Section: **Utilization Management**	Procedure Name: **Adverse Action Procedure**	Procedure #: **MHL P04.04.01**
Overarching Policy: **MHL 04.04 – Service Authorizations & Notice of Determinations**		
Owner: **Manager of UM & Call Center**	Reviewed By: **Elizabeth Guisinger, LPC, CAADC** **Bangalore Ramesh, MD**	Total Pages: **9**
Required By: ☒ **BBA** ☒ **MDHHS** ☒ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: Elizabeth Guisinger Elizabeth Guisinger (May 12, 2020) B K Ramesh B K Ramesh (May 19, 2020 15:29 EDT)	Date Approved: May 12, 2020
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: **5/6/2020**

Policy: MHL 04.04 – Service Authorizations & Notice of Determinations

Purpose: To describe a clear method for handling authorization requests that have been determined to not meet medically necessity criteria, in whole or in part, or for requests that meet the definition of administrative/technical denial.

Scope: An Adverse Action is a denial of authorization for a requested service, or the termination, reduction or suspension of a previously approved service. Any determination where Southwest Michigan Behavioral Health (SWMBH) denies a service authorization request, or authorizes a service in an amount, duration, or scope that is less than requested, requires notification to the requesting provider, and written notice to the customer regarding said decision (42 CFR, §438.210,c). Non-authorization decisions can be based on either appropriateness, medical necessity, benefit coverage, or administrative/technical requirements. A denial of services is the difference between the service(s) requested and the service(s) approved. A partial approval of care and service(s) is also considered a denial. Terminations, reductions, and suspensions of previously authorized services are also considered denials.

This Adverse Action procedure applies to all preservice/prospective, concurrent and post service/retrospective authorization requests and shall apply when:

A. SWMBH or its designee is identified as the reviewing entity to make the authorization determination **and**

B. Authorization/Coverage request does not meet medical necessity criteria for the service requested, in whole or in part, of the authorization timeframe requested **or**
C. Authorization/Coverage request is deemed as meeting criteria for an Administrative/Technical denial.

Responsibilities:

SWMBH Utilization Management staff are responsible for processing authorization requests; including, determining eligibility and if the requested service meets medical necessity criteria.

Definitions: **ASAM (American Society of Addiction Medicine) Patient Placement Criteria:** A set of criteria designed to assist clinicians in providing outcome-orientated and results-based care in the treatment of addiction. ASAM criteria provides guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

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

Procedure:

A. **Medical Necessity Denials (Benefit Determinations):** Medical necessity denials are denials of authorization/coverage for services that have been determined as not medically necessary, based on the SWMBH policy, nationally recognized Medical Necessity Criteria, ASAM Level of Care Criteria, Supports Intensity Scale (SIS), LOCUS, and/or SWMBH Clinical Practice Guidelines. 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 who has appropriate clinical expertise in treating the customers condition, before the issuance of the determination. The Utilization Management (UM) staff responsible for processing the authorization shall follow the procedure as outlined below.

1. Medical Necessity Denial Procedure
    a. Ensure the denial determination is fully documented in the customer's file with a handwritten signature, handwritten initials or unique identifier from the appropriate provider making the decision or signed or initialed note by the UM reviewer who denoted the specific provider that made the denial determination.
    b. Ensure that the denial is adequately captured in the customer's record through a review event which indicates the authorization request date and time, the time and date of the denial, the denied service, including the dates denied, code(s) denied, and provider denied, if involved in the request. If

there is no provider involved, the Care Manager will enter the denial under "Unknown Provider" in order to capture the information in the Managed Care Information System (MCIS).

c. Inform the treating/requesting provider, if applicable, of how to contact SWMBH to discuss the denial with the appropriate reviewer. Notification can be made via phone, written letter, and/or notification through the MCIS. Timeframe for the notification and method of determination notification will be dependent on the urgency/type of authorization request, method the authorization request was submitted, and will be completed based on the timeframes indicated in SWMBH Policy 4.3 Service Authorization- Outlier Management.

d. If the provider is notified by telephone, UM staff will document the time and date of the denial notification and notate that the provider was informed of the physician reviewers' availability, if warranted. A copy of the written denial shall include the specific reason for the denial, a reference to the benefit provision, guideline, or protocol, or other criteria in which the denial decision was based, and notification that the customer (and providers acting as customer's authorized representative) can obtain a copy of the referenced criterion. Notice must also include a description of the appeal rights, including the right to submit written comments, documents or other information relevant to the appeal, and explanation of the appeals process, including the customer's right to representation and time frames for deciding appeals, a description of the expedited appeals process for urgent preservice or urgent concurrent denials, as well as that expedited external review can occur concurrently with the internal appeals process for urgent care.

e. Ensure that all information/correspondence, relating to the denial determination and notification, is entered into the member's record in the MCIS.

f. Inform the Members Service Specialist of the denial and include the rationale and specific criteria used in making the determination. The Members Service Specialist will complete the written customer denial determination/Action Notice and ensure any verbal or written correspondence shall be entered into the customer's record.

