LAPEER COUNTY COMMUNITY MENTAL HEALTH **Date Issued** 09/11/2008
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CHAPTER Service Delivery	**CHAPTER** 02	**SECTION** 003	**SUBJECT** 10
SECTION Access to Services	**DESCRIPTION** Treatment Authorization		
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APPLICATION:

☒CMH Staff	☐Board Members	☐Provider Network	☐Employment Services Providers
☐Employment Services Provider Agencies	☐Independent Contractors	☐Students	☐Interns
☐Volunteers	☐Persons Served		

POLICY:

Lapeer County Community Mental Health (LCCMH) ensures all specialty benefit services and supports meet medical necessity criteria, and are appropriate to the conditions, needs and desires of each person served.

STANDARDS:

A. Service Authorization: Regulatory Standards

1. LCCMH ensures the provider network 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 requirements / Standards, and the 2013 Michigan Application for Participation (AFP).

2. LCCMH complies with the Region 10 Prepaid Inpatient Health Plan (PIHP) policy and procedures and develops internal policies and procedures that define the use of service authorization.

3. LCCMH assures each service authorization defines and specifies the amount, duration, intensity and scope of each service.

4. LCCMH 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 person served. The agency may, however, place appropriate limits on a service:

   a. On the basis of criteria applied under the State Plan or MDHHS Contract;

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

5. LCCMH may define medical necessary services in a manner that is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, MDHHS/PIHP Contract, and other State rules and policies.

B. Service Authorization: Program Standards:

1. **Authorization – Purpose:** For LCCMH, authorization of services exists to ensure appropriate services are matched with the needs and desires of the person served, and the service requested meets the medical necessity criteria specified in the PIHP's clinical protocols.

2. **Authorization – Review / Approval Criteria:** In reviewing any request for services, the "qualified" Level I authorization staff must assess all of the following prior to approving any service:

   a. The requested service is desired and needed by the person served.

   b. The requested service has been identified through the person-centered planning process.

   c. The requested service is specified in the IPOS documentation for the person served, which defines the amount, intensity, duration and scope of services.

   d. The service relates to one of the following: (CFR 438.210)

1) The prevention, diagnosis, and treatment of health impairments;

2) The ability to achieve age-appropriate growth and development; and/or

3) The ability to attain, maintain or regain functional ability.

e. The requested service is not the responsibility of any other State Plan service; or cannot be provided by the natural support system of the person served.

f. The requested service is listed as a covered service in the Services Benefit Plan of the person served.

g. The requested service meets the medical necessity and coverage criteria as specified in the PIHP's Clinical Protocols.

h. The requested service is at a level to achieve the desired support or outcome.

3. **Authorization - Emergency Services:** Crisis intervention services, if not already part of the IPOS / service authorization, should be authorized within one working day of service provision. In the event of an emergent service need for a person served that is a Level II service, the Primary Case holder / designee shall contact the PIHP by telephone for immediate authorization of necessary Level II services.

4. **Authorization - Person-Centered Planning:** The service authorization process (whether for Level I or Level II services) is an integral part of the person-centered planning process. All service authorizations must be completed in compliance with the agency and PIHP's person-centered planning policies.

5. **Level I Authorization - Staff Credentials:** All Level I service authorization staff shall meet the following requirements, prior to conducting any Level I service authorizations on behalf of the PIHP:

a. Trained and credentialed by LCCMH. Minimal training shall include: clinical protocols, utilization management and information management policies / procedures of the PIHP.

b. Credentialed by LCCMH, with the current review / privileging form on file.

c. Designated as the Primary Case holder for the person served.

6. **Authorization of Level I Services:** LCCMH ensures any requested service(s) emanating from the person-centered planning process is reviewed and approved by its designated Level I authorization staff, prior to finalization and sign-off on the IPOS. These service authorization(s) are to be documented as a part of the IPOS including scope, duration, and intensity. Should a requested Level I service not meet the medical necessity criteria of the clinical protocol, the primary case holder, acting as the credentialed (qualified) authorization staff, shall not approve or include that service within the IPOS at time of finalization, and shall immediately inform the person served of their appeal rights, providing the appropriate adequate (or advance notice) form.

