Independent Review Organization

POLICY

It shall be the policy of Detroit Wayne Mental Health Authority (DWMHA) that enrollees/members receiving and practitioners/providers requesting behavioral health services have access to an external review program whereby an independent review organization (IRO) will conduct an independent and impartial review of the medical necessity and appropriateness of behavioral health care and/or substance use services being provided, proposed to be provided, that have been provided to an enrollee/member or have been denied and appealed.

PURPOSE

The purpose of this policy is to provide procedural and operational guidance to DWMHA, Access Center, Crisis Service Vendor, Managers of Comprehensive Provider Networks (MCPN), Contractual staff, Network and Out of Network Providers, MI Health Link enrollees/members or their authorized representatives and all staff involved in utilization management functions with an external review program for an independent and impartial review by an independent review organization of the medical necessity and appropriateness of behavioral health care and/or substance use services being provided, proposed to be provided, or that have been provided to a MI Health Link employee/member.

APPLICATION

This policy applies to DWMHA staff, IRO, 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.

KEYWORDS

1. Action
2. Appeal
3. Adverse Determinations
4. Authorization
5. Behavioral Health Supports and Services
6. Expedited Appeal
7. Independent Review Organization (IRO)
8. Medical Necessity Appeal
9. Pended
10. Same Specialty
11. Similar Specialty

STANDARDS

1. A case may be referred to an IRO under the following circumstances:
   a. All internal appeal requests have been exhausted for MI Health Link enrollee/members; or
   b. A physician with the same or similar area of specialty as the original provider(s) is not available; or
   c. There is not a physician reviewer who is a subordinate of the previous physician decision maker; or
   d. A provider or enrollee/member specifically requests an IRO; or
   e. An impartial review is required; or
   f. The denial reason is “not medically necessary” and considered to be experimental/investigational.

2. All requests by providers must be in writing to DWMHA and include at a minimum the following information:
   a. An explanation of what is being requested to be reviewed by the IRO and the name, address and telephone number of the person responsible for filing the request; and
   b. Any additional supporting documentation such as additional clinical information that has not been previously submitted.

3. The provider’s request for an external review by an IRO can be standard or expedited. An expedited review is a request to review a decision concerning eligibility, benefit coverage, screening, admission, continued/concurrent stay, or other behavioral health and/or substance use services for an enrollee/member who has received urgent services but has not been discharged from a facility, or when a delay in decision-making might seriously jeopardize an enrollee/member’s life, health, or ability to attain, maintain, or regain maximum function. Note that expedited external reviews are not available when services have already been rendered.

4. DWMHA will assess any requests for an expedited external review and determine if there is clinical rationale that shows the decision or delay in making the decision may have an adverse impact on the enrollee/member’s health and well-being. If an expedited request does not meet the expedited criteria, the appeal will be re-directed through the standard external review process and notification mailed to the provider within twenty four (24) hours of the decision to process as a standard appeal.

5. The IRO utilizes a network of board-certified physicians with diverse specialties, who have appropriate experience and expertise to render a decision for each independent review request.

6. The IRO upon receipt of a case review request, will select a credentialed psychiatrist who has a current Michigan license and at least five (5) years experience and is currently engaged in clinical practice twenty (20) hours or more per week.
7. If it is a substance use disorder (SUD) case, the IRO will provide a psychiatrist who in addition to meeting the requirements in #5 and #6 will also be certified in addiction medicine.

8. Upon receipt of a request for an IRO review, the following information will be emailed to the IRO:
   a. a copy of the provider’s written request for an IRO review;
   b. the complete clinical case record/documentation; and
   c. the completed IRO Referral Review Request form.

9. Upon receipt of the above information: the IRO shall complete an external review according to the following time frames:
   a. For a urgent review within twenty four (24) hours of receipt of the request; or
   b. For a standard review or a post-service review within seven (7) calendar days of receipt of the request.

10. The time frame starts upon receipt of the request for a review and ends once the organization issues a determination to all requisite parties as required by contract, law or regulation.

11. DWMHA does not influence the IRO review process and must adhere to and implement the IRO's decision within the time frame specified by the IRO.

