NORTHCARE NETWORK

POLICY TITLE: MI Health Link Program and Service Authorization	**CATEGORY:** Utilization Management	
EFFECTIVE DATE: 2/9/16	**BOARD APPROVAL DATE:** 3/9/16	
REVIEWED DATE: 3/7/23	**REVISION(S) TO POLICY STATEMENT** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☐ **Yes** ☒ **No**
RESPONSIBLE PARTY: UM Coordinator	**CEO APPROVAL:** 3/7/23 Megan Rooney, Interim CEO	

APPLIES TO

NorthCare Network Personnel
MI Health Link Network Providers

POLICY

It is the policy of NorthCare Network to ensure individuals enrolled in the MI Health Link (MHL) Program are appropriately screened and authorized for services that are medically necessary to meet the needs of the individual.

PURPOSE

To describe NorthCare Network's process of managing services and authorizations for individuals enrolled in the MI Health Link (MHL) program.

DEFINITIONS

Altruista- Electronic medical record managed by the Upper Peninsula Health Plan (UPHP). Altruista is the vehicle by which select NorthCare staff can access MI Health Link beneficiary medical records and participate in direct messaging with UPHP clinical staff for those beneficiaries/consumers.

Behavioral Health Provider – A Psychiatrist, Clinical Psychologist, Physician Assistant, Certified Nurse Practitioner, or Licensed Masters level Social Worker who provides behavioral health services within their scope of practice.

Behavioral Health Services – a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for mental and/or substance use disorders. (SAMHSA)

Clean Claim - a claim that has no defect, impropriety, lack of any required substantiating documentation- including the substantiating documentation needed to meet the requirements for encounter data- or particular circumstance requiring special treatment that prevents timely payment as indicated by Provider Manual; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Consolidated Billing- reimburses the skilled nursing facility (SNF) for the entire package of care that a resident would receive during a covered Medicare Part A stay, except for:

a. Psychiatrist only
b. Psychiatric nurse practitioner
c. Nurse Practitioner (non-psychiatric service only)

Note: Physician (non-psychiatrist) Professional Services are not covered by NorthCare Network

Continuing Stay Review- A review conducted by a Utilization Management reviewer to determine if the current place of service is still the most appropriate to provide the level of care required by the client.

Continuity of Care – Persons who had been actively involved with a provider within the last 12 months prior to enrollment into the MHL program. The Continuity of Care period will be the 90 days after the beneficiary becomes eligible for MHL.

Deeming Status – If a consumer had a period of eligibility under the MI Health Link program but current eligibility checks show them to be ineligible, the consumer may be placed in a "Deeming" status for up to three months. During that period, the consumer may be eligible for Medicare benefits under the MI Health link program. Situations where the consumer would not be eligible for MI Health Link during the three month deeming status include: the consumer deciding they no longer wanted to participate in the MI Health Link program. "Deeming" status should be confirmed by talking to a UPHP case manager.

Distant Site- The location of the health professional providing psychiatric services via the telecommunications system.

Emergent Care – A situation in which a beneficiary's condition is thought to need immediate behavioral health intervention to prevent serious harm to themselves or others, or care must be provided within 24 hours as the beneficiary's condition is likely to deteriorate to the point where they are a danger to themselves or others.

Episode of Care – All behavioral health services provided to a beneficiary related to a specific behavioral health condition, within a specific period of time, by a provider.

Excluded from Consolidated Billing- means that the service provided must be billed to Medicare by the physician that performed the service. Excluded services are to be separately billed by physicians or other qualified providers.

Federally Qualified Health Center- is a reimbursement designation from the Bureau of Primary Health Care Centers for Medicare and Medicaid. FQHC's include organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid as well as other benefits. FQHCs must be a nonprofit or public organization, serve an underserved population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program and have a governing board of directors. Federally Qualified Health Centers may provide Mental Health Services.

Non-Covered Medicare Part A Stay- (Part A stay days are exhausted or no longer meet medical necessity). There is no consolidated billing (PPS) for non-skilled or non-Part A stay days. Physician Professional and Ancillary Services are billed to MHL Medicare by the physician or other service provider.

a. Psychiatrist
b. Psychiatric Nurse Practitioner under the direction of the physician
c. Nurse Practitioner (non-psychiatric service only)
d. Clinical Psychologist
e. Licensed Master Social Worker (LMSW)

Note: Physician (non-psychiatrist) professional and ancillary services are not covered by NorthCare Network.

Originating Site- The location of the individual at the time the service is occurring via the telecommunications system. Per MDHHS policy, the following sites are eligible as originating sites via telecommunications: Community Mental Health Service Provider (CMHSP), Federally Qualified Health Center (FQHC), Hospital (inpatient, outpatient, or critical access hospital (CAH), Office of physician or other practitioner, Rural Health Clinic (RHC), Skilled Nursing Facilities, and Tribal Health Center (THC).

