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Mid-South Substance Abuse Commission Policy and Procedures		History	
Policy Number:	Subject/Title:	Replaces:	July 2003
Q004	Utilization Management	Last Reviewed:	6/2009
Issued By:	Approved By:	Effective:	06/22/2009
Executive Director	Board of Directors Date: 06/22/2009	All Contracted Providers	

## 1. POLICY

Mid-South assures appropriate substance use disorder treatment services are provided to clients through its use of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, Second Edition Revised (ASAM PPC-2R) and Mid-South's Best Practice Guidelines by providers. Mid-South reviews, approves, pends, or denies initial and re-authorization requests according to federal, state, and local guidelines, policies, and timeliness standards.

## 2. PURPOSE

This policy describes Mid-South standards, requirements, structures, and processes necessary to ensure the efficient, effective, and appropriate utilization management of substance use disorder treatment services. Mid-South monitors to assure clients receive services that are medically necessary, appropriate as to type, frequency, intensity, scope and duration, and are consistent with the clients' needs and desires. Mid-South's Care Coordination Center (CCC) analyzes patterns of service authorization decisions to ensure services provided to clients at a given time are appropriate.

## 3. PROCEDURE

- 3.1. CCC and contracted treatment providers will adhere to the ASAM PPC-2R and Mid-South's Best Practice Guidelines to determine appropriate level of care.
- 3.2. Mid-South's Best Practice Guidelines are updated through ongoing interaction of CCC staff, providers, and Medical Director. Requests for initial authorizations and reauthorizations are sent to CCC through the CareNet system. Requests are reviewed for intensity, scope, duration, frequency, and justification with submitted evidence. If there is a meaningful discrepancy in the submission, a request for a medical review by Mid-South's Medical Director is may be generated. Requests to the Medical Director for review or assurance of a decision may be made through verbal contact if the request has the client at risk, or made in writing and faxed to the Medical Director for review and recommendation. Providers are informed of the Medical Director's recommendation accordingly, taking no longer than 14 days of the authorization request.
- 3.3. The CCC considers at least the following when applying criteria to a given client: age; co-morbidities; complications; progress of treatment; psychosocial situation; home environment; availability of alternative levels of care, such as intensive outpatient programs, outpatient detoxification programs, or residential treatment centers to support the client; coverage of benefits for alternative levels of care, such as intensive outpatient programs, detoxification programs, or residential treatment centers, where needed; and ability of providers to deliver recommended services within the estimated length of stay. Utilization management criteria are reviewed and updated by the Medical Director and Mid-South staff at least annually.
- 3.4. To ensure accuracy and consistency of utilization management/service authorization decisions, providers' clinical supervisors are responsible for overseeing and periodically reviewing the utilization decisions made by their staff. Any utilization management decisions to deny, reduce, suspend, or terminate services will be made by staff with appropriate clinical competencies.
- 3.5. CCC reviews initial and re-authorization requests and responds according to the timelines posted in Mid-South's Standards for CareNet Entry. If requests reviewed by CCC are not justified with

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evidence, and/or do not meet medical necessity, and/or do not provide the intensity, scope, duration, and frequency; or a particular level of care is inappropriate as written in the request for authorization, the CCC may ask for the clients' assessment/assessment update, treatment plan(s), treatment plan review(s), or other documentation, such as urine drug screens (UDS) as necessary to make a determination. In cases of clinical concern, Mid-South's Medical Director will review the request and provide recommendations to the CCC who will forward the recommendations to the provider.

- 3.6. The clinical administrative information to be reviewed by CCC includes, but is not limited to, the following: history of the presenting problem, office and hospital records, clinical exam, diagnostic testing results, treatment plans and progress notes, patient psychosocial history, printed copy of criteria related to the request, information regarding benefits for service or procedures, and client characteristics and information.

#### 4. ACCESS

- 4.1. CCC staff is available for utilization management from 8:00 a.m., to 5 p.m., Monday through Friday during normal business hours. Inbound communication from providers regarding utilization management issues after normal business hours is available by voice-mail or e-mail message. The CCC has a toll-free number and ability to accept collect calls regarding utilization management issues. The CCC is accessible to callers who have questions about the utilization management process.
- 4.2. Client calls to the CCC are transferred to the provider via warm transfer while the client remains on the phone and the CCC transfers the call to the provider. The client, CCC, and provider representative conference to screen the client and schedule an assessment appointment.

#### 5. APPROVED, PENDED, OR DENIED AUTHORIZATION REQUESTS

- 5.1. Authorizations may be approved, pended, or denied by the CCC as follows:
- 5.1.1. When approved, CCC enters the beginning and ending dates of authorizations, approving the level of care requested by the provider.
- 5.1.2. Authorizations may be pended for lack of justification to enter a client into treatment or continue in treatment. If pended, the CCC writes in the comment box at the bottom of the authorization request form that certain information is missing (such as amount, scope, duration, frequency, evidence, etc.) and asks questions to obtain information that was not provided. Providers are to respond within timeliness standards as noted on the Standards for CareNet Entry. If a provider response is not returned to the CCC within the timeline specified in the standards when approved, the authorization request begin date will be the date the authorization was received by the CCC.
- 5.1.3. Authorizations may be denied if provider response information to a pended authorization continues to lack justification or if there is no justification for treatment services whatsoever.
- 5.1.4. If an authorization for a level of care is denied by the CCC, the Medicaid and/or ABW (MA/ABW) client must be notified. The CCC will notify the provider (if applicable) and the MA/ABW client of the action to be taken. A Notification of Service letter is sent to the MA/ABW client through the treating therapist (if the MA/ABW client is still in therapy) or sent to the MA/ABW client in the mail if not in therapy. If the provider and/or the MA/ABW

