MCCMH MCO Policy 12-004

Chapter: **UTILIZATION MANAGEMENT**
Title: **SERVICE AUTHORIZATIONS**

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Chief Executive Officer Date

Approved by: Al Lorenzo 08/24/2023
County Executive Office Date

I. ABSTRACT

This policy establishes the standards and procedures of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, to ensure that service authorization requests are processed in an amount, scope, and duration that are medically necessary and consistent with applicable state and federal law, the Michigan Medicaid Provider Manual, and MCCMH's Prepaid Inpatient Health Plan (PIHP) Contract.

II. APPLICATION

This policy shall apply to MCCMH administrative staff, directly-operated, and contract network providers of MCCMH.

III. POLICY

It is the policy of MCCMH to ensure that medical necessity determination decisions are made by appropriate professionals, based on established criteria, and completed in a timely manner that meets the needs of individuals requesting services.

IV. DEFINITIONS

A. Adequate Notice of Medicaid Adverse Benefit Determination:
Written statement advising individuals of a decision to deny or limit authorization of Medicaid services that were requested. Adequate Notice of Medicaid Adverse Benefit Determination will be provided on the same date the Medicaid Adverse Benefit Determination takes effect.

B. Advance Notice of Adverse Benefit Determination:
Written statement advising individuals of a decision to reduce, suspend, or terminate Medicaid services currently provided. Advance Notice is sent to the individual at least ten (10) days prior to the proposed date when the Medicaid Adverse Benefit Determination is to take effect.

C. Expedited (Urgent) Pre-Service Request:
An authorization request where application of the timeframe for making routine or non-life-threatening care determinations could seriously jeopardize the life, health, or safety of the person served or others, due to the person's psychological state or in the opinion of the practitioner would subject the person to adverse health consequences without the care or treatment.

D. Legal Representative:
An adult person's legal guardian or a minor's parent or legal guardian.

E. Medicaid Adverse Benefit Determination:
Any of the following, as it relates to Medicaid enrollees:

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 in part, of payment for a 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" is not an adverse benefit determination.

4. Failure to make a standard authorization decision and provide notice about the decision within fourteen (14) calendar days from the date of receipt of a standard request for service. (Note: This timeframe may be extended up to an additional 14-calendar days in certain circumstances.)

5. Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited service authorization. (Note: This timeframe may be extended up to an additional 14-calendar days in certain circumstances.)

6. The failure to provide services in a timely manner. The State defines timely as being within fourteen (14) calendar days of the start date agreed upon during the person-centered planning and as authorized by MCCMH.

7. Failure of MCCMH to resolve standard appeals and provide notice within thirty (30) calendar days from the date of a request for a standard appeal.

8. Failure of MCCMH to resolve expedited appeals and provide notice within seventy-two (72) hours from the date of a request for an expedited appeal.

9. Failure of MCCMH to resolve grievances and provide notice within ninety (90) calendar days of the date of the request.

10. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network; or

11. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

F. Medical Necessity

Mental health, developmental disabilities, and substance use services when they meet the following criteria, or other criteria as set forth in the current version of the Michigan Medicaid Provider Manual and applicable MCCMH policies:

1. Necessary for screening and assessing the presence of a mental illness, developmental disability, or substance use disorder;

2. Required to identify and evaluate a mental illness, developmental disability, or substance use disorder;

3. Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, developmental disability, or substance use disorder;

4. Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

5. Designed to assist the beneficiary to attain or maintain a sufficient level of functioning to achieve their goals of community inclusion and participation, independence, recovery, or productivity.

   Note: MCCMH is part of Michigan's CCBHC Demonstration Project under which services to individuals who meet the criteria for mild to moderate mental health issues may be able to receive services.

G. Non-Urgent Pre-Service Request:

An authorization request for which application of the time periods for making a decision do not jeopardize the life or health of the person or the person's ability to regain maximum function and would not subject the person to severe pain.

H. Person Served:

Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by MCCMH, including Medicaid beneficiaries, and all other recipients of services.

