



MACOMB COUNTY

COMMUNITY MENTAL HEALTH

Subject: Utilization Management	Procedure: Licensed Professionals in UM Decision Making	
Last Updated: 10/15/2026	Owner: Managed Care Operations	Pages: 4

I. PURPOSE

To provide procedural and operational guidance on the qualifications and decision-making authority for staff who make or supervise prospective, concurrent, or post-service Utilization Management (UM) decisions.

II. DEFINITIONS

A. Concurrent Review:

Concurrent review is the process of ongoing review of hospitalizations, through communication with the hospital physicians and other healthcare professionals. This communication process is conducted through telephonic and electronic reviews to approve appropriate, medically necessary care for continued medical treatment. Review determinations are based on the medical information obtained at the time of the review. The frequency of continued stay review is based upon diagnosis, guidelines, or a change in the person's health condition status.

B. 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).

C. Post-Service Request:

An authorization request for services already provided.

D. Prospective Review:

Prospective review is the process by which clinical information and requests are reviewed to determine medical necessity before services are rendered. 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, the determination of medical necessity, and the assessment of the level of care prior to the delivery of service. Prospective screening

for the medical necessity and appropriateness of specified services is performed by a master's-level clinician and, if needed, reviewed by a physician.

E. 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.

F. Utilization Management:

The process by which MCCMH 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 assigns each level of Utilization Management (UM) decision making to staff whose qualifications, licensure, clinical expertise, and authority match the review.

1. Licensed UM professionals review requests that require clinical interpretation or individualized clinical judgement within their scope of practice.
2. An appropriately licensed behavioral health professional supervises medical necessity decision making and the staff who perform UM reviews.
3. Staff who are not licensed health care professionals may process an authorization request only when explicit UM criteria are met, no clinical judgement is required, and their role is allowed to approve the request.

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

C. MCCMH uses formalized utilization management criteria and evidence-based guidelines to ensure consistent, objective, medically necessary, and clinically appropriate service authorization decisions.

D. 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.

E. MCO has seven (7) calendar days to make a medical necessity determination on these requests.

- F. The service authorization request is initially reviewed for eligibility and medical necessity by an appropriately licensed, master's-level MCO staff member.
- G. 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 authorized under MCCMH policy and the applicable agreement, with relevant clinical expertise and within the professional's scope of practice.
- H. The MCO staff member refers the case and relevant clinical information to the physician reviewer, records the identity and credentials of the decision maker, and records the physician reviewer's clinical rationale in the FOCUS EMR.
- I. When the determination results in a partial or full denial of the service authorization request, the MCO staff member sends a Notice of Adverse Benefit Determination.
- J. 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.
- K. MCCMH MCO Clinical Supervisors are licensed behavioral health care professionals who supervise UM activities and:
 - 1. Provide day-to-day supervision of assigned UM staff.
 - 2. Participate in staff training.
 - 3. Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
 - 4. Monitor documentation for adequacy.
 - 5. Are available to UM staff on site, via electronic communication, or by telephone.

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