MODEL MMC/MLTC INITIAL ADVERSE DETERMINATION (NO AC) (Revised 11/21)
Template begins below this line

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

INITIAL ADVERSE DETERMINATION DENIAL NOTICE

[Date]

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

Enrollee Number: [ID number or CIN]
Coverage Type: [coverage type]
Service: [service including amount/duration/date of service]
Provider: [requesting provider]
Plan Reference Number: [Reference Number]

Dear [Enrollee]:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by **[DATE+60].** 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?

On [date] {*for Fast Track requests insert:*} [at [hour received]], you or your provider asked for [SERVICE TYPE: HOURS/DAYS, VISITS, LEVEL, QTY, etc.] {*insert as applicable*} [provided by [provider name].

You are getting this notice because [PLAN NAME] has [partially] denied [your request for services][payment for a claim].

{*insert for partial approvals or concurrent review*}
[{*insert as applicable*} [Before this decision, from [STARTDATE] to [ENDDATE], the plan approved:
    [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]]
On [date] you or your provider requested approval for:
    [HOURS/DAYS, VISITS, LEVEL, QTY, etc.]
On [EFFDATE], the plan approval [**is only for**:] [**stays** at:]
    [HOURS/DAYS, VISITS, LEVEL, QTY, etc.]
This means from [NEWSTARTDATE] to [NEWENDDATE], your service is approved for:
    [HOURS/DAYS, VISITS, LEVEL, QTY, etc. AND NEW TOTAL AMOUNT]
{*Insert as applicable*} [We will review your care again [IN TIME FRAME/ ON DATE]].

This 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]?

On [Date], [[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].

{INSERT IF THE DECISION IS AN ADMINISTRATIVE OR BENEFIT DENIAL AND IS NOT 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 NEW SERVICE INCLUDING PARTIAL APPROVALS, AND IS NOT 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) *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 the enrollee to determine the basis for appeal.*}

{INSERT IF THE DECISION IS CLINICAL AND ABOUT A REQUEST FOR MORE OF A CURRENT SERVICE 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 OF A CURRENT SERVICE (CLINICAL OR ADMINISTRATIVE), OR DELETE THIS SEGMENT}

- The request for [service] was [denied][partially approved]. 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.}

{INSERT FOR OON SERVICE DENIALS BASED ON SERVICES NOT MATERIALLY DIFFERENT FROM SERVICES AVAILABLE IN-NETWORK, OR OON REFERRAL DENIALS IF IN-NETWORK PROVIDERS HAVE TRAINING/EXPERIENCE TO MEET ENROLLEE'S NEEDS, OR DELETE}

- You asked for [service] because [insert the nature of the enrollee's condition].
- {*Insert for denials of OON Not Materially Different services*} The following in-network service is available to treat your condition: [Insert a description of the similar service that is available in network.] We believe that this service is not very different from the service you requested because [Insert why the in-network service is not materially different than the OON service, and is adequate to meet the enrollee's clinical/social needs.] You can get this service by [insert how to access and get approval, if needed, for the in-network service].

- {*Insert for OON referral denial based in training and experience*} The in-network providers listed below are available to provide [service] and have the correct training and experience to meet your needs. You can check the provider directory or call us for other provider options. [Insert providers and contact information who are available to provide the requested service, and have training and experience to meet the enrollee's particular needs.]

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

{*Insert for denials for services not covered by the Benefit Package that are available through Fee-For-Service Medicaid*} [While this service is not covered by [Plan Name], you may be able to get it from regular Medicaid. To get this service, use your New York State Benefit card to see any provider that accepts New York Medicaid.]

What if I don't agree with this decision?

If you think our decision is wrong, you can tell us why and ask us to change our decision. This is called a **Plan Appeal.** There is no penalty and we will not treat you differently because you asked for a Plan Appeal.

You have **60 calendar days** from the date of this notice to ask for a Plan Appeal. The deadline to file a Plan Appeal is **[date+60]**.

Who can ask for a Plan Appeal?

