MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Subject: **Clinical Practice**	Procedure: **Change in Level of Care Requests**	
Last Updated: **04/06/2022**	Owner: **Managed Care Operations**	Pages: **2**

I. PURPOSE:

To define and describe operational guidelines for changes in level of care (LOC).

II. DEFINITIONS:

None.

III. PROCEDURE:

A. When it is determined to be medically necessary, providers shall assist persons served with a change in LOC. This includes requests to move to higher levels of care such as Assertive Community Treatment (ACT), Serious Emotional Disturbance (SED) Waiver, SED Wraparound, and SED Home-Based Services as well as requests to move to lower levels of care such as Outpatient Therapy Services.

B. When a primary provider identifies that the person's treatment needs are better met in another LOC, the provider shall:

1. Identify the recommended level of care;
2. Discuss the change with the person and their legal guardian, if applicable; and
3. Assist the person in deciding if the alternate level of care is medically necessary.

C. The primary provider completes the documentation in the person's record to support the request. This includes, but is not limited to:

1. Adding the service to the person-centered plan (PCP);
2. Completing an updated PECFAS, CAFAS, or LOCUS, when applicable;
3. Updating the person's Annual Assessment to document the medical necessity of the requested LOC.

D. The primary provider notifies Managed Care Operations (MCO) of the request through the designated email alias: MCORequests@mccmh.net

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

F. When MCO staff receive a completed request, they have fourteen (14) calendar days to make a level of care (LOC) determination.

G. When the requested LOC is approved:

1. The determination is communicated to the primary provider;
2. MCO provides the primary provider with a referral to a provider for the approved LOC and guidance on referral procedures;
3. The primary provider coordinates the referral and assists in linking the person to the new provider for the updated LOC;
4. The primary provider continues to provide clinical services throughout the transition process; and
5. Admissions/authorizations are completed in the FOCUS EMR by either the primary provider or MCO, as appropriate.

H. When the requested LOC is denied:

1. The determination is communicated to the primary provider; and
2. A Notice of Adverse Benefit Determination is sent by MCO to the person served/guardian.

IV. REFERENCES:

None.

V. RELATED POLICIES

A. MCCMH MCO Policy 2-001, "Person-Centered Planning Practice Guideline"
B. MCCMH MCO Policy 2-013, "Access, Eligibility, Admission, Discharge"
C. MCCMH MCO Policy 2-090, "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