HEALTHWEST

Policy and Procedure

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Prepared by:

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Approved by:

Subject: Utilization Management

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I. POLICY

HealthWest will have a comprehensive Utilization Management (UM) process that meets its contractual obligations with the Lakeshore Regional Entity (LRE), regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) Contract, and Centers for Medicare and Medicaid Services (CMS) Code of Federal Regulations (CFR).

The UM policy will ensure a comprehensive integrated process that provides verification that all individuals served by HealthWest and its provider network receive the right service at the right time and in the right amount sufficient to meet their needs.

II. PURPOSE

HealthWest's Utilization Management (UM) program supports the services provided by its employees and contract agencies, and ensures appropriate allocation of limited resources. The UM program is a key component of HealthWest's "Quality Assessment and Performance Improvement Program" (QAPIP). The UM Program operates under the guidance of the Director of Utilization Management and Substance Use Services, and ensures the delivery of high-quality, medically necessary care through appropriate utilization of resources in a cost-effective and timely manner.

The HealthWest Utilization Management Committee (UMC) oversees and directs Utilization Management activities. This policy outlines the standards and guidelines that detail how the HealthWest and its provider network comply with the Federal laws and Lakeshore Regional Entity contract requirements pertaining to UM responsibilities.

III. APPLICATION

This Policy applies to HealthWest employees and contract agencies.

IV. DEFINITIONS

A. Adverse Notice of Benefit Determination: A written statement advising the individual served of a decision to reduce, suspend or terminate Medicaid services.

B. Appeal: A process in which an authorization decision that adversely affects services provided to an individual, or involves denial of services to an individual, is reviewed by a

licensed professional who was not part of the original denial decision. This professional evaluates the medical needs of the individual for possible decision reversal.

C. Authorization: Approval of payment for a covered service on behalf of HealthWest.

D. Clinical Practice Guideline: Protocols that guide clinical decisions regarding individuals' access to covered services. The Michigan Medicaid Provider Manual Mental Health and Substance Abuse Section, HealthWest Service Packages, CANS/ANSA Person-Centered Planning (PCP) Process are all used to determine appropriate service.

E. Concurrent Review: Concurrent review encompasses those aspects of utilization review that take place during the course of facility-based or outpatient treatment.

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

G. Medically Necessary: A determination that a specific service is clinically appropriate and necessary to meet the person's needs; is consistent with the person's diagnosis, symptoms and functional impairments; is the most cost-effective option in the least restrictive setting; and is consistent with medical necessity criteria.

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

I. Prior or Prospective Authorization: The process to obtain approval or authorization to perform a covered service in advance of its delivery.

J. Utilization Management: Managed care procedures for the determination of medical necessity, appropriateness, location, and cost-effectiveness of behavioral health care services.

K. Utilization Management Program: The managed care system ensuring that eligible recipients receive clinically appropriate, cost-effective services designed to meet their needs.

V. PROCEDURES

A. Program Oversight

The Utilization Management Committee is charged with the following:

1. Defining, maintaining and reviewing UM protocols.

2. Collecting and analyzing data on utilization trends, outliers, as well as over-utilization and under-utilization for all services.

3. Ensuring consistency of UM practices and application of Service Selection Guidelines.

4. Developing a written UM Program Plan to be reviewed at least annually that includes the program's focus, methods, and goals for the upcoming year.

5. Periodic reporting of UM activity, including an annual status report to the HealthWest Board of Directors on the overall success of the UM Program.

B. Program Structure

As required by the LRE and MDHHS contracts, the UM Program must include the following:

1. A written UM Plan that is reviewed at least annually. The plan will include a description of the procedures used to evaluate medical necessity, criteria used, information sources, and the processes used to review and approve the provision of services.

2. Services packages are established according to intensity of service need and level of care. Outliers are monitored for over-utilization and under-utilization and recommendations to change the frequency, scope or duration may be a product of those case reviews.

