ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued 01/24

CHAPTER Fiscal Management		**CHAPTER** 07	**SECTION** 003	**SUBJECT** 0065
SECTION Reimbursement	**SUBJECT**	Specialized/Enhanced Medical Equipment and Supplies, Environmental Modifications and/or Enhanced Pharmacy		
WRITTEN BY Diana McShane-Farr	**REVISED BY** Danielle Hazlewood		**AUTHORIZED BY** Tracey Pingitore	

I. APPLICATION:

- ☐ SCCCMHA Board
- ☒ SCCCMHA Providers & Subcontractors
- ☒ Direct-Operated Programs
- ☒ Community Agency Contractors
- ☒ Residential Programs
- ☐ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health Authority (SCCCMHA) shall ensure that individuals, who are not covered by any other funding source, may submit requests for funds for specialized and enhanced medical equipment and supplies and/or environmental modifications and enhanced pharmacy.

III. DEFINITIONS:

A. Specialized and Enhanced Medical Equipment and Supplies: Includes devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances.

B. Environmental Modifications: Physical adaptations to the home and/or workplace, due to medical necessity, and addressed in the individual's IPOS to ensure the health, safety and welfare of the recipient, or enable the individual to function with greater independence within the environment and without which the individual would require more restrictive living arrangements.

C. Enhanced Pharmacy: Physician-ordered, nonprescription "medicine chest" items as specified in the individual's support plan. Items that are not of direct medical or remedial benefit to the individual are not allowed.

IV. STANDARDS:

A. Individuals in need of specialized and enhanced medical equipment and/or environmental modifications and/or enhanced pharmacy will have the request(s) assessed on a uniform basis by SCCCMHA.

B. Requests for these items will be prioritized based upon:

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Reimbursement				

1. The urgency of need with supporting evidence.

2. The availability of funds for each individual item.

C. Requests will be reviewed on an individual basis, taking into account all information and materials presented to justify the request.

D. SCCCMHA is the payer of last resort. All other sources of funding must be exhausted, then documented.

E. Financial documentation must be submitted with the Prior Review and Approval request for Specialized/Enhanced Medical Equipment and Supplies, Environmental Modifications and/or Enhanced Pharmacy form (Form #0091).

F. Form #0091 pertaining to prescriptions is effective for six months. All other requests for supplies, etc., is effective for 3 months.

V. PROCEDURES:

PART 1:

Primary Caseholder/Requestor

1. Identifies, with assistance from the individual and their planning team, as appropriate, the need for specialized and enhanced medical equipment and supplies and/or environmental modifications and/or enhanced pharmacy.

2. Agrees that as a result of treatment and associated equipment or modifications, a more restrictive placement will be prevented and/or the identified item(s) will enable the individual to perform activities of daily living with a greater degree of independence than without them.

3. Agrees to move forward with the request by initiating Part 1 on Form #0091 after consulting with appropriate staff (OT, RN, etc.) to justify medical necessity and completing certification order triggering professional assessment, if needed.

PART 2:

Primary Caseholder/Requestor

4. Provides Financial Documentation Request Letter to responsible party and forwards form #0091 to Finance Department designee. The responsible party will have 30 days to submit requested financial documentation for process to continue. If not submitted within 30 days, the process will end.

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Financial Information that must be submitted:

- Most current assets which includes (but not limited to): Checking and Savings account(s), Debit Cards, Trusts (OBRA-93 Trust, Common Law Special Needs Trust, Pooled Trust, etc.) Stocks, Bonds, MiAble accounts, Cash on Hand. Account number(s) may be blacked-out.
    - If a minor (17 years and younger) – Requires TOTAL HOUSEHOLD assets (This includes Responsible Party, Guardian(s), Parent(s), etc.).
    - If individual is residing in specialized residential housing, must also include all applicable Resident Funds Part II Forms(s): Cash, Checking, Debit cards (True Link, etc.).
- Any resources above $2,000 for a single individual will be considered available assets to be used towards Medical Reimbursement; $3,000 for married couples.
    - Specialized Residential persons, who have been identified as having abundant benefits left over after room and board is paid each month, may be requested to pay towards Medical Reimbursement.

