

KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

ADMINISTRATIVE POLICY & PROCEDURE 30.01

Subject: Utilization Management	Section: Utilization Management	
Applies To: <input checked="" type="checkbox"/> KCMHSAS Staff <input checked="" type="checkbox"/> KCMHSAS Contract Providers		Page: 1 of 7
Approved: <div style="text-align: center;">----- (Jeff Patton, Chief Executive Officer)</div>		
Revised: 01/08/2018	Supersedes: 05/08/2017	First Effective: 02/15/2012

PURPOSE

To assure that services provided by Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) are appropriate to meet the needs of individuals served. To assure that KCMHSAS clinical staff and the KCMHSAS contracted Provider Network are informed and follow all KCMHSAS Utilization Management policies, procedures, and expectations.

DEFINITIONS

Appeal

A request from an individual served, assigned/primary staff, attending physician, provider or facility representing an individual served to re-evaluate a denial decision made by the KCMHSAS Access/Utilization Department pertaining to a covered service.

Authorization

Approval of payment on behalf of KCMHSAS.

Denial

A determination that a specific service is **NOT** medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, the most cost-effective option in the least restrictive environment and/or consistent with clinical standards of care, and/or per policy and contractual requirements.

Medical Necessity

Criteria used to determine which services, supports and/or treatment protocols are required for the diagnosis or severity of illness that meets accepted standards of medical practice.

Pended

The status of an authorization decision awaiting judgment or final decision to approve or deny authorization of service(s) (placing authorization in a hold status).

Reconsideration of a Benefit Decision

A provider and/or primary staff may request a reconsideration of a benefit decision without a formal appeal in cases such as additional information pertaining to the services in question not previously available in the determination or processes corrected that were inconsistent with policy and contractual obligations.

UM

Utilization Management

Utilization Review

A formal evaluation (pre-service, concurrent or post-service) of the coverage, medical necessity, efficiency or appropriateness of the services, supports and Individual Plan of Service (IPOS).

POLICY

It is the policy of KCMHSAS to ensure that individuals served receive appropriate services at the right time and in the sufficient amounts to meet their needs.

STANDARDS

- I.** The Utilization Management staff must be experienced and qualified mental health clinician(s) and deemed capable in making a medical necessity determination for the services they authorize.
- II.** The Medical Director is available for consultation and review functions for services requiring a physician. The Medical Director may also provide appeal determinations for Administrative Appeals (see policy [06.02 \[Second Opinions/Grievance & Appeals/Dispute Resolution\]](#) for more information).
- III.** Medical necessity criteria applied within the utilization review function includes services, supports and treatment used to screen and assess, identify and evaluate, and treat (ameliorate, diminish or stabilize) the presence of a mental health, developmental disability and/or co-occurring disorder. Service is anticipated to arrest and/or delay progression of the disorder, and assists the individual served in attaining and/or maintaining a level of functioning and related community inclusion and participation, independence, recovery or productivity goals. These supports, services and/or treatment

must be documented in the plan of service, made in a timely fashion and include the amount, scope and duration of the service(s) to reasonably achieve the desired purpose.

- IV. Methods to determine amount, scope and duration of service may include prior authorization for services, concurrent utilization review, centralized assessment and referral, gate-keeping arrangements, protocols and guidelines. Determination, while individualized, is also based on an individual’s self-report (and those who know the individual), evaluation by a trained experienced treatment professional and the evaluation includes person-centered planning.
- V. KCMHSAS review criteria is based upon current clinical principles and processes and consist of the Michigan Department of Health and Human Services (MDHHS) Practice Guidelines, MDHHS Michigan Medicaid Provider Manual, Southwest Michigan Behavioral Health’s (SWMBH) established Clinical Practices, and coordination agency established guidelines. Review criteria are evaluated at least annually, in collaboration with SWMBH.
- VI. KCMHSAS does not provide financial incentives, reimbursements or bonuses to staff based on the utilization of covered services for individuals served.

