Utilization Management 101

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Overview of Training

What is Utilization Management (UM)?

Medicaid Requirements for UM

Medical Necessity Criteria for SUD Services

Individualized Treatment Plans

MSHN Benefit Plans

- Medicaid/Healthy Michigan
- Block Grant

MSHN Authorization Process

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What is Utilization Management (UM)?

Utilization management (UM) is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called "utilization review."

Utilization Review Accreditation Commission (URAC)

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Medicaid Requirements

- Michigan Medicaid Provider Manual
  - Eligibility requirements for SUD services
  - Medical Necessity Criteria
  - Authorization Guidelines for specific services

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Medicaid Requirements

- MDHHS/PIHP Master Contract
  - PIHPs must have UM program and UM plan
  - Authorization decisions are made by qualified professionals
  - Timeliness requirements for authorization decisions (Expedited 72 hours, Standard 14 Days)
  - Adverse Benefit Determination (ABD) notifications due to authorization decisions

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Medical Necessity Criteria

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Michigan Medicaid Provider Manual

Determination that a specific service is……

- Medically (clinically) appropriate
- Necessary to meet needs
- Consistent with the person's diagnosis, symptomatology and functional impairments
- Most cost-effective option in the least restrictive environment
- Consistent with clinical standards of care

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Michigan Medicaid Provider Manual

- The American Society of Addiction Medicine (ASAM) Criteria are used to determine substance abuse treatment placement, admission and/or continued stay needs

- Medical necessity of a service shall be documented in the individual plan of services.

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PIHPs cannot authorize services that are not documented in the treatment plan

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Individualized Treatment Plans

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What is an Individualized Treatment Plan?

The document that identifies a client's needs and the supports and services that will help them reach their goals.

It identifies what will be worked on during the client's time spent in treatment

Agreement between client and provider

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Individualized Treatment Plan Requirements

- Goals/objectives directly relate to needs identified in assessment
- Address health & safety concerns
- Interventions (ie: group therapy, peer support)
- Describe amount, scope & duration
- Target dates for completion
- Incorporate individual's strengths
- Signatures

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What do you mean by Amount, Scope & Duration?

How Much, How Often, How Long

Goal	Objective	Intervention
I need to regain healthier coping skills so I am not in a situation where alcohol becomes the only solution.	I will explore activities I can engage in during my down time. I will explore fitness centers near me. I will explore options to be social outside of meetings.	Recovery Coach will offer individual coaching sessions **Start Dt:** 08/09/21 **Target Dt:** 02/07/22 **Frequency:** Weekly **Duration:** 15-30 min

Credit to Ten16 Recovery Network

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Goal Requirements

- Clearly stated goals and measurable objectives.
- Identification of the activities designed to assist the individual to attain his/her goals and objectives.
- Delineate what role support staff, family and/or natural supports will take in goal.

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Writing Goals

- Goals should reflect the individual's clearest articulation of the **destination**: The end results of what they hope to achieve in treatment.
- Goals are developed from information gained during development/writing of the biopsychosocial assessment.
- Write SMART goals!

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Smart Goal Writing

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Specific:

A specific goal has a much greater chance of being accomplished than a general goal. To set a specific goal you must answer the six "W" questions:

- Who: who is involved?
- What: what does the client hope to accomplish?
- Where: Where will the goal take place?
- When: Time frame?
- Which: Requirements and restraints?
- Why: Reasons/purpose for accomplishing the goal?

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Measurable:

- Establish concrete criteria for measuring progress toward the attainment of each goal you set. How will you measure the goal? Is it measurable?

To know a goal is measurable, ask questions like:

- How much?
- How many?
- How will I know when it is accomplished?

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Attainable:

- The goal(s) should push the client forward, but, still be within the client's ability
- Is it in the client's ability to attain the goal(s)?
- Is the goal attainable in the time allotted?

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Realistic:

- To be realistic, a goal must represent an objective toward which you and the client are both *willing* and *able* to work.
- How do you know that the client can actually achieve this goal?
- Is the timeframe realistic for the goal(s) that have been set?

