



Origination:	05/2017
Last Approved:	06/2018
Last Revised:	06/2018
Next Review:	06/2019
Owner:	<i>Sherri Ruza</i>
Policy Area:	<i>Utilization Management</i>
References:	<i>NCQA UM 8</i>

Utilization Management/Provider Local and Alternative Dispute Resolution

POLICY

It is the policy of Detroit Wayne Mental Health Authority (DWMHA) that uninsured or under insured enrollees/ members receiving and practitioners/providers requesting behavioral health and/or substance use services have access to a local and alternative dispute resolution review process consistent with state and federal requirements.

PURPOSE

The purpose of this policy is to provide procedural and operational guidance to DWMHA, the Access Center, the Crisis Service Vendor, Managers of Comprehensive Provider Networks (MCPNs), Contractual staff, Network and Out of Network Providers, uninsured or under insured enrollees/members and all staff involved in utilization management functions for the development and consistent processing of UM local and alternative dispute resolution reviews.

APPLICATION

This policy applies to DWMHA staff, the Access Center, the Crisis Service Vendor, Managers of Comprehensive Provider Networks (MCPNs), Contractual staff. This policy serves all populations: adults children, This policy applies to DWMHA staff, the Crisis Service Vendor staff, Managers of Comprehensive Provider Network (MCPN) staff, Contractual staff. This policy serves all populations: Adults, Children, 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). This policy impacts the uninsured or under insured enrollee/member.

KEYWORDS

1. Action
2. Alternative Dispute Resolution Hearing
3. Administrative Appeal
4. Adverse Determination
5. Benefit Appeal

6. Expedited Appeal
7. Grievance
8. Independent Review Organization (IRO)
9. Medical Necessity Appeal
10. Recipient Rights Complaint
11. Same Specialty
12. Similar Specialty

STANDARDS

1. DWMHA, the Crisis Service Vendor, the IRO and/or the MCPNs' UM staff will:
 - a. Ensure that all local and alternative dispute resolution processes are:
 1. Timely;
 2. Fair to all parties;
 3. Administratively simple;
 4. Objective and credible;
 5. Accessible and understandable to the enrollee/members and providers;
 6. Subject of quality improvement review;
 7. Developed in a manner to assure that the individual provider/practitioner who participates in the appeal process on behalf of the enrollee/member are free from discrimination or retaliation;
 8. Developed in a manner to assure that they do not interfere with communication between the enrollee/member and the recipient of services;
 9. Developed in a manner to assure that an enrollee/member who requests an appeal is free from discrimination or retaliation.
 - b. Ensure that staff and providers are compliant with the local and alternative dispute resolution requirements as evidenced by:
 1. Including all necessary language in contracts and requiring contractor's language is in compliance with state and federal requirements;
 2. Structuring the local and alternative dispute resolution process that promotes the resolution of the enrollee/member's concerns about services;
 3. Providing technical assistance and training on the local and alternative dispute resolution process to promote the resolution of concerns as well as support and enhance services;
 4. Engaging providers in consultative meetings to provide information and guidance in establishing and implementing the local and alternative dispute resolution policy;
 5. Providing standardized documents related to the local and alternative dispute resolution process in the form of templates to providers to customize with their specific identifying information;
 6. Ensure all forms related to the local and alternative dispute resolution process are available, easily accessible, understandable and linguistically appropriate to enrollees/members and providers via websites, Individual Plan of Service meetings and at provider sites;

7. Incorporate a written procedure in operational manuals consistent and compliant with this policy;
 8. DWMHA, Crisis Service Vendor and the MCPNs' local and alternative dispute resolution materials are 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/or the MCPNs will provide materials in alternative formats to meet the needs of vision and/or hearing impaired enrollees/members, including large font (at least 16 point font), Braille and audio formats. Translation services will be provided at no cost the enrollee/member.
- c. Provide access to one or more of the following dispute resolution options that may be utilized:
1. Grievance;
 2. Recipient Rights Complaint
 3. Alternative Dispute Resolution Review
- d. Provide in writing the standardized [Advance Notice of Adverse Benefit Determination form \(Uninsured or Under Insured\)](#) or the standardized [Adequate Notice of Adverse Benefit Determination form \(Uninsured or Under Insured\)](#) to the enrollee/member and provider in the event of an adverse action.
- e. The Notice form shall include:
1. A statement of what action is being taken in easy, understandable language which does not include:
 - i. abbreviations or acronyms that are not defined; and
 - ii. is culturally and linguistically sensitive to the enrollee/member's needs; and
 - iii. health care procedure codes that are not explained.
 2. An explanation of the action including the denial of services in amount, scope and duration if less than what is requested;
 3. 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;
 4. A statement that there is only one (1) internal level of review for all pre-service, concurrent and/or post-service provider/practitioner medical necessity or benefit denials and a description of the expedited and standard local dispute review process including time frames;
 5. A statement that the enrollee/member has a right to an (external) alternative dispute resolution review with the Michigan Department of Health and Human Services (MDHHS) and an explanation of how to file an alternative dispute resolution review;
 6. A statement that the standard local (internal) review must occur prior to the enrollee/member requesting an (external) alternative dispute resolution review with MDHHS;
 7. 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 standardized Appointment of Representative form and the [Local Dispute Review Request form \(Uninsured or Under Insured\)](#) to DWMHA;
 8. 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 the local dispute resolution review;
9. A statement that the enrollee/member, his/her legal representative and/or provider can request copies of all documents relevant to the local dispute resolution review, free of charge; and
 10. Includes the title and qualification, including specialty of the reviewer participating in the dispute review for a medical necessity determination and the reviewers title for a benefit determination. The reviewers' name does not have to be included in the enrollee/members written notification.
- f. The standardized [Advance Notice of Adverse Benefit Determination form \(Uninsured or Under Insured\)](#) is sent to the enrollee/member regarding a decision to reduce, suspend or terminate services currently authorized or provided. The standardized [Adequate Notice of Adverse Benefit Determination form \(Uninsured or Under Insured\)](#) is sent to the enrollee/member regarding a decision to deny or limit services being requested.
- g. Within ten (10) calendar days of the Notice, the physician, physician certified in addiction medicine and/or provider can verbally or in writing request a telephonic peer to peer review before requesting a local dispute resolution review as long as the enrollee/member has not been discharged from the treatment/services. This is **NOT** considered to be a local dispute review.
- h. For all pre-service and post-service medical necessity and benefit local dispute resolution reviews:
1. DWMHA, the Crisis Service Vendor, the IRO and/or the MCPN physician or physician certified in addiction medicine shall make reasonable attempts to review telephonically with the treating physician or in any case where a final adverse or adverse action determination is anticipated (i.e. the requested services is not medically necessary). The treating physician is expected to comply with these efforts in a timely manner per his/her contractual review requirements. In those situations where the attending/treating practitioner does not comply with the telephonic review, a clinical adverse action determination may be rendered.
 2. An eligibility, benefit coverage, screening, and/or clinical adverse action determination may only be made when the clinical information presented does not meet screening, benefit and/or medical necessity criteria. The DWMHA, the Crisis Service Vendor, IRO and/or MCPN physician or physician with an addiction-medicine certification must provide written documentation to justify the eligibility, screening, benefit or clinical adverse action determination, and the documentation must include an explanation of the next level review process. The individual rendering the adverse action determination must have their written signature with credentials on the document.
 3. DWMHA, the Crisis Service Vendor and MCPNs shall provide practitioners with an opportunity to discuss any UM adverse determinations with a physician reviewer upon request by calling the appropriate UM Department (DWMHA, Crisis Service Vendor or MCPN).
 4. DWMHA, the Crisis Service Vendor, IRO and MCPN staff are prohibited from taking any punitive actions toward a provider who requests a local dispute resolution review.
2. *DWMHA, the Crisis Service Vendor and the MCPNs' UM staff will adhere to the UM Provider Local Dispute Resolution Process for the Uninsured or Under Insured enrollee/member:*
- a. ***Pre-Service (Redetermination) Medical Necessity or Benefit Local Dispute Resolution Review:***
 1. The provider/practitioner and/or enrollee/member has up to thirty (30) calendar days from the receipt of the standardized [Adequate Notice of Adverse Benefit Determination form \(Uninsured or Under Insured\)](#) or the standardized [Advance Notice of Adverse Benefit](#)

- [Determination form \(Uninsured or Under Insured\)](#) to request a pre-service (redetermination) medical necessity or benefit internal local dispute resolution review with DWMHA. (Per MDHHS and DWMHA (CMHSP) contract, September 2017).
2. The provider/practitioner's request for a pre-service (redetermination) internal medical necessity or benefit local dispute review can be verbal or in writing to DWMHA, If the enrollee/member has been discharged from services, treatment, or care then the post-service local dispute review process must be followed.
 3. All requests for a pre-service (redetermination) internal medical necessity or benefit local dispute resolution review must include at a minimum the following:
 - i. An explanation of what is being disputed and the name, address and telephone number of the person responsible for filing the local dispute resolution request;
 - ii. Any new additional supporting documentation or evidence such as additional clinical information that has not been previously submitted; and
 - iii. The staff member preparing case for physician review will review all information in their electronic medical record system and gather any other information available such as previous dispute resolution reviews and follow-up care that has occurred after the denial.
 4. The provider's request for a pre-service (redetermination) internal medical necessity or benefit local dispute resolution review can be standard or expedited. An expedited local dispute is a request to review a decision concerning eligibility, benefit coverage, screening, admission, continued/concurrent stay, or other behavioral health care 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.
 5. The provider/practitioner or enrollee/member has up to ten (10) calendar days from receipt of the standardized [Adequate Notice of Adverse Benefit Determination form \(Uninsured or Under Insured\)](#) or the standardized [Advance Notice of Adverse Benefit Determination form \(Uninsured or Under Insured\)](#) to request an expedited (redetermination) internal medical necessity or benefit local dispute resolution review as long as the enrollee/member is actively receiving treatment/services.
 6. DWMHA shall send the standardized [Notice of Receipt of Local Dispute Resolution Request form \(Uninsured or Under Insured\)](#) within twenty four (24) hours of a pre-service expedited (redetermination) medical necessity or benefit local dispute resolution review request or within five (5) calendar days of a pre-service standard (redetermination) medical necessity or benefit local dispute resolution review request to the enrollee/member and provider.
 7. DWMHA then has seventy two (72) hours from receipt of the pre-service expedited (redetermination) medical necessity or benefit local dispute resolution review request to review and make a determination or within thirty (30) calendar days from receipt of the pre-service standard (redetermination) medical necessity or benefit local dispute resolution review request to review and make a determination.
 8. The enrollee/member and/or DWMHA may need to ask for an extension to obtain more information that will assist in the local dispute resolution process using the standardized [Request for Additional Information form \(Uninsured or Under Insured\)](#) which is sent to the provider and the standardized [Enrollee Agreement for Request for Additional Information form \(Uninsured or Under Insured\)](#) to the enrollee/member.