5. Once Finance Department designee receives financial information, a review will occur with recommendations for approval/denial based on financial need and the form will be routed to the Program Director for review.

PART 3:

Program Director

6. The Program Director will approve/deny based on medical necessity, estimated cost of supplies/equipment/pharmacy to meet need and individual/guardian financial review. Form #0091 will be sent back to requestor.

PART 4:

Occupational Therapist/Requestor

7. Completes professional assessment, if needed, and adds recommendations into IPOS.

8. Obtains all necessary documents:

- Physician's prescription (good for one year from physician's signature) or Certificate of Medical Necessity signed by physician. Equipment repairs do not require this documentation.
- If applicable, landlord/property owner agreement when modifications are recommended.
- Three estimates required when it is expected the cost of modifications will exceed $10,000.
- Notes needed equipment/supplies/pharmacy, quantity and cost in section 4 of Form #0091.

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9. Forwards Form #0091 to Program Director for final review.

PART 5:

Program Director

10. Reviews Form #0091 and makes decision based on appropriateness of request on justification provided and availability of funds.

11. If denied, returns form to requestor with reasoning.

12. If approved, forward to Finance Department designee, who will alert requestor of approval.

Occupational Therapist/Requestor

13. Notifies individual/guardian

a. If denied – For individuals denied due to excess assets/sufficient funds, request the responsible party to purchase requested item(s). Requestor will connect the responsible party/vendors with all applicable information/documentation for requested purchase.

b. If approved – Proceeds with supply/equipment/modification purchase/process.

Administration Clerical Support / Requestor

14. Orders approved items.

a. For established vendors, provide account information.
b. For new vendors, if not using a credit card or Amazon account, complete purchase order and follow the process provided in Administrative Procedure #07-003-0015 Administrative Procedures related to Board Fiscal Responsibilities.

Finance Designee

15. Processes payment of services to vendors.

VI. REFERENCES:

A. Michigan Department of Health and Human Services

B. Michigan Medicaid Provider Manual

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VII. EXHIBITS:

A. Form 03-0091

B. Financial Documentation Request Letter

VIII. REVISION HISTORY:

Dates issued 11/98, 02/01, 02/03, 03/04, 10/05, 02/08, 06/08, 08/10, 05/12, 01/13, 09/13, 09/14, 09/15, 01/17, 01/18, 11/18, 11/19, 11/20, 12/22, 12/23.

St. Clair County Community Mental Health Authority
3111 Electric Ave. Port Huron, MI. 48060

Specialized/Enhanced Medical Equipment and Supplies, Environmental Modifications and/or Enhanced Pharmacy

PART I

REQUESTER/CASE HOLDER

Individual: _____ Case #: _____ Date: _____

Requesting Staff: _____ Case Holder: _____

Contact Person and/or Guardian: _____ Phone #: _____

Address: _____

If Applicable Corporation Name/Home: _____

If Prescription- List Months Needed: _____
Prescriptions - 6 month max, Supplies - 3 month max (ex. Jan, Feb, March)

Current need and preliminary estimate of most cost effective solution: _____

_____

_____

_____

What options if any have been attempted/taken: _____

_____

_____

CASE HOLDER/OT MUST COMPLETE

- Individual on H/SW ☐ Yes ☐ No
- Individual's Medicaid has been verified _____ _____
  Medicaid is a requirement Initials Date
- Medicaid Number: _____

  Completed for prescription ONLY, INDIVIDUAL RESPONSIBLE FOR CO-PAYS
- Additional Insurances ☐ Medicare ☐ Private Insurance (i.e. Aenta, BCBS etc.): _____
- Financial informational letter forwarded to contact person and/or guardian _____ _____
  Initials Date

