Behavioral Health Service Medical Necessity Criteria Policy

POLICY

It is the policy of the Detroit Wayne Integrated Health Network (DWIHN) to use objective and evidenced-based criteria/best practices, when available, taking into consideration the enrollee/member's individual circumstances and the local delivery system when determining the medical appropriateness of behavioral health care services. The DWIHN uses written criteria based on sound clinical evidence to make Utilization Management (UM) decisions, and specified procedures for appropriately applying the criteria to validate the appropriate level of care.

PURPOSE

The purpose of this policy is to ensure that medical necessity determination decisions are conducted using defined criteria and standardized service selection guidelines, and to ensure the criteria used is applied consistently by all staff making UM decisions.

APPLICATION

This policy applies to all DWIHN staff, Access Center staff, Contractual staff, Provider Network Services staff, and Crisis Screening Entities. This policy serves all populations: Adults with Severe Mental Illness (SMI), Children with Serious Emotional Disturbance (SED), Persons with Intellectual/Developmental Disabilities (I/DD) and Persons with Substance Use Disorders (SUD) and all funding streams and waiver programs such as MI Health Link, SUD, Autism Spectrum Disorder and Medicaid.

KEY WORDS

1. American Society of Addiction Medicine (ASAM)
2. Behavioral Health Supports and Services
3. Clinical Appropriateness
4. Evidence Based Practice

5. Indicia

6. Local Coverage Determination (LCD)

7. Level of Care

8. Medical Necessity Criteria

9. National Coverage Determination (NCD)

**STANDARDS**

1. DWIHN has adopted nationally developed and published Behavioral Health guidelines from MCG which is part of the Hearst Health Network. MCG utilizes clinical editors who analyze and classify more than 150,000 peer reviewed papers and research studies each year. By applying rigorous evidence classification techniques, they select more than 41,000 unique references to formulate into medical necessity clinical guidelines. Nationally recognized quality measures from the Hospital Quality Alliance are also embedded in the guidelines. The clinical editors are supported by a team of data analysts, librarians, and medical copy editors who together have over 115 cumulative years of guideline development experience. In addition, the team coordinates peer reviews by panels that include approximately 100 additional clinicians.

2. The MCG Behavioral Health Medical Necessity Guidelines describe best practice care for the majority of mental health and substance related disorder diagnosis, covering 15 diagnostic groups with graded evidence from published resources. Some of the best known resources include the American Psychiatric Association, the American Association of Pediatrics, the American Society of Addiction Medicine, the National Institute on Alcohol Abuse and Alcoholism and the Local and National Coverage Determination criteria due to their acceptance as the best of evidence-based/best practice and emerging practice for mental health and substance use disorders. This criteria then serves as a decision support tool to help define the most appropriate treatment setting and help assure consistency of care for each individual. DWIHN believes it's criteria should be transparent and available to everyone and be flexible enough to continuously adapt to the changes in mental health and substance use disorder treatment systems.

3. MCG Behavioral Health Criteria, 24th Edition includes the following:
   a. 43 Guidelines that help identify the most effective level of care for specific behavioral health conditions; and
   b. Level of care guidelines that assess an enrollee/member's level of care needs in situations where a diagnosis-specific guideline does not apply, including crisis intervention and observation; and
   c. Detailed discharge criteria that focus on specific care elements to consider when discharging an enrollee/member to a lower level of care; and
   d. Flexible recovery courses to manage longer behavioral health episodes; and
   e. Alternate care planning to help with select alternative therapies and level of care based on specifics of enrollee/member's case.

4. For MI Health Link enrollees/members, the National Coverage Determination (NCD) criteria developed by the Centers for Medicare and Medicaid Services (CMS) is utilized. If no NCD has been issued or an NCD requires further clarification, a Local Coverage Determination (LCD) is used. LCD's are developed by the Medicare Administrative Contractor for the geographic service area and either supplements or explains when an item or service will be covered if there is no NCD. In addition, the CMS Coverage Manual or
other CMS based resources such as the Medicare Program Integrity and Medicare Benefit manuals are used to determine coverage provisions for this population. In coverage situations where there is no NCD or LCD or guidance on coverage in the original Medicare manuals, DWIHN may make its own coverage determination utilizing the MCG criteria or sends the case out to an Independent Review Entity who provides rationale for using an objective evidence based process. Communication will also be sent to the Medicare Administrative Contractor to be addressed.

