DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	N/A	April 1, 2010	Initial version Uniform Managed Care Manual Chapter 3.21, "Medicaid MCO's Notices of Actions Required Critical Elements."
Revision	2.0	November 15, 2014	Revision 2.0 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042. Applicability is updated to include Medicaid Dental.
Revision	2.1	November 15, 2015	Revision 2.1 applies to contracts issued as a result of HHSC RFP numbers 529-10-0020, 529-12-0002, 529-12-0003, 529-13-0042, 529-13-0071, and 529-15-0001. Applicability is updated to include the STAR Kids Program.
Revision	2.2	May 1, 2022	Revision 2.2 applies to contracts issued as a result of HHSC RFP numbers 529-12-0002, 529-10-0020, 529-13-0042, 529-15-0001, 529-13-0071, and HHS0002879. Additions to this chapter are the result of the newly implemented External Medical Review Process by an Independent Review Organization, as well as the standardization of language and procedures surrounding an Adverse Benefit Determination.
Revision	2.3	May 2, 2022	Updated with Spanish Translation
Revision	2.4	May 3, 2022	Administrative change
Revision	2.5	May 4, 2022	Administrative Change – Delete language from Notice #2B (both English and Spanish versions) that reads, "Going in person to a local HHSC office".
Revision	2.6	May 31, 2022	Revision to add requirements for written notice of final determinations. The title of the chapter is revised to appropriately reflect the content of the chapter. The title changed from, "Medicaid MCO's Notices of Actions Required Critical Elements" to "MMC ~~/CHIP~~ Service Authorization Notice

			Requirements."

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

I. Applicability and Purpose of Chapter 3.21

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS, STAR Kids, and the STAR Health Programs, and Dental Contractors providing Children's Medicaid Dental Services to Members through dental maintenance organizations (collectively the "Medicaid Programs"). The term "MCO" includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, dental maintenance organizations (DMOs), dental contractors, and any other entities licensed or approved by the Texas Department of Insurance. References to "Medicaid" apply to the STAR, STAR+PLUS, STAR Kids, and STAR Health Programs, and the Medicaid Dental Contractors, except where noted.

This chapter contains the template MCOs must use to notify Members when an Adverse Benefit Determination is made by the MCO. Adverse Benefit Determination is defined in Uniform Managed Care Contract Terms and Conditions, Article 2, Definitions. References to "partial denial" used in this chapter applies to a request for a service wherein a specific unit of service was not fully approved and to a request for a service wherein a different service type was instead approved. As used in this chapter, "emergency appeal" and "emergency state fair hearing" have the same meaning as "Expedited MCO Internal MCO Appeal" or "Expedited State Fair Hearing," respectively.

This chapter consolidates the Member notice requirements set forth in various sections of the managed care contracts, including the requirement to comply with 1 Tex. Admin. Code Chapter 357 and 42 CFR §438.404. To the extent that this chapter includes required language for Member notices, such language is excepted from HHSC's reading level requirements.

II. Service Authorization Notice Requirements

The MCO must provide the Member and Provider a written notice when health care services are approved or denied in accordance with the requirements in its respective Medicaid managed care contract. The MCO must send both Member and Provider a written notice of final determination no later than the next Business Day after a determination is made on a prior authorization request.

Provider Notifications:
The MCO must use at least one of the following modes of communication to contact the Provider:

- fax,
- electronic communication via secure provider portal, or
- postal mail

The MCO will not be required to mail notices to the Provider if notice is sent by fax or electronic communication via secure provider portal. A date and time stamp must be properly documented by the MCO if notice is sent by fax or electronic communication via secure provider portal.

The MCO must provide designated Member Advocates, as described in its respective Medicaid managed care contract, to assist Members in understanding and using the Appeal process. The MCO's Member Advocates must assist Members in writing or filing an Appeal and monitoring the Appeal through the MCO's Appeal process until the issue is resolved.

Date a Notice or Form is Mailed:
HHSC requires the MCO send notices via postal mail. The MCO must consider the date the notice is mailed to the Member to be the date the notice is postmarked. If a postmark is not present, the MCO must consider the date the notice is metered to be the date the notice is mailed. If there is no postmark or meter mark, the date on the notice must be the date the notice was mailed.

--Likewise,
MCOs must use the meter date if forms, referenced in this chapter, being mailed back by Members do not have a postmark. If there is no postmark or meter mark, the date on the form is considered the date the form was mailed.

