NORTHCARE NETWORK

POLICY TITLE: Service Authorization	**CATEGORY:** Utilization Management	
EFFECTIVE DATE: 6/26/02	**BOARD APPROVAL DATE:** 12/9/15	
REVIEWED DATE: 2/19/25	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☒ **Yes** ☐ **No**
RESPONSIBLE PARTY: QI-UM Director	**CEO APPROVAL DATE:** 4/3/25 Megan Rooney, CEO	

APPLIES TO

NorthCare Network Personnel
Member CMHSPs
SUD Provider

POLICY

It is the Policy of NorthCare Network that Member CMHSPs (Community Mental Health Service Providers) have in place mechanisms that assure service authorization and coverage determination decisions are made in compliance with federal and state regulations and all applicable contract requirements. Member CMHSPs and Providers of SUD (Substance Use Disorder) services must have an authorization process in place that is consistent with this policy. Any assessment or screening tool, including those required by the Michigan Department of Health and Human Services, may not be used as an arbitrary means for identifying the amount, scope, or duration of services that an individual will receive. NorthCare Network will provide oversight and monitoring activities to ensure consistent application of eligibility criteria for authorization decisions and consult with providers when appropriate. It is NorthCare Network's policy that the authorization process shall not prevent or delay the provision of necessary services to the consumer. MHL Members can continue to get services while the provider is being enrolled.

NOTE: Emergency services are NOT required to be prior authorized and may be accessed from the local Member CMHSP office during office hours or through the regional after hour crisis phone services at any other time.

PURPOSE

To assure criteria used for **non-emergent** service authorization decisions involving beneficiary eligibility and coverage determinations are consistently and uniformly applied.

DEFINITIONS

1. ***Adverse Benefit Determination (ABD):*** A decision that adversely impacts a Medicaid beneficiary's claim for services due to:
    - Denial or limited authorization of a requested service, including the type or level of service.
    - Reduction, suspension, or termination of a previously authorized service.
    - Denial, in whole or in part, of payment for a service.

- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within **72 hours** from the date of receipt of a request for expedited service authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP.
- Failure of the PIHP to act within **30 calendar days** from the date of a request for a standard appeal.
- Failure of the PIHP to act within **72 hours** from the date of a request for an expedited appeal.
- Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **90 calendar days** of the date of the request.
- For a resident of a rural area, the denial of an Enrollee's requests to exercise their right, to obtain services outside the network.
- Denial of Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility.

2. ***Appeal:*** A written or verbal request for a review of an "Adverse Benefit Determination" as defined above.

3. ***Authorization/Certification:*** (UM-Specific Definition) A determination by an organization that an admission, extension of stay, service or support or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

4. ***Clinical Rationale:*** For purposes of this policy, a statement that provides additional clarification of the clinical basis for a UM denial/non-certification decision. The clinical rationale should relate the non-certification decision to the consumer's clinical condition, provide specific reasons why the consumer's condition or clinical scenario did not meet clinical review criteria, and supply a sufficient basis for a decision to pursue an appeal.

5. ***Consumer/Enrollee/Individual***: interchangeable terminology to describe the person that is requesting to be, or is currently, the recipient of services.

6. ***Coverage Determination:*** For purposes of this policy, it is the process of determining what, if any, publicly funded benefit plan an individual is eligible for. The process involves applying coverage eligibility criteria of the respective benefit plans based on the unique circumstances that define the individual's relationship to the care system.

7. ***Denial/Non-Certification:*** A determination by an organization that an admission, service, or extension of service has been reviewed and, based on the information provided does not meet the clinical requirements for medical necessity, appropriateness, or effectiveness, is inconsistent with clinical standards of care, or otherwise fails to meet the requirements necessary to approve a benefit as payable or covered under the plan.

8. ***Emergent Care:*** Medical care that is required immediately to prevent serious jeopardy to someone's health.

9. ***Expedited Authorization Request:*** A request for which a consumer/provider indicates, or Utilization Management determines, that using the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. An expedited authorization decision must be made and notice provided as expeditiously as the member's health condition requires no later than 72 hours, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the member's best interest.
    a. Services that require expedited action due to potential of serious jeopardy include:
        i. Inpatient preadmission screening decisions
        ii. Detoxification, methadone, and residential services for SUD priority population individuals

10. **Extension:** the ability to extend an authorization request up to an additional 14 calendar days if the enrollee requests the extension or if the PIHP can show a need that is in the enrollee's best interest to extend the timeframe. Extensions require oral and written notification to the enrollee.

