ACTION NOTICE and HEARING RIGHTS

Medicaid Beneficiaries

Kalamazoo Community Mental Health and Substance Abuse Services

Name: Of individual served ID# CMH case record #

Guardian/Parent (as applicable) Use as necessary for each case Date: Of notice

This is to notify you that KCMHSAS has made the following decision(s) about the service(s) you have asked for or the service(s) you get from us. This does **not** mean that you will lose your Medicaid and will not affect any other Medicaid/ABW services you are getting, or may need in the future.

The Action we have taken is:	**Name of Service(s) Affected**	**Date**
☐ Service(s) Authorized Typically used by Emergency Services – NOT for Planning	Ex. Inpatient Psy hospitalization	Of screening
☐ Limited Service Authorization (less than requested) Use when a service is NOT being authorized as requested	Ex. CLS hours to be authorized at 14/day, not 24/day as requested	Of decision to authorize
☐ Undue Service Delay (over 14 days from agreed start date) If service not starting "on time" per what was agree to	Ex. CLS provider unable to start on 12/1/10 as written in the plan	Of decision Ex. 12/16/10
☐ Failure to provide timely authorization decision / Notice If a decision has not been made w/in 14 days about a service that was requested.	Ex. Intake done 12/1/10 and determination not made until 12/20/10. Or request from provider to Access not acted on per policy.	Of decision to authorize
☐ Service(s) Denied: ☐ At time of application/intake ☐ Requested Inpatient service ☐ Services in addition to Plan	Decisions here are typically made by Emergency or Intake screening. Or can be made via Access/Provider communication	Of screening or decision to not authorize
☐ Other: *Define* Before using - Contact Customer services if not an Action above		

	Name of Service(s) Affected	**Effective Date**
☐ Reduction in current services Less of something will be provided	**With all listings of services, please use the name of the service as it is authorized.**	12 calendar days after date of Notice
☐ Suspension of current services Service will be "on hold" for a while	**Examples: "Psychiatric services", not "meds". "Respite" not "babysitting".**	OR can be date of Notice if Exception to Advance Notice
☐ Termination of current services Service(s) to end	**"Outpatient Therapy" not "Counseling"**	requirement is met

If your services were denied, delayed, reduced, suspended, or terminated it is because:

☐ At this time, you do not meet the clinical eligibility criteria for specialty mental health or substance abuse services. Your current presentation is above what would qualify you for services as a person with a serious mental illness, or a developmentally disability, or a substance use disorder, or a child with a serious emotional disorder. For individuals who do not meet criteria for CMH/SA authorized services. The section is to be used at time of service eligibility screening, intake assessment, or at another time when eligibility is reviewed and no longer met.

☐ Lack of Medical Necessity. It has been determined that the service(s) identified in this notice are **not:** clinically appropriate, or necessary to meet your needs; or consistent with your diagnosis, symptoms or impairments; or the most cost effective option in the least restrictive environment; or consistent with current/clinical standards of care.
For individuals who are requesting service(s) and they do not have medical necessity for the service(s). Typically will be used during emergency screen for inpatient services or when another specific service is requested by an individual.

☐ You have other resources available that will provide payment for service(s). _____
For individuals who have a Medicaid HMO or Medicare or other insurance to cover service(s) being denied or terminated. To be used with not meeting clinical eligibility if appropriate.

☐ Residency. You live outside of our service area. We cannot authorize on-going/non-emergency services for you.
For instances in which a person either does not live in the "catchment" area upon application or moves during the course of services. IF a person requires 8+ hours of CLS supports, please contact your COFR rep.

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☐ Residency. You are currently residing in an institution in which KCMHSAS can not authorize your services. (e.g. jail, prison, state hospital, extended care facility)

Before closing the traditional CMH services, please coordinate with supervisor to review the plan for the individual regarding their jail/prison or nursing home stay. 12-day Advance Notice is not necessary in these instances. But, we need to make sure we are coordinating with courts and nursing home plans.

☐ Your Individual Plan of Service goals and objectives have been met.

If this is the case, the individual has no medical necessity for services. This type of notice is not necessary if the goals/objectives are met according to the date(s) on the Plan of Service, but necessary if accomplished outside of those dates.

☐ Lack of Participation. KCMHSAS cannot continue to authorize services for you if you are not participating. You have not attended or participated in your authorized services since (date): _____

Typically if an individual is not participating, the case should be closed at 3 months no contact at **the latest**. And, if no services in 3 months, a new eligibility screen is necessary. Sending this type of notice if no contact in 1 month will allow the individual to choose to engage or not before a new screening is necessary.

☐ Lack of Capacity to Benefit. It has been determined that the service(s) identified in this notice have been provided but are not significantly successful helping you: make substantial gains, meet the goals/objectives in your Plan of Service, recover from your symptoms, or improve your daily functioning skills/ability to care for yourself.

For times in which an individual has been receiving the same level of services for a long time (2+ yrs) and not observable progress is being made. There is a long period of stability with symptom management.

☐ You have requested the action to occur. See Signature area below for notes.