9. DWMHA and/or the enrollee/member can request the necessary information as long as the request is within fourteen (14) calendar days of the original turnaround time frame. If DWMHA is requesting the extension, they must notify the enrollee/member in writing of the request for extension. If the enrollee/member is not in agreement to this extension, he/she may file an expedited oral or written grievance with DWMHA.
10. For a pre-service (redetermination) internal medical necessity or benefit local dispute resolution review request, the physician who reviews the case is different from and not a subordinate of the physician who made the initial denial decision, and that the physician who reviews the case has a similar or same specialty, credentials, licensure and training as those who typically treat the condition or health problem in question.
11. Upon receipt of the pre-service (redetermination) medical necessity or benefit local dispute review request, the physician will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
12. The reviewing physician when reviewing a medical necessity local dispute review, in conjunction with independent professional medical judgment, will use nationally recognized guidelines, which include but are not limited to, third party guidelines, CMS guidelines, State guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.
13. The physician who made the original denial determination may review the case and overturn the initial denial.
14. A pre-service standard or expedited (redetermination) medical necessity or benefit local dispute resolution review request that results in upholding part or all of the initial denial is communicated verbally to the provider within three (3) hours of the decision. Written notification using the standardized [Notice of Local Dispute Resolution Denial form \(Uninsured or Under Insured\)](#) and the standardized [Physician Letter \(Uninsured or Under Insured\)](#) are sent to both the provider and enrollee/member within twenty four (24) hours of the decision. The only exception is when the decision for a pre-service expedited review is made on the last/3rd calendar day or when the decision is made for a pre-service standard review on the last/30th calendar day. In these cases, the standardized [Notice of Local Dispute Resolution Denial form \(Uninsured or Under Insured\)](#) and the standardized [Physician Letter \(Uninsured or Under Insured\)](#) must be mailed on the same day as the determination.
15. The standardized [Notice of Local Dispute Resolution Denial form \(Uninsured or Under Insured\)](#) must include a statement that this is the only internal level of review.
16. The standardized [Notice of Local Dispute Resolution Denial form \(Uninsured or Under Insured\)](#) must also include a statement that the enrollee/member has a right to a request an external Alternative Dispute Resolution Hearing with the Michigan Department of Health and Human Services (MDHHS) and an explanation of the process for an Alternative Dispute Resolution review.
17. The request for an external Alternative Dispute Resolution Hearing must be in writing and sent by the uninsured or under insured enrollee/member to:
Department of Health and Human Services
Division of Program Development, Consultation and Contracts
Bureau of Community Mental Health Services
ATTN: Request for MDHHS Level Dispute Resolution

Lewis Cass Building – 6 th Floor
Lansing, MI 48193

18. A pre-service standard or expedited (redetermination) medical necessity or benefit local dispute resolution review request that results in overturning part or all of the initial denial is communicated verbally to the provider within three (3) hours of the decision. For a complete overturned determination, written notification using the standardized [Notice of Local Dispute Resolution Approval form \(Uninsured or Under Insured\)](#) and the standardized [Physician Letter \(Uninsured or Under Insured\)](#) are sent within twenty four (24) hours of the decision. For a partially overturned determination, written notification using the standardized [Notice of Local Dispute Resolution Denial form \(Uninsured or Under Insured\)](#) and the standardized [Physician Letter \(Uninsured or Under Insured\)](#) are sent to both the provider and enrollee/member within twenty four (24) hours of the decision. The only exception is when the decision for a pre-service expedited local dispute resolution review decision is made on the last/3rd calendar day or when the decision for a pre-service standard local dispute resolution review is made on the last/30th day. In these cases, the standardized applicable Notice and Physician Letter must be mailed on the same day as the determination.
 19. The DWMHA physician is available to discuss a pre-service medical necessity or benefit local dispute resolution denial determination.
- b. ***Post-Service (Retrospective) (Redetermination) Medical Necessity or Benefit Local Dispute Resolution Review:***
1. An eligibility, benefit coverage, screening and/or clinical review of all documentation relevant to the appeal **after** the services have been provided is considered a post-service retrospective review. The review may be conducted for all or part of the treatment service/or encounter.
 2. The provider/practitioner and/or enrollee/member has up to thirty (30) calendar days from the receipt of the standardized [Adequate Notice of Adverse Benefit Determination form \(Uninsured or Under Insured\)](#) or the standardized [Advance Notice of Adverse Benefit Determination form \(Uninsured or Under Insured\)](#) to request a post-service (redetermination) medical necessity or benefit local dispute resolution review with DWMHA.
 3. The provider's request for a post-service medical necessity or benefit local dispute resolution review must be in writing to DWMHA.
 4. All requests for a post-service (redetermination) medical necessity or benefit local dispute resolution review must include at a minimum the following:
 - i. An explanation of what is being disputed and the name, address and telephone number of the person responsible for filing the local dispute resolution request; and
 - ii. The complete medical record including but not limited to intake, psychiatric evaluation, emergency department summary, physician progress notes, social work evaluation and progress notes, nurse evaluation and progress notes, consultations, labs and tests, treatment, medication administration notes and discharge summary.
 5. DWMHA shall send the standardized [Notice of Receipt of Local Dispute Resolution Review Request form \(Uninsured or Under Insured\)](#) within five (5) calendar days of a post-service (redetermination) medical necessity or benefit local dispute resolution review request to the enrollee/member and provider.
 6. DWMHA then has thirty (30) calendar days from receipt of the post-service (redetermination)

medical necessity or benefit local dispute resolution review request to review and make a determination.

7. A physician with the same or similar specialty will review the post-service (redetermination) medical necessity and benefit local dispute resolution review and will not be a subordinate of the physician who rendered the initial denial.
8. Upon receipt to the post-service (redetermination) medical necessity or benefit local dispute resolution review request, the physician will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
9. The reviewing physician when reviewing a medical necessity or benefit local dispute review request, in conjunction with independent professional medical judgment, will use nationally recognized guidelines, which include but are not limited to, third party guidelines, CMS guidelines, State guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.
10. A post-service (redetermination) medical necessity or benefit local dispute resolution review request that results in upholding part or all of the initial denial is communicated verbally to the provider within three (3) hours of the decision. Written notification using the standardized [Notice of Local Dispute Resolution Denial form \(Uninsured or Under Insured\)](#) and the standardized [Physician Letter \(Uninsured or Under Insured\)](#) are sent to both the provider/practitioner and enrollee/member within twenty four (24) hours of the decision. The only exception is when the decision for a post-service review is made on the last/30th calendar day. In this case, the standardized applicable Notice and the standardized [Physician Letter \(Uninsured or Under Insured\)](#) must be mailed on the same day as the determination.
11. The standardized [Notice of Local Dispute Resolution Denial form \(Uninsured or Under Insured\)](#) must include a statement that this is the only internal level of review.
12. The standardized [Notice of Local Dispute Resolution Denial form \(Uninsured or Under Insured\)](#) must also include a statement that the enrollee/member has a right to a request an external Alternative Dispute Resolution Hearing with the Michigan Department of Health and Human Services (MDHHS) and an explanation of the process for an Alternative Dispute Resolution review.
13. The request for an external Alternative Dispute Resolution Hearing must be in writing and sent by the uninsured or under insured enrollee/member to:
Department of Health and Human Services
Division of Program Development, Consultation and Contracts
Bureau of Community Mental Health Services
ATTN: Request for MDHHS Level Dispute Resolution
Lewis Cass Building – 6 th Floor
Lansing, MI 48193
14. A post-service (redetermination) internal local dispute resolution review request that results in overturning part or all of the initial denial is communicated verbally to the provider within three (3) hours of the decision. For a complete overturn determination, written notification using the standardized [Notice of Local Dispute Resolution Approval form \(Uninsured or Under Insured\)](#) and the standardized [Physician Letter \(Uninsured or Under Insured\)](#) are sent within twenty four (24) hour of the decision. For a partially overturned determination, written notification

using the standardized [Notice of Local Dispute Resolution Denial form \(Uninsured or Under Insured\)](#) and the standardized [Physician Letter \(Uninsured or Under Insured\)](#) are sent to both the provider and enrollee/ member within twenty four (24) hours of the decision. The only exception is when the decision for a post-service local dispute resolution review is made on the last/30th day. In this case, the standardized applicable Notice and the standardized [Physician Letter \(Uninsured or Under Insured\)](#) must be mailed on the same day as the determination.

15. The DWMHA physician is available to discuss a post-service medical necessity or benefit local dispute resolution denial determination.

c. ***Post-Service (Retrospective) (Redetermination) Administrative Local Dispute Resolution Review:***

1. The provider/practitioner has up to thirty (30) calendar days from the receipt of the standardized [Notice of Administrative Denial form \(Uninsured or Under Insured\)](#) to request an internal post-service administrative local dispute resolution review with DWMHA, the Crisis Service Vendor or the MCPN.
2. The provider's request must be in writing to DWMHA, the Crisis Service Vendor or the MCPN.
3. DWMHA, the Crisis Service Vendor and the MCPNs have one (1) local dispute resolution review level for an administrative denial. An example of an administrative denial is failure to authorize services in accordance with required time frames.
4. Once the service or procedure has occurred or the enrollee/member has been discharged from the facility, the provider/practitioner must utilize the described post-service process in order to request a local dispute review.
5. The provider/practitioner's request for a post-service internal (redetermination) administrative local dispute review must be in writing to DWMHA, the Crisis Service Vendor or the MCPN.
6. All requests for a post-service (redetermination) internal administrative local dispute resolution review must include at a minimum the following:
 - i. An explanation of what is being disputed and the name, address and telephone number of the person responsible for filing the local dispute resolution; and
 - ii. Documentation including the request, the reasons why the provider feels the services should be paid, and a copy of claim(s). The review request must also include new supporting evidence and or documentation justifying the service, care or treatment in question and the reason for notification outside of DWMHA's, the Crisis Service Vendor or MCPN's notification time frames.
7. All enrollee/member administrative local dispute resolution review requests are handled by DWMHA's Customer Service Department. Enrollees/members are to be held financially harmless for any provider/practitioner administrative denials.
8. DWMHA, the Crisis Service Vendor or the MCPN shall send the standardized [Notice of Receipt of Local Dispute Resolution Review Request form \(Uninsured or Under Insured\)](#) within five (5) calendar days of receipt of a post-service standard internal administrative local dispute resolution review request to the provider and enrollee/member.
9. DWMHA, the Crisis Service Vendor or the MCPN will review all documentation submitted with the review request and determine if the review request is based on medical necessity or only on not meeting notification time frames. If the review request is based on medical necessity, it will

be forwarded to a physician for review, if the request is based on time frames only, then the review request will be forwarded to a Supervisor for review.

