**DECISION ON YOUR APPEAL**

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| **Notice Date:** [DATE] | *Space intentionally blank* | **PA #**: [PA NUMBER] |
| **This Action will take effect on:** [EFFECTIVE DATE] | **Call** [LME HELP LINE] **for help** |
| [BENEFICIARY NAME or LEGAL GUARDIAN][ADDRESS LINE 1][ADDRESS LINE 2][CITY, STATE, ZIP] | [REQUESTOR NAME/ADDRESS][ADDRESS LINE 1][ADDRESS LINE 2][CITY, STATE, ZIP] |
| **MID:** [BENEFICIARY MID] | **DOB:** [BENEFICIARY DOB] | **Beneficiary:** [BENEFICIARY NAME] |
| [LME/MCO] manages Medicaid behavioral health services in [NAME OF BENEFICIARY COUNTY HERE]. On [DATE OF ORIGINAL APPROVAL], we approved a service for you.  |
| On [DATE], we made a decision to stop some of your services. On [DATE OF REQUEST FOR APPEAL] you asked for and appeal.  |
| **We have finished your appeal. We have decided to change part of our original decision.**  |
| **THIS DECISION CHANGES SERVICES YOU ARE GETTING NOW.** **IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN APPEAL IT.****READ THE INSTRUCTIONS IN THIS NOTICE CAREFULLY AND ASK US FOR HELP IF YOU NEED IT.**This letter tells you about our decision. Please read it carefully.To appeal this decision, you must ask us for a **State Fair Hearing.** You can ask for a State Fair Hearing by mail, by fax, or by phone. There are instructions in this Notice that will tell you what to do. Please read them carefully. The last day to ask for a State Fair Hearing is [DATE]. You have 120 days from the date on this Notice to ask for a State Fair Hearing. If the 120th day is a weekend or holiday, you have until the next business day. On [EFFECTIVE DATE] your services will change as explained in this letter. To keep your services the same during your State Fair Hearing, you must appeal by [EFFECTIVE DATE] and ask for your services to continue. There are instructions in this Notice that will tell you how to ask for your services to continue. If you do not appeal and ask for your services to continue by [EFFECTIVE DATE], your services will change as explained in this letter. If you need help filing your appeal, call us at [PHONE NUMBER]. |

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| **YOU WERE RECEIVING:** |
| **Service Description** | **Code 1** | **Code 2** | **Plan** | **Approved Dates** | **Approved Amount** |
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| **On [DATE OF ORIGINAL DECISION], we** Choose an item. |
|  **AFTER YOUR APPEAL, WE ARE APPROVING:** |
| **Service Description** | **Code 1** | **Code 2** | **Plan** | **Approved Dates** | **Approved Amount** |
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|  |  |  |  |  |  |
| **AFTER YOUR APPEAL, WE ARE STILL STOPPING OR REDUCING:** |
| **Service Description** | **Code 1** | **Code 2** | **Plan** | **Denied Dates** | **Denied Amount** |
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|  |  |  |  |  |  |
| **COMMENTS**: [LME DEFINED FREE TEXT AVAILABLE]  |
| DD 1:  **We have reviewed your medical records. Based on information in your medical records, we are** Choose an item. **Your records show that you no longer need the amount of service we approved on [DATE]. We asked your provider to send us more information to tell us why you still need your service. Your provider did not send us the information.**[CODE] [SERVICE DESCRIPTION]: * On [DATE OF REQUEST FOR ADDITIONAL INFORMATION], we asked your provider for the following important facts or documents:

[FREE TEXT STATEMENT ON ADDITIONAL INFORMATION REQUESTED]. * Without this additional information, your authorized services did not meet criteria found in [IDENTIFY SPECIFIC POLICY AND SECTION HERE].
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| DD 2: **We have reviewed your medical records. Based on information in your medical records, we are** Choose an item.[CODE] [SERVICE DESCRIPTION]: Policy rules found at [SPECIFIC POLICY NAME AND SECTION HERE] guided our decision. [FREE TEXT STATING RATIONALE FOR DECISION AND RELATED POLICY SECTION] |
| **Authority Supporting Decision:**We base our decision to approve or deny a request for Medicaid services on:* Established Clinical Practice Guidelines, found on our website at: [LME WEBSITE HERE]
* Medicaid Clinical Coverage Policies found at: <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>
* **10A NCAC 25A .0201: MEDICAL SERVICES** All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.
* The North Carolina State Plan for Medical Assistance, found at: <https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

If you want us to send you a free copy of any or all of these documents, please call [PHONE NUMBER]. We will mail the documents to you within five business days.   |
| **We can give you a free written copy of the full clinical rationale, rules or standards that we used and information we generated when we made this decision. If you want a free copy, call us at:** **[PHONE NUMBER].**You also have the right to see your entire case file. Your case file includes all your medical records, other documents and records. It may have more information about why your health care service was changed or not approved. To arrange to see your file, call [PHONE NUMBER]. If you say you want a copy of your entire case file, we will give you or your authorized representative a free copy before we finish your appeal.  |