POLICY AND PROCEDURE MANUAL

SUBJECT Service Authorization	ACCOUNTABILITY NMRE and NMRE Network Providers	Effective Date: 01/01/2022	Pages: 5
REQUIRED BY: 42 CFR §438.210(B)(1-2) 42 CFR §438.210(d)(2)(i-ii)	PIHP Contract Section L, Schedule E, Other: Appeal and Grievance Resolution Processes Technical Requirement	Last Review Date: 10/29/2025	Past Review Date:
Policy: ☒ Procedure: ☐	Review Cycle: Annual Author: Chief Clinical Officer	Responsible Department: Access	Reviewers: Compliance and Access

Definitions

Adverse Benefit Determination: A decision that adversely impacts a Medicaid beneficiary (42 CFR 438.400)

Authorization of Services: The processing of requests for initial and continuing service delivery.

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or his/her representative. For the purposes of this policy, the terms "beneficiary" and "member" are used interchangeably.

Code of Federal Regulations (CFR): The codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It is divided into 50 titles that represent broad areas subject to Federal regulation

Community Mental Health Services Program (CMHSP): For the purposes of this document, a CMHSP Member is one or more of the following: AuSable Valley Community Mental Health Authority, Centra Wellness Network, North Country Community Mental Health, Northeast Michigan Community Mental Health Authority, and Northern Lakes Community Mental Health Authority.

Electronic Medical Record (EMR): A digital record of a patient's health record, including but not limited to, medical history, demographics, medications, and diagnoses.

Expedited Authorization Decision: For cases in which a provider indicates, or PIHP determines, that following the standard timeframe could seriously jeopardize the enrollee's lise or heath or ability to attain, maintain or regain maximum function, the PIHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's condition requires and no later than 72 hours after receipt of the request for services.

Expedited Service Request: Expedited Service decisions are made within seventy-two (72) hours after receipt of a request.

Medical Necessity: A determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology, and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care.

Michigan Department of Health and Human Services (MDHHS): The principal department of the state of Michigan, headquartered in Lansing, which provides public assistance, child and family welfare services, and oversees health policy and management.

Northern Michigan Regional Entity (NMRE): Northern Michigan Regional Entity/Region 2 PIHP covering Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle Roscommon, and Wexford counties in northern Lower Michigan.

Notice of Adverse Benefit Determination: A written statement advising the beneficiary of a decision to reduce, suspend, or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid beneficiary at least 10 calendar days prior to the proposed date the Adverse Benefit Determination is to take effect.

Network Provider: Any provider, group of providers, or entity that has a provider agreement with the NMRE or its CMHSPs, and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the NMRE's Specialty Supports and Services Contract with the State.

Prepaid Inpatient Health Plan (PIHP): One of ten organizations in Michigan responsible for managing Medicaid services related to behavioral health, development disabilities, and substance use.

Service Authorization: PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration or scope less than requested, all as required under applicable law, including but not limited to 42 CFR 438.210.

Standard Service Request: A non-emergency request for mental health services for which a decision is to be provided within 14 calendar days from the date of receipt of a standard request for service. (42 CFR 438.210(d)(1))

SUD Provider Network: Refers to a Substance Use Disorder (SUD) Provider that is directly under contract with the NMRE to provide services and/or supports.

Purpose

The purpose of this policy is to ensure that medical necessity determination decisions are made by appropriate professionals, based on established criteria, and completed in a timely manner that meets the needs of individuals requesting services. Beneficiaries are informed of Adverse Benefit Determinations in a timely fashion as outlined below and in NMREs "Beneficiary Grievance and Appeal" policy.

Policy

A) All service authorizations will be made in compliance with applicable state and federal law, the Michigan Medicaid Provider Manual, and applicable NMRE policies.

B) The NMRE utilizes formalized, evidence based, care guidance to make utilization management decisions.

C) Mental health, intellectual/developmental disabilities, and substance use services may be deemed medically necessary when they meet the following criteria, or other criteria as set forth in the current version of the Michigan Medicaid Provider Manual and applicable NMRE policies:

   1) Necessary for screening and assessing the presence of a mental illness, developmental disability, or substance use disorder;
   2) Required to identify and evaluate a mental illness, developmental disability, or substance use disorder;
   3) Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, developmental disability, or substance use disorder;
   4) Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
   5) Designed to assist the person served to attain or maintain a sufficient level of functioning to achieve their goals of community inclusion and participation, independence, recovery, or productivity

D) All denials based on medical necessity will be made by appropriately trained and credentialed professionals with their credentials displayed in the Electronic Medical Record (EMR) and on documentation signatures.