10. DWMHA, the Crisis Service Vendor and/or the MCPN then has thirty (30) calendar days from receipt of a post-service (redetermination) provider/practitioner internal administrative local dispute resolution review request to review and make a determination.
11. A post-service (redetermination) provider/practitioner internal administrative local dispute resolution review request that results in upholding part or all of the initial denial of is communicated verbally to the provider/practitioner within three (3) hours of the decision. Written notification using the standardized [Administrative Local Dispute Review Determination Form \(Uninsured or Under Insured\)](#) is sent to both the provider/practitioner and enrollee/member within twenty four (24) hours of the decision. The only exception is when the decision for a post-service appeal is made on the last/30th day. In this case, the standardized [Administrative Local Dispute Review Determination form \(Uninsured or Under Insured\)](#) must be mailed on the same day as the determination.
12. The Administrative Local Dispute Resolution Review Determination Form must include a statement that this is the final level of review and that the enrollee/member is held harmless and provide direction the enrollee/member take if he/she receives a bill.
13. A post-service (redetermination) provider/practitioner internal administrative local dispute resolution review request that results in overturning part or all of the initial denial, is communicated verbally to the provider within three (3) hours of the decision. For a partial overturning decision, written notification using the standardized [Administrative Local Dispute Review Determination form \(Uninsured or Under Insured\)](#) is sent to both the provider and enrollee/member within twenty four (24) hours of the decision. If the decision is made on the 30th day, then the standardized [Administrative Local Dispute Review Determination form \(Uninsured or Under Insured\)](#) must be sent the same day.
14. A DWMHA, Crisis Service Vendor, or MCPN professional staff is available to discuss a post-service administrative local dispute resolution denial determination

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 programs or processes 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 appropriate vignettes from the Inter-Rater Reliability Indicia MCG module to assess Inter-Rater Reliability system wide based on the types of review the UM staff performs.
 - 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 and an item response analysis and detailed assessment report that pinpoints any areas the staff need additional training.
- c. It is the expectation of DWMHA that staff meet or exceed a score of 90%
 - d. In the event that a staff person does not meet or exceed the 90% 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 person pass at the next Inter-Rater Reliability case review test.
5. One additional re-test of 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 90%.
 - b. In the event that the person does not meet or exceed the 90% threshold, he/she will be subject to transfer outside the UM Department or to termination.
 6. The results of the Inter-Rater Reliability case review tests will be used to identify areas of variation among decision makers and/or types of decisions. The results will also 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 applicable appeal cases and their 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 review all (100%) denial and applicable 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.
 12. 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.
 13. 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
2. MDHHS and DWMHA (CMHSP) Contract, September 1, 2017
3. Title II, American with Disabilities Act of 1990, Public Laws 101-336
4. Michigan Mental Health Code, PA 258 of 1974, as amended
5. Michigan Department of Health and Human Services
6. United States Department of Health and Human Services, Office of Civil Rights, Limited English Proficiency Policy Guidance, 65 Fed. Reg. 52781

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. SUD Recipient Rights
8. UM 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 Disorders
10. Utilization Management

CLINICAL POLICY

YES

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

COPY

- Adequate Notice of Adverse Benefit Determination Form (Uninsured or Underinsured).docx
- Administrative Local Dispute Review Determination Form (Uninsured or Under Insured).docx
- Advance Notice of Adverse Benefit Determination Form (Uninsured or Underinsured).docx
- Appointment of Representative Form.pdf
- Enrollee Agreement for Request for Additional Information Form (Uninsured or Under Insured).docx
- IRO Physician Reviewer Documentation Form.docx
- IRO Referral Review Request Form.docx
- Local Dispute Resolution Review Request Form (Uninsured or Under Insured).doc
- Notice of Administrative Denial Form (Uninsured or Under Insured).docx
- Notice of Local Dispute Resolution Approval Form (Uninsured or Underinsured).docx
- Notice of Local Dispute Resolution Denial Form (Uninsured or Underinsured).docx
- Notice of Receipt of Local Dispute Resolution Request Form (Uninsured or Underinsured).docx
- Physician Letter (Uninsured or Under Insured).docx
- Post-Service Provider Local and Alternative Dispute Resolution Procedures for Uninsured or Under Insured.docx
- Pre-Service Provider Local and Alternative Dispute Resolution Procedures for Uninsured or Under Insured.docx
- Request for Additional Information Form (Uninsured or Under Insured).docx

Approval Signatures

Approver

Date

Dana Lasenby: Acting Chief Executive Officer

06/2018

Approver

Date

COPY

Applicability

Detroit Wayne Mental Health Authority



Adequate Notice of Adverse Benefit Determination Detroit Wayne Mental Health Authority

Important: This notice explains your internal appeal rights. Read this notice carefully. If you need help with this notice or asking for an appeal, you can call one of the numbers listed on the last page under “Get help & more information.”

Mailing Date:

Member ID: < MHWIN ID >

Name: <Member’s Name>

Type of Service Subject to Notice: Non-Medicaid

This is to tell you that the following action has been taken:

[Enter information regarding the adverse benefit determination taken to deny, reduce, suspend or terminate a covered benefit or payment with effective dates]:

This action is based on the following:

[Include citations with descriptions that are understandable to the member or applicable State and Federal rule, law and regulation that supports 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 can share a copy of this decision with your provider so you and your provider can discuss the next steps. If your provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

If you don’t agree with our action, you have the right to an Internal Local Dispute Review

You have to ask Detroit Wayne Mental Health Authority (DWMHA) for an internal appeal within **30 calendar days** of the date of this notice. You, your representative or your Provider can request an appeal verbally and/or in writing. If you need help filing your appeal, you can ask your provider or call DWMHA. The request must include:

- Your name
- Address
- Member Number
- Reason for appealing
- Whether you want a standard or fast local dispute review (for an expedited or a fast review, explain why you need one),
- Any evidence you want us to review, such as medical records, doctor(s) letters or other information that explains why you need the item or service. If you are asking for a fast local dispute review, you will need a doctor’s supporting statement. Call your doctor if you need this information.



Please keep a copy of everything you send us for your records.

There are 2 kinds of internal local dispute reviews:

Standard Local Dispute Review –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 you want to ask for an internal appeal, you can either call or send a written request to:

Detroit Wayne Mental Health Authority
707 W. Milwaukee Avenue
Detroit, MI 48202-2943
For providers, attention: UM Department
For enrollee/members: attention: Customer Service Department

Expedited or Fast Local Dispute Review – We'll give you a decision on a fast appeal within **72 hours** after we get your request. You can ask for a fast local dispute review 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 local dispute review if a doctor asks for one for you or supports your request.** If you ask for a fast local dispute review without support from a doctor, we'll decide if your request requires a fast review. If we don't give you a fast review, we'll give you a decision within **30 calendar days**. To ask for a fast review, you must call:

For members: Phone: 888-490-9698
TTY: 800-630-1044
Fax: 313-833-2217

For Providers: Phone: 313-344-9099 ext. 3328
TTY: 800-630-1044
Fax: 313-833-3680

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 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.

Access to Documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relative to your local dispute review. You must submit the request in writing.

What happens next?

- If you ask for an internal dispute review and we continue to deny your request for coverage or payment of a service, we'll send you a written Notice of Appeal Denial form. If you disagree with the decision, you can request an Alternate Dispute Resolution.
- The Notice of Appeal Denial will give you additional information about the Alternate Dispute Resolution process [or Patient Right to Independent Review Act] and how to file the request.



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
 - DWMHA's 24 hour Crisis Helpline Toll Free: 1-800-241-4949 (TTY: 711).
-

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](tel:1-888-490-9698), TTY [1-800-630-1044](tel: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](tel:888-490-9698) (TTY: [1-800-630-1044](tel: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 صوتياً عن طريق الإتصال برقم الهاتف المجاني 1-888-490-9698. خلال مواعيد العمل الرسمية من الإثنين إلى الجمعة من الساعة 8:00 صباحاً إلى الساعة 4:30 مساءً

CC: Provider, Enrollee/Member



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

ADMINISTRATIVE LOCAL DISPUTE RESOLUTION REVIEW DETERMINATION FORM

Date

Name
Address
City State Zip Code

Re: Member/Enrollee's Name:

Medicaid /Healthy Michigan/MI Health Link / No insurance (Circle all that apply) ID:

MHWIN ID:

We received your request for a local dispute review. Following the administrative local dispute review of services and supports for which you have requested, it has been determined that the following service(s) are being:

Authorization Request:

Service(s)

Effective Date(s)

The reason for this action is:

Member: If you receive a bill, please contact **Detroit Wayne Mental Health Authority (DWMHA)** at (313) 487-4400 or TTY (313) 487-4400. Your services will not be denied, reduced, suspended or terminated as a result of an Administrative denial.



Provider: This is the Final Level of Review. If you would like to speak with the professional who rendered the determination regarding the decision, please call the UM Department.

**Decision Maker (Printed Name) with
Credentials/Job Title**

Decision Maker's Signature

Date

cc: Service Provider & Member



Advance Notice of Adverse Benefit Determination Detroit Wayne Mental Health Authority

Important: This notice explains your internal appeal rights. Read this notice carefully. If you need help with this notice or asking for an appeal, you can call one of the numbers listed on the last page under “Get help & more information.”

