**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 Choose an item. On [DATE OF REQUEST FOR APPEAL] you asked for an appeal.  |
| **We have finished your appeal. We have decided** Choose an item. |
| **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]  |
| **For Beneficiaries Under 21 Years of Age:**Federal law requires us to cover most medical treatments and services for members under 21 years old. We will never deny a service request before we review it by FederalMedicaid Act standards. These standards are known as “EPSDT medical necessity criteria”. Policy requirements or limits for adults over age 20 do not apply in these cases. The section below is important. You will find all the reasons for our decision here. Our policy rules *and* the federal EPSDT policy were used in making this decision.  **For more information on EPSDT’s ‘correct or ameliorate’ standard, see the ‘EPSDT’ section of this Notice.** |
| 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 [INSERT 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].

**For beneficiaries under 21 years of age:** We must review your request by federal rules to approve it. These rules say that services we approve must be safe for children. Services must also work to make a child’s health problems better, or to keep them from getting worse. These decisions are made on a case-by-case basis. Getting more information is important. Without it we cannot be sure that the service you requested meets these rules.  |
| 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] |
| **For beneficiaries under 21 years of age, further review under federal EPSDT criteria was completed.**[LME NAME] found the following federal EPSDT criteria was not met for your request:EPSDT Option 1: **The federal** **Medicaid program does not cover this service:** [CODE] [SERVICE DESCRIPTION]Medicaid’s federal health care plan does not cover the service you asked for. EPSDT Option 2: **Your request is for an “experimental or investigational” treatment. This means that this service does not meet usual standards of medical and dental care for treating your health problem. This service may still be under scientific study.**[CODE] [SERVICE DESCRIPTION] [PROVIDE BRIEF STATEMENT].EPSDT Option 3: **The beneficiary’s health problem was reviewed. Usual standards of medical and dental practice were applied.** [CODE] [SERVICE DESCRIPTION]:* Your provider did not show that this service is medically necessary to:
	+ Help with your medical problem, or
	+ Keep your health problem stable, or
	+ Keep your health problem from getting worse, or
	+ Prevent the development of other health problems.

[PROVIDE BRIEF EFFECTIVENESS or STANDARD OF CARE STATEMENT].* There are equally effective and less costly ways to treat your health problem.

[PROVIDE BRIEF STATEMENT ON OTHER TREATMENT(S)].* This service has not been proven safe for treating your health problem**.**

[PROVIDE BRIEF SAFETY STATEMENT]. |
| **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.  |

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| **EPSDT: Medicaid’s Benefit for Children Under 21 Years of Age:**Medicaid’s children’s benefit is known as *“Early and Periodic Screening, Diagnostic and Treatment”* services, or EPSDT. For those under 21 years old, the EPSDT benefit requires us to cover any service available within the federal Medicaid Act *(42 U.S.C. §§ 1396(a)(10)(A))*, so long as it is medically necessary to ‘correct or ameliorate’ a physical or mental illness or condition. This means that the service is needed to:* improve or maintain the child’s health in the best condition possible; OR
* compensate for a health problem; OR
* prevent it from worsening; OR
* prevent the development of additional health problems.

When medically necessary, the requested service must be provided:* even when it doesn’t appear on the list of plan benefits and;
* in an amount, at times, and as frequently as needed, even if state or plan policy limits are exceeded. There is no limit on the number of visits or hours if medically necessary.

In addition, there is no waiting list to qualify for EPSDT services and there is no dollar limit on the amount of medically necessary EPSDT services that may be provided. EPSDT may require coverage of specialized services out of network or even out of state if specialized services are medically necessary and not available in-network or in North Carolina.The services must be ordered by a physician, therapist, or other practitioner appropriately licensed to prescribe or deliver the requested service. For more information, see:<https://medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services-right-you/medicaids-benefit-children-and-adolescents> See also the CMS publication; *“EPSDT-A Guide for States”,* found at: <https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf> |
| 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. |