MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Subject: **Utilization Management**	Procedure: **Retrospective Review Procedure**	
Last Updated: **2/4/2026**	Owner: **Managed Care Operations**	Pages: **3**

I. PURPOSE

To provide procedural and operational guidance to MCCMH directly operated and contract providers on the procedures for retrospective medical necessity review of services.

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.

D. Utilization Management (UM):
The process by which an organization reviews the use of medical services and resources to ensure they are medically necessary, are performed in the most appropriate care setting, and are at or above quality standards.

III. PROCEDURE

A. MCCMH conducts retrospective reviews as part of the utilization management (UM) process. These reviews will be conducted by the MCCMH Managed Care Operations (MCO) division.

B. Retrospective reviews are conducted for:

1. Services rendered by directly operated and contracted providers that were authorized by MCCMH without a prospective medical necessity review.

a) Please refer to Exhibit A of this procedure for the list of service codes that are automatically authorized in the FOCUS Electronic Medical Record (EMR) without a prospective medical necessity review.

C. Retrospective review is the process of determining coverage after treatment has been provided for the ongoing monitoring of care determination decisions.

1. Services rendered by directly operated and contracted providers will be reviewed to ensure the standards were met for eligibility and medical necessity along with mechanisms to correct for under and over utilization of services.

D. MCCMH shall conduct retrospective reviews at least quarterly for each applicable provider.

E. MCCMH applies standard sampling principles and reviews ten percent (10%) or a maximum of 100 files from the designated period of review.

1. MCCMH reserves the right to review additional case files if significant deficiencies are identified in the core sample reviewed.

2. The sampling will be drawn from all individuals served within the designated period of review.

F. MCCMH will select the sample case files and notify the provider of the upcoming retrospective review.

1. Providers shall be given notice at least thirty (30) calendar days prior to the upcoming retrospective review.

2. MCCMH reserves the right to conduct retrospective reviews with notice of less than thirty (30) calendar days when deemed necessary.

G. Review determinations are based solely on the clinical information as documented in the FOCUS Electronic Medical Record (EMR) and available to the MCO at the time of the review.

H. Upon completion of the retrospective review, MCO has ten (10) business days to issue a summary of the findings to the applicable provider.

I. MCO will report any issues discovered that are outside of the scope of eligibility and medical necessity to the applicable MCCMH divisions such as Quality, Compliance, or Recipient Rights.

J. MCO will report a summary of the findings from the retrospective reviews to the MCCMH UM Committee on a quarterly basis.

K. If the retrospective review determines that a service(s) was provided that did not meet the standards for eligibility and medical necessity, then the following will occur:

1. MCO will report the impacted services to the MCCMH Compliance Division for review.

2. If the MCCMH Compliance Division confirms that the services were unallowable, then the MCCMH Finance Division will reconsider the claims and issue credit memos to offset future payments.

3. The amount reconsidered will be reported as appropriate to the Office of the Inspector General (OIG).

4. The corresponding encounters will be voided because of these reconsiderations.

IV. REFERENCES

None.

V. RELATED POLICIES

A. MCCMH MCO Policy 12-002, "Utilization Management"

VI. EXHIBITS

A. Service Codes Authorized Without a Prospective Medical Necessity Review

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	2/26/2025	Creation of Procedure	MCCMH MCO Division
2	6/30/2025	Implementation of Procedure	MCCMH MCO Division
3	2/4/2026	Revision of Procedure	MCCMH MCO Division