12. The decision of the IRO is binding and final.

13. Enrollee/members and/or providers are not required to bear the costs of the IRO, including any filing fees.

QUALITY ASSURANCE/IMPROVEMENT

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

The quality improvement programs of MCPNs, their subcontractors, and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWMHA staff, Access Center, IRO, Crisis Service Vendor, MCPNs, 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
2. Contact between United States Department of Health and Human Services, Center 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 DWMHA Contract, October 1, 2016
RELATED POLICIES

1. Appropriate Professionals for Utilization Management Decision Making Policy
2. Behavioral Health Utilization Management Review Policy
3. Behavioral Health Medical Necessity Policy
4. Customer Service Enrollee/Member Appeal Policy
5. Denial of Service Policy
6. Member Grievance Policy
7. Utilization Management/Provider Appeals Policy
8. Utilization Management/Provider Local and Alternative Dispute Resolution 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 Disorders
10. Utilization Management

CLINICAL POLICY

YES

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

Acknowledgement of Provider IRO Review Request Form.doc
IRO Physician Reviewer Documentation Form.docx
IRO Procedures.docx
IRO Referral Review Request Form.docx
Notice of IRO Decision Form.docx
<table>
<thead>
<tr>
<th>Approver</th>
<th>Date</th>
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<tbody>
<tr>
<td>Ronald Hocking: Chief Operating Officer</td>
<td>04/2017</td>
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<tr>
<td>Dana Lasenby: Deputy Chief Operating Officer</td>
<td>03/2017</td>
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<tr>
<td>Allison Smith: Project Manager, PMP</td>
<td>03/2017</td>
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<tr>
<td>Rolf Lowe: Assistant General Counsel/HIPAA Privacy Officer</td>
<td>03/2017</td>
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<tr>
<td>Michele Vasconcellos: Director, Customer Service</td>
<td>03/2017</td>
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<tr>
<td>Muddasar Tawakkul: Director of Compliance/Purchasing [AS]</td>
<td>03/2017</td>
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<tr>
<td>Bessie Tetteh: CIO</td>
<td>03/2017</td>
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<tr>
<td>Julia Kyle: Director of Integrated Care</td>
<td>03/2017</td>
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<td>tracey Lee: Director Claims Management</td>
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<tr>
<td>Lorraine Taylor-Muhammad: Director, Managed Care Operations</td>
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<tr>
<td>Kip Kliber: Director, Recipient Rights</td>
<td>03/2017</td>
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<tr>
<td>crystal Palmer: Director, Children's Initiatives</td>
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<tr>
<td>Corine Mann: Chief Strategic Officer/Quality Improvement</td>
<td>03/2017</td>
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<tr>
<td>Mary Allix</td>
<td>03/2017</td>
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<tr>
<td>Darlene Owens: Director, Substance Use Disorders, Initiatives</td>
<td>03/2017</td>
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<tr>
<td>Jody Connally: Director, Human Resources</td>
<td>03/2017</td>
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<tr>
<td>Stacie Durant: CFO Management &amp; Budget</td>
<td>03/2017</td>
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<tr>
<td>Carmen McIntyre: Chief Medical Officer</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>Diana Hallifield: Consultant</td>
<td>03/2017</td>
</tr>
<tr>
<td>Maha Sulaiman [AS]</td>
<td>03/2017</td>
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<tr>
<td>Sherri Ruza</td>
<td>03/2017</td>
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</table>
OVERVIEW

Procedure Purpose: To provide procedural and operational guidance to DWMHA, Access Center, Crisis Service Vendor, Managers of Comprehensive Provider Networks (MCPN), Contractual staff, Network and Out of Network Providers, enrollees/members or their authorized representatives and all staff involved in utilization management functions with an external review program for an independent and impartial review by an independent review organization of the medical necessity and appropriateness of behavioral health care and/or substance use services being provided, proposed to be provided, or that have been provided to an enrollee/member.

Expected Outcome: Enrollees/members and providers will receive an objective, unbiased review of the medical necessity and decision appropriateness of behavioral health care and/or substance use services being provided, proposed to be provided, or that have been provided to an enrollee/member.

References: N/A

KEYWORDS

1. Action
2. Appeal
3. Adverse Determination
4. Authorization
5. Behavioral Health Supports and Services
6. Concurrent (continued stay) Review
7. Independent Review Entity (IRO)
8. Medical Necessity Appeal
9. Pended
10. Pre-Service (prior authorized) Review
11. Post-Service (Retrospective) Review
12. Same Specialty
13. Similar Specialty
PROCEDURE

1. If the enrollee/member requests the review by the Independent Review Organization (IRO), it is handled by DWMHA’s Customer Service Department.

