ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

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CHAPTER Access to Services		**CHAPTER** 02	**SECTION** 001	**SUBJECT** 0015
SECTION Access	**SUBJECT** Treatment Authorization			
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I. APPLICATION:

- ☐ SCCCMHA Board
- ☐ SCCCMHA Providers & Subcontractors
- ☒ Direct Operated Programs
- ☒ Community Agency Programs
- ☒ Residential Programs
- ☒ Specialized Foster Care
- ☐ SUD Providers

II. POLICY STATEMENT:

It shall be the policy of the St. Clair County Community Mental Health Authority (SCCCMHA) to ensure specialty benefit services and supports meet medical necessity criteria, and are appropriate to the conditions, needs and desires of each individual requesting service.

III. DEFINITIONS:

A. Adequate Notice of Adverse Benefit Determination (formerly known as an Adequate Action Notice): a written statement /letter advising an beneficiary after a request for services, of a decision (Action) to: limit or deny authorization of a requested services, which notice must be provided to the individual on the same date the Adverse Benefit Determination takes effects.

B. Advance Notice of Adverse Benefit Determination (formerly known as an Advance Action Notice): a written statement/letter to an individual receiving services of a decision (Action) to suspend or terminate services currently provided.

C. Adverse Benefit Determination: A decision that adversely impacts a Medicaid Enrollee's claim for services

D. Authorization of Services: The processing of a request for service delivery. All service authorizations must meet medical necessity review criteria as specified by the SCCCMHA clinical protocols and be defined in terms of amount, scope and duration. SCCCMHA has three (3) types of service authorizations:

(1) Initial Service Authorization: is a request for services for an individual new to or not in the SCCCMHA system.

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(2) Level I - Service Authorization: is a request for service for an individual who is initiating / currently receiving CMH Specialty services processed by credentialed Treatment Planning Team or Support Planning Team members. See clinical protocols and program supervisor for specifics.

(3) Level II – Service Authorization: is a request for service processed by Region 10 Access Center. Level II service authorization includes all crisis services.

D. Clinical Protocols (Service Practice Guidelines/Clinical Protocols): A set of service descriptions, which outline all services available to eligible individuals (refer to SCCCMHA's Clinical Protocols). The descriptions include medical necessity criteria for eligible clinical populations (mental illness, intellectual disability, serious emotional disturbance and co-occurring), service definitions, eligibility criteria, service settings, appropriate service providers, and typical utilization patterns.

E. Concurrent Review: Examining and evaluating the appropriateness of a service at the time of service request and throughout the period of service delivery.

F. Continued Stay Review: The process of continuing an inpatient hospitalization service beyond the authorization period or timeframe.

G. Eligibility/Eligibility Criteria: Eligibility is the determination of an individual's appropriateness for specialty services. Eligibility criteria are specified within the MDHHS specialty services contract(s); Medicaid Provider Manual–Behavioral Health and Intellectual Developmental Disability; the Michigan Mental Health Code, and SCCCMHA policy.

H. EPSDT: Early Periodic Screening, Diagnostic and Treatment Program. EPSDT services are comprehensive and preventative specialty benefit services for beneficiaries under age 21, as provided by the SCCCMHA master level Central Intake Unit in coordination with the individual's primary care physician to qualified individuals.

I. Individual Plan of Service (IPOS): A written plan of service directed by the individual, emanating from the person-centered planning process, as required by the Mental Health Code. This may be referred to as a treatment plan or support plan.

J. Medical Necessity: A term used to describe one of the criteria that must be met in order for a beneficiary to receive Medicaid services. Medical necessity means that specific services are provided to treat, ameliorate, diminish, arrest or delay the progression of symptoms, and to attain or maintain an adequate level of functioning.

K. Person-Centered Planning (PCP) / Individualized Treatment Planning (ITP): A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices, and abilities, while ensuring specialty services address their desired services, supports,

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outcomes and goals. The service (PCP, ITP) process involves families, friends, and professionals as the individual desires or requires.

L. Retrospective Review: Examining and evaluating the appropriateness of services authorized and provided for a particular consumer after the services have been rendered.

M. Service Bundling: Select groups of services available within the Medicaid Provider Manual e.g. ACT, Homebased provider system that are authorized in groups as stipulated within the Specific Benefit Plans.

N. Service Selection Guidelines: Best practice standards that guide service delivery.

O. Specialty Benefits Manager (SBM): Credentialed Master's Level behavioral healthcare professional staff within the Region 10 PIHP Caremanagement Department - Access Center who conduct system access eligibility screenings, and level-of-care determinations, referrals, service authorizations (Level II), and utilization management activities.

P. Utilization Management (UM): A set of functions and activities focused on ensuring that eligible individuals receive clinically appropriate, cost-effective services delivered according to clinical protocols, focused on obtaining the best possible outcomes.

Q. Utilization Review (UR): The Utilization Management medical record review process established to ensure that the Utilization Management Program's service standards, protocols, practice guidelines, authorization and billing procedures are adhered to by all network service providers.

IV. STANDARDS:

A. The SCCCMHA and its provider network organizations shall ensure that it complies with all service authorization requirements of the Center of Medicare and Medicaid Services (CMS), specifically 42 Part 438.210 (CFR); and the Michigan Department of Health and Human Services Contract.

