MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Subject: **Utilization Management**	Procedure: **Change in Level of Care Requests**	
Last Updated: **03/19/2025**	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 with a higher level of care (LOC), including, but not limited to, Assertive Community Treatment (ACT) and SED Home-Based 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. Requests for Specialized Residential Services (SRS), Intensive Care Coordination with Wraparound (ICCW), SED Waiver, and Children's Waiver must follow the procedures in the MCCMH Policy Manual that are specific to each of these LOCs.

C. 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.

D. The primary case holder submits a prior authorization request to Managed Care Operations (MCO) in the FOCUS EMR.
    1. The authorization request is submitted utilizing the Generic Provider ID.
    2. The authorization duration should be as follows:
        a. The effective date should be fourteen (14) calendar days from the date submitted to MCO.
        b. The total duration of the request should be ninety (90) calendar days long.
    3. The authorization should be requested in the amount of 40 units of the appropriate service code:
        a. H0036: SED Home-Based
        b. H0039: ACT
        c. If seeking another LOC, the primary case holder must determine the correct CPT code for that service.
    4. Within the Provider Notes section of the authorization request, the primary case holder must indicate that the request is for a LOC determination and specify what LOC is being requested.

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

F. MCO has fourteen (14) calendar days from the date a complete request is submitted to make a medical necessity determination.

    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. The MCO staff will indicate in the Authorizing Agent Notes what providers for the approved LOC are accepting referrals so that the primary case holder can coordinate the referral.

    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 an Adverse Benefit Determination (ABD) notice to the person served and/or their legal guardian.

G. 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 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.

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

H. If the approved services are not initiated within fourteen (14) days of the initiation date listed in the IPOS, the primary case holder must send an ABD notice to the person served and/or their legal guardian.

I. If the person served is not linked to the new provider within the duration of the approved authorization, then the primary case holder must submit another prior authorization request that aligns with all required steps listed in section III. D. of this procedure.

    1. This request will be subject to medical necessity determination by MCO as detailed in section III. E. of this procedure.

IV. REFERENCES:

None.

V. RELATED POLICIES

A. MCCMH MCO Policy 2-001, "Person-Centered Planning Practice Guideline"
B. MCCMH MCO Policy 4-020, "Medicaid and Non-Medicaid Notice of Adverse Benefit Determination"
C. MCCMH MCO Policy 12-001, "Access, Eligibility, Admission, Discharge"
D. 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	02/24/2025	Revision of Procedure	MCCMH MCO Division
3	03/19/2025	Revision of Procedure	MCCMH MCO Division