2. If the provider requests a review by the IRO, it is handled by DWMHA’s UM Department.

3. The IRO will be used by DWMHA, the Crisis Service Vendor or an MCPN if there is not a DWMHA, Crisis Service Vendor or MCPN physician reviewer available who is different from and not a subordinate of the physician who made the previous determination or a physician with the similar or same specialty, credentials, licensure and training as those who typically treat the condition or health problem in question.

4. If use of the IRO is initiated by DWMHA, the Crisis Service Vendor or the MCPN, it is handled by DWMHA’s UM Department.

5. DWMHA, the Crisis Service Vendor, the MCPN, the provider or enrollee/member can request an expedited review by the IRO as long as the enrollee/member has not been discharged from the treatment/services.

6. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person will assess any requests for an expedited review and determine if there is clinical rationale that shows the decision or delay in making the decision may have an adverse impact on the enrollee/member’s health and well-being. If an expedited request does not meet the expedited criteria, the review will be re-directed through the standard review process and notification mailed to the provider within twenty four (24) hours of the decision to process as a standard review.

7. Upon receipt of the provider request, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person scans and uploads the standardized Acknowledgement of Provider IRO Review Request form to the case in their electronic system and then mails it to the provider and enrollee/member within twenty four (24) hours of receipt of an expedited review or within five (5) calendar days of receipt of a standard review request.

8. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person must document the date and type (IRO review and standard or expedited) of the provider’s request and the date the Acknowledgement of Provider IRO Review Request form is sent to the provider and enrollee/member in their tracking log and in their electronic system.

9. If the provider’s requests for an IRO review is to the Crisis Service Vendor or the MCPN, the designated Crisis Service Vendor or designated MCPN staff person must fax the following to the DWMHA UM Appeal Coordinator:
   - a copy of the provider’s written request for an IRO review;
   - the complete clinical case record/documentation; and
   - all correspondences from and received by the Crisis Service Vendor or the MCPN concerning the treatment, including all appeal correspondences i.e. action notice form, acknowledgement of appeal request form, notice of appeal decision form.

10. The above information must be faxed within one (1) hour of receipt of an expedited review request or within one (1) calendar day of receipt of a standard review request.

11. The designated Crisis Service Vendor or designated MCPN staff person must document the date and time, he/she received the provider’s request for an IRO review on the fax cover sheet that is sent with the clinical case record in order for the DWMHA UM Appeal Coordinator to document the time and date of the original request in the DWMHA tracking log and in MHWIN.

12. The DWMHA UM Appeal Coordinator then scans and uploads all of the information received from the Crisis Service Vendor or the MCPN in the case in the DWMHA electronic system (MHWIN).

13. The DWMHA UM Appeal Coordinator completes the standardized IRO Referral Request form and scans and uploads it to the case in MHWIN.
14. The DWMHA UM Appeals Coordinator then forwards the following via fax or email to the IRO:
   ✓ a copy of the provider’s written request for an IRO review;
   ✓ the complete clinical case record/documentation;
   ✓ all correspondences from and received by the Crisis Service Vendor or the MCPN concerning
     the treatment, including all appeal correspondences i.e. action notice form,
     acknowledgement of appeal request form, notice of appeal decision form; and
   ✓ the standardized IRO Referral Review Request form.

15. The DWMHA UM Appeal Coordinator will forward the above information to the IRO within the same
day of receipt from the Crisis Service Vendor, MCPN or Provider request for an expedited review
request; within two (2) calendar days of receipt from the Crisis Service Vendor, MCPN or Provider’s
request for a standard review request or within five (5) calendar days of receipt from the Crisis Service
Vendor, MCPN or Provider’s request for a post-service review.

16. If the IRO was involved in the previous decision, the DWMHA UM Appeal Coordinator ensures that
the physician who reviews the case is different from and not a subordinate of any other physician who
has previously reviewed the case and that any other physician/appropriate professional who has
previously reviewed the case has a similar or same specialty, credentials and licensure as those who
typically treat the condition or health problem in question. The complete name and credentials of the
physician is entered in the DWMHA tracking log which is used to monitor this.

17. Upon receipt of the information listed in number 13 above, the IRO has the following timeframes to
review and make a determination:
   a. For a urgent review within twenty four (24) hours of receipt of the request; or
   b. For a standard review or a post-service review within seven (7) calendar days of receipt
      of the request.

