MCCMH MCO Policy 12-002

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

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Chief Executive Officer Date

Approved by: Al Lorenzo 03/31/2025
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 its 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 service eligibility and medical necessity determination decisions 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 (2) or more behavioral health utilization management clinicians.

B. MCG Health:
A company that provides clinical guidance to healthcare organizations by using evidence-based guidelines to support clinical decision-making through a process of documenting medical necessity and daily progression of care to optimize prior authorization workflows.

C. Medicaid Provider Manual (MPM):

The manual that details the eligibility, coverage, billing, and reimbursement policies for all health insurance programs administered by the Michigan Department of Health and Human Services (MDHHS). The Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter specifically addresses the coverage policies and reporting requirements for services provided through Prepaid Inpatient Health Plans (PIHPs).

D. Medical Necessity
Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology, 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's served individual plan of service (IPOS).

E. 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, evaluation of proposed treatment, determination of medical necessity, and level of care assessment prior to 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.

F. 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.

G. 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. MCCMH's Utilization Management (UM) system ensures that service eligibility and medical necessity determination decisions are conducted using defined criteria and standardized guidelines.

B. MCCMH's Utilization Management (UM) Committee shall:

1. Ensure the implementation of utilization management policies and procedures

2. Conduct ongoing reviews of service utilization and application of medical necessity criteria

3. Develop and monitor a regional utilization management plan

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

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

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

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

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

9. Recommend regional medical necessity and level of care criteria

10. Perform utilization management functions sufficient to analyze and/or make recommendations related to:

    a. Controlling costs

    b. Mitigating risk and ensuring quality of care

    c. Reviewing and monitoring utilization patterns

    d. Detecting and recommending remediation of over/under utilization

    e. Improving adverse utilization trends

    f. Sharing information to address continuity and efficiency of MCCMH processes

C. 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.

D. 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 and administrative license or are otherwise authorized to provide health care services by a licensing agency in the United States.

E. 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

F. MCCMH uses MCG, the Michigan Medicaid Provider Manual, and other health plan guidelines to assist in UM decision making. These criteria 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.

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

VI. PROCEDURES

None.

VII. REFERENCES / LEGAL AUTHORITY

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

B. Medicaid Provider Manual

VIII. EXHIBITS

A. UM Committee Charter

B. Retrospective Review Procedure

C. Inter-Rater Reliability Procedure