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: 9/3/24	**REVISION(S) TO POLICY STATEMENT** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☒ **Yes** ☐ **No**
RESPONSIBLE PARTY: QI/UM Director	**CEO APPROVAL:** 9/3/24 Megan Rooney, 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 Medicare covered behavioral health services that are medically necessary to meet the needs of the individual.

PURPOSE
To describe NorthCare Network's process of managing Medicare covered behavioral health 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.

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 – The MHL program allows members to remain enrolled for up to three months when members no longer meet the Medicaid eligibility requirements to participate in the program. Deeming allows members to continue to receive Medicaid services while they await Medicaid redetermination and prevents beneficiaries from being disenrolled from MHL. During the deeming period, NorthCare Network is required to provide MHL Medicare services and to pay providers for rendered services to MHL members during the deeming period.

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.

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

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, 7/1/24, 9/3/24
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, 7/1/24, 9/3/24
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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
MI Health Link Continuity of Care Guidance
Medicare Benefit Policy Manual Publication 100-02
NorthCare Request for Authorization Form
NorthCare Retrospective Preadmission Screening Procedure
NorthCare Preadmission Screening Policy

PROCEDURES

NorthCare Network requires authorization for Medicare covered inpatient and partial hospitalization psychiatric services for the UPHP MHL program.

Requests for services can be made by the following:

- UPHP MHL member
- Authorized member representative
- Contract or non-contract provider that furnishes or intends to furnish services to the member or staff of said provider acting on the provider's behalf

Requests can be verbal or written. The CMHSP will complete a preadmission screening for individuals requesting services. If a screening is not completed, retrospective reviews may be completed.

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. 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
   B. For Substance Use Services, an SUD Access Screening and appropriate assessment will be conducted by qualified staff to determine appropriate level of care.

3. Notification to NorthCare Network for Urgent and Emergent Services
   Emergent services can be provided in a variety of settings including at a Community Mental Health (CMH) office. Hospital Emergency Room or via a crisis call to a CMH agency. Emergency room visits are paid by UPHP. Emergency room crisis services provided by CMH 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. The CMH will assist in safety planning and crisis intervention but determination to admit to inpatient psychiatric care or not will be deferred to the Emergency Department (ED) physician. 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. NorthCare staff will arrange for a peer to peer review by an independent review organization psychiatrist if medical necessity appears to no longer be met.

4. Utilization Management

   NorthCare utilizes MCG behavioral health guidelines for psychiatric admissions. UM criteria area applied on a case-by-case basis to incorporate individual needs and to assess the local delivery system for applicable resources or alternatives. Criteria for Medicare covered behavioral health services will be sent at least annually to the UPHP Clinical Advisory Committee (CAC) for review and approval.

   Clinical information utilized to support UM decision making may include any documents submitted; however submission of the psychiatric notes and social work notes is encouraged.

5. Professionals Making UM Determinations

   Practitioner Reviewer - professional with education, training, or professional experience in medical or clinical practice possessing current licensure without restriction; may review medical necessity and benefit requests for health care services. The Practitioner Reviewer is the only UM professional allowed to deny a request for medical necessity services which includes the reduction in the amount, duration, or scope of an item or service less than requested. This Reviewer is a health care professional with appropriate clinical expertise in treating the indicated medical condition, performing the procedure, or providing the treatment.

   Physician – required for denial of inpatient psychiatric, partial hospitalization, and crisis residential levels of care.

   MCBAP credential– required for denial of residential substance use treatment. (Note – there is no Medicare benefit for residential SUD treatment, therefore payment reverts to Medicaid for MHL individuals).

   If a provider fails to provide documentation that sufficiently supports the need for ongoing authorization, authorization 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.

   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.

   If NorthCare Network UM determines that services no longer appear medically necessary, UM will provide whatever information was obtained for a review of

records by a psychiatrist. If that results in denial, appropriate notification will be sent to the member and NorthCare 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. Timeliness of UM Decisions and Notifications

Coverage requests are received on the date and time:

- NorthCare Network stamps a document received by regular mail
- A faxed document is successfully transmitted to NorthCare Network, as indicated on the fax transmission report.
- A verbal request made by telephone with CMH or NorthCare staff
- A message is left on NorthCare's voicemail after normal business hours as indicated on the voicemail.

UM decisions are made within 72 calendar hours for expedited requests and 14 calendar days for Routine requests.

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. Continuity of Care

NorthCare Network is required to cover previously approved Medicare covered behavioral health services, including out-of-network services, to prevent disruption of care when a new member is enrolled in the MHL program. The member must have a relationship with a provider to establish continuity of care. NorthCare Network will allow member access to any provider seen by the member within the previous twelve months. For members enrolled in the Habilitation Supports Waiver and Specialty Services and Supports Program, they can continue with their current provider for 180 calendar days and honor existing plans of care or prior authorizations. For all other UPHP MHL members, they may maintain their current provider for 90 calendar days or within 180 calendar days for existing plans of care and prior authorizations.

9. 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. 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.

10. Authorization and/or Documentation in NorthCare's Electronic Health Record (ELMER)
    - CMH Providers utilize the ELMER system for all clinical documentation.
    - SUD Providers utilize the ELMER system for claims and/or continued stay reviews