Issue Date: 11/13

Review and/or Revision Date: 05/16, 03/19, 12/20, 3/24

SUBJECT Utilization Management Program	**CHAPTER** 01	**SECTION** 05	**SUBJECT** 01
CHAPTER Administrative	**SECTION** Utilization Management		
WRITTEN BY Tom Seilheimer & Lauren Tompkins	**REVIEWED BY** Tom Seilheimer	**AUTHORIZED BY** PIHP Board	

I. APPLICATION:

☐ PIHP Board
☒ PIHP Staff
☒ CMH Providers
☒ CMH Subcontractors
☒ SUD Providers

II. POLICY STATEMENT:

It shall be the policy of the Region 10 PIHP to establish and operate a Utilization Management (UM) Program as required within the Region 10 PIHP Quality Improvement Committee (QIC). This policy describes UM Program responsibilities and operations directly carried out within the PIHP, UM Program operations delegated to the PIHP network entity (CMHSP/SUD Provider), and PIHP monitoring and oversight of delegated operations.

III. DEFINITIONS:

Authorization: A process designed to ensure that planned services meet eligibility and medical necessity criteria, as appropriate for the conditions, needs and desires of the member served.

Adverse Benefit Determinations: A decision that adversely impacts an enrollee's claim for services due to:

A. Denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
B. Reductions, suspension, or termination of a previously authorized service.
C. Denial, in whole or in part, of payment for a service.
D. Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service authorization.
E. Failure to make an expedited authorization decision within 72 hours from the date of receipt of a request for expedited service authorization.
F. Failure to provide service within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized by the PIHP.
G. Failure of the PIHP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal.
H. Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from

the date of a request for an expedited appeal.

I. Failure of the PIHP/CMH to provide disposition and notice of a grievance/complaint within 90 calendar days of the date of the request.
J. For residents of a rural area with only one provider, the denial of an Enrollee's request to exercise his/her right to obtain services outside the network.
K. Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibilities.

Adequate Adverse Benefit Determination Notice: Written statement advising the Enrollee of a decision to deny or limit the authorization for Medicaid services currently provided. Notice is provided to the Enrollee at least 10 calendar days prior to the proposed date the action is to take effect.

Advance Adverse Benefit Determination Notice: Written statement advising the Enrollee of a decision to reduce, terminate, or suspend Medicaid services currently provided. Notice is provided to the Enrollee at least 10 calendar days prior to the proposed date the action is to take effect.

Clinical Practice Guidelines: Developed and maintained by Region 10 PIHP, these are systematically developed standards of care that serve as a clinical basis for providing behavioral healthcare services to members.

Levels of Care for Mental Health Specialty Services: Also known as Continuum of Care, a process through which severity of service need is aligned with intensity of service, according to medical necessity criteria, as developed within the person-centered planning process. This process applies to persons receiving ongoing, non-emergent services, is configured within clinic populations (i.e., persons with SMI, COD, I/DD, or SED), and includes community inpatient psychiatric services.

Medical Necessity Criteria: Pertain to mental health, intellectual/developmental disabilities, and substance abuse services and supports necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or required to identify and evaluate a mental illness, developmental disability or substance use disorder; and / or intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or designed to assist the member to attain or maintain a sufficient level of functioning in order to achieve beneficiary goals of community inclusion and participation, independence, recovery, and/or productivity. Using criteria for medical necessity, a PIHP may deny services that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care; that are experimental or investigational in nature; or for which

there exists another appropriate, efficacious, less-restrictive, and cost-effective service, setting or support that otherwise satisfies the standards for medically necessary services; and / or employ various methods to determine the amount, scope, and duration of services, including prior authorization for certain services, concurrent and post-service utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines. The PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

Medical Necessity Determination: The application of criteria by which a credentialed practitioner determines the provision of appropriate services and supports for a particular person, condition, occasion, or place. Such criteria ensure that services and supports are provided to treat, ameliorate, arrest, or delay the progression of symptoms, and to attain or maintain an adequate level of functioning. It is utilized within the person-centered planning process and the clinical practice guidelines of the PIHP.

Parity: Based on the Mental Health Parity Act of 1996 (MHPA), standardized criteria and assessments employed by all PIHPs to ensure equitable assessment of need and distribution of treatment services.

Service Utilization Monitoring: The routine monitoring of service utilization patterns and trends, through use of a compendium of reports and audits to monitor and manage service over/under-utilization (i.e., access to services, utilization trends, focused service utilization monitoring, UM activity).

