Status Active PolicyStat ID 12817445

Origination	02/2023
Last Approved	02/2023
Effective	02/2023
Last Revised	02/2023
Next Review	02/2024

Owner	Tasha Bridges: UM Appeals Administrator
Policy Area	Utilization Management

Post-Service UM Provider Appeals for Medicare Services Procedure

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PROCEDURE PURPOSE

To provide procedural and operational guidance to all staff involved in utilization management functions for the development and consistent processing of Post-Service UM/Provider (Retrospective) Appeals for **Medicare Covered Services.**

EXPECTED OUTCOME

DWIHN and the Crisis Service Vendors will be compliant and consistent in the processing of pre-service UM/Provider Appeals for ***Medicare Covered Services*.**

PROCEDURE

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

1. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person verbally informs the provider of the determination and sends via mail the standardized Notice of Denial of Medical Coverage form which explains the adverse action including the denial of service in amount, scope and duration less than what was requested, reason for the adverse action (did not meet medical necessity criteria and why) and the appeal process to the enrollee/member, physician and/or provider. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person documents the date of the Notice form in their tracking log and in MHWIN.

Post-Service 1st Level Redetermination Medical Necessity or Benefit Appeal for Medicare

Covered Services:

1. The physician and/or provider has sixty (60) calendar days from the date of the standardized Notice of Denial of Medical Coverage form to request a post-service 1st level (redetermination) medical necessity or benefit appeal.
2. The provider's request for a post-service Medicare 1st level (redetermination) medical necessity or benefit internal appeal must be in writing to the DWIHN.
3. For all requests for a post-service Medicare 1st level (redetermination) medical necessity or benefit internal appeal, the provider must email at appeals@dwihn.org to the DWIHN UM Appeal Coordinator at a minimum the following:
    a. An explanation of what is being appealed and the name, address and telephone number of the person responsible for filing the appeal;
    b. The complete medical record (at a minimum the intake, psychiatric evaluation, psychiatric progress notes, social work evaluation, social work progress notes, nurse evaluation, nurse progress notes, medication administration notes and discharge summary if not provided previously); and
    c. Any additional supporting documentation that has not previously been submitted.
4. If the above information is sent to the Crisis Service Vendors, the designated Crisis Service Vendors staff person must email the information to the DWIHN UM Appeal Coordinator at appeals@dwihn.org within three (3) business days of receipt of the information. The DWIHN UM Appeal Coordinator then scans and uploads the information into the case in MHWIN.
5. Upon receipt of the provider's request for a first level (redetermination) medical necessity or benefit appeal, the DWIHN UM Appeal Coordinator completes, scans and uploads the standardized Notice of Receipt of Appeal form in MHWIN and then mails it to the provider and enrollee/member within five (5) calendar days of receipt of a post-service Medicare 1st level (redetermination) medical necessity or benefit appeal request.
6. The DWIHN UM Appeal Coordinator then determines if the provider or physician is contracted with DWIHN by checking via telephone or email the provider's current contract status with the DWIHN Contract Management Department.
7. For a non-contracted provider or physician, the standardized Waiver of Liability (WOL) form must be completed, signed and received by DWIHN before the appeal process can begin for Medicare covered services. If the WOL is not received with the initial appeal request, the DWIHN UM Coordinator will send a copy of the WOL form via mail and/or fax to the provider or physician within three (3) calendar days of receipt of the request for a pre-service Medicare 1st level (redetermination) medical necessity or benefit appeal. The DWIHN UM Appeals Coordinator will make two (2) attempts either in writing or telephonically to secure the WOL form and will document the date, time and method of all attempts in the DWIHN tracking log and in the case in MHWIN.
8. If the completed and signed WOL is ***NOT*** secured within sixty (60) calendar days of the request for a pre-service Medicare 1st level (redetermination) appeal to DWIHN, the DWIHN UM Appeals Coordinator sends the case certified mail to the Qualified Independent Contractor, MAXIMUS Federal Services, at 3650 Monroe Ave., Ste. 702, Victor, NY, 14543-1302 within five (5) calendar days to request a Notice of Dismissal. The DWIHN UM Appeals Coordinator

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documents the date the case was forwarded to MAXIMUS for a Notice of Dismissal in the tracking log and in the case in MHWIN.

