Denial of Service Policy

POLICY

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

DWMHA only allows physicians to render behavioral health care and substance use disorder medical necessity denials/adverse determinations. Providers/Practitioners have the opportunity to discuss any Utilization Management (UM) medical necessity adverse/denial determination with the physician who rendered the decision. Providers/Practitioners have the opportunity to discuss any non-medical necessity adverse/denial determinations with the appropriate professional who rendered the decision.

PURPOSE

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

APPLICATION

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

KEY WORDS

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

STANDARDS

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

2. DWMHA, the Access Center, the IRO, the Crisis Service Vendor and/or the MCPNs shall only allow physicians (MD or DO) to render behavioral health care and substance use disorder medical necessity denials. DWMHA ensures that practitioners have the opportunity to discuss any Utilization Management (UM) medical necessity denial determination with a physician reviewer.

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

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

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

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

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

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

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

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

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

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

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

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

h. Notification of the right to a Michigan Medicaid State Fair Hearing for Medicaid covered services for enrollee/member or Notification of the right to an Alternative Dispute Resolution Review with MDHHS for the Uninsured or Under Insured enrollee/member using General Funds; and

i. For denials resulting from medical necessity review of out-of-network requests, the criteria referenced may be excerpts from benefit documents and/or DWMHA policies specifying circumstances where out of network coverage will be approved or clinical criteria used to evaluate the member's clinical need relative to available network providers and services. The reference must specifically support the rationale for the decision and must relate to the reason for the request.

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

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

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

a. Request for Additional Information Form (Medicaid SMI, IDD, SUD)

b. Request for Additional Information Form (MHL)
c. **Request for Additional Information Form (Uninsured or Under Insured)**

d. **Enrollee Agreement for Request for Additional Information Form (Medicaid SMI, IDD, SUD)**

e. **Enrollee Agreement for Request for Additional Information Form (MHL)**

f. **Enrollee Agreement for Request for Additional Information Form (Uninsured or Under Insured)**

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

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

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

15. For an adverse determination of services that is based upon a request for service(s) which is deemed professionally and scientifically ineffective or experimental, and/or if the medically necessary standard of care may be met via a more appropriate, less restrictive, cost effective and appropriate service, the following will be adhered to:

   a. Further services may be limited to the coverage plan of the enrollee/member served and, in some circumstances, the enrollee/member served may be referred elsewhere for treatment and services; and

   b. DWMHA, the Access Center, the IRO, the Crisis Service Vendor and/or the MCPNs do not deny the use of a benefit based on preset limits of benefit duration but instead review the continued medical necessity on an individual basis. If it is determined that the medical necessity criteria for a specific service is not met, all efforts will be made to link the enrollee/member to the services he/she needs.

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

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

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

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

20. For situations where a provider or practitioner does not meet contractual agreements and requirements such as failure to authorize services according to required time frames, an administrative denial may be issued. Appeal or dispute review rights will be provided to the provider/practitioner.

21. The provider/practitioner must also be notified that the enrollee/member are held financially harmless.

22. The standardized Advance Notice of Adverse Benefit Determination form for the Medicaid SMI, IDD, SUD population or the standardized Advance Notice of Adverse Benefit Determination form for the Uninsured or Under Insured population is sent to the enrollee/member and provider regarding a decision to reduce, suspend or terminate services currently authorized and provided. The standardized Adequate Notice of Adverse Benefit Determination for the Medicaid SMI, IDD, SUD population or the standardized Adequate Notice of Adverse Benefit Determination form for the Uninsured or Uninsured population is sent to the enrollee/member and provider when the decision is to deny or limit authorization of services being requested. The standardized Notice of Denial of Medical Coverage form is sent to a MI Health Link enrollee/member and provider regarding a decision to reduce, suspend or terminate services currently authorized and provided or regarding a decision to deny or limit services being requested.

   a. Advance Notice of Adverse Benefit Determination Form (Medicaid SMI, IDD, SUD)
   b. Advance Notice of Adverse Benefit Determination Form (Uninsured or Under Insured)
   c. Adequate Notice of Adverse Benefit Determination Form (Medicaid SMI, IDD, SUD)
   d. Adequate Notice of Adverse Benefit Determination Form (Uninsured or Under Insured)
   e. Notice of Denial of Medical Coverage Form (MHL)

23. The standardized applicable Notice of Administrative Denial form is sent to the provider with a copy to the member/enrollee when an administrative denial is made based on the provider not meeting contractual agreements and requirements. The enrollee/member is informed of the denial and that he/she is held financially harmless.

   a. Notice of Administrative Denial Form (Medicaid SMI, IDD, SUD)
   b. Notice of Administrative Denial Form (Uninsured or Under Insured)
   c. Notice of Administrative Denial Form (MHL)

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

**QUALITY ASSURANCE/IMPROVEMENT**

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

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

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

4. Annually, the DWMHA UM Director or his/her designee identifies applicable vignettes from the Inter-Rater Reliability Indicia MCG module to assess Inter-Rater Reliability system wide based on the types of
reviews 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, an item response analysis and detailed assessment report that pinpoints any areas in which the staff need additional training.

c. It is the expectation of DWMHA that staff meet or exceed a score of 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 staff person pass at the next Inter-Rater Reliability case review test.

5. One additional re-test of at a minimum 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 staff person does not meet or exceed the 90% threshold for a second time, he/she will be subject to a transfer to a role outside the UM department or termination.

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

7. Monthly Access Center, Crisis Service Vendor and the MCPNs shall forward the complete records/charts of all (100%) denial and/or appeal cases and the DWMHA Denial and Appeal Master Tracking Log to DWMHA.

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

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

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

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

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

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

LEGAL AUTHORITY

1. DWMHA UM Program Description FY 16-18
4. MDHHS and DWMHA (PIHP) Contract November 1, 2017
5. MDHHS and DWMHA (CMHSP) Contract September 1, 2017

RELATED POLICIES

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

RELATED DEPARTMENTS

1. Clinical Practice Improvement
2. Compliance
3. Customer Service
4. Information Technology
5. Integrated Health Care
6. Managed Care Operations
7. Quality Improvement
8. Recipient Rights
9. Substance Use Disorder
10. Utilization Management
Adequate Notice of Adverse Benefit Determination Form (Medicaid SMI, IDD, SUD).docx
Adequate Notice of Adverse Benefit Determination Form (Uninsured or Underinsured).docx
Advance Notice of Adverse Benefit Determination Form (Uninsured or Underinsured).docx
Advance Notice of Benefit Determination Form (Medicaid SMI, IDD, SUD).docx
Denial Audit Tool.xlsx
Denial of Medicaid Service Procedures.docx
Denial of Service Procedures for the Uninsured or Under Insured.docx
DWMHA Access Center Eligibility Service Review Tool.docx
DWMHA Denial and Applicable Appeal Master Tracking Log.xlsx
DWMHA Prior Authorized Service UM Chart Review Tool.docx
Enrollee Agreement for Request for Additional Information Form (Medicaid SMI, IDD, SUD).docx
Enrollee Agreement for Request for Additional Information Form (MHL).docx
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
MI Health Link Denial of Service Procedures.docx
Notice of Administrative Denial Form (Medicaid SMI, IDD, SUD).docx
Notice of Administrative Denial Form (MHL).docx
Notice of Administrative Denial Form (Uninsured or Under Insured).docx
## Approval Signatures

<table>
<thead>
<tr>
<th>Approver</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dana Lasenby: Acting Chief Executive Officer</td>
<td>02/2018</td>
</tr>
<tr>
<td>Allison Smith: Project Manager, PMP</td>
<td>02/2018</td>
</tr>
<tr>
<td>Eric Doeh: Compliance Officer</td>
<td>02/2018</td>
</tr>
<tr>
<td>Bernard Hooper: Consultant</td>
<td>02/2018</td>
</tr>
<tr>
<td>Bessie Tetteh: CIO</td>
<td>02/2018</td>
</tr>
<tr>
<td>Andrea Smith: Director of Clinical Practice Improvement</td>
<td>02/2018</td>
</tr>
<tr>
<td>Mary Allix: Director of Quality Improvement</td>
<td>02/2018</td>
</tr>
<tr>
<td>Kip Kilber: Director, Recipient Rights</td>
<td>02/2018</td>
</tr>
<tr>
<td>Rolf Lowe: Assistant General Counsel/HIPAA Privacy Officer</td>
<td>02/2018</td>
</tr>
<tr>
<td>Darlene Owens: Director, Substance Use Disorders, Initiatives</td>
<td>02/2018</td>
</tr>
<tr>
<td>Julia Kyle: Director of Integrated Care</td>
<td>02/2018</td>
</tr>
<tr>
<td>Lorraine Taylor-Muhammad: Director, Managed Care Operations</td>
<td>02/2018</td>
</tr>
<tr>
<td>Crystal Palmer: Director, Children's Initiatives</td>
<td>02/2018</td>
</tr>
<tr>
<td>Donna Coulter: Dir. of OPA</td>
<td>02/2018</td>
</tr>
<tr>
<td>Brooke Blackwell: Communications Director</td>
<td>02/2018</td>
</tr>
<tr>
<td>Corine Mann: Chief Strategic Officer/Quality Improvement</td>
<td>02/2018</td>
</tr>
<tr>
<td>Stacie Durant: CFO Management &amp; Budget</td>
<td>02/2018</td>
</tr>
<tr>
<td>Jody Connally: Director, Human Resources</td>
<td>02/2018</td>
</tr>
<tr>
<td>Michele Vasconcellos: Director, Customer Service</td>
<td>02/2018</td>
</tr>
<tr>
<td>Michael Rangos: Director of Procurement</td>
<td>02/2018</td>
</tr>
<tr>
<td>Jean Alce: Interim Medical Director</td>
<td>02/2018</td>
</tr>
<tr>
<td>Sarah Sharp: Consultant</td>
<td>01/2018</td>
</tr>
<tr>
<td>Diana Hallifield: Consultant</td>
<td>01/2018</td>
</tr>
<tr>
<td>Approver</td>
<td>Date</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Maha Sulaiman: Director of Utilization Management</td>
<td>01/2018</td>
</tr>
<tr>
<td>Sherri Ruza</td>
<td>01/2018</td>
</tr>
</tbody>
</table>
OVERVIEW