Mailing Date:

Member ID: < MHWIN ID>

Name: <Member’s Name>

Type of Service Subject to Notice: Non-Medicaid

This is to tell you that the following action has been taken:

[Enter information regarding the adverse benefit determination taken to deny, reduce, suspend or terminate a covered benefit or payment with effective dates]:

This action is based on the following:

[Include citations with descriptions that are understandable to the member or applicable State and Federal rule, law and regulation that supports 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 can share a copy of this decision with your provider so you and your provider can discuss the next steps. If your provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

If you don’t agree with our action, you have the right to an Internal Local Dispute Review

You have to ask Detroit Wayne Mental Health Authority (DWMHA) for an internal appeal within **30 calendar days** of the date of this notice. You, your representative or your Provider can request an appeal verbally and/or in writing. If you need help filing your appeal, you can ask your provider or call DWMHA. The request must include:

- Your name
- Address
- Member Number
- Reason for appealing
- Whether you want a standard or fast local dispute review (for an expedited or a fast review, explain why you need one),
- Any evidence you want us to review, such as medical records, doctor(s) letters or other information that explains why you need the item or service. If you are asking for a fast local dispute review, you will need a doctor’s supporting statement. Call your doctor if you need this information.



Please keep a copy of everything you send us for your records.

There are 2 kinds of internal local dispute reviews:

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Detroit Wayne Mental Health Authority
707 W. Milwaukee Avenue
Detroit, MI 48202-2943
For providers, attention: UM Department
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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 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.

Access to Documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relative to your local dispute review. You must submit the request in writing.

What happens next?

- If you ask for an internal dispute review and we continue to deny your request for coverage or payment of a service, we’ll send you a written Notice of Appeal Denial form. If you disagree with the decision, you can request an Alternate Dispute Resolution.
- The Notice of Appeal Denial will give you additional information about the Alternate Dispute Resolution process [or Patient Right to Independent Review Act] and how to file the request.



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
 - DWMHA's 24 hour Crisis Helpline Toll Free: 1-800-241-4949 (TTY: 711).
-

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](tel:1-888-490-9698), TTY [1-800-630-1044](tel: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](tel:888-490-9698) (TTY): [1-800-630-1044](tel: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 صوتياً عن طريق الإتصال برقم الهاتف المجاني 1-888-490-9698. خلال مواعيد العمل الرسمية من الإثنين إلى الجمعة من الساعة 8:00 صباحاً إلى الساعة 4:30 مساءً

CC: Provider, Enrollee/Member

Appointment of Representative

Name of Party	Medicare or National Provider Identifier Number
---------------	---

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):
I appoint this individual, _____ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the "Act") and related provisions of title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation	Date	
Street Address	Phone Number (with Area Code)	
City	State	Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative	Date	
Street Address	Phone Number (with Area Code)	
City	State	Zip Code

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

Signature	Date
-----------	------

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date
-----------	------

Charging of Fees for Representing Beneficiaries Before the Secretary of the Department of Health and Human Services

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of the Department of Health and Human Services (DHHS) (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR §405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation

Authorization of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent): (1) your appeal if you are filing an appeal, (2) grievance if you are filing a grievance, or (3) initial determination or decision if you are requesting an initial determination or decision.

If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



ENROLLEE / MEMBER AGREEMENT FOR ADDITIONAL INFORMATION REQUEST

Date

Enrollee/Member Name

Address

City, State, Zip Code

Re: Enrollee/Member's Name: _____

MHWIN ID No: _____

Dear _____:

We received the request for an appeal change to 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 for a standard appeal request and immediately for an expedited appeal request from you 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 for a standard appeal request and within seventy two hours (72) for an expedited appeal request. 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

IRO Physician Reviewer Documentation Form

Member's Name:

Member's Date of Birth:

Provider Name:

Physician Name and Credentials:

Admission Date *(if applicable)*:

Last Authorized Day *(if applicable)*:

Review Type

Expedited Appeal

Initial

Standard Appeal

Continued Stay

Retrospective

Level of Care under Review

Mental Health:

Inpatient

Partial Hospitalization

Crisis Residential

ECT

Autism Spectrum Disorder

Other: _____

Substance Use Disorder:

Withdrawal Management

Residential Rehabilitation

Intensive Out-Patient

Out-Patient

Other: _____

Telephone Calls/Communication: *(Include all telephone calls and other communications conducted or received from onset of review to completion between MPRO and any other party regarding the case. Be sure to document findings.)*

Date/Time	Time Zone	Person/Mean of Contact	Results

Case Summary:

Medical Necessity Criteria Reviewed:

MCG for Inpatient Hospitalization, Crisis Residential Services, Partial Hospitalization

American Society of Addiction Medicine (ASAM) for Substance Use Disorder (SUD) Services

Medicaid Provider Manual for Autism Spectrum Disorder (ASD)

Reviewer's Decision:

Initial Disposition:

- Approve requested services
- Deny requested services
- Partially approve requested services (specify) _____

Appeal Disposition:

- Uphold denial of services
- Overturn the denial of services
- Modify the denial of services (specify) _____

Clinical Rational for Decision: (Include a reference to the benefit provision, guideline, protocol or other similar criterion with descriptions that are understandable to the member that supports the decision.)

1. _____

2. _____

3. _____

4. _____

Quality of Care Issues:

- Yes (describe): _____
- No

*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.*

I further certify that I do not have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity, the health benefits plan, the covered person whose treatment is the subject of this review, the covered person's authorized representative, the attending provider or other health care provider on the case, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review, the facility at which the recommended treatment will be or was provided, the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the patient.

Your case was reviewed by a Board certified psychiatrist **OR** Board certified forensic psychiatry **OR** Board certified child psychiatry **OR** certified addiction medicine physician. The physician reviewer has been certified since insert year. The physician reviewer is a insert MD **OR** DO.

Physician Signature, Title, Credentials and Specialty:

Date:

**When you complete the case, FAX your review to:
248-305-7093; ATTN: MELODY**



INDEPENDENT REVIEW ORGANIZATION REFERRAL REVIEW REQUEST FORM

Case Priority: Expedited <input type="checkbox"/>		Standard <input type="checkbox"/>	
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 Denial
and Appeal Coordinator

Telephone Number: 313-344-9099 ext. 3328
Fax Number: 313-833-3670



UNINSURED OR UNDER INSURED LOCAL DISPUTE RESOLUTION REQUEST FORM

SECTION Local Dispute Resolution Request

<input type="checkbox"/> Oral Request Date : <input type="text"/>	<input type="checkbox"/> Written Request Date: <input type="text"/>
Local Dispute Resolution Request for Providers: <input type="checkbox"/> Standard Resolution (<input type="text"/> days) or <input type="checkbox"/> Expedited Resolution (<input type="text"/> hours)	
Local Dispute Resolution Request for Enrollees/Members: <input type="checkbox"/> Standard Resolution (<input type="text"/> days) or <input type="checkbox"/> Expedited Resolution (<input type="text"/> hours)	
Who is requesting Local Dispute Resolution: <input type="checkbox"/> Enrollee/member <input type="checkbox"/> Authorized Representative <input type="checkbox"/> Provider	

SECTION Enrollee/member Information

Enrollee/Member's Name		Home phone <input type="text"/>		Work or Cell phone <input type="text"/>	
Address (No. & Street, Apt <input type="text"/> , etc.)			City		State
					<input type="checkbox"/> IP Code
Date of Birth	MHWIN ID <input type="text"/>	Member Signature		Date Signed	

SECTION Provider Information

Name of Provider:						Office phone <input type="text"/>		Date of Notice	
Address (No. & Street, Apt <input type="text"/> , etc.)				City		State		<input type="checkbox"/> IP Code	
Provider Contact Person:				Provider Signature				Date Signed	

SECTION Have you chosen someone to assist or represent you with this request

<input type="checkbox"/> YES (please fill in information below) <input type="checkbox"/> NO							
Name of Authorized Representative:			Home phone <input type="text"/>		Work or Cell phone <input type="text"/>		
Address (No. & Street, Apt <input type="text"/> , etc.)			City		State		<input type="checkbox"/> IP Code
Representative Signature						Date Signed	



SECTION Reason for Local Dispute Resolution

The following are my reason(s) for requesting a local dispute resolution. Use Additional Sheets if Needed.

I would like an opportunity to look at case/medical file or any records that will be considered during the appeal

Yes NO Date: Time: Staff Name:

I would like an opportunity to present information for review/ consideration during the appeal process

Yes NO Date: Time: Staff Name:

Form completed by:

Date completed:



INSTRUCTIONS FOR COMPLETION

SECTION Local Dispute Resolution Request

Check off if the request is filled out by enrollee/member, provider or authorized representative or if the form is being completed due to an oral request.

SECTION Enrollee/Member Information

Enter information about the enrollee/member who is the requesting the local dispute resolution, including the provider information.

SECTION Provider Information

Enter information about the provider who is the requesting the local dispute resolution, including the provider information.

SECTION Have you chosen someone to assist or represent you with this request

Enter information that identifies the authorized representative – the enrollee/member may choose someone to represent them or assist with the appeal process.

SECTION Reason for Local Dispute Resolution Request

This form may be completed by the enrollee/member, provider, authorized representative, or any person including D, M, A, M, PN or staff person who is assisting the uninsured or underinsured enrollee/member with the Local Dispute Resolution process.



Detroit Wayne Mental Health Authority (DWMHA)
100 West Milwaukee Street
Detroit Michigan 48201

NOTICE OF ADMINISTRATIVE DENIAL FORM

Date

Name
Address
City **State** **Zip Code**

Re: Member/Enrollee's Name:

Medicaid /Healthy Michigan/MI Health Link / No insurance (Circle all that apply) ID:

MHWIN ID:

We have received your request for a local dispute resolution review. Following the administrative review of services and supports for which you have requested, it has been determined that that the following service(s) are being administratively denied:

Authorization Request

Service(s)	Effective Date(s)
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

The reason for this action is:

This is due to contractual requirement(s) that was/were not met by the Provider. The member is not to be billed or held financially responsible for this administrative denial.



Member: If you receive a bill, please contact **Detroit Wayne Mental Health Authority (DWMHA)** at (313) 487-4400 or TTY(313) 487-4400. Your services will not be denied, reduced, suspended or terminated as a result of an Administrative denial.

Provider: If you do not agree with this action, **you may request an Administrative 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) 487-4400 or TTY (313) 487-4400. For a provider/utilization management appeal, ask for the UM Appeal Coordinator.