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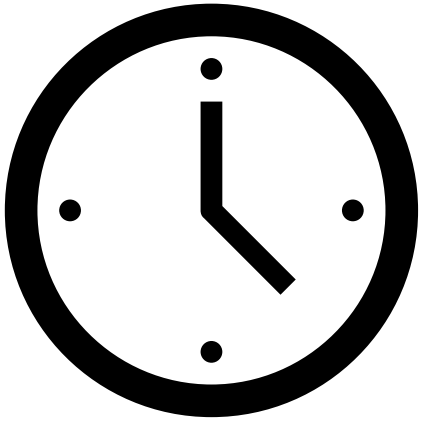
Time bound:

- A goal should be grounded within a time frame
- Set target dates
- By when does the client and clinician believe this goal can be completed?



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Goal: "I want to learn to increase and practice my ability to manage anger"

Target date: _____

Objectives:

1. Walk away from situations that trigger strong emotions (100%). Target date: ___
2. Learn two positive anger management skills. Target date:___
3. Learn three ways to communicate verbally when angry. Target date:____
4. Get through a whole week without fighting with _____. Target date:_____
5. Learn to express anger in a productive manner without destroying property or personal belongings. Target date:_____

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Objectives

- Form the steps the individual is going to take to accomplish the goal
- Involve action, rather than process
- Are measurable
- Use a strength-based approach
- Are achievable/reasonable
- Include a timeframe for attainment

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Objectives are also S.M.A.R.T.

Goal: "I want to be free of drug/alcohol use/abuse"
Target date:__

Objectives:

1. **Avoid people, places and situations where temptation might be overwhelming.** Target date:___
2. **Explore dynamics relating to being the [child/husband/wife] of an [alcoholic/addict] and discuss them each week at support group meetings.** Target date:_
3. **Learn five triggers for alcohol & drug use.** Target date:___
4. **Reach _____ days/months/years of clean/sober living.** Target date:____

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Common Mistakes:

Describing what action a clinician, recovery coach, or case manager will take instead of what action the client will take.

Case manager will meet with Joe twice per month

BETTER

Joe will meet with his case manager twice per month to work on housing applications

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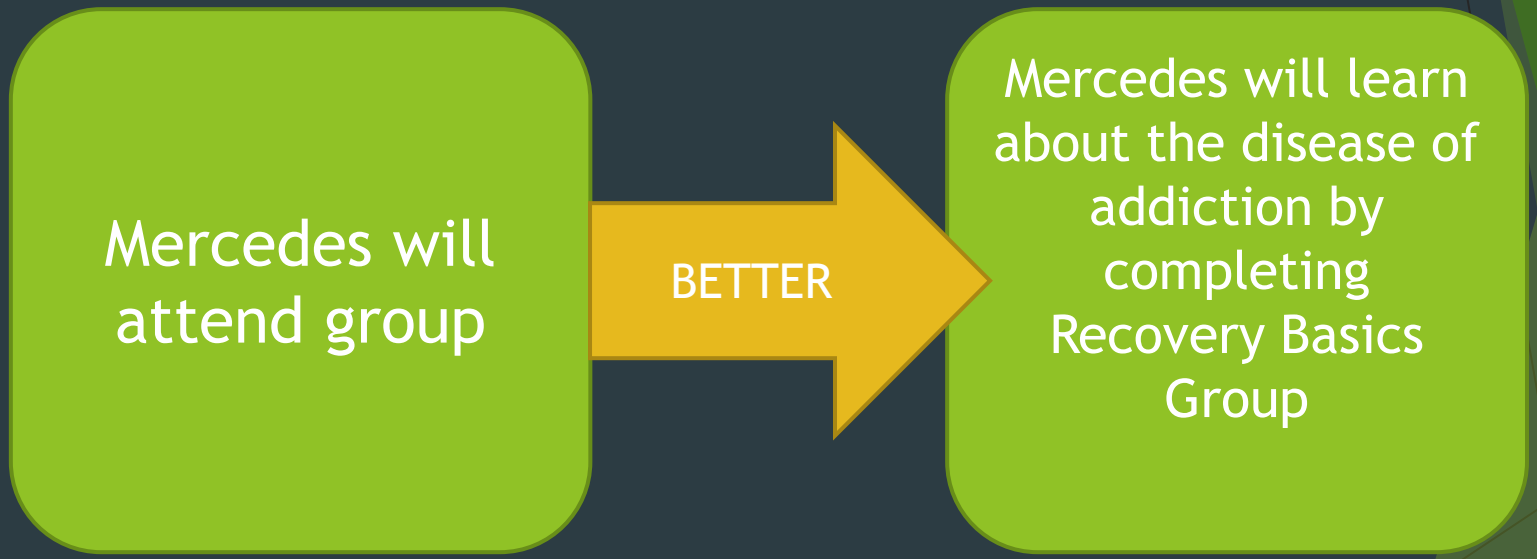
Common Mistakes:

Listing the service/intervention as the goal or objective



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Common Mistakes:

Using terms for measurement that are subject to many interpretations, are not action oriented, or are difficult to measure.

Jaylen will gain insight into why she relapses

BETTER

Jaylen will work with her recovery coach to list 10 triggers for relapse and 10 coping skills to use when she feels triggered

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Other Common Mistakes:

- Goal or objective is not related to the services the client is receiving
- Too many steps combined in one objective
- Goal or objective is not attainable, or it is attainable but not realistic for the period of time
- Clinical jargon or not stated in client's words, ie: "Michael will resolve his cognitive dissonance"

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Treatment Plan Reviews

Must include input from all treatment/recovery providers involved in care	Should reflect progress toward each goal/objective	Identify need to keep or discontinue specific goals/objectives
Add additional goals/objectives due to changing needs of person served	Plan reviews help with service authorization. Authorizations must be based on individual need and progress toward goals/objectives	PIHP cannot make authorization decisions about medical necessity without adequate documentation

R325.1363, Michigan Administrative Rules for Licensing and Regulatory Affairs
BHDDA Treatment Policy #6- Individualized Treatment & Recovery Planning

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Frequency of Treatment Plan Reviews

Michigan Administrative Rules for Outpatient Treatment

- Reviewed at least once every 120 days by the licensed counselor, LMSW, licensed psychologist, or certified counselor, or other licensed health professional

ASAM Guidelines for Other Levels of Care

- Level 2.1 IOP – review in 2 weeks
- Level 2.5 Partial Hospitalization – review weekly
- Residential levels – once a week, or more often if person is unstable

R325.1363, Michigan Administrative Rules for Licensing and Regulatory Affairs
ASAM Criteria, 2013

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MSHN Benefit Plans

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MSHN Benefit Plans: What Are They?

- Difference between Block Grant benefits and Medicaid/HMP benefits
  - Block Grant benefits are Federal Substance Abuse Prevention & Treatment Block Grant (SAPTBG) Funds which are available to subsidize cost of services for individuals who have no insurance or are underinsured
  - Block Grant benefits also used to fund discretionary services that are not funded by Medicaid or HMP (ex: recovery housing, case management, transportation)
  - Services covered under Medicaid/HMP are considered entitlements while services covered under Block grant are considered discretionary and are limited to available funding.

