Denial of Service Policy

POLICY

It shall be the policy of the Detroit Wayne Mental Health Authority (DWMHA) that enrollees/members and providers who receive an adverse determination for behavioral health care services be given a notification, in writing, of the reason for the denial in easily understandable language and the reference to the benefit provision, guideline or protocol criterion on which the denial decision was based. The written notification will also inform the enrollee/member and provider of their appeal rights consistent with the Michigan Department of Health and Human Services (MDHHS) and the Center for Medicare and Medicaid Services (CMS) standards and requirements, contracts, policy and accreditation guidelines.

DWMHA only allows physicians to render behavioral health care and pharmaceutical medical necessity denials. Certified addiction medicine physicians are available to review Substance Use Disorder (SUD) medical necessity cases. Providers/Practitioners have the opportunity to discuss any Utilization Management (UM) denial determination with a physician.

PURPOSE

The purpose of this policy is to provide procedural and operational guidance on the denial process to all staff performing UM functions including UM Reviewers, UM clinical specialists, UM appeal coordinators, and physicians. Also availing enrollees/members or their authorized representative of the right to appeal an adverse determination while ensuring all adverse decisions are fair, consistent, and in compliance with federal and state regulations.

APPLICATION

This policy applies to DWMHA staff, Contractual staff, Access Center staff, Managers of Comprehensive Provider Network (MCPN) staff, Crisis Service Vendor staff. This policy serves the following populations: Adults with Severe Mental Illness (SMI), Children with Serious Emotional Disturbance (SED), Persons with Intellectual/Developmental Disabilities (I/DD) and Persons with Substance Use Disorders (SUD) and all funding streams and waiver programs such as MI Health Link, SUD, Autism Spectrum Disorder and Medicaid.

KEY WORDS

1. Action
2. Administrative Appeal
3. Adverse Determination
4. Authorization
5. Independent Review Organization (IRO)
6. Medical Necessity Appeal
7. Pended

STANDARDS

1. DWMHA, Access Center, IRO, Crisis Service Vendor and/or MCPNs shall take steps to ensure that all staff performing UM functions are experienced, qualified, credentialed and trained mental health clinicians deemed capable of making medical necessity determinations for the services they review.

2. DWMHA, Access Center, IRO, Crisis Service Vendor and/or MCPNs shall only allow physicians (MD or DO) to render behavioral health care and pharmaceutical medical necessity denials. A physician (MD or DO) that is also certified in addiction medicine will review all SUD medical necessity cases. DWMHA ensures that practitioners have the opportunity to discuss any Utilization Management (UM) denial determination with a physician reviewer.

3. All physicians must have a current, unrestricted license to practice medicine independently in the state of Michigan, hold an unrestricted Controlled Substances license issued in the state of Michigan, and have a Drug Enforcement Authority registration for controlled substances. If required for certain programs ie. MI Health Link, be Board certified.

4. Psychiatrists must also complete a psychiatric residency approved by the Accreditation Council for Graduate Medical Education (ACGME).

5. Physicians certified as addiction medicine specialists must have certification through the American Board of Addiction Medicine or be a Psychiatrist certified by the American Board of Psychiatry and Neurology. Also, these physicians are required to complete a minimum number of hours focused on teaching, research, administration and clinical care in the prevention and treatment of individuals who are at risk for or have a substance use disorder, and have at least five (5) years experience post graduate or post-licensure.

6. DWMHA, Access Center, IRO, Crisis Service Vendor, and MCPNs shall provide practitioners/providers with an opportunity to discuss any UM adverse determinations with a physician or physician with an addiction medicine certification upon request by calling the UM Department. Practitioners/Providers are notified by telephone of the ability for a peer to peer review at the time of the verbal notification of an adverse determination. DWMHA, Wellplace/Access Center, Crisis Service Vendor, and/or MCPN UM review staff must document this notification in addition to the verbal notification of the adverse decision in their electronic system.

7. Professionals must be licensed practitioners of the healing arts with same or similar clinical expertise in treating the enrollee/member's condition or disease when an adverse determination is issued.

8. All adverse determinations are to be clearly documented in DWMHA's, Access Center's, Crisis Service Vendor, and/or MCPN's electronic system. The enrollee/member shall be notified in writing. The practitioner/provider rendering the service(s) shall be notified verbally and in writing.

9. Written notification of behavioral health care adverse determinations to the enrollee/member and their treating practitioner/provider shall consistently contain at least the following relevant information:
a. An explanation of the denial of service(s) in amount, scope and duration if less than what is requested; and

b. The specific reasons for the denial, in easily understandable language, which is specific to the enrollee/member's condition and includes no abbreviations or acronyms that are not defined or explained; and

c. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial was based; and

d. Notification that the enrollee/member or practitioner/provider when acting as the enrollee/member's authorized representative can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request, and how to formally request the information and that it is at no cost to the enrollee/member; and

e. A description of the appeal rights, including the right to submit written comments, documents or other information relevant to the appeal; and

f. An explanation of the appeal process including the time frame for filing an appeal, the enrollee/member's right to be represented by anyone of their choice, including an attorney and the time frames for deciding the appeal; and


g. A description of the expedited appeal process for urgent pre-service or urgent concurrent adverse determinations; and

h. Notification of the right to a Medicaid Fair Hearing for Medicaid covered services.

10. Materials used by DWMHA, Access Center, Crisis Service Vendor, and MCPNs must be compliant with all contractual, regulatory and accreditation requirements in regards to reading level, font, type size, medium, and language. Upon request, DWMHA, Access Center, Crisis Service Vendor, and MCPNs will provide materials in alternative formats to meet the needs of vision impaired enrollee/members, including large font (at least 16 point), Braille and audio formats. Translation services shall be made available to the enrollee/member whose primary language is not English, upon request. These services are provided at no cost to the enrollee/member.

11. There is staff coverage and availability to handle all urgent UM requests twenty four (24) hours a day/ seven (7) days a week. However, non-urgent (standard) UM requests will be handled the next business day.

12. There may be instances where clinical additional information is requested before making an adverse determination. DWMHA, Access Center, Crisis Service Vendor and the MCPNs will send the standardized Request for Additional Information form to the provider and the standardized Enrollee Agreement for Request for Additional Information form to the enrollee/member.

   a. Request for Additional Information form (Medicaid SMI, IDD, SUD)
   b. Request for Additional Information form (MHL)
   c. Request for Additional Information form (Uninsured or Under Insured)
   d. Enrollee Agreement for Request for Additional Information form (Medicaid SMI, IDD, SUD)
   e. Enrollee Agreement for Request for Additional Information form (Uninsured or Under Insured)
   f. Enrollee Agreement for Request for Additional Information form (MHL)

13. For urgent or non-urgent (standard) pre-service and/or concurrent adverse behavioral health care or pharmaceutical determinations, DWMHA, Access Center, Crisis Service Vendor and/or MCPNs' UM staff
will verbally inform the hospital's UM staff or the requesting practitioner/provider within three (3) hours of
the decision. Written notification must be sent within twenty-four (24) hours of the oral notification.

14. If the UM staff has insufficient clinical information to reference a specific criterion and was unable to
obtain it, the adverse determination notice shall state this and will specify the specific information that was
needed yet not provided.

15. DWMHA, Access Center, IRO, Crisis Service Vendor and/or the MCPNs may not make an adverse
determination of services based solely on preset limits of cost, amount, scope and duration of services.
Instead, adverse determinations shall be conducted on an individual basis.

16. For an adverse determination of services that is based upon a request for service(s) which is deemed
professionally and scientifically ineffective or experimental, and/or if the medically necessary standard of
care may be met via a more appropriate, less restrictive, cost effective and appropriate service, the
following will be adhered to:
   a. Further services may be limited to the coverage plan of the enrollee/member served and, in some
      circumstances, the enrollee/member served may be referred elsewhere for treatment and services;
      and
   b. DWMHA, Access Center, IRO, Crisis Service Vendor and/or the MCPNs do not deny the use of a
      benefit based on preset limits of benefit duration but instead review the continued medical necessity
      on an individual basis. If it is determined that the medical necessity criteria for a specific service is
      not met, all efforts will be made to link the enrollee/member to the services he/she needs.

17. There may be situations where DWMHA, Access Center, IRO, Crisis Service Vendor, or MCPNs may
suggest an alternative to the service being requested as it is felt this alternative service to be more
appropriate and it meets the enrollee/member's needs. If the treating practitioner or provider who is
requesting the initial service and/or enrollee/member agree to the alternative service and the service is
authorized, it is determined that the practitioner/provider and/or enrollee/member has essentially
withdrawn the initial request and thus a denial is not issued.

18. Practitioners/Providers may request a peer to peer review of an adverse determination within ten (10)
calendar days of the date of the initial notification. The request can be made verbally, via fax or sent to
the address listed for appeals. This will not affect their future appeal rights if the adverse determination is
maintained.

19. DWMHA, Access Center, IRO, Crisis Service Vendor and/or the MCPNs do not reward their physician
reviewers, case managers, or any other employees for issuing an adverse determination of coverage of
service.

20. DWMHA, Access Center, IRO, Crisis Service Vendor and/or the MCPNs do not pay incentives to their
physician reviewers, UM reviewers, case managers, or any other employees to reduce the provision of
care which is deemed medically necessary or to encourage decisions that result in under-utilization of
care or services.

21. The standardized Advance Action Notice form is sent to the enrollee/member regarding a decision to
reduce, suspend or terminate services currently authorized and provided. The standardized Adequate
Action Notice form is sent to the enrollee/member when the decision is to deny or limit authorization of
services being requested. The standardized Denial of Medical Coverage form is sent to a MI Health Link
enrollee/member regarding a decision to reduce, suspend or terminate services currently authorized and
provided or regarding a decision to deny or limit services being requested.
   a. Advance Action Notice (Medicaid SMI, IDD, SUD)
b. Advance Action Notice (Uninsured or Under Insured)
c. Adequate Action Notice (Medicaid SMI, IDD, SUD)
d. Adequate Action Notice (Uninsured or Under Insured)
e. Denial of Medical Coverage (MHL)

22. For the MI Health Link program, the standardized Notice of Our Failure to Make a Coverage Determination form (MHL) must be sent to the enrollee/member when a timely decision regarding authorization of services is not met. In such instances, the enrollee/member can then request an appeal.

QUALITY ASSURANCE/IMPROVEMENT

1. DWMHA shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

2. DWMHA’s Quality Improvement Program must include measures for both the monitoring of and the continuous improvement of the program or process described in this policy.

3. An Inter-Rater Reliability case review test is conducted by all DWMHA, Crisis Service Vendor and MCPN staff making UM decisions to ensure consistent application of medical necessity criteria and appropriate level of care decisions.

4. Annually, the DWMHA UM Director or his/her designee identifies at least ten (10) vignettes from the Inter-Rater Reliability MCG Indicia module to assess Inter-Rater Reliability system wide.
   a. All DWMHA, Crisis Service Vendor and MCPN staff performing UM functions must review the vignettes and select the appropriate level of care by applying the MCG and LCD and NCD Utilization Management Criteria.
   b. The MCG module immediately generates a compliance report which includes the test scores for each staff person, an item response analysis and detailed assessment report that pinpoints any areas in which the staff need additional training.
   c. It is the expectation of DWMHA that staff meet or exceed a score of 85%.
   d. In the event that a staff person does not meet or exceed the 85% threshold, a corrective action plan which may include such activities as face-to-face supervision, coaching and/or education and re-training is implemented with the expectation that the staff person pass at the next Inter-Rater Reliability case review test.

5. One additional re-test of at least ten (10) more vignettes will be given within thirty (30) days of the initial Inter-Rater Reliability case review test.
   a. It is the expectation of DWMHA that the staff person meet or exceed a score of 85%.
   b. In the event that the staff person does not meet or exceed the 85% threshold for a second time, he/she will be subject to a transfer to a role outside the UM department or termination.

6. The results of the Inter-Rater Reliability case review tests are used to identify areas of variation among decision makers and/or types of decisions. The results will help to identify opportunities for improvement as well as further training needs. However, all staff performing pre-admission reviews and/or UM functions shall be trained at least annually on the MCG and NCD and LCD Utilization Management Criteria.
7. Monthly Access Center, Crisis Service Vendor and the MCPNs shall forward the complete records/charts of all (100%) denial and/or appeal cases and the DWMHA Denial and Appeal Master Tracking Log to DWMHA.

8. DWMHA shall then review all of the denial and appeal case records/charts using the Denial Audit tool.

9. Quarterly, Access Center, Crisis Service Vendor and the MCPNs shall perform a documentation review of all (100%) denial and appeal case audits for all staff making UM decisions using the DWMHA Access Center Eligibility Review tool or the DWMHA Prior Authorized Service UM Review tool.

10. Quarterly, Access Center, Crisis Service Vendor and SMI MCPN shall also review ten (10) approved request for service cases for all staff making UM decisions. The I/DD MCPNs shall review five (5) approved request for service cases on all staff making UM decisions using the above tools.

11. It is the expectation of DWMHA that all staff from all entities meet or exceed an overall score of 85% or greater. In the event that a staff person does not meet this threshold of 85% or greater, a corrective action plan will be implemented with the expectation that the person pass at the next case review. Corrective action plans can involve such activities as face to face supervision, coaching and/or education and re-training. If at the next review, the staff person does not achieve 85% or greater, he/she will be subject to transfer outside the UM Department or termination.