7. **Authorization of Level II Services**: Level II services are centrally managed by the PIHP's Access Center. LCCMH staff will contact the PIHP Access Center via telephone to request authorization of Level II services. Level II service authorizations shall be integrated into the person-centered planning process for the person served.

8. **Person Served Appeals:** The LCCMH primary case holder will follow the agency Grievance and Appeal Policy, and procedures related to authorization denials. If necessary, the primary case holder also instructs the person served on how to contact the LCCMH Customer Services Department and/or the Region 10 PIHP Grievance and Appeal Office for advocacy assistance and/or to provide instruction / assistance on filing an appeal or recipient rights compliant.

9. **Coordination of Benefits (COB):** LCCMH, under contract with the PIHP, is responsible for managing services associated with Medicaid, State General Funds, Adult Benefit Waiver (ABW), and MI-Child dollars. Both the agency and the PIHP must jointly ensure Medicaid is payer of last resort. The agency shall manage all billings and collections through third-party reimbursement. The agency is responsible for service provision and related reimbursement collections pertaining to first and third-party payers, and must ensure appropriate assignment of credentialed network staff to maximize these billings / reimbursements. The PIHP is only liable for the net amount of any authorized service, in accordance with the agreed-upon payment methodologies contained in the PIHP / CMH sub-contract agreement.

10. **Claims Payment/Reporting.** LCCMH, in conjunction with the PIHP, shall maintain an integrated data system that is HIPAA compliant, and meets the transaction requirements of MDHHS.

PROCEDURES:

A. Initial Service Authorization:

1. The applicant Contacts the PIHP's access system for an eligibility screening and authorization for services. If necessary the LCCMH staff may assist the applicant in making this linkage.

2. The Access Center Specialty Benefits Manager completes the clinical screening, identifies a preliminary list of the individual's requests / needs, and authorizes the person for the start of specialty services.

3. The Access Center Specialty Benefits Manager refers the individual to LCCMH, providing LCCMH with the individual's demographic and clinical screening information; schedules the initial intake assessment within fourteen calendar days of referral; and authorizes initial services (e.g. bio-psychosocial assessment), and any necessary Level II services as indicated.

4. The Access Center Specialty Benefits Manager refers individuals not meeting eligibility criteria based on the specialty benefit plan admission criteria, to the appropriate community program for services best meeting their needs.

5. The Access Center Specialty Benefits Manager informs the individual of their rights, including right to a second opinion if not meeting access eligibility, by following PIHP Grievance / Appeals policy.

B. Level I Service Authorization:

1. The LCCMH staff credentialed for Level I authorizations completes the initial Biopsychosocial Assessment (BPS) on the referred individual within fourteen calendar days of referral from the PIHP. Following the initial BPS Assessment a final eligibility determination is made. If the individual is eligible for services the person centered planning process begins. If the individual is found not eligible they are referred to an appropriate community provider and informed of the appeal process by providing Advanced Notice.

2. The LCCMH staff credentialed for Level I authorizations starts the person-centered planning process and the IPOS within 14 days of initial BPS.
3. The LCCMH staff credentialed for Level I authorizations authorizes any additional assessments; and any medically necessary Level I services within the IPOS.
4. The LCCMH staff credentialed for Level I authorizations informs the individual of their appeal and grievance rights.
5. The LCCMH staff credentialed for Level I authorizations assures review of the Level I authorizations through the periodic review process and the annual development of a new IPOS including service authorization every 365 days.

C. Level II Service Authorization

1. The LCCMH assigned staff contacts the Region 10PIHP Access Center via telephone to process any Level II Authorizations.
2. The Access Center Specialty Benefits Manager receives Level II service requests via telephone from the LCCMH assigned staff and reviews Level II service requests using the established criteria.
3. The Access Center Specialty Benefits Manager authorizes or denies the service request.
4. The Access Center Specialty Benefits Manager enters authorized services into the data system.
5. The LCCMH assigned staff informs the individual of their appeal rights should any desired service be denied authorization.

