: 07/18/2025
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☐ **Other (please specify):** _____	Effective Date: **1/1/2014**

Policy: It shall be the policy of Southwest Michigan Behavioral Health (SWMBH) to have a comprehensive UM Program that meets the regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) Specialty Services Contract, MDHHS Access Standards, the MI Mental Health Code, and Centers for Medicare and Medicaid Services Code of Federal Regulations (CFR). The purpose of the Utilization Management (UM) Program is to provide a comprehensive integrated process that ensures persons served by SWMBH and its provider network receive high-quality, timely, medically necessary, and clinically appropriate behavioral healthcare in the most cost-effective manner with uniform benefit application.

Purpose: To establish the standards and guidelines that detail how SWMBH and its provider network system comply with the federal laws and MDHHS Contract requirements pertaining to the UM responsibilities of SWMBH. With the adoption, dissemination, and implementation of SWMBH's clinical protocols and practice guidelines throughout the network, implementation and uniform benefit in accordance with the contractual requirements will be met for UM best practices.

Scope: SWMBH Utilization Management will ensure policy is followed, fulfilling the following components: Access and Eligibility, Service Authorization and Reauthorization, Utilization Review, and Clinical Protocol.

Responsibilities:

SWMBH UM will have appropriate licensed clinicians to implement, supervise, and provide oversight and evaluation of the UM program. All decisions will be based on medical necessity.

Regional Utilization Management (RUM) and Regional Clinical Practices (RCP) Committees will review aggregated data on UM and service authorization trends and shall serve as a support and advisory capacity to the UM program.

Definitions: See definitions section of policy manual/folder.

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.

B. Regional Utilization Management/Clinical Practices
SWMBH shall maintain a RUM and RCP, consisting of both SWMBH and clinical representatives. The RUM/RCP shall serve in a support and advisory capacity to the UM Program. Standards and guidelines are adopted in consultation with the contracting providers and staff who utilize the protocols and guidelines.

C. Program Components
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 MDHHS Contract, the UM Program must have a written plan and address mechanisms to address over/under utilization and prospective, concurrent and retrospective 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 customer services, shall have a mechanism for tracking feedback regarding satisfaction with the UM Process from customers 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. SWMBH will perform

utilization management functions sufficient to control costs and minimize risk while assuring quality of care.

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 contractually identified practice guidelines, MDHHS public policy guidelines, technical advisories, nationally recognized medical necessity criteria and clinical practice guidelines (CPG's) that are based upon valid and reliable clinical evidence or a consensus of healthcare professionals in the field.

J. Care Management Review Mechanisms

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

K. UM Decision-Making Criteria

SWMBH shall use medical necessity written criteria based upon sound clinical evidence and specifics procedures for appropriately applying the criteria to make utilization. The medical necessity is reviewed periodically and updated as needed, with the approval of the Medical Director, Director of Utilization Management, and Chief Clinical Officer.

L. Service Authorizations

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, considering the needs of the member. 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. 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 be based on the standardized SWMBH policy developed and consistent with the MDHHS Practice Guidelines as specified in the MDHHS-PIHP Specialty Services Contract the Michigan Mental Health Code, and Michigan Medicaid Provider Manual. Medical necessity criteria is based off the mandated assessment and level of care tools, including the American Society of Addiction Medicine (ASAM) Level of Care Criteria, Michigan Child and Adolescent Needs and Strengths (MichiCANS), Level of Care Utilization System for Psychiatric and Addictive Services (LOCUS), Milliman Care Guidelines (MCG), and 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 who have appropriate clinical expertise in treating the customer's condition. 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. Denial/appeal reviewers will review service authorization decisions rendered by UM Care Managers and service denial decisions. 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 subordinate reporting relationship to SWMBH staff making medical necessity or level of care determinations and decisions rendered are conflict free.

O. Practitioner Access to UM Decision Criteria

SWMBH ensures its customers and practitioners have access to all the utilization decision criteria used by the network, 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 customer handbooks and on the SWMBH website.

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 Customer 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 5PM to discuss and process routine UM issues. Providers and customers have 24-hour availability to electronically submit requests and/or leave a voicemail. Additionally, interpreter services are made available to customers at no cost and critical documents.

Q. Appropriate UM Professionals

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

R. SWMBH Review Case Selection

Specific cases for UM Review are identified by SWMBH in accordance with the annual guidelines set forth in the UM Plan. In this regard, 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. To realize administrative efficiencies, SWMBH will complete 100% of Medicaid 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 increases, decreases, changes or services that stay the same.
2. The Regional Utilization Management (RUM) and Regional Clinical Practices (RCP) Committees 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.

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 website. SWMBH shall ensure there is a full and fair process for resolving service recipient 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

If SWMBH delegates any UM functions contained in this policy guideline, SWMBH shall have a Delegation Agreement with the delegate entity that meets all the conditions of the SWMBH delegation policy guideline. SWMBH shall always maintain its oversight and monitoring responsibilities of all delegated UM functions, and shall annually evaluate the delegate entity, in accordance with the requirements outlined in the UM area Delegation Agreement.

V. Wait Lists, Medicaid

It is impermissible to operate 'waiting lists', formal or informal, for Medicaid beneficiaries who receive specialty behavioral health services. Medicaid beneficiaries shall not be placed on waiting lists for any Medicaid service.

References:

- 42 CFR 438 Subparts B, C, D, F
- PIHP Contract Section: Part II (A): 4.11: Denials By A Qualified Professional; 4:12 Utilization Management Incentives, 7.10: Service and Utilization Management; Attachment 7.9.1: QAPI Programs for Specialty PIHP's; Attachment 6.3.1.: G&A Technical Requirements
- MDHHS Access Standards
- L 22-72-BH: Clarification on Policy and Procedure Related to the Denial, Suspension, Reduction, or Termination of Specialty Behavioral Health Services.

Attachments:

None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	4/22/2019	Scope & Responsibilities	Added, not in previous version	E. Guisinger
1	4/20/2020	Annual Review	No changes	E. Guisinger
2	8/31/2021	Standards and Guidelines M	Added MCG criteria	L. Mitchell
3	9/23/2022	NA	Annual Review	E. Guisinger
4	12/29/2023	Standards and Guidelines, A, M, P, V	Title, removal of SIS, business hours update, added priority population waitlist language	E. Guisinger
5	5/22/2025	Purpose; Standards & Guidelines B, H, I, K, L, M, O	Incorporation of language from SWMBH Policy 04.04 prior to archiving	E. Guisinger

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