You can ask for a Plan Appeal, or have someone else ask for you, like a family member, friend, doctor, or lawyer. If you told us before that someone may represent you, that person may ask for the Plan Appeal. If you want someone new to act for you, you and that person must sign and date a statement saying this is what you want. Or, you can both sign and date the attached Plan Appeal Request Form. If you have any questions about choosing someone to act for you, call us at: [phone number]. TTY users call [TTY number].

{*Insert for all MLTCP/MAP/HARP; Insert for MA/MMC/HIV SNP only when services are LTSS or Delete*} [You can also 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

How do I ask for a Plan Appeal?

You can call, write or visit us to ask for a Plan Appeal. You or your provider can ask for your Plan Appeal to be **fast tracked** if you think a delay will cause harm to your health. **If you need help, or need a Plan Appeal right away, call us at [1-800-MCO-PLAN].**

<u>Step 1</u> – Gather your information.

When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.
- [Insert any specific information needed for the plan to render a decision on appeal.]

{*Insert for OON not materially different, if plan requires for UR review*} [If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your appeal:

1) a statement in writing from your doctor that the out of network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.
2) two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal.]

{*Insert for OON referral denial based on training/experience*} [If you think our participating provider does not have the correct training or experience to provide this service, you can ask us to check if it is medically necessary for you to be referred to an out of network provider. You will need to ask your doctor to send this information with your appeal:

1) a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
2) that recommends an out of network provider with the correct training and experience who is able to provide the service.

Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for. If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal.]

If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review.

To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make this decision. You can ask to see these documents or ask for a free copy by calling [1-800-MCO-PLAN].

<u>Step 2</u> – Send us your Plan Appeal.
{*If the plan has different contact information for standard and fast track appeals, plans may replace/revise the contact information below.*}
Give us your information and materials by phone, fax, [email,] mail, [online,] or in person**:**

Phone………………………………………………. [1-800 MCO number]
Fax…………………………………………………. [fax number]
Email……………………………………………….. [email address]

Mail…………………….………………………….. [address] [city, state zip]
Online…………………………………………..…… [web portal]
In Person…………………………………….....… [address] [city, state zip]

To send a written Plan Appeal, you may use the attached Appeal Request Form, but it is not required. Keep a copy of everything for your records.

What happens next?

We will tell you we received your Plan Appeal and begin our review. We will let you know if we need any other information from you. If you asked to give us information in person, [plan name] will contact you (and your representative, if any).

We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.

We will send you our decision in writing. If fast tracked, we will also contact you by phone. If you win your Plan Appeal, your service will be covered. If you lose your Plan Appeal, we will send you our Final Adverse Determination. The Final Adverse Determination will explain the reasons for our decision and your appeal rights. If you lose your Plan Appeal, you may request a Fair Hearing and, in some cases, an External Appeal.

When will my Plan Appeal be decided?

Standard– We will give you a written decision as fast as your condition requires but no later than 30 calendar days after we get your appeal.

Fast Track –We will give you a decision on a fast track Plan Appeal within 72 hours after we get your appeal.

Your Plan Appeal will be fast tracked if:

- A delay will seriously risk your health, life, or ability to function;
- Your provider says the appeal needs to be faster;
- You are asking for more of a service you are getting right now;
- You are asking for home care services after you leave the hospital;
- You are asking for more inpatient substance abuse treatment at least 24 hours before you are discharged; or
- You are asking for mental health or substance abuse services that may be related to a court appearance.

If your request for a Fast Track Plan Appeal is denied, we will let you know in writing and will review your appeal in the standard time.

For both Standard and Fast Track - If we need more information about your case, and it is in your best interest, it may take up to 14 days longer to review your Plan Appeal. We will tell you in writing if this happens.

You or your provider may also ask the plan to take up to 14 days longer to review your Plan Appeal.

Can I ask for a State Fair Hearing?

You have the right to ask the State for a Fair Hearing about this decision **after** you ask for a Plan Appeal **and**:

- You receive a Final Adverse Determination. You will have 120 days from the date of the Final Adverse Determination to ask for a Fair Hearing;

OR

- The time for us to decide your Plan Appeal has expired, including any extensions. **If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.** To request a Fair Hearing call 1-800-342-3334 or fill out the form online at http://otda.ny.gov/oah/FHReq.asp.