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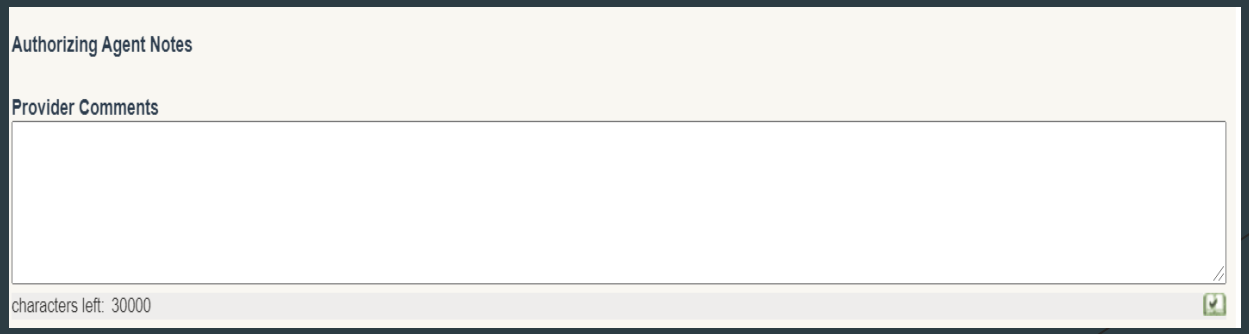
MSHN Benefit Plans: What Are They?

- Developed based on average utilization of specific service codes across the region and state
- NOT limits to service (for Medicaid/HMP)
  - If request is above the typical amount per authorization or treatment episode clinical rationale is necessary
  - Clinical rationale can be added under Provider Comments in the authorization request.



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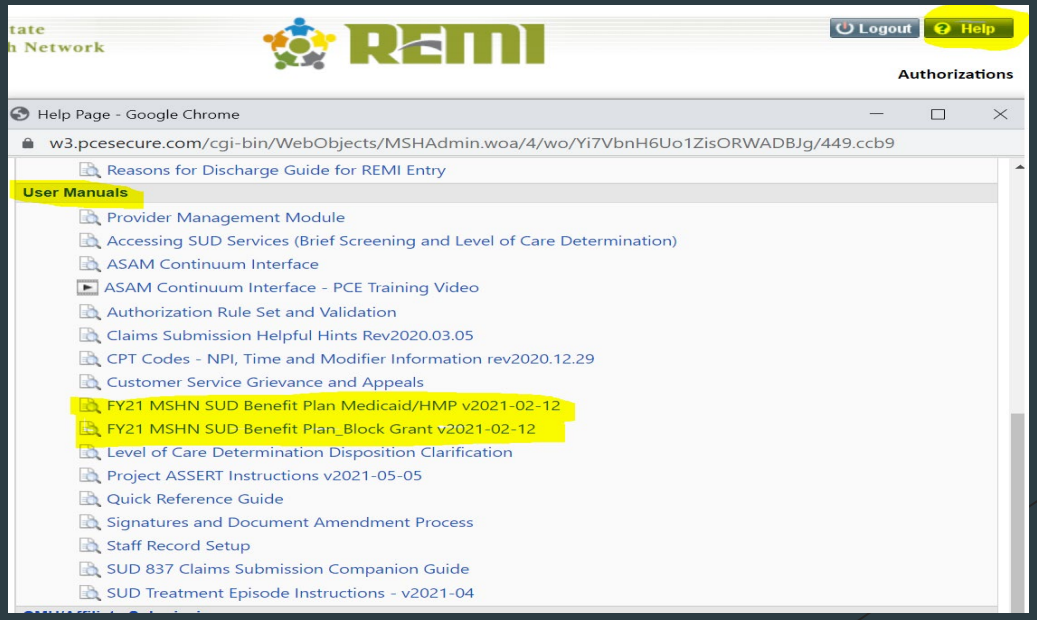
MSHN Benefit Plans: What Are They?

