POLICY TITLE:	UTILIZATION MANAGEMENT	POLICY #: 5.0	REVIEW DATES	
Topic Area:	**UTILIZATION MANAGEMENT**		11/21/2013	1/1/2015
Applies to:	LRE Operations, Member CMHSPs, and Provider Network	**ISSUED BY:** Chief Executive Officer	10/1/2021	6/16/22
			5/8/2023	8/14/2024
		APPROVED BY: Board of Directors		
Developed and Maintained by:	CEO and Designee			
Supersedes:	**N/A**	**Effective Date:** January 1, 2014	**Revised Date:** 8/14/2024	

I. PURPOSE:

To establish the standards and guidelines that detail how LRE and its Member CMHSPs comply with the federal laws and MDHHS Contract requirements pertaining to the UM responsibilities of LRE.

To ensure a comprehensive integrated UM process that provides verification that individuals who are Medicaid recipients served by LRE Member CMHSPs and affiliated providers receive the right service at the right time and in the right amount sufficient to meet their needs.

II. POLICY:

It shall be the policy of the Lakeshore Regional Entity (LRE) to have a comprehensive Utilization Management (UM) Program that meets the regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) Contract, and the Centers for Medicare and Medicaid Services (CMS) Code of Federal Regulations (CFR).

The LRE's Utilization Management (UM) Program ensures the delivery of high quality, medically necessary care through appropriate utilization of resources in a cost effective and timely manner.

The LRE UM Program shall operate in conjunction with the LRE Quality Assessment and Performance Improvement Plan (QAPIP). The UM Program is designed to ensure mechanisms to detect and correct under-and over-utilization of services and identify procedures for conducting prospective, concurrent and retrospective reviews.

LRE's UM Program includes oversight and monitoring of regional Access and Eligibility Standards, Service Authorization and Reauthorization, Utilization Review (UR), and Clinical Protocol Standards.

Standards and Guidelines:

A. **Program Oversight, Governance and Authority**: The LRE UM Program shall operate under the oversight of the Chief Operating Officer with assistance from LRE's Clinical Manager r.
B. **Regional Utilization Management/Clinical Practices**: LRE shall maintain a Utilization Management Regional Operations Advisory Team (UM ROAT), consisting of both LRE and Member Community Mental Health Service Programs (CMHSP) Utilization Management representatives. The UM ROAT shall serve in a support and advisory capacity to the UM Program.
    a. Utilization management activities within the LRE are reviewed by the UM ROAT.
    b. The UM ROAT membership is comprised of utilization management representatives from each of the five Member CMHSPs and is chaired by the LRE Clinical/UM Manager or their designee. Ongoing consultation and ad hoc representation from the LRE Medical Director is available to the committee.
C. **Program Structure**: The written UM Program description shall describe the program structure, lead staff, involvement of practitioners in its development, implementation of behavioral healthcare practitioners in its implementation.
D. **Financial Incentives**: The LRE and Member CMHSPs do not provide financial incentives, reimbursements or bonuses, to staff or providers, based on customer utilization of covered services. UM activities shall not be structured to provide incentives for individual or entities to deny, limit, or discontinue medically necessary services to any beneficiary. (42 CFR 348.210(e) n.d.)
E. **Annual Program Evaluation**: The UM ROAT shall clearly demonstrate that it has annually evaluated the UM Program, addressed trends, made systemic changes as indicated and has updated the UM Plan to reflect current need, as necessary.
F. **Satisfaction with the UM Process**: LRE, through various avenues including stakeholder satisfaction surveys and customer services, shall have a mechanism for tracking feedback regarding satisfaction with the UM Process from customers and providers.
G. **LRE Staff Roles**: The UM Program description shall clearly designate the LRE and CMHSP staff involved in the implementation, supervision, oversight and evaluation of the LRE UM Program.
H. **Program Information Sources**: In implementing the annual UM Program Plan, Member CMHSPs will use the publicly available clinical practice guidelines in conducting their reviews of the various clinical components of the LRE plan. These include contractually identified practice guidelines, MDHHS public policy guidelines, technical advisories, nationally recognized medical necessity criteria, and clinical practice guidelines (CPG's).
I. **Utilization Management Review Mechanisms**: LRE will assure inter-rater reliability related to LRE policy and criteria annually as identified through the UM Program and UM ROAT.
J. **UM Decision-Making Criteria**: LRE and Member CMHSPs shall use medical necessity written criteria based upon sound clinical evidence and specifics procedures for appropriately applying the criteria to make utilization decisions.
K. **Service Authorizations**: LRE and Member CMHSPs shall have UM review criteria that reviews utilization management decisions being made across its network for consistency

and alignment with its clinical practice guidelines. They shall ensure, through sampling reviews of the UM decisions, that all regulatory, statutory and policy requirements are met. Service determinations resulting in denials are made by appropriately licensed and credentialed staff.

L. **Level of Care Decisions**: Level of Care UM decisions shall be based on MDHHS Specialty Services Contract, Michigan Mental Health Code and Medicaid Provider Manual, medical necessity criteria, American Society of Addiction Medicine (ASAM) Level of Care Criteria, Child and Adolescent Functional Assessment Scale (CAFAS), Level of Care Utilization System for Psychiatric and Addictive Services (LOCUS), and clinical practice guidelines. Level of care decisions shall only be made by qualified staff with the expertise to make decisions and are reviewed, as appropriate, through supervisory, peer case and random UM review mechanisms. Service determinations resulting in denials are made by appropriately licensed and credentialed staff that has appropriate clinical expertise in treating the customer's condition.

