MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Subject: **Utilization Management**	Procedure: **Authorizations for Personal Emergency Response Systems**	
Last Updated: **8/8/2024**	Owner: **Managed Care Operations**	Pages: **3**

I. PURPOSE

To provide procedural and operational guidance to directly operated and contract providers on the documentation requirements for authorizations of personal emergency response systems.

II. DEFINITIONS

Personal Emergency Response Systems (PERS):
A device that connects to a 24/7 monitoring center that can enable individuals to secure help in the event of an emergency.

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).

III. PROCEDURE

A. When a person served notifies their primary clinical provider of a need for a Personal Emergency Response System (PERS), the provider shall:

1. Identify if this is a treatment need for the person served, per the Michigan Medicaid Provider Manual, specific to the service and medical necessity.

a) PERS coverage is limited to adult individuals living alone or with a roommate who does not provide supports, who are alone for significant parts of the day, who have no regular support or a service provider for those parts of the day, and who would otherwise require extensive routine support and guidance because of an intellectual/developmental disability or severe mental illness.

b) The person served must have active Medicaid benefits to be eligible for PERS coverage.

c) Medicaid is the payor of last resort. If the person has Medicare or a private insurance policy with this benefit, then the person must pursue authorization through these insurance options.

2. The primary clinical provider will discuss the PERS as a part of the person-centered planning process. The case manager will assist the person served in identifying a vendor for this service when needed.

3. The primary clinical provider will ensure that the PERS is an identified service in the individual's person-centered treatment plan.

    a) The goal must address the medical necessity of the PERS.

    b) For HAB Waiver individuals, the plan must document that, as a result of the PERS, institutionalization of the individual will be prevented.

4. The primary clinical provider will assist the person in obtaining an original physician's prescription for the requested service.

    a) The prescription must include all requirements as detailed in the Michigan Medicaid Provider Manual (MPM). It is the responsibility of the primary provider to ensure compliance with all updated standards within the MPM. These standards include the following:

        i. Person served's name;

        ii. Prescribing physician's name, address, and telephone number;

        iii. Prescribing practitioner's signature (a stamped or electronic signature is not acceptable);

        iv. The date the prescription is written;

        v. The specific service being prescribed (it must specify if for the installation of the system, the monthly monitoring, or both);

        vi. The expected start date of the order (if different from the prescription date); and

        vii. The length of time that the service is needed. The maximum length of time that a prescription can be valid for is one year. A new prescription is required to be obtained on an annual basis or sooner as based on the duration noted in the prescription.

B. The primary clinical provider submits the prior authorization request to MCCMH's Managed Care Operations (MCO) Division in the FOCUS electronic medical record (EMR). The appropriate service codes are:

1. S5160: PERS installation and testing. This code is requested one time only for the initial set-up of the device.

2. S5161: PERS service fee. This code is requested once per month, for a maximum benefit of 12 units per year, for the monthly monitoring service fee for the device.

C. MCO has fourteen (14) calendar days to make a medical necessity determination on these requests.

1. When it is determined that the person served meets the medical necessity criteria for the authorization of a PERS, the authorization is approved in the FOCUS EMR, and an electronic notification is sent to the primary clinical provider.

2. When it is determined that the person served does not meet the medical necessity criteria for the authorization of a PERS, the authorization is denied in the FOCUS EMR, and an electronic notification is sent to the primary clinical provider. MCO sends a Notice of Adverse Benefit Determination to the person served and/or their legal guardian.

IV. REFERENCES

None.

V. RELATED POLICIES

A. MCCMH MCO Policy 2-020, "Specialized Health Care Services"

B. MCCMH MCO Policy 12-004, "Service Authorizations"

VI. EXHIBITS

None.

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	8/8/2024	Creation of Procedure	MCCMH MCO Division
2	10/11/2024	Implementation of Procedure	MCCMH MCO Division