Section: **Utilization Management**	Policy Name: **Service Authorization Outlier Management**	Policy Number: **04.03**
Owner: **Director of Utilization Management**	Reviewed By: **Alena Lacey, MA, LPC** **Beth Guisinger, MA, LPC, CAADC** **Bangalore Ramesh, M.D.**	Total Pages: **13**
Required By: ☒ **BBA** ☒ **MDHHS** ☒ **NCQA** ☐ **Other (please specify):** ______________________	Final Approval By: Alena Lacey B.K. Ramesh (Dec 6, 2022 20:01 PST) Beth Guisinger (Dec 6, 2022 16:03 EST)	Date Approved: Dec 6, 2022
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** ☐ **MI Health Link** ☐ **Other (please specify):** ______________________	Effective Date: **1/1/2014**

Policy: It is the policy of SWMBH to assure that customers receive the right service at the right time and in the right amount sufficient to meet their need. SWMBH also ensures that service determinations are provided in compliance with all State and Federal regulations, contractual requirements, and National Committee for Quality Assurance (NCQA) standards where applicable, regarding decision timeframes, authorization determination notifications, and ensuring members are informed of the dispute resolution processes available to them.

Purpose: To establish standards and guidelines for the uniform authorization of services provided within the scope of Southwest Michigan Behavioral Health (SWMBH), while ensuring sound benefit management principles consistent with health plan industry business standards, and timely notice of authorization decisions. The service authorization process is intended to promote statewide consistency for access to Medicaid specialty behavioral health services (uniformity of benefit), to prevent unequal treatment limitations, maximize access and efficiency on the service delivery level, ensure consistency in meeting federal and state contractual requirements, while confirming customers, legal representatives, and providers, are provided timely notification of service determinations.

Scope: This policy is applicable to the SWMBH Utilization Management (UM) service authorization processes regarding prospective/preservice, concurrent, and retrospective/post service

authorization requests and determinations, and appeals for service outliers which include high cost, high risk and over and under-utilization.

Responsibilities: SWMBH and Community Mental Health Service Provider (CMHSP) UM Staff should comply with all the guidelines set forth in this policy. SWMBH and CMHSP UM Staff will have appropriately 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:

A. Utilization Review: The process of monitoring, evaluating medical necessity, use, delivery, cost effectiveness, appropriateness, and the efficient use of health care services provided by health care professionals on a prospective, concurrent, or retrospective basis. Utilization review activities include monitoring of individual consumer records, specific provider practices and system trends.   to determine appropriate application of Guidelines and Criteria in the following areas: level of care determination, Application of Service Selection Criteria, Application of Best Practice Guidelines, Consumer outcomes, Over-Utilization/under Utilization, and Review of clinical or resource utilization Outliers.
B. Prospective Review: The process of evaluating the appropriateness of a service prior to the onset of the service.
C. Concurrent Review: The process of evaluating the appropriateness of a service throughout the course of service delivery.
D. Retrospective Review: The process of evaluating the appropriateness of a service after the services have already been provided.
E. Medical Necessity: 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 least restrictive environment and is consistent with clinical standards of care. (Medicaid Provider Manual)
F. Uniform Benefit/Uniformity of Benefit: Consistent application of and criteria for benefit eligibility, level of care determination and service provision regardless of various demographics including geographic location, based upon the clinical and functional presentation of the person served, over time.

Standards and Guidelines:

A. Utilization Management Department

The SWMBH UM Program operates under the oversight of the SWMBH Medical Director (MD) and Utilization Management Director. The SWMBH Medical Director (MD) is accountable for management of the Prepaid Inpatient Health Plan's (PIHP) UM Program Jointly with the board-certified Medical Officer and the Utilization Management Director provides clinical supervision,

operational oversight, direction, and evaluation to the UM program and staff and ensures that the SWMBH region has qualified staff and providers accountable to the organization for decisions affecting customers. UM staff supervision consists of, but is not limited to, ensuring clinical criteria is being applied consistently, assuring completion of mandatory training, providing opportunities for continued education, as well as monitoring documentation in client records to ensure adequacy.