11. ***Initial Clinical Review:*** Clinical review of a request for a UM decision made by appropriately licensed, or certified health professionals. Initial clinical review staff may approve requests for services or supports that meet clinical review criteria but must refer requests that do not meet clinical review criteria to peer clinical review for certification or non-certification.

12. ***Medically Necessary/Medical Necessity:*** A determination that a specific service is medically (clinically) appropriate, necessary to meet an individual's needs, consistent with the person's diagnosis, symptomology, and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care.

13. ***Ordering Provider:*** The provider who specifically prescribes or requests the health care service being reviewed. Also referred to as the "requesting provider".

14. ***Peer Clinical Review:*** Clinical review conducted by appropriate health professionals when a request for a service or support was not approved/certified during initial clinical review.

15. ***Principal Reason:*** A statement that explains the general reason(s) for a non-certification decision. **NOTE:** "Service is not medically necessary" or "lack of medical necessity" are examples of <u>unacceptable</u> principal reasons.

16. ***Provider:*** A licensed health care facility, program, agency, or health professional that delivers health care services.

17. ***Utilization Management (UM):*** Utilization management is a set of administrative functions designed to ensure that only eligible beneficiaries receive plan benefits; and that they receive plan benefits when necessary and in an amount sufficient to meet their needs.

18. ***Urgent Care:*** Medical care necessary for a condition that is not life threatening but requires treatment that cannot wait for a regularly scheduled clinical appointment. If the medical care is not rendered, the condition could seriously jeopardize the life or health of the individual, or the ability of the individual to regain maximum function.

REFERENCES

- Balanced Budget Act of 1997
- Michigan Mental Health Code
- MDHHS/PIHP Contracts
- Michigan Medicaid Provider Manual
- PIHP/Member CMHSP Delegation Agreement
- NorthCare Network Access Policy
- NorthCare Network Utilization Management Plan
- NorthCare Network Level of Care Service Packages
- NorthCare Network Enrollee Grievances and Appeal Policy
- NorthCare Provider Grievance and Appeal Process Administrative Policy
- Appeal and Grievance Resolution Processes Technical Requirement
  Appeal-and-Grievance-Resolution-Processes-Technical-Requirement_704451_7.pdf (michigan.gov)
- 42 CFR 438.402
- 42 CFR 438.210a5

HISTORY

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BOARD APPROVAL DATE: 6/2/02; 2/23/05; 5/3/06; 2/4/09, 12/9/15

PROCEDURE

A. UM Staff Requirements & Responsibilities

1. **Qualifications**
   UM staff conducting peer clinical reviews are, at minimum, masters-level trained mental health professionals who hold a current, active, valid unrestricted Michigan license in the same licensure category as the ordering provider, or as a doctor of medicine or doctor of osteopathic medicine and have clinical expertise about the treatment under review, as defined by licensure scope of practice. Peer reviewers are deemed qualified by NorthCare Network or provider organization senior clinical staff; to make medical necessity determinations or render a clinical opinion about the condition and treatment that is the subject of the review. Peer clinical reviewers are responsible for conducting peer clinical reviews in all cases where a certification is not issued through initial clinical review or initial screening.

   UM staff conducting initial clinical reviews are, at minimum, Mental Health Professionals who hold an active Michigan license and/or certification with a scope

of practice relevant to the clinical area that is the subject of the initial clinical review. Initial clinical review staff may approve requests for admissions, supports, or services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to peer clinical review for certification or non-certification. Non-certifications are not issued based on initial screening or the initial clinical review. Initial clinical reviewers may, however, assist in the notification process for non-certifications.

2. **Access to Review Staff**
   At a minimum, UM staff are available 8:00AM-4:00PM local time Monday-Friday (except holidays) in each time zone where NorthCare Network conducts at least two percent of its review activities. UM staff can receive communications from providers and consumers during the business day and after business hours via toll free telephone, confidential FAX, email, or voice mail messaging. Communications not directly received by UM staff are responded to within one business day.