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

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

References: N/A

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

PROCEDURE:
1. If a DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer has concerns or questions about whether eligibility, screening, or medical necessity is met to approve the initial or continued stay review, or a provider did not meet contractual agreement or requirement, he/she may request additional information from the provider within twenty four (24) hours of the request. He/she may also elect to verbally consult with a DWMHA, Access Center, Crisis Service Vendor or MCPN UM Supervisor. The DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer then documents the supervisor’s name, credentials and recommendations into their electronic system which may include the recommendation to verbally consult with the DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician or to secure a formal consultation with a DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician.

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

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

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

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

7. If using an IRO physician, the designated Access Center staff person, designated Crisis Service Vendor staff person, designated MCPN staff person or DWMHA UM Reviewer emails at appeals@dwmha.com or faxes at 313-833-3670 the following to the DWMHA UM Appeal Coordinator:
   - a copy of the provider’s written request for an IRO review;
   - the complete clinical case record/documentation; and
   - all correspondences from and received by the Crisis Service Vendor or the MCPN concerning the treatment.

8. The DWMHA UM Appeal Coordinator then follows the standardized IRO procedures of the IRO policy.

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

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

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

12. If a peer to peer review is completed, the DWMHA, the Access Center, Crisis Service Vendor or MCPN physician will document the results of the peer to peer review in their electronic system and render a decision which will also be documented in their electronic system. The IRO physician will complete the standardized Physician Reviewer Documentation form which will then be emailed at appeals@dwmha.com or faxed at 313-833-3670 to the DWMHA UM Appeals Coordinator.

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

15. In any of the above 3 conditions, the DWMHA UM Appeal Coordinator, designated Access Center staff person, designated Crisis Service Vendor staff person or designated MCPN staff person will send the standardized Request for Additional Information form for Medicaid SMI, IDD, SUD population or the standardized Request for Additional Information form for the MI Health Link population to the provider.

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

17. In any of the above 3 conditions, the DWMHA UM Appeal Coordinator, designated Access Center staff person, designated Crisis Service Vendor staff person or designated MCPN staff person will send the standardized Request for Additional Information form for Medicaid SMI, IDD, SUD population or the standardized Request for Additional Information form for the MI Health Link population to the provider.

18. The DWMHA UM Appeal Coordinator, the designated Access Center, designated Crisis Service Vendor staff person or designated MCPN staff person must also notify the enrollee/member or enrollee/member’s representative of an extension and request for additional information from the provider using the standardized Enrollee Agreement for Request for Additional Information Form for the Medicaid SMI, IDD, SUD population or the standardized Enrollee Agreement for Request for Additional Information Form for the MI Health Link population within forty eight hours (48) of an urgent pre-service extension request, fifteen (15) calendar days of a non-urgent pre-service extension request or within thirty (30) calendar days of a post-service extension request.

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

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

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

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

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

24. The IRO physician will complete the standardized Physician Reviewer Documentation form and will immediately forward it to the designated IRO staff person. The designated IRO staff person will, in turn, immediately email it to appeals@dwmha.com or fax it at 313-833-3168 to the DWMHA UM Appeal Coordinator.

25. If the decision is to approve eligibility, the designated Access Center staff person emails the Access Center UM Reviewer who then calls the enrollee/member and completes the screening process within twenty four (24) hours of the decision.

26. If the decision is to authorize services, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person enters the authorization in their electronic system and verbally notifies the provider within twenty four (24) hours of the decision.

27. 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 and in their tracking log.

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

29. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person 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 their tracking log.

30. The DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person completes and generates the standardized Advance or Adequate Notice of Adverse Benefit Determination form for the Medicaid SMI, IDD, SUD population or the standardized Notice of Denial of Medical Coverage form for the MI Health Link population or the standardized Notice of Administrative Denial form for the Medicaid SMI, IDD, SUD population or the standardized Notice of Administrative Denial form for the MI Health Link population from their electronic system and mails it the provider and enrollee/member within twenty four (24) hours of the decision.

31. If the applicable Notice is manually generated, the DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor staff person or designated MCPN staff person will scan it and attach it to the case in their electronic system.
The standardized Advance Notice of Adverse Benefit Determination form is sent to the enrollee/member regarding a decision to reduce, suspend or terminate Medicaid services currently authorized or provided. The standardized Adequate Notice of Adverse Benefit Determination form is sent to the enrollee/member when the decision is to deny or limit authorization of Medicaid services requested. The standardized Notice of Administrative Denial form is sent to the enrollee/member when the decision is to deny the provider due not meeting their contractual agreement or requirements.

33. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person reviews the applicable Notice form to ensure it has the following:
   a. A statement of what action is being taken in easy, understandable language which does not include:
      ✓ abbreviations or acronyms that are not defined; and
      ✓ is culturally and linguistically sensitive to the enrollees/members’ needs; and
      ✓ health care procedure codes that are not explained.
   b. An explanation of the action including the denial of services in amount, scope and duration if less than what is requested;
   c. The specific justification that supports, or the change in the federal or state law that requires the action including a reference to the benefit provision, guideline, protocol or other similar criterion on which the action is based and the option of the enrollee/member to have a copy of the benefit provision, guidelines or protocol, upon request;
   d. A statement that the enrollee/member and/or provider has the right to an internal appeal with DWMHA and a description of the expedited and standard appeal process including time frames;
   e. A statement that the enrollee/member has a right to an external Medicaid State Fair Hearing after exhausting the internal appeal process and an explanation of how to file a State Fair Hearing for Medicaid covered services;
   f. A statement that Medicaid covered services will continue up to the end of the currently approved treatment or final decision whichever comes first if the enrollee/member requests an internal and/or external Medicaid State Fair Hearing within ten (10) calendar days from the date of the notice (per MDHHS and DWMHA (PIHP) contract November 1, 2017);
   g. A statement that the enrollee/member may have to pay for the continuation of services if the result of the internal appeal or external State Fair Hearing is to uphold the denial for Medicaid covered services;
   h. A statement that the enrollee/member, his/her legal representative and/or provider has the opportunity to submit written comments, documents or other information relevant to an appeal;
   i. A statement that the enrollee/member and/or provider can request copies of all documents relevant to the appeal, free of charge;
   j. Informs the enrollee/member of their right to designate an authorized representative to act on their behalf as long as the enrollee/member has provided written permission by completing and forwarding the standardized Appointment of Representative form to DWMHA, the Access Center, Crisis Service Vendor or MCPN;
   k. A statement that an expedited or standard external review process can occur after the internal expedited or standard review process has been exhausted; and
   l. Includes a list of the titles and qualifications, including specialties of the individuals participating in the appeal review.

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

35. The DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person documents the date and times of the verbal and written notifications in their tracking log.
36. The designated Access Center, designated Crisis Service Vendor and designated MCPN staff person must forward via email their tracking log to the DWMHA UM Appeals Coordinator by the 10th of each month for compliance monitoring.

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

38. Denial cases not scoring 90% or greater will be reviewed with the DWMHA, Crisis Service Vendor or MCPN UM Reviewer for the purposes of coaching and training.

39. Any UM Reviewer that scores below 90% on the audit tool three (3) times or more will be placed on a Corrective Action Plan.

**PROCEDURE MONITORING & STEPS:**

<table>
<thead>
<tr>
<th>Who monitors this procedure:</th>
<th>DWMHA UM Appeal Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td>DWMHA Utilization Management</td>
</tr>
<tr>
<td>Frequency of monitoring:</td>
<td>Monthly</td>
</tr>
<tr>
<td>Reporting provided to:</td>
<td>DWMHA UM Director, Access Center, Crisis Service Vendor, MCPNs</td>
</tr>
<tr>
<td>Regulatory Requirement(s):</td>
<td>Audit process developed in order to pass file review for UM 4, UM 5, UM 6 and UM 7, all elements, MDHHS and DWMHA (PIHP) Contract November 1, 2017, MI Health Link Three Way Contract, January 1, 2018</td>
</tr>
</tbody>
</table>

**MONITORING STEPS:**

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

2. Expectation is that any DWMHA, Access Center, Crisis Service Vendor and MCPN staff score 90% or greater on their monthly case audits. Failure to score 90% or greater three (3) times or more will result in a Corrective Action Plan (CAP) for the entity.
OVERVIEW

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

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

References: N/A

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

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

6. If using an IRO physician, the designated Access Center staff person, designated Crisis Service Vendor staff person, designated MCPN staff person or DWMHA UM Reviewer emails at appeals@dwmha.com or faxes at 313-833-3670 the following to the DWMHA UM Appeal Coordinator:
   - a copy of the provider’s written request for an IRO review;
   - the complete clinical case record/documentation; and
   - all correspondences from and received by the Crisis Service Vendor or the MCPN concerning the treatment.

