Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy and Procedure* **Utilization Management and Review**
Committee/Department: Utilization Management Committee	**Local Policy Number (if used)**
Implementation Date 07/08/2022	**Regional Approval Date** 06/24/2022

Reviewed by:	**Recommendation Date:**
ROC	05/11/2022
CMH Board:	**Approval Date:**
Lenawee	05/26/2022
Livingston	05/31/2022
Monroe	05/18/2022
Washtenaw	06/24/2022

I. PURPOSE

To establish consistent utilization management and review standards, requirements, structures, and activities to be used by Community Mental Health Service Providers (CMHSPs), Substance Use Disorder (SUD) Core Providers, primary contracted providers, and substance use disorder (SUD) provider systems; and to be monitored by the regional entity of Community Mental Health Partnership of Southeast Michigan (CMHPSM) as the Pre-Paid Inpatient Health Plan (PIHP).

II. REVISION HISTORY

DATE	MODIFICATION
12/20/2005	Revised to meet EQR CAP
06/21/2013	Revised for new regional entity and language/role clarity
12/10/2017	Revised to comply with Managed Care Rule of 2017
06/24/2022	3-year review; Language updates from Substance Abuse Coordinating Agency to SUD Core Providers; updated ABD and delay definitions to reflect state and federal requirements; addition of LTSS definition and requirements per state requirements and HSAG finding; updated state definitions of medical necessity; addition of state/federal parity requirements; clarification of review type definitions; addition of SUD specific UM practices, conflict of interest language (HSAG finding); committee role language update; updated references.

III. APPLICATION

This policy applies to:

- All regional entity, CMHSP, and primary contracted provider staff responsible for provision of and/or oversight of access system services within the CMHPSM.
- All Staff representing the ROSC SUD Core Provider for oversight of access to substance use disorder (SUD) services through the Recovery Oriented System of Care (ROSC) SUD provider network.
- CMHSP staff, SUD provider staff, and all contractual provider staff responsible for service authorization decisions or adverse actions, and their oversight.
- Staff responsible for the development, implementation, and updating of service eligibility, continuing stay, and discharge criteria.

- Members of the regional entity Utilization Review Committee and others involved in studying data-based service utilization patterns.

IV. POLICY

It is the policy of CMHPSM as the regional entity that utilization management and review standards, requirements, structures and activities will be implemented and practiced in a way that ensures the efficient and effective use of resources. This includes ensuring service decisions are made consistently and based on medical necessity, and that consumers/individuals served with comparable needs receive comparable services and those decisions are made based on medical necessity.

V. DEFINITIONS

Action (also referred to as adverse action) – A benefit/service determination related to Non-Medicaid/General Funds by which the CMHSP determines any of the following covered by Non-Medicaid/General Funds:

- Denial of inpatient psychiatric hospitalization or denial of a requested alternate service if inpatient is denied.
- Denial of services where there are rights to a second opinion.
- Suspension, reduction, or termination of reduction of existing supports/services.

Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

Adverse Benefit Determination (ABD) – A benefit/service determination specific to Medicaid, by which the Pre-Paid In-Patient Health Plan (PIHP)/ Community Mental Health Service Provider (CMHSP) determines any of the following for Medicaid services:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or part, of a payment for service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) of this chapter is not an adverse benefit determination.
4. The failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning process and as authorized by the PIHP/CMHSP.
5. The failure of a PIHP/CMHSP to resolve grievances and provide notice within 90 calendar days of the date of the request.
6. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a consumer/individual's request to exercise his or her right under 438.52(b)(2)(ii) to obtain services outside the network.
7. The denial of a consumer/individual's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other consumer/individual served financial liabilities.
8. The failure of the PIHP/CMHSP to act within the required timeframes regarding standard resolution of appeals.

Concurrent Review - part of a utilization management program in which health care is reviewed as it is provided. Reviewers monitor appropriateness of the care, the setting, and the progress of discharge plans. The ongoing review is directed at keeping costs as low as possible and maintaining effectiveness of care.

Delay – An action specific to Medicaid, by which the Pre-Paid In-Patient Health Plan (PIHP)/ Community Mental Health Service Provider (CMHSP) determines any of the following and for which Medicaid consumers/individuals served have a right to file a grievance:

1. A delay in making a standard/routine service authorization decision of a service request within 14 calendar days from the date of receipt of the request. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.
2. A delay in making a decision regarding a request for an expedited service authorization decision within 72 hours from the receipt of the request. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.
3. A delay in resolving standard internal appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. The resolution timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.
4. A denial of a request for an expedited appeal. The request for an expedited appeal within 72 hours can be denied and extended (hence delayed) to the standard 30-day appeal time frame if the consumer/individual served is notified of the right to file a grievance.
5. The failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal

Denial – A term used in this policy that includes the definition of an Action or an Adverse Benefit Determination.

