Subject: **Utilization Management**	Procedure: **Requests for Community Living Supports and Personal Care Services in Licensed Specialized Settings**	
Last Updated: **09/07/2023**	Owner: **Managed Care Operations (MCO)**	Pages: **3**

I. PURPOSE:

To provide procedural and operational guidance to directly operated and contract providers on requesting community living supports (CLS) and personal care services in licensed specialized settings.

II. DEFINITIONS:

Community Living Supports (CLS):
Supports used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of their goals of community inclusion and participation, independence, or productivity.

Personal Care Services:
Services provided in accordance with the individual plan of service (IPOS) to assist an individual in performing their own personal daily activities.

Staff Planning Guide:
A tool that helps project the amount of Community Living Supports (CLS) and/or Personal Care that are medically necessary to meet the needs of the individual, on average, on any given day.

III. PROCEDURE:

A. When an individual notifies their primary clinical provider of a desire or need for CLS and personal care services in a licensed specialized residential setting, the primary provider:

1. Identifies if this is a treatment need for this individual;
2. Processes the change with the individual; and
3. Assists the individual in determining if this higher level of care is medically necessary.

B. The primary clinical provider 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 individual's current strengths, needs, supports, and functioning;

   3. A completed Staff Planning Guide (Exhibit A) for adults utilizing personal care and/or CLS in a licensed setting;

   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.

C. The primary clinical provider notifies Managed Care Operations (MCO) of the request for a level of care determination by emailing MCO.SRS@mccmh.net

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

E. MCO staff have fourteen (14) days to make a level of care determination once they receive a complete request.

F. When it is determined that the individual meets medical necessity criteria for the authorization of CLS and personal care services in a licensed specialized residential setting:

   1. The determination is communicated to the primary clinical provider.

   2. The primary clinical provider completes an amendment to the treatment plan:

      a. CLS and personal care services in a licensed specialized setting 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.

      c. Each area identified in the Staff Planning Guide must be addressed in the treatment plan and provide the focus areas that the residential staff will address with the individual.

   3. The primary provider assists the individual in coordinating referrals to appropriate residential providers.

4. The primary provider continues to provide clinical services throughout the process and after the individual moves into the residential setting.

5. Once an accepting residential provider is determined, the primary provider completes the appropriate admission layers and requests authorization specific to that residential provider in the electronic medical record.

6. When an appropriate residential provider is not immediately available:

    a. The primary provider requests authorization for these services in the electronic medical record utilizing the generic provider ID.

    b. The primary provider sends an Adverse Benefit Determination Notice to the individual or their legal guardian indicating the delay in provision of a service in the treatment plan.

G. When it is determined that the individual does not meet the medical necessity criteria for the authorization of CLS and personal care services in a licensed specialized residential setting:

1. The determination is communicated to the primary clinical provider.

2. MCO sends an Adverse Benefit Determination notice to the individual and/or their legal guardian. When applicable, MCO will include recommendations for other treatment and support services.

IV. REFERENCES:

None.

V. RELATED POLICIES

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

MCCMH MCO Policy 12-004, "Service Authorizations"

VI. EXHIBITS:

A. Staff Planning Guide for Adults Utilizing Personal Care and/or CLS in a Licensed Setting

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