- Block Grant FAQ Document can be found here: Block Grant FAQ
- Benefit Plans can be found here: REMI Help Menu and MSHN website



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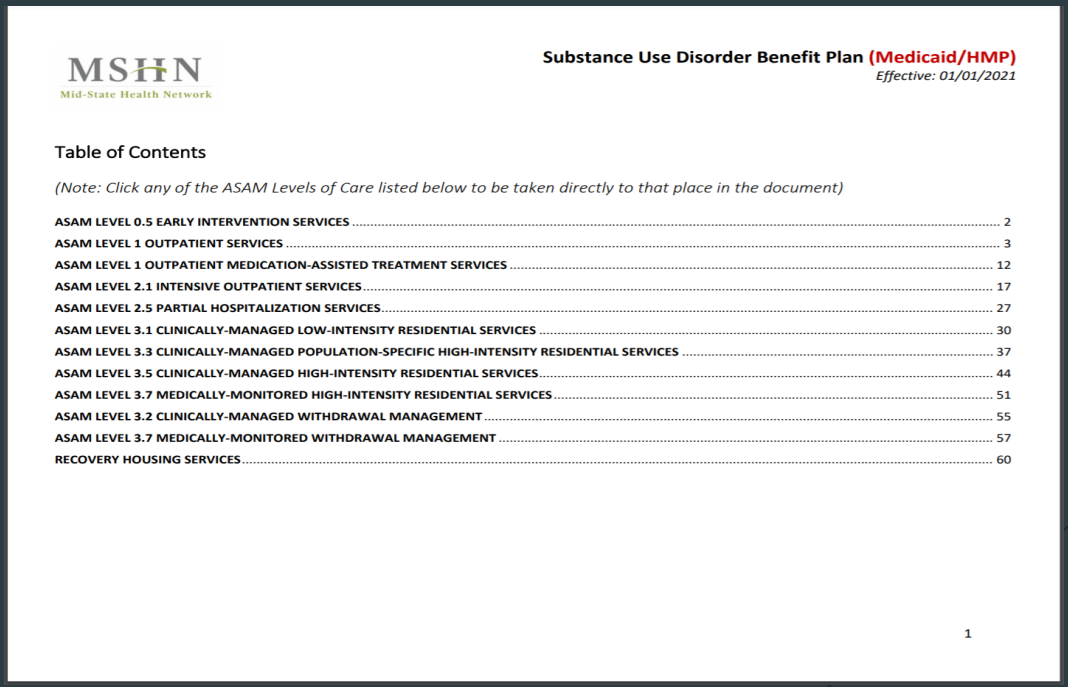
MSHN Benefit Plans: Table of Contents

- Table of Contents for both Medicaid/HMP and Block Grant are broken down by ASAM Level of Care.
- Each ASAM Level of Care is a link to that specific section of the document.



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Substance Use Disorder Benefit Plan (Medicaid/HMP)
Effective: 01/01/2021

Table of Contents

(Note: Click any of the ASAM Levels of Care listed below to be taken directly to that place in the document)

1

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MSHN Benefit Plans: How to Use Them

- Maximum length of authorization – listed beneath the heading for each Level of Care
- Broken down by service code, description, billing parameters, maximum number of units per authorization, total number of units per treatment episode, and MDHHS provider/staff qualifications
- Requests exceeding the maximum number of units will require additional utilization review and must contain clinical rationale in the provider comments section to be approved

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ASAM LEVEL 1 OUTPATIENT SERVICES

**Each authorization at this LOC may be a maximum of 180 days duration*

SERVICE CODE	DESCRIPTION (HCPCS/CPT)	BILLING PARAMETERS	MAXIMUM NUMBER OF UNITS PER AUTHORIZATION	TOTAL NUMBER OF UNITS PER TREATMENT EPISODE* (*Services exceeding threshold require additional utilization review*)	PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)
H0001 (Individual Assessment)	Alcohol and/or drug assessment face-to-face service for the purpose of identifying functional and treatment needs and to formulate the basis for the Individualized Treatment Plan (Minimum 60 minutes)	Encounter Not billable with H0010, H0012, H0018, or H0019	1	3	Provider agency licensed and accredited as substance abuse treatment program. Service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.
H0002 (Brief Screen, SBIRT; Face-to-Face)	Brief Screen	Encounter; REMI Level of Care Determination must be completed and signed prior to claim submission	1	1	
90832 (Psychotherapy Individual)	Psychotherapy, 30 minutes with individual and/or family member	Encounter	24 (Combination of 90832, 90834, and/or 90837)	48 (Combination of 90832, 90834, and/or 90837)	For psychotherapy (908xx series codes): Substance Abuse Treatment Specialist (SATS), Only Master's prepared with appropriate licensure and working under appropriate supervision may provide services.
90834 (Psychotherapy Individual)	Psychotherapy, 45 minutes with individual and/or family member	Encounter	24 (Combination of 90832, 90834, and/or 90837)	48 (Combination of 90832, 90834, and/or 90837)	Same as above
90837 (Psychotherapy Individual)	Psychotherapy, 60 minutes with individual and/or family member	Encounter	24	48 (Combination of 90832, 90834, and/or 90837)	Same as above