SWMBH's UM Department consists of appropriately credentialed staff that is deemed capable by the MD and Utilization Management Director in making medical necessity determinations for the services that they authorize. The MD is available for consultation and provides review functions for services requiring a physician (Inpatient Psychiatric, Crisis Residential, Substance Abuse Residential, Community Based Medical, Methadone and Electroconvulsive Therapy (ECT) Peer Review). The MD, and/or appropriately credentialed staff make all determinations that result in medical necessity denials for behavioral health and substance use disorder authorization requests within their scope of practice. The MD may also provide appeal determinations for Administrative and Medical Necessity Appeals (in cases in which they did not make the initial denial determination). Cases that require a medical necessity determination but present a real or perceived conflict of interest if reviewed by the SWMBH Medical Director are reviewed by an external board-certified consultant.

The Regional Utilization Management Committee (RUM) and the Regional Clinical Practices Committee (RCP) are PIHP Committees consisting of clinical and UM leadership representatives from each of the eight Community Mental Health Service Providers (CMHSP) who are experienced clinical professionals with specialty representation for Child and Adolescent Severe Emotional Disturbance, Developmental Disabilities, Adults with Serious and Persistent Mental Illness, and Substance Use Disorders. RUM and RCP provide input and coordination regarding UM and clinical practice issues and serve in a support and advisory capacity to the UM Program. Ongoing consultation and ad hoc representation from the MD are available to the committee. The RUM committee meets at a minimum of 6 times per year.

B. Review Criteria

Service determination criteria are constructed upon recognized, objective and evidence based medical necessity criteria, current clinical principles and processes consistent with the Michigan Department of Health and Human Services (MDHHS) Practice Guidelines, MDHHS Michigan Medicaid Provider Manual, and the Office of Recovery Oriented System of Care (OROSC) Technical Assistance guidelines and policy for behavioral health and substance use disorders, and will be applied based on individual needs. In instances where UM criteria is inadequate for making determinations on complex cases, and considerations must be made towards the member's complications, or a delivery system with insufficient alternatives to inpatient care, the UM decisions will be based on alternative/secondary criteria and/or consultations with the clinical supervisors.

Medical necessity and all behavioral health review criteria are evaluated at least annually by the RUM committee and updated (if necessary), with final approval by the Utilization Management Director, Clinical Quality Director, and Medical Director.

The SWMHB Provider Manual, and each CMHSP with delegated UM, informs practitioners/the provider network that they can obtain UM criteria, and methods available for obtaining those criteria.

UM decisions are made based only on appropriateness of a covered service and existence of coverage. Staff who make UM decisions, practitioners, providers, and members, are distributed an affirmative statement, confirming that there is no use of incentives to encourage barriers to care and service. SWMBH policy prohibits financial incentives, reimbursements or bonuses, to staff or providers, based on utilization of covered services, including denials of coverage and/or underutilization. Additionally, SWMBH prohibits making decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

C. Availability of UM Staff

The SWMBH UM program is available to members and providers by telephone (toll free) from 8:00 a.m. to 8:00 p.m., Monday through Friday of each normal business day. UM staff respond to communications within one business day during provider's reasonable and normal business hours. UM staff identify themselves by name, title, and organization during correspondence. Providers may leave messages and/or electronically communicated service determinations requests 24/7. Communication received from members or providers after normal business hours are returned on the next business day and communications received after midnight on Mon-Friday with exception of holidays are responded to on the same business day. UM requirements and procedures are made available upon request as well as contained in the SWMBH Provider Manual, and PIHP Customer Handbook. When a denial determination occurs, SWMBH policy provides the opportunity for the requesting provider to discuss the determination with either the reviewer making the determination or, if not available within one business day, a different clinical reviewer.

UM reviews may be conducted electronically via the managed care information system or via telephone. In the event an onsite review is scheduled, onsite review staff will carry a picture ID clearly identifying full name, title, and name of organization. Reviews will be scheduled at least one day in advance unless otherwise agreed upon. Reviewers will follow reasonable hospital or facility procedures, including checking in with the designated personnel.

