MACOMB COUNTY
COMMUNITY MENTAL HEALTH

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

I. PURPOSE

To provide procedural and operational guidance on the preadmission screening requirements for authorizations of inpatient psychiatric hospitalization, outpatient partial hospitalization, crisis residential, and intensive crisis stabilization.

II. DEFINITIONS

A. 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.

B. 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.

C. Intensive Crisis Stabilization:
Structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric hospitalization. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay.

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)
    4. Intensive Crisis Stabilization Programs (ICSP)

B. This prior authorization is obtained by requesting a prospective medical necessity review, also known as preadmission screening, through MCCMH. Preadmission screenings are reviewed by licensed MCCMH Managed Care Operations (MCO) staff or its delegates that have been determined to have the appropriate experience, credentials, and clinical competence. Physicians employed by or under contract with MCCMH to perform utilization review will oversee all preadmission authorization denials.

C. All preadmission screening requests, including co-payment requests, must include evidence that the person served resides in Macomb County therefore MCCMH is the County of Financial Responsibility (COFR). Examples include, but are not limited to, the person's legal identification, a lease agreement listing the person served as a resident, or a bill dated within the last thirty (30) days evidencing the Macomb County address.

D. The preadmission screening and resulting authorizations and/or denials will be fully documented in the FOCUS Electronic Medical Record (EMR) utilizing the Certificate of Need (CON) form.
    1. Hospital providers that are under contract with MCCMH as well as those that have access to the FOCUS EMR, must electronically submit the prescreening request in the EMR utilizing the CON form.

2. Hospital providers that are not under contract with MCCMH and who do not have access to the FOCUS EMR, must contact MCCMH to complete the preadmission screening telephonically.

E. When a CON is submitted in the FOCUS EMR that is missing information or requires additional supporting clinical clarification, MCO or its delegates may choose to return the CON back to the hospital provider requesting it be updated. If this occurs, MCO or its delegates will indicate what is needed and provide a timeframe for when the CON must be resubmitted.

F. 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 of inpatient, PHP, CRU, or ICSP the disposition section of the CON will be updated to reflect the authorized service 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 of inpatient, PHP, CRU, or ICSP, the disposition section of the CON 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.

G. Persons served who voluntarily request psychiatric inpatient hospitalization services and are denied authorization by MCO or its delegates have the right to request, at no cost to the person, a second opinion from the MCCMH Chief Medical Officer (CMO) or their designee. Refer to MCCMH Policy 4-005, "Second Opinion Rights" for additional information.

H. When a hospital provider is notified of the preadmission denial of authorization for inpatient psychiatric hospitalization services, the hospital physician may request a review with the MCO physician or their delegate. Refer to the MCCMH Doctor-to-Doctor Procedure for additional information.

I. When a hospital provider is notified of the preadmission denial of authorization for inpatient psychiatric hospitalization, and the treating physician chooses to admit the person served to an inpatient hospital without authorization from MCCMH, the hospital may choose to request a retroactive review by the MCO Physician.
   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 the receipt of the complete appeal request.

J. 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 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.

K. For persons served that are dual eligible (i.e. Medicare or another third-party insurance is the primary payor, and Medicaid is secondary) and in which the hospital provider is seeking inpatient hospitalization authorization for the Medicare Part A deductible and/or co-insurance portion up to the limit of Medicaid liability, the hospital must submit the CON in the FOCUS EMR within five (5) business days from the date of admission.

L. For persons served that are admitted to an inpatient hospital with Medicare as the primary payor, that have secondary Medicaid, and then the person exhausts their Medicare benefits while still inpatient, the hospital provider must obtain prospective authorization for inpatient treatment by submitting a CON in the FOCUS EMR for any remaining service days not covered by Medicare.

    1. The hospital provider must submit documentation to MCO that evidences all types of Medicare days have been exhausted. This includes full hospital days, lifetime psych days (LPSY) and reserve days.

    2. For persons served who become Medicaid eligible for secondary coverage after the inpatient treatment episode, and the hospital provider is seeking inpatient hospitalization authorization for the Medicare Part A deductible and/or co-insurance portion up to the limit of Medicaid liability, the hospital must submit a CON in the FOCUS EMR within ninety (90) days form the date of discharge. Within the CON, the hospital must indicate that Medicaid was activated on a retroactive basis and include the date that Medicaid was applied for, the date that Medicaid was approved, and the retroactive Medicaid approval date.

IV. REFERENCES

None.

V. RELATED POLICIES

A. MCCMH MCO Policy 4-005, "Second Opinion Rights"

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

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

VI. 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