3. Process for outlining utilization review workflow including:

   a. UM authorization and denial decisions are only made by qualified and credentialed professionals.

   b. Decisions to deny or reduce services are only made by professionals who have the appropriate clinical expertise to treat the condition.

   c. The HealthWest Medical Director provides review functions requiring physician oversight. The Medical Director may also provide determination for administrative appeals.

   d. Efforts are made to obtain all necessary clinical information to render a decision.

   e. The reasons for utilization review decisions are clearly documented and available to the provider or person served.

   f. There are well-publicized and available appeal mechanisms for both providers and persons served. Notifications of denials include a description of how to file an appeal.

   g. Decisions and appeals are made in a timely manner as required by Medicaid service contracts and established protocols.

C. UM Decision-Making Criteria and Processes

1. HealthWest prior authorizes medically necessary services through the application of criteria outlined in the Michigan Medicaid Provider Manual: Mental Health and Substance Abuse Section, established Service Selection Guidelines, and other best practice standards. Prior authorizations are not required to access emergent or non-emergent eligibility screening or crisis services.

2. Eligibility Determination and Authorization for Mental Health Services

   a. Emergent or urgent eligibility (inpatient admission or crisis residential) is determined through a crisis assessment documented on a Pre-Admission Screening (PAS).

   b. Initial, non-emergent eligibility is determined through the CANS/ANSA assessment process.

   c. Completed CANS/ANSA assessments and program recommendations are to be submitted by email for review by the UM staff.

      i. UM staff need to be responsive to adult and youth intake processes, with a determination made within 15 minutes of the request. Exceptions to this occur when further discussion or information is needed to make a determination on service array.

   d. Level of service determination is re-evaluated every three months by completing a CANS/ANSA, as well as through a PCP review process, and any time there is a significant change in clinical status (based on clinical and demographic information gathered).

      i. As part of the periodic re-evaluation of level of service, HealthWest staff must submit completed CANS/ANSA, updated PECFAS/CAFAS/LOCUS, and any other supporting documentation via email to UM staff.

   e. Ongoing eligibility determinations also occur through provider clinical reviews and/or utilization reviews. Reviews may be prospective, concurrent, or retrospective based on established protocols, or may be flexible based on an individual's unique situation.

   f. All service authorizations decisions not reached within 14 days for a standard request, or 72 hours for an expediated request, constitutes a denial, and notice is sent to the individual served on the date the resolution time frame expires.

      i. If UM is not able to make a determination within 48 hours to a request for service, UM staff enter request information in a spreadsheet, tracking date of request and any subsequent follow-up.

      ii. If a decision cannot be made within 14 days from date of receipt of request, a Notice of Adverse Benefit Determination will be provided by the UM department to the individual served.

3. Eligibility Determination and Authorization for Substance Use Services

   a. HealthWest supports a "no wrong door" philosophy to treatment entry, so services can be initiated by walking into any provider (including HealthWest), or by calling the HealthWest Request for Services line.

   b. Utilization management staff will review the ASAM, TEDS, and any relevant documentation in order to determine appropriate level of care/services.

c. Further discussion may occur with the provider in order to obtain more information regarding the individual's needs.

d. The provider submits their authorization requests electronically and based on the above information, utilization management staff process these requests.

e. Authorized services are reviewed prior to the end of the authorization period and any changes or increase in service array need to be substantiated by additional clinical information provided to the UM department by the provider/clinician.

4. Services authorized are:

a. Identified and requested through the assessment and person-centered planning processes;

b. Medically necessary as defined by the Michigan Medicaid Provider Manual;

c. Based on Best Practice and Evidence-Based Practice Clinical Guidelines;

d. Documented in the Individual Plan of Service (IPOS)/Person-Centered Plan (PCP);

e. Monitored via prospective, concurrent, and retrospective review processes; and

f. Provided in the least restrictive setting.

VI. REFERENCES

Michigan Mental Health Code, Chapter 3
Lakeshore Regional Entity Contract
Balanced Budget Act of 1997
Michigan Medicaid Manual, Policy 8.3 Grievance, Appeal and Second Opinion Process for Medicaid Beneficiaries.

PB/jec