Decision Maker (Printed Name) with

Credentials/Job Title

Decision Maker's Signature

Date

cc: Service Provider & Member



Notice of Local Dispute Resolution Approval Detroit Wayne Mental Health Authority

Important: This notice explains the results of your appeal. 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’s MHWIN ID#:

Name: <Member’s Name>

This Notice is in response to the local dispute resolution request that we received on <date local dispute resolution received>

Type of Service Subject to Notice: Non Medicaid

Your local dispute review was approved

Your local dispute review was thoroughly considered. This is to inform you that we approved your local dispute resolution review for the service/item listed below:

What this means:

Because your Local Dispute Resolution decision was approved, you may receive the following services as of <date authorized>: [List the services that were approved, including any applicable information about coverage amount, duration, etc. 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.]



If you do not receive the services or if the services are wrongly stopped or reduced, tell us immediately using the contact information below.

Detroit Wayne Mental Health Authority
707 W. Milwaukee Avenue
Detroit, MI 48202-2943
Phone: 888-490-9698
TTY: 1-800-630-1044
Fax: 1-313-833-2217

For enrollees/members, ask for the Customer Service Department
For providers, ask for the UM Department

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 local dispute review. You must submit the request in writing.

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
- DWMHA's 24 Hour Crisis HelpLine Toll Free: 1-800-241-4949, (TTY: 711).

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](tel:1-888-490-9698), TTY [1-800-630-1044](tel: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 برايل، بخط كبير أو صوتياً عن طريق الإتصال برقم الهاتف المجاني 1-888-490-9698. خلال مواعيد العمل الرسمية من الإثنين إلى الجمعة من الساعة 8:00 صباحاً إلى الساعة 4:30 مساءً

CC: Provider, Enrollee/Member



Notice of Local Dispute Resolution Denial Detroit Wayne Mental Health Authority

Important: This notice explains the results of your appeal. 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’s MHWIN ID#:

Name: <Member’s Name>

This Notice is in response to the internal local dispute resolution request that we received on <date local dispute resolution received>

Type of Service Subject to Notice: Non Medicaid

Your internal local dispute resolution request was denied

Your local dispute resolution request was thoroughly considered. This is to inform you that we [denied or partially denied] your internal local dispute resolution request for the service/item listed below:

Why did we deny your local dispute resolution request?

We [denied or partially denied] your internal local dispute resolution request for the service/item listed below:

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

You can also obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based, free of charge upon request .

If you don’t agree with our decision, you have the right to further appeal

You have the right to an External Review also known as an Alternate Dispute Resolution. The Alternate Dispute Resolution is reviewed by an independent organization that is not connected to us. You can file an Alternate Dispute Resolution yourself.



You can request an Alternate Dispute Resolution in writing by mailing your request to the following address:

**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 11TH FLOOR
LANSING MI 48201**

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 local dispute review. You must submit the request in writing.

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
- DWMHA's 24 Hour Crisis HelpLine Toll Free: 1-800-241-4949, (TTY: 711).

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](tel:1-888-490-9698), TTY [1-800-630-1044](tel: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.**

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CC: Provider, Enrollee/Member



Notice of Receipt of Local Dispute Review Request Detroit Wayne Mental Health Authority

Important: Read this notice carefully. If you need help, you can call one of the numbers listed on the next page under “Get help & more information.”

Mailing Date:

Member’s MHWIN ID#:

Name: <Member’s Name>

Type of Service Subject to Notice: Non Medicaid

This Notice is in response to a request that we received on <date received>.

You filed a Local Dispute Resolution Request:

We received your request for a Local Dispute Resolution Request on <date received>. You are appealing the decision made by <Service Provider/MCPN> to <description of subject of appeal>.

WHAT THIS MEANS

For enrollees/members, a decision on this appeal will be made by <the date received plus 30 calendar days >. A letter will be mailed to you telling you what our decision is and why we made that decision.

For providers, a decision will be made within thirty (30) calendar days from the date of your request. A letter will be mailed to you telling you what our decision is and why we made that decision.

For enrollees/members, we may contact you for more information or if we have more questions. If you have any questions or additional information to provide please call 313.344.9099/phone, 313.833.2217/fax.

For providers, we may contact you for more information or if we have more questions. If you have any questions or additional information to provide please call 313.344.9099 ext. 3328/phone, 313.833.3607/fax.

If you want someone to represent you

At any time during the process you may have another person act for you or help you. This person will be your representative. If you want someone to act for you, you must tell us that in writing.

If you already have someone to represent you, or if you have a legal guardian, power of attorney or someone authorized to make health care decisions on your behalf, you do not have to do anything else.

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
 - DWMHA's 24 hour Crisis Helpline Toll Free: 1-800-241-4949 (TTY: 711).
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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](tel:1-888-490-9698), TTY [1-800-630-1044](tel: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](tel:888-490-9698) (TTY: [1-800-630-1044](tel:1-800-630-1044)) durante las horas de trabajo: 8:00 am a 4:30 pm de Lunes a Viernes. **La llamada es gratuita.**

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CC: Provider and Enrollee/Member



Detroit Wayne
Mental Health Authority
707 W. Milwaukee St.
Detroit, MI 48202-2943
Phone: (313) 833-2500
www.dwmha.com

FAX: (313) 833-2156
TDD: (800) 630-1044 RR/TDD: (888) 339-5588

Date:

Address:

RE: Member Name: Member MHWIN ID:
Services Requested:

Dear Member/Provider:

Your case was reviewed by, insert Physician Name, a Board certified psychiatrist **or** Board certified forensic psychiatry **or** Board certified child psychiatry **or** certified addiction medicine physician. The Physician Consultant **or** Medical Director has been certified since insert year and is a insert MD **or** DO.

Detroit Wayne Mental Health Authority (DWMHA) provides your treating provider with the opportunity to discuss any Utilization Management (UM) denial decisions with a physician by contacting *DWMHA* at 3133449099.

Based on the clinical information available, we are not able to authorize this service because:

After reviewing our UM criteria, known as, MCG **or** ASAM **or** ASD Medical Necessity, for


we believe that your condition
in insert *partial hospitalization* **or**
crisis residential **or** *outpatient program* **or** Since your symptoms

 is *denied* **or** *partiall* denied

A copy of the criteria supporting this decision is available free of charge by contacting *DWMHA* at 3133449099 or members, asfor the Customer Service Department and for providers, asfor the UM Department

Respectfully,

insert DWMHA physician's complete name, title and credentials or the DWMHA's UM Denial and/or Appeals Coordinator's complete name, title and credentials

	Procedure Title: Post-Service UM Provider Local and Alternative Dispute Resolution Procedure
	Procedure Origination Date: 4/1/17
	Procedure Revision Date: 1/15/18
	Procedure Owner: Tasha Bridges, LLPC
	Department: Utilization Management
	Line of Business: Uninsured or Under insured
	Regulatory Requirements: Michigan Mental Health Code, PA 258 of 1974, as amended. MDHHS and DWMHA (CMHSP) contract, September 2017
	Associated Policy: UM Provider Local and Alternative Dispute Resolution Policy

OVERVIEW

Procedure Purpose: To provide procedural and operational guidance to all staff involved in utilization management functions for the development and consistent processing of Post-Service UM/Provider (retrospective) local and alternative dispute resolution reviews.

Expected Outcome: DWMHA, the Crisis Service Vendor, Managers of Comprehensive Provider Networks (MCPN) and the Independent Review Organization (IRO) will be compliant and consistent in the processing of post-service UM/Provider local and alternative dispute resolution reviews for uninsured or under insured enrollee/members.

References: N/A

KEYWORDS

1. Administrative Appeal
2. Benefit Appeal
3. Independent Review Organization (IRO)
4. Medical Necessity Appeal

PROCEDURE

Post-Service Eligibility, Screening, Benefit or Medically Necessary Appeals:

1. The DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person or designated MCPN staff person verbally informs the provider of the determination and sends via mail the standardized the Advance Notice of Adverse Benefit Determination form or the Adequate Notice of Adverse Benefit Determination form for the Uninsured or Under Insured which explains the adverse action including the denial of service in amount, scope and duration less than what was requested, reason for the adverse action and local dispute resolution process to the enrollee/member, physician and/or provider. The DWMHA UM Appeal Coordinator, the designated Crisis Service Vendor staff person or designated MCPN staff person documents the date of the Action Notice form in their tracking log and in their electronic system.

Post-Service 1st Level Redetermination Medical Necessity or Benefit Local and Alternative Dispute Resolution Review:

1. The physician and/or provider has thirty (30) calendar days from the date of the standardized the Advance Notice of Adverse Benefit Determination form or the Adequate Notice of Adverse Benefit Determination form for the Uninsured or Under Insured to request a post-service (redetermination) medical necessity or benefit internal local dispute resolution review to DWMHA. (Per MDHHS and DWMHA (CMHSP) contract September 2017).
2. The provider’s request for a post-service (redetermination) medical necessity or benefit internal local dispute resolution review must be in writing to DWMHA.

