Section: **Utilization Management**	Policy Name: **Service Authorizations & Notice of Determinations**	Policy Number: **MHL 04.04**
Owner: **Manager of UM & Call Center**	Reviewed By: **Elizabeth Guisinger, LPC, CAADC** **Bangalore Ramesh, MD**	Total Pages: **18**
Required By: ☒ **BBA** ☒ **MDHHS** ☒ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: Beth Guisinger (Dec 8, 2021 06:49 EST) Bangalore K Ramesh (Dec 8, 2021 11:37 EST)	Date Approved: Dec 8, 2021
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: **03/01/2015**

Policy: It is the policy of Southwest Michigan Behavioral Health (SWMBH) to assure that members receive the right service at the right time and in the right amount, sufficient to meet their needs. SWMBH also ensures that service determinations are provided in compliance with all State and Federal regulations, contractual requirements and National Council for Quality Assurance (NCQA) Managed Behavioral Healthcare Organization (MBHO) standards regarding decision timeframes, authorization determination notifications, and ensuring members are informed of the dispute resolution processes available to them. 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.

Purpose: To establish standards and guidelines for the authorization of services provided within the scope of 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 maximize access and efficiency on the service delivery level, ensure consistency in meeting federal and state contractual requirements, while confirming members, legal representatives and providers, are provided timely notification of service determinations.

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

- 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.

Responsibilities:

The SWMBH UM Department will make determinations and consult with the SWMBH Medical Director (MD) or another board-certified consultant. The SWMBH Member Services Department will notify members and providers of determinations within appropriate time frames.

Definitions: None

Standards and Guidelines:

A. Utilization Management Department

The SWMBH Utilization Management Program operates under the oversight of the SWMBH MD and Manager of Utilization Management & Call Center. The SWMBH MD is accountable for management of the Prepaid Inpatient Health Plan's (PIHP) UM Program and a consulting psychologist is available for consultation. The consulting psychologist holds an unrestricted doctoral clinical license, is qualified to provide clinical consultation for the services provided and has post-graduate experience in direct patient care. Jointly with the board-certified Medical Director, the Manager of UM and Call Center provides clinical supervision, operational oversight, direction, and evaluation to the UM program and staff ensures that SWMBH has qualified staff 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 Utilization Management Department consists of appropriately credentialed staff that is deemed capable by the Medical Director and Manager of UM and Call Center in making medical necessity determinations for the services that they authorize. The Medical Director (MD, psychiatrist) 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 Medical Director and/or the consulting psychologist make all determinations that result in medical necessity denials, for behavioral health and substance use disorder authorization requests. Cases that require a medical necessity determination but present a real or perceived conflict of

interest if reviewed by the SWMBH Medical Director and/or consulting psychologist, are reviewed by an external board-certified consultant.

SWMBH MHL Utilization Management Committee (UMC) provides input and coordination regarding utilization management and clinical practice issues. The MHL UMC serves in a support and advisory capacity to the UM Program. The MHL UMC is a PIHP Committee consisting of clinical leadership representatives from SWMBH including the Medical Director, the Manager of UM, Substance Abuse Disorders and Integrated Care, Provider Network Management and Clinical Improvement, the PIHP Supports Coordinator and Care Management Specialists. Ongoing consultation and ad hoc representation from SWMBH Customer Services, Finance, Information Technology (IT), the Customer Services Advisory is available to the committee. The MHL UMC committee meets at a minimum 10 times per year.

B. Review Criteria

Service authorization review criteria are constructed upon nationally recognized, objective and evidence based clinical criteria 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 department will utilize alternative/secondary criteria and/or consultations with the department's clinical supervisors.

Medical necessity and all behavioral health review criteria are evaluated at least annually by the MHL UMC and updated (if necessary), with final approval by the Medical Director.

The SWMBH Provider Manual informs practitioners that they can obtain UM criteria, and methods available for obtaining that criteria.

