What you can do: You can appeal our decision not to pay. Go to Section 5.3 on page 164 for information on making an appeal.

4. You got and paid for services or items you thought were covered, and you want us to reimburse you for the services or items.

   What you can do: You can ask us to pay you back. Go to Section 5.5 on page 175 for information on asking us for payment.

5. We reduced or stopped your coverage for a certain service, and you disagree with our decision.

   What you can do: You can appeal our decision to reduce or stop the service. Go to Section 5.3 on page 164 for information on making an appeal.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 on pages 188 and 195 to find out more.

• Section 5.2: Asking for a coverage decision

How to ask for a coverage decision to get medical care or long term supports and services (LTSS)

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

- You can call us at: (888) 654-0706, TTY: 711
- You can fax us at: (248) 663-3771
- You can write to us at: HAP Empowered MI Health Link
  PO Box 2578
  Detroit MI 48202

NOTE: Your Prepaid Inpatient Health Plan (PIHP) will make coverage decisions for behavioral health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for more information.

- Detroit Wayne Mental Health Authority (800) 241-4949, TTY: (866) 870-2599, 24 hours a day, seven days a week.

- Macomb County Community Mental Health (855) 996-2264, TTY: 711, 24 hours a day, seven days a week.

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you, your representative, or your provider asked unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part B prescription drug, we will give you a decision no more than 72 hours after we receive your request. If we don't give you our decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

> **The legal term** for "fast coverage decision" is **"expedited determination."**

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at (888) 654-0706 or fax us at (248) 663-3771. For details on how to contact us, go to Chapter 2.
- You can also have your doctor or your representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision only if you are asking about coverage for services or items you have not yet received. (You cannot get a fast coverage decision if your request is about payment for medical care or an item you already got.)
2. You can get a fast coverage decision only if the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) could cause serious harm to your health or hurt your ability to function.
    - If your provider says that you need a fast coverage decision, we will automatically give you one.
    - If you ask for a fast coverage decision without your provider's support, we will decide if you get a fast coverage decision.
        - If we decide that your condition does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) instead.
        - This letter will tell you that if your provider asks for the fast coverage decision, we will automatically give a fast coverage decision.
        - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, see Section 10 on page 204.

How will I find out the plan's answer about my coverage decision?

We will send you a letter telling you whether or not we approved coverage.

If the coverage decision is Yes, when will I get the service or item?

You will be approved (pre-authorized) to get the service or item within 14 calendar days (for a standard coverage decision) or 72 hours (for a fast coverage decision) of when you asked unless your request is for a Medicare Part B prescription drug.

If your request is for a Medicare Part B prescription drug, you will be approved (pre-authorized) to get the drug within 72 hours (for a standard coverage decision) or 24 hours (for a fast coverage decision).

If we extended the time needed to make our coverage decision, we will approve the coverage by the end of that extended period. We can't take extra time to make our coverage decision for a Medicare Part B prescription drug.

If the coverage decision is No, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to the Internal Appeals process (read the next section for more information).

• Section 5.3: Internal Appeal for services, items, and drugs (not Part D drugs)

What is an appeal?

An appeal is a formal way of asking us to review a coverage decision (denial) or any adverse action that we took. If you or your provider disagree with our decision, you can appeal.

NOTE: Your Prepaid Inpatient Health Plan (PIHP) handles appeals about behavioral health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for more information.

- Detroit Wayne Mental Health Authority (800) 241-4949, TTY: (866) 870-2599, 24 hours a day, seven days a week.
- Macomb County Community Mental Health (855) 996-2264, TTY: 711, 24 hours a day, seven days a week.

If you need help during the appeals process, you can call the MI Health Link Ombudsman at 1-888-746-6456. The MI Health Link Ombudsman is not connected with us or with any insurance company or health plan.

What is an adverse action?

An adverse action is an action, or lack of action, by our plan that you can appeal. This includes:

- We denied or limited a service or item your provider requested;
- We reduced, suspended, or ended coverage that was already approved;