7. The DWMHA UM Appeal Coordinator then follows the standardized IRO procedures of the IRO policy.

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

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

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

11. If a peer to peer review is completed, the DWMHA, the Access Center or the Crisis Service Vendor physician will document the results of the peer to peer review in MHWIN and render a decision which will also be documented in MHWIN. The IRO physician will complete the standardized Physician Reviewer Documentation form which will then be emailed at appeals@dwmha.com faxed at 313-833-3670 or to the DWMHA UM Appeals Coordinator.

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

13. DWMHA, the Access Center, IRO or crisis Service Vendor may extend an urgent pre-service time frame due to a lack of information, once, for forty-eight (48) hours, under the following conditions:
   a. Within twenty-four (24) hours of receipt of the urgent pre-service request, the DWMHA UM Appeal Coordinator, designated Access Center staff person or designated Crisis Service Vendor staff person asks the enrollee/member or their representative (provider/practitioner considered to be their representative) for the specific information necessary to make the decision;
b. DWMHA, the Access Center or Crisis Service Vendor gives the enrollee/member at least forty-eight (48) hours to provide the information; and

c. The extension period, within which a decision must be made begins on the date the enrollee/member’s response is received (even if not all of the information is provided), or at the end of the time period given to the enrollee/member to provide the information even if no response is received from the enrollee/member or their authorized representative.

14. In any of the above 3 conditions, the DWMHA UM Appeal Coordinator, designated Access Center staff person or designated Crisis Service Vendor staff person will send the standardized Request for Additional Information form for MI Health Link population to the provider.

15. DWMHA, the Access Center, IRO or Crisis Service Vendor may extend a non-urgent pre-service or post-service time frame due to a lack of information, once, for up to fifteen (15) calendar days under the following conditions:

   a. The specific information necessary to make the decision is requested from the enrollee/member or enrollee/member’s representative within the decision timeframe as well as the need and reason for the extension;

   b. The enrollee/member or the enrollee/member’s representative is given at least forty-five (45) calendar days to provide the information; and

   c. The extension period, within which a decision must be made by the organization, begins on the date when the enrollee/member or their representative’s response is received (even if not all of the information is provided), or at the end of the time period given to the enrollee/member to supply the information, if no response is received from the enrollee/member or their representative. If information is not received within the time frame, the request may be denied and enrollee/member or their representative may then appeal the denial.

16. In any of the above 3 conditions, the DWMHA UM Appeal Coordinator, designated Access Center staff person or designated Crisis Service Vendor staff person will send the standardized Request for Additional Information form for the MI Health Link population to the provider.

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

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

19. The IRO will follow their own internal procedures to ensure the IRO physician reviews the case within the appropriate timeframes.

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

21. The DWMHA, Access Center or Crisis Service Vendor physician will immediately notify via email or telephone the DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person of their decision.
22. The IRO physician will complete the standardized Physician Reviewer Documentation form and will immediately forward it to the designated IRO staff person. The designated IRO staff person will, in turn, immediately email it to appeals@dwmha.com or fax it at 313-833-3168 to the DWMHA UM Appeal Coordinator.

23. If the decision is to approve eligibility, the designated Access Center staff person emails or telephone the Access Center UM Reviewer who then calls the enrollee/member and completes the screening process within twenty four hours (24) of the decision.

24. If the decision is to authorize services, the DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person enters the authorization in MHWIN and verbally notifies the provider within twenty four (24) hours of the decision.

25. The DWMHA UM Appeal Coordinator or designated Crisis Service Vendor 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 MHWIN and in their tracking log.

26. If the decision is to deny eligibility or services, the DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor verbally notifies the provider within three (3) hours of the decision and documents the verbal notification in MHWIN including the date and time of the notification, the right to a peer to peer discussion regarding the determination, the appeal rights and process and the complete name and credentials of the person notified.

27. The DWMHA UM Appeal Coordinator or designated Crisis Service Vendor staff person also documents 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 their tracking log.

28. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person completes and generates the standardized Notice of Denial of Medical Coverage form for the MI Health Link population or standardized the Notice of Administrative Denial form for the MI Health Link population from MHWIN and mails it the provider and enrollee/member within twenty four (24) hours of the decision.

29. If the applicable Notice is manually generated, the DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person will scan the Notice and attach it to the case in MHWIN.

30. The standardized Notice of Denial of Medical Coverage form for the MI Health Link population is sent to the enrollee/member regarding a decision to reduce, suspend or terminate services currently authorized or provided or when the decision is to deny or limit authorization of services requested. The standardized Notice of Administrative Denial form is sent to the enrollee/member when the decision is to deny the provider due not meeting their contractual agreement or requirements.

31. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person reviews the applicable Notice form to ensure it has the following:
   a. A statement of what action is being taken in easy, understandable language which does not include:
      - abbreviations or acronyms that are not defined; and
      - is culturally and linguistically sensitive to the enrollees/members’ needs; and
      - health care procedure codes that are not explained.
   b. An explanation of the action including the denial of services in amount, scope and duration if less than what is requested;
   c. The specific justification that supports, or the change in the federal or state law that requires the action including a reference to the benefit provision, guideline, protocol or other similar criterion on which the action is based and the option of the enrollee/member to have a copy of the benefit provision, guidelines or protocol, upon request;
   d. A statement that the enrollee/member and/or provider has the right to an internal appeal with DWMHA and a description of the expedited and standard appeal process including time frames;
e. A statement that the enrollee/member has a right to an external Medicaid State Fair Hearing after exhausting the internal appeal process and an explanation of how to file a State Fair Hearing for Medicaid covered services;
f. A statement that Medicaid covered services will continue up to the end of the currently approved treatment or final decision whichever comes first if the enrollee/member requests an internal and/or external Medicaid State Fair Hearing within ten (10) calendar days from the date of the notice (per MDHHS and DWMHA (PIHP) contract November 1, 2017);
g. A statement that the enrollee/member may have to pay for the continuation of services if the result of the internal appeal or external State Fair Hearing is to uphold the denial for Medicaid covered services;
h. A statement that the enrollee/member, his/her legal representative and/or provider has the opportunity to submit written comments, documents or other information relevant to an appeal;
i. A statement that the enrollee/member and/or provider can request copies of all documents relevant to the appeal, free of charge;
j. Inform 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, the Access Center or Crisis Service Vendor;
k. A statement that an expedited or standard external review process can occur after the internal expedited or standard review process has been exhausted; and
l. Includes a list of the titles and qualifications, including specialties of the individuals participating in the appeal review.

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

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

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

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

36. Denial cases not scoring 90% or greater will be reviewed with the DWMHA or the Crisis Service Vendor UM Reviewer for the purposes of coaching and training.

37. Any UM Reviewer that scores below 90% on the audit tool three (3) times or more will be placed on a Corrective Action Plan.

PROCEDURE MONITORING & STEPS:

<table>
<thead>
<tr>
<th>Who monitors this procedure:</th>
<th>DWMHA UM Appeal Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td>DWMHA Utilization Management</td>
</tr>
<tr>
<td>Frequency of monitoring:</td>
<td>Monthly</td>
</tr>
<tr>
<td>Reporting provided to:</td>
<td>DWMHA UM Director, Access Center, Crisis Service Vendor</td>
</tr>
<tr>
<td>Regulatory Requirement(s):</td>
<td>Audit process developed in order to pass file review for UM 4, UM 5, UM 6 and UM 7, all elements</td>
</tr>
</tbody>
</table>
MONITORING STEPS:
1. DWMHA will perform monthly audits of all denials. Results will be reported to the DWMHA UM Director and to the entity that issued the denial.
2. Expectation is that any DWMHA, Access Center and Crisis Service Vendor staff score 90% or greater on their monthly case audits. Failure to score 90% or greater three (3) times or more will result in a Corrective Action Plan (CAP) for the entity.
OVERVIEW

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

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

References: N/A

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

PROCEDURE:
1. If a DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer has concerns or questions about whether eligibility, screening, or medical necessity is met to approve the initial or continued stay review, or a provider did not meet contractual agreement or requirement, he/she may request additional information from the provider within twenty four (24) hours of the request. He/she may also elect to verbally consult with a DWMHA, Access Center, Crisis Service Vendor or MCPN UM Supervisor. The DWMHA, Access Center, Crisis Service Vendor or MCPN UM Reviewer then documents the supervisor’s name, credentials and recommendations into their electronic system which may include the recommendation to verbally consult with the DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician or to secure a formal consultation with a DWMHA, Access Center, IRO, Crisis Service Vendor or MCPN physician.

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

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

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

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

7. If using an IRO physician, the designated Access Center staff person, designated Crisis Service Vendor staff person, designated MCPN staff person or DWMHA UM Reviewer emails at appeals@dwmha.com or faxes at 313-833-3670 the following to the DWMHA UM Appeal Coordinator:
   ✓ a copy of the provider’s written request for an IRO review;
   ✓ the complete clinical case record/documentation; and
   ✓ all correspondences from and received by the Crisis Service Vendor or the MCPN concerning the treatment.