For times in which an individual asks to end services. For termination of services, **if** the individual signs the notice below, the termination of service(s) can occur with adequate "now" notice and happen on the date the notice is signed. 12-day Advance notice is not necessary in this instance – however 12-day Advance notice is necessary if the request to end services was made and no signature from the individual is available. (example if a person asks for services to end while on the phone and cannot sign a document to attest to their request).

☐ Other: Contact Customer Services before using "Other" as a reason for an Action.

The legal basis for this decision and notice is 42 CFR 440.230(d) and applicable policy found in the Michigan Medicaid Provider Manual – Chapter: Mental Health and Substance Abuse Services.

The back of this page has more information about accessing information regarding the reasons for the Action taken.

IF YOU DO NOT AGREE WITH THIS ACTION, PLEASE READ *YOUR RIGHTS* ON THE BACK OF THIS PAGE.

_____ _____

Individual/Guardian Signature (as applicable) Date

Note: Signature of the Individual Served/Guardian is not required and does not mean agreement with the action, unless the action was initiated by the individual.

_____ _____ _____ _____

Staff Signature/ Credential Date Approving Signature (as necessary) Date

The staff person completing the notice, please sign and date with credential.

This is a new requirement.

CM and SC staff are not able to authorize or deny/terminate services – per MDCH contract. So, at this time, such Actions need co-signature of CM or SC supervisor.

Determinations made by a person acting in a screening capacity do not need co-signature.

Notice provided: ☐ via mail ☐in person

Notice copied to: ☐ Provider ☐ Access

In KCMHSAS, it will be expected that provider agency/internal service program completing Notice will ensure copy is added to EMR.

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Kalamazoo Community Mental Health and Substance Abuse Services

If you do not understand any part of this Action Notice, please call KCMHSAS at
(269) 553-7000 or 1-877-553-7160
All persons who are deaf or hard-of-hearing please contact us using the Michigan Relay Center.
Dial 7-1-1 and give (tell) MRC the number you are trying to reach.

Your Rights: If you are not happy with the action we have taken, you may:

- Ask to review your services/plan with your primary clinician or their supervisor ;and/or
- Contact the KCMHSAS Recipient Rights Office by calling (269) 364-6920; and/or
- Request a **Local Appeal** within 45 calendar days of the date of the Notice; and/or
- Request a **Medicaid Fair Hearing** within 90 calendar days of the date of this Notice.
- If you were denied initial access/entry to all services or were denied inpatient psychiatric hospitalization services you can request a Second Opinion of that decision. To request a Second Opinion, please contact KCMHSAS at (269) 553-7000 or 1-877-553-7160

You may choose to have another person represent you in exercising your rights – as your authorized representative. This person may be your legal counsel (attorney), a relative, a friend, or another spokesperson. You must give this person written permission to represent you, but you do not need to grant written permission if this person is your spouse or attorney.

Local Appeal Resolution

If you do not agree with this decision, you or your authorized representative may request a Local Level Appeal. Your request can be made orally or in writing and must be received by KCMHSAS within 45 calendar days of the Date of this Notice. You can write or call to: KCMHSAS Customer Services
2030 Portage Street – Kalamazoo MI 49001
(269) 553-7000 or 1-877-553-7160.

You have a right to an expedited local appeal if waiting the standard time (up to 45 calendar days) for the appeal would seriously jeopardize your life or health or your ability to attain, maintain or regain maximum function. To request an expedited appeal, you must call KCMHSAS.

Medicaid Fair Hearing

If you do not agree with this decision, you may request a Medicaid Fair Hearing within 90 calendar days of the date of this Notice. Hearing requests must be made in writing and signed by you or an authorized representative. To request a hearing, complete the "Request for Hearing" form and return it in the enclosed pre-addressed envelope and mail to:

State Office of Administrative Hearings and Rules
For the Department of Community Health
P.O. Box 30763
Lansing, MI 48909-9951

You can also use any piece of paper to request your hearing in writing and mail it to the address above. You have a right to an expedited hearing if waiting for the standard time (up to 90 days) for a hearing would seriously jeopardize your life or health or your ability to attain, maintain or regain maximum function. To request an expedited hearing, you must call the Administrative Tribunal office toll free at 1-877-833-0870.

Continuing Services: If the Action taken affects services you are currently receiving, you may ask that your services remain in place if you appeal prior to the **Effective Date** of the Action (as stated on the Notice) and you request that services continue. If services remain in place, you may have to repay the cost of these services if the determination upholds the Action**,** if you withdraw your appeal or hearing request, or if you (your representative) do not participate in the appeal process.

Reasons for the Action Taken

The Michigan Medicaid Provider Manual – Chapter: Mental Health and Substance Abuse Services sets the policies/rules and provides guidance to agencies providing Mental Health and Substance Abuse services. If you want to review the manual, you can find it at www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf. You can also contact Customer Services at KCMHSAS at (269) 553-7000 or 1-877-553-7160 for more information about the Manual and the reasons why the Action on this Notice is being taken. Specific sections of note are:

- Section 1.6. Information about beneficiary eligibility for specialty mental health supports and services.
- Section 2.5. Information about Medical Necessity determinations for services.
- Section 12. Information about Substance Abuse service eligibility, intensity, and excluded services.

**** EMERGENCY SERVICES REMAIN AVAILABLE TO YOU AT ALL TIMES****

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