3. **Consultation Resource Qualifications & Physician-level Review**
   Licensed UM health professionals provide ongoing availability, monitoring, and oversight of non-clinical administrative staff performing initial/pre-review screening. Initial clinical reviewers have access to consultation with a licensed doctor of medicine or osteopathic medicine, a licensed health professional in the same licensing category as the ordering/requesting provider, or a health professional with the same clinical education as the ordering provider in clinical specialties where licensure is not issued. Senior Clinical staff are available to UM staff for consultation on matters within their scope of practice and relevant to the clinical areas which are the subject of the review. Senior Clinical Staff are designated by NorthCare Network or the provider organization as qualified to perform clinical oversight of services provided; and who hold a current unrestricted clinical license, have post-graduate experience in direct consumer care, and are Board certified if the senior clinical staff is an M.D. or D.O. UM activities for services requiring physician review are carried out by qualified contracted physicians, or the provider organization Medical Director.

4. **Communications & Disclosure**
   UM staff identify themselves in all incoming and outgoing telephone communications. Staff are not required to provide their last name, however they must identify their first name, title, and organization name. Written communications sent to non-applicants in response to general informational requests only identify the organization and program name and do not require the UM staff name. Informational disclosures about specific UM requirements and procedures, benefit plan eligibility criteria, covered services, and program/service-specific eligibility requirements are verbally provided by UM staff upon request. Unless otherwise agreed upon, UM staff conducts outgoing communications related to utilization management during providers' reasonable and normal business hours.

5. **On-site Utilization Management (UM) Activities**
   UM activities are typically carried out using the NorthCare Network Electronic Medical Record (ELMER), and/or via the telephone. Unless otherwise agreed upon, UM staff schedule facility-based reviews at least one day in advance, check in with designated facility personnel upon arrival and carry identification (name, title, and organization) at all times while on-site. UM personnel must minimize disruption to

facility operations while conducting UM activities and follow reasonable facility procedures including adherence to policies and/or documented procedures for appropriate safeguards for confidentiality and security of any information gathered during the onsite review.

6. **Financial Prohibitions**
   Compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary as defined in 42CFR 438.210a5.

7. **Coverage and Authorization of Services**
   Services shall be provided in an amount, scope, and duration no less than the amount, scope, and duration of fee for service Medicaid individuals.

B. Review Criteria

1. **Development**
   Clinical review criteria used by NorthCare Network for all UM determinations are defined by the MDHHS which serves as the regulatory agency governing Michigan's public mental health system. Review criteria are issued by MDHHS and specified in the MDHHS/PIHP master contract, Block Grant Agreement with MDHHS for Substance Use Disorder Services (Contracts), and the Michigan Medicaid Provider Manual (Manual). NorthCare Network is issued clinical review criteria and obtains updates when the Contracts are renewed (typically annually), and upon publication of Manual updates (typically 4 times annually).

   Service authorization is a requirement for Medicaid beneficiaries and must be provided in accordance with 42 CFR § 438.210. Authorization for covered services and supports must be consistently applied in accordance with the 'eligibility guidelines' specified in the Manual, and/or Contracts, as applicable to the specific level of care coverage for which the individual is eligible. Reviewers should review criteria for authorization, consult with the requesting provider as necessary, and consider the individuals current needs and individual plan of service when authorizing services. While the Manual explicitly prohibits denial of a requested service "based solely on preset limits on cost, amount, scope and duration of services", it specifies conditions which allow for denial of a service or placing "appropriate" limits on amount, scope, or duration of a requested service.

   The clinical review criteria are based on current principles and processes which require a specific service planning process and, when appropriate, use of explicit practice guidelines which are based on current clinical principles. The Contracts identify the services NorthCare Network is required to offer, to whom services can legitimately be authorized, and require that services be provided when medically necessary. The Manual describes service/program eligibility requirements, defines each covered service, and includes a definition of medically necessary services. Collectively, the Contracts and the Manual define the review criteria and provide structure and framework to the procedures used when making eligibility, coverage, and service authorization decisions.

2. **Annual Review & Endorsement**
   Clinical criteria are reviewed annually by NorthCare Network and actively practicing providers representing each Member CMHSP who have current knowledge relevant to the clinical review criteria being evaluated and approved by the NorthCare Clinical Leadership. Clinical criteria are reviewed by the NorthCare Network Quality Management and Oversite Committee. Clinical criteria issued by MDHHS, including necessary updates, are approved/endorsed by the NorthCare Network Clinical Leadership.