Long-Term Services and Supports (LTSS) - services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the consumer/individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Medical Necessity – The basis by which service decisions are made for mental health, developmental disabilities, and substance abuse supports and services. Criteria are based on state law/policy and the Medicaid Provider Manual. For the purposes of this policy keys aspects of medical necessity are described below. For a complete definition of medical necessity, see the current version of the Medicaid Provider Manual (Mental Health/Substance Abuse Services Chapter, Section 2.5) and the MI Mental Health Code, Chapter 1, Definitions
Services must be:

- Necessary for screening, assessing, identifying, evaluating; and/or Intended to treat, ameliorate, diminish or stabilize the symptoms; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability or substance use disorder
- Designed for the prevention, diagnosis, and treatment of a consumer/individual's condition, and/or disorder that results in behavioral health and health impairments and/or disability.
- The ability for a member to achieve age-appropriate growth and development.
- Designed to assist the beneficiary to attain, maintain, or regain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

Service determinations must be:

- No more restrictive than that used in the MDHHS Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in MDHHS statutes and regulations, the MDHHS Plan, and other MDHHS policy and procedure
- Based on information provided by the individual, his/her family, and/or other individuals who know the individual and clinical information from the individual's primary care physician/health care professionals
- Based person centered planning or individualized treatment planning and documented in the plan
- Made by appropriately trained professionals with sufficient clinical experience;
- Accessible to the individual, and responsive to any cultural, sensory, or mobility needs
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Provided in the least restrictive, most integrated setting.
- Consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.
- Provide the opportunity for a consumer/individual served receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

For substance use/abuse services, ASAM (American Society of Addiction Medicine) Placement Criteria shall also be used when determining the medical necessity of placement, continued stay and transfer/discharge of consumers/individuals served with addiction and co-occurring conditions.

Parity – Based on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prevents group health plans and health insurance issuers providing mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. Parity includes that financial cost-sharing requirements for mental health/substance use disorder benefits (such as deductibles, copayments, coinsurance, and out-of-pocket limitations) must be comparable to those for medical surgical benefits. Parity rules also apply to rules regarding authorization for treatment and treatment limitations. Key measures of mental health parity are "quantitative treatment limitations" (QTLs) and non-quantitative treatment limitations" (NQTLs).This policy refers to NQTLs when addressing the concept of parity.

Non-Quantitative Treatment Limitations" (NQTLs) - Processes, strategies, evidentiary standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Certain utilization reviews, prior authorization, and plan provisions may only be applied to mental health/substance use disorder benefits if they are comparable to or less restrictive than those for medical surgical services. NQTL provisions are not prohibited outright; but are prohibited if they are applied more stringently to mental health/substance use disorder benefits than to medical surgical benefits.

Primary Contracted/Core Provider – a provider contracted by the CMHSP to provide primary community mental health services that would otherwise be directly operated by a CMHSP.

Prospective Review - (also known as **Preauthorization**) the prior assessment by a payer or payer's agent that proposed services are appropriate for a particular consumer/individual served, or that the consumer/individual served, and the categories of service are covered by a benefits plan. Preauthorization includes and Individual Plan of Service (IPOS) developed

through the person- centered planning process, whereby a CMHSP/SUD provider staff proposes the approval of or concurrence with the covered services in (IPOS), and those services are approved or denied by staff with the authority to make service authorization decisions prior to the provision of service. In most cases, with the exception of some crisis services, preauthorization is required before services can be provided.

Recovery Oriented System of Care (ROSC) – is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of consumers/individuals served, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

Retrospective Review - a post-treatment assessment of service utilization on a case-by-case or aggregate basis after the services have been performed. A retrospective review can include a review of whether payment of services will be authorized/ reimbursed when a provider requests retrospective payment of an inpatient psychiatric hospital stay, and/or whether payment of services found to be out of compliance with medical necessity would be recouped.

Utilization Management (UM) - Procedures and clinical decisions intended to ensure that the services provided to a specific consumer/individual served at a given time are appropriate, medically necessary, and cost effective.

Utilization Review (UR) - Analysis of the patterns of service authorization decisions and service usage in order to determine the means for increasing the value of services provided that include minimizing cost and maximizing effectiveness/appropriateness.

