**(Insert Name/Address/Email Address and Telephone Number of the LME-MCO)
Notice of Action**

**Denial of Request for Medicaid Services-Child**

«Date\_of\_Letter»

VIA TRACKABLE MAIL: {Fill from Tracking Number}

|  |  |
| --- | --- |
| «Name» or GUARDIAN of «Name»«Street»«City», «State» «Zip»  | Beneficiary: «Name»MID: «MID»County of Origin: «County\_of\_Origin»Service Authorization Request #: «SAR» |

Dear «Name» or GUARDIAN of «Name»:

We are writing to explain a decision about services requested for you. **(Insert Name of LME-MCO**) is responsible for approving Medicaid authorizations for people receiving mental health, intellectual/ developmental disabilities, and/or substance use services in **(Insert Name of Beneficiary’s Medicaid County).** We are sending you this Notice of Action because you or your provider asked **(Insert Name of LME-MCO)** to approve the following Medicaid services:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date Request was received by (Insert Name of LME-MCO** | **Service/Amount Requested** | **Authorization Period Requested** | **Decision****Date** | **Decision** |
| **(Insert Date)** | **(Insert Service and units)** | **(Insert dates requested)** | **(Insert Decision Date)** | Denied |

**(Insert Name of LME-MCO**) could not approve this service as requested. This Notice of Action explains the reason for our decision and tells you how to appeal if you disagree.

A licensed Psychiatrist or Psychologist with appropriate clinical expertise reviewed this request for <<service requested>>and used criteria found in <<Clinical Coverage Policy/Waiver>> to make this decision. Our reviewer decided that the service that you asked for is not medically necessary because:

**«Reason for Denial» - reason should cite specific regulations, statute or medical policy supporting the managed care action. If denying based on policy, include specific reference to policy criteria and what criteria is not met.**

The full clinical rationale used in making this decision will be provided in writing upon request. To request the clinical rationale, please contact the Appeals Department at **(Insert Name of LME-MCO)** at **(Insert LME-MCO Telephone Number).**

Children under age 21 who have Medicaid are entitled to medically necessary screening, diagnostic and treatment services that are needed to “correct or ameliorate defects and physical and mental illnesses and conditions” under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, regardless of whether the requested service is covered under the Medicaid State Plan.  In addition, the service limitations on scope, amount, duration, frequency, and other specific criteria described in DMA’s clinical coverage policies may be exceeded or may not apply if documentation submitted by the provider shows that all EPSDT criteria are met.  The services must be prescribed by the recipient’s physician, therapist, or other licensed practitioner.

Because the beneficiary is under 21 years of age, the provider’s request for service was evaluated under the applicable Medicaid clinical coverage policies as well as the EPSDT criteria.  If the request cannot be approved under the clinical coverage policy criteria, all of the EPSDT criteria must be met to approve the request.  **(Insert Name of LME-MCO)** [**Insert: denied or reduced**] this request under EPSDT for the reason(s) specified below.  **Insert the applicable reason(s) from the list below**:

* The requested service is not a coverable service within the scope of those listed in the

Federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act

* The requested service is not medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient’s physician, therapist, or other licensed practitioner because [insert explanation].
* The requested service was not determined to be medical in nature because [insert explanation—if applicable].
* The requested service was not found to be safe because [insert explanation].
* The requested service was not found to be effective for this recipient because [insert explanation].
* The requested service was not determined to be generally recognized as an accepted method of medical practice or treatment for this recipient because [insert explanation].
* The requested service was found to be experimental/investigational in that [insert explanation].

**Requesting Other Services**

You may be eligible for other services. Please check with your provider or **(Insert Name of LME-MCO)** Care Coordinator (if you have one assigned to you) to find out if there are other services that may be appropriate for you. Requests for Medicaid services should always be submitted at least 15 days before you want the services to start, unless your health or safety will be at risk if you don’t have the service immediately. This gives **(Insert Name of LME-MCO)** enough time to carefully review the request.

