MCCMH MCO Policy 12-002

Chapter: **UTILIZATION MANAGEMENT**
Title: **UTILIZATION MANAGEMENT**

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Proposed by: Traci Smith 10/29/2026
Chief Executive Officer Date

Approved by: Al Lorenzo 10/29/2026
County Executive Office Date

I. ABSTRACT

This policy establishes the standards of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, for the utilization management system for monitoring and evaluating the provision of medically necessary services.

II. APPLICATION

This policy shall apply to all directly operated and contract network providers of MCCMH.

III. POLICY

It is the policy of MCCMH, as an official agency of the County of Macomb, that a formal utilization management process be established to ensure that determinations of service eligibility and medical necessity are conducted using defined criteria and standardized guidelines.

IV. DEFINITIONS

A. Inter-Rater Reliability (IRR):
A performance measurement to compare and evaluate the level of consistency in healthcare determinations between two or more behavioral health utilization management clinicians.

B. Medicaid Provider Manual (MPM):
This manual outlines the eligibility, coverage, billing, and reimbursement policies for all health insurance programs managed by the Michigan Department of Health and Human Services (MDHHS). The chapter on Behavioral Health and Intellectual and Developmental Disabilities Supports and Services specifically covers the coverage policies and reporting requirements for services provided through Prepaid Inpatient Health Plans (PIHPs).

C. Medical Necessity
Determination that a service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology, and functional impairments, consistent with clinical standards of care, and is the most cost-effective option in the least restrictive environment. The medical necessity of a service shall be documented appropriately in a person served's Individual Plan of Service (IPOS).

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

F. Utilization Management (UM)
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.

V. STANDARDS

A. Utilization Management (UM) is the process of monitoring the provision of services to MCCMH persons served. MCCMH UM ensures adherence to statutory, regulatory, and contractual obligations. Furthermore, UM activities are designed to be consistent and supportive of assuring the achievement of MCCMH's mission, vision, and guiding principles.

B. MCCMH's UM policies and procedures provide a description of processes and criteria necessary to ensure cost-effectiveness and achievement of the best outcome for persons served using the available resources.

C. MCCMH's Utilization Management Committee shall ensure the implementation of MCCMH utilization management policies and procedures. The MCCMH UM Committee shall conduct an ongoing review of service utilization and the application of medical necessity criteria. The UM Committee shall:

1. Develop and monitor a regional utilization management plan.

2. Set utilization management priorities based on the MCCMH strategic plan and/or contractual policy expectations.

3. Recommend policies and practices for access, authorization, and utilization management standards consistent with external requirements and representing best practices.

4. Participate in the development of access, authorization, and utilization management monitoring criteria and tools to ensure compliance with approved policies and standards.

5. Support the development of materials and proofs for external quality review activities.

6. Establish improvement priorities based on results of external quality review activities.

7. Recommend regional medical necessity and level of care criteria.

8. Perform utilization management functions sufficient to analyze and make recommendations relating to:

    a. Controlling costs.

    b. Mitigating risk and assuring quality of care.

    c. Reviewing and monitoring utilization patterns.

    d. Analysis to detect and recommend remediation of over/under or inappropriate utilization.

    e. Recommend improvement strategies where adverse utilization trends are detected.

    f. Ensure UM coordination and information sharing to address continuity and efficiency of MCCMH processes.

D. MCCMH staff and delegates that perform utilization reviews do not observe, participate in, and are not present during a person's physical or mental examination, treatment, procedures, or therapy unless approved by the provider and the person served.

E. Physicians and other health care providers employed by or under contract with MCCMH to perform utilization review are appropriately trained, qualified, and currently licensed. Personnel conducting utilization review hold unrestricted licenses, an administrative license, or are otherwise authorized to provide health care services by a licensing agency in the United States.

F. MCCMH staff and delegates that perform utilization reviews are not permitted to receive compensation, nor is it a condition of employment, to base performance ratings on:
    1. Volume of adverse determinations.
    2. Reductions or limits on length of staff, benefits, services, or charges.
    3. The number or frequency of telephone contacts with providers or persons served.

G. MCCMH utilizes written Utilization Management (UM) decision making criteria that are evidence-based, scientifically valid, outcome-focused, and comply with the requirements in Michigan Insurance Code §4201.153. In circumstances where evidence-based medicine is not available for a particular health care service, generally accepted standards of medical practice that are recognized in the medical community are used for decision-making. The following UM criteria are used as appropriate by MCCMH in making medical necessity decisions:

    1. The American Society of Addiction Medicine (ASAM) Criteria
    2. Devereaux Early Childhood Assessment (DECA)
    3. Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS)
    4. MCG Care Guidelines
    5. Michigan Child and Adolescent Needs and Strengths (MichiCANS)
    6. Michigan Medicaid Provider Manual
    7. Michigan Mental Health Code
    8. MCCMH Policies and Procedures

H. Inter-rater reliability testing is performed twice annually to ensure criteria are consistently applied by MCCMH staff and delegates who perform utilization reviews.

VI. PROCEDURES

None.

VII. REFERENCES / LEGAL AUTHORITY

A. Michigan Department of Health and Human Services Medicaid Provider Manual, in effect and as amended

B. Michigan Mental Health Code, 300.1100(a)(25)

C. Medicaid Provider Manual

VIII. EXHIBITS

None.