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client disagrees with the decision made by the CCC there are several options for additional review:

- 5.1.4.1. The notification of denial of services sent to the MA/ABW client will provide information on how to file a Recipient Rights complaint in accordance with the grievance process specified in the Administrative Rules for Substance Abuse Programs in Michigan, Part 3, Client Rights, Section R 325.14303.
- 5.1.4.2. The notification of denial will include information on how to request an Administrative Hearing and inform the MA/ABW client of his/her right to representation.

## 6. APPEAL PROCESS

- 6.1. There are extenuating circumstances that arise that keeps authorization requests from being submitted timely, such as flooding, car accident, power outages, CareNet system problems, immediate staff termination, employee resigns without notice, unexpected lengthy illness (4+ days), the client is in jail, etc. The CCC works with providers in these situations.
- 6.2. The following are some circumstances, not all inclusive, of reasons that will NOT be accepted: staff vacation, sick leave up to and including 3 days, losing track of the number of sessions for re-authorizations, clinician resigns with notice, clinician forgot to do the initial/re-authorization request on time, clinician forgot to check to see if there were available units from current authorization, client missed sessions, part-time employment of the clinician, data entry clerks not receiving CareNet information from clinicians in a timely manner, et.al. Approval in these circumstances will be with an effective date corresponding to the Request Date auto-completed by CareNet in the top section of the initial/re-authorization request screen. Pended requests that fall outside of the response time without adequate explanation will be dated from the date in which the pended response was received by the CCC. This is the same for each subsequent pending.
- 6.3. To assure provider/clinical directors are aware of the nature and extent of requests for extensions and changes to initial/re-authorization dates, the provider/clinical director is to review requests internally first. If a provider/clinical director wishes to appeal a CCC approval/denial, the following is to be applied:
  - 6.3.1. Therapist discusses the request for change(s) with his/her provider/clinical director.
  - 6.3.2. Providers wishing to appeal the decision to set the effective date to a date other than that requested by the provider should type a note beginning with "CCC:" requesting the change(s) on the CareNet Notes page. This request must be submitted within seven (7) calendar days of the Authorization Comment date stamp.
  - 6.3.3. The CareNet Notes page is printed and signed by the provider/clinical director and faxed to the CCC at (517) 853-0496.
  - 6.3.4. The request is reviewed and a determination is made. If approved, the CCC will apply the change(s) on the initial/re-authorization request. If not approved, the UC will inform the therapist of the response with a note beginning with "**Response:**"
  - 6.3.5. If the provider/clinical director are dissatisfied with the determination, the provider/clinical director may contact the CCC Manager, at 853-0495, extension 111.
  - 6.3.6. If still dissatisfied, the provider/clinical director may contact the Executive Director, at (517) 337-4406, extension 114.

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## 7. QUALITY MONITORING

- 7.1. The CCC staff monitor the number of approved, pending, and denied authorizations monthly. Pending and denied authorizations are noted as clinical, non-clinical, or both. If there are 15% or more clinical pendings and clinical denials, or trends are noted; or if there are more than a combined percentage of 21% clinical and nonclinical pendings and clinical and nonclinical denials, CCC staff will provide technical assistance by requesting provider staff meet with CCC staff and review provider processes, definitions, answer any questions, and clarify misinterpretations. The provider will be asked to submit its corrective action plan to reduce the number of pending and denied authorizations to CCC. If the provider continues to have 15% or more pending/denied authorizations or an adverse trend continues (whether the same or a different one), the concern will be brought to the attention of Mid-South's quality management team. The concern may be taken to the Program Development Committee. The Program Development Committee may consider putting the program on probationary status or suggest corrective action as necessary.
- 7.2. Mid-South will hold Utilization Review meetings whenever there is need to review for consistency of application of utilization management decision criteria, implementation of corrective actions when necessary, or there are concerns with provider authorization-related trends, misuse of guidelines, and/or the number of pending/denied authorizations is 15% or higher.
- 7.3. CCC staff monitors quality of provider services by scheduling a visit at the provider site and reviewing authorizations, treatment plans, progress notes, discharges and the client's continuum of care plan. Review is on overall quality treatment services based on the client's individual needs and continuum of care. At the same time, CCC staff answers questions and provide technical assistance on immediate provider needs, and schedule future meetings to discuss, review, and clarify other provider concerns.
- 7.4. Mid-South will track provider complaints to the utilization management process at least annually through the number of provider appeals. CCC will distribute satisfaction surveys to providers to gather provider feedback.

### References:

ASAM Patient Placement Criteria, Second Edition Revised  
Mid-South Best Practice Guidelines  
Administrative Rules for Substance Abuse Programs  
Mid-South Standards for CareNet Entry  
Notification of Service Letter