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

**Notice of Action**

**Partial 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 abuse 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 Received by (Insert Name of LME-MCO** | **Service/Amount Requested** | **Authorization Period Requested** | **Decision** | **Effective Date of Action** |
|  |  |  | **Denied** |  |

**(Insert Name of LME-MCO)** cannot approve all of this service as requested but did approve the following:

|  |  |  |
| --- | --- | --- |
| **Authorization Period Approved** | **Amount Approved** | **Decision** |
| «Dates\_of\_Service\_Approved» | «Units\_Approved» units | Approved |

This Notice of Action explains the reason for our decision and tells you how to appeal if you disagree

**(Insert Name of LME-MCO)** reviewed the request and denied part of **«Insert Service\_Requested»** because the service is not medically necessary. **(Insert Name of LME-MCO)** used criteria found in «10 NCAC 25A .0201, North Carolina State Plan for Medical Assistance, Medicaid Clinical Coverage Policies, North Carolina MH/I-DD/SA Health Plan Waiver, NC Innovations Waiver or established Clinical Practice Guidelines)» to make this decision. Our reviewer decided to authorize some of your request because:

**«Reason\_for Partial 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**

However, 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)’s Decision**

You have the right to appeal **(Insert Name of LME-MCO)’s** decision to deny your request for Medicaid services. 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 Form no later than 30 days after the mailing date of this notice.**
* 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.
* Your provider or someone else can help you with the appeal if you give them written permission.
* You can ask for your appeal to be decided sooner if you meet certain conditions.
* 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.
* **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.**

If you are confused about how to appeal or need assistance, please call **(Insert Name of LME-MCO Contact)** at **(Insert LME-MCO Telephone Number).** We can help with interpretation and other services. You may also contact your local Legal Aid/Legal Services office at **(Insert LME-MCO Telephone Number)** for assistance.

***Si desea apelar esta decisión, debe responder a no más tarde 30 días desde la fecha de este aviso. Si necesita ayuda para leer y comprender el aviso, por favor llámenos al (Insert LME-MCO Telephone Number). Diga el operador que necesita ayuda con Formulario “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 Form

cc: **«Provider»**