MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Subject: **Utilization Management**	Procedure: **Change in Level of Care Requests**	
Last Updated: **02/24/2025**	Owner: **Managed Care Operations**	Pages: **3**

I. PURPOSE:

To define and describe operational guidance to directly operated and contract providers for requesting a change in level of care (LOC) for person served.

II. DEFINITIONS:

A. 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 primary provider identifies that the person's treatment needs are better met in an alternative level of care (LOC), including, but not limited to, requests to move to higher LOCs such as Assertive Community Treatment (ACT), Intensive Care Coordination with Wraparound (ICCW), and SED Home-Based Services as well as requests to move to lower LOCs such as Outpatient Therapy Services, the provider shall:

   1. Identify the recommended LOC, and
   2. Discuss the change with the person served and their legal guardian, if applicable; to ensure they consent to the change.

B. The primary case holder completes the documentation in the person served's FOCUS Electronic Medical Record (EMR) to support the request. This includes, but is not limited to:

   1. Amending the treatment plan to include the requested service(s).
   2. Completing an updated MichiCANS or LOCUS, when applicable.
   3. Updating the person's Annual Assessment to document the medical necessity of the requested LOC.

C. The primary case holder submits a prior authorization request to Managed Care Operations (MCO) in the FOCUS EMR. The request is submitted utilizing the Generic Provider ID.

D. MCO staff review the request and communicate with the primary case holder if additional documentation is needed.

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

1. When it is determined that the person meets medical necessity criteria for the requested LOC, 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 does not meet the medical necessity criteria for the prior authorization of SRS 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.

E. Following the approved authorization for the change in LOC:

1. The primary case holder coordinates the referral to a provider for the approved LOC and assists in linking the person to the new provider.

2. The primary provider continues to provide clinical services throughout the transition process.

3. The primary case holder updates the authorization from the Generic Provider ID to the new provider and opens a program admission for the new provider in the FOCUS EMR.

IV. REFERENCES:

None.

V. RELATED POLICIES

A. MCCMH MCO Policy 2-001, "Person-Centered Planning Practice Guideline"
B. MCCMH MCO Policy 12-001, "Access, Eligibility, Admission, Discharge"
C. MCCMH MCO Policy 12-004, "Service Authorizations"

VI. EXHIBITS:

None.

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	04/06/2022	Implementation of Procedure.	MCCMH MCO Division
2	2/24/2025	Revision of Procedure	MCCMH MCO Division