MCCMH PROVIDER AGENCY/ STAFF INSTRUCTIONS

Instructions for use by MCCMH Provider Agency / Staff in completing Adequate and Advance Adverse Benefit Determination Notice letters follows. Please choose from those items listed within each category (Service, Reason, Unit Type, Period) as applicable. Please take note of any exceptions or special instructions.

- **Advance and Adequate Adverse Benefit Determination Notices MUST include the SERVICE that is being denied, limited, reduced, terminated or suspended, and the REASON for the action.**
- **List of services (NOTE: Always refer to the Medicaid Provider Manual for most updated list of services):**

ACT	Environmental Accessibility Modifications	Medication Training and Support	Respite Care - Other
Adult Residential	Enhanced Pharmacy	Non-Family Training	Respite Care - Overnight
All Services	Extended Observation Bed (23 Hrs)	Nursing Facility MH Monitoring	SED Waiver
Assessments	Fiscal Intermediary Services	Occupational Therapy	School Based Services
Assistive Technology (PERS)	Family Training Support	Other (specify service on notice)	Skill Building Assistance - Out-of-Home Adaptive
BMRC	Habilitation Supports (Hab) Waiver	Out-of-Home Non-vocational Habilitation	Skill Building Assistance - Work-Prep
Children's Residential	Health Services	Outpatient Partial Hospital	Speech, Hearing and Language Therapy
Children's Waiver	Home-based Services	Peer Delivered or Operated Supports	Specialty Services (Music, Recreation, Art, & Massage Therapies)
Chore Services	Housing Assistance	Personal Care in Licensed Specialized Residential	Sub-Acute Hospitalization
Crisis Intervention	ICF/MR or State Hospital	Personal Emergency Response System	Substance Abuse
Clubhouse PSR	Infant Mental Health	Physical Therapy	Supported/Integrated Employment
Community Living Supports	Initial Assessment	Prevention Services	Supports Coordination
Crisis Residential Services	Inpatient Hospitalization - Psychiatric	Private Duty Nursing	Targeted Case Management
Dental	Integrated Dual Diagnosis Treatment	Prevocational Services	Therapy (Child, Individual/Group Family)

Early On Program	Intensive Crisis Stabilization Services	Psychiatric Evaluation	Transportation
ECT	Medication Administration	Psychological Testing	Treatment Planning
Enhanced (specialized) Equipment & Supplies	Medication Review	Respite Care - Hourly	Wraparound Services

- **List of REASONS for the Adverse Benefit Determination*:**

Consumer is deceased	You were admitted to an institution where you are ineligible for service
More time needed / decision pending	Your whereabouts are unknown (no forwarding address)
Not medically necessary	Your treating agent / treatment team prescribed a change in level of care
You requested the change	Date of action will occur in less than 12 days
You withdrew from service	Documentation submitted does not justify requested service
Consumer does not meet criteria for services requested.	Consumer no longer meets eligibility standards.
Consumer has Medicare which covers the services requested	Consumer has private insurance which covers the services requested.
Consumer's Medicaid assigned Health Plan covers the services requested.	Federal, State or Local law has changed regarding covered service.
Consumer has been referred to CARE for substance abuse treatment.	Consumer is not a Macomb County resident.
Consumer has stabilized and can be served in less restrictive environment/ has other resources.	Other*

**** For REASONS given, do not state budgetary constraints or utilization management. You may state service(s) is a non-crisis, non-urgent General Fund Service, if applicable.***

- **In the event that there is a reduction, suspension or termination of services during a current authorization period FOR THE FOLLOWING REASONS, an Adequate Notice of Adverse Benefit Determination (not an Advance Notice of Adverse Benefit Determination) shall be sent:**

Consumer is deceased	Consumer moved out of our county
Consumer requested the change	Consumer withdrew from service
Consumer was admitted to an institution where he/she is ineligible for service	Consumer's whereabouts are unknown (no forwarding address)
Consumer's treating agent / treatment team prescribed a change in level of care	Date of action will occur in less than 10 days

- **List of Unit Type:**

Day	Hour	Month	Item
Encounter	15 minute interval	30 minute interval	

- **List of Period Type:**

Day	Month
Week	Year