D. Emergency Services

In the process of conducting UM, staff receive telephone calls from members with varying levels of severity of illness and needs. It is important role of Care Managers, to ensure that customers who demonstrate severe symptoms, receive the services appropriate for their condition. There is potential for receiving phone calls from customers who present as a risk to themselves or others. Protocol for situations in which a customer has presented with such risk is to signal a

peer care manager(s) who phones 911. In no circumstances is the call transferred, placed on hold, or ended until appropriate safe mechanisms are in place for handling the emergency (i.e., police have arrived, family is transporting for a prescreen, or otherwise the crisis situation is no longer presented).

E. Afterhours Urgent Service Need/Authorizations

After-hours emergency services are available to customers and providers through a phone service outside of normal business hours staffed by licensed professional staff who provide emergency triage, screening, referral, and information. Licensed professional staff are available 8:00 a.m. - 8:00 p.m. Monday through Friday, after normal business hours, weekends, and holidays, to provide urgent pre-service and urgent concurrent authorization determinations. Additionally, customers and providers may leave messages for UM staff through this service and also may provide information electronically after hours.

Toll free numbers are made available for members and providers. Voices for Health (or other similar organizations) and the Michigan Relay Center are utilized to assist customers who require interpreter services and are provided at no cost to the customer. All services related to Limited English Proficiency (LEP) are provided in accordance with the SWMBH LEP policy. Information about free LEP related services is available in the PIHP Customer Handbook. The policy and handbook are available on the SWMBH website at www.swmbh.org and/or the county specific CMHSP web site.

F. Review Process

All UM determinations are made by a clinical reviewer who is an appropriately licensed health professional, holds a current and valid license in the same licensing category as the ordering provider, or is a Medical Doctor or Doctor of Osteopathic Medicine, and is qualified to render clinical opinions as determined by the Medical Director. Any authorization request, which results in a medical necessity denial determination, are rendered by the MD or Consulting Psychologist or appropriately licensed professional within their scope of practice, to assure clinical appropriateness. SWMBH does not utilize an "initial screening", nor utilize non-qualified health professionals in any capacity for service authorization requests. Non-qualified health professionals within the UM Department are utilized for the purposes of administrative support only.

Determinations are made within the following timeframes:

Type of Review	Time Frame
Prospective Review	Determination must occur as soon as possible based upon clinical condition not to exceed 72 hours if urgent; within 14 calendar days if non-urgent; and may be extended up to 14 calendar days for non-urgent cases when situation is beyond the organization's control. Customer must be

	notified before the initial 14 days expire of the circumstances requiring the extension.
Retrospective Review	Determination within 30 calendar days within receipt of the request for authorization. May be extended one time for up to 15 days when situation is beyond the organization's control. Customer/provider must be notified prior to the initial 30 days expire of the circumstances that required the extension.
Concurrent Review	For requests to extend a current course of treatment, determination is made within 24 hours if the request occurs at least 24 hours before the expiration of the currently approved treatment and within 72 hours if request occurs in less than 24 hours of expiration of the current course of treatment.

Reviews occur at a frequency based upon the severity or complexity of the illness or related to discharge planning activities, not on a routine predetermined basis. Information obtained during the review process is obtained from any reasonable source applicable to determining medical necessity criteria for the service type, and amount/scope/duration of service.

Only information necessary for making an authorization determination is required (i.e., providers are not asked to send the entire medical chart for review). Services are not arbitrarily denied based upon one specific element such as lack of numerical diagnostic code, or blood alcohol level, etc.

If an extension is required to make an authorization determination, the member is notified before the expiration of the Prospective/Preservice, Retrospective/Post service, or Concurrent Review timeframes, of the circumstances that require an extension as well as when a decision is expected to be made.

Information shared is on a need-to-know basis with efforts to minimize redundant requests for information. Prospective/Preservice, Retrospective/Post service, and Concurrent Review determinations, are based upon information available at the time of the review. Retrospective review determination is based solely upon information available at the time the service was provided.

