

NORTHCARE NETWORK

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PURPOSE

The NorthCare authorization policy is designed to ensure that services delivered according to person-centered planning meet eligibility and medical necessity criteria and are appropriate to the conditions, needs and desires of the individual. Medical necessity criteria for those with a serious mental illness or developmental disability have been established by the Michigan Department of Community Mental Health and are located in the Medicaid Provider Manual in the chapter on Mental Health/Substance Abuse Services. Eligibility criteria and service authorizations for Substance Abuse Services are covered in the NorthCare Substance Abuse Services Provider Manual located on the NorthCare website: www.northcare-up.org. Service authorizations provide NorthCare with utilization management data to ensure that the provider(s) will be able to meet service demands in a timely way. Service authorization data also ensures that NorthCare will be able to manage the costs associated with the provision of specialty behavioral health services and supports for those members with a serious mental illness, serious emotional disturbance, developmental disability, or substance abuse disorder.

POLICY

This policy is applicable for NorthCare and all affiliate providers. Refer to the NorthCare Substance Abuse Services Provider Manual for detailed information regarding authorization procedures for substance abuse services.

Acute inpatient psychiatric care requires ongoing authorization from NorthCare; all other services are authorized at the local provider level. Community Mental Health Specialty Programs (CMHSPs) must have an authorization process in place that is consistent with this policy and the NorthCare Utilization Management Plan, as the responsibility for service authorization has been delegated to them. Oversight and monitoring activities by NorthCare will occur as outlined in this policy.

PROCEDURES

NorthCare maintains a direct referral system to providers operating under sub-capitated contracts for Medicaid consumers who request access to specialty mental health services. Providers, including the NorthCare Substance Abuse Provider Network, must assure Medicaid consumers are not held liable for services authorized by them including payment for a second opinion should that be necessary. NorthCare's Access policy and Clinical Management Criteria (located in the UM Plan) should be used to guide eligibility and service authorization decisions.

A. Services Authorized by the CMHSPs:

- 1. Crisis services:** are available to any individual in need and do not require prior authorization. There is no payment required of the individual receiving a crisis intervention service.

- 2. Outpatient services and residential treatment services:** are authorized at the local provider level. After a consumer receives a clinical assessment and an initial Plan of Service, the eligibility criteria and level of care are submitted to NorthCare through the Data Warehouse. The specific services and supports to be provided within any level of care are determined through the person-centered planning process and authorized by the provider. Standard reports reviewing over and under utilization of services will be submitted as determined to NorthCare. Chart audits conducted by NorthCare will monitor the degree to which services outlined in the PCP have been provided and will also determine whether services not identified in consumers' plans were provided. Reviews conducted on random samples of the plans of service will assure that providers are delivering services consistent with the needs and outcomes defined by the PCP process.

- 3. Out of Home CMHSP Area Service Requests:** The five (5) participating CMHSPs apply uniform eligibility criteria and are able to arrange and authorize services across county of residence boundaries. Both NorthCare and the five (5) CMHSPs have the responsibility to inform the member of their rights to grieve and to a fair hearing if they disagree with the scope, duration or intensity of the services provided. When consumers initiate contact with a CMHSP outside of their area, they will be informed of the services offered in their local community. When possible, the consumers will be directed to their local CMHSP.
 - If consumers are explicit in stating they do not want services from the home CMHSP, they will be informed of available options and may make a choice as to where to receive office-based services.
 - The specific guidelines for authorization and payment procedures are outlined in the NorthCare Board of Financial Responsibility Plan (effective 10-05) and the companion protocol for implementation (effective 10-05).

- 3. Out of Region (Out of Network) Requests for CMHSP/SA Services:** These will be arranged by the individual's home CMHSP/NorthCare SA Service Provider. Currently, each CMHSP/NorthCare SA Service Provider has the authority to contract for any specialty service required outside its established network. The CMHSP may not require payment by a Medicaid consumer for authorized services provided out of network. NorthCare will be a resource for both the authorizing entity and the consumer for locating and accessing any specialty service out of the region.