B. SCCCMHA shall provide the beneficiary a written service authorization within specified timeframes and as expeditiously as the beneficiary's health condition requires.

C. The initial Intake (Biopsychosocial) Assessment must be provided as expeditiously as the individual's health condition requires, and no later than 14 calendar days following receipt of a request for services and within seven (7) calendar days following a discharge from a psychiatric unit in a hospital If the individual or provider request an extension OR if the PIHP justifies (to the state agency upon request) a need for additional information and how the extension is in the individual's interest: the PIHP may extend the 14 calendar day time period by up to 14 additional calendar days.

D. Expedited Authorization: in cases in which a provider indicates, or the PIHP determines, that following the standard timeframe could seriously jeopardize the individual's life or health or

ability to attain, maintain, or regain maximum functioning, the PIHP must make an expedited authorization decision and provide notice of the decision as expeditiously as the individual's health condition requires, and no later than three (3) working days after receipt of the request for services. If the individual requests an extension, or if the PIHP/SCCCMA justifies (to the State agency upon request) a need for additional information and how the extension is in the individual's interest; the PIHP/SCCCMHA may extent the three (3) working day time period by up to 14 calendar days.

E. Extended Standard or Expedited authorization of services decisions must be submitted to the individual in a written notice explaining the reason for the decision to extend the timeframe and informing the individual of the right to file an appeal. The PIHP/SCCCMHA must issue and carry out its determination as expeditiously as the individual's health condition requires and no later than the date the extension expires.

F. The SCCCMHA shall have procedures that define the use of service authorization throughout its provider network.

G. The SCCCMHA shall assure that each service authorization defines and specifies the amount, duration, intensity and scope of each service.

H. The SCCCMHA cannot deny or reduce the amount, duration, intensity or scope of a required, desired and medically necessary service solely on the basis of diagnosis, type of illness, or condition of the beneficiary. The PIHP/SCCCMHA may, however, place appropriate limits on a service:

1. On the basis of criteria applied under the State Plan, MDHHS Contract, such as medical necessity criteria and service selection guidelines; or

2. For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required by in Standard A., of this policy guideline (CFR 42 Subpart 438.210(a)(iii)(A)(B).

I. SCCCMHA shall have a Grievance Process (policy 02-001-0040) in place for individuals to express dissatisfaction with treatment authorizations, services, provider of services etc.

J. R-10 PIHP shall handle Appeals. See SCCCMHA Grievance Process policy (02-001-0040).

K. SCCCMHA shall permit appropriately credential Treatment Planning Team or Support Planning Team staff to complete Level I Authorization - See program supervisor for specifics.

L. Level II Authorization shall be completed by R-10 PIHP Master's Level Clinical staff.

M. Coordination of Benefits (COB). Region 10 PIHP shall be responsible for managing services associated with public Mental Health Funds. Both Region 10 PIHP and SCCCMHA must jointly

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ensure public Mental Health Funds are payer of last resort. SCCCMHA shall manage all billings and collections through third-party reimbursement.

N. SCCCMHA Utilization Management Program via its Utilization Review (UR) process shall provide oversight of authorized and implemented services to evaluate medical necessity, decision making criteria and process used to review and approve the provision of medical services.

O. SCCCMHA authorizations and services are subject to Concurrent and Retrospective UR to identify and correct Underutilization and Overutilization.

V. PROCEDURES:

Applicant

1. Contacts the Region 10 PIHP Access Center, Customer Services Department with a request for Behavioral Health services.

Region 10 Customer Services Department

2. Attains/keys into MIX database demographic and insurance information (name, address, benefit plan etc.) Immediately transfers emergency calls to SBM staff. (See Customer Services and Customer Services Department (02-002-0005)

3. Sends/forwards information (demographics, insurance, guardian etc.) to SBMs.

Region 10 Specialty Benefit Managers

4. Triages all applicant emergent situations, providing stabilization services and/or linking the applicant to any specialty benefit plan emergency service (e.g. psychiatric hospitalization, crisis residential, psychiatric evaluation, CMH clinical response, etc.), and authorizes any necessary services

5. Completes the clinical "Access Screening" which identifies a preliminary list of consumer requests/needs, and may or may not, authorize the individual as eligibility to receive an Intake (Biopsychosocial) Assessment within the SCCCMHA Central Intake Unit (CIU).

6. Refers approved Accessing Screen applicant to the SCCCMHA.

7. Informs applicant of SCCCMHA's "Open Access" system and applicant hours of operation.

8. Authorizes eligibility to receive an initial services (e.g. Biopsychosocial assessment), and any necessary Level II services as indicated.

9. Notifies applicant of option of same day intake at SCCCMHA.

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10. Refers Access Screening applicants that do not meet eligibility criteria (based on specialty benefit plan admission criteria) to the appropriate community program (e.g. MHP; Commercial Insurance; Local Agency) for services that best meet their needs.

11. Initiates a written Action Notice of Access Screening decision results and grievance process. (See Grievance Process 02-001-0040)

12. Informs applicant of his/her rights (SCCCMHA – Enrollee Rights 05-001-0020), including right to a second opinion. Note Region 10 PIHP addresses all appeals. (See Region 10 policy Appeals Process policy 07-02-04).

13. Transfers the applicant back to a Customer Service Technician for processing and follow-up.

VI. REFERENCES:

None Available

VII. EXHIBITS:

None Available