PROCEDURE

- I. The qualified individual conducting the UM review will review the unique history, diagnosis, assessment scores (i.e., DECA, PECFAS, CAFAS, LOCUS, SIS, ASAM), service recommendations and needs of the individual served. The completed standardized assessment tool will inform the process of determining medical necessity and appropriate level of care for each population served. A review of conducted assessments and identified needs of the person served shall ensure that services are authorized and provided in a manner that is sufficient, necessary and germane to the diagnosis of the individual served and are in congruence with the determined level of care in accordance with the SWMBH level of care guidelines, as appropriate.
- II. The review process utilizes various types of analysis based upon the immediate need of the individual and may include a prospective, retrospective and/or concurrent review. A prospective review involves evaluating the appropriateness of a service prior to the onset of the service. A concurrent review involves evaluating the appropriateness of a service throughout the course of service delivery. A retrospective review involves evaluating the appropriateness of a service after the services have already been approved. Determinations are made within the following timeframes:

Type of Review	Timeframe	Response
Prospective Review	Determination must occur as soon as possible based upon clinical condition not to exceed 72 hours if urgent; within 14 calendar days if non-urgent; and may be extended up to 14 calendar days for non-urgent cases when situation is	If the individual served is expected to provide necessary information for review, the individual served is given at least 45 calendar days to respond before the determination is made. If there is a failure to submit the necessary

Type of Review	Timeframe	Response
	beyond the organization’s control. Individual served must be notified before the initial 14 days expire of the circumstances requiring the extension.	information, the notice of extension must describe the required information.
Retrospective Review	Determination within 30 calendar days within receipt of the request for authorization. May be extended one time for up to 14 days when situation is beyond the organization’s control. Individual served must be notified prior to the initial 30 days expiration of the circumstances that required the extension.	If the individual served is expected to provide necessary information, the individual served is given 45 calendar days to respond – the individual served is notified before 30 days expire. If there is a failure to submit the necessary information, the notice of extension must describe the required information.
Concurrent Review	Providers must request within 20 calendar days. Requests must be responded to within 14 calendar days for routine services. Urgent or emergent requests are responded to within 24 hours.	For reduction or termination of previously approved treatment, the determination is made early enough to allow the individual served to request a review and receive a decision before the reduction / termination occurs. Authorizations are extended in coordination with customer services unit for all customer appeals, until such time that the appeal is decided.

III. Reviews occur at a frequency based upon the severity or complexity of the illness or related to discharge planning activities.

- A. Retrospective Utilization Reviews will be performed in accordance with adopted KCMHSAS procedures, though the monitoring and review of data for the purposes of outlier management to monitor:
 1. High Cost/High Utilization of services
 2. Low Utilization of authorized services

- B. Targeted UM reviews may also be conducted on:
 1. Hospital/Specialized Residential admissions
 2. Outcome outliers
 3. Sentinel Event occurrences (refer to policy [03.06 \[Incident, Event and Death Reporting\]](#))

IV. 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. Prospective and concurrent reviews are typically managed via reviews or through information exchange in the managed care information system. Retrospective reviews may occur through record review. Only information necessary for making an authorization determination is required (i.e., external providers are not asked to send the entire medical chart for review). Services are not arbitrarily denied based upon one specific element.