**Authority of (Insert Name of LME-MCO)**

**(Insert Name of LME-MCO)** has the authority to make decisions about Medicaid services because we have a Contract with the North Carolina Medicaid agency pursuant to 42 C.F.R. Part 438. We can only approve services that are medically necessary. We base our decision to approve or deny a request for Medicaid services on 10A NCAC 25A .0201, found at <http://reports.oah.state.nc.us/ncac.asp>, the North Carolina State Plan for Medical Assistance, found at <http://www.ncdhhs.gov/dma/plan/index.htm>, Medicaid Clinical Coverage Policies, found at  [http://www.ncdhhs.gov/dma/mp/index.ht](http://www.ncdhhs.gov/dma/mp/index.htm)m, the North Carolina MH/I-DD/SA Health Plan Waiver and the NC Innovations Waiver, found at  [http://www.ncdhhs.gov/dma/waiver](http://www.ncdhhs.gov/dma/waiver/)/, and established Clinical Practice Guidelines, which can be found on our website at **(Insert LME-MCO Web Address).** If you don’t have Internet access or want us to send you a copy of these documents, please call **(Insert LME-MCO Telephone Number).**

**Appealing (Insert Name of LME-MCO) Decision**

You have the right to appeal this decision by **(Insert Name of LME-MCO)**. The first step in that process is to request a Reconsideration Review. There is a Reconsideration Review form and detailed instructions enclosed with this Notice of Action that tells you how to file the appeal:

* **(Insert Name of LME-MCO**) **must receive your Reconsideration Review Request Form no later than 30 days after the mailing date of this notice.**The due date is noted on the enclosed Reconsideration Review Request Form.
* You can call us at **(Insert LME-MCO Telephone Number)** to request an appeal over the phone, but you will still have to submit a signed form no later than 30 days after the mailing date of this notice. The due date is noted on the enclosed Reconsideration Review Request form.
* Your provider or someone else can help you with the appeal if you give them written permission. There is space to give written permission on the enclosed Reconsideration Review Request form. Please note: **(Insert Name of LME-MCO)** may requirewritten consent from you before we can speak with your representative.
* **(Insert Name of LME-MCO)** will process your Reconsideration Review Request within 30 calendar days from the date we receive your request. You can ask for your Reconsideration Review to be decided sooner if you think waiting 30 days might seriously jeopardize your life, health or functional abilities. Call **(Insert LME-MCO Telephone Number)** to request an expedited review. If accepted as expedited, your appeal will be processed within 3 days. If not accepted as expedited, your appeal will be processed within the standard time frame of 30 days. If more time is needed by you, your provider or **(Insert Name of LME-MCO)** there may be an extension granted to either the standard or expedited Reconsideration timeframe.
* **You must go through our appeal process before you can appeal to the State.**
* **If you receive an adverse (LME-MCO) Reconsideration Review decision, you can appeal the adverse (LME-MCO) Reconsideration Review decision to the State before an administrative law judge.**
* **You can ask for your services to continue during the appeal if you meet certain conditions; however you may be required to pay the costs of these services. You can call us at (Insert LME-MCO Telephone Number) if you have any questions.**

If you need assistance filling out or submitting the Reconsideration Review Request Form, understanding this notice, or accessing interpretation services, please contact us at **(Insert LME-MCO Telephone Number)** and someone will assist you.

***Si usted quiere apelar esta decisión, usted debe responder antes de 30 días a partir de la fecha de este aviso. Si necesita ayuda para entender este aviso, por favor llame al* (Insert LME-MCO Telephone Number)*. Díga a la operadora que necesita ayuda con la forma de solicitud de “Reconsideration Review".***

Sincerely,

Utilization Management Department

**(Insert Name of LME-MCO)**

Enclosures:
**(Insert Name of LME-MCO)** Reconsideration Review-Information and Instructions

**(Insert Name of LME-MCO)** Reconsideration Review Request Form

cc: **«Provider»**

**(Insert method of LME-MCO posting to provider)**

**(Insert Name of LME-MCO) Reconsideration Review Request Form**

To request a Reconsideration Review, please complete this form and return it to **(Insert Name of LME-MCO)** by mail, fax or hand delivery no later than***30 days after the mailing date of the notice of action.***

**(Insert Name of LME-MCO)**

Attention: Appeals Coordinator

 **(Insert LME-MCO Mailing Address)**

**(Insert LME-MCO Mailing Address)**

**Phone:** **(Insert Telephone Number)** **Fax: (Insert LME-MCO Fax Number)**

|  |  |
| --- | --- |
| «Name» or GUARDIAN of «Name»«Street»«City», «State» «Zip»  | Beneficiary: «Name»MID: «MID»County of Origin: «County\_of\_Origin»Service Auth Request #: «SAR» |

I would like to request a Reconsideration Review of **(Insert Name of LME-MCO)**’s partial denial of the following Medicaid service(s):

|  |  |
| --- | --- |
| **Service** | **Authorization Period** |
| «Service\_Requested», «Units\_Requested» units | «Dates\_of\_Service\_Requested» |

