ACTION NOTICE and HEARING RIGHTS For Medicaid Beneficiaries

Southwest Michigan Behavioral Health Affiliation for the counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren

Name: _____ ID# _____

Guardian/Parent (as applicable) _____ Date: _____

This is to notify you that Southwest Michigan Behavioral Health (SWMBH) 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/ABW and will not affect any other 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		
☐ Limited Service Authorization (less than requested)		
☐ Undue Service Delay (over 14 days from agreed start date)		
☐ Failure to provide timely authorization decision / Notice		
☐ Service request is Denied: ☐Initial Requested Service ☐Continued service request		
☐ Other: *Define*		

	Name of Service(s) Affected	**Effective Date**
☐ Reduction in current services		
☐ Suspension of current services		
☐ Termination of current services		

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.

☐ **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.

☐ **You have other resources available that will provide payment for service(s).** _____

☐ **Residency.** You live outside of our service area. We cannot authorize on-going/non-emergency services for you.

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

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

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

☐ **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.

☐ **Administrative Discharge.** Based on your actions and behaviors, you have not demonstrated compliance with the administrative rules of the service you are receiving. SWMBH can no longer authorize these services for you.

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

☐ **Other:** _____

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* Section of this Notice.

_____ _____ _____ _____

Individual/Guardian Signature (as applicable) Date Staff Signature/ Credential Date

By signing this notice, I understand the changes to my current services can happen on the date I sign.

Notice provided: ☐ via mail ☐in person

If you do not understand any part of this Action Notice, please call SWMBH at 1-800-890-3712.
All persons who are deaf or hard-of-hearing please contact us using the Michigan Relay Center.
Dial 7-1-1 or 1-800-649-3777 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
- 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. and/or
- Contact your Recipient Rights Office if you feel your rights have been violated during the appeal process.

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, service provider, your legal guardian (with copy of guardianship papers provided) or another spokesperson. You must give this person written permission to represent you, but you may not need to grant written permission if this person is your spouse or attorney.

Local Appeal Resolution

If you do not agree with this action, 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 Southwest Michigan Behavioral Health within 45 calendar days of the Date of this Notice. You can write or call to: Southwest Michigan Behavioral Health
Customer Services Department
5250 Lovers Lane, Portage, MI 49002
1-800-890-3712

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 Southwest Michigan Behavioral Health within 12 calendar days of the date of this Notice.

Medicaid Fair Hearing

If you do not agree with this action, 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 your authorized representative. To request a hearing can use any piece of paper to request your hearing in writing and mail it to the address below.

Michigan Administrative Hearing System (MAHS)
For the Department of Community Health
P.O. Box 30763
Lansing, MI 48909

Or you can contact Customer Services to receive a copy of the formal "Request for Hearing" form as used by MAHS.
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 Michigan Administrative Hearing System office toll free at 1-877-833-0870. You may also be asked to make such a request in writing by the Hearing System.

Continuation of Current Services(s) During Appeal Process

If the action you wish to appeal is a suspension, reduction or termination of current services, you may ask that your services remain in place if your appeal/hearing request is made within 12 calendar days of this notice; and, authorization for your services has not expired, and if the authorization was ordered by an authorized/approved SWMBH provider. If services remain in place, you may have to repay the cost of these services if: the hearing or appeal upholds this decision, if you withdraw your appeal or hearing request, or if you/your representative does not attend the scheduled hearing.

You may be asked to pay for a portion of the services you received during the appeal process if the appeal outcome upholds the decision you are appealing. This is **NOT** always true, but if you need to pay, you will be notified of the amount.

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 SWMBH Customer Services at 1-800-890-3712 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.