9. The DWIHN UM Appeal Coordinator also completes the standardized Dismissal of Appeal Request form, scans it and uploads it to the case in MHWIN and then mails it to the provider within five (5) calendar days of the date of DWIHN's request for a dismissal to MAXIMUS. The DWIHN UM Appeal Coordinator enters the date the Dismissal of Appeal Request form was sent to the provider in the tracking log.
10. If the WOL has been secured by the DWIHN UM Appeal Coordinator, he/she will scan and upload it to the case in MHWIN and will continue processing the post-service Medicare 1st level (redetermination) medical necessity or benefit appeal request by the provider.
11. The DWIHN UM Appeal Coordinator must document the date and type (post-service, medical necessity *or* benefit and standard) and the method of notification (written) of the provider's post-service Medicare 1st level (redetermination) medical necessity appeal request and the date the Notice of Receipt of Appeal form was sent to the provider and enrollee/member in the tracking log and in the case in MHWIN.
12. For a post-service Medicare 1st level (redetermination) medical necessity or benefit appeal request, the DWIHN UM Appeal Coordinator ensures that the physician who reviews the case is different from and not a subordinate of the physician who made the initial denial decision and that the physician who reviews the case has a similar or same specialty, credentials, licensure and training as those who typically treat the condition or health problem in question. The complete name and credentials of the physician is entered in the tracking log which is used to monitor this.
13. Upon receipt of the post-service Medicare 1st level (redetermination) appeal request, the physician will review all documentation and fully investigate all aspects of the clinical care provided without deference to the original determination.
14. The reviewing physician when reviewing a medical necessity appeal, in conjunction with independent professional medical judgment, will use nationally recognized guidelines, which include but are not limited to, third party guidelines, CMS guidelines, State guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.
15. The physician who made the original determination may review the case and overturn the initial denial.
16. A determination and written notification of the determination by DWIHN is required within thirty (30) calendar days of receipt of the post-service Medicare 1st level (redetermination) medical necessity or benefit appeal request. The only exception is when the decision is made on the last/30th calendar day. In this case, the standardized Notice of Appeal Decision form and the standardized Physician Letter for the MI Health Link population must be mailed on the same day as the determination.
17. For a post-service Medicare 1st level (redetermination) medical necessity or benefit appeal request, the DWIHN UM Appeals Coordinator completes the Physician Referral Review form in MHWIN. Also, any additional information that is sent in with the appeal request is scanned and attached to case in MHWIN. The MHWIN case is then placed in a MHWIN queue for a DWIHN physician to review.

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18. The DWIHN UM Appeals Coordinator manually checks the MHWIN queue twice a day to ensure that a DWIHN physician has retrieved the case from the queue and reviews it within the appropriate timeframe.
19. For the post-service Medicare standard 1st level (redetermination) medical necessity or benefit appeal, the DWIHN UM Appeal Coordinator will communicate daily via email, face to face or telephonically with the DWIHN if after the initial seven (7) calendar days the DWIHN physician has not reviewed the case. The DWIHN UM Appeal Coordinator documents all attempts (date and time) to contact the physician in the tracking log. The DWIHN UM Appeal Coordinator will use the tracking log as a tool to monitor the timeframe.
20. The DWIHN physician will document their decision in MHWIN and document their name, title, and credentials if not done by electronic signature.
21. The DWIHN will then immediately notify via email the DWIHN UM Appeal Coordinator via email of their decision.
22. The DWIHN UM Appeal Coordinator must document the physician reviewer's complete name and credentials and the type of decision rendered (approve, deny or split decision), the decision date and the date of the Notice of Appeal Decision (if applicable) in the tracking log and in MHWIN.
23. If the decision is to ***overturn*** part or all of the initial denial, the DWIHN UM Appeal Coordinator verbally notifies the provider within three (3) hours of the decision and documents the date and time of the verbal notification in the tracking log.
24. The DWIHN UM Appeal Coordinator enters the authorization in MHWIN within twenty four (24) hours of the determination.
25. The DWIHN UM Appeal Coordinator also documents the date the authorization was issued in the tracking log.
26. For a partially overturned determination, written notification using the standardized Notice of Appeal Decision form and the standardized Physician Letter for the MI Health Link population are sent to both the provider and enrollee/member within twenty four (24) hours of the decision. The only exception is when the decision for a post-service appeal is made on the last/30th day. In this case, the Notice and Physician Letter must be mailed on the same day as the determination.
27. The Notice and Physician Letter are sent to the provider and enrollee/member by the DWIHN UM Appeal Coordinator who also retains a copy in MHWIN.
28. The DWIHN UM Appeal Coordinator will ensure that written notification is sent to the provider and enrollee/member within thirty (30) calendar days of a post-service Medicare standard 1st level (redetermination) medical necessity or benefit appeal.
29. The DWIHN UM Appeal Coordinator must document the complete name and credentials of the person to whom the verbal notification was given and the date and time of the verbal notification in the case notes in MHWIN.
30. If the decision is to ***uphold*** part or all of the initial denial, the DWIHN UM Appeal Coordinator verbally notifies the provider within three (3) hours of the decision and documents the date and time of the verbal notification in their tracking log. Written notification is sent within twenty four (24) hours of the determination to the provider and enrollee/member using the standardized Notice of Appeal Decision form and the standardized Physician Letter for the MI