B. Psychiatric Inpatient Services Authorized by NorthCare

1. All Inpatient psychiatric services, except those provided in state facilities, require authorization from NorthCare beyond the initial day(s) of admission authorized by the local affiliates during the pre-admission screening process. The provider will submit the pre-admission screening information to NorthCare within one working day of the date of admission (preferably by 10:00 AM EST.) If the admission is to Marquette General Hospital, NorthCare staff will conduct the continuing stay reviews. For all other hospitals, the CMHSP responsible for the hospitalization will designate staff to conduct the continuing stay reviews.
 - a. **Marquette General Hospital Admissions:** Upon receipt of the preadmission screening, NorthCare staff will conduct a review and establish a length of stay according to severity of illness and intensity of service needs. A continuing stay review cannot be conducted unless pre-screen is received by 10 AM EST the next working day. Continuing stay reviews are conducted as clinically necessary and are submitted electronically to the CMHSP responsible for discharge planning, aftercare and follow up services. NorthCare will issue an authorization for payment and provide notice of appeal rights to the consumer based on the concurrent review. A Medicaid consumer may not be billed by the provider if the inpatient service is denied by NorthCare.
 - b. **All Other Hospital Admissions:** The CMHSP responsible for the hospitalization will submit an authorization request to NorthCare based on the CMHSP continuing stay review. Authorization requests need to be completed in a timely manner to ensure the adequate notice requirements are met. Once the authorization information has been submitted to NorthCare, NorthCare will issue an authorization for payment to the hospital and the consumer and provide notice of appeal rights to a Medicaid consumer. A Medicaid consumer may not be billed by the provider if the inpatient service is denied by NorthCare. If hospitalization is medically necessary beyond the authorized days, the CMHSP staff will request another authorization and the above process would repeat. Each CMHSP shall designate one contact person who is responsible for ensuring this process occurs with every non-MGH hospital admission.
2. **Service Authorization relative to claims management:** After the pre-admission screening is received by NorthCare and the continuing stay review occurs, a length of stay authorization is electronically registered. Claims for inpatient days are to be submitted directly to NorthCare, and these claims are entered and checked against authorizations previously registered. As each CMHSP operates under a subcapitated arrangement with NorthCare, a notice will be sent to the responsible CMHSP indicating the amount to be paid to the provider of inpatient services. Payment to the inpatient facility is expected within 30 days of the date the bill is received by NorthCare.

- C. Staff qualifications:** As a minimum, NorthCare's PIHP Utilization Management personnel will have a master's degree with the appropriate State of Michigan or

national certification or licensure and a minimum of three years of clinical experience. Utilization management functions delegated to the CMHSP will be staffed according to 42CFR 438, Subpart D, Section 438.210(b) (3) which states:

That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has the appropriate clinical expertise in treating the enrollee's condition or disease.

- D. Assurance of Receipt of Necessary Services:** It is NorthCare's policy that the authorization process shall not prevent or delay the provision of necessary services to the consumer. Initial authorizations for inpatient care are provided by the local CMHSP to assure that necessary services are not delayed by the authorization process. Crisis Support Services require no authorization and providers are held to specific time requirements for responding to emergent and routine requests for services, monitored via QI Performance Indicators.
- F. Appeal Mechanisms:** It is expected the local CMHSP appeal processes are consistent with the NorthCare Consumer Grievance and Appeals Policy. At the time a plan of service is developed, consumers/guardians are asked to sign the plan. The consumer must receive a written copy of the treatment plan within 15 days of its signing. The consumer /guardian must be given adequate notice of their grievance and appeal rights at the time the treatment plan is signed or when the written copy is given to the consumer. The adequate notice includes information regarding the right to a second opinion. This notice shall include information regarding their right to appeal any decisions made as a result of utilization review/service authorization, and also provides the name and number of the provider recipient rights/customer service staff available to assist them in the appeal process. Denial of service notices issued to consumers are monitored at the NorthCare level and quarterly reports are reviewed by the NorthCare UM committee. Provider appeal mechanisms are covered either within the individual contract or in the policy: Provider Network Selection, Management and Appeal Mechanisms.
- G. Impact of Service Authorizations:** NorthCare reviews encounter data that summarizes the type and frequency of services provided. The analysis of the data allows NorthCare to determine whether the full service array is being offered to Medicaid consumers. If there are concerns about access or ongoing services, these concerns are directed to the NorthCare Utilization Management Committee and the NorthCare Quality Council. Provider performance on UM indicators as defined by the NorthCare UM committee will be examined within the QI process.

REFERENCES

Federal Code of Regulations, Volume 42, Part 438, Subpart D
MSA Medicaid Provider Manual, Chapter on Mental Health/ Substance Abuse Services
Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program

Contract FY03-04 including both Amendments
Medicaid Subcontracting Agreements with the Five Upper Peninsula CMHSP
NorthCare Utilization Management Plan
NorthCare Substance Abuse Services Provider Manual
NorthCare Policies
NorthCare Board of Financial Responsibility Plan (10-05) and Board of Financial
Responsibility Protocol (10-05)