

Important: This notice explains your appeal rights. 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 these services by calling <phone number>.

[PLAN NAME/LOGO]

Appeal Level: 1

APPEAL DECISION NOTICE

Name:

Date of Notice:

Enrollee Number:

Appeal Number:

Date Appeal Filed: *[Insert date appeal filed]*

Date of Appeal Determination: *[Insert date of appeal determination]*

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

Dear <Enrollee name>,

<Plan name> reviewed your appeal, received on <date appeal received, orally or in writing> *[for expedited appeals insert: at <hour received>]*, about the following action: *[Insert a detailed description of the Plan action (e.g. denial, reduction, etc.) being appealed and the benefits involved. Also, include the original rationale for the Plan action that is the basis of the enrollee's appeal.]*

Level 1 Appeal decision

Your appeal was *[Insert if applicable: partially]* denied on <date of appeal decision>. That means we upheld *[Insert if applicable: part of]* the previous decision made on <date of plan coverage determination >. We *[Insert if applicable: partially]* denied your appeal because: *[Insert specific rationale for the appeal decision, addressing each initial decision and rationale listed above. Include citations or clear references to State or Federal coverage rules and guidelines, or other clinical guidelines that were used to support the appeal decision. Describe the clinical rationale, if any, and indicate that the enrollee, or his/her representative, if applicable, may request the relevant clinical review criteria at no cost to them.]*

[Insert the following three paragraphs for decisions that are partially favorable to the enrollee:

However, we decided to approve the following services: *[List the services that were approved, including any applicable information about coverage amount, duration, etc.]*

You are authorized to get these services as of <date authorized (no later than one business day after the Plan appeal decision date)>. If you do not get the services, or if the services are stopped or reduced, tell us immediately using the contact information below:

<Plan name>
<Name of Appeals/Grievance Department>
<Mailing Address for Appeals/Grievance Department>
Phone: <phone number> TTY: <TTY number>

Fax: <fax number>]

You can also contact the **Independent Consumer Advocacy Network (ICAN)** to help you resolve the issue. Call ICAN at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800.

What this means

Because our Level 1 Appeal decision is not fully in your favor, the appeal process automatically continues. You will now begin Level 2 of the appeal process, and we are forwarding your case to the **Office of Administrative Hearings (OAH)**. The OAH is an independent organization that is not connected to <plan name>.

Someone from the OAH will contact you to schedule a hearing about the following disputed services: *[List all services that are still fully or partially disputed after the Level 1 decision.]*

The OAH will conduct the hearing and make a decision as soon as your condition requires. You can choose to participate in the hearing either over the phone or in-person. If you need reasonable accommodations because of a disability, tell the OAH and they will provide those accommodations for you. If you are homebound, or if transportation could be harmful to your health, make sure to ask that the hearing is conducted at your home or other residence.

Do I have other appeal rights?

You have other appeal rights for services **covered by Medicaid** if we 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 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 us or the State. You may need your doctor's help to fill out the External Appeal application.

You have 4 months to ask for an External Appeal from when you receive this notice.

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 on line: www.dfs.ny.gov

The External Appeal decision will be made in 30 days. You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called a Fast track decisions. 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 we automatically forward your case to the Office of Administrative Hearings (OAH), the decision of the fair hearing officer will be the one that that determines which services you can receive.

Continuation of services during your Level 2 Appeal

[Insert the following two paragraphs if any of the disputed services are continued:

Because you had continuing services during Level 1 of your appeal, the following disputed services will also continue pending the outcome of your Level 2 appeal: *[List the disputed services that qualify for continuation of benefits.]*

If these services are stopped before the OAH makes a decision, contact us at <phone number> or the **Independent Consumer Advocacy Network (ICAN)** at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800. If the OAH upholds our decision, you will not have to pay for any continued services.]

[Insert the following paragraph if none of the disputed services qualify for continued benefits:

You will not get the disputed services at this time. <Plan name> will not take any action regarding these benefits until your appeal is resolved by the OAH, or until we come to an agreement about the disputed services.]

[Insert the following paragraph if the enrollee did not qualify for continuation of services, but the plan partially (but not fully) approved any of the disputed benefits from the original Plan action: You asked for [insert benefit and amount requested]. <Plan name> approved [insert benefit and amount approved]. You are appealing this approval because it is not what you requested. We will provide you with the approved services while your appeal goes to Level 2 of the appeal process to decide whether we have to provide you with what you requested.]

Getting your case file and submitting evidence

We will send you a copy of the evidence packet (the information we will use to support our decision) that will help you, at your OAH hearing, show why our decision was wrong.

If you would like the OAH to consider information that was not considered by <plan name>, you should submit it **as soon as possible**. We recommend that you submit the information by phone, fax, or email. You may also submit it by mail, bring it to the OAH office, or present it at an in-person hearing. We recommend keeping a copy of everything for your records.

Office of Administrative Hearings (OAH)

Mailing Address: Integrated Appeals/OAH-10A, P.O. Box 1930, Albany, NY 12201

Physical Address: 40 N Pearl,

Albany, NY

Phone: 1-844-523-8777

TTY Phone: Call 711, then follow the prompts to dial 844-523-8777

Fax: 518-473-8783

Email: otda.sm.MAP.Integrated.Appeals.Office@otda.ny.gov

If you want someone to represent you

You can have someone else represent you during your appeal. You can choose anyone to represent you, like a family member, friend, doctor, or attorney.

If you already named someone to represent you when you asked for this appeal, or if you have someone who is otherwise able to act for you because he or she is a legal guardian, power of attorney, or otherwise authorized to make health care decisions on your behalf, you do not have to do anything else.

If you have not already named someone to represent you and want to choose someone now, before the person can act for you, 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 Appointment of Representative form available at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>. Send your letter or form to OAH by fax or mail. Keep a copy for your

records. If you have any questions about naming your representative, such as what to say in your letter, contact OAH using the information above or call us at: <phone number>. TTY users call <TTY number>.

The state created the **Independent Consumer Advocacy Network (ICAN)** to help you with appeals and other issues with the MAP 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. Call ICAN at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800.

[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>
<phone number>]

Get help & more information

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

- <Plan name>
Website: <plan website>
Toll Free Phone: <phone number>
TTY users call: <TTY number>
<days and hours of operation>
- Independent Consumer Advocacy Network (ICAN)
633 Third Ave, 10th Floor
New York, NY 10017
Website: <http://icannys.org>
Email: ICAN@cssny.org
Toll Free Phone: 1-844-614-8800
8:00am – 6:00pm, Monday – Sunday
- 1-800-MEDICARE (1-800-633-4227)
TTY users call: 1-877-486-2048
24 hours a day, 7 days a week
- NYS Department of Health
Bureau of Managed Long Term Care
Toll Free Phone: 1-866-712-7197
- Medicare Rights Center
Toll Free Phone: 1-888-HMO-9050
- Community Health Access to Addiction and Mental Healthcare Project (CHAMP)
633 Third Ave, 10th Floor
New York, NY 10017
Web:
<https://www.cssny.org/programs/entry/community-health-access-to-addiction-and-mental-healthcare-project-champ>
Email: ombuds@oasas.ny.gov
Phone: 1-888-614-5400 (TTY Relay Service: 711)

[Plans must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidance and any state-specific guidance provided by the New York State Department of Health.]