8. The DWMHA UM Appeal Coordinator then follows the standardized IRO procedures of the IRO policy.

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

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

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

12. If a peer to peer review is completed, the DWMHA, the Access Center, Crisis Service Vendor or MCPN physician will document the results of the peer to peer review in their electronic system and render a decision which will also be documented in their electronic system. The IRO physician will complete the standardized Physician Reviewer Documentation form which will then be emailed at appeals@dwmha.com faxed at 313-833-3670 or to the DWMHA UM Appeals Coordinator.

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

15. In any of the above 3 conditions, the DWMHA UM Appeal Coordinator, designated Access Center staff person, designated Crisis Service Vendor staff person or designated MCPN staff person will send the standardized Request for Additional Information form for the Uninsured or Under Insured population to the provider.

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

17. In any of the above 3 conditions, the DWMHA UM Appeal Coordinator, designated Access Center staff person, designated Crisis Service Vendor staff person or designated MCPN staff person will send the standardized Request for Additional Information form for the Uninsured or Under Insured to the provider.

18. The DWMHA UM Appeal Coordinator, the designated Access Center, designated Crisis Service Vendor staff person or designated MCPN staff person must also notify the enrollee/member or enrollee/member’s representative of an extension and request for additional information from the provider using the standardized Enrollee Agreement for Request for Additional Information Form for the Uninsured or Under Insured population within forty eight hours (48) of an urgent pre-service extension request, fifteen (15) calendar days of a non-urgent pre-service extension request or within thirty (30) calendar days of a post-service extension request.

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

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

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

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

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

24. The IRO physician will complete the standardized Physician Reviewer Documentation form and will immediately forward it to the designated IRO staff person. The designated IRO staff person will, in turn, immediately email it to appeals@dwmha.com or fax it at 313-833-3168 to the DWMHA UM Appeal Coordinator.

25. If the decision is to approve eligibility, the designated Access Center staff person emails the Access Center UM Reviewer who then calls the enrollee/member and completes the screening process within twenty four hours (24) of the decision.

26. If the decision is to authorize services, the DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person enters the authorization in their electronic system, and verbally notifies the provider within twenty four (24) hours of the decision.

27. 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 and in their tracking log.

28. If the decision is to deny eligibility or services, the DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person verbally notifies the provider within three (3) hours of the decision and documents the verbal notification in their electronic system including the date and time of the notification, the right to a peer to peer discussion regarding the determination, the local dispute review rights and process and the complete name and credentials of the person notified.

29. The DWMHA UM Appeal Coordinator, designated Crisis Service Vendor staff person or designated MCPN staff person 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 their tracking log.

30. The DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor or designated MCPN staff person completes and generates the standardized Advance or Adequate Notice of Adverse Benefit Determination form for the Uninsured or Under Insured population or the Notice of Administrative Denial form for the Uninsured or Under Insured population from their electronic system and mails it the provider and enrollee/member within twenty four (24) hours of the decision.

31. If the applicable Notice is manually generated, the DWMHA UM Appeal Coordinator, designated Access Center, designated Crisis Service Vendor staff person or designated MCPN staff person will scan it and attach it to the case in their electronic system.
32. The standardized Advance Notice of Adverse Benefit Determination form 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 is sent to the enrollee/member when the decision is to deny or limit authorization of services requested. The standardized Notice of Administrative Denial form is sent to the enrollee/member when the decision is to deny the provider due not meeting their contractual agreement or requirements.

33. The DWMHA UM Appeal Coordinator, designated Access Center or designated Crisis Service Vendor staff person reviews the applicable Notice form to ensure it has the following:
   a. A statement of what action is being taken in easy, understandable language which does not include:
      - abbreviations or acronyms that are not defined; and
      - is culturally and linguistically sensitive to the enrollees/members’ needs; and
      - health care procedure codes that are not explained.
   b. An explanation of the action including the denial of services in amount, scope and duration if less than what is requested;
   c. The specific justification that supports, or the change in the federal or state law that requires the action including a reference to the benefit provision, guideline, protocol or other similar criterion on which the action is based and the option of the enrollee/member to have a copy of the benefit provision, guidelines or protocol, upon request;
   d. A statement that the enrollee/member and/or provider has the right to an internal local dispute review with DWMHA and a description of the expedited and standard review process including time frames;
   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) after exhausting the internal local dispute review process and an explanation of how to file an alternative dispute resolution review with MDHHS;
   f. 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;
   g. A statement that the enrollee/member and/or provider can request copies of all documents relevant to the appeal, free of charge;
   h. 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, the Access Center, Crisis Service Vendor or MCPN;
   i. A statement that an expedited or standard external review process can occur after the internal expedited or standard review process has been exhausted; and
   j. Includes a list of the titles and qualifications, including specialties of the individuals participating in the local dispute review.

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

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

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

37. The DWMHA UM Appeal Coordinator will audit all denials rendered by the Crisis Service Vendor and the MCPNs monthly using the denial audit tool, collate the results of the audits and provide a monthly report to the DWMHA UM Director.
38. Denial cases not scoring 90% or greater will be reviewed with the DWMHA, Crisis Service Vendor or MCPN UM Reviewer for the purposes of coaching and training.
39. Any UM Reviewer that scores below 90% on the audit tool three (3) times or more will be placed on a Corrective Action Plan.

**PROCEDURE MONITORING & STEPS:**

<table>
<thead>
<tr>
<th>Who monitors this procedure:</th>
<th>DWMHA UM Appeal Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td>DWMHA Utilization Management</td>
</tr>
<tr>
<td>Frequency of monitoring:</td>
<td>Monthly</td>
</tr>
<tr>
<td>Reporting provided to:</td>
<td>DWMHA UM Director, Access Center, Crisis Service Vendor, MCPNs</td>
</tr>
<tr>
<td>Regulatory Requirement(s):</td>
<td>Michigan Mental Health Code, PA 258 of 1974, as amended. MDHHS and DWMHA (CMHSP) contract, September 2017</td>
</tr>
</tbody>
</table>

**MONITORING STEPS:**

1. DWMHA will perform monthly audits of all denials. Results will be reported to the DWMHA UM Director and to the entity that issued the denial.
2. Expectation is that any DWMHA, Access Center, Crisis Service Vendor and MCPN staff score 90% or greater on their monthly case audits. Failure to score 90% or greater three (3) times or more will result in a Corrective Action Plan (CAP) for the entity.
REQUEST FOR ADDITIONAL INFORMATION

Date

Provider Name
Address
City, State, Zip Code

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

Dear ____________:

We received your request for an appeal on <insert date>.

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

○ Psychiatric Evaluation
○ Nursing Assessment
○ Social Work Assessment
○ 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. 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
REQUEST FOR ADDITIONAL INFORMATION

Date

Provider Name
Address
City, State, Zip Code

RE: Enrollee/Member’s Name: ____________________________
Medicare ID No: (if applicable)__________________________
Michigan Medicaid ID No: (if applicable) __________________

Dear ____________:

We received your request for an appeal on <insert date>.

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

- Psychiatric Evaluation
- Nursing Assessment
- Social Work Assessment
- 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. 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>
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:

- 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. 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>
ENROLLEE / MEMBER AGREEMENT FOR ADDITIONAL INFORMATION REQUEST

Date

Enrollee/Member Name
Address
City, State, Zip Code

Re: Enrollee/Member’s Name:__________________________________________
Medicare ID No (if applicable):______________________________
MI. Medicaid ID No (if applicable):______________________________

Dear ____________:

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

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

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

Sincerely,

<Name of Responsible Party>
>Title>
ENROLLEE / MEMBER AGREEMENT FOR ADDITIONAL INFORMATION REQUEST

Date

Enrollee/Member Name
Address
City, State, Zip Code

Re: Enrollee/Member’s Name: ________________________________
Medicare ID No (if applicable): __________________________
Mi. Medicaid ID No (if applicable): _______________________

Dear ____________:

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

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

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

Sincerely,

<Name of Responsible Party>
>Title>
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 a local dispute review on <insert date> from your provider. However, in order to make a fair and informed determination, we requested the following information be sent within five (5) calendar days from your provider:

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

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

Sincerely,

<Name of Responsible Party>
<Title>
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>  Beneficiary ID:
<Member’s Medicaid ID Number>

Type of Service Subject to Notice: □ MI. Medicaid  □ Healthy Michigan

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 Appeal
You have to ask Detroit Wayne Mental Health Authority (DWMHA) for an internal appeal within 60 calendar days of the date of this notice. You, your representative or your Provider can request an appeal. The request must include:

- Your name
- Address
- Member Number
- Reason for appealing
- Whether you want a standard or fast appeal (for an expedited or a fast appeal, 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 appeal, 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 appeals:

**Standard appeal** – We’ll give you a written decision on a standard appeal within 30 calendar days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If 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 Appeal** – We’ll give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision. We’ll automatically give you a fast appeal if a doctor supports your request. If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within 30 calendar days. To ask for a fast appeal, 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: 313-833-3670

**Continuation of services during an Internal Appeal**
For the enrollee/member, if you are receiving a Michigan Medicaid service and you file your appeal within 30 calendar days of this notice of adverse benefit determination <put effective date here>, you may request to continue to receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending and should submit your request to Detroit Wayne Mental Health Authority.
Your benefits for that service will continue if you request your services to continue AND request an internal appeal within 30 calendar days from the date of this notice or from the intended effective date of the proposed adverse action which is later.