17. The IRO physician will complete the standardized IRO Physician Reviewer Documentation form.

18. The IRO will notify the DWMHA UM Appeal Coordinator via email or telephonically of the decision
within three (3) hours for an expedited review request or within two (2) calendar days of a standard
review request. The IRO will also fax the completed IRO Physician Reviewer Documentation form to
the DWMHA UM Appeal Coordinator.

19. If the decision by the IRO physician is to approve services or overturn part or all of the denial of
services by the Crisis Service Vendor or the MCPN, the DWMHA UM Appeal Coordinator will contact
the designated Crisis Service Vendor or designated MCPN staff person either telephonically or by
email about the IRO decision when the authorization is to be generated by the Crisis Service Vendor
or MCPN. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or
designated MCPN staff person enters the authorization of services in their electronic system. Written
notification is concurrently sent to the provider and enrollee/member and a copy of the letter is
retained in their electronic system. The DWMHA UM Appeal Coordinator, designated Crisis Service
Vendor or designated MCPN staff person will ensure that written notification is sent to the provider
and enrollee/member within seventy-two (72) hours for an expedited IRO review request or within
ten (10) calendar days of a standard or post service IRO review request.

20. If the decision by the IRO physician is to deny services or uphold part or all of the denial of
services by the Crisis Service Vendor or MCPN, the DWMHA UM Appeal Coordinator will immediately
contact the designated Crisis Service Vendor or designated MCPN staff person either telephonically or by
email about the IRO decision when the denial is to be generated by the Crisis Service Vendor or MCPN.

21. Within three (3) hours of the decision, the DWMHA UM Appeal Coordinator, designated Crisis Service
Vendor staff person or designated MCPN staff person verbally notifies the provider about the
determination and explains the appeal rights and process.

22. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff
person documents the date and time of the verbal and written notification in their tracking log.
23. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person must also document the complete name and credentials of the person to whom the verbal notification was given and the date and time of the verbal notification in the case notes in their electronic system.

24. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person completes the standardized Notice of IRO Decision form, scans it and uploads it to the case in their electronic system and then mails it to the provider and enrollee/member.

25. If the Notice of IRO Decision form is manually generated, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person will scan the Notice and attach it to the case in their electronic system.

26. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person will ensure that written notification is sent to the provider and enrollee/member within seventy-two (72) hours for an expedited IRO review request or within ten (10) calendar days of a standard or post service IRO review request.

27. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor or designated MCPN staff person documents the date the Notice of IRO Decision form (if applicable) is mailed in their tracking log and their electronic system.

28. The Notice of IRO Decision form includes a statement that the decision of the IRO is binding and final.

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**PROCEDURE MONITORING & STEPS**

<table>
<thead>
<tr>
<th>Who monitors this procedure:</th>
<th>DWMHA UM Appeals Coordinator</th>
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<tbody>
<tr>
<td>Department:</td>
<td>Utilization Management</td>
</tr>
<tr>
<td>Frequency of monitoring:</td>
<td>Monthly</td>
</tr>
<tr>
<td>Reporting provided to:</td>
<td>Director of UM</td>
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<tr>
<td>Regulatory Requirement(s):</td>
<td>NCQA-UM 4, element D and the MI Health Link Three Way Contract as of September 1, 2015</td>
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**MONITORING STEPS**

1. The designated Access Center, designated Crisis Service Vendor and designated MCPN staff persons must forward via email their completed standardized tracking log to the DWMHA UM Appeals Coordinator by the 10th of each month for compliance monitoring. In addition, a copy of the appeal case is forwarded to the DWMHA UM Appeals Coordinator for purpose of performing an audit to ensure the case was processed in accordance with the UM Provider Appeal Policy and Procedures.

2. The results of the monthly audits will be reported to the DWMHA UM Director as well as to the designated Access Center, designated Crisis Service Vendor or designated MCPN staff member.