3. For all requests for a post-service (redetermination) medical necessity or benefit internal local dispute resolution review, the provider must email at appeals@dwmha.com to the DWMHA UM Appeal Coordinator at a minimum the following:
 - a. An explanation of what is being disputed and the name, address and telephone number of the person responsible for filing the Local and Alternative Dispute Resolution request; and
 - b. The complete medical record (at a minimum the intake, psychiatric evaluation, psychiatric progress notes, social work evaluation, social work progress notes, nurse evaluation, nurse progress notes, medication administration notes and discharge summary) if not provided previously; and
 - c. Any additional supporting documentation that has not been previously submitted.
4. If the above information is sent to the Crisis Service Vendor or the MCPN, the designated Crisis Service Vendor staff person or designated MCPN staff person must email the information to the DWMHA UM Appeal Coordinator at appeals@dwmha.com within three (3) business days of receipt of the information. The DWMHA UM Appeal Coordinator then scans and uploads the information into the case in MHWIN.
5. Upon receipt of the provider's request for a (redetermination) medical necessity or benefit local dispute resolution review, the DWMHA UM Appeal Coordinator completes, scans and uploads the standardized Notice of Receipt of Appeal form for the Uninsured or Under Insured form in MHWIN and then mails it to the provider and enrollee/member within five (5) calendar days of receipt of a post-service (redetermination) medical necessity or benefit internal local dispute resolution review request.
6. The DWMHA UM Appeal Coordinator must document the date, time, type (post-service, medical necessity or benefit, standard) and the method of notification (written) of the post-service (redetermination) medical necessity or benefit local dispute resolution request and the date the Notice of Receipt of Appeal form for the Uninsured or Under Insured form is sent to the provider and enrollee/member in the tracking log and in MHWIN.
7. For a post-service (redetermination) medical necessity or benefit local dispute resolution review request, the DWMHA UM Appeal Coordinator ensures that the physician who reviews the case is different from and not a subordinate of the physician who made the initial denial decision and that the physician who reviews the case has a similar or same specialty, credentials, licensure and training as those who typically treat the condition or health problem in question. The complete name and credentials of the physician is entered in their tracking log which is used to monitor this.
8. Upon receipt of the post-service (redetermination) medical necessity or benefit local resolution review request, the physician will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
9. The reviewing physician when reviewing a medical necessity local resolution review, in conjunction with independent professional medical judgment, will use nationally recognized guidelines, which include but are not limited to, third party guidelines, CMS guidelines, State guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.
10. The physician who made the original denial determination may review the case and overturn the initial denial.
11. A determination and written notification of the determination by the DWMHA is required within thirty (30) calendar days of receipt of a post-service (redetermination) medical necessity or benefit local dispute resolution review request. The only exception is when the decision for a post-service (redetermination) local dispute resolution review is made on the last/30th calendar day. In this case, the standardized Notice for the Uninsured or Under Insured form and Physician Letter for the Uninsured or Under Insured must be mailed on the same day as the determination.
12. The DWMHA UM Appeals Coordinator completes the Physician Referral Review form in MHWIN. Also, any additional information that is sent in with the review request is scanned and attached to case in MHWIN. The MHWIN case is then placed in a MHWIN queue for a DWMHA physician to review.
13. The DWMHA UM Appeal Coordinator manually checks the MHWIN queue twice a day to ensure that a DWMHA physician has retrieved the case from the queue and reviews it within the appropriate timeframe.

14. For a post-service redetermination) medical necessity or benefit local dispute resolution review, the DWMHA UM Appeal Coordinator will communicate via email, face to face or telephonically with the DWMHA physician reviewer if after the initial seven (7) calendar days the DWMHA physician has not reviewed the case.
15. The IRO physician can be used in the following circumstances:
 - a. A physician with the same or similar area of specialty as the original provider(s);
 - b. There is not a physician reviewer who is a subordinate of the previous decision maker;
 - c. A provider specifically requests an IRO;
 - d. An impartial review is required; or
 - e. The denial reason is “not medically necessary and considered to be experimental/investigational.
16. If an IRO physician is used, the IRO designated staff person will follow their own internal procedures to ensure the IRO physician reviews the case within the appropriate timeframes.
17. The DWMHA physician will document their decision in MHWIN and document their name, title, and credentials if not done by electronic signature.
18. The DWMHA physician will then immediately notify via email the DWMHA UM Appeal Coordinator 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 at appeals@dwmha.com.
20. The DWMHA UM Appeal Coordinator must document the physician reviewer’s complete name and credentials and the type of decision rendered (approve, deny or split decision), the decision date and the date of the Notice in the tracking log and in MHWIN.
21. If the decision is to **overturn** part or all of the initial denial, the DWMHA UM Appeal Coordinator verbally notifies the provider within three (3) hours of the decision and documents the date and time of the verbal notification in the tracking log.
22. If the services are for the SMI, IDD and SUD population who are uninsured or under insured, the DWMHA UM Appeal Coordinator will also immediately notify via email or telephone the designated MCPN staff person about the decision to overturn the initial denial so the MCPN can enter the authorization into their electronic system.
23. For a complete overturned determination, written notification using the standardized Notice of Approval form for the Uninsured or Under Insured population and the standardized Physician Letter are sent within twenty four (24) hours of the decision. For a partially overturned determination, written notification using the standardized Notice of Appeal Denial form for the Uninsured or Under Insured and the standardized Physician Letter for the Uninsured or Under Insured are sent to both the provider and enrollee/member within twenty four (24) hours of the decision. The only exception is when the decision for a post-service local dispute resolution review decision is made on the last/30th day. In this case, the Notice and Physician Letter must be mailed on the same day as the determination.
24. The Notice and Physician Letter are sent to the provider and enrollee/member by the DWMHA UM Appeal Coordinator who also retains a copy in MHWIN.
25. The DWMHA UM Appeal Coordinator will ensure that written notification is sent to the provider and enrollee/member within thirty (30) calendar days of a post-service medical necessity or benefit local dispute resolution review request.
26. The DWMHA UM Appeal Coordinator must 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 MHWIN.
27. The DWMHA UM Appeal Coordinator or designated MCPN staff person must also enter the authorization of services in their electronic system within twenty-four (24) hours of determination.
28. The DWMHA UM Appeal Coordinator or designated MCPN staff person documents the date the authorization was issued in their tracking log.

29. If the decision is to **uphold** part or all of the initial denial, the DWMHA UM Appeal Coordinator verbally notifies the provider within three (3) hours of the decision and documents the date and time of the verbal notification in their tracking log. Written notification is sent within twenty four (24) hours of the determination to the provider and enrollee/member and provider using the standardized Notice of Appeal Denial form for the Uninsured or Under Insured and the standardized Physician Letter for the Uninsured or Under Insured. The only exception is when the decision for a post-service local dispute resolution review is made on the last/30th calendar day. In this case, Notice and Physician Letter must be mailed on the same day as the determination.
30. The Notice and Physician Letter are sent to the provider and enrollee/member by the DWMHA UM Appeal Coordinator who also retains a copy in MHWIN.
31. The DWMHA UM Appeal Coordinator will ensure that written notification is sent to the provider and enrollee/member within thirty (30) calendar days of a post-service (redetermination) medical necessity or benefit local dispute resolution review.
32. The DWMHA UM Appeal Coordinator 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 MHWIN.
33. If the Notice and Physician Letter are manually generated, the DWMHA UM Appeal Coordinator will scan the Notice and Physician Letter and attach them to the case in MHWIN.
34. The DWMHA UM Appeal Coordinator must review the Notice of Appeal Denial form for the Uninsured or Under Insured to ensure it the form 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;
 - ✓ 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 this is the final internal level of review;
 - e. A statement that the enrollee/member has a right to an (external) alternative dispute resolution review with the Michigan Department of Health and Human Services (MDHHS) and a description of the review process including time frames;
 - f. A statement that the standard local (internal) review must occur prior to an the enrollee/member requesting an (external) alternative dispute resolution review with MDHHS;
 - g. 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 standardized Appointment of Representative form to DWMHA;;
 - 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. Includes a list of the titles and qualifications, including specialties of the individuals participating in the internal local dispute review.
35. The DWMHA UM Appeal Coordinator documents the date the Notice of Appeal Denial form for the Uninsured or Under Insured or the Notice of Appeal Approval form for the Uninsured or Under Insured is mailed in the tracking log and in MHWIN.
36. The designated Crisis Service Vendor staff person and designated MCPN staff person forward via email their complete tracking log to the DWMHA UM Appeals Coordinator by the 10th of each month for compliance monitoring.

Post-Service Provider Administrative Appeal:

1. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person verbally informs the physician and/or provider of the determination and sends via mail the standardized Notice of Adverse Determination form for the Uninsured or Under Insured which explains the adverse action, reason for the adverse action (administrative reasons) and the review process to the enrollee/member, physician and/or provider. The DWMHA UM Appeal Coordinator, the designated Crisis Service Vendor staff person or designated MCPN staff person documents the date of the Action Notice in their tracking log and in their electronic system. .

Post-Service Redetermination Provider Administrative Local Dispute Resolution Review:

1. The physician and/or provider has thirty (30) calendar days from the receipt of the standardized Uninsured or Under Insured Advance Notice form to request a post-service 1st level (redetermination) administrative internal local dispute resolution review request to DWMHA. (Per MDHHS and DWMHA (CMHSP contract September 2017)
2. The provider's request for a post-service (redetermination) administrative internal local dispute resolution review request must be in writing to DWMHA, the Crisis Service Vendor or the MCPN.
3. All requests for a post-service (redetermination) administrative internal local dispute resolution review, must include at a minimum the following:
 - An explanation of what is being disputed and the name, address and telephone number of the person responsible for filing the local dispute resolution review request; and
 - Any additional supporting documentation such as additional clinical information that had not been previously submitted; and
 - Documentation including the request, reasons why the provider feels the services should be paid and a copy of the claim(s).
4. Upon receipt of the provider's request for a post-service (redetermination) administrative local dispute resolution review request, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person completes the standardized Notice of Receipt of Appeal form for the Uninsured or Under Insured, scans it and uploads it to the case in their electronic system and then mails it to the provider and enrollee/member within five (5) calendar days of receipt of a post-service (redetermination) administrative local dispute resolution review request.
5. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person must document the date and type (post-service, administrative and standard) and method of notification (written) of the provider's post-service (redetermination) administrative local dispute resolution review request and the date the Notice of Receipt of Appeal form for the Uninsured or Under Insured is sent to the provider and enrollee/member in their tracking log and in their electronic system.
6. The DWMHA UM Appeal Coordinator, the designated Crisis Service Vendor staff person or the designated MCPN staff person will review all documentation submitted with the local dispute resolution review request and determine if the request is based on medical necessity or only on not meeting notification time frames. If the request based on medical necessity, it will be forwarded to a physician for review. If the request is based on administrative reasons only, then it will be forwarded to a Professional staff person i.e. Supervisor for review.
7. For a post-service (redetermination) administrative local dispute resolution review request, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person ensures that the Professional staff person who reviews the case is different from the Professional staff person who made the initial denial decision. The complete name and credentials of the Professional staff person is entered in their tracking log which is used to monitor this.