In the event insufficient information is available for conducting the review (Lack of Information), the authorization may be "suspended" for up to 14 business days. The ordering provider may submit additional information within the timeframe of the "suspended status." If the provider does not submit additional information within that time frame or if the information submitted does not demonstrate criteria, a denial will be rendered, and the provider will be notified of appeal options (i.e., standard/expedited appeal). Expedited appeals are completed with verbal notification of the determination to the requesting party within 72 hours of the request followed by written confirmation within 3 calendar days to the customer, the ordering provider, and facility.

Standard appeals are completed, and written notification issued within 30 calendar days of the receipt of the request for the appeal to the customer, ordering provider and facility.

G. Levels of Review

Requests for services may arrive to SWMBH UM from various sources including Managed Care Information System (MCIS), telephonic, fax, etc.

SWMBH beneficiaries have access to an Independent Review process after other internal appeal mechanisms have been exhausted. Independent Review services meet the following standards:

1. Utilizes staff with appropriate clinical expertise and licensure/certification in rendering independent review determinations.
2. Does not have direct financial interest in SWMBH or in the outcome of the independent review.
3. Renders UM determinations for non-urgent cases within 30 calendar days from the date of the customer request for independent review.
4. Renders UM determinations for urgent cases within 72 hours from the date the customer requested independent review.
5. Is not involved in the original determination that is considered in the appeal. If a review and appeal are both conducted from the Independent Review Organization (IRO), the two staff making the determinations may not be the same person.

All Michigan Medicaid beneficiaries also have the right to a State Fair Hearing after the local level appeal has been exhausted. The State Fair Hearing determination overrides any prior determination. Medicaid beneficiaries also have the right to request a Second Opinion if admission to psychiatric hospitalization or eligibility for community mental health services is denied.

H. Peer Clinical Review

UM staff are available to discuss authorization decisions with the requesting customer, provider and attending physician (if applicable). The UM staff assist with physician-to-physician communication with the MD and assist in obtaining relevant clinical information and documentation for review. When a decision is made to deny an authorization request, SWMBH UM Department provides within one business day, upon request, the opportunity to discuss the determination with the UM Reviewer who made the determination, or another clinical reviewer if the original reviewer cannot be available within one business day. If this communication does not result in an authorization, the provider is given information regarding how to appeal the determination and any applicable timelines. Upon request, SWMBH will provide specific clinical rationale on which the decision to deny the authorization was made.

I. Documentation of Utilization Review Decisions

All approvals and denials are clearly documented and utilize a tracking number. The attending physician, ordering provider or facility rendering the service to the customer is notified of the determination (including how many additional days/units of service are authorized, next review

date, total units approved, and the date of admission or service onset) either by phone and/or via the MCIS system and/or written notification of the determination.

Written notification of denials of service authorization provided to customers and/or their treating practitioner, provides specific reason(s) for the denial, in an easily understood language, with reference to the benefit provision and or clinical criteria rationale on which the decisions was based. Written notification also includes that the customer can also obtain a copy if the benefit provision or clinical criteria/rationale on which the denial decision was based and that it is available to them, upon request, and instructions of how to do so. Information is also provided regarding how to appeal the denial determination.

J. Service Determinations/Authorization Decisions

Medical necessity approval determinations for all services and denial determination for all services except Substance Use Disorder (SUD) Residential, SUD Detox, SUD Medication Assisted Treatment (MAT), Psychiatric Inpatient and ECT are made by SWMBH UM staff licensed by the State of Michigan in their respective field (Michigan fully or limited Licensed Masters Level Social Workers LLMSW/LMSW, Michigan fully or limited Licensed Psychologists TLLP/LLP/LP, Michigan fully or limited Licensed Professional Counselors LLPC/LPC, Registered Nurse, Physicians MD, DO, Occupational (OT) or Physical Therapists (PT), OT, PT). Service determination decisions resulting in denials for SUD Residential, SUD Detox, SUD MAT, Psychiatric Inpatient and ECT are made by appropriately licensed and credentialed staff limited to the SWMBH Medical Director or a contracted board-certified psychiatrist When a covered service is requested, SWMBH will ensure the determination is made within the specified timeframes for each review type, and as expeditiously as the beneficiary's health condition requires. The service determination/authorization decision must meet the requirements for either standard or expedited timeframe. In the event the SWMBH fails to provide the customer with timely notice of the determination, this constitutes an adverse action and appeal processes are available to that customer. Notice of the service determination/authorization decisions must be provided within contractual and regulatory timeframes outlined under Section (F).