E) When a beneficiary and/or their authorized representatives requests services from an out-of-network provider, the NMRE will make an authorization and/or non-authorization determination on a case-by-case basis. The NMRE expects that an out-of-network provider makes an effort to secure prospective authorization before services are initiated and agrees to enter into a single case agreement.

F) The NMRE will ensure that authorized services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished and as otherwise consistent with NMRE PIHP contract.

G) Medicaid enrollees shall be provided an appropriate Notice of Adverse Benefit Determination in any case where a service authorization request is denied, or a Medicaid service is authorized in an amount, duration, or scope that is less than requested.

H) NMRE will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition.

I) NMRE may place appropriate limitations on services rendered:

   1) Services may be denied when:
      a) They are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

b) They are experimental or investigational in nature; and/or
c) There exists another appropriate, efficacious, less restrictive, and cost-effective service, setting or support that otherwise satisfies the standards for medically necessary services.

2) NMRE will 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 will be conducted on an individualized basis.

3) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the individual's ongoing need for such services and supports.

J) For the processing of requests for initial and continuing authorizations, NMRE will:

a) Have mechanisms in place to ensure consistent application of review criteria for authorization decisions: standardized interrater reliability process that includes standardized test case scenarios and review of the performance of each individual authorization decision-maker.
b) Consult with the requesting provider for medical services when appropriate.

K) When a service authorization is processed, NMRE provides the individual with a written service authorization decision within specified the timeframes and as expeditiously as the person's health condition requires. The service authorization must meet the requirements for either a standard authorization or expedited authorization:

1) Standard Authorization: Notice of the authorization decision must be provided as expeditiously as the person's health condition requires and no later than fourteen (14) calendar days following receipt of a request for service. NMRE may extend the fourteen (14) calendar day timeframe by up to an additional fourteen (14) days if either of the following occurs:

a) The person served or provider requests an extension; or
b) The NMRE justifies a need for additional information and how the extension is in the person's interest.

If the NMRE extends the review of the service authorization timeframe NOT at the request of the beneficiary, the NMRE must:

Make reasonable efforts to give the beneficiary same day oral notice of the delay and within 2 calendar days, provide the beneficiary with written notice of the reason for the decision to extend the timeframe and inform the beneficiary of their right to file a grievance if they disagree with the decision;

2) Expedited Authorization: In cases in which a provider indicates or NMRE determines that following the standard timeframe could seriously jeopardize the person's life; health; or ability to attain, maintain, or regain maximum function, the NMRE must make an expedited authorization decision and provide notice of the decision as expeditiously as the person's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. NMRE may extend the seventy-two (72) hour timeframe by up to fourteen (14) calendar days if either:

a) The person requests an extension, or
b) The NMRE justifies a need for additional information and how the extension is in the person's interest.

In the event of an extension, a same day oral notice will be provided to the beneficiary and written notice will be sent to the beneficiary within 2 calendar days.

L) When additional information is needed to make coverage or appeal decisions, the NMRE will request the clinical and related documentation needed and document a minimum of one (1) attempt to obtain the necessary information. If, after the documented attempt, the NMRE does not receive any additional information, the NMRE will make the best decision based on the available information within the required timeframes.

M) NMRE will notify the requesting provider of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Notice to the beneficiary must be sent within the applicable standard or expedited authorization timeframes described previously.

N) A service authorization decision not reached within the relevant timeframe described previously constitutes a denial of services and is therefore considered an Adverse Benefit Determination. Notice must be mailed to the Medicaid beneficiary no later than the date that the authorization timeframe expired.

O) The NMRE will monitor its member CMHSPs to ensure timely authorization and that authorization decision-makers have appropriate credentials.

P) Compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Medicaid enrollee. The NMRE's Utilization Management (UM) staff will sign the Utilization Management acknowledgement attestation affirming that the UM Program and Protocol is not structured to provide compensation or incentives to staff making authorization decisions.

Approval Signature

NMRE Chief Executive Officer

October 29, 2026

Date