

Appendix E: Template Notice

PLAN ID: XXXXXXXXXXXXXXXXXXXXX

<<ENROLLEE>> and/or

<<LEGAL REPRESENTATIVE>>

<<STREET ADDRESS>>

<<CITY, STATE ZIP>>

NOTICE OF ADVERSE BENEFIT DETERMINATION

Dear <<ENROLLEE/LEGAL REPRESENTATIVE>>:

<<LTC PLAN>> has reviewed your request for <<SERVICE and AMOUNT>>, which we received on <<DATE>>. After our review, this service has been:

<<PARTIALLY DENIED, DENIED, TERMINATED, SUSPENDED, REDUCED>> as of <<EFFECTIVE DATE OF ADVERSE BENEFIT DETERMINATION>>

We made our decision because:

(Check all boxes that apply)

We determined that your requested services are **not medically necessary** because the services do not meet either of the reason(s) checked below: *(See Rule)*

Meet all of the criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR

Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

and one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or
2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

The requested **service is not a covered benefit.**

Other authority <<explain and cite authority>>

The facts that we used to make our decision are: <<explain>>

SAMPLE This determination of the Medical Director has been made based on medical necessity (as defined by Florida law – specifically see checked box above) and reflects the application of the Plan's approved review criteria and guidelines.

Clinical rationale: for clinician to write – see example for detail below – it would be different for each type of clinician

Example from eQHealth

Clinical Rationale for Decision: The patient is a ____ old with a history of gastroesophageal reflux disease and apnea. The patient is on an apnea monitor. Over the past month, the patient had four reported incidences on the monitor. No skilled interventions were required for these reported events. The patient is on oral ____ every 4 hours and requires positioning after meals. The patient is on two scheduled medications and as needed nebulizer treatments. The patient is currently attending ____ during the day. The request is for skilled nursing for 12 hours per day 7 days per week. The patient lives with his ____ and _____. The clinical information provided does not support the medical necessity of the requested services. The patient does not have any ongoing skilled interventions which would support skilled nursing. Additionally, the patient does not require nighttime monitoring by a skilled nurse.

You, or someone legally authorized to do so, can ask us for a complete copy of your file, including medical records, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information relevant to the adverse benefit determination. These will be provided free of charge.

You may request these documents by contacting: <<Plan supplied contact information>>

Right to Request a Plan Appeal

If you do not agree with this decision, you have the right to request a plan appeal from <<LTC PLAN>>. When you ask for a plan appeal, <<MANAGED CARE PLAN>> has a different health care professional review the decision that was made.

How to Ask for a Plan Appeal:

You can ask for a plan appeal in writing or by calling us. Your case manager can help you with this, if you have one. We must receive the request *within 60 days* of the date of this letter. (If you wish to continue your services until a final decision is made on your appeal,

we must receive your request sooner. See the “How to Ask for your Services to Continue” section below for details.) Here is where to call or send your request:

<<MCO>>

<<MAILING ADDRESS>>

<<PHONE>>

<<FAX>>

<<EMAIL>>

Your written request for a plan appeal must include the following information:

- Your name
- Your member number
- Your Medicaid ID number
- A phone number where we can reach you or your legal representative

You may also include the following information if you have it:

- Why you think we should change the decision
- Any medical information to support the request
- Who you would like to help with your plan appeal

Within five days of getting your plan appeal request, we will tell you in writing that we got your plan appeal request unless you ask for an expedited (fast) plan appeal. We will give you an answer to your plan appeal within 30 days of you asking for a plan appeal.

How to Ask for an Expedited (Fast) Plan Appeal if Your Health is At Risk:

You can ask for an “expedited plan appeal” if you think that waiting 30 days for a plan appeal decision resolution could put your life, health, or your ability to attain, maintain, or regain maximum function in danger. You can call or write us (see above), but you need to make sure that you ask us to *expedite* the plan appeal. We may not agree that your plan appeal needs to be expedited, but you will be told of this decision. We will still process your plan appeal under normal time frames. If we do need to expedite your plan appeal, you will get our plan appeal resolution within 48 hours after we receive your plan appeal request. This is true whether you asked for the plan appeal by phone or in writing.

How to Ask for your Services to Continue:

If you are now getting the service that is scheduled to be reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made in a plan appeal and, if requested, fair hearing. If your services are continued, there will be no change in your services until a final decision is made in your plan appeal and, if requested, fair hearing.

If your services are continued and our decision is upheld in a plan appeal or fair hearing, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

To have your services continue during the plan appeal, you **MUST** file your plan appeal **AND** ask to continue your services within this time frame:

File a request for your services to continue with <<LTC PLAN>> no later than 10 days after this letter was mailed OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, whichever is later. You can ask for a plan appeal by phone. If you do this, you must then **also** make a request in writing. **Be sure to tell us if you want your services to continue.**

To have your services continue during the fair hearing, you **MUST** file your fair hearing request **AND** ask for continued services within this time frame:

If you were receiving services during your plan appeal, you can file the request for your services to continue with the Agency for Health Care Administration (Agency) **no later than 10 days** from the date on your notice of plan appeal resolution OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, ***whichever is later.***

What to Do if You Disagree with the Plan Appeal Decision

You will receive the result of the plan appeal process in a notice of plan appeal resolution (notice) that outlines the outcome of the plan appeal. If you still do not agree with our decision, or if you do not receive your notice on time, you can ask for a fair hearing.

How to Ask for a Fair Hearing:

When you ask for a Medicaid fair hearing, a hearing officer who works for the state reviews the decision that was made. You may ask for a fair hearing any time up to 120 days after you get our notice of plan appeal resolution. **You must finish your plan appeal process first.**

You may ask for a fair hearing by calling or writing to:

Agency for Health Care Administration

Medicaid Hearing Unit

P.O. Box 60127

Ft. Myers, FL 33906

(877) 254-1055 (*toll-free*)

239-338-2642 (*fax*)

MedicaidHearingUnit@ahca.myflorida.com

After getting your fair hearing request, the Agency will tell you in writing that they got your fair hearing request.

If you have questions, call us at <<PHONE>> or <<TTY NUMBER>>. For more information on your rights, review the Grievance and Appeal section in your Member Handbook. It can be found online at: <<WEB ADDRESS>>.

Notice of Nondiscrimination

<< INSERT NONDISCRIMINATION LANGUAGE>>

Sincerely,

<<NAME>>

<<Medical Director or title of other professional who made the adverse benefit determination in accordance with Attachment II, Section VII.G.4 of the SMMC contract>>