MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Subject: **Utilization Management**	Procedure: **Prior Authorization Requests for Specialized Residential Services**	
Last Updated: **1/2/2025**	Owner: **Managed Care Operations (MCO)**	Pages: **5**

I. PURPOSE:

To provide procedural and operational guidance to directly operated and contract providers on the requirements for requesting prior authorization for Specialized Residential Services.

II. DEFINITIONS:

A. Community Living Supports (CLS):
Medicaid funded supports and services used to increase or maintain personal self-sufficiency, facilitating a person's achievement of their goals of community inclusion and participation, independence, or productivity. CLS provides training and/or teaching to the person served by assisting, prompting, guiding, and/or training with activities such as money management, meal preparation, routine household care, activities of daily living, shopping, and community inclusion.

B. Home and Community-Based Services (HCBS) Waiver:
Medicaid funded services that enable persons served to receive long-term care services and supports in the community rather than an institutional setting. The goal of HCBS is to endure that the services provided give persons served the opportunity for independence in making life decisions, to fully participate in the community, and to ensure that their rights are respected.

C. 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).

D. Personal Care in Licensed Specialized Residential Settings:
Services provided in accordance with the individual plan of service (IPOS) to assist an individual in performing their own personal daily activities. Personal care services may be provided only in a licensed adult foster care setting with a specialized residential certification by the State of Michigan. Personal care services include assisting the person served with activities such as assistance with eating/feeding, toileting, bathing,

grooming, dressing, transferring, ambulation, and assistance with administering medications.

E. SMART Goals:
SMART Goals are specific, measurable, achievable, realistic, and time bound. The elements in this framework work together to create a goal that is carefully and thoughtfully planned out, executable, and trackable.

III. PROCEDURE:

A. Specialized Residential Services (SRS) are provided within licensed Adult Foster Care (AFC) homes in the community pursuant to the HCBS Waiver mandates. SRS are provided to persons served who require intensive services and supports to maintain their placement in an AFC home with the goal of averting more restrictive services or settings such as hospitalization or institution. SRS includes Personal Care in Licensed Specialized Residential Settings and Community Living Supports.

1. The person served must have active Medicaid entitlements.

2. The person served must meet eligibility standards for MCCMH services as a person with a Severe Mental Illness or a person with an Intellectual/Developmental Disability.

3. Through the person-centered planning process, it has been deemed medically necessary for the person served to receive intensive services and supports within a licensed AFC home beyond the level of services already required to be provided in that setting per State licensure.

B. When a person served notifies their primary case holder of their interest in SRS in a licensed residential setting, 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.

2. The primary clinical provider discusses this service need as a part of the person-centered planning process.

C. The primary case holder ensures the appropriate documentation is in the individual's medical record to support the request. This includes, but is not limited to,

   1. An updated LOCUS, as applicable;

   2. An annual biopsychosocial assessment to reflect the person's current strengths, needs, supports, and functioning;

   3. The primary case holder completes an amendment to the treatment plan:

      a. A goal for SRS must be added to the individual's treatment plan.

      b. SMART goals and objectives are included to specify what tasks will be addressed by the residential provider staff. Listed tasks must align with the Medicaid Provider Manual.

   4. Psychological testing evaluation(s), if completed;

   5. The most recent psychiatric evaluation and two most recent medication reviews, if not already in the medical record; and

   6. Any applicable physical health evaluations and assessments that document the individual's support needs.

D. The primary case holder submits a prior authorization request to Managed Care Operations (MCO) in the FOCUS Electronic Medical Record (EMR). The request is submitted utilizing the Generic Provider ID for the service codes T1020 and H2016. Please note: the primary case holder does not add any modifiers to this request. MCO staff will add the appropriate modifier to the service codes when the request is processed.

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 prior authorization of SRS, 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.

D. When it is determined that the person served meets medical necessity criteria for the prior authorization of SRS in a licensed specialized residential setting:

1. The primary case holder assists the person served in identifying a provider for this service.

   a. A list of all contracted SRS providers can be found in the MCCMH Provider Directory.

   b. All reported vacancies within the contracted residential provider network can be found within the Bed Management Module in the FOCUS EMR

   c. MCCMH has identified a subset of the residential provider network as providing intensive services within their residential settings. Referrals to these programs require additional prior approval. Please refer to the MCCMH Referrals to Intensive SRS Settings procedure for additional details.

   d. A directory of all State of Michigan licensed AFC homes can be found at **https://adultfostercare.apps.lara.state.mi.us/**

2. The primary case holder is responsible for coordinating all aspects of the referrals to residential providers.

   a. Per MCCMH contract requirements, a Pre-Placement Visit (PPV) is to be scheduled within forty-eight (48) hours and held within seven (7) calendar days of the initiation of the referral. The residential provider must provide a decision regarding acceptance of the person served to the primary case holder within forty-eight (48) hours of the completion of the PPV.

   b. The primary case holder is responsible for communicating with all involved parties throughout the process. This includes, but is not limited to, the person served, the guardian, the hospital provider (if applicable), the transitional housing provider (if applicable), and the prospective residential providers.

   c. All referrals should include the documentation of the MCCMH approval of these services found in the Generic Provider ID authorization.

3. The primary case holder continues to provide clinical services throughout the referral process and after the person served moves into the residential setting.

    a. Once an accepting residential provider is determined, the primary provider completes the appropriate admission layers and adjusts the already approved Generic Provider ID authorization to reflect the accepting residential provider in the electronic medical record.

    b. If for any reason the primary case holder is unable to continue to provide clinical services after the person served moves into the residential setting, then they are responsible to obtain the consent of the person served and their guardian to transfer them to another provider. The primary case holder must secure an alternative primary provider and continue to provide all necessary clinical services until the transition is complete and the person served has had their first appointment with the accepting provider.

IV. REFERENCES:

None.

V. RELATED POLICIES

MCCMH MCO Policy 2-013, "Access, Eligibility, Admission, Discharge"

MCCMH MCO Policy 12-004, "Service Authorizations"

MCCMH MCO Policy 2-004 "Residential Services Policy"

MCCMH Referrals to Intensive SRS Settings Procedure

VI. EXHIBITS:

None

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	11/5/2021	Creation of Procedure	MCCMH MCO Division
2	6/12/2023	Revision of Procedure	MCCMH MCO Division
3	8/7/2023	Revision of Procedure	MCCMH MCO Division
4	8/6/2024	Revision of Procedure	MCCMH MCO Division
5	1/2/2025	Revision of Procedure	MCCMH MCO Division