MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Subject: **Utilization Management**	Procedure: **Authorizations that Utilize the Generic Provider ID**	
Last Updated: **1/13/2026**	Owner: **Managed Care Operations**	Pages: **3**

I. PURPOSE

To provide procedural and operational guidance to directly operated and contract providers on the use of the generic provider identification code with authorization requests.

II. DEFINITIONS

A. 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).

B. 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.

C. Retrospective Review:
A utilization management review that occurs after a service was provided to confirm that the service met the standards for eligibility and medical necessity.

III. PROCEDURE

A. The primary case holder is responsible for ensuring that all services listed in the Individual Plan of Service (IPOS) are authorized in the FOCUS Electronic Medical Record (EMR).

B. For all services in which there is not an identified provider, the primary case holder must enter the authorization utilizing the Generic Provider Identification (PID) code until an accepting provider is secured.

C. The primary clinical provider submits the prior authorization request to Managed Care Operations (MCO) in the FOCUS Electronic Medical Record (EMR). Authorization requests can be submitted up to sixty (60) calendar days, and no less than fourteen (14) calendar days, prior to the effective date of the authorization.

    1. The primary case holder must enter an authorization for each service code in the amount, scope, and duration that is medically necessary for the person served as supported in the documentation in the medical record.

    2. Service codes that do not require a prospective medical necessity review will be automatically approved in the FOCUS EMR. These authorizations are subject to retrospective medical necessity reviews.

D. MCO has fourteen (14) calendar days to make a prospective medical necessity determination on these requests.

    1. When it is determined that the individual meets the medical necessity criteria for the authorization of the requested service, the authorization is approved in the Focus EMR, and an electronic notification is sent to the primary clinical provider.

    2. When it is determined that the individual does not meet the medical necessity criteria for all or part of the authorization of the requested service, the authorization is denied in the Focus EMR, and an electronic notification is sent to the primary clinical provider. MCO sends an Adverse Benefit Determination (ABD) notice to the person served and/or their legal guardian.

E. When a service does not begin within fourteen (14) calendar days of the start date agreed upon in the IPOS, the primary case holder must send an ABD notice. Refer to MCCMH Policy 4-020, "Medicaid and Non-Medicaid Notice of Adverse Benefit Determination" for additional information.

F. The primary case holder must continue to seek an appropriate provider for all services to ensure that they are implemented as soon as possible.

    1. All efforts to locate an appropriate provider must be documented in the FOCUS EMR.

G. If the person served is not linked to a provider within the duration of the approved generic PID authorization, then the primary case holder must submit another prior authorization request that aligns with all required steps listed in section III. C of this procedure.

    1. This request will be subject to medical necessity determination by MCO as detailed in section III. D of this procedure.

H. When a provider has been secured for the service, the primary case holder must update the generic PID authorization to assign it to the accepting provider. The primary case holder must also add a program assignment for the accepting provider in the FOCUS EMR admission layer.

IV. REFERENCES

None

V. RELATED POLICIES

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

B. MCCMH MCO Policy 12-004, "Service Authorizations"

VI. EXHIBITS

None

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	3/27/2025	Creation of Procedure	MCCMH MCO Division
2	5/5/2025	Implementation of Procedure	MCCMH MCO Division
3	1/13/2026	Revision of Procedure	MCCMH MCO Division