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

**Notice of Resolution**

**Outcome of Medicaid Reconsideration Request-Upheld**

**(Date of Letter)**

VIA TRACKABLE MAIL: {Fill from Tracking Number}

|  |  |
| --- | --- |
| NAME or GUARDIAN of NameStreetCity, NC zip code | MID: DOB:County of Origin: Waiver:  |

Dear Name or GUARDIAN of Name:

**(Insert Name of LME-MCO)** was asked to complete a Reconsideration Review of:

* the decision to deny some or all of your request for the service and dates listed below; ***or***
* the decision to terminate, reduce or suspend a currently authorized service ***before the expiration of the authorization*** for the service and dates listed below

**(Insert Name of LME-MCO)** is responsible for approving Medicaid authorizations for mental health, intellectual/ developmental disabilities, and/or substance abuse services. After reviewing your request and all of the information submitted for the Reconsideration Review, **(Insert Name of LME-MCO)** decided to **UPHOLD** the original decision. This notice explains why this decision was made.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Reconsideration Review** | **Service / Amount****Initially Requested** | **Authorization Period Initially Requested** | **Service / Amount****Initially Approved** | **Authorization Period Initially Approved** | **Decision** |
|  |  |  | Delete this column if fully denied | Delete this column if fully denied | Denial; ***or***Partial Denial; ***or*** Termination, Reduction, orSuspension Decision Upheld |

**Background Information**

1. **Diagnosis:**

**Click here to enter text.**

1. **Medications listed on Service Request:**

**Click here to enter text.**

1. **Documents Reviewed:**

**Click here to enter text.**

1. **Clinical Summary:**

The clinical rationale used in making this Reconsideration Decision is: **(Enter Clinical Summary)**

Please contact the Appeals Department at **(Insert Name of LME-MCO)** at **(Insert Telephone Number)** if you have any questions about the clinical summary.

 **Reason decision was upheld: reason should cite specific regulations, statute or medical policy supporting the decision being upheld. If upholding decision based on policy, include specific reference to policy criteria and what criteria is not met and the facts that support criteria not being met.**

**Recommendations**

**Click here to enter text.**

**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 **(Inset 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 Telephone Number).**

For more information or detail on any of the above information, please contact the Appeals Department at **(Insert Name of LME-MCO)** at the number listed below.

You have the right to appeal **(Insert Name of LME-MCO)**’s decision by filing a request for a State fair hearing with the North Carolina Office of Administrative Hearings (OAH) no later than **thirty (30) days** after the mailing date of this notice of resolution. Please review the enclosed forms for additional information about the OAH State fair hearing.

***Si necesita ayuda para leer y comprender el aviso, por favor llámenos al (Insert Telephone Number). Diga el operador que necesita ayuda con Formulario “State Fair Hearing.”***

Sincerely,

Appeals Department

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

**(Insert Telephone Number)**

cc: **Provider**

Enclosure: State Fair Hearing Information and Instructions

 State Fair Hearing Request Form