K. Use of Licensed Specialty Practitioners

SWMBH utilizes licensed behavioral healthcare practitioners to consult on cases requiring specialized assistance in making medical necessity determinations. Cases that require a medical necessity determination by a specialty consultant (i.e., child psychiatrist, certified addiction medicine specialist) are reviewed by a board-certified consultant/specialist through a contracted external review organization. In the event an external consultant is sought, SWMBH Care Manager's and/or Member Engagement Specialist's provides supporting clinical documentation to the contracted external review organization, outlining the request and time the determination must be completed by.

L. Prospective/Preservice Requests and Determinations

A Prospective/Preservice Review involves evaluating the appropriateness of a service authorization prior to the onset of services. Prospective determinations are based solely on

information available at the time of the review. Written notification of denial and appeal rights, for an authorization request that results in a denial, in whole or part, of the service authorization requested, will contain elements described under “Written Notification of Denial Determination” contained in this policy.

M. Concurrent Requests and Determinations

A Concurrent Review involves evaluating the appropriateness of a service throughout the course of service delivery. Reviews occur at a frequency based upon the severity or complexity of the illness or related discharge planning activities, not on a routine predetermined basis. Concurrent review determinations are based solely on information available at the time of the review. Information obtained during the review process is obtained from any reasonable source, applicable to determining medical necessity criteria for the service requested and specific to determining admission/discharge/transfer, service type, and amount/scope/duration of services. Concurrent reviews are typically associated with inpatient care, residential behavioral healthcare, intensive outpatient behavioral healthcare and ongoing ambulatory care. Written notification of denial and appeal rights, for an authorization request that results in a denial, partial denial, termination, reduction, or suspension of a service of an authorization requested, will contain elements described under “Written Notification of Denial Determination” contained in this policy.

If a request to extend treatment beyond the period of time or number of treatments previously approved and does not meet the definition of “urgent care”, the request is handled as a new request and are subject to the determination and notification time frames (including extensions) appropriate for the type of decision (i.e., preservice or post service). When determining whether a concurrent request meets the definition of “Urgent” SWMBH considers the content of the request and whether making the decision in accordance with the standard timeframe could lead to adverse health consequences and/or if the application of a non-urgent time frame could involve unnecessary interruption in the customer’s treatment that may jeopardize the customer’s health or ability to recover.

N. Retrospective/Post service Determinations

A Retrospective Review involves evaluating the appropriateness of a service after the services have already been provided. Retrospective/Post service review determinations are based solely upon information available at the time of the service was provided. Written notification of denial and appeal rights, for an authorization request that results in a denial, in whole or part, of the service authorization requested, will contain elements described under “Written Notification of Denial Determination” contained in this policy.

O. Denial of Benefit

Using criteria for Medical Necessity, SWMBH may deny the use of a benefit based on the following parameters set forth by the Department of Health and Human Services (MI Medicaid Provider Manual) and Medicare Regulations

1. When the service is deemed ineffective for a given condition based upon a practitioner and scientifically recognized and accepted standards of care; or
2. When the service is experimental or investigational in nature; or
3. When there exists an appropriate, efficacious, less restrictive, and cost-effective alternative service, setting or support, that otherwise satisfies the standards for medically necessary services; or
4. When the person requesting behavioral health services is ineligible for Medicaid or general fund support.

SWMBH does not deny the use of a benefit based on preset limits of benefit duration but instead reviews the continued medical necessity criteria on an individualized basis. If it is determined that the medical necessity criteria for a specific service is not met, all efforts will be made to link the member to the services they need.