III. Notice #1 Content: Member Notice of Adverse Benefit Determination

Overview

MCOs must provide a Member with a notice that is mailed no later than 15 Business Days before each Adverse Benefit Determination. This advance notice requirement only applies to Adverse Benefit Determinations for the termination, suspension, or reduction of previously authorized Medicaid-covered services. The MCO must consider the date the notice is mailed to be the date the notice is postmarked. If a postmark is not present, the MCO must consider the date the notice is metered to be the date the notice is mailed. If there is no postmark or meter mark, the date on the notice must be the date the notice was mailed.

Notice #1 includes three documents: a letter, flyer, and form. The MCO must send all three documents to the Member at the time each Adverse Benefit Determination is made, in accordance with the timeframes established in its respective Medicaid managed care contract. In this section, the letter will be known as "Notice #1A"; the flyer will be known as "Notice #1B"; and the form will be known as "Notice #1C". HHSC does not expect MCOs to use these titles or numbering system in the notice of Adverse Benefit Determination to the Member.

For each Adverse Benefit Determination, the MCO is required to send the following two notices: 1) notice to the Member that contains the elements identified in this chapter; and 2) notice to the provider that meets the requirements detailed under "Medical or legal reason(s) for the Adverse Benefit Determination." The Member notice and provider notice must explain, in sufficient detail, the medical and legal reasons for a medical denial, as described in the "Medical or legal reason(s) for the Adverse Benefit Determination." The notices to providers should not be reduced to a

4th-6th grade reading level if the language details the rationale for the Adverse Benefit Determination.

The MCO's notices of MCO Adverse Benefit Determination to a Member must include the following elements:

- The MCO must make notices person-centered by removing any language from the notice template that do not apply to the Member's Adverse Benefit Determination.
- The MCO must enter the relevant information applicable to the Member and service into applicable areas identified by "<" and ">"
- The MCO must use plain language (i.e., 4^{th}-6^{th} grade reading level), unless HHSC has prescribed specific language.
- The MCO must use formatting to ensure the form/flyer/letter is easily readable. This could include: size 11 or 12 sanserif fonts, bolding, and paragraph breaks, as appropriate.

Notice #1A: Member Notice of Adverse Benefit Determination - Letter

<MCO letterhead>

Date of Notice: <Date Notice is Mailed>

<Member/Parent/Guardian Name and Address>

Member Name: <Member Name>

Member Identification Number: <Medicaid ID and Subscriber Number>

Date of Birth: <Date>

<Denial Reference Number: Number, if applicable>

<Authorization Number: Number, if applicable>

Subject Line: Important Notice About Your Benefits - Service <Denial/Partial Denial/Reduction/Suspension/Termination>

Service(s) Affected: <Service>

Date your services will change: <Date must be at least 15 Business Days after the date this notice is mailed>

Date Decision is effective: < Date must be at least 15 business days after the date the notice is mailed>

Dear <Member Name>,

We're sending this letter on behalf of your health plan, <MCO>. This important letter is about the services you get from <MCO>.

<The MCO must apply the relevant minimum language requirements for various service scenarios here and as noted below.>

For all service and treatment denials, reductions, suspensions, and terminations

[Partial denials]:

You or <health care provider> asked for <# units, if applicable> <per week or month, if applicable> of <service or treatment> on <date>. **We approved <# units, if applicable> per <week or month, if applicable> of <service or treatment> starting <date>**.

[Denials]:

You or <health care provider> asked for <# units, if applicable> <per week or month, if applicable> of <service or treatment> on <date>. **We denied the request.**

[Reductions, suspensions, and terminations]:

Your <service or treatment> <is or are> going to change. We are <reducing/stopping> the services you get. Right now, you get <# units> per <week or month>. **Starting <date>, you will get <# units> per <week or month> of <service or treatment>.**

We reviewed your request on <date> and determined that you don't need the same services.