C. Utilization Management Activities

1. **Components of Utilization Management**
   Utilization management functions are carried out through the application of one set of common policies, procedures, and protocols that are used by NorthCare Network and each Member CMHSP throughout the region. Utilization management functions may be retained by NorthCare Network or delegated fully or partially to the Member CMHSPs as stipulated in the written delegation agreement. The components of utilization management include:

   a. Access and Eligibility Determination. This includes initial screening, funding source verification, service referral, or appointment scheduling of applicants for services.
   b. Utilization Management Protocols. These include treatment decision-support tools used to assure criteria used in determinations involving medical necessity, level of care, service type and intensity, clinical practices patterns, or service denials, reductions, or terminations are consistently and uniformly applied and determined by a properly credentialed staff.
   c. Authorization. This component of UM links the payment process to an admission, extension of stay, or other services provided.
   d. Utilization review. These activities focus on proper application of level of care protocols, practice guidelines, over/under utilization, and outliers.

   Review will be completed through data analysis or clinical records as necessary to ensure compliance with all applicable federal and state laws, regulations, and policies, identify, monitor, and address trends, and monitor timeliness.

2. **Independent Review Organization (IRO)**
   NorthCare Network holds a contract with an Independent Review Organization to provide appeal determinations performed by physicians experienced in the applicable service in situations in which the NorthCare Network Medical Director functions as the Peer Reviewer. NorthCare may also utilize the IRO for peer-to-peer consultations resulting in a clinical decision of medical necessity. NorthCare adopts the opinion of the IRO when making those clinical review decisions.

3. **Review Process**
   Peer Clinical Reviewers in the NorthCare Network Utilization Management Department evaluate medical necessity and make authorization determinations for the following UM review requests:

   a. Prospective reviews for requests for outpatient public mental health or residential substance abuse treatment services.

b. Concurrent reviews for:
    - Inpatient psychiatric hospitalization services and mental health crisis residential services beyond the initial authorization period.
    - Outpatient substance abuse treatment services beyond the initial authorization period.
    - Ongoing Residential substance abuse treatment services.

Requests for services are processed by UM staff through various methods depending on the type of service and who, or what, entity is making the request. Service authorization requests are typically processed via telephone communications or through the electronic health record (ELMER). Requests made by applicants for initial entry into outpatient mental health or residential SUD services occur via telephone. Providers of outpatient SUD services submit continued service authorization requests through the electronic health records supplemented with telephone, confidential fax, email, and/or voice mail messaging when necessary. Reviews involving continued authorization of psychiatric inpatient and crisis residential services are conducted via telephone.

The review process incorporates the specific benefit plan and scope of coverage requirements for which an individual is eligible; and is designed to ensure that only eligible beneficiaries receive plan benefits; that all beneficiaries receive medically necessary services when needed and that value-purchasing guides the selection and provision of services. As applied to services and supports, value purchasing assures appropriate access, quality, and is the least expensive of available alternatives yet sufficient to achieve their purpose. Only those services that meet the medical necessity criteria defined in the Michigan Medicaid Provider Manual and/or Block Grant Agreement with MDHHS for Substance Use Disorder Services can legitimately be authorized for payment with plan benefits.

In processing requests for initial and continued authorization of services, all UM determinations of a medically necessary support, service, or treatment must be:

- Based on information provided by the individual and/or people who know the individual; and/or qualified professionals who have evaluated the individual; and
- Based on person-centered planning; and
- Made within timeliness standards as defined in the table below; and
- Sufficient in amount, scope, and duration to reasonably achieve the intended purpose; and
- Consistent with additional service-specific criteria, as applicable.

Determinations may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the individual. Determinations can place appropriate limits on a service based on medical necessity criteria or for purposes of UM as long as the services furnished can achieve their purpose, and are authorized in a manner that reflects the individuals ongoing need for such services and supports and protects the individuals freedom to choose the method of planning to be used.

UM decisions are made by staff who meet the qualifications established in this policy and in accordance with the determination criteria described above. All UM reviews are

conducted by staff that are located in the United States when conducting review activities. UM reviews may include non-clinical administrative staff who perform scripted initial screening and are explicitly limited to the acquisition of structured clinical data contained within the scripted review. In all other situations, use of non-clinical administrative staff in the UM process is limited to collecting, entering, and/or transferring non-clinical data (demographic, insurance, etc.), or other activities that do not require evaluation or interpretation of clinical information. Non-clinical administrative staff do not perform reviews of service request documentation for completeness of information.