I. Plan of Service:

A formal written plan, accepted by the person served or their legal representative, for the provision of services which describes the issues/problems to be addressed, the desired outcomes of the service, the activities/interventions designed to facilitate achievement of desired outcomes, the individual(s) or program(s) responsible for implementing the activity/intervention, and the dates upon which service reviews will occur. The Plan of Service may include clinical services, supportive services, or both. The Plan of Service may be designed to serve an individual or a family.

J. Post-Service Request:

An authorization request for services already provided.

K. Service Authorization:
Processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested.

L. Urgent Concurrent Pre-Service
An authorization request made while a person served is in the process of receiving the requested care, even if there was not previous approval for the care.

V. STANDARDS

A. All service authorizations shall be made in compliance with applicable state and federal law, the Michigan Medicaid Manual, the Michigan Health Link Demonstration Three-Way Contract, and applicable MCCMH policies.

B. MCCMH uses formalized utilization management criteria to make its utilization decisions. MCCMH's utilization management criteria is available on its website at www.mccmh.net and can be requested by contacting MCCMH's Managed Care Operations (MCO) department at 586-948-0224.

C. All denials based on medical necessity shall be made by appropriate professionals including board-certified physicians or doctoral-level clinical psychologists.

D. Treating physicians and providers are given contact information if they would like to discuss a medical necessity denial with a physician when the determination is provided telephonically.

E. When enrollees or their authorized representatives request services from an out-of-network provider/practitioner, MCCMH will make an authorization and/or non-authorization determination on a case-by-case basis.

F. MCCMH expects that an out-of-network provider/practitioner makes an effort to secure prior authorization before services are initiated and agrees to enter a single case agreement with MCCMH.

G. MCCMH shall ensure that services authorized are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished, and as otherwise consistent with MCCMH's PIHP Contract.

H. Medicaid enrollees shall be provided an appropriate Notice of Medicaid Adverse Benefit Determination in any case where a service authorization request is denied, or a Medicaid Service is authorized in an amount, duration, or scope that is less than requested.

I. MCCMH shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition.

J. Consistent with the criteria applied under the State plan, MCCMH may place appropriate limitations on services rendered.

1. Services may be denied when:

a. They are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

b. They are experimental or investigational in nature; and/or

c. There exists another appropriate, efficacious, less restrictive, and cost-effective service, setting or support that otherwise satisfies the standards for medically necessary services.

2. MCCMH uses various methods to determine amount, scope, and duration of services, including but not limited to prior authorization for certain services, concurrent utilization reviews, and centralized assessments and referrals.

3. MCCMH 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.

4. For the purpose of utilization control, limitations on services may occur provided that:

a. The services furnished can reasonably achieve their purpose;

b. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the individual's ongoing need for such services and supports; and

c. Family planning services are provided in a manner that protects and enables the individual freedom to choose the method of family planning to be used consistent with 42 CFR 441.20.

K. For the processing of requests for initial and continuing authorizations, MCCMH shall:

1. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

2. Consult with the requesting provider for medical services when appropriate.

L. When a service authorization is processed, MCCMH shall provide the individual with a written service authorization decision within specified timeframes and as expeditiously as the person's health condition requires. The service authorization must meet the requirements for either a standard authorization or expedited authorization:

1. Standard Authorization:

Notice of the authorization decision must be provided as expeditiously as the person's health condition requires, and no later than fourteen (14) calendar days following receipt of a request for service.

a. MCCMH may extend the fourteen (14) calendar day timeframe by up to an additional fourteen (14) days if either of the following occur:

i. The person served or provider requests an extension, or

ii. MCCMH justifies (to MDHHS upon request) a need for additional information and how the extension is in the person's interest.

2. Expedited Authorization:

In cases in which a provider indicates or MCCMH determines that following the standard timeframe could seriously jeopardize the person's life; health; or ability to attain, maintain, or regain maximum function. MCCMH must make an expedited authorization decision and provide notice of the decision as expeditiously as the person's health condition requires, and no later than seventy-two (72) hours after receipt of the request for service.

a. MCCMH may extend the seventy-two (72) hour timeframe by up to fourteen (14) calendar days if either:

i. The person requests an extension, or

ii. MCCMH justifies (to MDHHS upon request) a need for additional information and how the extension is in the person's interest.