MSHN Benefit Plans: How to Use Them

Benefit to clinicians:

- Authorizations are returned less frequently
- Faster/easier if clinician is familiar with parameters for services being requested

Importance of providing explanations/comments:

- Authorizations will be returned if clinical rationale is missing
- Clear clinical picture of the client's needs and reasons for continued services

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MSHN Authorization Process

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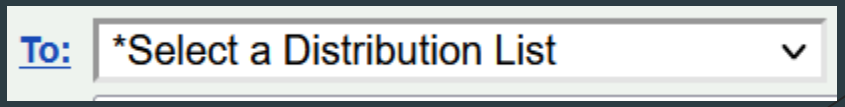
Helpful REMI Items

- The Help Menu includes all user manuals, how-to videos, and how-to guides for using REMI
- The envelope next to the Home button is used for REMI secure messaging system. (HIPAA and 42 CFR Compliant)
- To send a message to UM Team:
  - Click the envelope
  - Select Compose New Message
  - Click the icon with two people 
  - Select Utilization Management from the dropdown



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Authorization Process

- Exception based system- 90% of authorizations automatically approved
- UM Team reviews “exceptions” based on routing rules
- What are routing rules?
  - Validations to check for auth dates, code/unit amounts, and other factors that may require additional review
- Where to find the routing rules?
  - In the Help Menu under User Manuals:

- Outcomes: Approve, Return, Deny, Pending Data Entry

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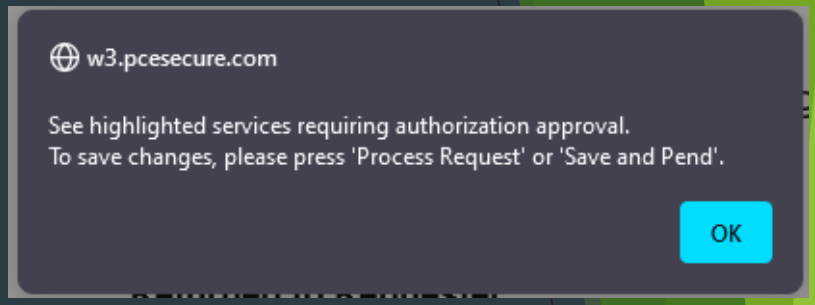
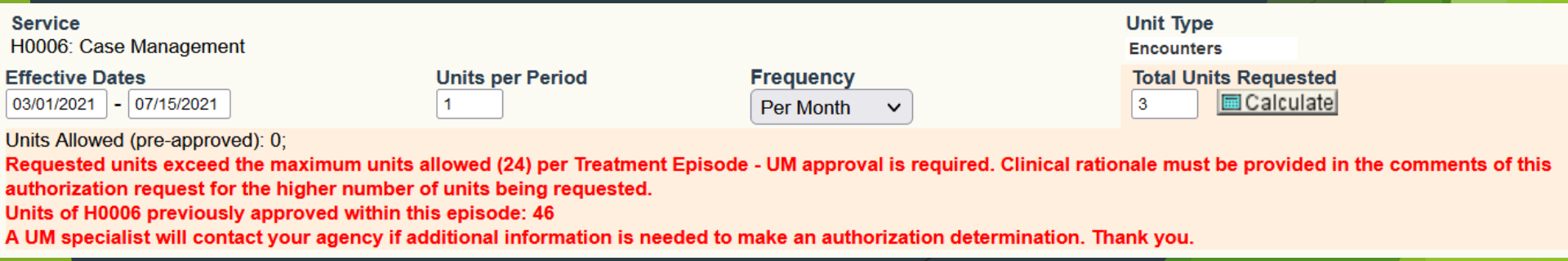
Error Messages