UM staff do not issue reversals of previously authorized services unless new information, relevant to the decision and not available at the time of the review, is received. Reversing a previously authorized service could be done in situations where:

- It is learned that a provider had given inaccurate information on a consumer.
- When it has been determined that a consumer was not in fact eligible for benefits.
- Provider did not live up to contractual obligations.
- Documents reviewed during the retrospective review process do not support the service was provided in a manner consistent with benefit plan requirements for which an individual is eligible.

UM staff that conduct peer clinical reviews are available to discuss clinical information with attending physicians or other requesting/ordering providers. If a determination is made to issue a denial (prospective and concurrent reviews only) and no peer-to-peer consultation has occurred, the ordering provider is permitted the opportunity to discuss the denial. The ordering provider may, within one business day of the request, discuss the denial with the peer reviewer issuing the denial. If the original peer reviewer cannot be available within one business day, an alternative clinical peer reviewer is available to discuss the denial. If the discussion between the ordering provider and peer reviewer does not result in a reversal of the decision to issue the denial, the consumer are informed of their right to initiate an appeal and how to do so.

If a certification is not issued through the initial clinical review, the provider is offered a peer-to-peer clinical review so that additional information can be obtained through the peer-to-peer process. The peer-to-peer review is conducted within 24 hours of the provider request and decision is made following review. It is the responsibility of the provider to provide times which they can be available for the peer-to-peer clinical review. Failure to request a peer-to-peer clinical review or provide the additional clinical information within the required timeframe will result in peer review of NorthCare documentation and a decision will be rendered.

Administrative denials involve issues outside of the scope of the clinical review which include:

- Lack of information denial: Provider/facility failed to provide NorthCare with clinical information regarding an inpatient admission or continuing stay within 24 hours of the previously approved course of treatment. Provider/facility did not respond to, or decided not to participate in, a peer-to-peer consultation before the expiration of the previously approved course of treatment when they were

notified that the initial clinical reviewer could not continue recertification of the stay. A peer reviewer will review information available and make determination based on available information.

- Lack of authorization denial: When the provider/facility provides services to a consumer without prior authorization.

a. **Types of Reviews**
Requests for authorizations of services are processed using three types of reviews: Prospective, Concurrent, and Retrospective. Prospective reviews apply the review criteria prior to the onset of a service and focus on determining whether a service should begin. Retrospective reviews determine whether a service, already delivered, should have been provided. Concurrent reviews are conducted during a course of service delivery to determine whether a service should continue. Concurrent reviews occur at a frequency based on the severity or complexity of the individual's condition, or on necessary treatment and discharge planning activity. While individual circumstances may warrant daily reviews, concurrent reviews are not routinely conducted on a daily basis. Time frames for a UM decision and special conditions for each type of review are described in the following table:

i. Prospective Review
    a. Urgent: As soon as possible but not to exceed 72 hours
    b. Non-Urgent: within 14 calendar days with the option of extending an additional 14 calendar days at the request of the individual or provider or by NorthCare Network if determined an extension to allow additional information to be submitted is necessary due to circumstances beyond its control

ii. Retrospective Review
    a. Within 14 calendar days of receipt of the request for UM decision.
        i. May be extended one time for an additional 14 calendar days if NorthCare Network determines, because of circumstances beyond control, an extension is necessary to allow time for additional information to be submitted.

iii. Concurrent Review
    a. Reduce or Terminate
        i. Early enough to permit the individual to request a review and receive an UM decision before the decision occurs
    b. Extension
        i. Within 24 hours if the request is received at least 24 hours before the expiration of the currently approved course of services
        ii. Within 72 hours if the request is received less than 24 hours before the expiration of the currently approved course of services.

iv. Special Conditions involving extensions
    a. Individuals are notified in writing of the circumstances requiring the extension before the initial 14 days expire. Individuals are

informed of the right to file a grievance if they disagree with that decision. The extension notice includes the date the decision is expected to be made.

b. If the circumstances are due to insufficient information, and the individual is expected to provide the information, the written notice of extension specifically describes the required information.

b. **Scope of review information**

UM staff collect only the information required to render a UM decision and is accepted from any reasonably reliable source that will assist in the determination process. Examples of reasonably reliable sources include the consumer, individuals who know the consumer personally, or qualified health care professionals who have evaluated the consumer. UM staff do not routinely request copies of entire medical records, or require providers to numerically code diagnoses, procedures or specify any other clinical or demographic attribute to be considered in the determination process. To avoid the need for duplicate information requests, information collected is made available to any UM staff with a valid need to know.

