BAY-ARENAC BEHAVIORAL HEALTH
POLICIES AND PROCEDURES MANUAL

Chapter: 04	Care and Treatment		
Section: 4	Eligibility and Utilization Management		
Topic: 36	Authorization Process		
Page: 1 of 9 Affiliation CEO Approval Date: 4-3-02	(BABH) Supersedes: Pol: 8-21-03, 6-20-02 Proc: 6-18-18, 5-15-15, 12-18-08, 8-21-03, 6-20-02	(BABH) Date: Pol: 12-18-08 Proc: 6-1-2021	*Board Chairperson Signature* *Chief Executive Officer Signature*
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Policy

It is the policy of Bay-Arenac Behavioral Health (BABH) that uniform screening procedures be implemented for purposes of promoting access to services, determining benefit eligibility, and evaluating medical necessity for the provision of specialty mental health and substance use disorder services.

Purpose

This policy and procedure is established to detail prior, concurrent, and retro authorization processes used for managed care operations.

Applicability

☐ All BABH Staff
☐ Selected BABH Staff, as follows:
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: LIPs, Primary Care and Substance Abuse
☐ Policy Only ☒ Policy and Procedure
☐ Other:

Definitions

N/A

Procedure

1. The Access Center will authorize initial service. The Access Specialist will determine, based on the information gathered, if the person's request for services is consistent with applicable Procedures and Protocol. The amount of information obtained may vary depending on the type of review.

2. To obtain Authorized services, the primary case holder (PCH) will complete an Authorization Request via the Electronic Health Record. The authorization request for all services will be directly reflected in the Individual Plan of Service (IPS). Services that are requested over a pre-determined threshold will need approval by either Access Clinical Specialist, Access Team Leader, Program Manager, or Director. Approving individual will review the authorization request to ensure that it is consistent with applicable procedures and the Clinical Protocol for that service and meets medical necessity.

3. Should the BABHA Provider Network be unable to provide the necessary services being requested for a particular person who meets medical necessity criteria for the requested specialty mental health services and would be covered under the Medicaid contract, Michigan Department of Health and Human Services (MDHHS) Specialty Services Contract, Administrative Rules for Substance Use Disorder Services in Michigan or the Michigan Mental Health Code, Access Center will ensure adequate and timely access to those services from an out of network provider.

4. It is expected that the Access Center and the out of network provider will coordinate with respect to payment to ensure the cost to the person is no greater than his/her established Ability to Pay (ATP).

Authorized Services

To obtain authorized services, the PCH completes an Individual Plan of Service and submits an authorization request via the electronic health record (EHR). Authorization requests must be submitted in conjunction with the annual Individual Plan of Service (IPS) or IPS addendum; authorization dates should correlate with effective dates on the Individual Plan of Service (IPOS). The PCH is responsible for requesting all services the individual is receiving. By doing this, the PCH acts as the gatekeeper for all services for the individual regardless of the service provider.

Access Center will be reviewing authorization requests made by external contractors that are over a pre-determined threshold; in addition, they will be authorizing all DBT services. Access Clinical Specialist will review the request to ensure that the services requested are consistent with the protocols for that service. If the request meets the protocol, the authorization will be approved. If problems are identified, the authorization request will not be approved.

1. Additional units of the same service may be requested if it appears that all currently authorized units of that service will be used prior to the lapse date and that more will be needed until the next IPS. This information should be reflected in the request and requested dates of services should be coordinated with the annual IPS.

2. To ensure that individual's needs are being met, authorization of a new service may occur any time an IPS is modified via an IPS addendum.

3. Any provider of an "authorized" service, after following the appropriate procedure that resulted in the original referral of the persons to their service delivery system, may provide any array of "authorized" services to him/her within the parameters of the relevant clinical protocols with the only stipulation being that the services be determined through the Individual Plan of Service process. These service requests are screened for appropriateness by the assigned PCH for the person.

