Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." Oral interpretation is available for all languages. Access this service by calling <phone number>.

<Plan Name/Logo>

COVERAGE DETERMINATION NOTICE

Service Plan Update

[*Insert if the PCSP is re-authorized without changes (i.e. without additions or increases):* **No Change to Current Services**]

Name: **Date:**

Participant number:

[*Insert other identifying information, as necessary (e.g., provider name, Participant's Medicaid number, service subject to notice, date of service)*]

[*Insert as applicable:* Your Service Plan was created *or* Your Service Plan was changed *or* Your Service Plan was renewed].

Please review the proposed Service Plan (attached) to see a full list of your authorized services. [*Insert if the PCSP is reauthorized without changes (i.e. without additions or increases)*: No changes have been made to your Service Plan (dated <prior service plan effective date>).]

This Service Plan will take effect on: <effective date>.

Keep reading to learn what you can do if you disagree with the services in your Service Plan. You have the right to appeal.

Who [*Insert as applicable:* created *or* changed *or* renewed] your Service Plan?

Your Service Plan was [*Insert as applicable:* created *or* changed *or* renewed] by your Interdisciplinary Team (IDT).

You can appeal this Service Plan update.

You have the right to ask <plan name> to review your Service Plan by asking for an appeal. You may appeal even if you previously agreed to this Service Plan. You may appeal if you feel you should have different or additional items or services in your Service Plan that are not included. You can also appeal to increase services you already have in your Service Plan. <Plan name> will review your request and determine whether to give you the requested services. There are four levels of appeal. Asking <plan name> to review your Service Plan is Level 1.

How to appeal: Ask <plan name> for an appeal within **<u>60 calendar days</u>** of the postmark date of this notice. If you appeal late, we may still be able to accept your appeal if you have a good reason for missing the deadline.

Anybody can request an appeal for you.

You can have someone else file your appeal or represent you during your appeal. You can choose anyone to represent you, like a family member, friend, doctor, attorney, or an ICAN staff member (see below). Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You can write a letter or use the enclosed Appointment of Representative form. Send your letter or form to us by fax or mail, or give it to your Care Manager. If you have any questions about naming your representative, call us at: <phone number>. TTY users call <TTY number>.

<Plan Name>
<Name of Relevant Department>
<Mailing Address>
Fax: <Fax>

The state created the **Independent Consumer Advocacy Network (ICAN)** to help you with appeals and other issues with the FIDA program. ICAN is independent, and the services are available to you for free. They can help answer your questions about the appeals process, give you advice, and may even represent you. Call ICAN at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800.

When will we decide your appeal?

<u>Standard Appeal</u> – 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 (or 7 calendar days for Medicaid drug appeals).

<u>Fast Appeal</u> – You have the right to request a Fast Appeal. We will give you a decision on a Fast Appeal within 72 hours after we get your appeal. You can ask for a Fast Appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

We will automatically give you a fast appeal if a doctor asks for one or if your doctor supports your request in writing. If you ask for a Fast Appeal without support from a doctor, we will decide if your request requires a Fast Appeal. If we do not give you a Fast Appeal, we will treat your case as a Standard Appeal and give you a decision with 30 days (or 7 calendar days for Medicaid drug appeals).

For both Standard and Fast Appeals, we can take up to 14 days longer to decide if you ask for an extension, or if delaying the decision is best for you. If we take this extra time to decide, we will send you a written notice to explain why.

How to ask for an appeal with <plan name>:

Step 1 – Gather your information and materials. You will need the following:

- Your name
- Address
- Participant number
- Reason(s) for appealing
- Whether you want a Standard or Fast Appeal (For a Fast Appeal, explain why you need one. It is very helpful to have a doctor submit a statement in support of your Fast Appeal.)
- Whether you want to have an in-person review
- Any evidence or information that you want us to review to support your case, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

[*If applicable, include a request for any information specific to this action that should be provided in order for the plan to render a decision on appeal.*]

You may use the attached Appeal Request Form if you wish, but it is not required.