SWMBH UM decisions are made based only on appropriateness of a covered service and existence of coverage. SWMBH employees who make UM decisions, practitioners, providers, and members, are distributed an affirmative statement, confirming that SWMBH does not use incentives to encourage barriers to care and service. SWMBH does not provide financial incentives, reimbursements or bonuses, to staff or providers, based on utilization of covered services; including denials of coverage and/or underutilization. Additionally, SWMBH does not make 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 Utilization Management Staff

The SWMBH UM Department 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 identify themselves by name, title, and organization during all correspondence, including incoming and outgoing phones calls regarding utilization management issues. Providers have the ability to 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 MI Health Link Member publications. When a denial determination occurs, SWMBH provides the opportunity for the ordering provider to discuss the determination with either the reviewer making the determination or, if not available within one business day, a different clinical reviewer.

Utilization Management reviews may be conducted electronically via the managed care information system or via telephone. In the event an onsite review is scheduled, SWMBH 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. SWMBH reviewers will follow reasonable hospital or facility procedures, including checking in with the designated personnel.

D. Emergency Services

In the process of conducting Utilization Management, 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 members who demonstrate severe symptoms, receive the services appropriate for their condition. There is potential for receiving phone calls from members who present as a risk to themselves or others. Protocol for situations in which a member 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 members and providers through a phone service outside of normal business hours staffed by licensed professional staff who provide emergency triage, screening, referral and information. SWMBH 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, members and providers have the ability to leave a message for UM staff through this service and also may

provide information electronically to SWMBH after hours. Members are provided information regarding UM staff availability at the time of enrollment, when provided the MHL Member Welcome packet, as well as annually thereafter through the MHL Member newsletter and/or MHL Member handbook.

Toll free numbers shall be made available for members and providers. Voices for Health and the Michigan Relay Center are utilized to assist members who require interpreter services and are provided at no cost to the member. All services related to Limited English Proficiency (LEP) are provided in accordance with the SWMBH LEP policy. Information about free LEP related services are available in the MI Health Link Handbook. The Policy and handbook are available on the SWMBH website at www.swmbh.org.

F. Review Process

All Utilization Management determinations are made by a clinical reviewer who is an appropriate health professional, holds a current and valid license in the same licensing category as the ordering provider, or is a Doctor of Medicine 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 SWMBH's Medical Director, 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.

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 requested and specific to determining admission/discharge/transfer, 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 time-frame 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 member and provider will be notified of appeal options (i.e. standard/expedited appeal).

G. Peer Clinical Review

Utilization Management staff are available to discuss authorization decisions with the requesting member, provider and attending physician (if applicable). The Utilization Management staff assist with physician-to-physician communication with the Medical Director 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.

H. 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.

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 member 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 Managed Care Information System (MCIS) and/or written notification of the determination.

Written notification of denials of service authorization provided to members 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 member 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 are made by SWMBH UM staff licensed by the State of Michigan in their respective field (Michigan fully or temporary/limited Licensed Masters Level Social Workers LLMSW/LMSW, Michigan fully or temporary/Limited Licensed Psychologists TLLP/LLP/LP, Michigan fully or temporary/Limited Licensed Professional Counselors LLPC/LPC, Registered Nurse, Physicians MD, DO, Occupational or Physical Therapists, OT, PT). Service determinations resulting in denials are made by appropriately licensed and credentialed staff limited to the SWMBH Chief Medical Officer, contracted board-certified psychiatrist or contracted fully licensed psychologist. When a MI Health Link 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 member with timely notice of the determination, this constitutes an adverse action and appeal processes are available to that member.

1. Standard Determination/Authorization Decision:
    a. Requests may be made for a standard determination/authorization decision by the member, an authorized representative of the member, a MI Health Link service provider who provides, or intends to provide services to the member, and/or legal representative of a deceased member's estate.
    b. Notice of the standard service determination/authorization decision must be provided within the timeframes outlined under Sections (K) Prospective/Preservice Review, (L) Concurrent Review and (M) Retrospective/Post service Review.
2. Urgent/Expedited Determination/Authorization Decision:

a. Requests may be made for an urgent/expedited determination/authorization decision by the member, or a physician, either orally or in writing directly to SWMBH, when situations in which applying the standard calendar day timeline could seriously jeopardize the enrollee's life, health or ability to regain maximum function.