For denials of requests for out-of-network providers

[Denial or termination]:

You or <health care provider> requested that you be allowed to see an out-of-network provider <health care provider> on <date>. **We denied the request on <date>.**

For all letters

[Medical or legal reason(s) for the Adverse Benefit Determination]:

We made this decision because:

<An explanation of the reasons for the MCO's decision. Clear and concise information about the provisions of the Texas Medicaid Provider Procedures Manual, the relevant managed care contract, managed care handbook, or manual or MCO-approved clinical criteria that support the Adverse Benefit Determination.>

<If the decision is based on state or federal laws, the MCO must explain how the law applies to the Member's request and supports the MCO's action. The MCO must refer to the specific subsection of the rule if there is more than one reason on which the Adverse Benefit Determination can be based. The MCO must explain how the laws apply to the Member's request and support

the MCO's action. For example, if the basis for a decision is that the requested service is not Medically Necessary for the Member, the Medically Necessary criteria must be stated and must explain why that specific Member does not meet the criteria. The MCO must: 1) explain the medical basis for the decision, applying the MCO's policy or accepted standards of medical practice to the Member's particular medical circumstances; 2) explain how the requested service does not meet one or more of the criteria for medical necessity, as set forth in the managed care contract's definition of "Medically Necessary;" and (3) identify the specific provision of the Texas Administrative Code the MCO maintains is not met and provide the factual basis for this determination. For example, a general reference to the rule without further detail does not suffice. Listing the following TAC citations, "1 TAC 353.2(69), 1 TAC 363.309, and 1 TAC 363.311" would not be a sufficient explanation of the basis for the denial. Referencing a guideline (e.g., McKesson, InterQual, MCG), protocol, or other document without explanation as to why it is not Medically Necessary is not sufficient for Medically Necessary Adverse Benefit Determinations.>

<For Members 21 years of age and older, if the basis for a decision is that the requested service is not a Covered Service, the MCO must explain in detail that the service is excluded from coverage or does not fit within one of the categories of Covered Services for adults under the State Plan or applicable waiver(s). However, a request for durable medical equipment (DME), including medical supplies, through the home health benefit for Members 21 years of age or older cannot be denied on the basis that the requested DME item or medical supply is not a Covered Service. If the request identifies the DME item or medical supply as Medically Necessary, the request must through the home health exceptional circumstances process outlined in section 2.2.3.1 of the Texas Medicaid Provider Procedures Manual – Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook.

For Members under 21 years of age, the MCO cannot deny the service on the basis that the requested service is not a Covered Service if the service *could*

be covered under Medicaid. Any Adverse Benefit Determination against a Member under 21 years of age must clearly explain the factual basis for the MCO's contention that the requested service will not correct or ameliorate the Member's medical condition or disability, in accordance with 42 U.S.C. § 1396d(r)(5). The requirements of 42 U.S.C. § 1396d(r)(5), also known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, apply regardless of whether the Medicaid-covered service is covered under the state plan. Experimental services are not covered at this time. However, an MCO can provide experimental services on a case-by-case basis.>

If an item, requested by a provider, qualifies as DME (including medical supplies) under the home health benefit, the MCO cannot deny the item on the basis that the requested service is not a Covered Service for the Member (children and adults). For example, informing a Member that a requested item of DME is "not allowed by your plan" or "is not a payable code" is the same as denying the item on the basis of non-coverage. If an item, requested by a provider, qualifies as DME (including medical supplies), then the denial must be based on medical necessity. The notice must clearly explain the factual basis for the MCO's contention that the requested service is not Medically Necessary, in accordance with 42 C.F.R. § 440.70(b)(3)(v) and 1 TAC § 354.1039(a)(4)(D). The fact that Medicare may not provide the requested item is not determinative of the question of Medicaid coverage.>

<If the basis for a decision is based on lack of supporting documentation from a health care provider, the MCO must identify the provider and describe the supporting documentation that needs to be submitted, in accordance with the Uniform Managed Care Manual Chapter 3.22—Process for Standard Prior Authorization (PA) received with Incomplete or Insufficient Documentation. The identification of missing information must be specific to the Member and the actual documentation that was submitted on the Member's behalf.>

You or your provider can talk with us about this decision by calling us at <MCO telephone number>. You can also get a free copy of the information, including criteria and guidelines, as well as records used to make this decision by calling us at <MCO telephone number>, emailing us at <MCO email address>, writing to us at <MCO mailing address>, or utilizing our secure portal located at <MCO web address>.

For all Mental Health Targeted Case management or Mental Health Rehabilitative Services

We used the Texas Resiliency and Recovery Utilization Management Guidelines: Adult Mental Health Services to make this decision. You can see them here:

https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-adult.pdf.

If you do not have access to the internet, contact us at <MCO telephone number> to get a free copy of the guidelines.

You might still be eligible to get outpatient or other types of mental health services through community resources:

<list mental health services through community resources, if applicable.>

For Value-added Services

[Include the following passage if the MCO offers Value-Added services applicable the Member's condition or situation.]