B. **Administrative/Technical Denials (Benefit Determinations):**
Administrative/Technical denials are denials of authorization/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 exclusion, benefit exclusion, insufficient information to make a medical necessity determination, or due to non-compliance with a state or federal regulation, standard and/or guideline (Michigan Mental Health Code, Medicare Benefit Policy Manual,

Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual, PIHP/Provider Contract, Memorandum of Understanding or Letter of Agreement) and/or administrative policies and procedures established by Southwest Michigan Behavioral Health, and do not require a clinician to apply clinical judgement. The Utilization Management staff responsible for processing the authorization shall follow the procedures as outlined below.

1. Provider Requested Administrative/Technical Denials
    a. Determine if the requestor made the service authorization request in error, in whole or in part. If insufficient information, UM reviewer may pend the request and allow 14 days for the documentation to be submitted before making a determination.
    b. If the request was entered in error, per communications with the requesting provider, in whole, or in part (i.e. requested authorizations for a timeframe or units that exceed the service documented in the treatment plan, coverage ended during the timeframes, incorrect modifier was used, etc.), and the SWMBH UM reviewer may change the units or timeframe to reflect what the requestor actually wanted to request in the MCIS and document the discussion with the requestor in the "Reviewer Comments" section of the review event. The determination status shall be set to "Approved" as modified if medical necessity is met, or "Denied-Requested in Error" if the requestor did not intend to request the authorization/code.
    c. If the authorization was not requested in error, per the discussion with the requestor, or the requestor did not return communication to clarify the request, determine the type of Administrative/Technical denial the authorization request falls under.
    d. If only part of the request can be approved, set the determination to "Partially Approved", modify the determination to the timeframe/units that are being approved, document the discussion with the requestor, or attempts to discuss the request, and the timeframe and/or number of units that are being denied by creating a new authorization and entering the determination for these units as denied.
    e. Ensure the denial determination is fully documented in the customer's file and includes 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 signed by the UM reviewer who made the determination.
    f. Inform the treating/requesting provider of how to contact SWMBH to discuss the denial with the appropriate reviewer. Notification will be made via phone or notification through the MCIS and the time and date must be documented in the customer record. Timeframe for the notification and method of determination notification will be dependent on the urgency/type of

authorization request and will be completed based on the timeframes indicated in SWMBH MI Health Link Policy 4.4 Service Authorization and Notice of Determination.

i. If the provider is notified by telephone, e-mail, or messaging, UM staff will document the time and date of the denial notification and notate that the provider was informed of the UM reviewers' availability, if warranted, in the customer's record. A copy of the written denial shall follow, and include the 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 customer's authorized representative) can obtain a copy of the referenced criterion. Notice must also include a description of the appeal rights, including the right to submit written comments, documents or other information relevant to the appeal, and explanation of the appeals process, including the customer's right to representation and time frames for deciding appeals, a description of the expedited appeals process for urgent preservice or urgent concurrent denials, as well as that expedited external review can occur concurrently with the internal appeals process for urgent care.

ii. Ensure that all information/correspondence, relating to the denial determination and notification, is entered into the customer's record in the MCIS.

2. Member Requested Administrative/Technical Denial

a. If a customer requests a service that cannot be authorized due to an Administrative/Technical reason determine the type of Administrative/Technical denial the authorization request falls under.

b. Inform the customer of the denial, explain the reason the request was denied and that they will receive notice in the mail explaining their appeal options. Timeframe for the notification and method of determination notification will be dependent on the urgency/type of authorization request and will be completed based on the timeframes indicated in SWMBH Policy: 4.3 Service Authorization- Outlier Management.

c. Ensure that the denial is adequately captured in the customer's record through a review event which indicates the authorization request date and time and the denied service, including the dates denied, code(s) denied, and provider denied, if involved in the request. If there is no provider involved, the Care Manager will enter the denial under "Unknown Provider" to capture the information in the Managed Care information System (MCIS).

d. Ensure the denial determination is fully documented in the customer's record and includes 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 signed by the UM reviewer who made the determination.
e. Ensure that all information/correspondence, relating to the denial determination and notification, is entered into the customer's record in the MCIS
f. Inform the Members Service Specialist of the denial and include the rationale and specific criteria used in making the determination. The Member Triage & Engagement Specialist will complete the written member denial determination and ensure any verbal or written correspondence shall be entered into the customer's record.