VI. STANDARDS

A. Utilization management decisions will be conducted as a delegated function by the regional entity to the CMHSPs, ROSC Core Providers, and primary contracted providers, and occur as close as possible to local provision of services. Concurrent or continued care reviews of SUD services will be conducted by CMHSP SUD Core Provider staff or CMHPSM SUD UM staff, where indicated in CMHPSM contract language.

B. The basis by which service determinations are made is founded on state and regional entity policy and will be in compliance with medical necessity and all state/federal rules. The regional entity will include this basis in its delegation of UM functions to CMHSPs, primary contractual providers, and ROSC Core Providers. Any relevant updates to standards on service determinations will be communicated by the regional entity and implemented locally by the CMHSPs, primary contractual providers, and ROSC Core Providers.

C. The CMHSPs, primary contractual providers, and ROSC Core Providers are delegated by the regional entity to be responsible for local implementation, evaluation and updating of service-specific entry, continuing stay and discharge criteria.

D. The regional entity shall have auditing and monitoring mechanisms in place to ensure utilization management standards and delegated functions are met by the CMHSPs, primary contractual providers, and ROSC Core Providers. The regional entity shall also enact and oversee any corrective action for areas of non-compliance.

E. Decisions regarding the type, frequency, intensity and duration of services to authorize or deny must be:
   1. Furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under FFS Medicaid, as set forth in §440.230, and for members under the age of 21, as set forth in subpart B of part 441 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21.
   2. Include mechanisms that comprehensively assess each consumer/individual served identified (per MDHHS definitions) as needing LTSS or having special health care needs, to identify any ongoing special conditions of the consumer/individual served that require a course of treatment or regular care monitoring for members with special health care needs. Decisions to authorize LTSS shall be based on a consumer/individual's current needs assessment and consistent with the person-centered service planning process.
   3. Accurate and consistent with state and federal medical necessity criteria, including relevant to goals developed through the person-centered planning process, and sufficient in amount, duration, and scope to reasonably achieve its purpose.
   4. Made in accordance with state requirements with Long Term Supports and Services, based on the consumer/individual's current needs assessment(s), and consistent with the person-centered service plan
   5. Consistent with Medicaid Provider Manual eligibility, entry, continuing stays and discharge criteria as applicable, and state law/policy as defined by MDHHS.
   6. Consistent with federal standards and state standards for meeting the Mental Health Parity and Addiction Equity Act (MHPAEA)
   7. Consistent with formal assessments of need and consumer/individuals' desired outcomes,
   8. Conducted with an effort to obtain all necessary information including pertinent clinical information and consultation with treating physicians/ clinicians as appropriate.
   9. Adjusted appropriately as consumer/individuals' needs, status, and/or service requests change,
   10. Timely,
   11. Provided to the consumer/individual served in writing, including reasons for the decision that are clearly documented,
   12. As applicable, shared with affected service providers in writing as to the specific nature of the decision and its reasons, (refer to the CMHPSM Provider Appeals Policy) if there are any concerns with decisions made,
   13. Documented in the clinical case record as to the specific nature of the services authorized or denied and its reasons and accompanied by the appropriate notice to consumers/individuals regarding their appeal rights with a copy of the notice placed in the consumer/individual's clinical case record. (refer to the CMHPSM Consumer Appeals Policy)
   14. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the consumer/individual served.

F. The above utilization management / service authorization decisions and their associated procedures are required at numerous points during the course of service provision:
   1. The completion of the Initial Assessment or Pre-Screen to assess initial CMH eligibility and medical necessity.

2. The completion of assessments related to specific services, specialties, or parity programs.
3. The completion of the Initial Individual Plan of Service through the Person-Centered Planning Process
4. The consumer/individual served requires, or a consumer/individual served or provider requests, a more intensive or less intensive level of a current service

5. The consumer/individual served requires, or a consumer/individual served or provider requests, the addition of a new service
6. The consumer/individual served requires or requests the termination of a current service
7. The expiration of a service authorization
8. The completion of the annual review of need/periodic review or other assessment including assessment of ongoing CMH eligibility and medical necessity of supports and services
9. The completion of the annual Individual Plan of Service (IPOS)through the Person-Centered Planning Process
10. The need to modify a current IPOS due to a significant change in a consumer/individual's needs or change in level of care
11. Review of services that may be denied, suspended, reduced, or terminated

G. Utilization management decisions (both service authorization and denials) will be made by staff with appropriate clinical competencies as defined at minimum by state policy and will possess the required competencies and clinical expertise to treat the conditions relevant to the decisions being reviewed. Where necessary, review decisions are supervised by qualified medical professionals.

H. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, will be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or long-term services and supports needs.

I. Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any consumer/individual served.

J. Any decision to deny a service authorization request in whole or in part shall follow state and federal notification requirements where applicable to providers and consumers/individuals served as outlined in the CMHPSM Consumer Appeals Policy.

K. Utilization management decisions may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the consumer/individual served.

L. Utilization management decisions shall not be made by case managers, supports coordinators, or supports brokers. Case managers, supports coordinators, and other professional staff responsible for treatment planning will assess need and make treatment recommendations per their function in the development of Individualized Plans of Service, including requesting services, and as a way to inform the utilization management process. This information will be reviewed at minimum by qualified UM

staff or supervisors with the appropriate clinical expertise or who will make the relevant service authorization decisions.

M. Each local CMHSP, primary contractual provider, and ROSC Core Provider will have a written internal process to oversee and review compliance with utilization management practices, including, eligibility, medical necessity, service authorization, service denial, and service verification.

N. Each local CMHSP primary contractual provider, and ROSC Core Provider will have a local UM/UR review processes to monitor the accuracy of service decisions.

O. The Utilization Review Committee for the regional entity will provide the following functions:

- Evaluate the success of utilization management processes used in the region and ensure the accuracy, appropriateness and consistency of utilization management decisions.
- Coordinate ongoing utilization review activities and projects recommended by the committee or assigned by the CMHPSM on behalf of the region
- Conduct UM/UR studies on behalf of the region or local CMHSP/core provider as requested by the local CMHSP/core provider or regional entity.
- Report findings/results of committee activities/ studies to the regional entity, including any areas of trending, performance improvement projects, or compliance that requires follow-up or oversight by the regional entity
- Make recommendations and suggestions to the regional entity on local or regional performance improvements related to UM/UR functions
- Serve as a reporting body to the regional entity. Where compliance issues or trends arise during committee work, the committee will report issues/trends to the regional entity for CMHPSM action or oversight; the responsibility of monitoring CMHSP/core provider compliance with UM/UR standards and auditing UM/UR functions delegated to CMHSPs/core provider will remain in the jurisdiction of the CMHSPM as the regional entity.
- Any activity the regional entity would delegate or assign to the Utilization Review Committee as a regional entity function, or on behalf of the regional entity will be determined and assigned by the CMHPSM.

P. In evaluating the success of utilization management processes and to ensure the accuracy, appropriateness and consistency of utilization management decisions, priority should be given to:

a. high-cost services,
b. highly utilized services,
c. services associated with a high number of consumer/individual served grievances and appeals,
d. services for which there are large differences in cost per case and/or cost per unit among individual affiliates,
e. services which are under and/or over utilized and,
f. PIHP studies/assignments priorities.

Q. Consideration should be given to the following utilization review methods in evaluating the effectiveness of UM decisions:

- Analyzing aggregated case record review data reflecting the degree to which consumers/individuals served meet service eligibility criteria
- Analyzing aggregated case record review data to determine the degree to which consumers/individuals served meet entry criteria for a specific service
- Analyzing aggregated case record review data to determine the degree to which frequency and intensity of services are consistent with medical necessity criteria
- Data collection and analysis of cost per unit or cost per case for a service or program type
- Data collection of average length of stay for a specified service
- Data collection and analysis of consumer/individual served and provider satisfaction with the Utilization Management/ Utilization Review process
- Studies of under and over-utilization of services
- Studies of inpatient admissions per capita
- Studies of utilization of alternatives to high cost care

VII. EXHIBITS

None

VIII. REFERENCES

Medicaid and CHIP Managed Care Final Rule, April 2016 42 CFR 431, 42 CFR 433, 42 CFR 438 42 CFR 440, 42 CFR 457, 42 CFR 495 (Replaces Balanced Budget Act of 1998 (42 CFR 438; 438.210, 438.240)		
Michigan Mental Health Code, Act 258 of 1974		
Mental Health Parity and Addiction Equity Act of 2008; 45 CFR Parts 146 and 147		
MDHHS Medicaid Provider Manual (current version)		
The Joint Commission Behavioral Health Standards		
CMHPSM Consumer Appeal Policy		
CMHPSM Service Verification Policy		
MDHHS CMHSP Managed Mental Health Supports and Services Contract (current version)		
MDHHS PIHP Medicaid Managed Specialty Supports and Services Contract (current version)		

IX. PROCEDURES

None