- Help providers fix issues so that MSHN UM review is not required
- Notification box lets user know there are items that need to be corrected
- Please review the issue. The code will be highlighted and red text will describe the specific issue.
- Please attempt to resolve the issue before clicking “Process Request”





Timeframes for Authorization Decisions

Adverse Benefit Determination: A decision that adversely impacts a Medicaid Enrollee's claim for services due to: (42 CFR 438.400)

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 42 CFR 438.400 (b)(1).
- Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2).
- Denial, in whole or in part, of payment for a service. 42 CFR 438.400(b)(3).

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Timeframes for Authorization Decisions

Adverse Benefit Determination, Continued

- Failure to make a standard Service Authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service. 42 CFR 438.210(d)(1).
- Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization. 42 CFR 438.210(d)(2).

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Timeframes for Authorization Decisions

- Adequate Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect. 42 CFR 438.404(c)(2).

- Advance Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid Enrollee at least 10 calendar days prior to the proposed date the Adverse Benefit Determination is to take effect. 42 CFR 438.404(c)(1); 42 CFR 431.211.

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Returned Authorizations

Return is not Denial

Provider Responsibilities

- More information needed
- Timely Response- still needs to be processed in 14 days or MSHN must issue an ABD to the client

Potential confusion for person served if they receive ABD notice when not necessary

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Common Reasons for Returned Authorizations

- More clinical information is needed to make a decision
- Duplication of Services
  - The same code cannot be authorized/paid at 2 different providers
  - Work with the client to obtain signed release and coordinate with the other provider
  - Only resubmit once care coordination has taken place
  - If issues arise, please call the UM Team for assistance

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Common Reasons for Returned Authorizations

- Requesting above benefit plan
  - Additional clinical information MUST be provided in the Comment Section of the authorization prior to submitting for UM Review
- Requesting services that are not listed on the treatment plan
  - All services being requested MUST be identified as a need and addressed specifically on the treatment plan

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Tips for Increasing Authorization Approval

More information is helpful! Please use comments to provide additional context for unique situations

If requesting above benefit plan recommended amounts clinical explanation is always needed

Pay attention to pop up messages- they will tell the user what needs to be corrected

Treatment plans must include progress review, not just changed dates

Check that any services being requested are identified on treatment/recovery plan

If no insurance, must submit Block Grant eligibility documents with authorization

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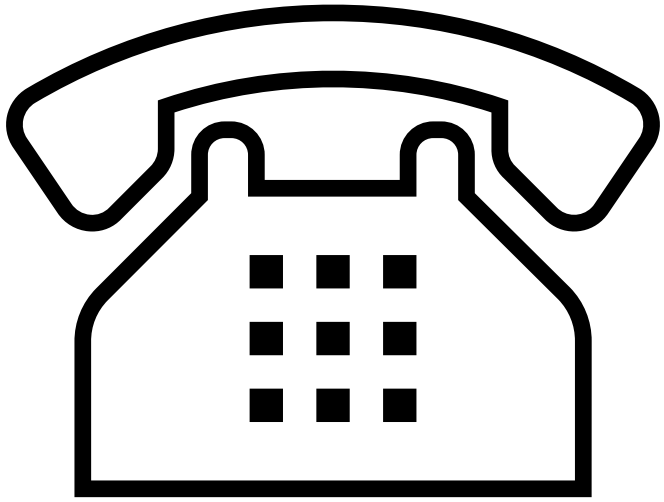
Questions?
Suggestions?

We’re Here to Help!



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