PROCEDURE # 5.0a	EFFECTIVE DATE	REVISED DATE
TITLE: UTILIZATION MANAGEMENT PROCEDURE	January 1, 2014	3/13/2022
ATTACHMENT TO	REVIEW DATES	
POLICY #: 5.0 POLICY TITLE: UTILIZATION MANAGEMENT CHAPTER: UTILIZATION MANAGEMENT	11/21/2013, 1/1/2015, 3/13/2022, 8/14/2024	

I. PURPOSE

Lakeshore Regional Entity (LRE), either directly or through delegation of function to its provider network, is responsible for the region's Utilization Management (UM) program. Through contract, LRE has identified the retained and delegated functions of the network's UM program. LRE is responsible for oversight and monitoring of all UM functions.

II. PROCEDURE:

UM is a set of administrative functions that assure appropriate clinical service delivery by applying medically necessary criteria in the right amount, scope and duration to meet the individual's needs. These functions occur through the consistent application of written policies and eligibility criteria.

A. Program Oversight

The Utilization Management Regional Operation Advisory Team (UM ROAT) is charged with the following:

1. Develop and monitor a regional utilization management plan.
2. Set utilization management priorities based on the LRE strategic plan and/or contractual/public policy expectations.
3. Recommend policy and practices for access, authorization and utilization management standards that are consistent with requirements and represent best practices.
4. Participate in the development of access, authorization and utilization management monitoring criteria and tools to assure regional compliance with approved policies and standards.
5. Support development of materials and proofs for external quality review activities.
6. Establish improvement priorities based on results of external quality review activities.
7. Recommend regional medical necessity and level of care criteria.
8. Perform utilization management functions sufficient to analyze and make recommendations relating to controlling costs, mitigating risk and assuring quality of care; review and monitor utilization patterns and analysis to

detect and recommend remediation of over/under or inappropriate utilization.

9. Recommend improvement strategies where adverse utilization trends are detected; and
10. Implement policies and systems to ensure consistency with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
11. Ensure UM ROAT coordination and information sharing to address continuity and efficiency of PIHPprocesses.

The LRE Medical Director, CMHSP Medical Directors or Independent Review Organization (IRO) are available for consultation and provide review functions for services requiring physician oversight. The LRE Medical Director or CMHSP Medical Directors may also provide determinations for Administrative Appeals.

B. Authorization for Treatment & Support Services:
1. Initial and ongoing approval or denial of requested services is delegated to the local Member CMHSPs. This approval or denial includes the screening and authorization of psychiatric inpatient services, partial hospitalization, and initial and ongoing authorization of services for individuals receiving community mental health services. Communication with individuals regarding UM decisions, including adequate and advance notice, right to second opinion, and grievance and appeals shall be provided in accordance with the Medicaid Managed Specialty Supports and Services Contract with the Michigan Department of Health and Human Services (MDHHS). The reasons for treatment decisions shall be clearly documented and available to Medicaid beneficiaries. Information regarding all available appeals processes and assistance through customer services is communicated to the consumer. LRE shall monitor affiliate authorization, second opinions and appeals processes to ensure compliance with PIHP, State and Federal requirements.

2. Utilization reviews are conducted using Milliman Care Guidelines (MCG's) and Michigan Medicaid Provider Manual (MMPM) to guide the level of care and medical necessity determinations. This may include, but is not limited to, appropriate length of stay for each level of care according to identified needs of the beneficiary for payment to be authorized.

3. The responsibility for managing the utilization of clinical care resources is delegated to the LRE Member CMHSPs to assess the needs of and authorize care for beneficiaries receiving services funded by the PIHP.

4. Decisions regarding the type, amount, scope, duration, and intensity of services to authorize or deny must be:
    a. Accurate and consistent with medical necessity criteria;

   b. Consistent with Medicaid eligibility, entry, continuing stays and discharge criteria as applicable;
   c. Consistent with formal assessments of need and beneficiary desired outcomes;
   d. Consistent with established guidelines (MCG, MMPM);
   e. Adjusted appropriately as beneficiary needs, status, and/or service requests change;
   f. Timely;
   g. Provided to the consumer in writing as to the specific nature of the decision and its reasons;
   h. As applicable, shared with affected service providers verbally or in writing as to the specific nature of the decision and its reasons if there are any concerns with decisions made;
   i. Clearly documented as to the specific nature of the services authorized or denied and the reasons for denial; and
   j. Accompanied by the appropriate notice to consumers regarding their appeal rights with a copy of the notice placed in the consumer's clinical case record.

5. Additional mental health services (through authority of Section 1915(b) of the Social Security Act) are intended to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. Authorization and use of Medicaid funds for any supports and services (including amount, scope, and duration) are dependent upon:
   a. The Medicaid beneficiary's eligibility for specialty services and supports;
   b. Services have been identified during person-centered planning;
   c. Services are medically necessary;
   d. Services are expected to achieve one or more of the goals listed;
   e. Decision to authorize services (including amount scope and duration) must take into account LRE's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services.

