



MACOMB COUNTY

COMMUNITY MENTAL HEALTH

Subject: Utilization Management	Procedure: Use of Licensed External Consultants in Medical Necessity Reviews	
Last Updated: 10/15/2026	Owner: Managed Care Operations	Pages: 3

I. PURPOSE

To provide procedural and operational guidance on the use of licensed external consultants in medical necessity determinations.

II. DEFINITIONS

- A. Delegation:
The process of assigning responsibility and authority for a decision to another entity while still maintaining overall accountability for the outcome.
- B. Licensed Consultant:
A healthcare professional holding a current, unrestricted license in an applicable clinical discipline who is responsible for conducting medical necessity reviews.
- C. 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).
- D. Service Authorization Review:
Processing of evaluating a request for services to determine if they meet established criteria for coverage, medical necessity, and benefit eligibility before approving, partially denying, or denying.

III. PROCEDURE

- A. All service authorizations shall comply with state and federal law, the Michigan Medicaid Provider Manual, applicable MCCMH policies, and contractual requirements.

- B. MCCMH uses formalized utilization management criteria and evidence-based guidelines to ensure consistent, objective, medically necessary, and clinically appropriate service authorization decisions.
- C. The primary clinical provider submits a service authorization request to the MCCMH Managed Care Operations (MCO) division 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.
- D. MCO has seven (7) calendar days to make a medical necessity determination on these requests.
- E. The service authorization request is initially reviewed for eligibility and medical necessity by an appropriately licensed, master's-level MCO staff member.
- F. When the MCO staff member review results in a recommendation of a partial or full denial of the service authorization request based on medical necessity, the request must be reviewed by an appropriate professional, including a board-certified physician or a doctoral-level clinical psychologist.
- G. MCCMH uses licensed external consultants to provide the physician review and issue adverse determinations of service authorization requests. MCCMH has delegation agreements with the following companies for this purpose:
 - 1. Prest & Associates
 - 2. MLS Group of Companies, LLC
- H. To submit the request to a licensed external consultant, the MCO staff member notes the following information in their company's portal:
 - 1. Clinical records and supporting documentation
 - 2. Applicable medical necessity criteria
 - 3. Specific review questions
 - 4. Required turnaround times
- I. The licensed external consultant reviews the service authorization request for medical necessity and provides the physician-level review required for adverse determinations. The consultant enters a summary of their determination into their company's portal.
- J. The MCO staff member documents the licensed external consultant's medical necessity determination and treatment recommendations, along with the consultant's name, qualifications, and clinical credentials in the FOCUS EMR.

- K. When the determination results in a partial or full denial of the service authorization request, the MCO staff member processes the denial in the FOCUS EMR and sends a Notice of Adverse Benefit Determination.
- L. MCCMH ensures that staff, including physicians involved in the decision-making process, do not benefit financially from denying treatment or encourage decisions that result in under-utilization of care or services to persons served.

III. REFERENCES

None.

IV. 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 12-002, "Utilization Management"
- D. MCCMH MCO Policy 12-004, "Service Authorizations"

V. EXHIBITS

None.

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	10/15/2026	Implementation of Procedure	MCCMH MCO Division