M. When a standard or expedited authorization of services decision is extended, MCCMH must:

1. Make reasonable efforts to give the individual prompt oral notice of the delay;

2. Within two calendar days, provide written notice of the reason for the decision to extend the timeframe, and inform them of their right to file a grievance if they disagree with that decision; and

3. Issue and carry out the service authorization determination as expeditiously as the person's health condition requires and no later than the date the extension expires.

N. When additional information is needed to make coverage or appeal decisions, MCCMH shall request the needed clinical documentation and document a minimum of one attempt to obtain the necessary information. If, after the documented attempt, MCCMH does not receive any additional information, MCCMH shall make the best decision it can based on the available information within the required timeframes. In its sole discretion, MCCMH may extend a previous existing authorization for up to thirty (30) days while it gathers needed information on which to base the authorization.

O. For all covered outpatient drug authorization decisions, MCCMH shall provide notice to the Medicaid enrollee as described in Section 1927(d)(5)(A) of the Social Security Act.

P. MCCMH must notify the requesting provider and give the person served written notice of:

1. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Notice to the person served must be sent within the applicable standard or expedited authorization timeframes described above.

2. A service authorization decision not reached within the relevant timeframe prescribed above constitutes a denial of services and is therefore considered an Adverse Benefit

Determination. Notice must be mailed to the Medicaid enrollee no later than the date on the date that the timeframe expired.

3. In such cases, MCCMH must provide the Medicaid enrollee with Adequate Notice of Medicaid Adverse Benefit Determination that meets the requirements described in MCCMH MCO 4-004, "Due Process System."

Q. 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 Medicaid enrollee.

R. Requests for continued authorization may be submitted for review up to sixty (60) calendar days, and no later than fourteen (14) calendar days, in advance to ensure that authorization is in place at the start of the new authorization period.

VI. PROCEDURES

A. The MCCMH Managed Care Operations Division (MCO) and other units performing the utilization review function shall:

1. Process all service authorization requests (Medicaid and non-Medicaid);

2. If the services are Medicaid Services:

a. Provide written notice of the authorization decision to the person served; and

b. Send Adequate Notice of Medicaid Adverse Benefit Determination in any case where a service authorization request is denied, or services are authorized in an amount, duration, or scope that is less than requested.

B. All authorized services must begin within fourteen (14) calendar days of a non-emergent assessment with a professional or the agreed upon start date in the person-centered plan.

C. Procedures specific to the implementation of this policy and the standards listed above shall be contained in Provider Manuals for each service as relevant to that provider's role in the transmission of Notices of Medicaid Adverse Benefit Determinations.

D. MCCMH ensures that staff, including physicians involved in the decision-making process, do not benefit financially from denying treatment or encourage decisions that result in under-utilization of care or services to persons served.

VII. REFERENCES / LEGAL AUTHORITY

A. Michigan Department of Health and Human Services Medicaid Provider Manual, in effect and as amended.

B. MDHHS-MCCMH Managed Specialty Supports and Services Contract (the PIHP Contract)

C. 42 CFR Part 431

D. 42 CFR Part 438

E. 42 CFR 438.210 - Coverage and Authorization of Services

F. 42 CFR 441.20

G. U.S. Congress. (1934) United States Code: Social Security Act, 42 U.S.C. Section 301-1940.

H. MCCMH MCO Policy 2-013, "Access, Eligibility, Admission, Discharge"

I. MCCMH MCO Policy 2-014, "Assessment Services"

J. MCCMH MCO Policy 4-020, "Medicaid & Non-Medicaid Notice of Adverse Benefit Determinations (Advance and Adequate) & Appeal Rights"

K. MCCMH MCO Policy 4-030, "MI Health Link Services – Notices, Grievances, and Appeals"

L. MCCMH MCO Policy 9-170, "Local Dispute Resolution Process"

M. MCCMH MCO Policy 9-171, "Local Appeal Process (Medicaid)"

N. MCCMH MCO Policy 4-005, "Second Opinion Rights"

VIII. EXHIBITS

None.