12. The results of the audit case reviews will be used to identify areas of variation among decision makers and/or types of decisions. The results will help to identify opportunities for improvement as well as further training needs. However, all staff performing pre-admission reviews and/or UM functions shall be trained at least annually on the MCG and NCD and LCD Utilization Management Criteria.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWMHA staff, Access Center staff, Crisis Service Vendor staff, MCPN staff, contractors and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. DWMHA UM Program Description FY 16-18
3. Contract for Medicare and Medicaid Services in Partnership with the State of Michigan and the Integrated Care Organizations, November 1, 2016 (The Three Way Contract)
4. MDHHS Mental Health and Substance Abuse Administration Contract, October 1, 2016

RELATED POLICIES

1. Appropriate Professionals for Utilization Management Decision Making Policy
2. Behavioral Health Service Medical Necessity Criteria Policy
4. Inter-Rater Reliability Policy
5. Independent Review Organization Policy
6. Customer Service Member Appeal Policy
7. Standard of Conduct Policy
8. Utilization Management/Provider Appeal Policy

RELATED DEPARTMENTS
1. Clinical Practice Improvement
2. Compliance
3. Customer Service
4. Information Technology
5. Integrated Health Care
6. Managed Care Operations
7. Quality Improvement
8. Recipient Rights
9. Substance Use Disorder
10. Utilization Management

CLINICAL POLICY
Yes

INTERNAL/EXTERNAL POLICY
EXTERNAL

Attachments:

Adequate Action Notice Form (Medicaid SMI, IDD, SUD).docx
Adequate Action Notice Form (Uninsured or Under Insured).docx
Advance Action Notice Form (Medicaid SMI, IDD, SUD).docx
Advance Action Notice Form (Uninsured or Under Insured).docx
Denial Audit Tool.xlsx
Denial of Medicaid Service Procedures.docx
Denial of Service Procedures for the Uninsured or Under Insured.docx
DWMHA Access Center Eligibility Review Tool.docx
DWMHA Denial and Appeal Master Tracking Log.xlsx
DWMHA Prior Authorized Service UM Review Tool.pdf
Enrollee Agreement for Request for Additional Information Form (Medicaid SMI, IDD, SUD).docx

<table>
<thead>
<tr>
<th>Approver</th>
<th>Date</th>
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<tbody>
<tr>
<td>Ronald Hocking: Chief Operating Officer</td>
<td>05/2017</td>
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<tr>
<td>Dana Lasenby: Deputy Chief Operating Officer [AS]</td>
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<td>Allison Smith: Project Manager, PMP</td>
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<tr>
<td>William Sabado</td>
<td>04/2017</td>
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<tr>
<td>Muddasar Tawakkul: Director of Compliance/Purchasing [AS]</td>
<td>04/2017</td>
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<tr>
<td>Lorraine Taylor-Muhammad: Director, Managed Care Operations</td>
<td>03/2017</td>
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<tr>
<td>Bessie Tetteh: CIO</td>
<td>03/2017</td>
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<td>Darlene Owens: Director, Substance Use Disorders, Initiatives [DH]</td>
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<tr>
<td>Rolf Lowe: Assistant General Counsel/HIPAA Privacy Officer [DH]</td>
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<tr>
<td>Crystal Palmer: Director, Children's Initiatives [DH]</td>
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<tr>
<td>Stacie Durant: CFO Management &amp; Budget [DH]</td>
<td>03/2017</td>
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<tr>
<td>Tracey Lee: Director Claims Management [DH]</td>
<td>03/2017</td>
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<td>Jody Connally: Director, Human Resources [DH]</td>
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<td>Julia Kyle: Director of Integrated Care [DH]</td>
<td>03/2017</td>
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<tr>
<td>Kip Kliber: Director, Recipient Rights [DH]</td>
<td>03/2017</td>
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<tr>
<td>Corine Mann: Chief Strategic Officer/Quality Improvement [DH]</td>
<td>03/2017</td>
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<tr>
<td>Michele Vasconcellos: Director, Customer Service [DH]</td>
<td>03/2017</td>
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<tr>
<td>Mary Allix [DH]</td>
<td>03/2017</td>
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<tr>
<td>Carmen McIntyre: Chief Medical Officer [DH]</td>
<td>03/2017</td>
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<tr>
<td>Diana Hallifield: Consultant</td>
<td>03/2017</td>
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<tr>
<td>Sarah Sharp: Consultant</td>
<td>03/2017</td>
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<tr>
<td>Maha Sulaiman</td>
<td>03/2017</td>
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<tr>
<td>Tasha Bridges: UM Appeals Coordinator</td>
<td>03/2017</td>
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Detroit Wayne Mental Health Authority (DWMHA)
707 West Milwaukee Street
Detroit, Michigan 48202

ADEQUATE NOTICE OF ACTION
Michigan Medicaid and Healthy Michigan Members/Enrollees

Date

Name
Address
City, State, Zip

Re: Member/Enrollee’s Name: ____________________________________________________________

Mi. Medicaid /Healthy Michigan (Circle all that apply) ID#: ________________________________
MHWIN ID#: __________________________________________________________________________

Following a review of the mental health services and supports for which you have applied or are receiving, it has
been determined that the following service(s) are being reduced, terminated, suspended or denied.

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The reason for this action is ____________________________________________________________

The legal basis for this decision is 42 CFR 440.230(d) and the Medicaid Provider Manual Behavioral Health and
Intellectual and Developmental Disability Supports and Services Chapter.

If you do not agree with this action, you may request a Local Appeal, either orally or in writing, within 45
calendar days of the date of this notice by contacting Detroit Wayne Mental Health Authority (DWMHA) at
(313) 344-9099 or TTY (800) 630-1044. For an enrollee/member appeal, ask for the DWMHA Customer Service
Department and for a provider/utilization management appeal, ask for the DWMHA Utilization Management
Department.

You can send us any evidence you want us to review, such as medical records, doctors’ letters, or other
information that explains why you need the item or service. Call your doctor for this information. Our address is
707 West Milwaukee Street, Detroit, Michigan 48202 Attention: Customer Service.

You can ask to see the medical records and other documents we used to make our decision before or during the
appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

EXPEDITED LOCAL APPEAL
You have a right to an expedited (faster) local appeal if waiting for the standard time would seriously jeopardize
your life, health and/or your ability to attain, maintain, or regain maximum function. To request an expedited local
appeal, contact the Customer Service Department at Detroit Wayne Mental Health Authority (DWMHA) at the
numbers listed above. You can also choose to have someone help you with your Local Appeal. You can also
choose to have someone represent you during the Local Appeal process. If you want someone else to act for
you, call us at: (313) 344-9099 to learn how to name your representative. TTY users call (800) 630-1044. Both
you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax (313) 833-2217 this statement to the DWMHA Customer Service Department. Upon receiving an appeal request, we will review your request, make a decision and provide you with a written explanation of the decision within 30 calendar days for a standard appeal request and within 72 hours for an expedited appeal request.

For an enrollee/member, if you do not agree with this action, you may also request a Medicaid Fair Hearing within 90 calendar days of the date of this notice. Medicaid Fair Hearing requests must be made in writing and signed by you or an authorized person. To request a hearing, complete the attached “Request for Hearing” form, and mail to:

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 30763
LANSING, MI 48909

EXPEDITED MEDICAID FAIR HEARING
You have a right to an expedited Medicaid Fair Hearing if waiting for the standard time seriously jeopardize your life, health, and/or your ability to attain, maintain, or regain maximum function. To request an expedited Medicaid Fair Hearing, you must call the following toll-free number (800) 648-3397.

You can choose to have another person represent you at the Medicaid Fair Hearing. The person you choose to represent you can be anyone you choose as long as:

1. He/she is at least 18 years old;
2. You have given them written permission on the “Request for Hearing” form;
3. Your guardian or conservator can provide a copy of the court order naming the guardian/conservator. This information should be sent with “Request for Hearing” to the Michigan Administrative Hearing System, Department of Health and Human Services.

You may request both a fair hearing and a local appeal. The Medicaid Fair Hearing and local appeal processes may occur at the same time. You may contact DWMHA’s Customer Service Department at (888) 490-9698 if you have any further questions about an expedited Medicaid Fair Hearing.

_________________________ _______________________________ __________
Decision Maker (Printed Name) with Decision Maker’s Signature Date
Credentials/Job Title

Enclosures: Local Appeal Request Form, Hearing Request Form & Business Reply Envelope
cc: Enrollee and/or authorized Representative, Service Provider

Revised 5.10.17
Detroit Wayne Mental Health Authority (DWMHA)  
707 West Milwaukee Street  
Detroit, Michigan 48202  

ADEQUATE NOTICE OF ACTION  
Uninsured or Under Insured Members/Enrollees

Date  
Name  
Address  
City, State, Zip

Re: Member/Enrollee’s Name: ____________________________________________________________

Medicaid /Healthy Michigan (Circle all that apply) ID#: __________________________________
MHWIN ID#: ________________________________________________________________________

Following a review of the mental health services and supports for which you have applied or are receiving, it has been determined that the following service(s) are being reduced, terminated, suspended or denied.

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The reason for this action is ____________________________________________________________

The legal basis for this decision is 42 CFR 440.230(d) and the Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter.

If you do not agree with this action, you may request a Local Appeal, either orally or in writing, within 45 calendar days of the date of this notice by contacting Detroit Wayne Mental Health Authority (DWMHA) at (313) 344-9099 or TTY (800) 630-1044. For an enrollee/member appeal, ask for the DWMHA Customer Service Department and for a provider/utilization management appeal, ask for the DWMHA Utilization Management Department.

You can send us any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor for this information. Our address is 707 West Milwaukee Street, Detroit, Michigan 48202 Attention: Customer Service.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

EXPEDITED LOCAL DISPUTE RESOLUTION  
You have a right to an expedited (faster) local dispute resolution if waiting for the standard time would seriously jeopardize your life, health and/or your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, contact the Customer Service Department at Detroit Wayne Mental Health Authority (DWMHA) at the numbers listed above. You can also choose to have someone help you with your Local Dispute Resolution. You can also choose to have someone represent you during the Local Dispute Resolution process. If you want someone else to act for you, call us at: (313) 344-9099 to learn how to name your representative. TTY users call (800) 630-1044. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You’ll need to mail or fax (313) 833-2217 this statement to the DWMHA Customer Service Department.
Upon receiving an appeal request, we will review your request, make a decision and provide you with a written explanation of the decision within 30 calendar days for a standard appeal request and within 72 hours for an expedited appeal request.

For an enrollee/member, if you do not agree with the outcome of the Local Dispute Resolution action, you may request an Alternative Dispute Resolution in writing to The Michigan Department of Health and Human Services (MDHHS) at:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PROGRAM DEVELOPMENT, CONSULTATION AND CONTRACTS
BUREAU OF COMMUNITY MENTAL HEALTH SERVICES
ATTENTION: REQUEST FOR MDHHS LEVEL DISPUTE RESOLUTION
LEWIS CASS BUILDING-6TH FLOOR
LANSING, MI. 48193

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<tr>
<th>Decision Maker (Printed Name) with Credentials/Job Title</th>
<th>Decision Maker’s Signature</th>
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Enclosures: Local Dispute Resolution Form
cc: Member/Enrollee and/or Authorized Representative, and Service Provider

Revised 5.10.17
Detroit Wayne Mental Health Authority (DWMHA)
707 West Milwaukee Street
Detroit, Michigan 48202

ADVANCE NOTICE OF ACTION
Michigan Medicaid and Healthy Michigan Member/Enrollees

Date
Name
Address
City, State Zip

Re: Member/Enrollee’s Name: ______________________________________________________________

Michigan Medicaid /Healthy Michigan (Circle all that apply) ID#: ____________________________
MHWIN ID#: __________________________________________________________________________

Following a review of the mental health services and supports you are currently receiving, it has been determined that
the following service(s) shall be reduced, terminated, suspended or denied.

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provider/utilization management appeal, ask for the DWMHA Utilization Management Department.

You can send us any evidence you want us to review, such as medical records, doctors’ letters, or other information
that explains why you need the item or service. Call your doctor for this information. Our address is 707 West
Milwaukee Street, Detroit, Michigan 48202 Attention: Customer Service.

You can also ask to see the medical records and other documents we used to make our decision before or during
the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

EXPEDITED LOCAL APPEAL
You have a right to an expedited (faster) local appeal if waiting for the standard time would seriously jeopardize your
life, health and/or your ability to attain, maintain, or regain maximum function. To request an expedited local appeal,
contact the Customer Service Department at Detroit Wayne Mental Health Authority (DWMHA) at the numbers listed
above. You can also choose to have someone help you with your Local Appeal. You can also choose to have
someone represent you during the Local Appeal process. You can name a relative, friend, attorney, doctor, or
someone else to act as your representative. If you want someone else to act for you, call us at: (313)-344-9099 to
learn how to name your representative. TTY users call (800)-630-1044. Both you and the person you want to act for
you must sign and date a statement confirming this is what you want. You’ll need to mail or fax (313-833-2217) this
statement to the DWMHA Customer Service Department.
Upon receiving an appeal request, we will review your request, make a decision and provide you with a written explanation of the decision within 30 calendar days for a standard appeal request and within 72 hours for an expedited appeal request.

For an enrollee/member, if you do not agree with this action, you may also 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 person. To request a hearing, complete the attached “Request for Hearing” form, and mail to:

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 30763
LANSING, MI 48909

EXPEDITED MEDICAID FAIR HEARING
You have a right to an expedited Medicaid Fair Hearing if waiting for the standard time seriously jeopardize your life, health, and/or your ability to attain, maintain, or regain maximum function. To request an expedited Medicaid Fair Hearing, you must call the following toll-free number (800)-648-3397.

You can choose to have another person represent you at the Medicaid Fair Hearing. The person you choose to represent you can be anyone you choose as long as:

1. He/she is at least 18 years old;
2. You have given them written permission on the “Request for Hearing” form;
3. Your guardian or conservator must provide a copy of the court order naming the guardian/conservator. This information should be sent with “Request for Hearing” to the Michigan Administrative Hearing System, Department of Health and Human Services.

You may request both a Fair Hearing and a Local Appeal. The Medicaid Fair Hearing and Local Appeal processes may occur at the same time. You may contact DWMHA’s Customer Service Department if you have any further questions about an expedited Medicaid Fair Hearing.

CONTINUATION OF SERVICES:
You may continue to receive the affected services until the Local Appeal or Medicaid Fair Hearing decision is rendered if your request for an appeal is received prior to the effective date of action. The Beneficiary must continue to receive Michigan Medicaid services previously authorized while a Local Appeal and/or Medicaid Fair Hearing are pending if:

- The enrollee/member specifically requests to have the services continued services by calling the DWMHA Customer Service at (313)-344-9099 or at (888)-490-9698 or TTY (800)-630-1044.
- The enrollee/member or provider files the appeal timely; and
- The appeal involves the termination, suspension, or reduction of authorized treatment and services the enrollee/member currently receives, and
- The services were ordered by an authorized provider, and
- The original period covered by the original authorization has not expired.

