MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Utilization Management**		
Title:	**Service Authorization Denials Reporting and Monitoring**		
Policy: ☐ **Procedure:** ☒ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** Chief Population Health Officer	**Adopted Date: 05.07.2024** **Review Date:**	**Related Policies:** Utilization Management Procedure

Purpose

The Service Authorization Denials Reporting and Monitoring procedure outlines the reporting and monitoring requirements for utilization management service authorization denials, to ensure compliance with the Michigan Department of Health & Human Services (MDHHS) Service Authorization Denials Reporting requirements, and to document the requirement for a corrective action plan of Adverse Benefit Determination (ABD) timeframe non-compliance. A denial is defined as not authorizing a service that was requested or authorizing the service in an amount, duration, or scope less than requested [*42 Code of Federal Regulations (CFR) 438.210.b.3)]*

Procedure

Per MDHHS requirements, the Pre-paid Inpatient Health Plan (PIHP) shall report all ABDs issued as a result of service authorization denials for new requests for service on a quarterly basis each year, due February 15 (Quarter 1), May 15 (Quarter 2), August 15 (Quarter 3), and November 15 (Quarter 4). MSHN and its Community Mental Health Services Participants (CMHSPs) adhere to the following procedure to ensure the submission of accurate and timely reports.

Each CMHSP is required to submit a quarterly report by the first day of the month when the report is due. This allows MSHN a 14-day period to aggregate the regional data, review for accuracy, and perform any necessary follow-up with the CMHSPs before submitting the final report to MDHHS. CMHSPs shall submit via the template provided by MDHHS in accordance with the schedule identified below.

Quarter	Due Date
1 (Oct 1 – Dec 31)	February 1
2 (Jan 1 – Mar 31)	May 1
3 (Apr 1 – Jun 30)	August 1
4 (Jul 1 – Sep 30)	November 1

CMHSPs should closely follow all reporting requirements as outlined in the Instructions and Definitions worksheets of the report template, including but not limited to:

a. Include only pre-service denials (prior authorizations and eligibility). Do not include denials (termination, suspension, or reduction) of previously authorized services, reconsiderations, second opinions, or appeals.
    i. Denials for inpatient psychiatric hospitalization must be reported as it is a service which requires prior authorization.

b. Include only service authorizations that were closed during the reporting quarter. (i.e.: cases included in the report template must be based on the Date/Time of ABD notice to the consumer; the Date/Time of Receipt of the service request may occur prior to the reporting quarter, but the Date/Time of Notice must occur during the reporting quarter).
c. If "Other" is selected as the reason or subreason for denial, an "Other" reason description is required in Column R of the report template.
d. If the timeframe requirement is not met (14 days for standard requests, 72 hours for expedited requests), a reason for untimeliness and a summary of improvement efforts are required in Column S of the report template.

MSHN shall review the CMHSP submitted reports and complete data validation activities to ensure completeness and accuracy of reporting. MSHN will also fulfill reporting requirements for Substance Use Disorder (SUD) service authorization denials managed by the PIHP and its contracted Substance Use Disorder Service Provider (SUDSP) network.

A corrective action plan will be required for any CMHSP with less than 90% compliance with authorization timeframe requirements during a reporting period. Corrective action plans must include systemic remediation efforts. If a CMHSP has a corrective action plan in place they will be required to submit progress updates and evidence of implementation of the identified corrective actions with each subsequent quarterly report until the 90% compliance threshold is achieved.

Applies to:

☐All MSHN Staff

☒Selected MSHN Staff, as follows:

☒MSHN CMHSP Participants: ☐Policy Only ☒Policy and Procedure

☒Other: subcontracted providers

Definitions:

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

a. 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).*
b. Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2).*
c. Denial, in whole or in part, of payment for a service. *42 CFR 438.400(b)(3).*
d. 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*).
e. 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).*
f. Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP. *42 CFR 438.400(b)(4).*
g. Failure of the PIHP to resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).*

h. Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).*

i. Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of the date of the request. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

j. For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under *§ 438.52(b)(2)(ii)*, to obtain services outside the network. *42 CFR 438.400(b)(6).*

k. Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. *42 CFR 438.400(b)(7).*

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.*

Authorization of Services: The processing of requests for initial and continuing service delivery. *42 CFR 438.210(b).*

CFR: Code of Federal Regulations

CMHSP: Community Mental Health Services Participant in the MSHN Region with delegated authority to manage a network of behavioral health providers; responsible for conducting credentialing and recredentialing activities.

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

MDHHS: Michigan Department of Health and Human Services

MSHN: Mid-State Health Network, the Pre-Paid Inpatient Health Plan responsible for oversight of delegated functions, including credentialing activities.

SUD: Substance Use Disorder

SUDSP: Substance Use Disorder Service Provider

References/Legal Authority:

42 CFR 438.400
42 CFR 438.210(b)(d)
42 CFR 438.404(c)(2)
MDHHS Contract: Non-Financial Reporting Requirements (Schedule E)
MDHHS Appeal and Grievance Resolution Processes Technical Requirement

Change Log:

Date of Change	Description of Change	Responsible Party
3.2024	New Procedure	Director of Utilization & Care Management