All review determinations are made based strictly on case-specific information necessary to make the decision. In the case of prospective and concurrent reviews, decisions are based solely on information obtained at the time of the review determination. When making retrospective review determinations, consideration is only given to information available to the provider at the time the service was rendered.

In the event that insufficient information is available for conducting the review (Lack of Information), the UM review can be extended for up to 14 calendar days if it is in the best interest of the member. If additional information is not available within that time frame or if the information submitted fails to meet applicable criteria, a denial is issued and the enrollee is notified of appeal options (i.e. standard/expedited appeal). The provider is also informed of the decision. The provider may appeal on behalf of the enrollee with the written permission from the enrollee.

Appeals

Expedited appeals are completed, and verbal notification of the determination provided to the requesting party within 72 hours of the request. Verbal notification is followed by written confirmation sent at time of decision to the consumer, the ordering provider, and facility. Standard appeals are completed and written notification issued within 30 calendar days of the receipt of the request for the appeal to the consumer, ordering provider and facility.

c. **Review Processes Involving Potential Safety Issues**

While conducting utilization review activities, staff may be presented with information about consumers or providers reflecting varying levels of safety concerns.

With Consumers, there is the potential for UM staff to encounter situations in which consumers present a risk to themselves or others. Under no circumstances is the consumer to be left unattended, or call transferred, placed on hold, or ended until appropriate safety mechanisms are in place for handling the emergency (i.e. police have arrived, family is transporting for a prescreen, or other such action to avert the crisis situation or secure the involvement of another entity with the authority or responsibility to resolve the safety issue.)

With providers, there is the potential for UM staff to encounter situations where a provider's current or past actions or inactions present a risk to the consumer. In these situations, UM staff must take appropriate action to ensure that potential or known safety issues identified during the review process are addressed through to resolution.

Action steps involving potential safety issues may include:

- Referring the potential safety issue to another entity to determine if it is an actual safety issue.
- Referring the potential safety issue internally within the organization for further action.
- Referring a known safety issue to another entity or authority for further action.
- Referring a known safety issue internally within the organization for further action.

d. **Notice and Tracking of UM Review Determinations**
All UM determinations are automatically assigned a reference number generated by the Electronic Health Record at the time the UM decision is made. The unique "authorization number" can be tracked by the authorization number, consumer name or case number, or provider rendering the service. Notification of UM determinations occur as follows:

- UM approvals/certifications. The requesting consumer is notified in writing of all UM approvals. Verbal notifications of approvals are made to the ordering provider, attending physician, and/or facility rendering the service. For continued hospitalization or services, confirmation of approval/certification may occur through verbal, electronic, or mail notification. Verbal notification must be documented in the case notes. Continued certification decision requirements include all the following information:
    - Number of extended days or units of service
    - The next anticipated review point,
    - The new total number of days or services approved, and
    - The date of admission or onset of services

  Upon request, the attending physician, ordering provider, and/or facility are provided written notification of any UM approval/certification.

- UM denials/non certifications and reductions. For UM decisions involving denials/non-certification and reductions of requested services, the consumer, ordering provider, and/or facility are provided written notification of the determination not to certify that includes all of the following information:
    - The principal reasons for the denial/non-certification
    - A statement explaining that, upon request, the clinical rationale used in making the denial/non-certification decision will be provided in writing; and
    - Instructions for initiating an appeal and for requesting the clinical rationale.

e. **Appeals Process**

NorthCare's appeal process is outlined in the Enrollee Grievance and Appeal Policy. Providers are allowed to request an appeal on behalf of the individual only with the written permission of the individual. UM review will ensure the PIHP Grievance and Appeal, Second Opinion, and Enrollee Rights and Protections are adhered to.

1. See the MHL Provider Claims Reconsiderations Medicare Policy for Medicare specific claim reconsiderations.