When the Service Provider continues or reinstates the enrollee/member’s services while the appeal is pending, the Michigan Medicaid services must be continued until one of the following occurs:

- The enrollee/member withdraws the request for a Local Appeal and/or Medicaid Fair Hearing.
- Thirty (30) calendar days pass after the Service Provider mails the notice of disposition providing the resolution of the appeal against the beneficiary, unless the enrollee/member, within the 12 day timeframe, has requested a Medicaid Fair Hearing with continuation of services until a Medicaid Fair Hearing decision is reached.
- The Michigan Administrative Hearing System issues a hearing decision adverse to the enrollee/member.
- The time period or service limits of the previously authorized service has been met.

If you continue to receive benefits because you requested an appeal you may be required to repay the benefits. This may occur if:


Revised 5.10.17
- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.
- You or the person you asked to represent you does not attend the hearing.

You may request both a Medicaid Fair Hearing and a local appeal. The Medicaid Fair Hearing and local appeal processes may occur at the same time. If there are additional questions, contact Detroit Wayne Mental Health Authority (DWMHA) at (313)-344-9099 or TTY (800) 630-1044. For an enrollee/member appeal, ask for the DWMHA Customer Service Department and for a provider/utilization management appeal, ask for the DWMHA Utilization Management Department.

<table>
<thead>
<tr>
<th>Decision Maker (Printed Name) with Credentials/Job Title</th>
<th>Decision Maker’s Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Enclosures: Local Appeal Request Form, State of Michigan Request for Hearing & Business Reply Envelope
cc: Enrollee and/or Authorized Representative, Service Provider & Case Record

Revised: 05.10.17
Revised 5.10.17

Detroit Wayne Mental Health Authority (DWMHA)
707 West Milwaukee Street
Detroit, Michigan 48202

ADVANCE NOTICE OF ACTION
Uninsured or Under Insured Members/Enrollees

Date

Name
Address
City, State Zip

Re: Member/Enrollee’s Name: _______________________________________________________

MHWIN ID#: _______________________________________________________________________

The reason for this action is _______________________________________________________

Following a review of the mental health services and supports you are currently receiving, it has been determined that the following service(s) shall be reduced, terminated, suspended or denied.

<table>
<thead>
<tr>
<th>Service(s)</th>
<th>Effective Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

The reason for this action is _______________________________________________________

For a provider, if you do not agree with this action, you may request a Local Dispute Resolution, either orally or in writing, within 45 calendar days of the date of this notice by contacting Detroit Wayne Mental Health Authority (DWMHA) at (313) 344-9099 or TTY (800) 630-1044 and speaking with the Utilization Management Department.

For an enrollee/member, if you do not agree with this action, you may request a Local Dispute Resolution, either orally or in writing, within 30 calendar days of the date of this notice by contacting Detroit Wayne Mental Health Authority (DWMHA) at (313) 344-9099 or TTY (800) 630-1044 and speaking with the Customer Service Department.

You can send us any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor for this information. Our address is 707 West Milwaukee Street, Detroit, Michigan 48202 Attention: Customer Service.

You can also ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.
EXPEDITED LOCAL DISPUTE RESOLUTION

You have a right to an expedited (faster) local dispute resolution if waiting for the standard time would seriously jeopardize your life, health and/or your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, contact the Customer Service Department at Detroit Wayne Mental Health Authority (DWMHA) at the numbers listed above. You can also choose to have someone help you with your Local Dispute Resolution. You can also choose to have someone represent you during the Local Dispute Resolution process. If you want someone else to act for you, call us at: (313) 344-9099 to learn how to name your representative. TTY users call (800) 630-1044. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax (313) 833-2217 this statement to the DWMHA Customer Service Department.

Upon receiving a local dispute resolution review request from a provider, we will review your request, make a decision and provide you with a written explanation of the decision within 20 calendar days for a standard request and within 72 hours for an expedited request.

Upon receiving a local dispute resolution review request from an enrollee/member, we will review your request, make a decision and provide you with a written explanation of the decision within 10 calendar days for a standard request and within 72 hours for an expedited request.

For an enrollee/member, if you do not agree with the outcome of the Local Dispute Resolution action, you may request an Alternative Dispute Resolution in writing to The Michigan Department of Health and Human Services (MDHHS) at:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PROGRAM DEVELOPMENT, CONSULTATION AND CONTRACTS
BUREAU OF COMMUNITY MENTAL HEALTH SERVICES
ATTENTION: REQUEST FOR MDHHS LEVEL DISPUTE RESOLUTION
LEWIS CASS BUILDING-6TH FLOOR
LANSING, MI. 48193

<table>
<thead>
<tr>
<th>Decision Maker (Printed Name) with Credentials/Job Title</th>
<th>Decision Maker’s Signature</th>
<th>Date</th>
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</table>

Enclosures: Local Dispute Resolution Request Form
cc: Member/Enrollee and/or Authorized Representative, and Service Provider

Revised 5.10.17
<table>
<thead>
<tr>
<th>UM</th>
<th>Element</th>
<th>Description</th>
<th>Met (1)/Not Met (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>C</td>
<td>The organization ensures that a physician or appropriate behavioral health practitioner reviews any behavioral healthcare denial based on medical necessity.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>A1</td>
<td>For urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>A2</td>
<td>For urgent preservice decisions, the organization makes decisions within 72 hours of receipt of the request.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>A3</td>
<td>For nonurgent preservice decisions, the organization makes decisions within 15 calendar days of receipt of the request.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>A4</td>
<td>For postservice decisions, the organization makes decisions within 30 calendar days of receipt of the request.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>B1</td>
<td>For urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within 24 hours of the request.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>B2</td>
<td>For urgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>B3</td>
<td>For nonurgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 15 hours of the request.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>B4</td>
<td>For postservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.</td>
<td></td>
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<tr>
<td>6</td>
<td>A</td>
<td>There is documentation that relevant clinical information is gathered consistently to support UM decision making.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>B1</td>
<td>Written notification of denial includes the specific reasons for the denial, in easily understandable language.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>B2</td>
<td>Written notification of denial includes a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>B3</td>
<td>Written notification of denial includes notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>C1</td>
<td>Written notification of denial includes a description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>C2</td>
<td>Written notification of denial includes an explanation of the appeal process, including member’s right to representation and time frames for deciding appeals.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>C3</td>
<td>Written notification of denial includes a description of the expedited appeal process for urgent preservice or urgent concurrent denials.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>C4</td>
<td>Written notification of denial includes notification that expedited external review can occur concurrently with the internal appeals process for urgent care.</td>
<td></td>
</tr>
</tbody>
</table>

Total: 0
OVERVIEW

Procedure Purpose: To provide detailed steps required to issue an adverse determination.

Expected Outcome: DWMHA, Access Center, IRO, Crisis Service Vendor, MCPNs and Service Providers will understand and be compliant with the requirements to issue an adverse determination.

References: N/A

KEYWORDS:
1. Action
2. Administrative Appeal
3. Adverse Determination
4. Independent Review Organization (IRO)
5. Medical Necessity Appeal
6. Pended

PROCEDURE:
1. If DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer has concerns or questions about whether eligibility, screening, or medical necessity is met to approve the initial or continued stay review, he/she may request additional information from the provider within twenty four (24) hours of the request. He/she may also elect to verbally consult with a DWMHA, Access Center, Crisis Service Vendor or MCPN UM Supervisor. The DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer then documents the supervisor’s name, credentials and recommendations into their electronic system which may include the recommendation to verbally consult with the DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician or to secure a formal consultation with a DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician.
2. If the DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer verbally consults with a DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician, he/she will document the name, credentials and the recommendations of their physician in their electronic system.
3. If after the verbal consult, the DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician determines approval cannot be determined at this time, the DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer will secure a formal physician consultation.
4. The DWMHA, Access Center or Crisis Service Vendor UM Reviewer completes the Physician Case Review form in MHWIN and sends the case to the queue in their electronic system (MHWIN) for retrieval by a DWMHA, Access Center or Crisis Service Vendor physician.
5. The DWMHA, Access Center or Crisis Service Vendor UM Reviewer will immediately notify the DWMHA UM Appeal Coordinator, the designated Access Center or designated Crisis Service Vendor staff person via email of the need for a DWMHA, Access Center or Crisis Service Vendor physician to review the form and the case in order for the DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person to track the case and ensure it is reviewed and a determination is made within the appropriate time frames.

6. If using an IRO physician, the UM Reviewer completes the standardized IRO Referral Review Request form and has the DWMHA UM Appeal Coordinator forward via email the form to the IRO Medical staff person to facilitate an IRO physician review of the case.

7. The MCPN physician reviews the case according to their own internal procedures but adhering to all required timeframes and rules of extensions.

8. The DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician may elect to conduct a peer to peer review with the treating physician. If this is the case, the DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician will make reasonable attempts (at least two) to telephonically contact the treating physician. The DWMHA, Access Center, Crisis Service Vendor or MCPN physician will document the day and time of each attempt in their electronic system. The IRO physician will document the day and time of each attempt in the standardized Physician Reviewer Documentation form.

9. The DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person will also document the day and time of each attempt by their physician in their tracking log. Note that the DWMHA UM Appeal Coordinator will document the day and time of each attempt by the IRO physician in the tracking log.

10. The physician reviewing will also decide if the case would better be reviewed by a different physician such as a physician certified in addiction medicine. If yes, the physician will notify the DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person, and the DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person will be responsible to facilitate the case review by the appropriate physician.

11. If a peer to peer review is completed, the DWMHA, the Access Center, Crisis Service Vendor or MCPN physician will document the results of the peer to peer review in their electronic system and render a decision which will also be documented in their electronic system. The IRO physician will complete the standardized Physician Reviewer Documentation form.

12. The DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician will review the case and render a decision within the following time frames:
   a. For an urgent pre-service initial review, within seventy two (72) hours of the request;
   b. For a non-urgent (standard) pre-service initial review, within fourteen (14) calendar days of the request;
   c. For a post-service review, within thirty (30) calendar days of the request; or
   d. For urgent concurrent reviews, within twenty-four (24) hours if the request was made prior to twenty-four (24) hours of the expiration of the current authorization or within seventy-two (72) hours if the request is made less than twenty-four (24) hours of the expiration of the current authorization.
13. DWMHA, the Access Center, IRO, Crisis Service Vendor or MCPN may extend an urgent pre-service time frame due to a lack of information, once, for forty-eight (48) hours, under the following conditions:
   a. Within twenty-four (24) hours of receipt of the urgent pre-service request, the DWMHA UM Appeal Coordinator, designated Access Center staff person, designated Crisis Service Vendor staff person or designated MCPN staff person asks the enrollee/member or their representative (provider/practitioner considered to be their representative) for the specific information necessary to make the decision;
   b. DWMHA, the Access Center, Crisis Service Vendor or MCPN gives the enrollee/member at least forty-eight (48) hours to provide the information; and
   c. The extension period, within which a decision must be made begins on the date the enrollee/member’s response is received (even if not all of the information is provided), or at the end of the time period given to the enrollee/member to provide the information even if no response is received from the enrollee/member or their authorized representative.

14. DWMHA, the Access Center, IRO, Crisis Service Vendor or MCPN may extend a non-urgent pre-service or post-service time frame due to a lack of information, once, for up to fifteen (15) calendar days under the following conditions:
   a. The specific information necessary to make the decision is requested from the enrollee/member or enrollee/member’s representative within the decision timeframe as well as the need and reason for the extension;
   b. The enrollee/member or the enrollee/member’s representative is given at least forty-five (45) calendar days to provide the information; and
   c. The extension period, within which a decision must be made begins on the date when the enrollee/member or their representative’s response is received (even if not all of the information is provided), or at the end of the time period given to the enrollee/member to supply the information, if no response is received from the enrollee/member or their representative. If information is not received within the timeframe, the request may be denied and enrollee/member or their representative may then appeal the denial.

15. The DWMHA UM Appeal Coordinator, the designated Access Center, designated Crisis Service Vendor staff person or designated MCPN staff person must notify the enrollee/member or enrollee/member’s representative of the extension and request for additional information using the standardized Enrollee Agreement for Request for Additional Information Form within fifteen (15) calendar days of a non-urgent pre-service extension request or within thirty (30) calendar days of a post-service extension request.

16. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person manually checks the MHWIN queue twice a day to ensure that the DWMHA, Access Center or Crisis Service Vendor physician has retrieved the case from the queue and reviews it within the appropriate time frames. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person will communicate daily via email, face to face or telephonically with the DWMHA, Access Center or Crisis Service Vendor physician or other appropriate professional if after twenty four (24) hours for an urgent pre-service initial review, or if after seven (7) hours for a concurrent review or within seven (7) calendar days for a non-urgent (standard) pre-service initial review, the DWMHA, Access Center or Crisis Service Vendor physician has not reviewed the case. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person documents all attempts (date and time) to contact the physician in their tracking log. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person will use their tracking log as a tool to monitor the timeframes.
17. The MCPNs and IRO Medical Review staff will follow their own internal procedures to ensure the MCPN or IRO physician reviews the case within the appropriate timeframes. However, the MCPNs will also use their tracking log as a tool to monitor this.

18. The DWMHA, Access Center or Crisis Service Vendor physician will document their decision in their electronic system (MHWIN) and document their name, title, and credentials if not done by electronic signature.

19. The DWMHA, Access Center or Crisis Service Vendor physician will immediately notify via email the DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person via email of their decision.

20. The MCPN physician will document the results/decision either in their electronic system or by manually completing a standardized form. The MCPN physician will then immediately notify the designated MCPN staff person according to their internal procedures.

21. The IRO physician will complete the standardized Physician Reviewer Documentation form and immediately fax it to the IRO Medical Review staff. The IRO Medical Review staff will, in turn, immediately email it to the DWMHA UM Appeal Coordinator.

22. If the decision is to approve eligibility, the designated Access Center staff person emails the Access Center UM Reviewer who then calls the enrollee/member and completes the screening process.

23. If the decision is to authorize services, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person enters the authorization in their electronic system, generates an authorization letter from their electronic system and then mails the letter to the provider and enrollee/member within twenty four (24) hours of the decision.

24. If the decision is to deny eligibility or services, the DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person enters the denial in their electronic system and generates the standardized Medicaid Adequate or Advance Action Notice form from their electronic system.