4. The process for the issuance of Standard and Expedited authorization decisions is covered in BABH Policy and Procedure C04-S04-T37Enrollment, Screening and Referral.

5. Whenever units of a specific service are not completely used by the ending date of the applicable authorization, the remaining units are considered expired/void. Services must be provided within the timeframe established by the Authorization. All providers have access to view authorizations in the BABH EHR system.

6. If the individual fails to meet the medical necessity for the requested services, where such criteria have been established, a determination will be made as to whether he/she meets criteria for any other services and if these services are so desired by the individual. The Access Clinical Specialist will assist the PCH in determining what services may be appropriate to meet both the Individual's Plan of Service and related clinical needs.

7. Denial of an authorization may occur if the individual no longer meets criteria for specialty mental health services, the individual's needs do not meet Medicaid service criteria (via the Medicaid Provider Manual) for the service requested, or as the result of a records review (retrospective review). If a service request is denied, the provider or individual will be notified and alternatives may be suggested. The individual has the right to use the appeal and grievance procedures. Denials will be processed in accordance with established Customer Services procedures and guidelines.

8. If needed, Access Department provides for the opportunity of a second opinion from a qualified health care professional within the network, or Access may arrange for the person to obtain a second opinion from outside the network based on his/her Medicaid eligibility or at a cost based on his/her calculated ATP. It is expected that Access and the out of network provider will coordinate with respect to payment to ensure the cost to the person is no greater than the person's established ATP.

9. If a service is approved but the time frame or number of units is outside of service authorization threshold values, the case may be subject to a retrospective case review. The Access Staff approving the services shall refer the case for review to the Access Team Leader.

10. There also may be periodic retrospective reviews for authorized services based upon the schedule and guidelines for initial length of stay/continuing stay criteria included in the protocol for each specific service.

11. It is the responsibility of the providers to keep track of the authorized units they have used. Services provided without proper authorization may *not* be reimbursed. Claims submitted that do not meet criteria, as outlined in BABH Policy and Procedure Claims Submission and Reimbursement, Provider Education, are subject to being denied or being placed in a “Pended” status.

Urgent/Emergent Services

1. The prescreening unit of the responsible Community Mental Health Services Program (CMHSP) determines initial authorization for Emergent services. Access/Emergency Services will issue the LOA to the provider identified in the prescreening documentation.

2. The Access Center will complete concurrent reviews on CMHSP sponsored individuals admitted into inpatient, crisis residential, or Crisis Stabilization programs. The decision regarding continued authorization of care will be based on provider information, changes in the relevant LOCUS and CALOCUS indexes, and the clinical criteria defined in the MDHHS Mental Health Service and Selection Guidelines for high acuity conditions.

3. Any denials of Emergent services based upon a concurrent review will be communicated immediately to the provider via phone or within one working day of the decision. This notification will include identification of a least restrictive, alternative care option that is currently available for the situation in question.

4. The individual and the provider organization will be informed of his/her option to appeal any denials of care resulting from a utilization management decision. The individual is informed of multiple appeal options including (1) the Internal CMHSP Grievance process, (2) the MDHHS Office of Recipient Rights, (3) the Medicaid Fair Hearing process or alternative dispute resolution process, and/or (4) reconsideration by the Medical Director. The provider agency is informed of its option to appeal any such denial of care through the BABHA Medical Director and the CMHSP Board Executive Director. (see BABH PP C03-S08-T07 Appeals and Grievance Procedural Processes)

Ancillary Service Authorization Process:

1. **Verification of Prescription** for Ancillary Service(s): determine if there is evidence in the EHR of a valid prescription specific to the requested ancillary service(s) that is signed and dated by the PHCP.
   i. Verify the **date range of the script** matches the IPOS/authorization.
   ii. If there is no prescription in the EHR, the Primary Caseholder should coordinate obtaining the prescription form with the family and/or PHCP.
   iii. If you are not able to obtain a prescription for the services, put a **note in the authorization request.** Ancillary Service requests will not be approved without a current and valid prescription in the EHR, but the authorization request must be submitted to allow for denial due process.

