

**MODEL MMC/MLTC INITIAL ADVERSE DETERMINATION (WITH 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  
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES**

[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]**. **If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by [DATE+10]**. 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 [PLAN NAME] is [reducing] {or} [suspending] {or} [stopping] the service(s) you are getting now.

Before this decision, from [STARTDATE] to [ENDDATE], the plan approved:  
[HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]

On [EFFDATE], the plan approval **changes** to:  
[HOURS/DAYS, VISITS, LEVEL, QTY, etc. and NEW TOTAL AMOUNT]  
From [new start date] to [new end date] {or}  
**is suspended** from {start date} to {end date} {or} [ **ends.**]

{Insert as applicable} [We will review your care again [IN TIME FRAME/ ON DATE].]

{Insert for continuing services}[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 [reduce][suspend][stop] your service?**

[[UR Agent/benefit manager] on behalf of] [Insert Plan Name] is taking this action because [the service is not medically necessary] {or} [other decision].

- Your [service] will be [reduced][suspended][stopped] because:
  - [Indicate the change in the enrollee's medical condition, social, or environmental circumstances since the previous authorization was made.]
  - [State when the change occurred.]
  - [Include the criteria requirements and other information relied on to make the decision.]
- You no longer meet the criteria for your current level of service because:
  - [Describe why or how the change in medical condition, social, or environmental circumstances no longer meet the criteria for the previous authorization or why/how this change necessitates a change in services.]

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

## 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.

### If you want to keep your services the same

- You **must** ask for a **Plan Appeal** within **10 calendar days** or by the date this decision takes effect, whichever is later.
- The last day to ask for a **Plan Appeal** and keep your services the same is **[date+10]**.
- Your services will stay the same until we make our decision. If the Plan Appeal is not decided in your favor, you may have to pay for the services you got while waiting for the decision.

You have a total of **60 calendar days** from the date of this notice to ask for a Plan Appeal. The deadline to ask for 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, 10<sup>th</sup> Floor  
New York, NY 10017

**Phone:** 1-844-614-8800 (**TTY Relay Service:** 711)

**Web:** [www.icannys.org](http://www.icannys.org) | **Email:** [ican@cssny.org](mailto: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, 10<sup>th</sup> Floor

New York, NY 10017

**Phone:** 1-888-614-5400 (**TTY Relay Service:** 711)

**Web:** [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org) | **Email:** [cha@cssny.org](mailto: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, 10<sup>th</sup> 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](mailto: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].**

### Step 1 – 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.]

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].

### Step 2 – 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 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:

- 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 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 also 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](http://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 make a decision about 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 representative, 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 SERVICES BEING REDUCED, SUSPENDED, OR STOPPED**

**Mail To:**  
[Plan Name/UR AGENT]  
[Address]  
[City, State Zip]

**Fax to:** [Fax number]

Today's date: \_\_\_\_\_

**DEADLINE:**

- **If you want to keep your services the same** until the Plan Appeal decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later. (If you lose your appeal you may have to pay for services you got while waiting for the decision.)
- **The last day to ask for a Plan Appeal to keep your services the same is [Date+10].**
- You have a total of 60 calendar days from the date of this notice to ask for a Plan Appeal. **The last day to ask for a Plan Appeal for this decision is [DATE+60]. If you want a Plan Appeal, you must ask for it on time.**

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**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 reduced, suspended or stopped: [SERVICE]

**I think the plan's decision is wrong because:**

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Check all that apply:

- I do NOT want my services to stay the same** while my Plan Appeal is being decided.
- 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
لحوظة: إذا كنت تتحدث اللغة العربية فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل بالرقم <toll free number> <TTY/TDD>.	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 <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