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

**Notice of Resolution**

**Outcome of Medicaid Reconsideration Review-Upheld**

Date of Letter: Click here to enter a date.

VIA TRACKABLE MAIL: {Fill from Tracking Number}

|  |  |
| --- | --- |
| RECIPIENT NAME or GUARDIAN of RECIPIENT  Street  City, NC zip code | Beneficiary:  MID:  DOB:  County of Origin:  Waiver: |

Dear RECIPIENT or GUARDIAN of Recipient:

**(Insert Name of LME-MCO)** is responsible for approving Medicaid authorizations for mental health, intellectual/developmental disabilities, and/or substance use services.  **(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**.**

After completing this Reconsideration Review, **(Insert Name of LME-MCO)** decided to **UPHOLD** the original decision. This notice explains why this decision was made.

|  |  |
| --- | --- |
| **Service Originally Requested** | **Dates/Units Originally Requested** |
| (Insert Service Originally Requested) | (Insert Dates/Units Originally Requested) |

Through a peer review process, (Insert Name of LME-MCO) decided to approve the following:

|  |  |
| --- | --- |
| **Service Originally Approved** | **Dates/Units Originally Approved** |
| (Insert Service Originally Approved) | Insert Dates/Units Originally Approved |

Through the Reconsideration Review process, **(Insert Name of LME-MCO)** decided to approve the following:

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of (LME-MCO)’s Reconsideration Review Decision** | **Reconsideration Review Decision** | **Service Approved after Reconsideration Review** | **Dates/Units Approved after Reconsideration Review** |
| (Insert Date of Reconsideration Review Decision) | (Insert Reconsideration Review Decision) | (Insert Service Approved) | (Insert Dates/Units Approved) |

**This means no additional units or dates have been approved through the Reconsideration Review.**

**Background Information**

1. **Date Reconsideration Review was completed: (Insert Review Date)**
2. **Documents Reviewed: (Insert documents reviewed in Reconsideration Review)**
3. **Clinical Coverage Policies Reviewed: (Insert policies cited in Reconsideration Review)**

**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.**

1. **EPSDT Criteria not met: (Insert all of the EPSDT criteria not met)**

The clinical rationale used in making the Reconsideration Review decision will be provided in writing upon request. To request the clinical rationale, please call **(Insert LME-MCO Telephone Number)**

**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 LME-MCO 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 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).**

Sincerely,

Appeals Department

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

**(Insert LME-MCO Telephone Number)**

cc: **Provider**

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

Enclosure: State Fair Hearing Information and Instructions

State Fair Hearing Request Form

**State Fair Hearing**

***Information and Instructions***

***(1) What is a State Fair Hearing?***

Under the federal Medicaid system, after a Medicaid beneficiary has completed the first level of the “appeal” process, known as a “Reconsideration Review,” the beneficiary may file a request for a State fair hearing. A State fair hearing offers the Medicaid beneficiary the opportunity to appear before an administrative law judge when **(Insert Name of LME-MCO)** has taken an “action,” for example, if **(Insert Name of LME-MCO)** made a decision to deny, reduce, suspend or terminate Medicaid services. For more detail, see 42 C.F.R. § 438.400(b). You may request a State fair hearing by completing and timely filing (by mail or fax) the enclosed ***State Fair Hearing Request Form*** with the North Carolina Office of Administrative Hearings (OAH), *and* sending a copy to **(Insert Name of LME-MCO).** **To be timely filed, the request must be received no later than 30 days after the mailing date of the Reconsideration Review decision**. The mailing addresses and telephone and fax numbers for OAH and **(Insert Name of LME-MCO**) are included on the ***State Fair Hearing*** ***Request Form***. Please note that you ***must*** have completed a Reconsideration Review before you can request a Statefair hearing.

**(2) *What happens after I timely file the completed State Fair Hearing Request Form?***

You will be contacted by the Mediation Network of North Carolina and offered an opportunity for mediation in an effort to resolve your case. If your case is not resolved at mediation, or you choose not to participate in mediation, your case will proceed to a State Fair Hearing before an administrative law judge with OAH. If you accept a mediation but do not attend, your appeal may be dismissed*.* You will be notified by mail of the date, time, and location of your State Fair Hearing. To ensure you receive all notices, please notify OAH and **(Insert Name of LME-MCO)** of any changes in your address or other contact information.

**(3) *What will happen at the State Fair Hearing?***

You or your representative will have the opportunity to present your case to an administrative law judge. **(Insert Name of LME-MCO**) will also present its case. The administrative law judge will make a decision to uphold or overturn **(Insert Name of LME-MCO)’s** decision on your request for Medicaid services. You will receive a written copy of the administrative law judge’s decision. If you do not agree with the administrative law judge’s decision, you may ask for a judicial review in Superior Court. Go to <http://www.oah.state.nc.us/hearings/medicaid.html> for more information about State fair hearings.