25. If the Medicaid Adequate or Advance Action Notice form is manually generated, the DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor staff person or designated MCPN staff person will scan the Notice and attach it to the case in their electronic system.

26. The standardized Medicaid Advance Action Notice form is sent to the enrollee/member regarding a decision to reduce, suspend or terminate Medicaid services currently authorized or provided. The standardized Medicaid Adequate Action Notice form is sent to the enrollee/member when the decision is to deny or limit authorization of Medicaid services requested.

27. The DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person verbally notifies the practitioner/provider within three (3) hours of the decision and documents the verbal notification in their electronic system including the date and time of the notification, the right to a peer to peer discussion regarding the determination, the appeal rights and process and the complete name and credentials of the person notified.

28. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person reviews the Medicaid Adequate or Advance Action Notice form to ensure it has the following:
   a. A statement of what action is being taken in easy, understandable language which does not include:
      ✓ abbreviations or acronyms that are not defined; and
      ✓ is culturally and linguistically sensitive to the enrollees/members’ needs; and
      ✓ health care procedure codes that are not explained.
   b. An explanation of the action including the denial of services in amount, scope and duration if less than what is requested;
c. The specific justification that supports, or the change in the federal or state law that requires the action including a reference to the benefit provision, guideline, protocol or other similar criterion on which the action is based and the option of the enrollee/member to have a copy of the benefit provision, guidelines or protocol, upon request;

d. A statement that the enrollee/member and/or provider has the right to an internal appeal with DWMHA, the Access Center, Crisis Service Vendor or the MCPN and a description of the expedited and standard appeal process including time frames;

e. A statement that the enrollee/member has a right to an external Medicaid Fair Hearing and an explanation of how to file a Medicaid Fair Hearing for Medicaid covered services;

f. A statement that Medicaid covered services will continue up to the end of the currently approved treatment or final decision whichever comes first if the enrollee/member requests an internal and/or external Medicaid Fair Hearing within twelve (12) calendar days from the date of the notice (per MDHHS and DWMHA contract October 1, 2016);

g. A statement that the enrollee/member may have to pay for the continuation of services if the result of the internal appeal or external Medicaid Fair Hearing is to uphold the denial for Medicaid covered services;

h. A statement that the enrollee/member, his/her legal representative and/or provider has the opportunity to submit written comments, documents or other information relevant to an appeal;

i. A statement that the enrollee/member and/or provider can request copies of all documents relevant to the appeal, free of charge;

j. Informs the enrollee/member of their right to designate an authorized representative to act on their behalf as long as the enrollee/member has provided written permission by completing and forwarding the Appointment of Representative form to DWMHA, the Access Center, Crisis Service Vendor or MCPN;

k. A statement that an expedited or standard external review can occur the same time as an internal expedited or standard review; and

l. Includes a list of the titles and qualifications, including specialties of the individuals participating in the appeal review.

29. The DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person mails the standardized Medicaid Adequate or Advance Action Notice form to the enrollee/member and provider within twenty four (24) hours of the verbal/oral notification.

30. The DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person documents the date and times of the verbal and written notifications in their tracking log.

31. The designated Access Center, designated Crisis Service Vendor and designated MCPN staff person must forward via email their tracking log to the DWMHA UM Appeals Coordinator by the 10th of each month for compliance monitoring.

32. The DWMHA UM Appeal Coordinator will audit all denials rendered by the Access Center, Crisis Service Vendor and the MCPNs monthly using the denial audit tool, collate the results of the audits and provide a monthly report to the DWMHA UM Director.

33. Denial cases not scoring 85% or greater will be reviewed with the DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer for the purposes of coaching and training.

34. Any UM Reviewer that scores below 85% on the audit tool three (3) times or more will be placed on a Corrective Action Plan.
### PROCEDURE MONITORING & STEPS:

<table>
<thead>
<tr>
<th>Who monitors this procedure:</th>
<th>DWMHA UM Appeal Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td>DWMHA Utilization Management</td>
</tr>
<tr>
<td>Frequency of monitoring:</td>
<td>Monthly</td>
</tr>
<tr>
<td>Reporting provided to:</td>
<td>DWMHA UM Director, Access Center, Crisis Service Vendor, MCPNs</td>
</tr>
<tr>
<td>Regulatory Requirement(s):</td>
<td>Audit process developed in order to pass file review for UM 4, UM 5, UM 6 and UM 7, all elements</td>
</tr>
</tbody>
</table>

### MONITORING STEPS:

1. DWMHA will perform monthly audits of all denials. Results will be reported to the DWMHA UM Director and to the entity that issued the denial.

2. Expectation is that any DWMHA, Access Center, Crisis Service Vendor and MCPN staff score 85% or greater on their monthly case audits. Failure to score 85% or greater three (3) times or more will result in a Corrective Action Plan (CAP) for the entity.
OVERVIEW

Procedure Purpose: To provide detailed steps required to issue an adverse determination.

Expected Outcome: DWMHA, Access Center, Crisis Service Vendor, MCPNs and Service Providers will understand and be compliant with the requirements to issue an adverse determination.

References: N/A

KEYWORDS:
1. Action
2. Administrative Appeal
3. Adverse Determination
4. Independent Review Organization (IRO)
5. Medical Necessity Appeal
6. Pended

PROCEDURE:
1. If DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer has concerns or questions about whether eligibility, screening, or medical necessity is met to approve the initial or continued stay review, he/she may request additional information from the provider within twenty four (24) hours of the request. He/she may also elect to verbally consult with a DWMHA, Access Center, Crisis Service Vendor or MCPN UM Supervisor. The DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer then documents the supervisor’s name, credentials and recommendations into their electronic system which may include the recommendation to verbally consult with the DWMHA, Access Center, Crisis Service Vendor or MCPN physician/appropriate professional or to secure a formal consultation with a DWMHA, IRO, Access Center, Crisis Service Vendor or MCPN physician.
2. If the DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer verbally consults with a DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician, he/she will document the name, credentials and the recommendations of their physician/appropriate professional in their electronic system.
3. If after the verbal consult, the DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician determines approval cannot be determined at this time, the DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer will secure a formal physician consultation.
4. The DWMHA, Access Center or Crisis Service Vendor UM Reviewer completes the Physician Case Review form in MHWIN and sends the case to the queue in their electronic system (MHWIN) for retrieval by a DWMHA, Access Center or Crisis Service Vendor physician.
5. The DWMHA, Access Center or Crisis Service Vendor UM Reviewer will immediately notify the DWMHA UM Appeal Coordinator, the designated Access Center or designated Crisis Service Vendor staff person via email of the need for a DWMHA, Access Center or Crisis Service Vendor physician to review the form and the case in order for the DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person to track the case and ensure it is reviewed and a determination is made within the appropriate time frames.

6. If using the IRO physician, the UM Reviewer completes the standardized IRO Referral Review Request form and has the DWMHA UM Appeal Coordinator forward via email the form to the IRO Medical Review staff person to facilitate an IRO physician review of the case.

7. The MCPN physician reviews the case according to their own internal procedures but adhering to all required timeframes and rules of extensions.

8. The DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician may elect to conduct a peer to peer review with the treating physician. If this is the case, the DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician will make reasonable attempts (at least two) to telephonically contact the treating physician. The DWMHA, Access Center, Crisis Service Vendor or MCPN physician will document the day and time of each attempt in their electronic system. The IRO physician will document the day and time of each attempt in the standardized Physician Reviewer Documentation form.

9. The DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person will also document the day and time of each attempt by their physician in their tracking log. Note that the DWMHA UM Appeal Coordinator will document the day and time of each attempt by the IRO physician in the tracking log.

10. The physician reviewing will also decide if the case would better be reviewed by a different appropriate professional such as a certified in addiction medicine. If yes, the physician will notify the DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person, and the DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person will be responsible to facilitate the case review by with the appropriate physician.

11. If a peer to peer review is completed, the DWMHA, the Access Center, Crisis Service Vendor or MCPN physician or appropriate professional will document the results of the peer to peer review in their electronic system and render a decision which will also be documented in their electronic system. The IRO physician will complete the standardized Physician Reviewer Documentation form.

12. The DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician will review the case and render a decision within the following time frames:
   a. For an urgent pre-service initial review, within seventy two (72) hours of the request;
   b. For a non-urgent (standard) pre-service initial review, within fourteen (14) calendar days of the request;
   c. For a post-service review, within thirty (30) calendar days of the request; or
   d. For urgent concurrent reviews, within twenty-four (24) hours if the request was made prior to twenty-four (24) hours of the expiration of the current authorization or within seventy-two (72) hours if the request is made less than twenty-four (24) hours of the expiration of the current authorization.

13. DWMHA, the Access Center, IRO, Crisis Service Vendor or MCPN may extend an urgent pre-service time frame due to a lack of information, once, for forty-eight (48) hours, under the following conditions:
   a. Within twenty-four (24) hours of receipt of the urgent pre-service request, the DWMHA UM Appeal Coordinator, designated Access Center staff person, designated Crisis Service Vendor staff person or designated MCPN staff person asks the enrollee/member or their representative (provider/practitioner considered to be their representative) for the specific information necessary to make the decision;
b. DWMHA, the Access Center, Crisis Service Vendor or MCPN gives the enrollee/member at least forty-eight (48) hours to provide the information; and
c. The extension period, within which a decision must be made begins on the date the enrollee/member’s response is received (even if not all of the information is provided), or at the end of the time period given to the enrollee/member to provide the information even if no response is received from the enrollee/member or their authorized representative.

14. DWMHA, the Access Center, IRO, Crisis Service Vendor or MCPN may extend a non-urgent pre-service or post-service time frame due to a lack of information, once, for up to fifteen (15) calendar days under the following conditions:
   a. The specific information necessary to make the decision is requested from the enrollee/member or enrollee/member’s representative within the decision timeframe as well as the need and reason for the extension;
   b. The enrollee/member or the enrollee/member’s representative is given at least forty-five (45) calendar days to provide the information; and
   c. The extension period, within which a decision must be made by the organization, begins on the date when the enrollee/member or their representative’s response is received (even if not all of the information is provided), or at the end of the time period given to the enrollee/member to supply the information, if no response is received from the enrollee/member or their representative. If information is not received within the time frame, the request may be denied and enrollee/member or their representative may then appeal the denial.

15. The DWMHA UM Appeal Coordinator, the designated Access Center, designated Crisis Service Vendor staff person or designated MCPN staff person must notify the enrollee/member or enrollee/member’s representative of the extension and request for additional information using the standardized Enrollee Agreement for Request for Additional Information Form within fifteen (15) calendar days of a non-urgent pre-service extension request or within thirty (30) calendar days of a post-service extension request.

16. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person manually checks the MHWIN queue twice a day to ensure that the DWMHA, Access Center or Crisis Service Vendor physician or other appropriate professional has retrieved the case from the queue and reviews it within the appropriate time frames. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person will communicate daily via email, face to face or telephonically with the DWMHA, Access Center or Crisis Service Vendor physician or other appropriate professional if after twenty four (24) hours for an urgent pre-service initial review, or if after seven (7) hours for a concurrent review or within seven (7) calendar days for a non-urgent (standard) pre-service initial review, the DWMHA, Access Center or Crisis Service Vendor physician or appropriate professional has not reviewed the case. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person documents all attempts (date and time) to contact the physician or other appropriate professional in their tracking log. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person will use their tracking log as a tool to monitor the timeframes.

17. The MCPNs and IRO Medical Review staff will follow their own internal procedures to ensure the MCPN physician reviews the case within the appropriate timeframes. However, the MCPNs will also use their tracking log as a tool to monitor this.

18. The DWMHA, Access Center or Crisis Service Vendor physician will document their decision in their electronic system (MHWIN) and document their name, title, and credentials if not done by electronic signature.

19. The DWMHA, Access Center or Crisis Service Vendor physician will immediately notify the DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person via email of their decision.
20. The MCPN physician will document the results/decision either in their electronic system or by manually completing a standardized form. The MCPN physician will then immediately notify the designated MCPN staff person according to their internal procedures.

21. The IRO physician will complete the standardized Physician Reviewer Documentation form and immediately fax it to the IRO Medical Review staff. The IRO Medical Review staff will, in turn, immediately email it to the DWMHA UM Appeal Coordinator.

22. If the decision is to approve eligibility, the designated Access Center staff person emails the Access Center UM Reviewer who then calls the enrollee/member and completes the screening process.

23. If the decision is to authorize services, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person enters the authorization in their electronic system, generates an authorization letter from their electronic system and then mails the letter to the provider and enrollee/member within twenty four (24) hours of the decision.

24. If the decision is to deny eligibility or services, the DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person enters the denial in their electronic system and generates the standardized Medicaid Adequate or Advance Action Notice form from their electronic system.

25. If the Medicaid Adequate or Advance Action Notice form is manually generated, the DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor staff person or designated MCPN staff person will scan the Notice and attach it to the case in their electronic system.

26. The standardized Medicaid Advance Action Notice form is sent to the enrollee/member regarding a decision to reduce, suspend or terminate Medicaid services currently authorized or provided. The standardized Medicaid Adequate Action Notice form is sent to the enrollee/member when the decision is to deny or limit authorization of Medicaid services requested.

27. The DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person verbally notifies the practitioner/provider within three (3) hours of the decision and documents the verbal notification in their electronic system including the date and time of the notification, the right to a peer to peer discussion regarding the determination, the appeal rights and process and the complete name and credentials of the person notified.

28. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person reviews the Medicaid Adequate or Advance Action Notice form to ensure it has the following:
   a. A statement of what action is being taken in easy, understandable language which does not include:
      ✓ abbreviations or acronyms that are not defined; and
      ✓ is culturally and linguistically sensitive to the enrollees/members’ needs; and
      ✓ health care procedure codes that are not explained.
   b. An explanation of the action including the denial of services in amount, scope and duration if less than what is requested;
   c. The specific justification that supports, or the change in the federal or state law that requires the action including a reference to the benefit provision, guideline, protocol or other similar criterion on which the action is based and the option of the enrollee/member to have a copy of the benefit provision, guidelines or protocol, upon request;
   d. A statement that the enrollee/member and/or provider has the right to an internal appeal with DWMHA, the Access Center, Crisis Service Vendor or the MCPN and a description of the expedited and standard appeal process including time frames;
   e. A statement that the enrollee/member has a right to an external Medicaid Fair Hearing and an explanation of how to file a Medicaid Fair Hearing for Medicaid covered services;
   f. A statement that Medicaid covered services will continue up to the end of the currently approved treatment or final decision whichever comes first if the enrollee/member requests an internal and/or external Medicaid Fair Hearing within twelve (12) calendar days from the date of the notice (per MDHHS and DWMHA contract October 1, 2016);
g. A statement that the enrollee/member may have to pay for the continuation of services if the result of the internal appeal or external Medicaid Fair Hearing is to uphold the denial for Medicaid covered services;

h. A statement that the enrollee/member, his/her legal representative and/or provider has the opportunity to submit written comments, documents or other information relevant to an appeal;

i. A statement that the enrollee/member and/or provider can request copies of all documents relevant to the appeal, free of charge;

j. Informs the enrollee/member of their right to designate an authorized representative to act on their behalf as long as the enrollee/member has provided written permission by completing and forwarding the Appointment of Representative form to DWMHA, the Access Center, Crisis Service Vendor or MCPN;

k. A statement that an expedited or standard external review can occur the same time as an internal expedited or standard review; and

l. Includes a list of the titles and qualifications, including specialties of the individuals participating in the appeal review.

29. The DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person mails the standardized Medicaid Adequate or Advance Action Notice form to the enrollee/member and provider within twenty four (24) hours of the verbal/oral notification.

30. The DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person documents the date and times of the verbal and written notifications in their tracking log.

31. The designated Access Center, designated Crisis Service Vendor and designated MCPN staff person must forward via email their tracking log to the DWMHA UM Appeals Coordinator by the 10th of each month for compliance monitoring.

32. The DWMHA UM Appeal Coordinator will audit all denials rendered by the Access Center, Crisis Service Vendor and the MCPNs monthly using the denial audit tool, collate the results of the audits and provide a monthly report to the DWMHA UM Director.

33. Denial cases not scoring 85% or greater will be reviewed with the DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer for the purposes of coaching and training.

34. Any UM Reviewer that scores below 85% on the audit tool three (3) times or more will be placed on a Corrective Action Plan.

**PROCEDURE MONITORING & STEPS:**

<table>
<thead>
<tr>
<th>Who monitors this procedure:</th>
<th>DWMHA UM Appeal Coordinator</th>
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</thead>
<tbody>
<tr>
<td>Department:</td>
<td>DWMHA Utilization Management</td>
</tr>
<tr>
<td>Frequency of monitoring:</td>
<td>Monthly</td>
</tr>
<tr>
<td>Reporting provided to:</td>
<td>DWMHA UM Director, Access Center, Crisis Service Vendor, MCPNs</td>
</tr>
<tr>
<td>Regulatory Requirement(s):</td>
<td>Audit process developed in order to pass file review for UM 4, UM 5, UM 6 and UM 7, all elements</td>
</tr>
</tbody>
</table>
MONITORING STEPS:

1. DWMHA will perform monthly audits of all denials. Results will be reported to the DWMHA UM Director and to the entity that issued the denial.

2. Expectation is that any DWMHA, Access Center, Crisis Service Vendor and MCPN staff score 85% or greater on their monthly case audits. Failure to score 85% or greater three (3) times or more will result in a Corrective Action Plan (CAP) for the entity.
# DWMHA ACCESS CENTER ELIGIBILITY REVIEW TOOL

<table>
<thead>
<tr>
<th>Enrollee/Member Name:</th>
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<tbody>
<tr>
<td>MHWIN ID No.:</td>
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<tr>
<td>Medicaid ID No.:</td>
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<tr>
<td>Date of Screening</td>
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<tr>
<td>Name of Access Center Clinician</td>
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<thead>
<tr>
<th>Item</th>
<th>Documentation Found</th>
<th>Documentation Not Found</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>1.</td>
<td>Insurance Information</td>
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<td>2.</td>
<td>Wayne County Residency</td>
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<td>3.</td>
<td>Start time of screening</td>
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<td>4.</td>
<td>Name, address and phone number of caller</td>
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<td>5.</td>
<td>Documentation of call being an Emergency or Crisis</td>
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<td>6.</td>
<td>Reason for call/presenting problem identified</td>
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<td>7.</td>
<td>Type of Services Request</td>
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<td>8.</td>
<td>Contact Information</td>
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<td>9.</td>
<td>Guardianship</td>
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<td>10.</td>
<td>Past Treatment History</td>
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<td>11.</td>
<td>History of Abuse (Sexual/Physical/Emotional)</td>
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<td>12.</td>
<td>Current living situation</td>
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<td>13.</td>
<td>Financial Information including Income</td>
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<td>14.</td>
<td>Education Information</td>
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<td>15.</td>
<td>Current Health/Medical Problems</td>
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<td>16.</td>
<td>Referral to ER for Treatment/Clearance</td>
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<td>17.</td>
<td>Time ER Contacted and Consumer Referred</td>
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<td>18.</td>
<td>Medications (name, dose, prescribing physician)</td>
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<td>19.</td>
<td>Primary care physician information</td>
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<td>20.</td>
<td>Mental Health Symptoms Identified</td>
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<td>21.</td>
<td>Substance Use Issues</td>
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<td>22.</td>
<td>Risk (Suicidal/Homicidal) assessment</td>
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<td>23.</td>
<td>Autism Screening Tool Completed</td>
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<td>24.</td>
<td>IDD Screening Tool Completed</td>
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<td>25.</td>
<td>Provisional Disability Designation</td>
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<td>26.</td>
<td>Diagnoses</td>
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<td>27.</td>
<td>Medical and/or Advance Directives</td>
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<td>28.</td>
<td>Diagnoses</td>
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<td>29.</td>
<td>Medical and/or Psychiatric Advance Directives</td>
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<td>30.</td>
<td>Eligibility Criteria Met</td>
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<td>31.</td>
<td>Eligibility Criteria Not Met</td>
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<td>32.</td>
<td>If Eligibility Criteria Not Met, enrollee/member given community resource referrals</td>
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<td>33.</td>
<td>If Eligibility Criteria Not Met, Access Center Physician Review Case and Provide Documentation</td>
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<td>34.</td>
<td>Adequate or Advance Notice Sent to enrollee/member (using DWMHA standard form)</td>
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<td>35.</td>
<td>Notice of Denial of Medical Coverage form sent to enrollee/member for MI Health Link (using DWMHA standard form)</td>
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<td>36.</td>
<td>Notice of Denial sent to uninsured enrollee/member (using DWMHA standard form)</td>
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Signature, title and credential of Staff Auditor (person who completed the case audit)  
Date of the case audit

Revised 3.1.17
INSTRUCTIONS FOR COMPLETION OF PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL

The purpose of these reviews are to ensure correct documentation, appropriate level of care decisions and to meet External Quality Review requirements relative to Utilization Management.

- On a quarterly basis, the Access Center shall review the following:
  - All (100%) denial and appeal cases based on all staff making Utilization Management decisions.
  - Access Center -ten (10) approved cases for all staff making Utilization Management decisions.

- Reviews should be completed on requests for all levels of care requiring prior authorization, including Acute Inpatient, Partial Hospitalization, State Hospitalization, Crisis Stabilization, Intensive Crisis Residential and/or Child Caring Institutions.

- An Analysis of all Prior Authorized Service UM Chart Reviews for the fiscal year shall be included in the Access Center's Annual UM Evaluation.

Revised 3.1.17
<table>
<thead>
<tr>
<th>Member Name</th>
<th>Medicaid No. (if applicable)</th>
<th>Other Funding Source</th>
<th>Medicare No. (if applicable)</th>
<th>MHWIN ID No.</th>
<th>Name of MCPN</th>
<th>Facility/ Provider Name</th>
<th>Level of Service</th>
<th>Discharge Date</th>
<th>Type of Peer to Peer Review (Standard or Expedited)</th>
<th>Name &amp; Speciality of COPE Physician rendering Adverse Action</th>
<th>Date &amp; Time Adverse Action made by COPE Physician</th>
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<tr>
<td>Date &amp; Time of Verbal Notification to Provider by COPE of Adverse Action (must be within 3 hrs of decision)</td>
<td>Type of Notice sent to Provider &amp; Member (Adequate Action Notice or Denial of Medical Coverage Notice)</td>
<td>Type of Review (expedited pre-service initial review, standard pre-service initial review, expedited pre-service concurrent review, post-service review)</td>
<td>Date Adequate Action Notice or Denial of Medical Coverage sent by COPE to Provider &amp; Member (within 72 hrs of receipt of request for an expedited pre-service initial review, within 14 calendar days of receipt of a request for a standard pre-service initial review, within 72 hrs of receipt of request for an expedited concurrent review or within 30 calendar days of receipt of a request for post-service review)</td>
<td>Date &amp; Time of 1st Level Appeal Request received from Provider to COPE (must be within 45 calendar days of receipt of the Adequate Notice of Action Letter date or Denial of Medical Coverage Letter)</td>
<td>Type of 1st Level Appeal Request (standard or expedited and pre-service or post-service)</td>
<td>Method of 1st Level Appeal Request (Verbal or Written)</td>
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<td>Date 1st Acknowledgement Letter sent by COPE (must be within 24 hours of an expedited pre-service 1st level request or within 5 calendar days of a standard pre-service or post-service 1st level request)</td>
<td>Name &amp; Specialty COPE Physician rendering 1st Level Decision</td>
<td>Date &amp; Time of 1st Level Decision was made (must be within 72 hrs for an expedited pre-service 1st level request or within 20 calendar days for a standard pre-service 1st level request or within 30 calendar days for a post-service 1st level request)</td>
<td>Type of Decision rendered for 1st level appeal (number of days approved and/or number of days denied)</td>
<td>Date Initial Notice of Appeal Decision Letter sent by COPE to Provider &amp; Member (if applicable) &amp; (must be within 3 hrs of decision)</td>
<td>Date &amp; Time verbal notification given by COPE to Provider of 1st level appeal decision (must be within 3 hrs of decision)</td>
<td>Date &amp; Time Provider notified COPE of 2nd level request (if applicable)</td>
<td>Date &amp; Time COPE notified DWMHA of the 2nd level request from the Provider and forwarded the chart to DWMHA (must be within 1 hour of an expedited pre-service or post-service 2nd level request or within 1 business day of a standard pre-service or post-service 2nd level request)</td>
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<td>Date 2nd Acknowledgement Letter sent by DWMHA (must be within 24 hours of an expedited pre-service 2nd level request or within 5 calendar days of a standard pre-service or post-service 2nd level request)</td>
<td>Name &amp; Speciality DWMHA Physician rendering 2nd Level Decision</td>
<td>Date &amp; Time of 2nd Level Decision was made (must be within 72 hrs for an expedited pre-service 2nd level request or within 10 calendar days for a standard pre-service 2nd level request or within 15 calendar days for a post-service 2nd level request)</td>
<td>Type of Decision rendered for 2nd level appeal (number of days approved and/or number of days denied)</td>
<td>Date &amp; Time verbal notification given by DWMHA to Provider of 2nd level appeal decision (must be within 3 hrs of decision)</td>
<td>Date Second Notice of Appeal Decision Letter sent by DWMHA to Provider &amp; Member (if applicable) &amp; (must be within 24 hr of decision)</td>
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<td>1. Date and time of initial call to request the review</td>
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<td>6. Level of Care being requested</td>
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<td>12. Presenting Symptoms/Current Stressors</td>
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<td>13. Risk Assessment <em>(Suicide/Homicide/Other Dangerous or Self Aggressive Behavior)</em></td>
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<td>21. Physical/Medical Health History</td>
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<td>23. Current Medications <em>(medication name, dose, frequency, complete name of prescriber)</em></td>
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<td>24. Compliance with Medications</td>
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<td>25. Presence of a Crisis Plan and/or Behavioral Plan</td>
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<td>26. Diagnosis</td>
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<td>27. Treatment Plan/Identified Goals</td>
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<td><strong>28.</strong> Discharge Plan</td>
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<td><strong>29.</strong> Estimated Length of Stay (ELOS)</td>
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<td><strong>30.</strong> SI/IS criteria identified and documented <em>(medical necessity criteria met for level of service)</em></td>
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<td><strong>31.</strong> Complete Clinical Summary (in clinical note section of criteria authorization screen)</td>
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<td><strong>32.</strong> Consult with Organization’s Supervisor and/or Organization’s Physician</td>
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<td><strong>33.</strong> Number of Days/Units Authorized</td>
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<td><strong>34.</strong> Diversion Information</td>
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<td><strong>35.</strong> Date and Time of PAR Disposition</td>
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<td><strong>36.</strong> Complete name and credentials of Organization’s Staff UM Reviewer and Date <em>(can be electronic signature)</em></td>
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<td><strong>37.</strong> Complete name of staff at hospital/facility to which admission/authorization was given <em>(in PAR Disposition)</em></td>
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<td><strong>38.</strong> Complete name and credentials of the admitting physician <em>(in PAR Disposition)</em></td>
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**DWMHA PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL**