DEFINITIONS:

Adequate Notice: A written statement advising the Enrollee of a decision to deny or limit authorization services requested (not currently provided), of which the notice must be provided to the Enrollee at the time of the action affecting the claim (*42 CFR 438.404 (c)(2)).*

Advance Notice: A written statement advising the Enrollee of a decision to reduce, suspend or terminate previously authorized/currently provided Medicaid services. Notice must be provided/mailed to the Medicaid Enrollee at least ten (10) calendar days prior to the proposed effective date.

Authorization: Service authorization is a process designed to help assure planned services meet medical necessity criteria and are appropriate to the conditions, needs, and desires of the individual. Authorization generally occurs before services are delivered, but may occur at some point during service delivery or after services have been delivered in cases of emergent situations. In all situations, all service authorizations must meet PIHP medical necessity review criteria as specified in the clinical protocols. For LCCMH, there are **three** types of service authorizations:

1. Access – Initial Service Authorization: The function performed directly by the PIHP that determines (a) the individual is eligible for specialty benefit services; and (b) authorizes the start of specialty services, including the initial intake, any Level II services, and (c) commencement of the person-centered / treatment planning process.

2. Level I - Service Authorization occurs: (a) as part of and as an outcome to the person-centered planning process, (b) for services meeting the medical necessity criteria of the PIHP's clinical protocols, and (c) for services specified by the primary case holder in the Individual Plan of Service.

3. Level II - Service Authorization: The function performed directly by the PIHP prior-authorizes all requested Level II services emanating from the person-centered planning process, meet the medical necessity criteria of the PIHP's clinical protocols, and are specified in the Individual Plan of Service.

Clinical Protocols: A set of service descriptions, which outline all services available to eligible persons served. The descriptions include service definitions, eligibility criteria, service settings, appropriate service providers, and typical utilization patterns. The clinical protocols are routinely updated to reflect consistency with utilization findings (utilization trends, successful clinical outcomes / best practices) and service purchaser contracts, such as Medicaid.

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

Continued Stay Review: The process of continuing a service beyond the authorization period or time frame.

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); MSA Medicaid Chapter II Manual; the Michigan Mental Health Code, and PIHP Policy. Eligibility criteria are applied as a clinical screening template to determine the prospective applicant's eligibility for specialty services.

EPSDT (Early Periodic Screening, Diagnostic and Treatment Program): EPSDT services are comprehensive and preventative specialty benefit services for individuals under age 21, as provided by the PIHP / provider network in coordination with the primary care physician to qualified individuals.

Individual Plan of Service (IPOS): A written plan of service directed by the person served, 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.

Medical Necessity: The criteria by which a credentialed professional determines the provision of medically-appropriate health care suitable for a particular individual, condition, occasion, and place. Medical necessity assures that services are provided to treat, ameliorate, diminish, arrest or delay the progression of symptoms, and to attain or maintain an adequate level of functioning. The determination of medically necessary services is based upon the outcomes derived from the person-centered planning process, and the established clinical protocols and service selection guidelines of the PIHP.

Person-Centered Planning (PCP): A process for planning and supporting the person receiving services that builds upon the capacity of the person served to engage in activities that promote community life and honor the preferences, choices, and abilities of the person served, while ensuring specialty services address their desired services, supports, outcomes and goals. The person-centered planning process involves families, friends, and professionals as the person served desires or requires.

Service Selection Guidelines: Best practice standards guiding service delivery, based on the status of professional knowledge and understanding of which service and support interventions work best under identifiable person served, family, and community circumstances, within existing resources. These are developed for uniform application

within the PIHP provider network, providing service and support to persons served within PIHP jurisdiction, and adherence to the MDHHS Contract requirements.

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

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

Utilization Management (UM): The care management system which consists of a set of functions and activities focused on ensuring eligible persons receive clinically appropriate, cost-effective services delivered according to clinical protocols, focused on obtaining the best possible outcomes.

Utilization Review (UR): A medical record review process established to ensure all network service providers adhere to the PIHP's Utilization Management Program's service standards, protocols, practice guidelines, authorization and billing procedures.

REFERENCES:

PIHP Typical Levels of Service by Benefit Plan
MDHHS Contract Requirements and Standards
Center for Medicare and Medicaid Services (CMS) guidelines
Medicaid Regulations

BS/lr

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This policy supersedes
#09/08042 dated 09/11/2008.
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