2. V**erification of Evidence of Medical Necessity-** The Primary Caseholder will conducts a chart review to include:
   i. Is the need for the ancillary service identified in the clinical assessment?
   ii. If available, does the most recent professional assessment(s) identify treatment needs and recommendations for the ancillary service(s).
   iii. Is there evidence in other EHR documentation to support the request for additional services (primary case holder and/or other service providers)?
   iv. ABA consumers – Does the ABA evaluation recommend ancillary services. *If "No", please consult with program leadership (Manager, Team Leader).

3. **Authorization:** Once the above steps are completed, the Primary Caseholder shall complete the usual process to create the authorization in Phoenix. The Primary Caseholder should add details to the note section of the authorization if there is not sufficiently evidence to support the request.

4. **Renewal of Approved Service authorization**- The Primary Caseholder will conducts a chart review to include:
   i. Professional assessment (OT/PT/SLP): Does the current assessment provide evidence of clinical justification/medical necessity?
   ii. Authorization details: Does the authorization fall in the parameters of the clinical justification/recommendations of professional in the most recent assessment.
   iii. Ancillary service documentation: Do the ancillary notes provide evidence that progress is being made? If not, do the notes reflect the barriers and the planned changes to interventions?
   iv. Previous authorizations: Review previous authorization utilization.

5. **Consultation:** The Primary Caseholder should consult with the Team Leader or Program Manager regarding:
   i. AAC (speech communication device) authorizations
   ii. Authorizations requests (units/frequency) that are not supported by the professional's documentation (assessment/notes).
   iii. Authorization requests (units/frequency) that is "Over the Threshold" of the allowed parameters.
   iv. ABA consumers being referred for ancillary services that are not recommended in the ABA evaluation.

6. **Denial of Service**:
   i. If the clinical documentation does not provide evidence of medical necessity and/or a valid prescription for the requested ancillary service is not obtained, the Primary Caseholder should add these details to the "Note" section of the

authorization request. Access will deny the authorization request and send an ABD notice to the consumer (and the primary caseholder).

ii. If the authorization request is for a consumer receiving ABA services, Access will consult with the Psychologist prior to denying the request.

Attachments

N/A

Related Forms

N/A

Related Materials

N/A

References/Legal Authority

1.) BABH Policy and ProcedureC04-S04-T34 Access and Eligibility for Specialty Mental Health Services. ,
2.) BABH Policy and Procedure C04-S04-T36Enrollment, Screening, Referral and Authorizations
3.) BABH Policy and ProcedureC04-S04-T39, Utilization Management Structure
4.) BABH Policy and Procedure, Claims Submission and Reimbursement, Provider Education
5.) BABH Policy and Procedure C03-S08-T07 Appeals and Grievance Procedural Processes
6.) Medicaid Provider Manual, l Behavioral Health Chapter
7.) MDHHS Mental Health Code, Revised2001.
8.) MDHHS/MSHN (PIHP) Managed Specialty Supports and Services Contract: Section 4.0 and related attachments
9.) 42 CFR 438.206(b)(3)(4)(5)

SUBMISSION FORM

AUTHOR/ REVIEWER	APPROVING BODY/COMMITTEE/ SUPERVISOR	APPROVAL /REVIEW DATE	ACTION (Deletion, New, No Changes, Replacement or Revision)	REASON FOR ACTION - If replacement list policy to be replaced
J. Hahn	C. Pinter	09/19/08	Revision	Update and review
N. Kulhanek	C. Pinter	05/05/14	Revision	Updated to reflect current practice
N. Kulhanek J. Hahn	C. Pinter	05/15/15	Revision	Numbering scheme/section change, updated referenced PP numbers, updated to reflect current process Was 11-4-4, now 4-4-36.
S. Krasinski K. Moore		6/8/18	Revision	Review. Update process change.
J. Hahn		6/1/2021	Revision	Added Ancillary Service Authorization process.