First Continued Stay Review

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<th>Enrollee/Member Name:</th>
<th>Name of Organization:</th>
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<tr>
<td>MHWIN ID No.:</td>
<td>Medicaid Number</td>
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<tr>
<td>Level of Care:</td>
<td>Name of UM Staff Reviewer:</td>
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<td>Admit Date:</td>
<td>Discharge Date:</td>
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<td>3. Telephone number of caller completing the review</td>
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<td>4. Current status of symptoms</td>
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<td>5. Treatment progress to date</td>
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<td>6. Baseline functioning</td>
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<td>7. Any changes to previous treatment plan/goals</td>
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<td>8. Goal statement</td>
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<td>9. Current medications, doses and frequency</td>
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<td>10. Any side effects from medications</td>
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<td>11. Any consultations and/or assessment results</td>
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<td>12. Presenting symptoms/current stressors</td>
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<td>13. Status of communication/Interactions with family, guardian, legal representative, CMH service provider or other identified support systems</td>
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<td>14. Presence of a Crisis Plan and/or Behavioral Plan</td>
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<td>15. SI/IS Criteria Identified</td>
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<td>16. After Care/Discharge Plan (indicate level of care, provider name and date and time of initial appointment with provider)</td>
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<td>17. Placement Issues/Status of Placement (if no placement issues, indicate where and with whom member will live after discharge)</td>
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<td>18. Estimated Length of Stay (ELOS)</td>
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<td>19. Consult with Organization’s Supervisor and/or Organization’s Physician</td>
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<td>20. Number of days/units authorized</td>
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<td>21. Date and time of disposition</td>
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<td>22. Complete name and credentials of Organization’s UM staff reviewer</td>
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<td>12. Presenting symptoms/current stressors</td>
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<tr>
<td>13. Status of communication/Interactions with family, guardian, legal representative, CMH service provider or other identified support systems</td>
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<tr>
<td>14. Presence of a Crisis Plan and/or Behavioral Plan</td>
<td>N/A</td>
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<tr>
<td>15. SI/IS Criteria Identified</td>
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<tr>
<td>16. After Care/Discharge Plan <em>(indicate level of care, provider name and date and time of initial appointment with provider)</em></td>
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<tr>
<td>17. Placement Issues/Status of Placement <em>(if no placement issues, indicate where and with whom member will live after discharge)</em></td>
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<tr>
<td>18. Estimated Length of Stay (ELOS)</td>
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<tr>
<td>19. Consult with Organization’s Supervisor and/or Organization’s Physician</td>
<td>N/A</td>
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<tr>
<td>20. Number of days/units authorized</td>
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<tr>
<td>21. Date and time of disposition</td>
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<tr>
<td>22. Complete name and credentials of Organization’s UM staff reviewer</td>
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<tr>
<td>Documentation</td>
<td>Found</td>
<td>Found but Not Accurate/Complete</td>
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<tr>
<td>1. Date and time of concurrent review was initiated</td>
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<td>2. Name and credentials of caller completing the review</td>
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<td>3. Telephone number of caller completing the review</td>
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<td>4. Current status of symptoms</td>
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<td>5. Treatment progress to date</td>
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<tr>
<td>6. Baseline functioning</td>
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<tr>
<td>7. Any changes to previous treatment plan/goals</td>
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<tr>
<td>8. Goal statement</td>
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<td>9. Current medications, doses and frequency</td>
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<td>10. Any side effects from medications</td>
<td>N/A</td>
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<tr>
<td>11. Any consultations and/or assessment results</td>
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<tr>
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<tr>
<td>22. Complete name and credentials of Organization’s UM staff reviewer</td>
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</table>

Signature, title and credential of Staff Auditor
*(person who completed the case audit)*

Date of the case audit

Revised 12.1.16
For any areas where the documentation was not found or was not complete or not accurate please indicate the nature of the deficiency and any corrective action given to the Organization’s UM staff reviewer:

INSTRUCTIONS FOR COMPLETION OF PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL

The purpose of these reviews are to ensure correct documentation, appropriate level of care decisions and to meet External Quality Review requirements relative to Utilization Management.

➢ On a quarterly basis, COPE and the MCPNs shall review the following:
  • All (100%) denial and appeal cases based on all staff making Utilization Management decisions.
  • COPE and Carelink -ten (10) approved cases (PAR Screenings) for all staff making Utilization Management decisions.
  • Consumer Link, Community Living Services and Integrated Care Alliance- five (5) approved request for service cases on all staff making Utilization Management decisions.

➢ Reviews should be completed on all levels of care requiring prior authorization, including Acute Inpatient, Partial Hospitalization, State Hospitalization, Crisis Stabilization, Intensive Crisis Residential and/or Child Caring Institutions.

➢ COPE must forward all the completed Prior Authorized Service UM Chart Review sheets to Tasha Bridges at fax: (313) 833-3160 or email at tbridges@dwmha.com each quarter.

➢ An Analysis of all Prior Authorized Service UM Chart Reviews for the fiscal year shall be included in the MCPNs Annual UM Evaluation.

Revised 12.1.16
ENROLLEE / MEMBER AGREEMENT FOR ADDITIONAL INFORMATION REQUEST

Date

Enrollee/Member Name
Address
City, State, Zip

Re: Enrollee/Member’s Name: ________________________________
Medicare ID No (if applicable): ____________________________
Medicaid ID No (if applicable): ____________________________
MHWIN ID No: ____________________________

Dear ____________:

We received the request for an (Insert either First Level Appeal request or Second Level Appeal request) on <insert date> from your provider. However, in order to make a fair and informed determination, we requested the following information be sent within five (5) calendar days from your provider:

☐ Psychiatric Evaluation
☐ Nursing Assessment
☐ Social Work Assessment
☐ Attending Physician Progress Notes
☐ Clinical Group Progress Notes
☐ Clinical Individual Progress Notes
☐ Medication Administration Record
☐ Vital signs and Meal Flow Chart
☐ Discharge Summary
☐ Other ________________________________

Because of our request for additional information, we are extending the decision date by fourteen (14) calendar days. If you or your representative are not in agreement with this extension, you or your representative can verbally request an expedited grievance with DWMHA’s Customer Service Department at (313) 344-9099 or (888) 490-9698 or TTY (800)-630-1044 or in writing at 707 West Milwaukee, Detroit Mi. 48202.

Sincerely,

<Name of Responsible Party>
>Title

Revised 5.10.17
ENROLLEE / MEMBER AGREEMENT FOR ADDITIONAL INFORMATION REQUEST

Date

Enrollee/Member Name
Address
City, State, Zip

Re: Enrollee/Member’s Name: ________________________________
Medicare ID No (if applicable): ____________________________
Medicaid ID No (if applicable): ____________________________

Dear ____________:

We received the request for an (Insert either First Level Appeal request or Second Level Appeal request) on <insert date> from your provider. However, in order to make a fair and informed determination, we requested the following information be sent within five (5) calendar days from your provider:

- [ ] Psychiatric Evaluation
- [ ] Nursing Assessment
- [ ] Social Work Assessment
- [ ] Attending Physician Progress Notes
- [ ] Clinical Group Progress Notes
- [ ] Clinical Individual Progress Notes
- [ ] Medication Administration Record
- [ ] Vital signs and Meal Flow Chart
- [ ] Discharge Summary
- [ ] Other ________________________________

Because of our request for additional information, we are extending the decision date by fourteen (14) calendar days. If you or your representative are not in agreement with this extension, you or your representative can verbally request an expedited grievance with DWMHA’s Customer Service Department at (313) 344-9099 or (888) 490-9698 or TTY(800) 630-1044 or in writing at 707 West Milwaukee, Detroit Mi. 48202.

Sincerely,

<Name of Responsible Party>
>Title

Revised 5.10.17
ENROLLEE / MEMBER AGREEMENT FOR ADDITIONAL INFORMATION REQUEST

Date

Enrollee/Member Name
Address
City, State, Zip

Re: Enrollee/Member’s Name: ____________________________
Medicare ID No: __________________
Medicaid ID No: __________________

Dear ____________:

We received the request for an (Insert either First Level Appeal request or Second Level Appeal request) on <insert date> from your provider. However, in order to make a fair and informed determination, we requested the following information be sent within five (5) calendar days from your provider:

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☐ Medication Administration Record
☐ Vital signs and Meal Flow Chart
☐ Discharge Summary
☐ Other ____________________________

Because of our request for additional information, we are extending the decision date by fourteen (14) calendar days. If you or your representative are not in agreement with this extension, you or your representative can verbally request an expedited grievance with DWMHA’s Customer Service Department at (313) 344-9099 or (888) 490-9698 or TTY (800) 630-1044 or in writing at 707 West Milwaukee, Detroit Mi. 48202.

Sincerely,

<Name of Responsible Party>
<Title>

Revised 5.10.17
IRO Physician Reviewer Documentation Form

Member’s Name:
Member’s Date of Birth:
Hospital Physician Name and Credentials:

Specific Question(s) to be answered:
Based on standards of care, your medical experience and evidence based literature:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Reviewer’s Decision and Principal Reason(s) for Decision:

Deny services

Uphold denial of services

Overturn the denial of services

Modify the denial of services

Clinical Rational for Decision:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Evidence based References: (Provide a minimum of two (2) and a maximum of five (5) peer review CURRENT (within 3 years) medical references to support your opinion in this review.
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
I certify that I have experience providing direct clinical care to patients within the past three (3) years that represent the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review; and have current, relevant experience and/or knowledge to render a determination for this case under review.

Physician Signature and Credentials: ________________________ Date: __________________
Case tracking # _________________________

When you complete the case, FAX your review to:
248-305-7093; ATTN: MELODY
# INDEPENDENT REVIEW ORGANIZATION REFERRAL REVIEW REQUEST FORM

<table>
<thead>
<tr>
<th>Case Priority: Expedited</th>
<th>Standard</th>
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<table>
<thead>
<tr>
<th>Enrollee/Member Name:</th>
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<tr>
<th>Enrollee/Member’s Address:</th>
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<table>
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<tr>
<th>DOB:</th>
<th>Telephone Number:</th>
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<table>
<thead>
<tr>
<th>Provider Name:</th>
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<table>
<thead>
<tr>
<th>Provider Address:</th>
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<table>
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<tr>
<th>Treating Physician Name and Credentials:</th>
<th>Telephone Number:</th>
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<tr>
<th>Name of Person responsible for filing the request:</th>
<th>Telephone Number:</th>
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<tr>
<th>Level and Type of Services in Dispute:</th>
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<table>
<thead>
<tr>
<th>Dates of Services in Dispute:</th>
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<tr>
<th>Type of Services Currently Authorized (if applicable):</th>
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<table>
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<tr>
<th>Dates of Services Currently Authorized (if applicable):</th>
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<tr>
<th>Reason for the IRO referral:</th>
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</table>
Chronology of Care: (This should be a brief overview of the timeline of events in this case.)

DWMHA Contact Person: Tasha Bridges, LPC
Telephone Number: 313-344-9099 ext. 3328
Fax Number: 313-833-3670
OVERVIEW

Procedure Purpose: To provide detailed steps required to issue an adverse determination for enrollee/members in the MI Health Link Program.

Expected Outcome: DWMHA, Access Center, Crisis Service Vendor, MCPNs and Service Providers will understand and be compliant with the requirements to issue an adverse determination.

References: N/A

KEYWORDS:
1. Action
2. Administrative Appeal
3. Adverse Determination
4. Authorization
5. Independent Review Organization (IRO)
6. Medical Necessity Appeal
7. Pended

PROCEDURE:
1. If DWMHA, Access Center or Crisis Service Vendor UM Reviewer has concerns or questions about whether eligibility, screening, or medical necessity is met to approve the initial or continued stay review, he/she may request additional information from the provider within twenty four (24) hours of the request. He/she may also elect to verbally consult with a DWMHA, Access Center or Crisis Service Vendor UM Supervisor. The DWMHA, Access Center or Crisis Service Vendor UM Reviewer then documents the supervisor’s name, credentials and recommendations into MHWIN which may include the recommendation to verbally consult with the DWMHA, Access Center or Crisis Service Vendor physician/appropriate professional or to secure a formal consultation with a DWMHA, Access Center, IRO or Crisis Service Vendor physician.

2. If the DWMHA, Access Center or Crisis Service Vendor UM Reviewer verbally consults with a DWMHA, Access Center, IRO or Crisis Service Vendor physician, he/she will document the name, credentials and the recommendations of their physician/appropriate professional in MHWIN.

3. If after the verbal consult, the DWMHA, Access Center, IRO or Crisis Service Vendor physician determines approval cannot be determined at this time, the DWMHA, Access Center or Crisis Service Vendor UM Reviewer will secure a formal physician consultation.

4. The DWMHA, Access Center or Crisis Service Vendor UM Reviewer completes the Physician Case Review form in MHWIN and sends the case to the queue in MHWIN for retrieval by a DWMHA, Access Center or Crisis Service Vendor physician/appropriate professional.
5. The DWMHA, Access Center or Crisis Service Vendor UM Reviewer will immediately notify the
DWMHA UM Appeal Coordinator, the designated Access Center or the designated Crisis Service
Vendor staff person via email of the need for a DWMHA, Access Center or Crisis Service Vendor
physician to review the form and the case in order for the DWMHA UM Appeal Coordinator,
designated Access Center or designated Crisis Service Vendor staff person to track the case and
ensure it is reviewed and a determination is made within the appropriate time frames.

6. If using an IRO physician, the UM Reviewer completes the standardized IRO Referral Review Request
form and has the DWMHA UM Appeal Coordinator forward via email the form to the IRO Medical
staff person to facilitate an IRO physician review of the case.

7. The DWMHA, Access Center, IRO or Crisis Service Vendor physician may elect to conduct a peer to
peer review with the treating physician. If this is the case, the DWMHA, Access Center, IRO or Crisis
Service Vendor physician will make reasonable attempts (at least two) to telephonically contact the
treating physician. The DWMHA, Access Center, IRO and Crisis Service Vendor physician will
document the day and time of each attempt in MHWIN.

8. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor
staff person will also document the day and time of each attempt by their physician/appropriate
professional in their tracking log. Note that the DWMHA UM Appeal Coordinator will document the
day and time of each attempt by the IRO physician in the tracking log.

9. The physician reviewing will also decide if the case would better be reviewed by a different physician
such as a physician certified in addiction medicine. If yes, the physician will notify the DWMHA UM
Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN
staff person, and the DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis
Service Vendor or designated MCPN staff person will be responsible to facilitate the case review by
with the appropriate physician.

10. If a peer to peer review is completed, the DWMHA, the Access Center or Crisis Service Vendor
physician or appropriate professional will document the results of the peer to peer review in MHWIN
and render a decision which will also be documented in MHWIN. The IRO physician will complete the
standardized Physician Reviewer Documentation form.

11. The DWMHA, Access Center, IRO or Crisis Service Vendor physician will review the case and render a
decision within the following time frames:
   a. For an urgent pre-service initial review, within seventy two (72) hours of the request;
   b. For a non-urgent (standard) pre-service initial review, within fourteen (14) calendar days of
      the request;
   c. For a post-service review, within thirty (30) calendar days of the request; or
   d. For urgent concurrent reviews, within twenty-four (24) hours if the request was made prior
to twenty-four (24) hours of the expiration of the current authorization or within seventy-two (72)
hours if the request is made less than twenty-four (24) hours of the expiration of the
current authorization.