Do I have other appeal rights?

You have other appeal rights if your plan said the service was: 1) not medically necessary, 2) experimental or investigational, 3) not different from care you can get in the plan's network, or 4) available from a participating provider who has the correct training and experience to meet your needs.

For these types of decisions, if we do not answer your Plan Appeal on time, the original denial will be reversed.

For these types of decisions, you may be eligible for an External Appeal. An External Appeal is a review of your case by health professionals that do not work for your plan or the State. You may need your doctor's help to fill out the External Appeal application.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; or
- If you ask for a Fast Track Plan Appeal, you may also ask for a Fast Track External Appeal at the same time; or
- You and your plan may jointly agree to skip the Plan Appeal process and go directly to the External Appeal.

You have 4 months to ask for an External Appeal from when you receive your plan's Final Adverse Determination, or from when you agreed to skip the Plan Appeal process.

To get an External Appeal application and instructions:

- Call [plan name] at [PLAN'S TOLL FREE #]; or
- Call the New York State Department of Financial Services at 1-800-400-8882; or
- Go online: www.dfs.ny.gov

The External Appeal decision will be made in 30 days. Fast track decisions are made in 72 hours. The decision will be sent to you in writing. If you ask for an External Appeal and a Fair Hearing, the Fair Hearing decision will be the final decision about your benefits.

{*Insert for medical necessity denials of inpatient substance abuse treatment requested 24 hours prior to discharge*} [SPECIAL NOTICE: If you asked for inpatient substance use treatment at least 24 hours before you were to leave the facility, the plan will continue to pay for your stay if:

- you ask for a Fast Track Plan Appeal within 24 hours of receipt this notice AND

- you ask for a Fast Track External Appeal at the same time.

The plan will continue to pay for your stay until there is a decision made on your appeals. Your plan will decide your Fast Track Plan Appeal in 24 hours. The Fast Track External Appeal will be decided in 72 hours.]

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].

You can call [PLAN NAME] at [1-800-MCO-PLAN] if you have any questions about this notice.

Sincerely,

MCO/UR AGENT/BENEFIT MANAGER Representative

Enclosure: Appeal Request Form

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]]

[PLAN NAME] APPEAL REQUEST FORM
FOR DENIAL OF SERVICES

Mail this form to:
[Plan Name/UR AGENT]
[Address]
[City, State Zip]

Fax to: [Fax number]

Today's date: ____________________

Deadline: If you want a Plan Appeal, **you <u>must</u> ask for it on time. You have 60 days** from the date of this notice to ask for a Plan Appeal. The last day to ask for a Plan Appeal about this decision is [**DATE+60**].

Enrollee Information
Name: [First Name] [Last Name]
Enrollee ID: [Enrollee ID]
Address: [Address] [City, State Zip]
Home Phone: [Home Phone] Cell Phone: [Cell Phone]
Plan Reference Number: [Reference Number]
Service being Denied: [SERVICE]

I think the plan's decision is wrong because:

____

____

____

<u>Check all that apply:</u>

- ☐ I request a Fast Track Appeal because a delay could harm my health.
- ☐ I enclosed additional documents for review during the appeal.
- ☐ I would like to give information in person.
- ☐ I want someone to ask for a Plan Appeal for me:
  - Have you authorized this person with [Plan Name] before? YES ☐ NO ☐
  - Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind. YES ☐ NO ☐

Requester (person asking for me)

Name: ______________________________ E- mail: ______________________

Address: ____

City: ______________________ State: ______ Zip Code: __________

Phone #: (_____)_______________ Fax #: (_____)__________________

Enrollee Signature: ____________________________________ Date: _______________

Requester Signature: ____________________________________ Date:_______________

If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.

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
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم TTY/TDD >(رقم هاتف الصم والبكم 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 کی خدمات مفت میں دستیاب ہیں ۔ کال کریں < toll free number> <TTY:>.	Urdu