Prior Authorization- A review conducted by a Utilization Management reviewer to determine if a requested service is medically necessary.

Retroactive Review- A review conducted by a Utilization Management reviewer to determine if a service that had been provided was medically necessary.

Routine Care - All other requests for mental health services that do not fit under the Urgent or Emergent Care categories

Skilled Nursing Facilities (SNF)- are reimbursed by Medicare under the SNF Consolidated Billing Perspective Payment System (PPS). All services provided to the patient in a Medicare Part A stay are considered covered under consolidated billing. In other words, services provided to a beneficiary whose nursing home stay is being covered by Medicare would be covered under consolidated billing.

Urgent Care – A situation in which a beneficiary's condition is thought to need behavioral health intervention within 48 hours or the beneficiary's condition could deteriorate to a point where they are a danger to themselves or others.

HISTORY

NEW POLICY: 2/9/16
REVISION DATE: 5/10/16, 2/27/17, 12/20/17, 11/5/18, 2/26/20, 3/1/21, 2/28/22
REVIEW DATE: 5/10/16, 2/27/17, 12/20/17, 11/5/18, 2/26/20, 3/1/21, 2/28/22, 3/7/23
CEO APPROVAL DATE: 5/16/16, 3/8/17, 1/8/18, 11/6/18, 2/26/20, 3/2/21, 3/3/22, 3/7/23
BOARD APPROVAL DATE: 3/9/16

REFERENCES

MI Health Link ICO/PIHP Contract
NorthCare Network Coordination, Communication, Consent to Share Information Policy
Mental Health Code
Medicaid Provider Manual
MI Health Link Continuity of Care Guidance
Medicare Benefit Policy Manual Publication 100-02
Wisconsin Physician Services Local Coverage Determination
NorthCare Request for Authorization Form
NorthCare Retrospective Preadmission Screening Procedure
NorthCare Preadmission Screening Policy

PROCEDURES

1. Eligibility
   MHL beneficiaries are identified via CHAMPS eligibility check and have an insurance code of ICO-MC and the county. MHL enrollment must be tied to one of the 15 counties in the Upper Peninsula. MI Health Link eligibility should also be verified in Altruista. If there are discrepancies in eligibility between the two systems, NorthCare will contact UPHP to clarify eligibility issues. A MHL beneficiary may be eligible for mild to moderate mental health services during a deeming status or continuity of care period. Verification of MI Health Link (MHL) enrollment by the provider is required; claims for services provided to non-MHL eligible enrollees will not be paid by NorthCare Network.

2. Access To Service
   A. MHL beneficiaries have a choice of providers, including their local Community Mental Health Agencies. All providers are listed in the NorthCare Provider Directory and can be found at www.northcarenetwork.org If an individual is already in care and wishes to continue with their current provider they can do so; as long as their current provider is enrolled in NorthCare Network's MHL Provider Network. If the provider is not enrolled and chooses not to enroll or is ineligible for the MHL provider panel, NorthCare Network Access staff will assist the individual in identifying enrolled providers.
   B. An Access Screening and a Level II Assessment (LOCUS, ASAM, SIS) will be conducted by qualified staff to determine appropriate level of care within 15 days of a Level I referral from UPHP, if the consumer is willing to participate in the assessment.
   C. Individuals determined to need SMI/IDD/SUD level of care and are agreeing to that level of care, will be referred to their local Community Mental Health or a SUD provider.
   D. Individuals requesting or determined to need Mild/Moderate level of care may:
      i. be directly connected to a provider of their choice by NorthCare Access staff; or
      ii. contact a MHL enrolled provider and notify NorthCare Access which provider they chose and date/time of their first appointment. The Access Staff will add the appropriate admission and authorization in the electronic record once notified of chosen provider.

3. Notification to NorthCare Network Access Unit for Urgent and Emergent Services
   Emergent services can be provided in a variety of settings including at a CMHSP, Hospital Emergency Room or via a crisis call to a CMHSP. Emergency room visits are paid by UPHP. Emergency room crisis services provided by CMHSP Emergency Services staff are paid by the PIHP under MHL. Prior authorization is not required for urgent or emergent services. NorthCare does not delegate the authorization of Medicare benefits. NorthCare does request notification of inpatient hospitalization by the provider for inpatient services. NorthCare will conduct inpatient Continuing Stay Reviews once the inpatient service begins once notified that inpatient hospitalization has occurred. If an inpatient hospitalization had occurred and NorthCare had not been notified, NorthCare will conduct a Retroactive Review to determine the Medical Necessity for services provided.

4. Notification to NorthCare Network for Routine Services
   NorthCare does not require prior authorization for routine Medicare services. NorthCare does not delegate the authorization of Medicare benefits. NorthCare does request notification of routine services by the provider. NorthCare will conduct Retroactive Reviews with providers of routine services when utilization patterns warrant a review.