My current phone number where I can be reached is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would like this decision to be reconsidered because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please check all that apply**:

* I would like to submit additional information to be considered during the Reconsideration Review. I understand that I should submit this information to **(Insert Name of LME-MCO)** within the next 10 days to allow enough time for the information to be reviewed.
* I would like my authorized representative identified below to help me with this appeal.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Medicaid Beneficiary/ Legal Guardian* ***(Required)*** *Date*

If you are acting as the representative for the Medicaid beneficiary, please complete this section:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Beneficiary\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you would like to review the information that is being used in the Reconsideration Review, please call **(Insert LME-MCO Telephone Number)** and we will send you the information within 7 days. Please see the Medicaid Reconsideration Review Instructions for the conditions that must apply for your services to continue during the Reconsideration Review process.

***Si necesita ayuda con esta forma, por favor llámenos al* (Insert LME-MCO Telephone Number)*. Diga al operadora que necesita ayuda con “Reconsideration Review Request Form”.***

**(Insert Name of LME-MCO) Reconsideration Review**

***Information and Instructions***

 **(1) *What is the first step?***

The first step in appealing **(Insert Name of LME-MCO)’s** denial of a request for Medicaid services is to ask for a “Reconsideration Review.” A Reconsideration Review means that someone at **(Insert Name of LME-MCO)** who was not involved in any previous level of review or decision-making and who has the appropriate clinical expertise will take a second look at our decision and reconsider your request for Medicaid services. You ***must*** request a Reconsideration Review and wait to receive **(Insert Name of LME-MCO)’s** decision ***before*** you can ask for an appeal at the North Carolina Office of Administrative Hearings (OAH).

**(2) *How much time do I have to ask for a Reconsideration Review?***

The request for a Reconsideration Review must be filed with **(Insert Name of LME-MCO)** no later than **thirty (30) days after the mailing** date of the Notice of Action. Reconsideration Review requests received after this time will not be accepted or reviewed. Please call **(Insert Name of LME-MCO)** at the phone number below if you need assistance filing the request for a Reconsideration Review. **(Insert Name of LME-MCO)** will mail you a letter confirming that we received your request for a Reconsideration Review. This letter is mailed by **(Insert Name of LME-MCO)** within one business day of the date your request was received.

**(3) *How do I ask for a Reconsideration Review?***

To request a Reconsideration Review, complete the enclosed form and fax, mail or hand deliver the form to:

(**Insert Name of LME-MCO)**

**Fax: (Insert Fax Number)**

**Mail or Hand Delivery: (Insert Address) Attn: (Insert Department Name)**

**(Insert City), NC (Insert Zip Code)**

You may also call **(Insert Telephone Number)** if you want to make your request for a Reconsideration Review by phone, but you will still have to file a signed Reconsideration Review Request Form. Your appeal will not be processed if we do not receive the signed form within 30 days after the **mailing date** of this Notice of Action. **(Insert Name of LME-MCO)** will help you file the appeal if you ask us for assistance. For example, if you need help filling out the form, understanding your notice, or accessing interpretation services, please contact us at **(Insert LME-MCO Telephone Number)** and someone will assist you. Your provider, a family member, or a friend can also help you with completing the form and filing the appeal if you give them written permission. There is a space to give your written permission on the Reconsideration Review Request Form that is enclosed with this Notice of Action.

 **(4) *What is the timeline for the Reconsideration Review?***

The Reconsideration Review must be completed no later than 30 days after you file your request for a Reconsideration Review. A licensed clinician who has the appropriate clinical expertise and was not involved in the initial decision will complete a desk review. This person will review the information used in making our decision, in addition to any other information that you wish to submit. If you want the reviewer to consider additional information, please send it to us at the address listed above when you file your appeal or within 10 days of filing this Reconsideration Review Request Form so that we have enough time to consider the information. We will mail you a decision (called a Notice of Resolution) within 30 days.

In some cases more than 30 days to complete the Reconsideration Review may be needed by either you or **(Insert Name of LME-MCO) .**You can ask for an extension if you need more time to get additional information to the clinician completing the Reconsideration Review. Call **(Insert LME-MCO Telephone Number)** to arrange for this extension. **(Insert Name of LME-MCO)** may also need additional time to complete the Reconsideration Review. **(Insert Name of LME-MCO)** will only extend the Reconsideration Review timeframe if it is in your best interest. You will be notified promptly in writing if an extension will occur, the reason for the extension and what you can do if you disagree with the reason for the extension.