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Health Link population. The only exception is when the decision for a post-service Medicare (redetermination) appeal is made on the last/30th calendar day. In this case, the Notice and Physician Letter must be mailed on the same day as the determination.

31. The Notice and Physician Letter are sent to the provider and enrollee/member by the DWIHN UM Appeal Coordinator who also retains a copy in MHWIN.
32. The DWIHN UM Appeal Coordinator will ensure that written notification is sent to the provider and enrollee/member within thirty (30) calendar days of a post-service Medicare (redetermination) medical necessity or benefit appeal.
33. The DWIHN UM Appeal Coordinator must also document the complete name and credentials of the person to whom the verbal notification was given and the date and time of the verbal notification in the case notes in MHWIN.
34. If the Notice of Appeal Decision form and the standardized Physician Letter for the MI Health Link population are manually generated, the DWIHN UM Appeal Coordinator will scan them and attach them to the case in MHWIN.
35. The DWIHN UM Appeal Coordinator must review the Notice of Appeal Decision form to ensure the form has the following:
    a. A statement of what action is being taken in easy, understandable language which does not include:
        - abbreviations or acronyms that are not defined
        - is culturally and linguistically sensitive to the enrollees/members' needs
        - 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. Includes an explanation that the case is automatically being forwarded to MAXIMUS for a 2nd level (reconsideration) medical necessity appeal by DWIHN.
    e. A statement that the services will continue up to the end of the currently approved treatment or final decision whichever comes first;
    f. A statement that the enrollee/member may have to pay for the continuation of services if the result of the Medicare 2nd level (reconsideration) appeal with MAXIMUS is to uphold the denial;
    g. 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;
    h. A statement that the enrollee/member and/or provider can request copies of all documents relevant to the appeal, free of charge;
    i. 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

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permission by completing and forwarding the Appointment of Representative form to DWIHN; and

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

36. The DWIHN UM Appeal Coordinator documents the date the Notice of Appeal Decision form (if applicable) is mailed to the provider and enrollee/member in the tracking log and in MHWIN.
37. The designated Crisis Service Vendors staff person forwards via email their complete tracking log to the DWIHN UM Appeals Coordinator by the 10th of each month for compliance monitoring.

<u>Post-Service 2nd Level Reconsideration Medical Necessity or Benefit Appeal for Medicare Covered Services:</u>

1. The DWIHN UM Appeals Coordinator copies or prints the complete case record including but not limited to the following to MAXIMUS:
   - Reconsideration background data form
   - Eligibility and benefit information
   - Clinical case reviews with the treating physician
   - Medical Necessity Criteria and/or benefit information utilized
   - Copy of Denial Letter
   - Authorization Summary
   - Reason for the Appeal
   - Any supporting information sent by the physician, provider, enrollee/member, or enrollee/member representative