P. Adverse Benefit Determinations/Authorization Decisions

Any adverse benefit determination based on lack of medical necessity, in whole or in part, and based on the initial review of the service request, will be rendered by the SWMBH MD or other appropriate healthcare professional with sufficient medical or other clinical expertise and current unrestricted license to practice as identified in section J of this document, before issuing the determination.

SWMBH will ensure that adverse benefit determinations are fully documented in the customer's record with the handwritten signature, handwritten initials or unique electronic identifier from the appropriate provider making the decision or signed or initialed note by the UM reviewer who denotes the specific provider that made the determination.

Upon an adverse benefit determination, the treating/requesting provider will be informed of how to contact SWMBH to discuss the determination with the appropriate reviewer. If the UM staff notifies the requesting provider by telephone, UM staff will document the time and date of both the notification of the adverse benefit determination and the notification of the reviewing physician's availability, if warranted.

Practitioners have the option of also discussing pending medical necessity denials, terminations, denials, reductions, and suspensions through a direct peer to peer review with the MD or UM reviewer, prior to the denial. This is not deemed to be the initiation of a formal appeal of the determination.

If SWMBH issues an adverse benefit determination notice due to lack of necessary information, and then receives the required information, or new information becomes available prior to the end date of the approved authorization, the practitioner who issued the adverse determination may review the case with the new information and reverse the determination. If the original determination of adverse action stands, this does not constitute the need for a new adverse benefit notice to be provided, and appeal rights, including timelines to appeal the decision, still apply.

SWMBH will ensure that board certified consultants are used in making medical necessity determinations, under appropriate circumstances

Q. Administrative Denials

Administrative denials are denials of coverage for services that are based on reasons other than clinically based rationale and does not require a medical director review. Administrative denials are decisions that result from coverage requests for services that are not covered based on a contractual obligation, contractual exclusion, benefit exclusion, insufficient information to make a medical necessity determination, or due to non-compliance with administrative policies and procedures established by Southwest Michigan Behavioral Health, and do not require a clinician to apply clinical judgement.

R. Written Notification of Adverse Benefit Determinations

SWMBH will provide members/authorized representative, and or provider if one is involved, written notification in the event a decision has been made to deny service or payment in whole or in part, or reduce, suspend, or prematurely discontinue the level of care for a previously authorized ongoing course of treatment.

1. Written notification of an adverse benefit determination will be in accordance with MDHHS contractual requirements and NCQA Standard UM 7: Element E, and will consist of:
    a. Approved notice language in a readable and understandable form
    b. Specific reasons for the denial
    c. Benefit provision, guideline, protocol, or other criteria the denial decision is based on
    d. Statement that customers can obtain a copy of the actual benefit provision, guideline, protocol, or other criteria on which the denial was based upon, and how to request the copy
    e. The customer's right to a reconsideration
    f. Standard and expedited reconsideration processes and time frames, including the right to, and conditions for, obtaining an expedited reconsideration and the additional appeal mechanisms available
    g. The right to appoint a representative to file an appeal on the customer's behalf
    h. The customer's right to submit additional evidence in writing or in person
2. Notice will be delivered using the most efficient manner of delivery to ensure the member (and representative when applicable) receives the notice in time to act.
3. In the event SWMBH fails to provide the member with timely notice of the determination, this failure is considered an adverse action and may be appealed.
4. Written notification will also be provided if a customer requests SWMBH to provide an explanation of a provider's decision to deny a service in whole or in part.

References:

A. Medicaid Provider Manual
B. Balanced Budget Act of 1997/Medicaid Managed Care Regulations 2018
C. NCQA Standards
D. MDHHS/PIHP Contract
E. 04.02 Utilization Management
F. 06.05 Limited English Proficiency
G. The Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
H. Medicaid Managed Care Regulations (42 CFR §438.910(b))

Attachments: 04.10A SMI-SED-IDD-SUD LOC Core Service Menu

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	9/27/22	Transferred to updated template	Reviewed and updated Standards and Guidelines and reference. Added Definitions and Responsibilities.	A. Lacey

04.03 Service Authorization Outlier Management

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