8. A determination and written notification of the determination using the standardized Administrative Appeal Determination form by DWMHA, Crisis Service Vendor or the MCPN Professional staff person is required within thirty (30) calendar days of receipt of a post-service (redetermination) administrative local dispute resolution review request. The only exception is when the decision for a post-service (redetermination) local dispute resolution review is made on the last/30th calendar day. In this case, the form must be mailed on the same day as the determination.
9. If the post-service 1st level (redetermination) administrative local dispute resolution review request is to DWMHA or Crisis Service Vendor, the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person forwards via email or face to face the administrative appeal request to the DWMHA or Crisis Service Vendor UM Supervisor or designee for review and determination.
10. The MCPNs will follow their own internal procedures to ensure the MCPN reviews the case within the appropriate timeframe. However, the MCPNs will also use their tracking log as a tool to monitor this.
11. The DWMHA, the Crisis Service Vendor or MCPN UM Supervisor or designee will document their decision in their electronic system and document their name, title, and credentials if not done by electronic signature.
12. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person must document the complete name and credentials of DWMHA, Crisis Service Vendor or MCPN UM Supervisor or designee and the type of decision rendered (approve, deny or split decision), the decision date and the date of the Administrative Appeal Determination form in their tracking log and in their electronic system.
13. If the decision is to **overturn** part or all of the initial denial, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person verbally notifies the provider within three (3) hours of the decision and documents the date and time of the verbal notification in their tracking log. Written notification using the standardized Administrative Appeal Determination form is sent within twenty four (24) hours of the decision to the provider and enrollee/member. The only exception is when the decision for a post-service (redetermination) administrative local dispute review decision is appeal is made on the last/30th calendar day. In this case, the form must be mailed on the same day as the determination. A copy of the form is also retained in their electronic system.
14. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person will ensure that written notification is sent to the provider and enrollee/member within thirty (30) calendar days of a post-service (redetermination) administrative local dispute resolution review request.
15. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person must 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.
16. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person must also enter the authorization of services in their electronic system within twenty-four (24) hours of determination.
17. If the decision is to **uphold** part or all of the initial denial, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person verbally notifies the provider within three (3) hours of the decision and documents the date and time of the verbal notification in their tracking log. Written notification using the standardized Administrative Determination form is sent within twenty four (24) hours of the decision to the provider and enrollee/member. The only exception is when the decision for a post-service (redetermination) administrative local resolution review request is made on the last/30th calendar day. In this case, form must be mailed on the same day as the determination. A copy of the form is also retained in their electronic system.
18. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person will ensure that written notification is sent to the provider and enrollee/member within thirty (30) calendar days of a post-service (redetermination) administrative local dispute resolution review request.


19. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person 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.
20. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person will review the Administrative Appeal Determination form to ensure it includes a statement that this is the final level of appeal and that the enrollee/member is to be held harmless and to provide direction should he/she receive a bill.
21. If the form is manually generated, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or the designated MCPN staff person will scan the form and attach it to the case in their electronic system.
22. The designated Crisis Service Vendor staff person and designated MCPN staff person forward via email their complete tracking log to the DWMHA UM Appeals Coordinator by the 10th of each month for compliance monitoring.

PROCEDURE MONITORING & STEPS

Who monitors this procedure:	<u>DWMHA UM Appeal Coordinator</u>
Department:	<u>Utilization Management</u>
Frequency of monitoring:	<u>Monthly</u>
Reporting provided to:	<u>Director of UM</u>
Regulatory Requirement(s):	<u>Michigan Mental Health Code, PA 258 of 1974, as amended. MDHHS and DWMHA (CMHSP) contract, September 2017</u>

MONITORING STEPS

1. The designated Crisis Service Vendor staff person and designated MCPN staff person 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 any applicable appeal cases are 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 local and alternative dispute resolution Policy and Procedures.
2. Appeal and denial audit tools are used to audit 100% of the cases.
3. The results of the monthly audits will be reported to the DWMHA UM Director as well as to the designated Crisis Service Vendor or designated MCPN staff member.
4. Quarterly results of the audits will be presented to the Utilization Management Committee (UMC).
5. For any cases scoring less than 85%, one on one review of the case will be done by the DWMHA UM Appeal Coordinator to either the designated Crisis Service Vendor or MCPN staff member.
6. If any cases score less than 85% on the audit for three (3) consecutive months, Crisis Service Vendor or MCPN will be placed on a corrective action plan (CAP).

	Procedure Title: Pre-Service UM/Provider Local and Alternative Dispute Resolution procedures
	Procedure Origination Date: 4/1/17
	Procedure Revision Date: 1/15/18
	Procedure Owner: Tasha Bridges, LLC
	Department: Utilization Management
	Line of Business: Uninsured or Under Insured
	Regulatory Requirements: Michigan Mental Health Code, PA 258 of 1974, as amended. MDHHS and DWMHA (CMHSP) contract, September 2017
	Associated Policy: UM Provider Local and Alternative Dispute Resolution Policy

OVERVIEW

Procedure Purpose: To provide procedural and operational guidance to all staff involved in utilization management (UM) functions for the development and consistent processing of pre-service UM/Provider local and alternative dispute resolution reviews.

Expected Outcome: DWMHA, the Crisis Service Vendor, Managers of Comprehensive Provider Networks (MCPN) and the Independent Review Organization (IRO) will be compliant and consistent in the processing of pre-service UM/Provider local and alternative dispute resolution reviews for uninsured or under insured enrollee/members.

References: N/A

KEYWORDS

1. Administrative Appeal
2. Benefit Appeal
3. Independent Review Organization (IRO)
4. Medical Necessity Appeal

PROCEDURE

Pre-Service Eligibility, Screening, Benefit or Medically Necessary Local Dispute Resolution Reviews:

1. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person verbally informs the provider of the determination and sends via mail the standardized the Advance Notice of Adverse Benefit Determination form or the Adequate Notice of Adverse Benefit Determination form for the Uninsured or Under Insured which explains the adverse action including the denial of services in amount, scope and duration if less than what is requested, reason for the adverse action and the local dispute resolution process to the enrollee/member, physician and/or provider. The DWMHA UM Appeal Coordinator, the designated Crisis Service Vendor staff person or designated MCPN staff person documents the date of the Notice form in their tracking log and in their electronic system.
2. Within ten (10) calendar days of the date of the Advance Notice of Adverse Benefit Determination form or the Adequate Notice of Adverse Benefit Determination form for the Uninsured or Under Insured, the physician and/or provider can verbally or in writing request a telephonic peer to peer review before requesting a (redetermination) local dispute resolution review as long as the enrollee/member has not been discharged from the treatment/services. This is **NOT** considered to be a local dispute resolution review.

3. The DWMHA, Crisis Service Vendor, IRO or MCPN physician or physician certified in addiction medicine must make reasonable (at least two) attempts to contact the treating physician within two (2) business days of physician/provider request and document the time and dates of all attempts in the case in their electronic system and their respective tracking log. The treating physician/provider is expected to return the call(s) in a timely manner per the contractual review requirements with DWMHA, Crisis Service Vendor and/or the MCPN. In those instances where the treating physician/provider does not comply with calling back for the telephonic peer to peer review, the denial will stand and the provider will need to file a local dispute resolution review request by telephone or in writing.

Pre-Service Redetermination Medical Necessity or Benefit Local Dispute Resolution Review:

1. The physician and/or provider has thirty (30) calendar days from the receipt of the standardized the Advance Notice of Adverse Benefit Determination form or the Adequate Notice of Adverse Benefit Determination form for the Uninsured or Under to request a pre-service (redetermination) medical necessity or benefit internal local dispute resolution review to DWMHA. (Per MDHHS and DWMHA (CMHSP) contract, September 2017)
2. The physician or provider's request for a pre-service (redetermination) medical necessity or benefit internal local dispute resolution review request can be verbally at 313-344-9099 or in writing to DWMHA's email at appeals@dwmha.com.
3. For all requests for a pre-service (redetermination) medical necessity or benefit internal local dispute resolution review request, the physician and/or provider must email at appeals@dwmha.com to the DWMHA UM Appeal Coordinator at a minimum the following:
 - An explanation of what is being appealed and the name, address and telephone number of the person responsible for filing the appeal; and
 - Any new additional supporting documentation or evidence such as additional clinical information that has not been previously submitted to justify the service, care, or treatment being appealed.
 - The staff member preparing case for physician review will review all information in their electronic medical record system and gather any other information available such as previous denials and appeals and follow-up care that has occurred after the denial.
4. If the request for a pre-service Medicaid (redetermination) internal medical necessity or benefit local dispute review is received by DWMHA, the DWMHA UM Appeals Coordinator will immediately contact via email or telephone the designated COPE staff person or the designated MCPN staff person. The designated COPE staff person or designated MCPN staff person will, in turn, email at a minimum the following to the DWMHA UM Appeal Coordinator at appeals@dwmha.com within three (3) hours of receipt of DWMHA's contact or by the end of the business day (whichever is less) unless the request is on a Friday or one (1) day before a holiday. In such instances, at a minimum the following information must be emailed within one (1) hour of receipt of DWMHA's request:
 - A copy of the signed Physician Denial letter or signed Physician Denial Report; and
 - All concurrent reviews for the episode of care being appealed.
5. If the request for a pre-service Medicaid (redetermination) internal medical necessity or benefit local dispute resolution review is received directly by the Crisis Service Vendor or MCPN, the designated Crisis Service Vendor or designated MCPN staff person must email at a minimum the following to the DWMHA UM Appeal Coordinator at appeals@dwmha.com within three (3) hours of receipt of the provider's request or by the end of the business day (whichever is less) unless the request is on a Friday or one (1) day before a holiday. In such instances, at a minimum the following information must be emailed within one (1) hour of receipt of the provider's request:
 - A copy of the signed Physician Denial letter or signed Physician Denial Report; and
 - All concurrent reviews for the episode of care being disputed.

