[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR Agent/Benefit Manager Name]
[Address]
[Phone]

FINAL ADVERSE DETERMINATION DENIAL NOTICE

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage type: [coverage type]
Plan reference number: [plan reference number]
Provider: [provider to perform the service]
Facility: [Facility]
Service developer/manufacturer: [service developer/manufacturer]
Date appeal filed: [date appeal filed]
Date of appeal determination: [date of appeal determination]]

Dear [Enrollee]:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, [you have **four months** to ask for an External Appeal or] you can ask for a Fair Hearing by [**Date+120**]. You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: [1-800-MCO-PLAN].

Why am I getting this notice?

You are getting this notice because on [date appeal filed] {*for Fast Track appeals insert*} [at [hour received]], you or your provider asked for a Plan Appeal about our decision to [partially] deny [service]. [Insert summary of appeal].

On [date of appeal determination], we decided we are [not changing our decision to [partially] deny] {or} [changing our decision and will partially approve] your [request][this claim].

{INSERT FOR CONCURRENT REVIEW OR PARTIAL APPROVALS OR DELETE THIS SEGMENT}
{*Insert as applicable*} [From [STARTDATE] to [ENDDATE], the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]]
{*Insert as applicable*} [ON [Date] you or your provider requested approval for: [HOURS/DAYS, VISITS, LEVEL, QTY, etc.]]
On [DATEIAD] the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and IAD TOTAL AMOUNT].

On [DATEFAD], the plan approval [**is only for**:] {or} [**changes** to:] {or} [**stays** at:] [HOURS/DAYS, VISITS, LEVEL, QTY, etc. and NEW TOTAL AMOUNT] from [STARTDATE] to [ENDDATE].
{*Insert as applicable*} [We will review your care again [IN TIME FRAME/ ON DATE].]

{*Insert for partial approvals*} [This health care service will be provided by [a participating][an out of network] provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.]

Why did we decide to [partially] deny the [request][claim]?

[[UR Agent] on behalf of] [Plan Name] decided to [deny] *{or}* [partially approve] this [service] *{or}* [claim] because the *{insert reason as applicable*}*

[service is not medically necessary]
[request did not have enough information to determine if the service is medically necessary]
[service is experimental/investigational]
[service is not covered by your managed care benefits]
[the benefit coverage limit has been reached]
[service can be provided by a participating provider]
[service is not very different from a service that is available from a participating provider]
[other decision].

{*For OON denials:}* [State if only the service is not covered or if only the out of network access is not covered or both are not covered] {insert if applicable} [You can get [requested service] [[alternate service], which is not very different the service you requested,] from one of our providers. We have confirmed [a provider][providers] in our network that are available and able to perform this service. To get this service contact:

[Provider 1]	[Provider 2]
[Mailing Address]	[Mailing Address]
[Phone Number]	[Phone Number]]

{INSERT IF THE DECISION IS AN ADMINISTRATIVE OR BENEFIT DENIAL AND IS <u>NOT</u> ABOUT LTSS, OR DELETE THIS SEGMENT}

[Insert a detailed reason for the decision, including the specific services not covered, the plan requirement for coverage not met, and/or where benefit coverage is dependent on the enrollee's condition, a description of the benefit coverage criteria not met.]

{INSERT IF THE DECISION IS CLINICAL AND ABOUT A REQUEST/CLAIM FOR A <u>NEW</u> SERVICE INCLUDING PARTIAL APPROVALS, AND IS <u>NOT</u> ABOUT LTSS OR DELETE THIS SEGMENT}

- You asked for [service] because [Insert the nature of the enrollee's condition].
- To approve this service {*Insert for partial approvals*}[in full], the following criteria must be met: [Insert criteria required for the service to be approved].
- These criteria are not met because [Insert enrollee-specific details from the enrollee's unique clinical/social profile to show why/how the enrollee does not meet the required criteria for service approval (necessitating a service denial) <u>or</u> why/how the enrollee does not fully meet the required criteria for service approval (necessitating a partial

service approval) *or* insert model prescriber prevails language or case-specific information about why the service is experimental/investigational. For OON not medically necessary, clearly state if only the service is not medically necessary, or if only the out of network access is not medically necessary, or both are not medically necessary]

{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}

{INSERT IF THE DECISION IS CLINICAL AND FOR A CONCURRENT REVIEW INCLUDING PARTIAL APPROVALS AND IS NOT ABOUT LTSS, OR DELETE THIS SEGMENT}

- You were receiving [service] because [Insert the nature of the enrollee's condition].
- [This service will stay the same] {*or*} [The request to increase this service is partially approved] because you do not meet the criteria to [fully] approve this request. To approve this service [in full], the following criteria must be met: [Insert criteria required for the service to be approved].
- These criteria are not met because [Insert enrollee-specific details from the enrollee's unique clinical/social profile to show why/how the enrollee does not meet the required criteria for service approval (necessitating a service denial) *or* why/how the enrollee does not fully meet the required criteria for service approval (necessitating a partial service approval) *or* Insert model prescriber prevails language *or* case-specific information about why the service is experimental/investigational.].