5. DWIHN has adopted nationally developed and published criteria from the American Society of Addiction Medicine (ASAM) to determine medical necessity and level of care decisions for substance use disorders (SUD). This criteria has become the most widely used and comprehensive guidelines for placement, continued stay, and transfer/discharge of enrollee/members with addiction and co-occurring conditions. ASAM's criteria provide separate placement criteria for adolescents and adults developed through a multidimensional assessment over five (5) broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety, and security provided and the intensity of treatment services provided. It uses six (6) dimensions including Acute Intoxication and/or Withdrawal Potential, Biomedical Conditions and Complications, Emotional/Behavioral Conditions, Treatment/Acceptance/Resistance, Relapse/Continued Use Potential and Recovery Environment to create a holistic assessment of an individual to be used for service planning and treatment across all service and levels of care. Through this strength-based multidimensional assessment, the ASAM criteria addresses the individual's needs and obstacles as well as their strengths, assets, resources and support structure. The website https://ASAM.org, and the attached Level of Care Grid further describe the medical necessity criteria. The ASAM Criteria, Third Edition, is copyrighted and only available in hard copy but can be purchased by contacting:

**American Society of Addiction Medicine 4601 North Park Ave**
**Upper Arcade Suite 101**
**Chevy Chase, MD 20815**
**Telephone: 301-656-3920 Fax: 301-656-3815**
**Email: email@asam.org**

6. Oversight and revision of the criteria is collaborative between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria. The coalition represents major stakeholders in addiction treatment and has been meeting regularly since the development of the first ASAM Patient Placement Criteria in 1991. The coalition addresses feedback and ensures that the Criteria adequately serves and supports medical professionals, employers, purchasers and providers of care in both the public and private sectors.

7. The most recent Michigan Medicaid Provider Manual describes services and medical necessity criteria for Children and Young Adults with Autism Spectrum Disorders.

8. The following services must receive a clinical review and application of medical necessity criteria utilizing the MCG Behavioral Health Guidelines prior to the service being rendered:
   a. Acute inpatient; or
   b. Partial hospitalization; or
   c. Crisis residential.

9. Pharmaceutical Services - In the event, an uninsured consumer requires medication, a "General Fund Exception for Medication Only Form" is submitted to DWIHN for authorization approval.

10. The MCG Behavioral Health Medical Necessity Criteria and DWIHN's procedures for application is reviewed at least annually. MCG annual updates are based on the most current research, relevant quality...
standards and evidence-based/best practice, and emerging practice models of care. As noted above, in the event there are changes to the ASAM Criteria and/or National Coverage Determination Criteria or the Local Coverage criteria (LCD/NCD criteria), these changes are reviewed as they occur or at a minimum, annually.

11. Any updates to the MCG, ASAM or LCD/NCD criteria, or Medicaid Provider Manual for Autism Spectrum Disorders will be reviewed and shared with the applicable clinicians and/or committees or professional work groups as applicable:
   a. Practice Collaboratives such as Adult MI Learning Collaborative;
   b. Provider partnership meetings; and
   c. DWIHN Improving Practices Leadership Team (IPLT) Meetings.

12. Once approved by the Chief Medical Officer, and reviewed by the applicable practitioner/provider groups, DWIHN requires the Access Center, the Crisis screening entities and providers using MCG software to have the on-line version of the MCG Behavioral Health guidelines installed and make it accessible to all clinical practitioners during hours of operation should the Internet not be available. DWIHN makes the most current version of the personal computer (PC) software of the Behavioral Health Medical Necessity Guidelines available for download at the time of initial distribution through various means such as: secured Google drive, or removable media such as a flash drive or DVD thus allowing access to the criteria in the event of a mass or individual Internet outage or for contracted practitioners/providers without Internet access. Notification is emailed, mailed, or faxed to all contracted practitioners/providers using the behavioral health guidelines advising them when the criteria or updates to the criteria are available.