You may be able to get these services:

We offer extra services for members, such as <list related/relevant value-added services and benefit parameters such as dental cleaning, one exam with x-rays, etc.>.

You can request these services by emailing us at <MCO email address>, calling us at <MCO telephone number>, or writing to us at <MCO mailing address>.

For Members age 20 and younger, if the MCO finds requested services do not meet the criteria to be delivered by a licensed nurse but documentation might support authorization of personal care services (PCS), the MCO must add:

[For all Members except STAR Members]:

You may be able to get personal care services.

Personal care services can help you with daily tasks like bathing, eating, getting dressed, preparing your meals, and housekeeping. To learn more about getting personal care services, call us at <MCO telephone number>.

[For STAR Members only]:

You may be able to get personal care services.

Personal care services can help you with daily tasks like bathing, eating, getting dressed, preparing your meals, and housekeeping. To learn more about getting personal care services, call us at <MCO telephone number> or call the Texas Health and Human Services Commission at 888-276-0702.

For Medicaid Members under 21 years of age, if the MCO finds requested private duty nursing visits are more appropriately provided on a per-visit basis through home health skilled nursing visits, the MCO must add*:

You may be able to get home health skilled nursing visits.

Home Health skilled nursing visits can help you with your short-term nursing needs. To learn more about getting home health skilled nursing

visits, call us at <MCO telephone number>. STAR members may also contact the Texas Health and Human Services Commission at 888-276-0702.

***Informing the Member of the option to receive home health skilled nursing visits does not release the MCO from their contractually required services coordination responsibilities to ensure that the Member receives needed services.**

For all letters

[If applicable, add]:

<Information about accessing case management services (such as the case management services identified in the contract's provisions regarding Managed Care Service Coordination, Managed Care Service Management, Case Management for Children and Pregnant Women, or Noncapitated Services).>

[If applicable, add]:

We approve <# units> per <week or month> of service or treatment starting <date>.

[For all Medicaid Members]:

The decision about your services was made by:

Title: <Title-Medical Director for Medical Necessity or Utilization Management Reviewer for all other decisions>
Delegated Reviewer(s): < Add additional delegated reviewing agent or URA entity, if applicable>
Specialization: <Specialty, if applicable>

Phone: <MCO telephone number>
Fax: <MCO fax number>

Email: <MCO email address>

Your doctor can discuss your denial with our medical director or clinical reviewer by calling us at <MCO telephone number>.

You have the right to appeal this decision.

You may be able to keep your services during your appeal. If you want to continue receiving your services, you must make your appeal request by **<date must be the later of the following: date 10 Days from the date this notice is mailed, or the date services will change>.**

More important dates and details are on the attached documents Health Plan Appeals and Health Plan Appeal Request Form.

Aviso número 1A: Notificación al beneficiario de una determinación negativa sobre sus beneficios. Carta

<MCO letterhead>

Fecha del aviso: <Date Notice is Mailed>

<Member/Parent/Guardian Name and Address>

Nombre del beneficiario: <Member Name>

Número de identificación del beneficiario: <Medicaid ID and Subscriber Number>

Fecha de nacimiento: <Date>

<Denial Reference Number: Number, if applicable>

<Authorization Number: Number, if applicable>

Asunto: Aviso importante sobre sus beneficios. <Denegación/Denegación parcial/Reducción/Suspensión/Terminación> de servicios

Servicios afectados: <Service>

Fecha en que sus servicios cambiarán: <Date must be at least 15 Business Days after the date this notice is mailed>

Estimado(a) <Member Name>,

Le estamos enviando esta carta en nombre de su plan médico, <MCO>. Este importante aviso se refiere a los servicios que usted recibe de <MCO>.

[Partial denials]:

Usted o su <proveedor médico> solicitaron <número de unidades, si corresponde> <por semana o mes, si corresponde> de <servicio o tratamiento> el <fecha>. **Hemos aprobado <número de unidades, si corresponde> por <semana o mes, si corresponde> de <servicio o tratamiento> a partir del <date>**.

[Denials]:

Usted o su <proveedor médico> solicitaron <número de unidades, si corresponde> <por semana o mes, si corresponde> de <servicio o tratamiento> el <date>. **Hemos denegado la solicitud.**

[Reductions, suspensions, and terminations]:

Su <servicio o tratamiento> <va o van> a cambiar. Vamos a <reducir/suspender> los servicios que usted recibe. Actualmente, usted está recibiendo <número de unidades> por <semana o mes>. **A partir del**

<date>, usted recibirá <número de unidades> por <semana o mes> de <servicio o tratamiento>.