If the request is made by the member, SWMBH must determine whether applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function and will apply the expedited timeframes if determined necessary. If the request is made by, or supported by a physician, SWMBH will provide an urgent/expedited determination/authorization decision, if the physician indicates that applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Notice of the expedited service determination/authorization decision must be provided within the timeframes outlined under Sections (K) Prospective/Preservice Review, and (L) Concurrent Review. In the event an expedited determination request is denied, the member, member's authorized representative, or provider acting as member's representative, will be notified orally, and mailed a written notification of this decision within 3 calendar days of the oral notification. The notice of the expedited determination will state the specific reasons for the determination in an understandable language and will inform the member that SWMBH will automatically transfer and process the request using the time frame for standard determinations, his or her right to file an expedited grievance if he or she disagrees with the decision not to expedite the determination a reconsideration. It will additionally inform the member of their right to resubmit a request for an expedited determination, and that if the member gets a physician's support indicating that applying standard timeframe for making determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, the request will be expedited automatically. Notification also provides instruction about the expedited grievance process and its time frames, and other any other appeal options available to them.

K. <u>Prospective/Preservice Requests and Determinations</u>

A Prospective/Preservice Review involves evaluating the appropriateness of a service authorization prior to the onset of services. Prospective/Preservice medical necessity approval determinations are made by SWMBH UM staff licensed by the State of Michigan in their respective field (Michigan fully or temporary/limited Licensed Masters Level Social Workers LLMSW/LMSW, Michigan fully or temporary/limited Licensed Psychologists TLLP/LLP/LP, Michigan fully or temporary/limited Licensed Professional Counselors LLPC/LPC, Registered Nurse, Physicians MD, DO, Occupational or Physical Therapists, OT, PT). Service determinations resulting in denials are made by appropriately licensed and credentialed staff limited to the SWMBH Chief Medical Officer, contracted board-certified psychiatrist or contracted fully licensed psychologist.

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 Adverse Determination" contained in this policy.

1. Standard Timeframes for a Prospective/Preservice Determination
    a. When a member/authorized representative has made a non-urgent prospective/preservice request for a service, SWMBH will make a determination and notify the member (and practitioner if one is involved) of the determination as expeditiously as the member's/authorized representative's health condition requires, but no later than 14 calendar days after the date SWMBH receives the request for a standard organization determination.
    b. If the authorization request results in an approval, the member/authorized representative will be notified verbally of the approval, and documentation of the time and date the notification occurred, as well as who spoke with the member/authorized representative (unless this is the same staff entering the contact note) will be entered into the member's file.
    c. Written and/or electronic notification of the authorization determination regarding, and approval of a MI Health Link covered service will be provided to the provider, upon the determination if the provider is involved in the request, or at the time the member determines their choice of provider if one is not involved in the request.
    d. Written notification of a denial, in whole or part, of an authorization request for a MI Health Link covered service, will be provided to the member/authorized representative (and provider if applicable) within 14 calendar days from the request for the service. If notification is also provided verbally, documentation of the time and date the notification occurred, as well as who spoke with the member or provider (unless this is the same staff entering the contact note) will be entered into the member's file.
    e. If a provider or member fails to follow SWMBH's procedures for requesting a standard preservice decision, SWMBH will notify the provider or member/authorized representative verbally, within 5 calendar days of the failure, and explain the proper procedures to be followed when requesting a preservice decision. Written notification can be provided, upon request by the provider or member.
2. Extension of Standard Timeframe for Prospective/Preservice Determination
    a. SWMBH may extend the timeframes by up to 14 calendar days if the member/authorized representative requests an extension or if SWMBH justifies the need for additional information and how the delay is in the interest of the member. Members/authorized representatives may also

voluntarily agree to extend the decision-making time frame for nonurgent preservice service decisions.