13. Since the MCG Behavioral Health Medical Necessity Guidelines are proprietary, access to the entire criteria is limited to the DWIHN provider network. Specific criteria related to an individual case is available by request to non-contracted providers/practitioners and enrollee/members as noted below. A log in and password can be obtained from the DWIHN UM Department. The URL to the MCG Behavioral Health Guidelines is https://cgi.careguidelines.com/login-careweb.htm. DWIHN mails the criteria to practitioners without Internet access.

14. All staff making utilization management decisions receive initial training on the criteria. Staff are also able to access MCG web seminars/webinars on the behavioral health guidelines and a variety of behavioral health utilization management and health-care related topics on demand.

15. The determination of a medically necessary support, service or treatment must be:
   a. Based on information provided by the enrollee/member, the enrollee/member's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the individual; and
   b. Based on clinical information from the enrollee/member's health care professionals with relevant qualifications who have evaluated the member; and
   c. For enrollee/members with mental illness or intellectual developmental disabilities, based on person centered planning; and for members with substance use disorders, based on individualized treatment planning; and
   d. Made by appropriately educated, trained and licensed mental health, substance abuse and/or intellectual and/or developmental disabilities professionals such as a Qualified Mental Health Professional (QMHP) and/or a Qualified Intellectual Disability Professional (QIDP), Children's Mental Health Professional (CMHP) and Substance Abuse Treatment Specialist (SATS) as defined by the Medicaid Provider Manual.

16. When applying the criteria, UM Reviewers shall consider the characteristics of the local delivery system
that are available to the member, such as the availability of alternative levels of care; highly specialized services, recommended services within the estimated length of stay and the benefit plan coverage options.

17. When applying the medical necessity criteria, UM Reviewers shall ensure that treatment is provided at the most appropriate, least restrictive level of care necessary to provide safe and effective treatment and meets the enrollee/member's individual needs. Consideration is given to at least the following individual characteristics when applying the medical necessity criteria: age, comorbidities, complications, progress of treatment, psychosocial situations, available services in the local delivery system and home environment, as applicable. In assessing the local delivery options that would meet an individual's specific health care needs, consideration is given to the availability of services including:

a. Availability of inpatient, outpatient and transitional facilities.

b. Availability of highly specialized services, such as detoxification facilities.

c. Availability of partial hospitalization and other step-down services in the organization's service area to support the patient after hospital discharge.

d. Local hospitals’ ability to provide all recommended services within the estimated length of stay.

18. Decisions about the following require medical necessity review:

a. Covered medical benefits defined by DWIHN's Benefit Policy

b. Preexisting conditions, when the enrollee/member has creditable coverage and if there exists a policy to deny preexisting care or services; or

c. Care or services whose coverage depends on specific circumstances; or

d. Out-of-Network services when they may be covered in clinically appropriate situations; or

e. Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program; or

f. Experimental or investigational requests, unless the requested services or procedures are specifically excluded from the benefits plan and deemed never medically necessary under any circumstance in DWIHN's policies, then medical necessity review is not required.

19. Decisions about the following do not require medical necessity review:

a. Services in the enrollee/member's benefits plan that are limited by number, duration or frequency;(such as SED Waiver Services)

b. Extension of treatments beyond the specific limitations and restrictions imposed by the enrollee/member's benefits plan;

20. DWIHN believes that all treatment decisions made in alignment with the applicable medical necessity criteria or other utilized criteria must be first and foremost clinically based. Care must be patient-centered and take into account the enrollee/member's needs, clinical and environmental factors, and personal values. The applicable criteria do not replace clinical judgment, and every treatment decision must allow for the consideration of the unique situation of the individual. In this way, the Criteria promote advocacy for the enrollee/member and enhance the collaboration between DWIHN and providers to achieve optimal, patient-centered outcomes. They also promote consistent communication and coordination of care from one treatment setting to the next.