5. Utilization Management
   NorthCare utilizes the criteria established in the Michigan Medicaid Provider Manual to make authorization decisions for MHL beneficiaries that are receiving SMI, I/DD or SUD services. NorthCare has adopted the most recent updated version of the Wisconsin Physician Services Local Coverage Determination (WPS LCD) document to assist in making authorization decisions for those consumers who are receiving mild to moderate mental health services.

   To ensure most successful outcome for each individual and the most effective and efficient use of resources, UM will review cases that seem excessive in requests for authorization or appear to have service duplication between providers. This will be completed via documentation reviews and/or site visits.

   If NorthCare UM determines that services no longer appear medically necessary authorizations will cease. At this time, UM will provide appropriate Action notice to the consumer and will also notify the requesting provider.

   UM staff do not issue reversals of previously authorized services unless new information, relevant to the decision and not available at the time of the review, is received. Reversing a previously authorized service will be done in situations where:
   - It is learned that a provider had given inaccurate information on a consumer.
   - When it has been determined that a consumer was not in fact eligible for benefits.
   - Provider did not live up to contractual obligations
   - Documents reviewed during the retrospective review process do not support the service was provided in a manner consistent with benefit plan requirements for which an individual is eligible.

6. Denial of Payment

   If a provider fails to provide documentation that sufficiently supports the need for ongoing authorization, payment may be denied in full or in part. NorthCare Network's Utilization Management (UM) staff will review clinical information provided. UM reserves the right to deny or reduce ongoing authorization due to treatment that is not effective, documentation not supporting the need for treatment or ongoing treatment, or if the service is a non-covered benefit. NorthCare identifies evidence-based guidelines as the basic platform to define established standards of effective care.

   Administrative denials involve issues outside of the scope of the clinical review which include:

   - Lack of information denial: Provider/facility failed to provide NorthCare with clinical information regarding an inpatient admission or continuing stay within 24 hours of the previously approved course of treatment. Provider/facility did not respond to, or decided not to participate in, a peer to peer consultation before the expiration of the previously approved course of treatment when they were notified that the initial clinical reviewer could not continue recertification of the stay.

7. Claims

   All claims are expected to be received at NorthCare within 30 days following service. Claims are processed and paid within 30 days of receipt of a "clean claim".
   Start and stop times are "required" for all Medicaid and block grant claims and are "preferred" for all Medicare claims. Providers using paper claims are encouraged to use the HICFA 1500 and will submit via the standard mail system or secure fax. NorthCare MHL payments are made in accordance with the Medicare Physician Fee Schedule. NorthCare MHL payment is considered payment in full. The patient/consumer cannot be balance billed for charges exceeding the Medicare Fee Schedule.

8. Coordination of Care

   Individuals enrolled in the MHL program have a choice of Care Coordinators. The Integrated Care Organization (ICO)/Upper Peninsula Health Plan (UPHP) has identified care coordinators whose primary focus is on primary health issues and NorthCare Network utilizes CMHSP Case Managers/Supports Coordinators whose primary focus is on behavioral health issues. Each is responsible to ensure proper coordination of care with the other. Individuals with Mild/Moderate needs may have their care coordinated by NorthCare Network qualified clinical staff. The Universal Consent will be obtained by their primary care coordinator who is responsible to ensure individuals understand the importance of including the Medicaid Health Plan/UPHP, NorthCare Network/PIHP, and all providers whom they want included in their integrated/coordinated care. The completed Universal Consent must be faxed to NorthCare and UPHP. Coordination, via care team meetings involving the consumer, and coordination between UPHP and NorthCare will happen regularly. With proper authorization from the individual/guardian, NorthCare and UPHP will utilize a direct messaging system (Altruista) to assist in communication, referrals, and coordination care activities for shared members/consumers.

9. Provider Enrollment

   Providers must be enrolled in NorthCare Network's Provider Panel in order to receive payment from NorthCare for services provided. If a service is provided and the provider is not enrolled, payment will be denied beyond the continuity of care period of 90 days from the date the individual enrolled in the MHL Program.

   Providers must be both Medicaid and Medicare enrolled with appropriate degree and current licensure. Providers will need to complete NorthCare paperwork to become enrolled and complete required training which may be through self-study.

10. Authorization and/or Documentation in NorthCare's Electronic Health Record (ELMER)
    - CMHSP Providers utilize the ELMER system for continued stay reviews and all clinical documentation.
    - SUD Providers utilize the ELMER system for claims and/or continued stay reviews
    - Other community providers currently have the option of using ELMER for continued stay reviews and the ability to view clinical documentation as authorized. This is highly recommended as it eliminates the need for faxing Requests for Authorization and supporting documentation and allows for quicker payment of claims.
    - Providers also have the ability to look up the available authorizations at any time.