St. Clair County Community Mental Health
Providing Opportunities for Health, Wellness, & Connection

Administrative Policy

Policy Title: **Treatment Authorization**

Policy #: **02-001-0015**

Effective Date:	01/29/2025
Approved by:	Telly Delor, Chief Operating Officer
Functional Area:	Access to Services
Responsible Leader:	Kathleen Gallagher, Chief Clinical Officer
Policy Owner:	Kristen Thompson, Adult Services Director
Applies to:	All SCCCMH Staff, Directly Operated Programs, Network Providers, Contractors

Purpose: It is the purpose of St. Clair County Community Mental Health to ensure specialty benefit services and supports meet medical necessity criteria and are appropriate to the conditions, needs and desires of each individual requesting services.

I. Policy Statement

It is the policy of St. Clair County Community Mental Health (SCCCMH) 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.

II. Standards

A. SCCCMH 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. A written determination in response to a request of policy exception shall be completed in a timely manner.

B. SCCCMH 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 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 (10 days for CCBHC) 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 daytime 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/SCCCMH justifies (to the State agency upon request) a need for additional information and how the extension is in the individual's interest; the PIHP/SCCCMH may extent the three (3) working daytime 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/SCCCMH 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. SCCCMH shall have procedures that define the use of service authorization throughout its provider network.

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

H. SCCCMH 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/SCCCMH 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 administrative procedures' guideline (CFR 42 Subpart 438.210(a)(iii)(A)(B).

I. SCCCMH shall have an Administrative Policy #02-001-0040, Grievance Process in place for individuals to express dissatisfaction with treatment authorizations, services, provider of services etc.

J. R-10 PIHP shall handle Appeals. See SCCCMH Administrative Policy #02-001-0040, Grievance Process.

K. Level II Authorization shall be completed by R-10 PIHP Access Clinical staff.

L. Coordination of Benefits (COB); Region 10 PIHP shall be responsible for managing services associated with public Mental Health Funds. Both Region 10 PIHP and SCCCMH must jointly ensure public Mental Health Funds are payer of last resort. SCCCMH shall manage all billings and collections through third-party reimbursement.

M. SCCCMH 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.

N. SCCCMH authorizations and services are subject to Concurrent and Retrospective UR to identify and correct underutilization and overutilization.

III. Procedures, Definitions, and Other Resources

A. Procedures

Responsibilities

Position	Responsibilities
Region 10 Access Clinicians	1. Triage calls 2. Refer emergency calls to stabilizing supports. 3. Complete access screening for routine calls. 4. Authorize initial services for eligible individuals and refer to SCCCMH's intake unit. 5. Complete Level II authorizations.
SCCCMH Authorizing Staff (caser managers and clinicians)	1. Assure authorizations defines and specifies the amount, duration, intensity, and scope of each service. 2. Inform individuals about the grievance and appeal process when there is dissatisfaction.
Region 10 staff	Manage all appeals
SCCCMH Utilization Management Staff	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.

Actions – Initial Request

Action Number	Responsible Stakeholder	Details
1.0	Applicant	1. Contact the Region 10 PIHP Access Center, Customer Services Department with a request for Behavioral Health services.
2.0	Region 10 Customer Services	2. Attain/key into MIX database demographic and insurance information (name, address, benefit plan etc.). Immediately transfer emergency calls to Access clinical

	Department	staff. (See Administrative Policy #02-002-0005, Customer Services and Access Customer Service Department.) 3. Send/forward information (demographics, insurance, guardian etc.) to Access clinician.
3.0	Region 10 Access Clinicians	4. Triage 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, Mobile Crisis Unit, CMH clinical response, etc.), and authorizes any necessary services 5. Complete 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 Assessment within the SCCCMH Central Intake Unit (CIU). 6. Refer approved Accessing Screen applicant to the SCCCMH. 7. Inform applicant of SCCCMH's "Open Access" system and applicant hours of operation. 8. Authorize eligibility to receive an initial service (e.g. Intake assessment), and any necessary Level II services as indicated. 9. Notify applicant of option of same day intake at SCCCMH. 10. Refer Access Screening applicants that do not meet SCCCMH eligibility criteria (based on specialty benefit plan admission criteria) to the appropriate community program or CCBHC (e.g. Michigan Health Plan; Commercial Insurance; Local Agency) for services that best meet their needs. 11. Initiate a written *Adverse Benefit Determination* when Access Screening decision results in services limited, denied, terminated, suspended and/or grievance process. (See Grievance Process #02-001-0040) 12. Inform applicant of his/her rights (SCCCMH – Administrative Policy #05-001-0020, Enrollee Rights), including right to a second opinion. (See Region 10 policy Appeals Process policy #07-02-04). 13. Transfer the applicant back to a Customer Service Technician for processing and follow-up.

B. Related Policies

Administrative Policy #02-001-0040 Grievance Process

Administrative Policy #02-002-0005 Customer Services and Customer Service Department

Board Policy #03-001-0005 Person-Centered Planning Process, Individual Plan of Service

Administrative Policy #05-001-0020 Enrollee Rights

C. Definitions

1. *Adverse Benefit Determination:* A decision that adversely impacts a Medicaid beneficiary or non-Medicaid individuals' claim for services due to: a denial, reduction or termination of a benefit; a failure to provide or pay for a benefit; or a denial of participation in the plan. (Refer to Board Policy #03-001-0005, Person-Centered Planning Process, Individual Plan of Service.)
2. *Authorization of Services:* The processing of a request for service delivery. All service authorizations must meet medical necessity review criteria as specified by the SCCCMH *clinical protocols* and be defined in terms of amount, scope and duration. SCCCMH has three (3) types of service authorizations:

    a. *Initial Service Authorization*: is a request for services for an individual new to or not in the SCCCMH system.

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

    c. *Level II – Service Authorization:* is a request for service processed by Region 10 Access Center. Level II service authorization includes all crisis services.
3. *Clinical Protocols (Service Practice Guidelines/Clinical Protocols):* A set of service descriptions, which outline all services available to eligible individuals (refer to SCCCMH'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.
4. *Concurrent Review:* Examining and evaluating the appropriateness of a service at the time-of-service request and throughout the period of service delivery.
5. *Continued Stay Review:* The process of continuing an inpatient hospitalization service beyond the authorization period or timeframe.

6. *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; CCBHC Handbook, and SCCCMH policy and administrative procedures.
7. *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 SCCCMH master level Central Intake Unit in coordination with the individual's primary care physician to qualified individuals.
8. *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.
9. *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.
10. *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, outcomes and goals. The service (PCP, ITP) process involves families, friends, and professionals as the individual desires or requires.
11. *Retrospective Review:* Examining and evaluating the appropriateness of services authorized and provided for a particular consumer after the services have been rendered.
12. *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.
13. *Service Selection Guidelines:* Best practice standards that guide service delivery.
14. *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.

15. *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.

D. Forms

N/A

E. Other Resources (i.e., training, secondary contact information, exhibits, etc.)

N/A

F. References

1. MDHHS Contract
2. Center for Medicare and Medicaid Services (42 CFR Part 238.210)
3. PIHP/SCCCMH contract

IV. History

- Initial Approval Date: 10/2003
- Last Revision Date: 09/2023 BY: Amy Kandell
- Last Reviewed Date: 12/2024 BY: Kristen Thompson
- Non-Substantive Revisions: N/A
- Key Words: treatment, authorization, appeal, Level II, Region 10, utilization, services