- V. Information shared is on a need-to-know basis with efforts to minimize redundant requests for information. Prospective or concurrent review determination is 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.
- VI. In the event that insufficient information is available for conducting the review, the authorization is “pending” for up to 14 business days from that date and time. If the provider/staff does not submit additional information within that timeframe or if the information submitted does not demonstrate criteria, a denial will be rendered and the provider/staff will be notified of appeal options. Expedited appeals are completed with verbal notification of the determination to the requesting party within 72 hours of the request followed by written confirmation within three calendar days to the individual served, the ordering provider/staff and facility, as applicable. Standard appeals are completed and written notification issued within 30 calendar days of the receipt of the request for the appeal to the individual served, ordering provider/staff and facility, as applicable.
- VII. Medicaid beneficiaries have access to an independent review process via SWMBH after other local appeal mechanisms have been exhausted. SWMBH provides the review services that meet the following standards:
- A. Utilize staff with appropriate clinical expertise and licensure/certification in rendering independent review determinations.
 - B. Renders utilization management determinations for non-urgent cases within 30 calendar days from the date the individual served requests an independent review.
 - C. Renders utilization management determinations for urgent cases within 72 hours from the date the individual served requests an independent review.
 - D. If a review and appeal are both conducted by SWMBH, the staff making the determination may not be the same person.
- VIII. All Michigan Medicaid beneficiaries also have the right to a State Fair Hearing at any level of review or simultaneous with a review level. The State Fair Hearing determination overrides any prior determination. Medicaid beneficiaries also have the right to request a second opinion if admission to psychiatric hospitalization or access to behavioral health services is denied (see policy [06.02 \[Second Opinions/Grievance & Appeals/Dispute Resolution\]](#)).
- IX. All approvals and denials are clearly documented in the managed care information system or electronic health record (EHR). The ordering provider/staff or facility rendering service to the individual served 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, via the managed care information system and/or written notification of the determination. Denials of

service includes the principle reason for the denial, a statement that the rationale used is available, in writing, upon request, and instructions regarding how to appeal and how to formally request the clinical rationale used in the determination. Approved exceptions to a determined level of care will be clearly documented by KCMHSAS Access Center as to why the exception was made and shall include any planned or recommended follow-up to monitor the level of care exception over the course of the authorization period. Upon request from the individual served, staff, or external provider, the clinical rationale for any denial will be provided.

- X.** Should there be a denial of services, the denial may be based upon a request for service which is deemed professionally and scientifically ineffective or experimental and/or if the medically-necessary standard of care may be met via a more appropriate, less restrictive, cost-effective and effective service. Further, services may be limited to the coverage plan of the individual served and, in some circumstances, the individual served may be referred elsewhere for treatment/services. KCMHSAS does not deny the use of a benefit based on preset limits of benefit duration but instead reviews the continued medical necessity 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 individual served to the services they need.
- XI.** KCMHSAS does not reverse an approved authorization for services that has been made unless it receives new information that is relevant to the authorization that was not available at the time the approval was issued. Based on medical necessity, the authorization for services may be partially approved. In such an instance, the reviewer will enter a note into the EHR or managed care system explaining why the service has been partially approved. A partial approval is not a denial of service and may include authorization for a number of units less than requested or for a shorter time-span than requested.

XII. QUALITY MANAGEMENT

This policy/procedure will be evaluated by the KCMHSAS Quality Improvement Council (KQIC) on an annual basis to enhance and improve the quality.

The Program Services Director Committee (DIRS) will review all aggregated data on Utilization Management and service authorization trends on a regular basis. The efficacy of services and supports as well as their cost-effectiveness will be assessed and decisions regarding improvements and needed changes in the system(s) will be discussed and reviewed.

REFERENCES

- [Michigan Mental Health Code, Chapter 3](#)
- [MDHHS/CMHSP Contract](#) Sections:
 - C.3.1.1 - Access System Standards

- Customer Services, Grievance & Appeals
- 6.9 - Service and Utilization Management

- [Balanced Budget Act of 1997](#) – Section Subparts D and F

- [American Society of Addiction Medicine \(ASAM\)](#)

- [Southwest Michigan Behavior Health Policy](#)
 - 4.1 (Access Management)
 - 4.2 (Utilization Management)
 - 4.4 (Service Authorizations Outlier Management)
 - 4.8 (Retrospective Review)
 - 4.8.1 (Retrospective Review)

- SWMBH Utilization Management Program for Members Enrolled in Medicaid, Health Michigan Plan, SUD Community Grant, Flint 1115 Waiver, Autism Benefit or Habilitation Supports Waiver