MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Subject: **Utilization Management**	Procedure: **Concurrent Reviews**	
Last Updated: **3/11/2025**	Owner: **Managed Care Operations**	Pages: **5**

I. PURPOSE

To provide procedural and operational guidance on the concurrent review requirements for continued authorizations of inpatient psychiatric hospitalization, outpatient partial hospitalization, and crisis residential.

II. DEFINITIONS

A. Concurrent Review
Concurrent review decisions are reviews for the extension of previously approved services while the person served remains admitted to a facility. Review determinations are based on the medical information obtained at the time of the review. Concurrent review allows for a determination of medical necessity and level of care assessment prior to the continued delivery of a service.

B. Crisis Residential:
The provision of mental health services in a community-based setting that provides twenty-four (24) hours of structured daily care for persons who cannot be safely and/or adequately managed at a lower level of care. Services are designed for persons who meet psychiatric inpatient admission criteria but who can be safely served in a setting that is less intensive than a hospital. Services may only be used to avert a psychiatric admission or to shorten the length of an inpatient stay.

C. Inpatient Psychiatric Hospitalization:
The provision of mental health services in a community-based hospital that provides twenty-four (24) hours of daily care in a structured, intensive, and secure setting for persons who cannot be safely and/or adequately managed at a lower level of care.

D. Medical Necessity:
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. The medical necessity of a service shall be documented in the individual plan of service (IPOS).

E. Outpatient Partial Hospitalization:
The provision of mental health services in a community-based setting that provides a structured, intensive daily treatment program without overnight stays in a hospital. Treatment is provided for six (6) or more hours per day, five (5) business days per week. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay.

F. Prospective Review
Prospective review is the process in which clinical information and requests are reviewed to determine medical necessity before rendering services. Review determinations are based on the medical information obtained at the time of the review. Prospective review allows for a person's eligibility and benefit determination, the evaluation of proposed treatment, determination of medical necessity, and level of care assessment prior to the delivery of service. Prospective screening for medical necessity and appropriateness of specified services is performed by a master's level clinician and if needed, reviewed by a physician.

III. PROCEDURE

A. The Michigan Medicaid Provider Manual requires prior authorization for the following services:

1. Inpatient Psychiatric Hospitalization

2. Outpatient Partial Hospitalization Programs (PHP)

3. Crisis Residential Units (CRU)

B. When a person served is approved for one of the above services and the treating provider is requesting an extension of the service, then that provider must request a concurrent medical necessity review, also known as a continued stay review through MCCMH.

C. Concurrent reviews will be reviewed by licensed MCCMH Managed Care Operations (MCO) staff that have been determined to have the appropriate experience, credentials, and clinical competence. MCO physicians employed by or under contract with MCCMH to perform utilization review or their delegates will oversee all concurrent review denials.

D. The concurrent review and resulting authorizations and/or denials will be fully documented in the FOCUS Electronic Medical Record (EMR) utilizing the Continued Stay Review (CSR) form.

1. Hospital providers that are contracted with MCCMH as well as those that have access to the FOCUS EMR, must electronically submit the concurrent review request in the EMR utilizing the CSR form.

2. Hospital providers that are not contracted with MCCMH and do not have access to the FOCUS EMR, must contact MCCMH to complete the concurrent review telephonically.

E. Concurrent reviews for inpatient, PHP, or crisis residential must be submitted to MCO by 2:00PM on the last covered day of the approved authorization.

F. When a CSR is submitted in the FOCUS EMR that is missing information or requires additional supporting clinical clarification, MCO may choose to return the CSR back to the treating hospital provider requesting that it be updated. If this occurs, MCO will indicate what is needed and the provider must resubmit the CSR on the same day.

G. MCO has three (3) hours to make a medical necessity determination on these requests.

1. When it is determined that the person meets medical necessity criteria for the authorization extension of inpatient, PHP, or crisis residential, the disposition section of the CSR will be updated to reflect the extension resulting in an electronic notification being sent to the hospital provider.

2. When it is determined that the person does not meet the medical necessity criteria for the authorization extension of inpatient, PHP, or crisis residential, the disposition section of the CSR will be updated to reflect the denial resulting in an electronic notification being sent to the hospital provider. MCO sends a Notice of Adverse Benefit Determination to the person served and/or their legal guardian.

H. When a hospital provider is notified of the denial of authorization for continued inpatient psychiatric hospitalization, and the treating hospital physician is not in agreement with the decision, the hospital may choose to continue to provide treatment to the person served and then request a retroactive review by the MCO Physician upon discharge.

1. The hospital must submit the following documentation to the MCO physician or their designee within thirty (30) calendar days of the person's discharge from treatment. Failure to submit all required documentation will result in an administrative denial of the retrospective review request without consideration.

a) A written statement providing the clinical rationale for the review and the dates of service.

b) A copy of the complete medical record.

c) A copy of the person's explanation of benefits (EOB) or rejection letter from the third-party insurance, if applicable.

2. This retrospective review request, also known as a first level appeal, must be submitted in writing utilizing an encrypted email sent to the following email address: MCCMH.Appeals@mccmh.net

3. The MCO Physician or their designee will complete the retrospective review and convey a written response to the hospital within forty-five (45) business days of receiving the complete appeal request.

I. When a hospital provider disagrees with the retrospective review decision of the MCO physician or their designee, then the hospital provider may choose to appeal this determination to the MCCMH Chief Medical Officer (CMO).

1. The hospital must submit the following documentation to the MCCMH CMO or their designee within thirty (30) calendar days of the first level appeal decision.

a) A written statement providing the clinical rationale for the review and the dates of service.

b) A copy of the complete medical record.

2. This retrospective review request, also known as a second level appeal, must be submitted in writing utilizing an encrypted email sent to the following email address: MCCMH.Appeals@mccmh.net

3. The MCCMH CMO or their designee will complete the retrospective appeal and convey a written response to the hospital within forty-five (45) business days of the receipt of the complete appeal request.

4. Decisions of the MCCMH CMO are final.

I. The treating hospital provider is responsible for the development of a clinically appropriate discharge plan for the person served. Discharge planning begins at admission and will occur in collaboration with the MCCMH primary treatment provider.

1. MCO regularly updates the MCCMH Discharge Plan in the CSR to reflect recommendations for aftercare LOC and services. The hospital provider must review this information and incorporate it into the discharge plan.

J. The hospital provider must complete the Discharge CSR within the FOCUS EMR within twenty-four (24) hours of discharge. The hospital provider must upload the following documents into the EMR:

1. Psychiatric evaluation

2. Physical examination

3. Discharge diagnosis and summary

4. Aftercare instructions including the name of the treatment provider, date, time, and location of the appointment(s)

5. Current Medication list. For persons served that are prescribed a long-acting medication the list must indicate the date that the last dose was administered and the date of when their next dose is due.

6. Laboratory results or any other studies completed for the purpose of the psychiatric admission and treatment.

IV. REFERENCES

None.

IV. RELATED POLICIES

A. MCCMH MCO Policy 4-020, "Medicaid and Non-Medicaid Notice of Adverse Benefit Determination"

B. MCCMH MCO Policy 12-003, "Emergency and Post-Stabilization Services"

V. EXHIBITS

None.

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	3/11/2025	Creation of Procedure	MCCMH MCO Division
2	4/17/2025	Implementation of Procedure	MCCMH MCO Division