**(4) *Can I continue to receive services during the State Fair Hearing process?***

If you received a Reconsideration Review decision that was adverse to you, and if your request for a Reconsideration Review was based on **(Insert Name of LME-MCO**) terminating, reducing or suspending your ***current*** Medicaid services ***before the expiration of the authorization***, you may continue to receive those current Medicaid services during theState fair hearing process if you meet all of the following conditions:

* You requested a State Fair Hearing within **ten (10) days** of **(Insert Name of LME-MCO)** mailing the Reconsideration Review decision to you;
* The State Fair Hearing involves the termination, suspension, or reduction of currently authorized services;
* The services were ordered by an authorized provider;
* The authorization period for the current services has not expired; and
* You requested that your services continue.

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

* You withdraw your request for a State fair hearing;
* A State Fair Hearing decision adverse to you is made; or
* The current authorization expires or authorization service limits are met.

If your services aren’t approved through the State Fair Hearing process, **(Insert Name of LME-MCO** may recover from you or your spouse (or your parent or legal guardian if you are under 18) the cost of the Medicaid services you received during the appeal process. We cannot recover these costs from the parents or guardians of individuals over 18 or from providers.

Please call **(Insert Name of LME-MCO)** at **(Insert LME-MCO Telephone Number)** if you have questions or need assistance.

**(5) *Can I ask someone else to represent me during the State Fair Hearing?***

You may represent yourself during the State Fair Hearing, hire an attorney, or ask a relative, your provider, a friend, or other spokesperson to speak for you. There is space on the State Fair Hearing Form for you to authorize a representative and give consent to **(Insert Name of LME-MCO)** to speak with your representative throughout your appeal.

**(6) *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.

**(7) *What if I have more questions?***

For questions concerning the decision **(Insert Name of LME-MCO)** made about your request for Medicaid services, please contact **(Insert Name of LME-MCO)** at **(Insert LME-MCO Telephone Number).** Should you have questions about the State Fair Hearing, please contact OAH using the contact information below, or visit  [http://www.oah.state.nc.us/hearings/medicaid.htm](%20http://www.oah.state.nc.us/hearings/medicaid.htm)l.

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency** | **Mailing Address** | **Telephone Number** | **Fax Number** |
| North Carolina Office of Administrative Hearings (OAH) | Attn: Clerk  6714 Mail Service Center  Raleigh, NC 27699-6700 | 919-431-3000 | 919-431-3100 |
| (**Insert Name of LME-MCO)** | Appeals Department  **(Insert Mailing Address of LME-MCO)** | **(Insert Telephone Number)** | **(Insert Fax Number)** |

**STATE FAIR HEARING REQUEST FORM**

Name OR GUARDIAN OF Name County of Origin: «County\_of\_Origin»

Street DOB: «Date of birth»

City, NC zip code SAR: «SAR»

To request a State Fair Hearing with the North Carolina Office of Administrative Hearings based on **(Insert Name of LME-MCO)’s** decision to deny some or all of the request for Medicaid services, please mail or fax this completed form to OAH and **(Insert Name of LME-MCO)** at the addresses or fax numbers listed at the bottom of this form. This form must be received by [**INSERT DUE DATE].**

|  |  |  |
| --- | --- | --- |
| Service | Authorization Period | Units |
| (Service Originally Requested) | (Insert Dates Originally Requested) | (Units Originally Requested) |

I would like a State Fair Hearing because **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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I understand I have the right to be represented at the contested case hearing by a lawyer, my provider, a relative, a friend or other spokesperson. To locate a lawyer, I can 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.

**Please check one of the following:**

* I will represent myself. Telephone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I will be represented by someone other than myself. If you check this box, please provide the following information:

Name(s) of Representative(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Medicaid Beneficiary: \_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone Number(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that, if my medical records contain information relating to a substance use diagnosis or treatment, this information is protectedby the Confidentiality of Alcohol and Drug Abuse Patient Records regulations at 42 CFR Part 2. I understand that, by signing below, I authorize **(LME-MCO Name)** to disclose this information to The Mediation Network of NC, the NC Office of Administrative Hearings, and the NC General Court of Justice, for the purposes of identifying treatment options, and for mediating and resolving disputes concerning authorization for my services as listed above. I understand that this information may not be re-disclosed without my further written authorization unless otherwise provided for by state or federal law. I also understand that I may revoke this consent at any time by calling **(LME-MCO Name)**, except to the extent that **(LME-MCO Name)** has already taken action in reliance on it. If not previously revoked, this consent will automatically expire upon completion of the appeals process or within 365 days of my dated signature below, whichever comes first.

I authorize **(LME-MCO Name)** to release substance use information as specified above. Initial here to agree:

I authorize **(LME-MCO Name)** to release HIV/AIDS information as specified above. Initial here to agree:

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

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Print Name Telephone Number Address

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

*Signature of Beneficiary under the age of 18 if disclosing Substance Abuse information Date*

**Mail or fax this completed form to:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency** | **Mailing Address** | **Telephone Number** | **Fax Number** |
| North Carolina Office of Administrative Hearings (OAH) | Attn: Clerk  6714 Mail Service Center  Raleigh, NC 27699-6700 | 919-431-3000 | 919-431-3100 |
| (Insert Name of LME-MCO) | Appeals Department  (Insert Mailing Address of LME-MCO) | (Insert LME-MCO Telephone Number) | (LME-MCO Fax Number) |