6. LRE Member CMHSPs shall not deny the use of a covered service based on preset limits of units or duration; but instead reviews the continued medical necessity on an individualized basis.

7. LRE assures that 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 beneficiary.

8. UM Process
   a. Procedures to outline utilization review work including:

i. UM authorization and denial decisions are only made by qualified and credentialed professionals. Decisions to deny or reduce services are only made by professionals who have the appropriate clinical expertise to treat the condition.
ii. Efforts are made to obtain all necessary clinical information to render a decision.
iii. The reasons for utilization review decisions are clearly documented and available to the LRE, CMHSP, and provider or individual.
iv. There are well-publicized and available appeals mechanisms for both providers and individuals receiving services. Notifications of denials include a description of how to file an appeal.
v. Decisions and appeals are made in a timely manner as required by the MDHHS contract, service contracts and established protocols.
vi. If the utilization management activity is delegated to CMHSPs, the LRE ensures that all of the above standards are met by the delegate.
vii. A process to ensure inter-rater reliability of professionals involved in UM decision making.

9. UM Decision Making Criteria
   a. The LRE and its partner CMHSPs prior authorize medically necessary services through application of criteria outlined in the MCGs and MMPM.
   b. Service authorizations are requested by providers through the development of the individual plan of service, plan addendums, and treatment plans. Prior authorizations are not required to access emergent or non-emergent eligibility screening, or crisis services.
   c. Utilization management processes for mental health and substance use disorder services are based on three determinations:
      i. <u>Eligibility Determination</u>
         1. initial, non-emergent eligibility is determined through the Access screening process;
         2. initial, emergent eligibility is determined through pre-admission reviews and;
         3. ongoing eligibility determination through continued stay and or retrospective reviews;
         4. Reviews may be prospective, concurrent or retrospective based on established protocols or may be flexible based on an individual's unique situation.
      ii. <u>Level of Care Determination</u> - established initially and re-evaluated annually, as well as any time there is a significant change in clinical status, based on clinical and demographic information gathered and updated during person-centered planning.

iii. Service Selection Determination- providers utilize established service selection guidelines to determine expected service utilization at the assessed level of care. Services authorized are
1. identified through the person-centered planning process;
2. medically necessary as defined by the Michigan Medicaid Provider Manual;
3. based on Best Practice and Evidence Based Practice clinical guidelines; and
4. monitored via prospective, concurrent, and retrospective review processes by LRE or CMHSP utilization management staff.

10. LRE shall provide oversight and monitoring to ensure that the CMHSP participants meet the following standards:
    a. Member CMHSPs shall ensure access system staff are qualified, credentialed and trained consistent with the Medicaid Provider Manual, the Michigan Mental Health Code and the MDHHS/PIHP contract.
    b. Member CMHSPs shall ensure that there is no conflict of interest between the coverage determination and the access to, or authorization of, services.
    c. Member CMHSPs shall monitor provider capacity to accept new individuals and be aware of any providers not accepting referrals at any point in time.
    d. Member CMHSPs shall routinely measure telephone answering rates, call abandonment rates and timeliness of appointment and referrals at any point in time. Any performance issues shall be addressed through the LRE Quality Assurance and Process Improvement Plan. (QAPIP)
    e. Member CMHSPs shall assure that the access system maintains medical records in compliance with state and federal standards.
    f. Member CMHSPs shall work with individuals, families, local communities, and others to address barriers to using the access system, including those caused by lack of transportation.

III. RELATED POLICIES AND PROCEDURES:

A. 4.4 Credentialing/Recredentialing
B. 6.1 Grievance and Appeals/Due Process; 6.1a Grievance and Appeals Reporting Procedure
C. Policy 7.1 Quality Assessment and Performance Improvement Program
D. Policy 7.4 External Review Process
E. LRE Utilization Management Policies and Procedures

IV. REFERENCES/LEGAL AUTHORITY:

A. LRE Quality Assessment and Performance Improvement Plan (QAPIP)
B. LRE Utilization Management Plan

C. LRE Corporate Compliance Plan
D. MDHHS/PIHP Master Contract for Medicaid Managed Specialty Supports and Services
E. MDHHS Medicaid Providers Manual
F. MSA Bulletin: Mental Health/Substance Abuse 04-03 (Prepaid Inpatient Health Plans)
G. 42 CFR 438.404c(5)(6); 42 CFR 438.210(b)(c)(d)(e)(f)

V. CHANGE LOG

Date of Change	Description of Change	Responsible Party
11/21/2013	New Procedure	Chief Clinical Officer
1/1/2015	Annual Update	Chief Clinical Officer
10/1/2021	Annual Update	UM/Clinical Manager
8/14/2024	Definitions removed (already in policy); minor edits	UM/Clinical Manager