Utilization Management: The PIHP care management system designed to ensure that members receive clinically appropriate, cost-effective services and supports delivered according to clinic practices focused on obtaining the best possible clinical outcomes. Key operations include a range of service utilization monitoring activities, e.g., service access, eligibility determination (including denial and appeal activities), selection and provision of care, utilization trends (also including trends per prospective, concurrent, retrospective utilization case record reviews), and service outcomes.

Utilization Management Processes: A process through which services are authorized, based on medical necessity criteria, and based on three determinations: eligibility, level-of-care, and service selection.

IV. STANDARDS:

A. The PIHP Board shall have final authority and responsibility for the assurance of a flexible, comprehensive, and integrated UM Program.
B. The UM Program shall function within the PIHP Quality Assessment and Performance Improvement Program. The PIHP's UM program core goals are as follows:

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1. Prompt and easy access to services and supports for all service recipients.
2. Services and supports provided are appropriate for recipients' needs.
3. Services and supports provided are high quality, clinically appropriate, and are the most cost-effective available.
4. Coordination of care takes place among all providers of supports and services, to ensure a comprehensive and person-centered approach to service delivery.
5. Coordination of care also takes place to ensure a member's freedom and rights are addressed should another member's environmental modifications be imposed due to another member's physical condition or restrictions who also resides in the home.

C. To achieve its Utilization Management goals, Region 10 PIHP engages in several specific UM functions.
   1. Eligibility Screening, including Psychiatric Hospitalization pre-evaluation; (also refer to Parity Compliance Plan policy, 01.05.02).
   2. Service Authorization.
   3. Utilization Review.
   4. UM Committee: Retrospective Review & Outlier Management.
   5. Development and Maintenance of Standards and Guidelines.

   These functions and operating processes are detailed in the PIHP UM Program Plan, which is approved by the Region 10 PIHP Board. The UM Program Plan details the above UM functions performed by the PIHP and any delegated items.

D. Oversight of the PIHP's Utilization Management Program Plan is provided through two components: (i) The PIHP Medical Director provides clinical oversight and direction of the PIHP's overall UM program and staff; and (ii) The PIHP Chief Clinical Officer operates a Utilization Management Committee and UM Department to ensure both the PIHP staff and its provider network are following the PIHP's clinical policies and practices.

E. The UM Program Plan shall establish operations (retained and/or delegated) that ensure:
   1. Procedures to evaluate medical necessity.
   2. Criteria-based service utilization decisions, including processes to review and approve such decisions.
   3. Service plans include all documentation required by the Home and Community-Based Services (HCBS) Final Rule.
   4. A standardized interrater reliability process for UM clinical staff that includes standardized test case scenarios, using the results to inform targeted training and improve the consistency in authorization decision-making (also refer to Indicia Inter-Rater Reliability policy, 01.05.02).
   5. Mechanisms in place initially/annually for UM clinical staff to confirm their awareness and attestation to making authorization decisions that are not incentivized for denying, limiting, or discontinuing medically necessary services to any member.

6. Remediation of over/under-utilization of services.
7. Prospective/concurrent/retrospective utilization review by qualified reviewers.
8. Service coordination.
9. Notice and appeals.
10. Mechanisms to evaluate UM Program effectiveness.

F. The UM Program Plan shall establish operations designed to monitor all delegated UM Program activities.

V. PROCEDURES:

A. The Region 10 PIHP oversees operational management of the following PIHP retained activities:
1. Development, adoption, and dissemination of Clinical Practice Guidelines, Medical Necessity Criteria as defined in the Michigan Medicaid Provider Manual, and other Standards to be used by the local CMHSP/SUD Providers.
2. Development, modification, and monitoring of related PIHP UM Policy, Procedures and Annual UM Program Plan, as part of the QIC.
3. Review and analysis of the CMHSP/SUD Providers periodic service utilization reports and annual review of CMHSP/SUD Provider and PIHP overall utilization activities. Oversight activities include but are not limited to performance and compliance monitoring, QIC Committee reports, and other PIHP performance reviews.

B. Monitoring of the Adverse Benefit Determination (ABD) process at least quarterly, to ensure the PIHP and its providers utilize the appropriate action notices and procedures. Also, please refer to Region 10 PIHP policy 07.02.01 Grievances and Appeals, delineating all ABD determination and action notice requirements.
1. Notice of Adverse Benefit Determination must include (as specified in 42CFR 438.10):
    a. The Adverse Benefit Determination description that has been taken or is proposed.
    b. The reason for the Adverse Benefit Determination, including the policy/authority relied upon for the decision’ the effective date for the action.
    c. The right to file an Internal Review/Local Level Appeal through the PIHP Grievance and Appeal Office and instructions for doing so.
    d. The circumstances under which an expedited appeal can be requested and instructions for doing so.
    e. An explanation of how the Enrollee may represent him/herself or use legal counsel, a relative, a friend, or other spokesman.
    f. The right for the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee’s Adverse Benefit Determination (including medical necessity criteria and processes, strategies, or evidentiary standards

used in setting coverage limits).

g. The Enrollee's right to have benefits continued pending resolution for the Appeal, instructions on how to request benefit continuation, and a description of the circumstance under which the Enrollee may be required to pay the costs of the continued services. (Advance Notice only).