12. DWMHA, the Access Center, IRO or Crisis Service Vendor may extend an urgent pre-service time
frame due to a lack of information, once, for forty-eight (48) hours, under the following conditions:
   a. Within twenty-four (24) hours of receipt of the urgent pre-service request, the DWMHA UM
      Appeal Coordinator, designated Access Center staff person or designated Crisis Service
      Vendor staff person asks the enrollee/member or their representative (provider/practitioner
      considered to be their representative) for the specific information necessary to make the
decision;
   b. DWMHA, the Access Center or Crisis Service Vendor gives the enrollee/member at least forty-
      eight (48) hours to provide the information; and
c. The extension period, within which a decision must be made begins on the date the enrollee/member’s response is received (even if not all of the information is provided), or at the end of the time period given to the enrollee/member to provide the information even if no response is received from the enrollee/member or their authorized representative.

13. DWMHA, the Access Center, IRO or Crisis Service Vendor may extend a non-urgent pre-service or post-service time frame due to a lack of information, once, for up to fifteen (15) calendar days under the following conditions:
   a. The specific information necessary to make the decision is requested from the enrollee/member or enrollee/member’s representative within the decision timeframe as well as the need and reason for the extension;
   b. The enrollee/member or the enrollee/member’s representative is given at least forty-five (45) calendar days to provide the information; and
   c. The extension period, within which a decision must be made by the organization, begins on the date when the enrollee/member or their representative’s response is received (even if not all of the information is provided), or at the end of the time period given to the enrollee/member to supply the information, if no response is received from the enrollee/member or their representative. If information is not received within the time frame, the request may be denied and enrollee/member or their representative may then appeal the denial.

14. DWMHA, the designated Access Center or designated Crisis Service Vendor staff person must notify the enrollee/member or enrollee/member’s representative of the extension and request for additional information using the standardized Enrollee Agreement for Request for Additional Information Form within fifteen (15) calendar days of a non-urgent pre-service extension request or within thirty (30) calendar days of a post-service extension request.

15. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person manually checks the MHWIN queue twice a day to ensure that the DWMHA, Access Center or Crisis Service Vendor physician or other appropriate professional has retrieved the case from the queue and reviews it within the appropriate time frames. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person will communicate daily via email, face to face or telephonically with the DWMHA, Access Center or Crisis Service Vendor physician or other appropriate professional if after twenty four (24) hours for an urgent pre-service initial review, or if after seven (7) hours for a concurrent review or within seven (7) calendar days for a non-urgent (standard) pre-service initial review, the DWMHA, Access Center or Crisis Service Vendor physician or appropriate professional has not reviewed the case. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person documents all attempts (date and time) to contact the physician or other appropriate professional in their tracking log. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person will use their tracking log as a tool to monitor the timeframes.

16. The IRO Medical Review staff will follow their own internal procedures to ensure the MCPN or IRO physician reviews the case within the appropriate timeframes.

17. The DWMHA, Access Center or Crisis Service Vendor physician will document their decision in MHWIN and document their name, title, and credentials if not done by electronic signature.

18. The DWMHA, Access Center or Crisis Service Vendor physician will immediately notify the DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person via email of their decision.

19. The IRO physician will complete the standardized Physician Reviewer Documentation form and immediately fax it to the IRO Medical Review staff. The IRO Medical Review staff will, in turn, immediately email it to the DWMHA UM Appeal Coordinator.
20. If the decision is to approve eligibility, the designated Access Center staff person emails the Access Center UM Reviewer who then calls the enrollee/member and completes the screening process.
21. If the decision is to authorize services, the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person enters the authorization in MHWIN, generates an authorization letter from MHWIN and then mails the letter to the provider and enrollee/member within twenty four (24) hours of the decision.
22. If the decision is to deny eligibility or services, the DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person enters the denial in MHWIN and generates the standardized Notice of Denial of Medical Coverage form from MHWIN.
23. If the Notice of Denial of Medical Coverage form is manually generated, the DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person will scan the Notice and attach it to the case in MHWIN.
24. The standardized Notice of Denial of Medical Coverage form is sent to the enrollee/member regarding a decision to reduce, suspend or terminate services currently authorized and provided or regarding a decision to deny or limit services being requested.
25. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person verbally notifies the practitioner/provider within three (3) hours of the decision and documents the verbal notification in MHIWN including the date and time of the notification, the right to a peer to peer discussion regarding the determination, the appeal rights and process and the complete name and credentials of the person notified.
26. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person reviews the Notice of Denial of Medical Coverage form to ensure it has the following:
   a. A statement of what action is being taken in easy, understandable language which does not include:
      - abbreviations or acronyms that are not defined; and
      - is culturally and linguistically sensitive to the enrollees/members’ needs; and
      - health care procedure codes that are not explained.
   b. An explanation of the action including the denial of services in amount, scope and duration if less than what is requested;
   c. The specific justification that supports, or the change in the federal or state law that requires the action including a reference to the benefit provision, guideline, protocol or other similar criterion on which the action is based and the option of the enrollee/member to have a copy of the benefit provision, guidelines or protocol, upon request;
   d. A statement that the enrollee/member and/or provider has the right to an internal appeal with DWMHA, the Access Center or Crisis Service Vendor and a description of the expedited and standard appeal process including time frames;
   e. A statement that the enrollee/member has a right to an external Medicaid Fair Hearing and an explanation of how to file a Medicaid Fair Hearing for Medicaid covered services;
   f. A statement that Medicaid covered services will continue up to the end of the currently approved treatment or final decision whichever comes first if the enrollee/member requests an internal and/or external Medicaid Fair Hearing within twelve (12) calendar days from the date of the notice (per MDHHS and DWMHA contract October 1, 2016);
   g. A statement that the enrollee/member may have to pay for the continuation of services if the result of the internal appeal or external Medicaid Fair Hearing is to uphold the denial for Medicaid covered services;
   h. A statement that the enrollee/member, his/her legal representative and/or provider has the opportunity to submit written comments, documents or other information relevant to an appeal;
i. A statement that the enrollee/member and/or provider can request copies of all documents relevant to the appeal, free of charge;

j. Informs the enrollee/member of their right to designate an authorized representative to act on their behalf as long as the enrollee/member has provided written permission by completing and forwarding the Appointment of Representative form to DWMHA, the Access Center or Crisis Service Vendor;

k. A statement that an expedited or standard external review can occur the same time as an internal expedited or standard review; and

l. Includes a list of the titles and qualifications, including specialties of the individuals participating in the appeal review.

27. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person mails the standardized Notice of Denial of Medical Coverage form to the enrollee/member and provider within twenty four (24) hours of the verbal/oral notification.

28. The DWMHA UM Appeal Coordinator, designated Access Center or Crisis Service Vendor staff person documents the date and times of the verbal and written notifications in their tracking log.

29. If DWMHA, the Access Center or Crisis Service Vendor fails to make a timely decision regarding authorization of services, the standardized Notice of Our Failure to Make a Coverage Decision form must be mailed to the enrollee/member. In such instances, the enrollee/member can then request an appeal.

30. The designated Access Center and designated Crisis Service Vendor staff person must forward via email their tracking log to the DWMHA UM Appeals Coordinator by the 10th of each month for compliance monitoring.

31. The DWMHA UM Appeal Coordinator will audit all denials rendered by the Access Center and Crisis Service Vendor monthly using the denial audit tool, collate the results of the audits and provide a monthly report to the DWMHA UM Director.

32. Denial cases not scoring 85% or greater will be reviewed with the DWMHA, Access Center or Crisis Service Vendor UM Reviewer for the purposes of coaching and training.

33. Any UM Reviewer that scores below 85% on the audit tool three (3) times or more will be placed on a Corrective Action Plan.

PROCEDURE MONITORING & STEPS:

Who monitors this procedure: DWMHA UM Appeal Coordinator

Department: DWMHA Utilization Management

Frequency of monitoring: Monthly

Reporting provided to: DWMHA UM Director, Access Center, Crisis Service Vendor

Regulatory Requirement(s): Audit process developed in order to pass file review for UM 4, UM 5, UM 6 and UM 7, all elements

MONITORING STEPS:

1. DWMHA will perform monthly audits of all denials. Results will be reported to the DWMHA UM Director and to the entity that issued the denial.

2. Expectation is that any DWMHA, Access Center and Crisis Service Vendor staff score 85% or greater on their monthly case audits. Failure to score 85% or greater three (3) times or more will result in a Corrective Action Plan (CAP) for the entity
Notice of Denial of Medical Coverage

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

Mailing Date: Member Number:

Name:

Type of Service Subject to Notice: ☐ Medicare ☐ Mi. Medicaid ☐ Medicare/MI. Medicaid Overlap Service

Your request was (denied, stopped, reduced, suspended)

We [Insert appropriate term: denied, stopped, reduced, suspended] the {payment of} medical services/items listed below requested by you or your doctor {provider}:


Why did we (deny, stop, reduce, suspend) your request?

We [Insert appropriate term: denied, stopped, reduced, suspended] the {payment of} services/items listed above because: [Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.]

You have the right to appeal our decision

You have the right to ask Detroit Wayne Mental Health Authority (DWMHA) to review our decision by asking us for an internal appeal. You may also request a Medicaid Fair Hearing regarding a Michigan Medicaid covered service before, during, after, or instead of filing an internal appeal with us. The process is described later in this notice.

Internal Appeal: Ask DWMHA for an internal appeal within 60 calendar days of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

If we’re stopping or reducing a service, you can keep getting the service while your case is being reviewed. If you want the service to continue while your case is under review, you must ask for an appeal within 12 calendar days of the date of this notice or before the service is stopped or reduced, whichever is later.
If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 888-490-9698 to learn how to name your representative. TTY users call 1-800-630-1044. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You’ll need to mail or fax this statement to us.

Important Information About Your Appeal Rights

There are 2 kinds of internal appeals

1. **Standard Appeal** – We’ll give you a written decision on a standard appeal within 30 calendar days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If your appeal is for payment of a service you’ve already received, we’ll give you a written decision within 60 calendar days.

2. **Fast Appeal** – We’ll give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision.

We’ll automatically give you a fast appeal if a doctor asks for one for you or supports your request. If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within 30 calendar days.

How to ask for an internal appeal with DWMHA

**Step 1:** You, your representative, or your doctor {provider} must ask us for an internal appeal. Your request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

**Step 2:** Mail, fax, or deliver your appeal {or call us}.

For a Standard Appeal:

Detroit Wayne Mental Health Authority (DWMHA)
707 West Milwaukee Street
Detroit, Michigan 48202
Phone: 888-490-9698 (for members)
TTY: 800-630-1044
Fax: 313-833-2217 (for members)

For Providers: Phone: 313-344-9099 ext. 3328  Fax: 313-833-3680

You can ask to see the medical records and other documents we use to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

For a Fast Appeal:  Phone: 888-490-9698 (for members) for TTY: 800-630-1044
Fax: 313-833-2217 (for members)

For Providers: Phone: 313-344-9099 ext. 3328  Fax: 313-833-3680 for providers
What happens next?
If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we’ll send you a written decision. The letter will tell you if the service or item is usually covered by Medicare and/or Michigan Medicaid.

- If the service is covered by Medicare, we will automatically send your case to an independent reviewer, MAXIMUS Federal Services. If MAXIMUS denies your request, you will receive a written decision that will explain if you have additional appeal rights.

- If the service is covered by Michigan Medicaid, you can ask for a Medicaid Fair Hearing if you haven’t already done so. You can also ask for an External Review under the Patient Right to Independent Review Act by contacting DWMHA at 888-490-9698. Your written decision will give you instructions on how to request a Medicaid Fair Hearing and External Review. Information about the Medicaid Fair Hearing process is also below.

- If the service could be covered by both Medicare and Michigan Medicaid, we will automatically send your case to the independent reviewer. You can also ask for a Medicaid Fair Hearing or an External Review.

How to ask for a Medicaid Fair Hearing

You do not have to file an internal appeal with the plan before requesting a Medicaid Fair Hearing. You can request a Medicaid Fair Hearing at the same time as you file an internal appeal, after filing an internal appeal, or instead of filing an internal appeal.

You have 90 calendar days from date of this notice to request the hearing. If you want the service to continue while your case is under review, you must ask for a Medicaid Fair Hearing within 12 calendar days of the date of this notice or before the service is stopped or reduced, whichever is later.

A Request for Medicaid Fair Hearing form is included with this letter. It has instructions that you should review.

Step 1: You, your representative, or your doctor \{provider\} must ask for a Medicaid Fair Hearing. Your written request must include:
- Your name
- Address
- Member number
- Reasons for requesting a Medicaid Fair Hearing
- Any evidence you want the Administrative Law Judge to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: Send your request to: Michigan Administrative Hearing System (MAHS)
PO Box 30763
Lansing, MI 48909

Phone: 1-800-630-7044        Fax: 517-335-6088

What happens next?
The Michigan Administrative Hearing System (MAHS) will schedule a hearing. You will receive a written “Notice of Hearing” telling you the date and time. Most hearings are held by telephone, but you can request to have a hearing in person. During the hearing, you’ll be asked to tell an Administrative Law Judge why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You’ll get a written decision within 90 calendar days from the date your Request for Hearing was received by MAHS. The written decision will explain if you have additional appeal rights.

Revised 5.10.17
If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for an expedited (fast) Medicaid Fair Hearing. Your request must be in writing and clearly state that you are asking for a fast Medicaid Fair Hearing. Your request can be mailed or faxed to MAHS at 517-335-6088. If you qualify for an expedited Medicaid Fair Hearing, MAHS must give you an answer within 72 hours. However, if MAHS needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions about the Fair Hearings process, including the expedited (fast) Medicaid Fair Hearing, you can call MAHS at 1-800-630-7044.

