



MACOMB COUNTY

COMMUNITY MENTAL HEALTH

Subject: Utilization Management	Procedure: Authorizations for Goods and Services	
Last Updated: 6/12/2026	Owner: Managed Care Operations	Pages: 4

I. PURPOSE

To provide procedural and operational guidance to directly operated and contract providers on the documentation requirements for authorizations of goods and services.

II. DEFINITIONS

A. Goods:

Physical, tangible items that can be seen, touched, stored, and consumed.

B. 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).

C. Services:

Intangible tasks performed by someone for the benefit of another person.

D. Support Person:

A person served's spouse, children, parents, guardians, any person engaging in sexual activity with the person served, partners residing with the person served, and/or any person who provides paid services.

III. PROCEDURE

A. Goods and Services are equipment, services, or supplies not otherwise provided through the Habilitation Supports Waiver (HSW), the State Plan, or 1915(i) State Plan Amendment (SPA). The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by a person served using self-directed services.

1. To be eligible for Goods and Services, a person must be Medicaid eligible and on HSW.

2. The person served must self-direct their services through an individual budget lodged with a fiscal intermediary.
3. The use of Goods and Services must:
 - a) Increase independence, facilitate productivity, or promote, improve, or maintain community inclusion, and/or
 - b) Decrease the need for other Medicaid-funded services, and
 - c) Be provided to, or directed exclusively toward, the benefit of the person served.
4. Each item or service must address an identified need and be specified in the Individual Plan of Service (IPOS).
 - a) The IPOS must indicate that the person served does not have the funds to purchase the goods or services and that they are not available from another source.
 - b) The purchase of a warranty may be included when it is available for the item and is financially reasonable.

B. Coverage Limits:

1. Goods and Services authorizations have a cumulative limit of \$2000 per year.
2. Coverage for Goods and Services may not be used for the following:
 - a) To acquire goods or services that are prohibited by federal or state laws or regulations (e.g., the purchase, lease, or routine maintenance of a vehicle).
 - b) Services covered by third parties or services that are the responsibility of a non-Medicaid program/service.
 - c) Services already covered through Medicaid State Plan, EPSDT, and/or 1915(i) SPA.
 - d) Health-related services, equipment, or supplies.
 - e) Room and board (including rent and mortgage payments).
 - f) Vacation expenses (travel, lodging costs, food, etc.) for the person served and any paid staff who accompany them on vacation.
 - g) Academic tutoring or other services covered under the Rehabilitation Act or IDEA.
 - h) Internet, cell phones, utilities, or telephone purchase costs.
 - i) Any purchase that does not meet home and community-based services (HCBS) settings requirements.
 - j) Service animals or the cost of pet care.
 - k) Expenses and/or costs of meals incurred.
 - l) Items or services if the purchase, as determined by the PIHP:
 - i. Leads to significant monetary gain for a person served's support person(s).

- ii. Provides the support person(s) with significant influence over the person served.
 - iii. Constitutes a conflict of interest.
- C. The Healthcare Common Procedure Coding System (HCPCS) service code is T5999.
- D. The primary clinical provider submits a prior authorization request to Managed Care Operations (MCO) in the FOCUS Electronic Medical Record (EMR). Authorization requests can be submitted up to sixty (60) calendar days, and no less than fourteen (14) calendar days, prior to the effective date of the authorization.
- E. MCO has seven (7) 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 authorization of Goods and Services, 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 all or part of the authorization of Goods and Services, 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.

IV. REFERENCES

None

V. RELATED POLICIES

- A. MCCMH MCO Policy 2-032, “Person Centered Planning, Training, and the Role of Health and Safety Considerations”
- B. MCCMH MCO Policy 4-020, “Medicaid and Non-Medicaid Notice of Adverse Benefit Determination”
- 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	6/12/2026	Implementation of Procedure	MCCMH MCO Division