**SHIAWASSEE COUNTY COMMUNITY MENTAL HEALTH AUTHORITY**

**POLICY AND PROCEDURE MANUAL**

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| Section: Clinical | Effective Date: 4/29/02 |
| Policy Number: 75 | Last Revision Date: 10/29/15 |
| Subject: **Utilization Management** | Page: 1 of 6 |

## Policy

It is the policy of Shiawassee County Community Mental Health Authority (SCCMHA) that all consumers served receive timely access to the most appropriate, high quality, recovery-focused mental health and/or substance use services for consumers, while simultaneously striving to control the costs of providing those services through a utilization and clinical quality management system that supports all providers in delivering clinically necessary and effective care.

## Purpose

The purpose of this policy is to detail the activities associated with the utilization management process at SCCMHA and ultimately guides the vehicle through which Shiawassee County Community Mental Health Authority ensures that consumers receive services that:

- Support recovery;
- Are coordinated;
- Reflect consumer preferences;
- Are efficient and cost effective;
- Occur in the most appropriate and least restrictive setting;
- Consistent with medical necessity criteria;
- Promote evidence-based practices; and
- Promote good health outcomes.

## Application

This policy will apply to all SCCMHA programs and services.

## Standards

1. SCCMHA collects and uses data to monitor its performance. Data is collected in the following areas:
   a. Access to care
   b. Appropriateness of care
   c. Effectiveness (outcomes) of care
   d. Efficiency of care

e. Care Coordination
f. Satisfaction with care (PI)

2. SCCMHA analyzes data to determine patterns of service utilization, including clinical risk areas such as under and over utilization of services.

3. Information that is collected in the utilization and clinical quality management system is used to makes changes for improved care and safety, and reduced risk.

4. Data will be gathered at a frequency that is appropriate to the activity or process being studied, on a quarterly basis at a minimum.

5. Data is analyzed and compared internally over time and externally with other sources of information when available. External sources that may be used include state-wide data reports, regional reports, scientific, clinical and management literature, practice guidelines, and performance measurements.

6. Any decision that results in service alteration (i.e. increase, reduction, or denial) shall be due to an appraisal based on medical necessity. No reduction or denial of service shall occur solely based on the consumer's diagnosis or type of illness/condition.

7. The Utilization and Clinical Quality Management process is consultative and should be mutually beneficial to both the program staff and the Utilization Management staff. However, it is understood that there may be times when the program does not agree with the decisions of the Utilization Management staff; therefore, an appeals process has been developed for the program to use when necessary.

## Definition

Utilization Management: Utilization management (UM) is the evaluation of the medical necessity, appropriateness, and efficiency of the use of mental health and substance use services under the provision of the applicable benefits.

## Procedure

a.

1. A data report will be generated to identify consumers meeting criteria for utilization review including under and over utilization of services. The criteria shall consist of:

   - Randomized selection of new cases admitted to the program within the previous quarter.

- Randomized selection of cases where a level of service was changed or terminated.
- Randomized selection of cases both under and over an established mean for service usage or length of treatment episode (standard deviation to be established).
- Randomized selection of case for review of medical necessity and compliance with completeness and timeliness standards.
- Randomized selection of cases that were closed during the previous quarter.

2. Utilization management reviews shall be performed by personnel who are appropriately trained and qualified. Minimum qualification will be a master's level licensed practitioner, with knowledge in utilization management. Prior to any UR and/or disposition being finalized, the Director of Utilization and Clinical Quality Management will review and authorize. The findings shall be discussed to enhance review process and increase inter-rater reliability.

3. A case summary will be utilized as the basis for each utilization review.

4. Programmatic specific utilization management reviews will occur (at a minimum) quarterly. These reviews will be comprehensive and include, but not limited to, the following elements:
   - Open and closed cases in order to perform both concurrent and retrospective reviews.
   - Randomized review of 10 cases minimum.
   - Persons served, including legal guardian, custodian, parent(s) or any other legally appointed caregiver, were provided with a complete orientation and were actively involved in making informed choices regarding services.
   - Medical necessity for level of care and program eligibility criteria were present.
   - Goals and objectives are related to consumer input and/or his or her guardian as well as the assessment results.
   - Services provided were related to the goals and objectives and measured in appropriate amount, scope and duration according to the needs of the consumer.
   - Evidence of health integration.
   - Service delivery model included care coordination.
   - Services demonstrate use of evidence based practices.
   - Program/service transfers and discharge summaries have been completed within appropriate timeframes.
   - All services are documented, reviewed and updated in accordance with SCCMHA policy.

5. A clearly written report of the utilization management review and decision will be provided to applicable program supervisor, staff, and Leadership, as appropriate.

6. The report shall include written recommendations to aid the program in improving service quality.

   a) Improving service quality may be defined through:
      - Revisions to program design or service delivery
      - Personnel competencies, staff ratios, trainings
      - Financial resource allocation
      - Linking utilization management and quality assurance, including tracking program data related to outcomes, effectiveness, and progress of those consumers served

7. The appropriate program will provide a written response to the Director of Utilization and Clinical Quality Management that addresses the recommendations from the review within 10 business days of receiving them.

8. The program may appeal any utilization management decisions made that result in a denial or modification of care for a consumer receiving services. The program may initiate the appeal process by informing the Director of Utilization and Clinical Quality Management in writing and requesting reconsideration of the utilization management decision. The written appeal should include rationale.

9. Upon receipt of the written request, the Director of Utilization and Clinical Quality Management will initiate the appeal within 2 business days and provide a written response back to the program within 10 business days of receipt of the request. The Director may identify an appropriate person to conduct the appeal, ensuring that there is not a conflict of interest.

10. In the event that the program continues to be dissatisfied with the utilization management appeal decision, they request reconsideration by the SCCMHA Medical Director. This request must be made in writing, and shall set forth all of the reasons that the program does not agree with the decisions made up to this point.

11. The decision of the SCCMHA Medical Director will be provided to the program within 7 business days of the receipt of the written request, and shall be final.

12. Copies of all utilization management decision will be maintained by the Director of Utilization and Clinical Quality Management and the review of all decisions will be documented in the medical record.

13. The SCCMHA Grievance and Appeal Policy/Procedure, including Advance and Adequate Notice requirements and documentation of all activity in the Grievance and Appeal

database, shall take effect if a utilization management decision results in a service suspension, reduction or termination.

**References**

1. Utilization and Clinical Quality Management Program Plan
2. MSHN Utilization Management Policy

Approved by: _____ 4-18-2016
Board Chairperson — Date

_____ 4/19/16
Chief Executive Officer — Date

Review/Revision Dates:

| Date: | By: |
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| 2002-2007 | Review by Board |
| 7/27/2009 | Revised by Jerry Wardell |
| 1/11/10 | Reviewed by Program Committee |
| 1/4/13 | Reviewed and revised by Craig Hause |
| 01/30/14 | Reviewed and revised by Craig Hause |
| 12/29/15 | Reviewed by Craig Hause |
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