

Health Plan Logo with contact information

CCC Plus Logo - Optional

# NOTICE OF <PARTIAL >DENIAL (Adverse Benefit Determination)

<Date>

<Medicaid Number>

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| City, State Zip |  |

Dear <First\_Name> <Middle\_Initial> <Last\_Name>:

On <date> we received a request from <you, your authorized representative, or provider name> to cover the following <service(s) or item(s)>:

<List requested service(s)/item(s)>

<Date of service/Date of request>

We have <denied/partially denied> coverage for the medical services/items listed above for the following reasons:

<Provide clear statement of the specific denial/partial denial reason(s) *(including citation to the law or policy or reference to the medical criteria supporting the adverse benefit determination)* and date of each denial>

[For terminations or reductions of existing benefits or services, this also includes an explanation of what has changed in the member’s condition/circumstances between the time when the benefit or service was last approved and the current decision to reduce or terminate the benefit or service]

The decision was made by <insert titles and qualifications of individuals participating in the review>. The decision was made by reviewing your request against the medical criteria listed above. You can ask for copies of the documents, records, and other information relevant to this decision, such as the criteria listed above. If requested, this information would be provided at no cost to you. Call us at <insert phone number> if you would like a copy.

[Do not include language about financial responsibility in the notice.]

If you disagree with our decision, you have a right to an appeal. You should share a copy of this decision with your healthcare provider. You may also ask someone else to appeal for you. Please read the enclosed information. It explains your appeal rights with <MCO name>. Your request to appeal this decision must be filed no more than 60 days from the date of this letter.

 [<At the plan’s discretion, insert any additional NCQA language here (i.e., peer to peer timeframes) in order to ensure compliance with NCQA guidelines. If this is included, add the following sentence in bold: If a peer-to-peer review is requested, you must still file your internal appeal with us within 60 calendar days of the date of this letter. . >.]

If you have special needs or need help reading or understanding this letter, please call Member Services toll free at <insert phone number> from <insert times, time zone, and weekdays>.

Sincerely,

[Health Plan]

Attachments

Non-discrimination statement

Multi-language insert

# Member Appeal Information

## Your Right to Appeal our Decision

If you do not agree with the decision we have made, you or your authorized representative have the right to file an internal appeal with [MCO]. The deadline to file an internal appeal is 60 calendar days from the date on this letter.

You or your authorized representative can file your internal appeal by phone or in writing. Our appeal contact information is:

1. **Mail or delivery service**: <MCO Name, Attn: Appeals, Address 1, Address 2, City, State Zip>
2. **Fax:** <MCO Fax #>
3. **Electronic**: <MCO Appeal Email> and/or <MCO Appeal Portal Address>
4. **Phone**: <MCO Appeal Phone, including TDD #>

You or your doctor can ask that your appeal be reviewed under an expedited (fast) process if you believe your health condition requires it. The internal appeal request must list that an expedited appeal is being requested and filed through one of the methods listed above. Your doctor will need to explain how a delay will cause harm to your physical or behavioral health. If we have all of the information we need, an expedited appeal decision will be made within 72 hours of receiving your appeal request.

If your request for an expedited appeal is denied, we will tell you and the appeal will be reviewed under the standard process.

If you need assistance in filing an appeal, or assistance with completing the steps in the process of filing an appeal, you may contact us at the phone number listed above.

## Continuation of Benefits

You can request that the services scheduled to end, be reduced, or suspended continue during your appeal. Services may be continued if your appeal request meets one of these requirements:

(1) you ask for an appeal within ten (10) calendar days of being told that your request is denied or your care is changing; or,

(2) you ask for an appeal by the date the change in the service is scheduled to occur.

When filing your internal appeal, let us know if you would like your benefits continued by stating you are requesting continued coverage in your appeal request

It is important to know that if your appeal results in a denial, you may have to pay for any of the continued benefits received while the appeal was being handled.

## Processing the Internal Appeal

Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision and who have the appropriate clinical expertise in the treatment of your condition or disease.

Before and during the internal appeal, you or your authorized representative can see or request copies of your case file, including medical records, any other documents and records, or any laws or policies being used to make a decision on your case. This information is available at no cost to you. You may request this information by calling the phone number listed above.

You can also provide information that you want us to use to make the decision on your appeal. If you want to provide more information, this information must be received by < date>. If you need more time to provide this information to help us decide your case, you may request this by calling or writing to us using the contact information listed above.

You have the right to be represented by an attorney or other individual in the internal appeal process.

## Internal Appeal Timeframes

Standard Appeals – If we have all of the information we need, we will tell you our decision within 30 days from the date your appeal was received. We will send you our decision in writing.

Expedited Appeals – If we have all of the information we need, we will tell you our decision within 72 hours from the date/time your appeal was received. We will tell you our decision by telephone and also send our decision in writing.

If More Information is Needed – If we need more information, we will write you and tell you what is needed. For an expedited appeal, we will call you and also send a written notice. We will tell you why we need the additional information. The request for more information will add up to 14 more days to the standard and expedited timeframes. If you do not agree with our decision to take more time to review your appeal, you may file a grievance.

## Internal Appeal Decision

We will tell you, and your authorized representative if one is chosen, in writing of our appeal decision. If the decision is not in your favor, we will also explain the reason for the decision, including the citations to policies, procedures or authority that was used to make this decision and the name, title and qualifications of the person who made the decision. Once the internal appeal with <MCO Name> is exhausted, you have the right to request an appeal with the Department of Medical Assistance Services (DMAS).

## Appeals Rights to DMAS

After [MCO name] has made a decision on the internal appeal you filed, you have a right to appeal to DMAS. This is known as the State Fair Hearing.  The appeal to DMAS must be filed within 120 days after receiving our internal appeal decision or it can be filed at any time if there is a deemed exhaustion because you believe we have failed to follow the notice and timing requirements for our internal appeal process.  For further information on the DMAS appeal process, you can visit: [www.dmas.virginia.gov/appeals](http://www.dmas.virginia.gov/appeals) or call the DMAS Appeals Division at (804) 371-8488.

## Help from an Advocate

If you would like to speak to an independent Advocate that can help you with questions, concerns or filing an internal appeal or request for a State Fair Hearing, please call 1-800-552-5019 or TTY toll-free 1-800-464-9950, Office of the State Long-Term Care Ombudsman, Department for Aging & Rehabilitative Services.

***Additional information on this process is available in your Member Handbook available on our website at* (health plan should insert URL to member handbook).**