If your services are continued during your appeal and the appeal decision is not found in your favor, you may be liable to pay for the services received during the appeal timeframe.

**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 appeal any time before or during the appeal. You must submit the request in writing.

**What happens next?**
- If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we’ll send you a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a State Fair Hearing.
- The Notice of Appeal Denial will give you additional information about the State Fair Hearings process [or Patient Right to Independent Review Act] and how to file the request.
- If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing [with the Michigan Administrative Hearing System].

**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
- Michigan Medicare/Medicaid Assistance Program (MMAP): 1-800-803-7174
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

You can get this information for free in other languages or in other formats, such as large print, braille, or audio by calling Toll Free 1-888-490-9698, TTY 1-800-630-1044 during normal business hours Monday through Friday 8:00am to 4:30pm.
Usted puede hablar con una persona para obtener esta información gratuita en español o en varios formatos, tal como en letras grandes, idioma Braille o en forma hablada, llamando al (888) 490-9698 (TTY: 1-800-630-1044) durante las horas de trabajo: 8:00 am a 4:30 pm de Lunes a Viernes. La llamada es gratuita.

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

CC: Provider, Enrollee/Member
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. 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 **10 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 10 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 10 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

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

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

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

CC: Provider, Enrollee/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. 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 10 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 10 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

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

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

يمكنك الحصول على هذه المعلومات باللغة العربية أو بتنسيقات مختلفة مثل أسماء كبيرة أو شثوة عن طريق الهاتف المجاني 9698-490-9698 (TTY: 1-800-630-1044) خلال ساعات العمل: من الساعة 8:00 صباحاً إلى الساعة 4:30 مساءً.

CC: Provider, Enrollee/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: [Enter dates]
Member ID: <MHWIN ID>

Name: <Member’s Name>
Beneficiary ID:
<Member’s Medicaid ID Number>

Type of Service Subject to Notice: □ MI. Medicaid □ Healthy Michigan

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 Appeal
You have to ask Detroit Wayne Mental Health Authority (DWMHA) for an internal appeal within 60 calendar days of the date of this notice. You, your representative or your Provider can request an appeal. The request must include:

- Your name
- Address
- Member Number
- Reason for appealing
- Whether you want a standard or fast appeal (for an expedited or a fast appeal, 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 appeal, 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 appeals:

Standard appeal – We’ll give you a written decision on a standard appeal within 30 calendar days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If 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 Appeal – We’ll give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision. **We’ll automatically give you a fast appeal if a doctor asks for one for you or supports your request.** If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within 30 calendar days. To ask for a fast appeal, 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: 313-833-3670

Continuation of services during an Internal Appeal
For the enrollee/member, if you are receiving a Michigan Medicaid service and you file your appeal within 30 calendar days of this notice of adverse benefit determination <put effective date here>, you may request to continue to receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending and should submit your request to Detroit Wayne Mental Health Authority.
Your benefits for that service will continue if you request your services to continue AND request an internal appeal within 30 calendar days from the date of this notice or from the intended effective date of the proposed adverse action which is later.

If your services are continued during your appeal and the appeal decision is not found in your favor, you may be liable to pay for the services received during the appeal timeframe.

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 appeal any time before or during the appeal. You must submit the request in writing.

What happens next?
☐ If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we’ll send you a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a State Fair Hearing

☐ The Notice of Appeal Denial will give you additional information about the State Fair Hearings process [or Patient Right to Independent Review Act] and how to file the request.

☐ If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing [with the Michigan Administrative Hearing System].

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
• Michigan Medicare/Medicaid Assistance Program (MMAP): 1-800-803-7174
• Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).
• DWMHA’s 24 hour Crisis Helpline Toll Free: 1-800-241-4949 (TTY: 711).

You can get this information for free in other languages or in other formats, such as large print, braille, or audio by calling Toll Free 1-888-490-9698, TTY 1-800-630-1044 during normal business hours Monday through Friday 8:00am to 4:30pm.
Usted puede hablar con una persona para obtener esta información **gratuitamente** en español o en varios formatos, tal como en letras grandes, idioma Braille o en forma hablada, llamando al (888) 490-9698 (TTY: 1-800-630-1044) durante las horas de trabajo: 8:00 am a 4:30 pm de Lunes a Viernes. **La llamada es gratuita.**

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

CC: Provider, Enrollee/Member
Notice of Denial of Medical Coverage

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

---

Mailing Date: __________________________
Member Number: (Member’s Plan Number)

Name: __________________________
Beneficiary ID: (Medicaid Id No)

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

---

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

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

---

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

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

---

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

You have the right to appeal our decision

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

Internal Appeal: Ask DWMHA for an internal appeal within 60 calendar days of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled “How to ask for an internal appeal with Detroit Wayne Mental Health Authority (DWMHA)” for information on how to ask for a plan level appeal.
How to keep your services while we review your case: If we’re stopping or reducing a service, you can keep getting the service while your case is being reviewed. If you want the service to continue while your case is under review, you must ask for an appeal within 10 calendar days of the date of this notice or before the service is stopped or reduced, whichever is later.

If you want someone else to act for you

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

Important Information About Your Appeal Rights

There are 2 kinds of internal appeals with DWMHA

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

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

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

How to ask for an internal appeal with DWMHA

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

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

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

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.
Step 2: Mail, fax, or deliver your appeal {or call us}.

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

If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.

For a Fast Appeal: Phone: 888-490-9698 for members
313-344-9099 ext. 3328 for providers
Fax: 313-833-2217 for members
313-833-3680 for providers

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

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

- If the service is covered by Michigan Medicaid, you can ask for a State Fair Hearing if you haven’t already done so. You can also ask for an External Review under the Patient Right to Independent Review Act by contacting DWMHA at 1-888-490-9698. Your written decision will give you instructions on how to request a State Fair Hearing and External Review. Information about the State Fair Hearing process is also below.

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

- If you do not receive a notice or decision about your appeal from the plan within the timeframes listed above, you may see a State Fair Hearing (see below).

Members are not required to bear costs of the Independent reviewer, including filing fees.

How to ask for a State Fair Hearing

You must file an internal appeal with the plan before asking for a State Fair Hearing.

You have 120 calendar days from date of the appeal denial notice, called the Notice of Appeal Denial, to request the hearing. If you want the service to continue while your case is under review, you must ask for a State Fair Hearing within 10 calendar days of the date of the Notice of Appeal Decision form.

A Request for State Fair Hearing form is included with the Notice of Appeal Decision form. It has instructions that you should review.
Step 1: You, your representative, or your doctor (provider) must ask for a State Fair Hearing after you have appealed to our plan and received the Notice of Appeal Decision form. You can also ask for a State Fair Hearing if you do not receive a decision from our plan within the required timeframe. Your written request must include:

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

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

Phone: 1-877-833-0870  Fax: 1-517-373-4147

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

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

If you have any questions about the State Fair Hearing process, including the expedited (fast) State Fair Hearing, you can call MAHS at 1-877-833-0870.

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

Get help & more information
- Detroit Wayne Mental Health Authority (DWMHA): If you need help or additional information about our decision and the appeal process, call (313)-344-9099 or (888)-490-9698, TTY (800) 630-1044, Monday-Friday, 8:00am to 4:30pm. For an enrollee/member appeal, ask for the DWMHA Customer Service Department and for a provider/utilization management appeal, ask for the DWMHA Utilization Management Department. You can also visit our website at www.dwmha.com
• MI Health Link Ombudsman: You can also contact the MI Health Link Ombudsman for help or more information. The staff can talk with you about how to make an appeal and what to expect during the appeal process. The MI Health Link Ombudsman is an independent program and the services are free. Call 1-888-746-6456 (TTY: 711).
• Medicare: 1-800-MEDICARE (1-800-633-4227 or TTY: 877-486-2048), 24 hours a day, 7 days a week
• Medicare Rights Center: 1-888-HMO-9050
• Elder Care Locator: 1-800-677-1116 or www.eldercare.gov to find help in your community.
• Michigan Medicare/Medicaid Assistance Program (MMAP): 1-800-803-7174
• Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).
• DWMHA’s 24 hour Crisis Helpline Toll Free: 1-800-241-4949 (TTY: 711).

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

You can get this information for free in other languages or in other formats such as large print, braille or audio by calling toll free 1-888-490-9698, TTY: 1-800-630-1044 during normal business hours Monday through Friday 8:00am to 4:30pm. On weekends and on state and federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

**Notice of Non-Discrimination.** Detroit Wayne Mental Health Authority (DWMHA) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DWMHA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Detroit Wayne Mental Health Authority (DWMHA):

• Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
• Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Detroit Wayne Mental Health Authority’s Customer Service Department at 1-888-490-9698, TTY: 1-800-630-1044) from 8:30am to 4:40pm, Monday through Friday. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

If you believe that Detroit Wayne Mental Health Authority has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Detroit Wayne Mental Health Authority’s Customer Service Department is available to help you.


ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-888-490-9698 (TTY: 1-800-630-1044).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-490-9698 (TTY: 1-800-630-1044).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم -9698-490-888-1-888-490-9698 (رقم هاتف الصم والبكم: 1-800-630-1044).

注意：如果您使用繁體中文，您也可以免費獲得語言援助服務。請電 1-888-490-9698 (TTY: 1-800-630-1044)。


주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-490-9698 (TTY:1-800-630-1044) 번으로 전화해 주십시오。

প্রোটকল: যদি আপনি বাংলা বলতে পারেন, তাহলে নিচেরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-888-490-9698 (TTY: 1-800-630-1044)।


注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-888-490-9698（TTY: 1-800-630-1044）まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-490-9698 (TTY: 1-800-630-1044).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-490-9698 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-630-1044)


CC: Provider, Enrollee/Member

Revised 12/7/17
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 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) __________________________

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) 344-9099 or TTY (800) 630-1044. 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 60 calendar days of the date of this notice by contracting DWMHA at (313) 344-9099 or TTY (800) 630-1044. Providers ask for the UM Department.

Decision Maker (Printed Name) with Credentials/Job Title

Decision Maker’s Signature

Date

cc: Service Provider & Member
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 review. Following the administrative review of services and supports for which you have requested, it has been determined that the following service(s) are being administratively denied:

Authorization Request #: ________________________________

Service(s)                                             Effective Date(s)

________________________                               __________________________

________________________                               __________________________

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.

12/7/17
Member: If you receive a bill, please contact Detroit Wayne Mental Health Authority (DWMHA) at (313) 344-9099 or TTY (800) 630-1044. 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 contracting Detroit Wayne Mental Health Authority (DWMHA) at (313)-344-9099 or TTY (800) 630-1044. For a provider/utilization management appeal, ask for the UM Appeal Coordinator.

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

cc: Service Provider & Member
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 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)

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) 344-9099 or TTY (800) 630-1044. 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)-344-9099 or TTY (800) 630-1044. For a provider/utilization management appeal, ask for the UM Appeal Coordinator.

Decision Maker (Typed Name) with Credentials/Job Title

Decision Maker’s Signature

Date

cc: Service Provider & Member
Notice of Our Failure to Make a Coverage Decision
Detroit Wayne Mental Health Authority

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

---

**Mailing Date:** <Mailing Date>  
**Member Number:** <Member’s Plan ID Number>

**Name:** <Member’s Name>  
**Beneficiary ID:** (Medicaid Id No)

**Type of Service Subject to Notice:** □ Medicare □ MI. Medicaid □ Medicare/Medicaid Overlap Service

---

**We did not make a decision on your request**

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

---

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

**You have the right to appeal our failure to decide**

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

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

**Medicaid State Fair Hearing:** Ask for a State Fair Hearing within 120 calendar days of the date of this notice. See section titled “How to ask for a Medicaid State Fair Hearing” of this notice for information about how to ask for a Medicaid State Fair Hearing.
If you want someone else to act for you

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

Important Information About Your Appeal Rights

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

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

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

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

How to ask for an internal appeal with DWMHA

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

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

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

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

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

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

For a Fast Appeal: Phone: 888-490-9698 (for members) for TTY: 1-800-800-630-1044  
Fax: 313-833-2217 (for members)  
For providers: Phone: 313-344-9099 ext. 3328 for providers Fax: 313-833-3680
What happens next?

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

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

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

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

How to ask for a Medicaid State Fair Hearing

You have to file an internal appeal with the plan before asking for a State Fair Hearing. You can ask for a State Fair Hearing after you have exhausted the internal appeal process.

You have 120 calendar days from date of this notice to ask for the State Fair Hearing. A Request for Hearing form is included with this letter. It also has instructions that you should review.

**Step 1:** You, your representative, or your doctor {provider} must ask for a State Fair Hearing. Your written request must include:

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

**Step 2:** Send your request to:

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

Phone: 1-877-833-0870 Fax: 517-373-4147

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

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

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

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

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

You can get this information for free in other languages or in other formats such as large print, braille or audio by calling toll free 1-888-490-9698, TTY: 1-800-630-1044 during normal business hours Monday through Friday 8:00am to 4:30pm. On weekends and on state and federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Notice of Non-Discrimination. Detroit Wayne Mental Health Authority (DWMHA) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DWMHA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Detroit Wayne Mental Health Authority (DWMHA):
- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Detroit Wayne Mental Health Authority’s Customer Service Department at 1-888-490-9698, TTY: 1-800-630-1044) from 8:30am to 4:40pm, Monday through Friday. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

If you believe that Detroit Wayne Mental Health Authority has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a
grievance by calling the number above and telling them you need help filing a grievance; Detroit Wayne Mental Health Authority’s Customer Service Department is available to help you.


Language Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-888-490-9698 (TTY: 1-800-630-1044).


CC: Provider, Enrollee/Member
INDEPENDENT REVIEW ORGANIZATION REFERRAL REVIEW REQUEST FORM

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

<table>
<thead>
<tr>
<th>Enrollee/Member Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Enrollee/Member’s Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DOB:</th>
<th>Telephone Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Treating Physician Name and Credentials:</th>
<th>Telephone Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Person responsible for filing the request:</th>
<th>Telephone Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Level and Type of Services in Dispute:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dates of Services in Dispute:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Type of Services Currently Authorized (if applicable):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dates of Services Currently Authorized (if applicable):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reason for the IRO referral:</th>
</tr>
</thead>
</table>
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 |
IRO Physician Reviewer Documentation Form

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

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

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

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

Deny services  
Uphold denial of services  
Overturn the denial of services  
Modify the denial of services

Clinical Rational for Decision:

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Evidence based References: (Provide a minimum of two (2) and a maximum of five (5) peer review CURRENT (within 3 years) medical references to support your opinion in this review.

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
I certify that I have experience providing direct clinical care to patients within the past three (3) years that represent the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review; and have current, relevant experience and/or knowledge to render a determination for this case under review.

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 and Credentials: ________________________ Date: __________________

When you complete the case, FAX your review to:
248-305-7093; ATTN: MELODY
UM Decision Turn-Around Times for Initial Determinations

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Makes Decision</th>
<th>Fax/Phone Notification</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent pre-service review</td>
<td>Within 14 calendar days of receipt of the request. If additional information is needed, DWMHA, Crisis Service Vendor or MCPN must contact the provider within 2 business days of receipt of the request. The provider then has 2 business days to provide the needed information. A denial may be issued if the provider fails to secure the needed information within 2 business day of receipt of the DWMHA, Crisis Service Vendor or MCPN request.</td>
<td>Within 3 hours of determination but no later than within 14 calendar days of the receipt of the request.</td>
<td>Within 14 calendar days of receipt of the request.</td>
</tr>
<tr>
<td>Urgent pre-service review</td>
<td>Within 72 hours of receipt of the request.</td>
<td>Within 3 hours of determination but no later than 72 hours of receipt of the request.</td>
<td>Within 72 hours of receipt of the request.</td>
</tr>
<tr>
<td>Urgent concurrent review</td>
<td>Within 24 hours of receipt of the request, if all information received and request for service is made prior to 24 hours before expiration of the current authorization period or number of treatments.</td>
<td>Within 3 hours of determination but no later than within 24 hours of receipt of the request.</td>
<td>Within 24 hours of receipt of the request.</td>
</tr>
<tr>
<td></td>
<td>Within 72 hours if additional information had to be requested &amp; information requested within 24 hours of receipt of request or if request for service is not made prior to 24 hours before expiration of the current authorization period or number of treatments.</td>
<td>Within 3 hours of determination but no later than within 72 hours of receipt of the request.</td>
<td>Within 72 hours of receipt of the request.</td>
</tr>
<tr>
<td>Post-service review</td>
<td>Within 30 calendar days of receipt of the request.</td>
<td>N/A</td>
<td>Within 30 calendar days of the request.</td>
</tr>
</tbody>
</table>