6. The physician and/or provider or enrollee/member can request an **expedited** (redetermination) medical necessity or benefit internal local dispute resolution review within ten (10) calendar days from receipt of the Advance Notice of Adverse Benefit Determination form or the Adequate Notice of Adverse Benefit Determination form for the Uninsured or Under Insured as long as the enrollee/member is actively receiving treatment/services.
7. Upon receipt of the provider's request for a pre-service (redetermination) medical necessity or benefit internal local dispute resolution review, the DWMHA UM Appeal Coordinator completes, scans and uploads the standardized Notice of Receipt of Local Dispute Resolution form for the Uninsured or Under Insured in the case in MHWIN and then mails it to the provider and enrollee/member within twenty four (24) hours of receipt of a pre-service expedited (redetermination) medical necessity or benefit internal local dispute resolution review request or within five (5) calendar days of receipt of a pre-service standard (redetermination) medical necessity or benefit internal local dispute resolution review request.
8. The DWMHA UM Appeal Coordinator must document the date and type (pre-service, medical necessity or benefit and standard or expedited) and method of notification (verbal or written) of the provider's pre-service (redetermination) medical necessity or benefit local dispute resolution review request and the date the Notice of Receipt of Local Dispute Resolution form for the Uninsured or Under Insured is sent to the provider and enrollee/member in the tracking log and in MHWIN.
9. For a pre-service (redetermination) medical necessity or benefit local dispute review request, the DWMHA UM Appeal Coordinator ensures that the physician who reviews the case is different from and not a subordinate of the physician who made the initial denial decision and that the physician who reviews the case has a similar or same specialty, credentials, licensure and training as those who typically treat the condition or health problem in question. The complete name and credentials of the physician is entered in their tracking log which is used to monitor this.
10. Upon receipt of the post-service (redetermination) local dispute review request, the physician will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
11. The reviewing physician when reviewing a medical necessity appeal, in conjunction with independent professional medical judgment, will use nationally recognized guidelines, which include but are not limited to, third party guidelines, CMS guidelines, State guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.
12. The physician who made the original denial determination may review the case and overturn the initial denial.
13. A determination and written notification of the determination by the DWMHA is required within seventy two (72) hours of receipt of a pre-service expedited (redetermination) medical necessity or benefit local dispute resolution review request or within thirty (30) calendar days of receipt of a pre-service standard (redetermination) medical necessity or benefit local dispute resolution review request. The only exceptions are when the decision for a pre-service expedited (redetermination) local dispute resolution review is made on the last/third (3rd) calendar day or when the decision for a pre-service standard (redetermination) local dispute resolution review is made on the last/30th calendar day. In these cases, the standardized Notice for the Uninsured or Under Insured and the Physician Letter for the Uninsured or Under Insured must be mailed on the same day as the determination.
14. The DWMHA UM Appeals Coordinator completes the Physician Referral Review form in MHWIN. Also, any additional information that is sent in with the appeal request is scanned and attached to case in MHWIN. The MHWIN case is then placed in a MHWIN queue for a DWMHA physician to review.
15. The DWMHA UM Appeals Coordinator manually checks the MHWIN queue twice a day to ensure that a DWMHA physician has retrieved the case from the queue and reviews it within the appropriate timeframes.

16. For a pre-service expedited (redetermination) medical necessity or benefit local dispute resolution review, the DWMHA UM Appeal Coordinator will communicate at a minimum every six (6) hours via email, face to face or telephonically with the DWMHA physician reviewer if after the initial six (6) hours, the DWMHA physician has not reviewed the case. For a pre-service standard (redetermination) medical necessity or benefit local dispute resolution review, the DWMHA UM Appeal Coordinator will communicate daily via email, face to face or telephonically with the DWMHA physician reviewer if after the initial seven (7) calendar days the DWMHA physician has not reviewed the case. The DWMHA UM Appeal Coordinator documents all attempts (date and time) to contact the physician in the tracking log. The DWMHA UM Appeal Coordinator will use the tracking log as a tool to monitor the timeframes.
17. The IRO physician can be used in the following circumstances:
 - a. A physician with the same or similar area of specialty as the original provider(s) is not available;
 - b. There is not a physician reviewer who is a subordinate of the previous decision maker;
 - c. A provider specifically requests an IRO;
 - d. An impartial /independent review is required; or
 - e. The denial reason is “not medically necessary and considered to be experimental/investigational.
18. If an IRO physician is used, the IRO designated staff person will follow their own internal procedures to ensure the IRO physician reviews the case within the appropriate timeframes.
19. The DWMHA physician will document their decision in MHWIN and document their name, title, and credentials if not done by electronic signature.
20. The DWMHA physician will then immediately notify via email the DWMHA UM Appeal Coordinator via email of their decision.
21. The IRO physician will complete the standardized Physician Reviewer Documentation form and immediately fax it to the IRO Medical Review staff at 248-305-7093. The IRO Medical Review staff will, in turn, immediately email it to the DWMHA UM Appeal Coordinator at appeals@dwmha.com.
22. The DWMHA UM Appeal Coordinator must document the physician reviewer’s complete name and credentials and the type of decision rendered (approve, deny or split decision), the decision date and the date of the Notice in the tracking log and in MHWIN.
23. If the decision is to **overturn** part or all of the initial denial, the DWMHA UM Appeal Coordinator verbally notifies the provider within three (3) hours of the decision and documents the date and time of the verbal notification in the tracking log.
24. If the services are for the SMI, IDD and SUD population who are uninsured or under insured, the DWMHA UM Appeal Coordinator will also immediately notify via email or telephone the designated MCPN staff person about the decision to overturn the initial denial so the MCPN can enter the authorization into their electronic system.
25. For a complete overturned determination, written notification using the standardized Notice of Approval form for the Uninsured or Under Insured population and the standardized Physician Letter are sent within twenty four (24) hours of the decision. For a partially overturned determination, written notification using the standardized Notice of Appeal Denial form for the Uninsured or Under Insured population and the standardized Physician Letter for the Uninsured or Under Insured are sent to both the provider and enrollee/member within twenty four (24) hours of the decision. The only exception is when the decision for a pre-service expedited local dispute resolution review decision is made on the 3rd day or the pre-service standard local dispute resolution decision is made on the last/30th day. In these cases, the Notice and Physician Letter must be mailed on the same day as the determination.
26. The Notice and Physician Letter are sent by the DWMHA UM Appeal Coordinator who also retains a copy of each in MHWIN.
27. The DWMHA UM Appeal Coordinator will ensure that written notification is sent to the provider and enrollee/member within seventy-two (72) hours for a pre-service expedited (redetermination) medical necessity or benefit local dispute resolution or within thirty (30) calendar days of a pre-service standard (redetermination) medical necessity local dispute resolution.

28. The DWMHA UM Appeal Coordinator must 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 MHWIN.
29. The DWMHA UM Appeal Coordinator or designated MCPN staff person must also enter the authorization of services in their electronic system within twenty-four (24) hours of determination.
30. If the decision is to **uphold** part or all of the initial denial, the DWMHA UM Appeal Coordinator verbally notifies the provider within three (3) hours of the decision and documents the date and time of the verbal notification in the tracking log. Written notification is sent within twenty four (24) hours of the determination to the provider and enrollee/member and provider using the standardized Notice of Appeal Denial form for the Uninsured or Under Insured and the standardized Physician Letter for the Uninsured or Under Insured. The only exception is when the decision for a pre-service expedited local dispute resolution review decision is made on the 3rd day or the decision for the pre-service standard local dispute resolution decision is made on the last/30th day. In these cases, the Notice and Physician Letter must be mailed on the same day as the determination.
31. The Notice and Physician Letter are sent to the provider and enrollee/member by the DWMHA UM Appeal Coordinator who also retains a copy of each in MHWIN.
32. The DWMHA UM Appeal Coordinator will ensure that written notification is sent to the provider and enrollee/member within seventy-two (72) hours for a pre-service expedited (redetermination) medical necessity or benefit local dispute resolution review or within thirty (30) calendar days of a pre-service standard (redetermination) medical necessity or benefit local dispute resolution review.
33. The DWMHA UM Appeal Coordinator 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 MHWIN.
34. If the Notice and Physician Letter are manually generated, the DWMHA UM Appeal Coordinator will scan the Notice and Physician Letter and attach them to the case in MHWIN.
29. The DWMHA UM Appeal Coordinator must review the Notice of Appeal Denial form for the Uninsured or Under Insured 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;
 - ✓ 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 this is the final internal level of review;
 - e. A statement that the enrollee/member has a right to an (external) alternative dispute resolution review with the Michigan Department of Health and Human Services (MDHHS) and a description of the review process including time frames;
 - f. A statement that the standard local (internal) review must occur prior to an the enrollee/member requesting an (external) alternative dispute resolution review with MDHHS;
 - g. 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 standardized Appointment of Representative form to DWMHA;
 - 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 a review;
 - i. A statement that the enrollee/member, his/her legal representative and/or provider can request copies of all documents relevant to the appeal, free of charge;
 - j. Includes a list of the titles and qualifications, including specialties of the individuals participating in the internal local dispute review.

30. The DWMHA UM Appeal Coordinator documents the date the Notice of Appeal Denial form for the Uninsured or Under Insured (if applicable) or the Notice of Appeal Approval form for the Uninsured or Under Insured (if applicable) mailed in the tracking log and in MHWIN.
31. The designated Crisis Service Vendor staff person and designated MCPN staff person forwards via email their complete tracking log to the DWMHA UM Appeals Coordinator by the 10th of each month for compliance monitoring.

PROCEDURE MONITORING & STEPS

Who monitors this procedure:	<u>DWMHA UM Appeal Coordinator</u>
Department:	<u>Utilization Management</u>
Frequency of monitoring:	<u>Monthly</u>
Reporting provided to:	<u>Director of UM</u>
Regulatory Requirement(s):	<u>Michigan Mental Health Code, PA 258 of 1974, as amended. MDHHS and DWMHA (CMHSP) contract, September 2017</u>

MONITORING STEPS

1. The designated Crisis Service Vendor staff person and designated MCPN staff person 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 any applicable appeal cases are 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 Local and Alternative Dispute Resolution Policy and Procedures.
2. Appeal and denial audit tools are used to audit 100% of the cases.
3. The results of the monthly audits will be reported to the DWMHA UM Director as well as to the designated Crisis Service Vendor or designated MCPN staff member.
4. Quarterly results of the audits will be presented to the Utilization Management Committee (UMC).
5. For any cases scoring less than 85%, one on one review of the case will be done by the DWMHA UM Appeal Coordinator to either the designated Crisis Service Vendor or MCPN staff member.
6. If any cases score less than 85% on the audit for three (3) consecutive months, Crisis Service Vendor or MCPN will be placed on a corrective action plan (CAP).



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

REQUEST FOR ADDITIONAL INFORMATION

Date

Provider Name
Address
City, State, Zip Code

RE: Enrollee/Member's Name:
MHWIN ID No.:

Dear :

We received your request for a local dispute review 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 for a standard appeal request and immediately for an expedited appeal request:

- 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 fourteen (14) calendar days for a standard appeal request and within seventy two (72) hours for an expedited appeal request. 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