b. In the event SWMBH extends the timeframe, SWMBH will notify the member/authorized representative in writing within 14 calendar days of the reasons for the delay, the date in which it is expected to have the decision made by and inform the member of the right to file an expedited grievance if he or she disagrees with SWMBH's decision to grant an extension.

c. If the authorization request results in an approval, the member/authorized representative (and provider, if applicable) will be notified verbally of the approval within the timeframe of the extension, and documentation of the time and date the notification occurred, as well as who spoke with the member/authorized representative or provider (unless this is the same staff entering the contact note) will be entered into the member's file.

d. Written and/or electronic notification of the authorization determination regarding and approval of a MI Health Link covered service will be provided to the provider, upon the determination if the provider is involved in the request, or at the time the member determines their choice of provider if one is not involved in the request.

e. Written notification of a denial, in whole or part, of an authorization request for a MI Health Link covered service, will be provided to the member/authorized representative (and provider if applicable) within the timeframe allotted for the extension period. If notification is also provided verbally, UM staff will document of the time and date the notification occurred, as well as who spoke with the member/authorized representative or provider (unless this is the same staff entering the contact note) in the member's file.

3. Urgent Timeframes for Prospective/Preservice Determination

a. In the event SWMBH, approves the request for an Urgent Prospective/Preservice determination, SWMBH will notify the requesting provider and/or member/authorized representative verbally of the determination within 72 hours of the request. UM staff will document the time and date the notification occurred, as well as who spoke with the member/authorized representative and/or provider (unless this is the same staff entering the contact note) in the member's file.

b. For urgent care requests received by a provider, SWMBH may notify the provider only of the decision as it assumed that the treating provider is acting as the member's representative.

c. If the determination is adverse, SWMBH must mail confirmation of its determination to provider within 3 calendar days after providing the oral notification. In the event the denial poses financial risk to the member, written notification to the member will occur within that timeframe as well.

d. If a provider or member/authorized representative fails to follow SWMBH's procedures for requesting an urgent preservice decision, SWMBH will notify the provider or member orally, within 24 hours of the failure, and explain the proper procedures to be followed when requesting a preservice decision. Written notification can be provided upon request by the provider or member/authorized representative.

4. Extension of Urgent Timeframe for Prospective/Preservice Determination
   a. If SWMBH is unable to make a determination for an urgent prospective/preservice request due to a lack of necessary information, it may extend the decisions timeframe once, for up to 48 hours.
   b. Within 24 hours of the receipt of the request, SWMBH must notify the member/authorized representative and/or treating provider, of what specific information is necessary to make the decision and must provide 48 hours for them to provide this information.
   c. The 48-hour extension period beings either on the date that the member's response is received (regardless of whether all requested information is provided), or at the end of the specified time period that the member/authorized representative was given to supply the information, if no response is received
   d. Notification of the determination will be given within the time allowed for the extension of the request orally and/or in writing.
   e. For situations where notifications can be provided orally, documentation of the time and date that the notification occurred, as well as who spoke with the member or provider, will be entered into the member's record.
   f. For urgent care requests received by a provider, SWMBH may notify the provider only of the decision as it assumed that the treating provider is acting as the member's representative.
   g. If the determination is adverse, SWMBH will mail confirmation of its determination to provider within 3 calendar days after providing the oral notification. In the event the denial poses financial risk to the member, written notification to the member/authorized representative will occur within that timeframe as well.

L. <u>Concurrent Requests and Determinations</u>

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. Concurrent medical necessity approval determinations are made by SWMBH UM staff licensed by the State of Michigan in their respective field (Michigan fully or temporary/Limited Licensed Masters Level Social Workers LLMSW/LMSW, Michigan fully or temporary/Limited Licensed Psychologists

TLLP/LLP/LP, Michigan fully or temporary/Limited Licensed Professional Counselors LLPC/LPC, Registered Nurse, Physicians MD, DO, Occupational or Physical Therapists, OT, PT). Service determinations resulting in denials are made by appropriately licensed and credentialed staff limited to the SWMBH Chief Medical Officer, contracted board-certified psychiatrist or contracted fully licensed psychologist. 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 in 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 member's treatment that may jeopardize the member's health or ability to recover.