21. For urgent pre-service and concurrent adverse determination notices when an enrollee/member is hospitalized, the UM staff will inform the hospital UM department staff of its decision, either verbally or
electronically with the understanding that they will inform the attending/treating practitioner. Written notification of the adverse determination is addressed to both the provider and enrollee member.

22. Using the medical necessity criteria, appropriate professionals may deny services that are:
   a. Deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
   b. Experimental or investigational in nature; or
   c. For which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services.

23. A denial of service can only be made by a physician (DO or MD) or physician certified in addiction medicine.

24. Physicians may not deny services based solely on pre-set limits of the cost, amount, scope and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis applying clinical appropriateness.

25. Staff performing utilization management functions must be credentialed and re-credentialed. The credentialing process defined by the DWIHN ensures that staff making UM decisions meet at least Michigan Department of Health and Human Services (MDHHS) licensing, training and scope of practice, as well as contractual and Michigan Medicaid Provider Manual requirements.

26. Only highly qualified clinicians such as an MD, DO, PhD, PsyD, LPC, LMSW, LMFT, LLP, MSN, Psychology BA, Nurse Practitioner (NP) and BSN who have demonstrated experience in the specialty areas in which they are making decisions may initiate and carry out UM review functions.

27. Due to a potential conflict of interest, practitioners may not provide direct services; including crisis intervention, for the persons they are screening for pre-admission (pre-service), concurrent and/or retrospective (post-service) reviews or appeal reviews. Per MDHHS, an exception to this is ACT teams conducting PAR screenings for their ACT team members.

28. DWIHN shall provide its medical necessity criteria to the Access Center, Crisis Screening Entities, and Practitioners/Providers, ICOs, enrollees/members and other stakeholders upon request free of charge. Criteria can be requested to be provided by email, fax, mail, in person or by telephone. A log will be kept of any instances of request. The medical necessity criteria are compliant with contractual and regulatory requirements of font (at least 12 point type size) and available in alternative mediums such as larger font (at least 16 point font), Braille, or audio format.

QUALITY ASSURANCE/IMPROVEMENT

1. DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the Quality Assessment Performance Improvement Program (QAPIP) Goals and Objectives.

2. DWIHN's Quality Improvement Program must include measures for both the monitoring of and the continuous improvement of the program or process described in this policy.

3. Inter-Rater Reliability case review testing is required and completed annually by all DWIHN, Crisis Screening entity staff, and provider staff making UM decisions to ensure consistent application of medical necessity criteria and appropriate level of care decisions according to the Inter-rater Reliability Policy.
COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, Crisis Screening Entity staff, provider staff, contractors and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. DWIHN UM Program Description FY 2019-2021
2. MDHHS and DWIHN Contract, FY 19

RELATED POLICIES

1. Appropriate Professionals for Utilization Management Decision Making Policy
2. Behavioral Health Utilization Management Review Policy
3. Denial of Service Policy
4. Inter Rater Reliability Policy
5. Customer Service Member Appeal Policy
6. Standard of Conduct Policy
7. Utilization Management/Provider Appeal Policy
8. UM Review Procedure for Substance Use Disorders Procedure
9. Training Opportunities for Use of MCG Evidence Based Behavioral Health Guidelines, Including Indicia Procedure
10. Use of MCG Indicia for Case Management Software and Behavioral Health Guidelines Supporting Medical Necessity Procedure

RELATED DEPARTMENTS

1. Clinical Practice Improvement
2. Compliance
3. Customer Service
4. Information Technology
5. Integrated Health Care
6. Managed Care Operations
7. Quality Improvement
8. Recipient Rights
9. Residential Services
10. Substance Use Disorder
11. Utilization Management

CLINICAL POLICY

Yes

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments

Detroit Wayne Integrated Health Authority Medical Necessity Criteria References.docx

Approval Signatures

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