1. The complete case record is sent certified mail to MAXIMUS Federal Services at 3650 Monroe Ave., Ste. 702, Victor, NY, 14543-1302, within three (3) calendar days of the 1st level appeal determination.
2. The UM Appeal Coordinator documents the date the complete case record was sent to MAIXMUS in the DWIHN tracking log and in MHWIN. Note that the DWMA UM Appeal Coordinator must mail the chart within sixty (60) calendar days of receipt of the provider's initial post-service Medicare 1st level appeal request.
3. MAXIMUS tries to review the case, make a determination and provide written notification of their decision to the provider, enrollee/member and DWIHN within thirty (30) calendar days of receipt of the 2nd level appeal request. However, if they take longer, they do not incur any penalty.
4. Once determination is received from MAXIMUS, the DWIHN UM Appeal Coordinator will document the date of MAXIMUS' notification and the type of determination (approve, deny or

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split decision) in MHWIN and in the DWIHN tracking log.

5. If the decision by MAXIMUS is to ***overturn*** part or all of the post-service 1st level (redetermination) medical necessity or benefit determination, the DWIHN UM Appeal Coordinator enters the authorization for services into MHWIN. Written notification is mailed to the provider and enrollee/member within twenty-four (24) hours of the determination by the DWIHN UM Appeal Coordinator. A copy of the notification is retained in MHWIN.
6. The DWIHN UM Appeal Coordinator documents the date the authorization was issued (if applicable) in the DWIHN tracking log.
7. The DWIHN UM Appeal Coordinator then tracks the claim to ensure payment is made within thirty (30) calendar days of MAXIMUS' decision. The DWIHN UM Appeal Coordinator also has to provider MAXIMUS proof of payment by sending them a copy of the check number, check date, amount paid and an explanation of benefits within thirty (30) calendar days of their decision. The DWIHN UM Appeal Coordinator documents the date the claim was paid and the date of proof of payment was sent to MAXIMUS in MHWIN and in the DWIHN tracking log.
8. If the decision is to ***uphold*** part or all of DWIHN's post-service 1st level (redetermination) medical necessity or benefit determination, MAXIMUS notifies the provider, the enrollee/ member and DWIHN of the decision and also explains the next (3rd) level appeal that is available with the Administrative Law Judge (ALJ).

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Post-Service 3rd Level Medical Necessity or Benefit Appeal for Medicare Covered Services:

1. If at least $150 is still in controversy, the provider can request a post-service Medicare 3rd level appeal with the ALJ within sixty (60) calendar days of receipt of MAXIMUS' 2nd level decision.
2. In most cases, the ALJ reviews the case, makes a determination and provides written notification of their decision to the provider, the enrollee/member and DWIHN within ninety (90) calendar days of receipt of the 3rd level appeal request.

1. If the decision by the ALJ is to ***overturn*** part or all of MAXIMUS' 2nd level medical necessity or benefit determination, the DWIHN UM Appeal Coordinator enters the authorization for services into MHWIN. Written notification is mailed to the provider and enrollee/member within twenty-four (24) hours of the determination by the DWIHN UM Appeal Coordinator. A copy of the notification is retained in MHWIN.
2. The DWIHN UM Appeal Coordinator documents the date the authorization was issued (if applicable) in the DWIHN tracking log.
3. The DWIHN UM Appeal Coordinator then tracks the claim to ensure payment is made within thirty (30) calendar days of the ALJ's decision. The DWIHN UM Appeal Coordinator documents the date the claim was paid in MHWIN and the DWIHN tracking log.
4. If the decision is to ***uphold*** part or all of MAXIMUS' 2nd level medical necessity or benefit determination, the ALJ notifies the provider, the enrollee/member and DWIHN of the decision and also explains the next (4th) level of appeal that is available with the Medicare

Administrative Council (MAC).