1. Urgent Timeframes for Concurrent Determination
    a. Once it is determined that the request is urgent, SWMBH will make a determination and notify the requesting provider and/or member/authorized representative of the authorization determination within 24 hours. Documentation of the time and date that the notification occurred, as well as who spoke with the member/authorized representative or provider, will be entered into the member's record.
    b. For urgent care requests received by a provider, SWMBH may notify only the requesting provider the decision, as it assumed that the treating provider is acting as the member's representative.
        i. If the determination is adverse, SWMBH will mail confirmation of its determination to provider within 3 calendar days after providing the oral notification. In the event the denial poses financial risk to the member, written notification to the member will occur within that timeframe as well.
2. Extension of Urgent Timeframes for Concurrent Determination

a. SWMBH may extend the timeframes for up to 72 hours if:
   i. The request to extend urgent concurrent care was not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, or
   ii. The request to approve additional days for urgent concurrent care is related to care not previously approved by the organization and documentation supports that at least one attempt was made to acquire needed clinical information and said information was unable to be obtained, within the initial 24 hours after the request for coverage of additional days, or
   iii. The member/authorized representative voluntarily agrees to extend the decision-making timeframe.

M. Retrospective/Post service Determinations

A Retrospective Review involves evaluating the appropriateness of a service after the services have already been provided. Retrospective/Post service medical necessity approval determinations are made by SWMBH UM staff licensed by the State of Michigan in their respective field (Michigan fully or temporary/limited Licensed Masters Level Social Workers LLMSW/LMSW, Michigan fully or temporary/limited Licensed Psychologists TLLP/LLP/LP, Michigan fully or temporary/limited Licensed Professional Counselors LLPC/LPC, Registered Nurse, Physicians MD, DO, Occupational or Physical Therapists, OT, PT). Service determinations resulting in denials are made by appropriately licensed and credentialed staff limited to the SWMBH Chief Medical Officer, contracted board-certified psychiatrist or contracted fully licensed psychologist. 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.

1. Standard Timeframes for Retrospective/Post service Determinations
   a. When a member/authorized representative, or provider acting as the member's authorized representative, requests a Retrospective/Post service review for a service, SWMBH will make a determination and notify the member/authorized representative in writing, of that decision within 30 calendar days of receipt of the request.
   b. When a provider requests a Retrospective/Post service Review in attempt to receive payment for a service provided, which does not pose financial risk to the member, and is not acting as the member's authorized representative, the requesting provider will be notified in writing of a decision within 30 calendar days of the receipt of the request.
2. Extension of Standard Timeframes for Retrospective/Post service Determinations

a. In the event SWMBH is unable to make a decision due to matters beyond its control, the decision timeframe may be extended, one time, for up to 15 calendar days.
b. The member/authorized representative will be notified, within 30 days of the request, of the need for an extension, and the date SWMBH expects to make a determination by.
c. Members/authorized representative may also voluntarily agree to extend the decision-making time frame for post service decisions.
d. If unable to make a determination due to the lack of necessary information, the timeframe can be extended if SWMBH notifies the member/authorized representative of the specific information required within 30 calendar days and gives at least 45 days for the member/authorized representative to provide the information.
e. The 15-day extension period begins on the date on which the member's/authorized representative's response is received by SWMBH (regardless of whether all the requested information is provided) or at the end of the 45 calendar days given to the member/authorized representative to supply the information if no response is received from the member or member's authorized representative
f. Upon SWMBH's determination of the retrospective request, the member/authorized representative will be notified in writing, within the timelines associated with the extension

N. 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 Community Health (MI MCA 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 Medicare, 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.

O. Adverse Service Determinations

Any medical necessity denial decision, in whole or in part, based on the initial review of the service request, will be rendered by the SWMBH Medical Director or other appropriate healthcare professional with sufficient medical and other expertise and current unrestricted license to practice (i.e. Fully Licensed Psychologist), before the issuance of the determination.

SWMBH will ensure that denial determinations are fully documented in the members file 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 denial determination.