A copy of this notice has been sent to: Detroit Wayne Mental Health Authority (DWMHA)
707 West Milwaukee Street
Detroit, Michigan, 48202

Get help & more information

- Detroit Wayne Mental Health Authority (DWMHA): If you need help or additional information about our decision and the appeal process, call (313) 344-9099 or (888) 490-9698, TTY (800) 630-1044, Monday-Friday, 8:00am to 4:30pm. For an enrollee/member appeal, ask for the DWMHA Customer Service Department and for a provider/utilization management appeal, ask for the DWMHA Utilization Management Department. You can also visit our website at www.dwmha.com
- MI Health Link Ombudsman: You can also contact the MI Health Link Ombudsman for help or more information. The staff can talk with you about how to make an appeal and what to expect during the appeal process. The MI Health Link Ombudsman is an independent program and the services are free. Call 1-888-746-6456 (TTY: 711).
- Medicare: 1-800-MEDICARE (1-800-633-4227 or TTY: 877-486-2048), 24 hours a day, 7 days a week
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116 or www.eldercare.gov to find help in your community.
- Michigan Medicare/Medicaid Assistance Program (MMAP): 1-800-803-7174
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

Detroit Wayne Mental Health Authority is a behavioral health plan that subcontracts with Aetna Better Health of Michigan, AmeriHealth Michigan, Fidelis Secure Care of Michigan, HAP Midwest Health Plan, and Molina Healthcare of Michigan, which are health plans that contract with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

You can get this information for free in other languages or in other formats, such as large print, braille, or audio by calling Toll Free 1-888-490-9698, TTY 1-800-630-1044 during normal business hours Monday through Friday 8:00am to 4:30pm.

Usted puede hablar con una persona para obtener esta información gratuitamente en español o en varios formatos, tal como en letras grandes, idioma Braille o en forma hablada, llamando al (888) 490-9698 (TTY: 1-800-630-1044) durante las horas de trabajo: 8:00 am a 4:30 pm de Lunes a Viernes. La llamada es gratuita.

يمكنك الحصول على هذه المعلومات باللغة العربية أو بتنسيقات مختلفة مثل طريقة باريل، بخط كبير أو صوتيا عن طريق الإتصال برقم الهاتف المجاني 9698-490-888-1.خلال مواعيد العمل الرسمية من الاثنين إلي الجمعة من الساعة 8:00 صباحا إلي الساعة 4:30 مساءا.

CC: Provider, Enrollee/Member
Notice of Our Failure to Make a Coverage Decision
Detroit Wayne Mental Health Authority

Important: We did not respond to your request for coverage within the required time period. This notice explains your right to appeal our failure to respond. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

Mailing Date: <Mailing Date> Member MI. Medicaid ID: <Member’s Plan ID Number>
Name: <Member’s Name>

Type of Service Subject to Notice: [ ] Medicare [ ] MI. Medicaid [ ] Medicare/Medicaid Overlap Service

We did not make a decision on your request

The Detroit Wayne Mental Health Authority (DWMHA) received your request for coverage on <enter date received>. As of the date of this notice, we have not made a decision on the services/items listed below requested by you or your doctor {provider}:

You should share a copy of this notice with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this notice to your doctor.

You have the right to appeal our failure to decide

According to federal regulations, we must make a coverage decision within 14 calendar days for standard requests and 72 hours for expedited requests (with a possible 14 calendar day extension). Our failure to make a timely decision is considered a denial of coverage. You have the right to appeal this denial by asking us for an internal appeal. You may also ask for a Medicaid Fair Hearing regarding a Michigan Medicaid covered service before, during, after, or instead of filing an internal appeal with us.

Internal Appeal: Ask Detroit Wayne Mental Health Authority for an internal appeal within 60 calendar days of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled “How to ask for an internal appeal with Detroit Wayne Mental Health Authority for information on how to ask for a plan level appeal.

Michigan Medicaid Fair Hearing: Ask for a Michigan Medicaid Fair Hearing within 90 calendar days of the date of this notice. See section titled “How to ask for a Michigan Medicaid Fair Hearing” of this notice for information about how to ask for a Michigan Medicaid Fair Hearing.

Revised 5.10.17
If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-888-490-9698 to learn how to name your representative. TTY users call 1-800-630-1044. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You’ll need to mail or fax this statement to us. Keep a copy for your records.

Important Information About Your Appeal Rights

There are 2 kinds of internal appeals with Detroit Wayne Mental Health Authority

1. **Standard Appeal** – We’ll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If your appeal is for payment of a service you’ve already received, we’ll give you a written decision within **60 calendar days**.

2. **Fast Appeal** – We’ll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision.

We’ll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within 30 calendar days.

How to ask for an internal appeal with DWMHA

**Step 1:** You, your representative, or your doctor {provider} must ask us for an internal appeal. Your request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Whether you want a standard or fast appeal (for a fast appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors’ letters (such as a doctor’s supporting statement if you request a fast appeal), or other information that explains why you need the item or service. Call your doctor if you need this information.

We recommend keeping a copy of everything you send us for your records.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

**Step 2:** Mail, fax, or deliver your appeal or call us.

**For a Standard Appeal:**

Detroit Wayne Mental Health Authority (DWMHA)
707 West Milwaukee Street
Detroit, Michigan 48202
Phone: 888-490-9698 for TTY: 1-800-630-1044 (for members)
Fax: 313-833-2217 (for members)
For providers: Phone: 313-344-9099 ext. 3328 Fax: 313-833-3680

**For a Fast Appeal:**

Phone: 888-490-9698 (for members) for TTY: 1-800-800-630-1044
Fax: 313-833-2217 (for members)
For providers: Phone: 313-344-9099 ext. 3328 for providers Fax: 313-833-3680

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What happens next?

If you ask for an internal appeal and we deny your request for coverage or payment of a service, we will send you a written decision. The letter will tell you if the service or item is usually covered by Medicare and/or Michigan Medicaid.

- If the service is covered by Medicare, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, you will receive a written decision that will explain if you have additional appeal rights.

- If the service is covered by Michigan Medicaid, you can ask for a Michigan Medicaid Fair Hearing if you haven’t already done so. Your written decision will give you instructions on how to request a Michigan Medicaid Fair Hearing. Information about the Michigan Medicaid Fair Hearing process is also below.

- If the service could be covered by both Medicare and Michigan Medicaid, we will automatically send your case to an independent reviewer. You can also ask for a Michigan Medicaid Fair Hearing.

How to ask for a Michigan Medicaid Fair Hearing

You do not have to file an internal appeal with the plan before asking for a Michigan Medicaid Fair Hearing. You can ask for a Michigan Medicaid Fair Hearing at the same time as you file an internal appeal, after filing an internal appeal, or instead of filing an internal appeal.

You have **90 calendar days** from date of this notice to ask for the Michigan Medicaid Fair Hearing. A Request for Hearing form is included with this letter. It also has instructions that you should review.

**Step 1:** You, your representative, or your doctor *{provider}* must ask for a Michigan Medicaid Fair Hearing.

Your written request must include:

- Your name
- Address
- Member number
- Reasons for requesting a Michigan Medicaid Fair Hearing
- Any evidence you want the Administrative Law Judge to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

**Step 2:** Send your request to:  
Address: Michigan Administrative Hearing System (MAHS)  
PO Box 30763  
Lansing, MI 48909  
Phone: 1-877-833-0870  
Fax: 517-373-4147

You’ll get a written decision within 90 calendar days from the date your Request for Hearing was received by MAHS. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would put your life or health at risk, you may be able to qualify for an expedited (fast) Michigan Medicaid Fair Hearing. Your request must be in writing and clearly state that you are asking for a fast Michigan Medicaid Fair Hearing. Your request can be mailed or faxed to MAHS (see address and fax number for MAHS above). If you qualify for a fast Michigan Medicaid Fair Hearing, MAHS must give you an answer within 72 hours. However, if MAHS needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions about the Michigan Medicaid Fair Hearings process, including the expedited (fast) Michigan Medicaid Fair Hearing, you can call MAHS at 1-877-833-0870.
Get help & more information

- Detroit Wayne Mental Health Authority (DWMHA): If you need help or additional information about our decision and the appeal process, call (313) 344-9099 or (888) 490-9698, TTY (800) 630-1044, Monday-Friday, 8:00am to 4:30pm. For an enrollee/member appeal, ask for the DWMHA Customer Service Department and for a provider/utilization management appeal, ask for the DWMHA Utilization Management Department. You can also visit our website at www.dwmha.com.
- MI Health Link Ombudsman: You can also contact the MI Health Link Ombudsman for help or more information. The staff can talk with you about how to make an appeal and what to expect during the appeal process. The MI Health Link Ombudsman is an independent program and the services are free. Call 1-888-746-6456 (TTY: 711).
- Medicare: 1-800-MEDICARE (1-800-633-4227 or TTY: 877-486-2048), 24 hours a day, 7 days a week.
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116 or www.eldercare.gov to find help in your community.
- Michigan Medicare/Medicaid Assistance Program (MMAP): 1-800-803-7174
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

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Usted puede hablar con una persona para obtener esta información gratuitamente en español o en varios formatos, tal como en letras grandes, idioma Braille o en forma hablada, llamando al (888) 490-9698 (TTY: 1-800-630-1044) durante las horas de trabajo: 8:00 am a 4:30 pm de Lunes a Viernes. La llamada es gratuita.

يمكنك الحصول على هذه المعلومات باللغة العربية أو بمستويات مختلفة مثل طائفة باريل، بخط كبير أو صوتا عن طريق الاتصال برقم الهاتف المجاني 9698-490-888-1 خلال مواعيد العمل الرسمية من الاثنين إلى الجمعة من الساعة 8:00 صباحاً إلى الساعة 4:30 مساءً.

CC: Provider, Enrollee/Member
REQUEST FOR ADDITIONAL INFORMATION

Date

Provider Name
Address
City, State, Zip

RE: Enrollee/Member’s Name: _________________________________
Medicare ID No: (if applicable) _____________________________
Michigan Medicaid ID No: (if applicable) ____________________

Dear ____________:

We received your (Insert either First Level Appeal request or Second Level Appeal request) on <insert date>.

However, in order to make a fair and informed determination, we are requesting the following information be sent within five (five) calendar days:

- Psychiatric Evaluation
- Nursing Assessment
- Social Work Assessment
- Substance Abuse Assessment
- Master Treatment Plan
- Attending Physician Progress Notes
- Clinical Group Progress Notes
- Clinical Individual Progress Notes
- Medication Administration Record
- Vital Signs and Meals Flow Chart
- Discharge Summary
- Other ____________________________________________________

Because of our request for additional information, we are extending the decision date by 14 calendar days. If you have any questions please contact DWMHA at 313-344-9099. Providers ask for the Utilization Department and enrollees/members ask for the Customer Service Department.

Sincerely,

<Name of Responsible Party>
<Title>

Revised 5.10.17
REQUEST FOR ADDITIONAL INFORMATION

Date

Enrollee/Member Name
Address
City, State, Zip

Re: Enrollee/Member’s Name: ____________________________
Medicare ID No: __________________
Medicaid ID No: __________________

Dear ____________:

We received your (Insert either First Level Appeal request or Second Level Appeal request) on <insert date>.

However, in order to make a fair and informed determination, we are requesting the following information be sent within five (5) calendar days:

☐ Psychiatric Evaluation
☐ Nursing Assessment
☐ Social Work Assessment
☐ Attending Physician Progress Notes
☐ Clinical Group Progress Notes
☐ Clinical Individual Progress Notes
☐ Medication Administration Record
☐ Vital signs and Meal Flow Chart
☐ Discharge Summary
☐ Other ____________________________________________

Because of our request for additional information, we are extending the decision date by fourteen (14) calendar days. If you have any questions please contact DWMHA at 313 344-9099. Providers ask for the Utilization Management Department and enrollees/members ask for the Customer Service Department.

Sincerely,

<Name of Responsible Party>
<Title>
Revised 5.10.17
REQUEST FOR ADDITIONAL INFORMATION

Date

Provider Name
Address
City, State, Zip

RE: Enrollee/Member’s Name: ______________________________________
Medicare ID No: (if applicable)_____________________________________
Michigan Medicaid ID No: (if applicable)___________________________
MHWIN ID No: ___________________________

Dear ____________:

We received your (Insert either First Level Appeal request or Second Level Appeal request) on <insert date>.

However, in order to make a fair and informed determination, we are requesting the following information be sent within five (five) calendar days:

- Psychiatric Evaluation
- Nursing Assessment
- Social Work Assessment
- Substance Abuse Assessment
- Master Treatment Plan
- Attending Physician Progress Notes
- Clinical Group Progress Notes
- Clinical Individual Progress Notes
- Medication Administration Record
- Vital Signs and Meals Flow Chart
- Discharge Summary
- Other _______________________________________________________

Because of our request for additional information, we are extending the decision date by 14 calendar days. If you have any questions please contact DWMHA at 313-344-9099. Providers ask for the Utilization Department and enrollees/members ask for the Customer Service Department.

Sincerely,

<Name of Responsible Party>
>Title

Revised 5.10.17
Non-urgent request: A request for services for which application of the time periods for making a decision does not jeopardize the life or health of the enrollee/member or the enrollee/member’s ability to regain maximum function and would not subject the member to severe pain.

Urgent pre-service: A request for services where application of the time frame for making routine or non-life threatening care determinations could seriously jeopardize the life, health or safety of the enrollee/member or others, due to the enrollee/member’s psychological state or in the opinion of the practitioner would subject the member to adverse health consequences without the care or treatment.

Urgent-concurrent: A request for coverage of services made while an enrollee/member is in the process of receiving the requested services, even if there was not previous approval for the care.

Post-service request: A request for coverage of services that have already been received.

In a situation beyond DWMHA, Access Center, COPE or MCPN’s control such as in the case of waiting for an evaluation by a specialist, the pre-service non-urgent and post-service timeframes may be extended once for up to 15 calendar days. If DWMHA, Access Center, COPE or MCPN requests the extension they must do it within 15 days of a pre-service request or 30 calendar days of a post-service request and must notify the enrollee/member in writing within these timeframes of the need for an extension.

DWMHA, Access Center, COPE or MCPN is allowed to extend the urgent pre-service request if within 24 hours of receipt of request, a request is made to the enrollee/member or their representative for the specific information necessary to make the decision. The enrollee/member or their representative has 48 hours to provide the information.

If a non-urgent (standard) or post-service request lacks clinical information, DWMHA, Access Center, COPE or MCPN may request an extension once up to 15 calendar days if the needed information is requested from the enrollee/member or their representative and gives the enrollee/member or their representative at least 45 days to provide the information. The extension period begins on the date when the organization receives the enrollee/member’s or their representative’s response or at the end of the time period given to supply the information.

Revised 3.1.17