<u>Post-Service 4th Level Medical Necessity or Benefit Appeal for Medicare Covered Services:</u>

1. The provider can request a post-service Medicare 4th level appeal with MAC within sixty (60) calendar days of receipt of the ALJ's 3rd level decision.
2. In most cases, MAC reviews the case, makes a determination and provides written notification of their decision to the provider, the enrollee/member and DWIHN within ninety (90) calendar days of receipt of the 4th level appeal request.
3. Once the determination is received from MAC, the DWIHN UM Appeal Coordinator will document the date of MAC's notification and the type of determination (approve, deny or split decision) in MHWIN and in the DWIHN tracking log.
4. If the decision by MAC is to ***overturn*** part or all of ALJ's 3rd level medical necessity or benefit determination, the DWIHN UM Appeal Coordinator enters the authorization for services into MHWIN. Written notification is mailed to the provider and enrollee/member within twenty-four (24) hours of the determination by the DWIHN UM Appeal Coordinator. A copy of the notification is retained in MHWIN.
5. The DWIHN UM Appeal Coordinator documents the date the authorization was issued (if applicable) in the DWIHN tracking log.
6. The DWIHN UM Appeal Coordinator then tracks the claim to ensure payment is made within thirty (30) calendar days of MAC's decision. The DWIHN UM Appeal Coordinator documents the date the claim was paid in MHWIN and the DWIHN tracking log.
7. If the decision is to ***uphold*** part or all of ALJ's 3rd level medical necessity or benefit determination, MAC notifies the provider, the enrollee/member and DWIHN of their decision and also explains the next (5th) level of appeal that is available with the U.S. District Judge.

<u>Post-Service 5th Level Medical Necessity or Benefit Appeal for Medicare Covered Services:</u>

1. If at least $1,460 or more is still in controversy, the provider can request a post-service Medicare 5th level appeal before a U.S. District Judge within sixty (60) calendar days of receipt of the MAC's 4th level decision.
2. There is not time frame for the Federal Court decision which is the final appeal level.
3. Once the determination is received from the U.S. District Judge, the DWIHN UM Appeal Coordinator will document the date of the U.S. District Judge's notification and the type of determination (approve, deny or split decision) in MHWIN and in the DWIHN tracking log.
4. If the decision by the U.S. District Court Judge is to ***overturn*** part or all of the MAC's 4th level medical necessity or benefit determination, the DWIHN UM Appeal Coordinator enters the authorization for services into MHWIN. Written notification is mailed to the provider and enrollee/member within twenty-four (24) hours of the determination by the DWIHN UM Appeal Coordinator. A copy of the notification is retained in MHWIN.
5. The DWIHN UM Appeal Coordinator documents the date the authorization was issued (if applicable) in the DWIHN tracking log.

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6. The DWIHN UM Appeal Coordinator then tracks the claim to ensure payment is made within thirty (30) calendar days of the U.S. District Judge's decision. The DWIHN UM Appeal Coordinator documents the date the claim was paid in MHWIN and the DWIHN tracking log
7. If the decision is to ***uphold*** part or all of the MAC's 4th level medical necessity or benefit determination, the U.S. District Court Judge notifies the provider, the enrollee/member and DWIHN of their decision and explains there is no further appeal levels.

1. The designated Crisis Service Vendors staff person forwards via email their complete tracking log to the DWIHN UM Appeals Coordinator by the 10th of each month for compliance monitoring.

Post-Service Administrative Appeals:

1. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person verbally informs the physician and/or provider of the determination and sends via mail the standardized Administrative Denial form which explains that the provider did not abide by their contractual agreement or requirements (administrative reasons) and the appeal process to the enrollee/member, physician and/or provider. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person documents the date of the Administrative denial form in their tracking log.

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Post-Service 1st Level Redetermination Administrative Appeal for Medicare Covered Services:

1. The physician and/or provider has sixty (60) calendar days from the date of the standardized Administrative Denial form to request a post-service Medicare 1st level (redetermination) administrative appeal to DWIHN or Crisis Service Vendors.
2. The provider's request for a post-service Medicare 1st level (redetermination) administrative internal appeal must be in writing to DWIHN or the Crisis Service Vendors.
3. All requests for a post-service Medicare 1st level (redetermination) administrative internal appeal must include at a minimum the following:
    a. An explanation of what is being appealed and the name, address and telephone number of the person responsible for filing the appeal;
    b. Any additional supporting documentation such as additional clinical information that has not yet been previously submitted; and
    c. Documentation of the reasons why the provider feels the services should be paid and a copy of the claim(s).
4. Upon receipt of a provider's request for a post-service Medicare 1st level (redetermination) administrative appeal, the DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person completes the standardized Notice of Receipt of Appeal form, scans it and uploads it to the case in MHWIN and then mails it to the provider and enrollee/member within five (5) calendar days of receipt of a post-service 1st level (redetermination) administrative appeal request.

5. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person must document the date and type (post-service, administrative and standard) and the method of notification (written) of the provider's post-service 1st level (redetermination) administrative appeal request and the date the Notice of Receipt of Appeal form is sent to the provider and enrollee/member in their tracking log and in MHWIN.
6. The DWIHN UM Appeal Coordinator or designated staff at the Crisis Service Vendors will review all documentation submitted with the appeal and determine if appeal is based on medical necessity or only on not meeting notification time frames. If the appeal is based on medical necessity, it will be forwarded to a physician for review. If the appeal is based on administrative reasons only, then it will be forwarded to a Professional staff person i.e. Supervisor for review.
7. For a post-service 1st level (redetermination) administrative appeal request, the DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person ensures that the Professional staff person who reviews the case is different from the Professional staff person who made the initial denial decision. The complete name and credentials of the Professional staff person is entered in their tracking log which is used to monitor this.
8. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person forwards via email or face to face the administrative appeal request to the DWIHN or Crisis Service Vendors UM Supervisor or designee for review and determination.
9. The DWIHN or Crisis Service Vendors UM Supervisor or designee will document their decision in MHWIN and documents their name, title, and credentials if not done by electronic signature.
10. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person must document the complete name and credentials of DWIHN or Crisis Service Vendors UM Supervisor or designee and the type of decision rendered (approve, deny or split decision), the decision date and the date of the standardized Administrative Appeal Determination form in their tracking log and in MHWIN.
11. If the decision is to ***overturn*** part or all of the initial denial, the DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person verbally notifies the provider within three (3) hours of the decision and documents the date and time of the verbal notification in their tracking log. Written notification using the standardized Administrative Appeal Determination form is sent within twenty four (24) hours of the decision to the provider and enrollee/member. The only exception is when the decision for a post-service Medicaid (redetermination) administrative appeal is made on the last/30th calendar day. In this case, the form must be mailed on the same day as the determination. A copy of the form is also retained in MHWIN.
12. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person will ensure that written notification is sent to the provider and enrollee/member within thirty (30) calendar days of a post-service Medicaid (redetermination) administrative appeal request.
13. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person must document the complete name and credentials of the person to whom the verbal notification was given and the date and time of the verbal notification in the case notes in their electronic system.
14. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person also enter the authorization of services in MHWIN within twenty-four (24) hours of determination.

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15. If the decision is to ***uphold*** part or all of the initial denial, the DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person verbally notifies the provider within three (3) hours of the decision and documents the date and time of the verbal notification in their tracking log. Written notification using the standardized Administrative Determination form is sent within twenty four (24) hours of the decision to the provider and enrollee/member. The only exception is when the decision for a post-service Medicaid (redetermination) administrative appeal is made on the last/30th calendar day. In this case, form must be mailed on the same day as the determination. A copy of the form is also retained in MHWIN.
16. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person will ensure that written notification is sent to the provider and enrollee/member within thirty (30) calendar days of a post-service Medicaid (redetermination) administrative appeal request.
17. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors 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.
18. The DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person will review the Administrative Appeal Determination form to ensure it includes a statement that this is the final level of appeal and that the enrollee/member is to be held harmless and to provide direction if he/she receive a bill.
19. If the form is manually generated or the DWIHN UM Appeal Coordinator or designated Crisis Service Vendors staff person or will scan the form and attach it to the case in MHWIN.
20. The designated Crisis Service Vendors staff person forwards via email their complete tracking log to the DWIHN UM Appeals Coordinator by the 10th of each month for compliance monitoring.

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MONITORING STEPS

Who monitors this procedure:	UM Administrator
Department:	Utilization Management
Frequency of monitoring:	Monthly
Reporting provided to:	UM Director
NCQA-UM 8 & 9 and MDHHS and DWIHN (PIHP) contract and The Three-Way contract	

Approval Signatures

Step Description	Approver	Date

Policy Admin Approval	Allison Smith: Project Manager, PMP	02/2023

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