Upon an adverse authorization determination, the treating/requesting provider will be informed of how to contact SWMBH to discuss the denial 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 denial notification and the notification of the physicians' reviewer availability, if warranted.

Practitioners have the option of also discussing pending medical necessity denials through a direct peer to peer review with the Medical Director, 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 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 action notice to be provided, and appeal rights, including timelines to appeal the decision, still apply.

SWMBH does not reverse an approved authorization for a service that has been authorized unless it receives new information that is relevant to the authorization that was not available at the time the approval was issued.

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

P. Written Notification of Adverse 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 for a MI Health Link covered service will be in accordance with CMS Form 10003-NDMPC, and NCQA Standard UM 7 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 members 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 member'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 member's behalf
   h. The member'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 itself is an adverse action and may be appealed
4. Written notification will also be provided if a member requests SWMBH to provide an explanation of a provider's decision to deny a service in whole or in part.

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, and/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.

Administrative denials that result from a provider's failure to follow SWMBH's authorization request filing procedures, will be subject to the following notification timelines:

- *Urgent preservice and concurrent service authorization requests:* Providers will be notified by phone and/or through SWMBH's Managed Care Information System (MCIS) within 24 hours of receiving the request for services.
- *Non-urgent preservice authorization requests:* Providers will be notified by phone and/or through SWMBHs MCIS within 5 calendar days of receiving the request for services.

All Administrative Denials will result in a denial letter being sent to the provider indicating: the dates of service denied, specific reason for the denial, and reference the benefit provision, administrative procedure, or regulatory limitation in which the administrative/technical denial decision was based, and notification that the member (and providers acting as the member's authorized representative) can obtain a copy of the referenced criterion. Additionally, the letter will instruct the provider on how to re-request the authorization, if applicable.

References:

A. BBA Section: QAPI Subpart D and F, 42 CFR §438
B. PIHP Contract Section: Meridian ICO Contract, Section 2.6.2; Aetna ICO Contract 2.6.1-2.6.3
C. 2020 NCQA MBHO UM Standards

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	4/25/2019	Scope & Responsibilities	Not in the previous version	E. Guisinger
1	5/6/2020	NA	Annual Review	E. Guisinger
2	10/29/2020	Standards & Guidelines, 8	NCQA Standard 7, Element E no longer exists	E. Guisinger
3	11/19/2021	Effective Date Standards & Guidelines, C	Corrected effective date that was incorrectly modified when moved to new template; Specified "correspondence" includes incoming/outgoing phone calls	E. Guisinger

MHL 04.04 Service Authorizations & Notice of Determinations v.8.30.21

Final Audit Report 2021-12-08

Created:	2021-12-07
By:	Jody Vanden Hoek (jody.vandenhoek@swmbh.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAS7evVAcGb7vRLapOvNZC2NE2k6aLnc73

"MHL 04.04 Service Authorizations & Notice of Determinations v .8.30.21" History

Document created by Jody Vanden Hoek (jody.vandenhoek@swmbh.org)
2021-12-07 - 9:01:38 PM GMT

Document emailed to Beth Guisinger (beth.guisinger@swmbh.org) for signature
2021-12-07 - 9:02:59 PM GMT

Email viewed by Beth Guisinger (beth.guisinger@swmbh.org)
2021-12-08 - 11:49:28 AM GMT

Document e-signed by Beth Guisinger (beth.guisinger@swmbh.org)
Signature Date: 2021-12-08 - 11:49:34 AM GMT - Time Source: server

Document emailed to Bangalore K Ramesh (bkrameshmd@gmail.com) for signature
2021-12-08 - 11:49:36 AM GMT

Email viewed by Bangalore K Ramesh (bkrameshmd@gmail.com)
2021-12-08 - 4:36:56 PM GMT

Document e-signed by Bangalore K Ramesh (bkrameshmd@gmail.com)
Signature Date: 2021-12-08 - 4:37:22 PM GMT - Time Source: server

Agreement completed.
2021-12-08 - 4:37:22 PM GMT