Step 2 – Send the information and materials by mail, fax, or phone. You can also deliver it in person, or give it to your Care Manager.

[*If plans have different contact information for standard and fast appeals, plans may replace/revise the contact information below.*]

Appeals Contact Information:

Phone .... <phone number>
Regular Mail .... <address> <city, state zip>
Fax .... <fax number>
Delivery in Person .... <address> <city, state zip>
Contacting your Care Manager .... <phone number>

If you ask for a standard appeal by phone or by asking your Care Manager, we will send you a letter confirming your request.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

What happens next?

<Plan name> will review the appeal and any relevant material submitted. If an in-person review is requested, <plan name> will contact you (and your representative, if any) to schedule it. If you are homebound, or are otherwise unable to travel because of your health, the review can be held at your location or by phone.

If our decision is in your favor, we will notify you (and your representative, if any) and tell you how and when your services will be provided.

If our decision is **not** in your favor, or if we fail to decide by our deadline, we will notify you (and your representative, if any) in writing. Your case will be automatically sent to the state's **Integrated Administrative Hearings Office (IAHO)**. This is Level 2 in the four level FIDA Appeals process. If the IAHO denies your request, the written decision will explain your additional appeal rights.

[*If applicable, plans must send a copy of this notice to relevant parties (e.g. representative, designated caregiver, etc.) and include the following text:*]

A copy of this notice has been sent to: <name>
<address> <city, state zip>
<phone number>

Get help & more information

(TTY users call 711, then use the phone numbers below)

- <Plan name>
  Toll Free Phone: <phone number>
  TTY users call: <TTY number>
  <hours of operation>
- 1-800-MEDICARE (1-800-633-4227)
  TTY users call: 1-877-486-2048
  24 hours a day, 7 days a week
- Independent Consumer Advocacy Network (ICAN)
  Toll Free Phone: 1-844- 614-8800
  8:00am – 8:00pm, Monday – Sunday
- NYS Department of Health
  Toll Free Phone: 1-866-712-7197
- Elder Care Locator
  Toll Free Phone: 1-800-677-1116
- Medicare Rights Center
  Toll Free Phone: 1-888-HMO-9050

<Plan's legal or marketing name> is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

You can get this information for free in other languages. Call <toll-free number> and <TTY/TDD numbers> during <hours of operation>. The call is free. [*This disclaimer must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.*]

You can also ask for this information in other formats, such as Braille or large print.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any

services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org.

<Plan name>

APPEAL REQUEST FORM

Mail this form to: <Address>
<City, State Zip>

Fax to: <Fax number>
Email to: <Email address>

Participant Information *[the plan should auto-populate the Participant's Information]*

Name: <First Name> <MI> <Last Name>
Participant ID: <Participant ID>
Address: <Address> <City, State Zip>
Home Phone: <Home Phone> Cell Phone: <Cell Phone>
Date of Birth: <DOB>

Requester (if different from above)

Name: ______________________________ E- mail: ______________________

Address: ______________________________________ Fax #: (______) __________

City: ________________ State: ______ Zip Code: __________ Phone #: (______) __________

Does the Requester intend to represent the Participant? ☐ YES ☐ NO

Appeal Information

Today's date: ________________ Service you are appealing: ________________________

____

Reason for requesting appeal: ____

____

____

☐ I request an In-Person Review. If checked, is member homebound? ☐ YES ☐ NO

☐ Is an Interpreter needed? ☐ YES ☐ NO Language: ______________________

☐ I need an accommodation for my disability for this appeal. The accommodation(s) I need are:

____

☐ I enclosed additional documents for consideration for the appeal.

☐ I request a FAST APPEAL because my health could be seriously harmed if the decision takes 30 days.

☐ I request copies of my medical record and any documentation used to make the determination. Please send these documents to:
☐ Me ☐ My representative (see above)

☐ I request the clinical guidelines and/or other rules or regulations used to make my determination. Please send these documents to:
☐ Me ☐ My representative (see above)