3. Quarterly results of the audits will be presented to the Utilization Management Committee (UMC).
# Independent Review Organization Referral Review Request Form

<table>
<thead>
<tr>
<th>Case Priority:</th>
<th>Expedited</th>
<th>Standard</th>
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</table>

**Enrollee/Member Name:**

**Enrollee/Member’s Address:**

**DOB:**

**Telephone Number:**

**Provider Name:**

**Provider Address:**

**Treating Physician Name and Credentials:**

**Telephone Number:**

**Name of Person responsible for filing the request:**

**Telephone Number:**

**Level and Type of Services in Dispute:**

**Dates of Services in Dispute:**

**Type of Services Currently Authorized (if applicable):**

**Dates of Services Currently Authorized (if applicable):**

**Reason for the IRO referral:**
Chronology of Care: (This should be a brief overview of the timeline of events in this case.)

| DWMHA Contact Person: DWMHA UM Appeal Coordinator | Telephone Number: 313-344-9099 ext. 3328 |
| Fax Number: 313-833-3670 |
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.

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

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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, ATTENTION: MELODY
## Notice of Independent Review Organization (IRO) Decision

### 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.”

<table>
<thead>
<tr>
<th>Mailing Date:</th>
<th>Enrollee/Member Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrollee/Member Name:</strong></td>
<td><strong>Beneficiary ID (enrollee/member Medicaid ID Number):</strong></td>
</tr>
</tbody>
</table>

Provider Name:

This Notice is in response to the request for an external review by our IRO, MPRO that we received on (insert date)

Type of Service Subject to Review:

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**Your request was (approved, partially denied or denied)**

Your review request was thoroughly considered. This is to inform you that our IRO, MPRO, *(Insert appropriate term: denied or partially denied)* your request for the services/item listed below:

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**Why did we (approve, partially deny or deny) your appeal?**

MPRO *(Insert appropriate term: denied or partially denied)* your request for the service/item listed above because:

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You should share a copy of this decision 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 decision to your doctor.

For providers, the decision of our IRO, MPRO, is binding and final.

### For Enrollees/Members only:

**How to request a Michigan Medicaid Fair Hearing with MAHS**

To request a Michigan Medicaid Fair Hearing you must follow the directions on the enclosed “Request for Hearing” form which was also sent to you on (mailing date) along with our “Notice of Appeal Decision”. You must ask for a Michigan Medicaid Fair Hearing within 90 calendar days after the mailing date on that initial notice. If you need another copy of the form, you can request one by calling DWMHA.

Please note, if you have already asked for a Michigan Medicaid Fair Hearing on this issue, you cannot ask for another Michigan Medicaid Fair Hearing.

9/11/2017
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.

If the standard timeframe for review would jeopardize your life or health, 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 at (517)-335-6088. If you qualify for an expedited 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 Hearing process, including the expedited, fast Michigan Medicaid Fair Hearing, you can call MAHS at (517)-335-6088.

Michigan Administrative Hearing System (MAHS)
PO Box 30763
Lansing, MI. 48909

Continuation of Services
If we previously approved coverage for a service but then decided to reduce or stop the service before the authorization expired, you can continue your benefits during the reconsideration process in some cases.

• If the service is covered by Michigan Medicaid, your benefits for that service will continue if:
  o You asked for an appeal with MAHS within 12 calendar days from the date of the letter that told you that the service would be reduced or stopped OR
  o You qualified for continuation of benefits during your appeal with the plan and you ask for a reconsideration with MAHS within 12 calendar days from the date of this notice.

• If the service could be covered by both Medicare and Medicaid and you qualified for continuation of benefits during the appeal with the plan, your benefits for that service will automatically continue during the reconsideration review. You may also qualify for continuation of benefits during the MAHS review if you submit your request within the timeframes listed above.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal; 2) all entities that got your appeal decide “no” to your request; or 3) the authorization expired or you receive all of the services that were previously approved.

Access to Documents
You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing to:

Detroit Wayne Mental Health Authority (DWMHA)
707 W. Milwaukee Street
Detroit, MI. 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 the DWMHA Utilization Management Department. You can also visit our website at www.dwmha.com
- 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).
- DWMHA’s 24 hour Crisis Helpline Toll Free: 1-800-241-4949, (TTY:711)

Detroit Wayne Mental Health Authority is a behavioral health plan that subcontracts with Aetna Better Health of Michigan, AmeriHealth Michigan, Fidelis Secure 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 free1-888-490-9698, 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 informacion gratuitamente en español o en varios formatos, tal como enletras 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 الاتصال برقمه الهاتف المجاني 9698-490-888-1.خلال مواعيد العمل الرسمية من الاثنين إلى الجمعية من الساعة 8:00 صبحاً إلى الساعة 4:30 مساءً.

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