{Note: The clinical rationale must be sufficiently specific to enable an enrollee to determine the basis for appeal.}

*{**INSERT IF THE DECISION IS ABOUT LTSS REQUEST FOR A NEW SERVICE OR FOR MORE SERVICES (CLINICAL OR ADMINISTRATIVE), OR DELETE THIS SEGMENT}***

- The request for [service] was [denied][partially approved] because you do not meet the criteria. This decision was based on:
    - [Insert the criteria requirements and other information relied on to make the decision.]
    - [Insert the enrollee specific details, including medical condition, social, or environmental circumstances that support the decision and illustrate how/why criteria for coverage was not met.]

{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}

This decision was made under 42 CFR Sections 438.210 and 438.404; NYS Social Services Law Sections 364-j(4)(k) and 365-a(2); 18 NYCRR Section 360-10.8[; ADD SPECIFIC BENEFIT CITATION AS APPLICABLE].

What if I don't agree with this decision?

If you think this decision is wrong:

- **You can ask the State for a Fair Hearing** – and an Administrative Law Judge will decide your case.

- *{Insert if applicable}* [**You can ask the State for an External Appeal** – this is may be the best way to show how this service is medically necessary for you.

If you ask for both of these, the Fair Hearing decision will always be the final answer.]

How can I ask for a Fair Hearing?

You have a total of 120 calendar days from the date of this notice to ask for a Fair Hearing. The deadline to ask for a Fair Hearing is **[date+120].**

To ask for a Fair Hearing, you can:

- **Call:** 1-800-342-3334 (TTY call 711 and ask operator to call 1-877-502-6155)

- **Request online using the form at:** http://otda.ny.gov/oah/FHReq.asp

- **Use the Managed Care Fair Hearing Request Form that came with this notice.** Return it with this notice by mail, fax, or in person. Keep a copy of the request and notice for yourself.

  MAIL FAIR HEARING REQUEST FORM TO:
  New York State Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Unit
  P.O. Box 22023
  Albany, New York 12201-2023

  FAX FAIR HEARING REQUEST FORM TO: 518-473-6735

OR

- **WALK IN – New York City Only:**
  Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  14 Boerum Place - 1st Floor
  Brooklyn, New York 11201

After you ask for a Fair Hearing, the State will send you a notice with the time and place of the hearing. At the hearing you will be asked to explain why you think this decision is wrong. A hearing officer will hear from both you and the plan and decide whether our decision was wrong.

To prepare for the hearing:

- **We will send you a copy of the "evidence packet" before the hearing**. This is information we used to make our decision about your services. We will give this information to the hearing officer to explain our decision. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get the evidence packet by the week before your hearing, you can call [1-800 MCO-PLAN] to ask for it.
- **You have the right to see your case file and other documents.** Your case file has your health records and may have more information about why your health care service was changed or not approved. You can also ask to see guidelines and any other document we used to make this decision. You can call [1-800 MCO-PLAN] to see your case file and other documents, or to ask for a free copy. Copies will only be mailed to you if you say you want them to be mailed.
- **You have a right to bring a person with you to help you at the hearing**, like a lawyer, a friend, a relative or someone else. At the hearing, you or this person can give the hearing

officer something in writing, or just say why the decision was wrong. You can also bring people to speak in your favor. You or this person can also ask questions of any other people at the hearing.

- **You have the right to submit documents to support your case.** Bring a copy of any papers you think will help your case, such as doctor's letters, health care bills, and receipts. It may be helpful to bring a copy of this notice and all the pages that came with it to your hearing.
- **You may be able to get legal help** by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers" or go to www.LawhelpNY.org In New York City, call 311.

After the hearing, you will be sent a written decision about your case.

{Insert as applicable}[How can I ask for an External Appeal?

You have **four months** from receipt of this notice to ask for an External Appeal.

A description of your External Appeal rights and an application is attached to this notice. To ask for an External Appeal fill out and return the application to the New York State Department of Financial Services. You may need your doctor's help to fill out the External Appeal application. You can call the New York State Department of Financial Services at 1-800-400-8882 for help.

The External Appeal decision will be made in 30 days. Your appeal will be fast tracked if your provider says the appeal needs to be faster. If your External Appeal is fast tracked, a decision will be made in 72 hours. The decision will be sent to you in writing.]

Other Help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling [{for MMC}[1-800-206-8125] {or for MLTC} [1-866-712-7197].