3. Administrative/Technical Denial Reasons
   a. Insufficient Information: Not enough information has been submitted to make a medical necessity determination (i.e. No ASAM within the past 30 days, No UDS results submitted, etc.)
   b. Ineligible Coverage: The customer does not have coverage/benefits for the service and/or timeframe being requested. Used also when changing the end date to a previously approved auth due to coverage ending during the timeframe of the authorization.
   c. Treatment Plan does not cover service: The service requested is not in the treatment plan covering the dates of service requested.
   d. Treatment Plan does not cover requested date(s): Treatment plan starts after date of the service authorization request or treatment plan ends before the date(s) of the authorization request.
   e. Treatment Plan does not cover requested unit(s): Treatment plan does not cover the amount of units requested in the authorization requested.
   f. Service Not Covered: The service provided is not a covered benefit under the customer's plan.
   g. Service was previously denied and notice was given: Authorization was previously requested and appeal rights were given. No new information was provided for re-determination.
   h. Not Covered/Not Allowable by Contract: Service not covered/not allowable by contract for provider.
   i. Customer discontinued treatment prior to authorization end date: Customer determined that they no longer require a previously authorized service and was discharged from that service or treatment and this was noted in the customer's chart or a signed statement by the customer in agreement with this is contained in the customer's record. This reason is used when end date is changed on the previously approved authorization and does not constitute a decision based on medical necessity criteria.

j. Non-Contracted Provider Requested: Authorizations are being requested for a non-network provider and the 90-day grace period has expired.
k. Funding is provided by another organization: Funding for the requested service is provided through another organization (i.e. Auto Insurance (accident, no-fault), Worker's Disability Compensation, Court-Ordered Medical Support, General Liability Insurance)
l. No Treatment Plan Provided: Provider did not submit treatment plan for dates of service requested to support the authorization request.
m. Incorrect Code Requested: Provider requested incorrect code.
n. Duplicate Authorization Request: An authorization already exists for the service and date(s) requested.
o. Member did not sign treatment plan: No signed treatment plan was provided with the authorization request.
p. Ineligible Health Professional: The service was not provided by an eligible health professional as defined by MDHHS.
q. Ineligible provider for code requested: Provider is requesting a code that can only be utilized by a specific credential (i.e. Bachelor level clinician requesting authorization for service requiring a master's level clinician.)
r. No Valid Release of Information Provided for SUD Treatment Request: A valid release of information, in a format approved by SWMBH, has not been provided. This is required for any authorization request in regard to a substance abuse treatment/service.

C. **Exceptions to Notification:** For urgent preservice and urgent concurrent denials, SWMBH may only provide notification to the provider, as the treating provider is considered to be acting as the customer's representative. For Urgent Concurrent denials, SWMBH UM may inform the hospital UR department staff of its decision, with the understanding that staff will inform the attending/treating practitioner.

D. **Approving Alternative Services:** In situations when SWMBH UM approves an alternative to the service being requested, and the customer or the customer's authorized representative agrees to the alternative and the care is authorized, the customer or customer's representative has been deemed as withdrawing the request. If the customer or customer's representative does not request or agree to the alternative service or accepts the alternative and objects to the denial of the requested service, this would be deemed a denial of the original service requested and denial procedure applies.

E. **Reconsideration of an Adverse Action/Benefit Determination:** Providers have the option of 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 action 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 action notice to be provided, thus the customer's appeal rights, including timelines from the date of the action notice 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.

F. **Using Determination Reason "Denied-Requested in Error":** Use of this determination reason should be solely for when:

1. A malfunction occurred in the MCIS,
2. SWMBH staff made an error (entered the authorization into the SUD record not the Master record as intended)
3. The requestor clearly made an error and/or when the requesting provider agrees that it was not intended to be requested (wrong date(s), wrong code, duplicative request, etc.). The UM reviewer must clearly document in the customer's record the reason it is being denied in error (MCIS created duplicative or incorrect authorization requests, provider did not intend to request the authorization as entered, etc.).

Effectiveness Criteria:

All requested authorizations will be processed within contractual time requirements and determinations will be based on medical necessity criteria. Any denials will provide rationale for the service not being approved.

References: SWMBH Operating Policy: 4.3 Service Authorization-Outlier Management

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	5/13/2019	NA	Moved to new template	E. Guisinger
1	5/6/2020	NA	Annual Review	E. Guisinger

MHL P04.04.01 Adverse Action

Final Audit Report 2020-05-19

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