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

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

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

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

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

Revised 12/7/17
<table>
<thead>
<tr>
<th>UM</th>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>C</td>
<td>The organization ensures that a physician or appropriate behavioral health practitioner reviews any behavioral healthcare denial based on medical necessity.</td>
</tr>
<tr>
<td>5</td>
<td>A1</td>
<td>For urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request.</td>
</tr>
<tr>
<td>5</td>
<td>A2</td>
<td>For urgent preservice decisions, the organization makes decisions within 72 hours of receipt of the request.</td>
</tr>
<tr>
<td>5</td>
<td>A3</td>
<td>For nonurgent preservice decisions, the organization makes decisions within 15 calendar days of receipt of the request.</td>
</tr>
<tr>
<td>5</td>
<td>A4</td>
<td>For postservice decisions, the organization makes decisions within 30 calendar days of receipt of the request.</td>
</tr>
<tr>
<td>5</td>
<td>B1</td>
<td>For urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within 24 hours of the request.</td>
</tr>
<tr>
<td>5</td>
<td>B2</td>
<td>For urgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.</td>
</tr>
<tr>
<td>5</td>
<td>B3</td>
<td>For nonurgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 15 calendar days of the request.</td>
</tr>
<tr>
<td>5</td>
<td>B4</td>
<td>For postservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.</td>
</tr>
<tr>
<td>6</td>
<td>A</td>
<td>There is documentation that relevant clinical information is gathered consistently to support UM decision making.</td>
</tr>
<tr>
<td>7</td>
<td>A</td>
<td>The organization provides practitioners with the opportunity to discuss any UM denial decision with a physician, appropriate behavioral healthcare reviewer or pharmacist reviewer.</td>
</tr>
<tr>
<td>7</td>
<td>B1</td>
<td>Written notification of denial includes the specific reasons for the denial, in easily understandable language.</td>
</tr>
<tr>
<td>7</td>
<td>B2</td>
<td>Written notification of denial includes a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based.</td>
</tr>
<tr>
<td>7</td>
<td>B3</td>
<td>Written notification of denial includes notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.</td>
</tr>
<tr>
<td>7</td>
<td>C1</td>
<td>Written notification of denial includes a description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal.</td>
</tr>
<tr>
<td>7</td>
<td>C2</td>
<td>Written notification of denial includes an explanation of the appeal process, including member’s right to representation and time frames for deciding appeals.</td>
</tr>
<tr>
<td>7</td>
<td>C3</td>
<td>Written notification of denial includes a description of the expedited appeal process for urgent preservice or urgent concurrent denials.</td>
</tr>
<tr>
<td>7</td>
<td>C4</td>
<td>Written notification of denial includes notification that expedited external review can occur concurrently with the internal appeals process for urgent care.</td>
</tr>
</tbody>
</table>

**Total:** 0
# DWMHA Eligibility of Service Review Tool

<table>
<thead>
<tr>
<th>Enrollee/Member Name:</th>
<th>Date of Birth:</th>
<th>Medicaid ID No.:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Screening for Eligibility</td>
<td></td>
<td>Name of Access Center Clinician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Documentation Found</th>
<th>Documentation Not Found</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

1. Insurance Information
2. Wayne County Residency
3. Start time of screening
4. Name, address and phone number of caller
5. Documentation of call being an Emergency or Crisis
6. Reason for call/presenting problem identified
7. Type of Services Request
8. Contact Information
9. Guardianship
10. Past Treatment History
11. History of Abuse (Sexual/Physical/Emotional)
12. Current living situation
13. Financial Information including Income
14. Education Information
15. Current Health/Medical Problems
16. Referral to ER for Treatment/Clearance
17. Time ER Contacted and Consumer Referred
18. Medications (name, dose, prescribing physician)
19. Primary care physician information
20. Mental Health Symptoms Identified
21. Substance Use Issues
22. Risk (Suicidal/Homicidal) assessment
23. Autism Screening Tool Completed
24. IDD Screening Tool Completed
25. Provisional Disability Designation
26. Diagnoses
27. Medical and/or Advance Directives
28. Diagnoses
29. Medical and/or Psychiatric Advance Directives
30. Eligibility Criteria Met
31. Eligibility Criteria Not Met
32. If Eligibility Criteria not met, member was given community resource referrals.
33. If Eligibility Criteria Not Met, Access Center Physician reviewed case and provided documentation.
34. Adequate or Advance Notice Sent to the member (using DWMHA standard form)
INSTRUCTIONS FOR COMPLETION OF THE ELIGIBILITY OF SERVICE REVIEW TOOL
The purpose of these reviews are to ensure correct documentation, appropriate level of Care decisions and to meet External Quality Review requirements relative to Utilization Management.

➢ On a quarterly basis, the Access Center shall review the following:
  • Ten (10) denial cases based on all staff making Utilization Management decisions.
  • Ten (10) approved cases for all staff making Utilization Management decisions.

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

➢ The Access Center must forward all the completed Eligibility of Service Review sheets to DWMHA’s UM Department via fax or email each quarter.

➢ An Analysis of all Eligibility of Service UM Reviews for the fiscal year shall be included in the Access Center’s Annual UM Evaluation.
**DWMHA PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL**

**Initial Review (PAR Screening)**

<table>
<thead>
<tr>
<th>Enrollee/Member Name:</th>
<th>Name of Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHWIN ID No.:</td>
<td>Medicaid Number:</td>
</tr>
<tr>
<td>Level of Care:</td>
<td>Admit Date:</td>
</tr>
</tbody>
</table>

Complete name and credentials of COPE UM Staff who completed the initial review (PAR Screening):

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Found</th>
<th>Found but Not Accurate/Complete</th>
<th>Not Found</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Date and time of initial call to request the review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Date and time of initiation of review (PAR)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Complete name, credentials of caller completing the review (PAR)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Complete name of facility/location for the caller completing the review (PAR)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Phone number of caller completing the review (PAR)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Level of Care being requested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Living Arrangement prior to admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Education and/or Work status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Guardianship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Legal Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Vital Signs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Presenting Symptoms/Current Stressors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Risk Assessment <em>(Suicide/Homicide/Other Dangerous or Self Aggressive Behavior)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Past Treatment History</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Compliance with past outpatient treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Mental Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Substance Use Assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. UDS Screening Information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. ETOH Screening Information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Physical/Medical Health History</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Primary Care Physician information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Current Medications <em>(medication name, dose, frequency, complete name of prescriber)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Compliance with Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Presence of a Crisis Plan and/or Behavioral Plan</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Treatment Plan/Identified Goals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Discharge Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Estimated Length of Stay (ELOS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. SI/IS criteria identified and documented <em>(medical necessity criteria met for level of service)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Complete Clinical Summary <em>(in clinical note section of criteria authorization screen)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Consult with an Organization Supervisor and/or Physician</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Number of Days/Units Authorized</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Diversion Information</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Date and Time of PAR Disposition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Complete name and credentials of Organization Staff UM Reviewer and Date (can be electronic Signature)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Complete Name of hospital/facility to which admission/authorization was given <em>(in PAR Disposition)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Complete name and credentials of the admitting physician <em>(in PAR Disposition)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# DWMHA PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL

## First Continued Stay Review

<table>
<thead>
<tr>
<th>Enrollee/Member Name:</th>
<th>Name of Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHWIN ID No.:</td>
<td>Medicaid Number</td>
</tr>
<tr>
<td>Level of Care:</td>
<td>Name of UM Staff Reviewer:</td>
</tr>
<tr>
<td>Admit Date:</td>
<td>Discharge Date:</td>
</tr>
</tbody>
</table>

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

**Third Continued Stay Review**

<table>
<thead>
<tr>
<th>Enrollee/Member Name:</th>
<th>Name of Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHWIN ID No.:</td>
<td>Medicaid Number</td>
</tr>
<tr>
<td>Level of Care:</td>
<td>Name of UM Staff Reviewer:</td>
</tr>
<tr>
<td>Admit Date:</td>
<td>Discharge Date:</td>
</tr>
<tr>
<td></td>
<td>Documentation</td>
</tr>
<tr>
<td></td>
<td>Found</td>
</tr>
<tr>
<td>1. Date and time of concurrent review was initiated</td>
<td></td>
</tr>
<tr>
<td>2. Name and credentials of caller completing the review</td>
<td></td>
</tr>
<tr>
<td>3. Telephone number of caller completing the review</td>
<td></td>
</tr>
<tr>
<td>4. Current status of symptoms</td>
<td></td>
</tr>
<tr>
<td>5. Treatment progress to date</td>
<td></td>
</tr>
<tr>
<td>6. Baseline functioning</td>
<td></td>
</tr>
<tr>
<td>7. Any changes to previous treatment plan/goals</td>
<td></td>
</tr>
<tr>
<td>8. Goal statement</td>
<td></td>
</tr>
<tr>
<td>9. Current medications, doses and frequency</td>
<td></td>
</tr>
<tr>
<td>10. Any side effects from medications</td>
<td>N/A</td>
</tr>
<tr>
<td>11. Any consultations and/or assessment results</td>
<td></td>
</tr>
<tr>
<td>12. Presenting symptoms/current stressors</td>
<td></td>
</tr>
<tr>
<td>13. Status of communication/Interactions with family, guardian, legal representative, CMH service provider or other identified support systems</td>
<td></td>
</tr>
<tr>
<td>14. Presence of a Crisis Plan and/or Behavioral Plan</td>
<td>N/A</td>
</tr>
<tr>
<td>15. SI/IS Criteria Identified</td>
<td></td>
</tr>
<tr>
<td>16. After Care/Discharge Plan <em>(indicate level of care, provider name and date and time of initial appointment with provider)</em></td>
<td></td>
</tr>
<tr>
<td>17. Placement Issues/Status of Placement <em>(if no placement issues, indicate where and with whom member will live after discharge)</em></td>
<td></td>
</tr>
<tr>
<td>18. Estimated Length of Stay (ELOS)</td>
<td></td>
</tr>
<tr>
<td>19. Consult with MCPN Supervisor and/or Organization Physician</td>
<td>N/A</td>
</tr>
<tr>
<td>20. Number of days/units authorized</td>
<td></td>
</tr>
<tr>
<td>21. Date and time of disposition</td>
<td></td>
</tr>
<tr>
<td>22. Complete name and credentials of MCPN’s UM reviewer</td>
<td></td>
</tr>
</tbody>
</table>
INSTRUCTIONS FOR COMPLETION OF PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL

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

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

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

- The Crisis Service Vendor must forward all the completed Prior Authorized Service UM Chart Review sheets to DWMHA’s UM Department via fax or email each quarter.