**(5) *What if I want my Reconsideration Review to be processed faster****?*

You can ask for an expedited Reconsideration Review if you think that waiting 30 days might seriously jeopardize your life, health, or functional abilities. You, or with written permission, your provider can call **(Insert LME-MCO Telephone Number)** to request an expedited appeal. A family member or a friend can also help you with asking for an expedited review if you give them permission. If we approve your request for an expedited Reconsideration Review, we will mail you our decision no later than 3 days after receiving your request.

In some cases more than 3 days may be needed by you or (**Insert Name of LME-MCO)** to complete the expedited review. You can ask for an extension if you need more time to get additional information to the clinician completing the Reconsideration Review. Call **(Insert LME-MCO Telephone Number)** to arrange for this extension. **(Insert Name of LME-MCO)** may also need additional time to complete the Reconsideration Review. **(Insert Name of LME-MCO)** will only extend the Reconsideration Review timeframe if it is in your best interest. You will be notified promptly in writing if an extension will occur, the reason for the extension and what you can do if you disagree with the reason for the extension.

If we deny your request for an expedited Reconsideration Review, we will make reasonable efforts to promptly call you to tell you that the expedited review was not approved, and we will mail you a written notice no later than two calendar days after that phone call. You can contact **(Insert LME-MCO Telephone Number)** to file a grievance about our decision to deny an expedited review. If your request for an expedited review is denied, we will make a decision on your appeal within 30 days. You do not need to submit a new request.

**(6) *How and when do I submit additional information to be considered by the Reviewer?***

Additional information should be attached to your request for a Reconsideration Review or it should be received by **(Insert Name of LME-MCO)** within 10 days after you asked for the Reconsideration Review. It can be mailed, faxed or hand delivered to the contacts listed above. If you need assistance with submitting additional information, please call **(Insert LME-MCO Telephone Number).** **(Insert Name of LME-MCO)** makes every effort to ensure that additional information is considered during the Reconsideration Review so it is important that you submit this information as soon as possible.

**(7) *Will my services be authorized during the appeal process?***

If we terminate, suspend, or reduce your ***current*** Medicaid services ***before the authorization period ends***, you may continue to receive those services if you meet all of the following conditions:

* You timely file a Reconsideration Review request, meaning on or before the later of the following:

within **ten (10) days** of the date of mailing of the Notice of Action; or

the intended effective date of the Notice of Action;

* The decision involves the termination, suspension, or reduction of currently authorized services;
* The services were ordered by an authorized provider;
* The authorization period for the services has not expired; and
* You request that your services continue.

If all of these conditions are met, you will continue to receive your current services until:

* You withdraw your request for a Reconsideration Review; or
* **Ten days** after we mail the Reconsideration Review decision to you, unless you request a State Fair Hearing within those **ten (10) days**; or
* You lose your State Fair Hearing; or
* The authorization period for the services expires or authorization service limits are met.

Please be aware that **(Insert Name of LME-MCO)** may recover from you the cost of the Medicaid services that you appealed and received during the appeal process if the final resolution of the appeal upholds **(Insert Name of LME-MCO)**’s decision. For more details regarding continuation of services, see 42 C.F.R. § 438.420.

**(8) *What if I disagree with the Reconsideration Review decision?***

If you disagree with the Reconsideration Review decision, you may request a State Fair Hearing with the North Carolina Office of Administrative Hearings (OAH). The State Fair Hearing Request form and information explaining how to request a State Fair Hearing with OAH will be included with the Notice of Resolution. You ***must*** request a Reconsideration Review and wait to receive **(Insert Name of LME-MCO)’s** decision before you can request a State Fair Hearing. You can also learn more about requesting a State Fair Hearing by visiting [http://www.ncoah.com/hearings/medicaid.html or by calling 919-431-3000](http://www.ncoah.com/hearings/medicaid.html%20or%20by%20calling%20919-431-3000).

**(9) *What if I need legal assistance?***

To locate a lawyer, please call 1-800-662-7660 for the North Carolina Health Information Project Lawyer Referral Service or 1-800-662-7407 for the North Carolina State Bar Lawyer Referral Service. You can also call Disability Rights of North Carolina toll-free at 1-877-235-4210 or Legal Aid of North Carolina at 1-866-219-5262.

***Si usted quiere apelar esta decisión, usted debe responder antes de 30 días a partir de la fecha de este aviso. Si necesita ayuda para entender este aviso, por favor llame al* (Insert LME-MCO Telephone Number)*.***