# *SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY*

ADMINISTRATIVE POLICY

**NUMBER: BA141**

**NAME: UTILIZATION MANAGEMENT PROGRAM**

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| INITIAL APPROVAL DATE: | 05/30/2017 | BY: Sanilac CMH Board |
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## I. PURPOSE

The purpose of this policy is to ensure that Sanilac CMH meets the regulatory and accreditation bodies' requirements for monitoring. In addition, this policy/program will ensure that the services that Sanilac CMH provides are appropriate, medically necessary, and completed by professionals in accordance with the individual's plan of service.

## II. APPLICATION

Populations: **ALL**
Programs: **Direct - ALL**
**Contracted - ALL**

## III. POLICY

It shall be the policy of Sanilac CMH to establish and operate a Utilization Management (UM) Program as required within the Region 10 PIHP Quality Assessment and Performance Improvement Plan (QAPIP). This policy describes the UM Program responsibilities and operations directly carried out within Sanilac CMH and the UM Program operations delegated to Sanilac CMH by the PIHP along with PIHP monitoring and oversight of those delegated functions.

## IV. DEFINITIONS

Authorization: A process designed to ensure that planned services meet eligibility and medical necessity criteria, as appropriate to the conditions, needs and desires of the person being served.

Claims Verification Review: One of a three part process of the internal UM clinical case record review process designed to monitor and improve the overall compliance for the direct-operated programs and contract agencies with regard to clinical case record standards and billing procedures.

Clean Claims: A valid claim submitted to the CMH by a credentialed network provider, in the format and timeframes specified by the CMH that can be processed without obtaining additional information from the provider or a third-party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Levels of Care for Mental Health Specialty Services: A process through which severity of service need is aligned with intensity of service, according to medical necessity criteria, as developed within the person-centered planning process. This process applies to persons receiving ongoing, non-emergent services, is configured within clinical populations (i.e. SMI, COD, DD, SUD, SED), and includes community inpatient psychiatric services.

Medical Necessity: The criteria by which a credentialed practitioner determines the provision of appropriate services/supports for a particular person, condition, occasion and place. Such criteria ensures that services/supports are provided to treat, ameliorate, diminish, arrest or delay the progression of symptoms, and to attain or maintain an adequate level of functioning and least restrictive treatment. It is utilized within the person-centered planning process and the practice guidelines of the PIHP.

Practice Guidelines: Systematically developed standard of care that serves as a clinical basis for providing behavioral healthcare services to enrollees of its covered population.

Service Utilization Monitoring: The routine monitoring of service utilization patterns and trends, through use of a compendium of reports and audits to monitor and manage service over/under-utilization (i.e. access to services, utilization trends, focused service utilization monitoring, UM activity).

Utilization Management: The care management system consisting of a set of functions and activities ensuring that eligible beneficiaries receive clinically appropriate, cost-effective services delivered according to clinical protocols/practice guidelines focused on obtaining the best possible clinical outcomes.

Utilization Management Processes: A process through which services are authorized, based on medical necessity criteria, and based on three determinations:

1. Eligibility;
2. Level of care; and
3. Service selection.

## V. UTILIZATION MANAGEMENT STANDARDS

A. The UM Program shall function within the Sanilac CMH Data Management Department under the Quality Improvement Program.

B. The UM Program shall establish processes that ensure:
   1. Procedures to evaluate for medical necessity;
   2. Criteria-based service utilization decisions;
   3. Determination of over/under-utilization of services; and
   4. Prospective/concurrent/retrospective utilization review by qualified reviewers.

C. The Quality Improvement Committee shall oversee the Utilization Management Program and shall act as the final authority for the UM Program.

D. The Chief Operating Officer/COO, as a standing member of the QI Committee, shall provide clinical oversight of the Utilization Management Program.

E. Review and analysis of the quarterly utilization reports and annual review of overall utilization activities will go to Admin and QI Committees. Oversight activities include, but are not limited to: performance and compliance monitoring and other performance reviews.

F. Sanilac CMH may provide the following UM Program operations per delegation agreement with the PIHP:
   1. Initial approval or denial of requested service (initial assessment for authorization of psychiatric inpatient services; initial assessment for and authorization of psychiatric partial hospitalization services; initial and ongoing authorization of services to individuals receiving community based services).

   2. Grievance and Appeals, Second Opinion management, coordination and notification.

   3. Communication with consumers regarding UM decisions, including adequate and advance notice, right to second opinion and grievance and appeal.

   4. Persons who are enrolled on a Habilitation Supports Waiver, Children's Waiver, or SED Waiver must be certified as current enrollees and be re-certified annually. A copy of the certification form must be in the individual's file and signed by the local CMH representative.

G. Sanilac CMH completes local level concurrent and retrospective reviews of authorization and UM decisions/activities to internally monitor authorization decisions and congruencies regarding level of need with level of service, consistent with the policies, standards, and protocols of the State, PIHP, Grant Funders, and 3rd Party Payers.

## VI. CLAIM VERIFICATION STANDARDS

A. Sanilac CMH shall implement a post-payment randomized review process of valid claims that have been authorized for payment by the CMH.

B. The Claims Verification process shall concentrate on the following aspects within its post-payment review methodologies. Such verification shall consist of an electronic review of the medical record to verify the supporting clinical evidence of the paid claim exists for the date of the service encounter/claim. Verification methodologies include:
   - Verification that the clinical documentation supporting the claim is appropriately completed and signed (credentialed) in the case record.

   - Verification that the service/support was billed to the appropriate payer(s) and that any rejections were investigated and followed up on.

   - Verification that the staff were enrolled in the appropriate insurance panel and hold the appropriate license/credential to perform the service/support.

C. Sanilac CMH shall review a random pull of claims.

## VII. CLINICAL VERIFICATION STANDARDS

A. Sanilac CMH shall implement a review process of clinical services that has been authorized by CMH.

B. The clinical verification process will concentrate on reviewing charts against a set of questions that are utilized during external reviews to ensure we are meeting guidelines. The services areas of concentration will include all internal departments and contract providers. A random pull will be used to determine the charts to be reviewed.

## VIII. PROCEDURES

A. CIO or designee will pull a report of random cases on a quarterly basis. Random pulls will be based on a 5% case ratio for each direct service program. Additionally, 5% of contract services will be reviewed during the same period.

B. Programs/Contracts with noncompliant findings of 85% or less will be required to complete a Corrective Action Plan (CAP) that needs to outline the steps that will be taken to ensure compliance in the future. Programs/Contracts that are found to have noncompliant charts in multiple reviews (showing a trend) will be audited more frequently and will have clinical supervision at increased increments until results of audits show an improvement in the area in question. For more serious compliance issues (i.e.: fraudulent or inaccurate documentation) Sanilac CMH will follow the guidelines listed in the Sanctions Policy.

C. The results of the reviews are then sent to the primary case holder for review and/or correction. This staff member will also document if something cannot be corrected and the action that will be taken to ensure that, in the future, the issue will not occur again.

D. A PDF will be generated of the review once it has been completed and used to prepare the summary report.

E. A summary report of the findings is completed and shared with:
    1. The Chief Operating Officer (COO) and eventually Clinical Supervisors
    2. Quality Improvement Committee; and
    3. Clinical Divisional if trends identify that additional training is necessary.

## IX. ATTACHMENTS

## X. REFERENCES

Region 10 PIHP Policy 01-05-01.