- An Analysis of all Prior Authorized Service UM Chart Reviews for the fiscal year shall be included in the Crisis Service Vendor’s Annual UM Evaluation.
DWMHA DENIAL AND APPEAL MASTER TRACKING LOG
| Provider/Facility | Other Funding | Medicaid No. | Medicare No. (if applicable) | Source | MHWIN ID No. | Provider Level of Service | Level of Peer Review (Standard or Expedited) | Date Determined | Status of Provider | Type of Peer Review | Adverse Action Name & Date & Time of Decision | Date & Time of Adverse Action to Provider by DWMHA | Date Notice sent to Provider & Member (within 24 hours of the decision) | Date 1st Level Adverse Action was made by DWMHA (must be within 3 hrs of decision) | Date Of 1st Level Decision (Standard or post-service 1st level request or within 5 hrs of an expedited request) | Date & Time of 1st Level Decision was made must be within 30 calendar days for a standard 1st level appeal or 60 calendar days for an expedited pre-service 1st level appeal (if applicable) & (number of days of authorization letter sent by DWMHA to Provider & MAXIMUS) | Date 2nd Level Decision was notified by DWMHA of 2nd level appeal within 30 calendar days (if applicable) & (number of days of decision sent to Provider) | Date 3rd Level Decision was notified by DWMHA to Provider & MAXIMUS within 30 calendar days (if applicable) & (number of days of notification given by DWMHA to MAXIMUS) | Date 4th Level Decision was notified by DWMHA to Provider & MAXIMUS within 30 calendar days (if applicable) & (number of days of notification given by DWMHA to MAXIMUS) | Date Judicial Review by MAXIMUS (must be within 24 hrs of notification given by DWMHA to Provider & MAXIMUS) | Date proof of claim payment by DWMHA to MAC by 14 calendar days (if applicable) | Date proof of claim payment by DWMHA to Judicial Coordinator by 30 calendar days (if applicable) | Date MAC notified DWMHA of 3rd level decision notified (if applicable) | Date auth. letter sent by DWMHA to Provider by 30 calendar days (if applicable) | Date auth. letter sent by DWMHA to MAXIMUS by 30 calendar days (if applicable) | Date auth. letter sent by DWMHA to Judicial Coordinator by 30 calendar days (if applicable) | Date Initial Notice of Appeal sent by DWMHA to Provider & MAXIMUS by 72 hrs for an expedited pre-service 1st level request or within 30 calendar days for a standard pre-service 1st level request (if applicable) & (number of days of notification given by DWMHA to Provider & MAXIMUS) | Date Decision Letter sent by DWMHA to Provider by 30 calendar days & (number of days of notification given by DWMHA to Provider & MAXIMUS) | Date 5th level decision notified by DWMHA to Provider & MAXIMUS within 30 calendar days (if applicable) & (number of days of notification given by DWMHA to MAXIMUS) | Date proof of claim payment by DWMHA to Judicial Coordinator by 30 calendar days (if applicable) | Date Judicial Review by MAXIMUS (must be within 24 hrs of notification given by DWMHA to Provider & MAXIMUS) | Date proof of claim payment by DWMHA to MAC by 14 calendar days (if applicable) | Date proof of claim payment by DWMHA to Judicial Coordinator by 30 calendar days (if applicable) | Date auth. letter sent by DWMHA to Provider by 30 calendar days (if applicable) | Date auth. letter sent by DWMHA to MAXIMUS by 30 calendar days (if applicable) | Date auth. letter sent by DWMHA to Judicial Coordinator by 30 calendar days (if applicable) |

---

Page 1
<table>
<thead>
<tr>
<th>Member Name</th>
<th>Medicaid No. (if applicable) Other Funding Source</th>
<th>Medicare No. (if applicable) Other Funding Source</th>
<th>Provider/Facility Name</th>
<th>Level of Service</th>
<th>Discharge Date</th>
<th>Decision Date of Administrative Denial</th>
<th>Name, Title and Credentials of DWMHA Decision Maker</th>
<th>Date Provider Requested Administrative Appeal</th>
<th>Date Acknowledgment Letter sent to Provider by DWMHA staff (must be within 5 calendar days of receipt of an administrative appeal request)</th>
<th>Date Appeal Decision was made by DWMHA UM Supervisor (must be within 30 calendar days of receipt of an administrative appeal request)</th>
<th>Date Notice of Appeal Decision was sent by DWMHA staff to the Provider (must be within 24 hrs of decision)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>-----------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>-----------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>-----------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>-----------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>-----------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Member Name</td>
<td>Medicaid No.</td>
<td>Other Funding Source</td>
<td>Facility/Provider Name</td>
<td>MHWIN ID No.</td>
<td>Facility/Provider Name</td>
<td>Type of Service</td>
<td>Discharge Date</td>
<td>Type of Peer to Peer Review</td>
<td>Peer Review Physician rendering Adverse Action</td>
<td>Date &amp; Time of Verbal Notification to Provider by MCPN</td>
<td>Date of Provider Appeal Request received by MCPN</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------</td>
<td>----------------------</td>
<td>------------------------</td>
<td>--------------</td>
<td>----------------------</td>
<td>----------------</td>
<td>---------------</td>
<td>-----------------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MONTH:**

Page 3
| Member Name | Medicaid No. (if applicable) Other Funding Source | Medicare No. (if applicable) Other Funding Source | Provider/Facility Name | Level of Service | Discharge Date | Decision Date of Administrative Denial | Name, Title and Credentials of MCPN Decision Maker | Date Provider Requested Administrative Appeal | Date Acknowledgment Letter sent to Provider by MCPN staff (must be within 5 calendar days of receipt of an administrative appeal request) | Date Appeal Decision was made by MCPN UM Supervisor (must be within 30 calendar days of receipt of an administrative appeal request) | Date Notice of Appeal Decision was sent by MCPN staff to the Provider (must be within 24 hrs of decision) |
|-------------|--------------------------------------------------|-------------------------------------------------|------------------------|----------------|---------------|----------------------------------------|-------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
|             |                                                  |                                                 |                        |                |               |                                        |                                                  |                                |                                                                                 |                                                                                  |
|             |                                                  |                                                 |                        |                |               |                                        |                                                  |                                |                                                                                 |                                                                                  |
|             |                                                  |                                                 |                        |                |               |                                        |                                                  |                                |                                                                                 |                                                                                  |
|             |                                                  |                                                 |                        |                |               |                                        |                                                  |                                |                                                                                 |                                                                                  |
|             |                                                  |                                                 |                        |                |               |                                        |                                                  |                                |                                                                                 |                                                                                  |
|             |                                                  |                                                 |                        |                |               |                                        |                                                  |                                |                                                                                 |                                                                                  |
|             |                                                  |                                                 |                        |                |               |                                        |                                                  |                                |                                                                                 |                                                                                  |
| Member Name | Medicaid No. | Other Funding Source | Facility Name | Medico  No. | Level of Service | Discharge Date | Type of Peer Review (Standard or Expedited) | Name & Specialty of COPE Physician rendering Adverse Action | Date & Time of Adverse Action (Standard or Expedited) | Method of Appeal Request | Name & Specialty of DWMHA Physician rendering Appeal Decision | Date & Time of Appeal Decision was made | Type of Decision rendered (number of days approved and/or number of days denied) | Date Notice of Appeal Decision Letter sent by DWMHA to Provider & Member (must be within 24 hours for an expedited pre-service appeal request, within 5 calendar days of receipt of a standard pre-service appeal request or within 30 calendar days of receipt of a request for post-service appeal) | Date Notice of Appeal Decision Letter sent by DWMHA to Provider & Member (must be within 3 hrs of decision) | Date Notice of Appeal Decision Letter sent by DWMHA to Provider & Member (must be within 24 hours for an expedited pre-service appeal request, within 5 calendar days of receipt of a standard pre-service appeal request or within 30 calendar days of receipt of a request for post-service appeal) }
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member Name</td>
<td>Medicaid No. (if applicable)</td>
<td>Medicare No. (if applicable)</td>
<td>Other Funding Source</td>
<td>Other Funding Source</td>
<td>Provider/Facility Name</td>
<td>Level of Service</td>
<td>Discharge Date</td>
<td>Decision Date of Administrative Denial</td>
<td>Name, Title and Credentials of COPE Decision Maker</td>
<td>Date Provider Requested Administrative Appeal</td>
<td>Date Acknowledgment Letter sent to Provider by COPE staff (must be within 5 calendar days of receipt of an administrative appeal request)</td>
<td>Date Appeal Decision was made by COPE UM Supervisor (must be within 30 calendar days of receipt of an administrative appeal request)</td>
<td>Date Notice of Appeal Decision was sent by COPE staff to the Provider (must be within 24 hrs of decision)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------</td>
<td>-----------------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>-----------------------</td>
<td>---------------------</td>
<td>--------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Page 6
MEMBER APPEALS FORWARD TO CUSTOMER SERVICE DEPT. BY UM DEPARTMENT

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Medicaid ID No.</th>
<th>Medicare ID No.</th>
<th>MHWIN ID No.</th>
<th>Provider Name</th>
<th>Level of Service</th>
<th>Date Member request received by UM Dept.</th>
<th>Date UM Dept. sent request to Customer Service Dept.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>