{*Insert for all MLTCP/MAP/HARP; Insert for MA/MMC/HIV SNP only when services are LTSS or Delete*} [You can call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Independent Consumer Advocacy Network (ICAN)
Community Service Society of New York
633 Third Ave, 10th Floor
New York, NY 10017
Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org]

{*Insert for MA/MMC/HIV-SNP for non-LTSS Services or Delete*} [For advice about your coverage or help filing a complaint or appeal, you can contact Community Health Advocates (CHA) at:

Community Health Advocates (CHA)
Community Service Society of New York
633 Third Ave, 10th Floor
New York, NY 10017
Phone: 1-888-614-5400 (**TTY Relay Service**: 711)

Web: www.communityhealthadvocates.org | **Email**: cha@cssny.org]

Are you having trouble getting the substance use disorder or mental health services that you need? The Community Health Access to Addiction and Mental healthcare Project (CHAMP) is an ombudsman program that can help you with insurance rights and getting coverage for your care. CHAMP can help! Contact:

Community Health Access to Addiction and Mental Healthcare Project (CHAMP)
Community Service Society of New York
633 Third Ave, 10th Floor
New York, NY 10017
Phone: 1-888-614-5400 (**TTY Relay Service**: 711)
Web: https://www.cssny.org/programs/entry/community-health-access-to-addiction-and-mental-healthcare-project-champ
Email: ombuds@oasas.ny.gov

You can call [CONTACT PERSON NAME] at [PLAN NAME] at 1-800-MCO-PLAN if you have any questions about this notice. {*Insert as applicable*} [To talk to someone at [UR Agent], call [insert contact name] at [UR Agent number].

Sincerely,

MCO/UR AGENT/BENEFIT MANAGER Representative

Enclosure: Managed Care Fair Hearing Request Form
{*Insert as applicable*} [External Appeal Standard Description and Application]

cc: Requesting Provider

{*Plans must send a copy of this notice to parties to the appeal including, but not limited to authorized representatives, legal guardians, designated caregivers, etc. Include the following when such parties exist:*}

[At your request, a copy of this notice has been sent to:
[Fname Lname]]

{MMC}**[229]**{*or*}**[266]**{MLTC}**[212]**{*or*}**[211] MANAGED CARE DECISION FAIR HEARING REQUEST FORM**

MAIL TO: NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Unit
P.O. Box 22023
Albany, New York 12201-2023

FAX TO: 518-473-6735

DEADLINE:
You have 120 calendar days from the date of this notice to ask for a Fair Hearing. **The last day to ask for a Fair Hearing is [DATE+120]. If you want a Fair Hearing, you must ask for it on time.**

☐ **I want a Fair Hearing. This decision is wrong because:**

Enrollee	Name	Signature	Phone
Representative (if any)	Name	Signature	
	Relationship	Phone	

FOR NYS OTDA ONLY MANAGED CARE DECISION FAIR HEARING REQUEST FORM

Notice Date: [DATE]	Effective: [DATE]	Service Type: [Service]
Case Name (c/o, if present) and Address: [ENROLLEE NAME ENROLLEE ADDRESS] CIN: [MEDICAID CIN]		[MCO/URA NAME MCO/URA ADDRESS] Reference No.: [MCO REFERENCE NUMBER]

A Plan Appeal was filed on [date]. On [date of appeal determination], [UR Agent Name/Benefit Manager] on behalf of][Plan Name] decided we are [not changing our previous decision to [partially] deny] [changing our previous decision and will partially approve] the service.

[{*Include for only for partial approval, concurrent and LTSS*}
{include as applicable} From [STARTDATE] to [ENDDATE], the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]
{include as applicable} You or your provider requested approval for: [HOURS/DAYS, VISITS, LEVEL, QTY, etc.].
On [DATEIAD] the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and IAD TOTAL AMOUNT]]
On [EFFDATEFAD], the plan approval [is **only** for:] {or} [**changes** to:] {or} [**stays** at:] [HOURS/DAYS, VISITS, LEVEL, QTY, etc. and NEW TOTAL AMOUNT] from [start date] to [end date].]

NOTICE OF NON-DISCRIMINATION

[PLAN NAME] complies with Federal civil rights laws. **[PLAN NAME]** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[PLAN NAME] provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **[PLAN NAME]** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[PLAN NAME]** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **[PLAN NAME]** by:

Mail:	[ADDRESS], [CITY], [STATE] [ZIP CODE],
Phone:	[PHONE NUMBER] (for TTY/TDD services, call <TTY>)
Fax:	[FAX NUMBER]
In person:	[ADDRESS], [CITY], [STATE] [ZIP CODE]
Email:	[EMAIL ADDRESS]

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone:	1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call <toll free number> <TTY/TDD> .	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 <toll free number> <TTY/TDD>.	Chinese
لحوظة: إذاكنتتحدث اللغة فإن خدمات المساعدة اللغوية تتوافر لكمجان. اتصلبرقم <TTY/TDD رقم> toll free number	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다<toll free number> <TTY/TDD> 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <toll free number> (телетайп: TTY/TDD).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <toll free number> <TTY/TDD>.	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <toll free number> <TTY/TDD>.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>.	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט <toll free number/TTY/TDD.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <toll free number> <TTY/TDD>	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <toll free number/TTY/TDD>.	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-<toll free number> <TTY/TDD>	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <toll free number> <TTY/TDD>.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <toll free number> <TTY/TDD>.	Greek
خبردار: اگر آپ اردو بولتے ہیں تو آپ کو زبان کی مدد خدمات مفت میں دستیاب ہیں کال کریں <TTY> <toll free number>.	Urdu