M. **Authorization and Denial Review Criteria/Procedures**: The LRE and Member CMHSPs shall consistently apply medical necessity criteria. Denial/appeal reviewer will review service authorization decisions rendered by UM staff and service denial decisions.

N. **Practitioner Access to UM Decision Criteria**: LRE and its Member CMHSPs ensure customers and practitioners have access to the utilization decision criteria used by the network, have received information or training on the use of the criteria, and how to access it, as requested.

O. **Appropriate UM Professionals**: As identified via MDHHS contracts and BBA standards, LRE and Member CMHSPs shall ensure that only qualified licensed professionals assess the clinical information used to support and oversee the UM decisions.

P. **LRE Review Case Selection**: Specific cases for UM Review are identified by LRE and the Member CMHSPs in accordance with the annual guidelines set forth in the UM Plan. In this regard, LRE and Member CMHSPs may choose specific cases for review according to the UM Plan and may include random or targeted samples and cases of over-utilization and under-utilization.

Q. **UM Program Monitoring Results and Reporting**:
    a. Results of UM Reviews will be aggregated in a common format and compared across the LRE region for improvement of service delivery and cost effectiveness and to address over and underutilization. Those will include recommended increases, decreases, changes or services that stay the same.
    b. The UM ROAT will review all aggregated data on UM and service authorization trends on a regular basis. The efficacy of services, the quality of the services and supports as well as their cost-effectiveness will be assessed and decisions regarding improvements and needed changes in the system(s) will be discussed and reviewed.

R. **Delegation**: The LRE delegates the UM process to the Member CMHSPs. All requirements set forth by the MDHHS shall be met with the CMHSP UM process. LRE maintains its oversight and monitoring responsibilities of all delegated UM functions, and shall annually evaluate the delegate entity in accordance with the requirements.

S. **Retrospective Reviews**: LRE and CMHSPs shall maintain policies and procedures for retrospective reviews of CMHSP UM decisions. These policies shall be posted on the LRE and Member CMHSP websites. LRE shall ensure there is a full and fair process for resolving disputes and responding to an individual's request to reconsider a decision they find unacceptable. The LRE retrospective review process shall address regulatory and contractually mandated processes.

III. APPLICABILITY AND RESPONSIBILITY:

This policy applies to LRE, its Member CMHSPs and contracted providers of Medicaid funded services.

IV. MONITORING AND REVIEW:

This policy will be reviewed by the CEO or designee on an annual basis.

V. DEFINITIONS:

Appeal- A process to have an authorization decision that adversely affects services provided to an individual, or involves denial of services to an individual, reviewed by a licensed professional to evaluate the medical needs or the individual and not in the original denial decision, to evaluate the medical needs of the individual for possible decision reversal.

Authorization - Approval of Medicaid payment for a covered service on behalf of the LRE or CMHSP.A process designed to ensure that planned services meet eligibility and medical necessity criteria, as appropriate for the conditions, needs and desires of the member served.

Clinical Practice Guideline - Clinical practice guidelines, protocols or service selection guidelines promulgated by the LRE and CMHSPs, guide clinical decisions regarding individuals' access to covered services. These documents identify service eligibility criteria and the typical amount, scope and duration of covered services.

Concurrent Review- Concurrent review encompasses those aspects of utilization review that take place during the course of facility-based or outpatient treatment.

Denial - A determination that a specific service is not medically/clinically appropriate, necessary to meet needs, consistent with the person's diagnosis, symptoms and functional impairments, the most cost-effective option in the least restrictive environment, and/or consistent with clinical standards of care and/or per policy and contractual requirements.

Independent Review Organization (IRO) - Independent Review Organization, typically employing board certified psychiatrists or Addictionologists who provide clinical review and treatment recommendations.

Medical Director - Physician, Psychiatrist, Addictionologist serving in a leadership capacity for the LRE or partner CMHSPs.

Medically Necessary - A determination that a specific service is clinically appropriate, necessary to meet the person's needs, consistent with the person's diagnosis, symptoms and functional impairments, is the most cost-effective option in the least restrictive setting, and is consistent with the LRE's medical necessity criteria and service selection guidelines.

Medical Necessity Criteria - Criteria used to determine which services, equipment, and/or treatment protocols are required for the diagnosis or severity of illness that meets accepted standards of medical practice.

Prior or Prospective Authorization - The process of obtaining approval or authorization to perform a covered service in advance of its delivery.

Utilization Management Program - The LRE managed care system that ensures that eligible recipients receive clinically appropriate, cost-effective services designed to meet their needs.

Utilization Review - The LRE's service review process established to ensure that the UM Program's service standards, protocols, practice guidelines, authorization and billing procedures, and documentation standards are adhered to by all member CMHSPs and network service providers.

VI. RELATED POLICIES AND PROCEDURES

A. LRE Procedure 5.0a Utilization Management
B. LRE Policies 7.1 Quality Assurance and Performance Improvement Program

VII. REFERENCES &LEGAL AUTHORITY:

A. LRE Quality Assessment and Performance Improvement Plan (QAPIP)
B. LRE Utilization Management Plan
C. LRE Compliance Plan
D. LRE/CMHSP Sub Contract
E. MDHHS/PIHP Master Contract for Medicaid Managed Specialty Supports and Services ; General Requirements; Section K42 CFR 438.210(b)(c)(d)(e)(f)

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
11/21/2013	New Policy	Chief Clinical Officer
1/1/2015	Annual Update	Chief Clinical Officer
6/16/2022	Review/update	CEO and Designee
5/8/2023	Review	UM/Clinical Manager and UM ROAT
5/13/2024	Minor edits	UM/Clinical Manager and UM ROAT