2. That 42CFR440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
3. Adequate Benefit Determination Notice: For a Service Authorization decision that denies, or limits services, notice must be provided to the Enrollee within 14-days following receipt of the request for service for standard authorization decisions, or within 72-hours after receipt of a request for an expedited authorization decision. A service authorization decision not reached within 14 days for standard request, or 72 hours for an expedited request, constitutes a denial and is thus an adverse benefit determination on the date that the timeframe expires.
4. Advance Benefit Determination Notice: For a reduction, suspension, or termination of previously authorized/currently provided Medicaid Services, the Enrollee must be provided notice at least ten (10) calendar days prior to the proposed effective date.
5. If the Provider extends the review of the service authorization timeframe NOT at the request of the enrollee, the Provider must:
   a. Make reasonable efforts to give the Enrollee prompt oral notice of the delay.
   b. Within two calendar days, provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he/she disagrees with that decision.
   c. Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date.
6. The Provider must mail the notice within the following timeframes:
   a. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 CFR 431.211, 431.213 and 431.214.
   b. For denial of payment, at the time of any action affecting the claim.
   c. For standard or expedited service authorization decisions, (including the extension of service authorization timeframes), that deny or limit services, within the timeframe specified in 42 CFR 438.210(d)(I-2).
   d. For service authorization decisions not reached within the timeframes specified in 42 CFR 438.210(d), which constitutes a denial and is thus an adverse benefit determination, on the date that the timeframe expires.

C. A CMHSP/SUD Provider may provide the following UM Program operations per delegation agreement with the PIHP:

1. Initial approval or denial of requested service (initial assessment for authorization of psychiatric inpatient services; initial assessment for and authorization of psychiatric partial hospitalization services; initial and ongoing authorization of services to individuals receiving community-based services).
2. Grievance and Appeals, second opinion management, coordination, and notification.
3. Communication with consumers regarding UM decisions, including adequate and advance notice, right to second opinion and grievance and appeal.
4. Local-level Concurrent and Retrospective Reviews of Authorization and UM decisions/activities to internally monitor authorization decisions and congruencies regarding level of need with level of service, consistent with PIHP policy, standards, and protocols.
5. Persons who are enrolled on a habilitation supports waiver must be certified as current Enrollees and be re-certified annually. A copy of the certification form must be in the Individual’s file and signed by the local CMHSP representative.

D. The Provider must mail the notice within the following timeframes:
   1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 CFR 431.211, 431.213 and 431.214.
   2. For denial of payment, at the time of any action affecting the claim.
   3. For standard or expedited service authorization decisions (including the extension of service authorization timeframes), that deny or limit services, within the timeframe specified in 42 CFR 438.210(d)(I-2).
   4. For service authorization decisions not reached within the timeframes specified in 42 CFR 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

VI. EXHIBITS:

Exhibit A - Utilization Management Clinical Staff Affirmation Document

VII. REFERENCES:

42CFR 438.10
42CFR 440.230(d)
42CFR 431.211
42CFR 431.213
42CFR 431.214
42CFR 438.210(d)(I-2)
42CFR 438.210(d)
Michigan Medicaid Provider Manual
Michigan Mental Health Code
Medicaid Managed Specialty Supports and Service Contract Attachment:
MDHHS Appeal and Grievance Resolution Processes Technical Requirement
Person-Centered Planning Practice Guideline Section VII

Exhibit A

Region 10 PIHP
Utilization Management Clinical Staff Affirmation Document
(Compensation for Utilization Management Activities)

Region 10 PIHP ensures that, consistent with 42 CFR §§438.3(i), and MDHHS/PIHP Master Contract Section 1(K)(1)(a), compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Medicaid enrollee.

By my signature below, I affirm that, as a Utilization Management staff member, my authorization decisions will not be incentivized for denying, limiting, or discontinuing medically necessary services to any member. Further, affirm that services requested that receive my authorization are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

My signature of re/attestation is given upon employment and annually thereafter.

Signed_____________________________________
Name (print) ________________________________ Date ___________
Supervisor Signature_________________________ Date ___________