ACTIVITY CODE (Finance use only): _____

PART II

FINANCE DEPARTMENT

- Individual's Medicaid has been verified _____ _____ (proof attached)
  Initials Date
  Individuals' Medicaid #_____ *Medicaid is a requirement
- Additional Insurances ☐ Medicare ☐ Private Insurance (i.e. Aetna, BCBS etc.):_____
- All needed Financial information has been received _____ _____
  Initials Date

Finance Department Recommendations:

☐ Suggested Approval to Proceed to Program Director

☐ Suggested Denial: _____

_____

_____

PART III

PROGRAM DIRECTOR

☐ Preliminary Approval to Proceed: _____ _____ _____
Signature/Credentials Print Name Date

☐ Request Denied ***If denied, no further action required***

Reason: _____

_____

_____

_____

_____

_____ _____ _____
Signature/Credentials Print Name Date

PART IV

REQUESTER/CASE HOLDER - ONLY COMPLETE IF "Preliminary Approved to Proceed"

Description of services (SCCCMHA is payer as last resort: note the date and also if it is routine, emergency, non-routine, non-emergency, or if it is equipment; for equipment also include brand name/model number if applicable)	Quantity	Charge

Total Quantity: _____ **Total Charge:** _____

Prospective Service Provider Name:_____ Phone: _____

Prospective Service Provider Address:_____

Reimbursement other than to Home:_____

The following documentation of medical necessity must be included:

☐ **Health Care Provider** Prescription ☐ Yes ☐ No

☐ **Other Healthcare Profession:** Supplemental Justification

☐ Yes ☐ No

PART V

PROGRAM DIRECTOR

FINAL APPROVAL/DENIAL OF PROGRAM DIRECTOR

☐ PAYMENT APPROVED

☐ PAYMENT DENIED; explain: _____

_____

Program Director: _____ _____ _____

Signature/Credentials | Print Name | Date

Work Flow Process:

☐ Part I- Requester/Case Holder
☐ Part II- Finance Department
☐ Part III- Program Director
☐ Part IV- Requester/Case Holder
☐ Part V- Program Direct
☐ Return to Finance
☐ Return to Case Holder
☐ Scan/Uploaded OASIS

EXHIBIT B

Re: <CLIENT_NAME>, Case #: <CLIENT_CASE_NUMBER>

Dear Responsible Party,

Pertaining to the St. Clair County Community Mental Health Specialized / Enhanced Medical Equipment and Supplies, Environmental Modifications and/or Enhanced Pharmacy, 07-003-0065, SCCCMHA shall ensure that individuals, who are not covered by any other funding source, may submit requests for funds for Specialized / Enhanced Medical Equipment and Supplies, Environmental Modifications and/or Enhanced Pharmacy.

SCCCMHA (Medicaid) is the payor of last resort. All other available funding sources must be exhausted and documented. As such, we are required to obtain current financial information prior to approval.

Financial Documentation that must be submitted:

- Most current assets which includes (but not limited to): Checking and Savings account(s), Debit Cards, Trusts (OBRA-93 Trust, Common Law Special Needs Trust, Pooled Trust, etc.), Stocks, Bonds, MiAble accounts, Cash on Hand. Account number(s) may be blacked-out.
    - If a minor (17 years and younger) – Requires TOTAL HOUSEHOLD assets (This includes Responsible Party, Guardian(s), Parent(s), etc.).
    - If individual is residing in specialized residential housing, must also include all applicable Resident Funds Part II Form(s): Cash, Checking, Debit cards (True Link, etc.).

Please forward the applicable documentation above within 30 days to:

SCCCMHA
Attention: Theresa Lemerand
3111 Electric Avenue
Port Huron, MI 48060

If you have any questions regarding the information above, please contact:

Theresa Lemerand
tlemerand@scccmh.org
810-966-3523

Sincerely,

<STAFF_NAME>
<STAFF_PHONE>
<STAFF_TITLE>