Hemos revisado su solicitud el <date> y hemos determinado que ya no necesita esos servicios.

Para las denegaciones de solicitudes para recibir servicios de proveedores fuera de la red

[Denial or termination]:

Usted o su <proveedor médico> solicitaron la autorización para acudir a consulta con el proveedor fuera de la red <proveedor médico> el <date>. **Hemos denegado esa solicitud el <date>.**

[For all Medicaid Members]:

La decisión sobre sus servicios fue tomada por:

Título: <Title-Medical Director for Medical Necessity or Utilization Management Reviewer for all other decisions>
Examinador delegado: <Add additional delegated reviewing agent or URA entity, if applicable>
Especialización: <Specialty, if applicable>

Teléfono: <MCO telephone number>
Fax: <MCO fax number>
Correo electrónico: <MCO email address>

Su médico puede tratar sobre los detalles de la denegación con nuestro director médico o examinador clínico llamándonos al <MCO telephone number>.

Usted tiene derecho a apelar esta decisión.

Es probable que pueda seguir recibiendo sus servicios durante el proceso de apelación. Si desea seguir recibiendo sus servicios, deberá presentar su solicitud de apelación antes del **<esta fecha debe ser la más lejana de las siguientes: 10 días después de la fecha de envío de este aviso o de la fecha en que los servicios cambiarán>.**

Encontrará más fechas y detalles importantes en los documentos anexos: Apelaciones al plan médico y Formulario de solicitud de apelación al plan médico.

Notice #1B: Member Notice of Adverse Benefit Determination – Flyer

Health Plan Appeals

The processes outlined in this flyer apply to all health plan appeals including emergency appeals.

Request a health plan appeal by either:

- Filling out the attached "Health Plan Appeal Request Form" and mailing or faxing it to us using the address or fax number listed at the top of the form;
- Calling us at <MCO phone number>; or
- Emailing us at <MCO email address>.

You must request an appeal by <date 60 Days from the date this notice is mailed>.

If you have a good reason, like receiving our notice too late, we may be able to accept your appeal request after this date.

How to Keep Your Services during a Health Plan Appeal

- You may be able to keep getting your services during the health plan appeal process. Make a request by checking "Yes" where it says, "Do you want your services to continue?" on the Health Plan Appeal Request Form. You can also call <MCO name> at <MCO phone number> and say you want to keep your services during your appeal.

  You must make this request by <date must be the later of the following: date 10 Days from the date this notice is mailed or the date services will change>.

  If you lose your health plan appeal, you may have to pay your health plan back for services provided to you during your appeal. [insert MCO's

name] cannot ask you to pay them back for services you received without permission from HHSC.

If you don't ask for a health plan appeal and to keep your services by **<date must be the later of the following: date 10 Days from the date this notice is mailed or the date services will change>**, you will not continue to receive your services, but you still have time to ask for a health plan appeal. You must make your health plan appeal no later than **<date 60 Days from the date this notice is mailed>**If you have a good reason, we may be able to accept your appeal request after this date. This includes receiving our notice late with not enough time to request an appeal.

Emergency Health Plan Appeals

If you feel your health will be seriously harmed by waiting for a decision on your health plan appeal, you or your doctor can ask for an emergency health plan appeal. We'll review your case and determine if you qualify for an emergency health plan appeal. We must decide to approve or deny your appeal within 72 hours of your request. If you do not qualify for an emergency appeal, we will let you know. We will process your appeal according to the standard timeframe detailed below. You can file a complaint if you do not agree with our decision to deny your request for an emergency health plan appeal.

Your Rights During the Health Plan Appeal Process

- We must send you a letter letting you know we received your health plan appeal request within five business days of receiving your request.
- We must make a decision about your health plan appeal and send it to you in writing within 30 calendar days of your request.
- You can ask us for any facts we used to make our decision. If you ask for this information, we will send it to you for free, before your appeal, and within five calendar days of your request.

- You, your doctor, or your healthcare provider can submit written comments, documents, or other information about your health plan appeal by mail, fax, or email. If you need more time to send us information that may help your appeal, you can ask us to move your appeal date back for up to 14 calendar days.
- You can represent yourself or pick a relative, friend, lawyer, or someone else to represent you during the health plan appeal. You'll have to pay any fees if they charge to represent you. To find free legal help in your area, see the attached legal aid providers list that came with this letter and a directory at www.texaslawhelp.org.

- When we send you our decision about the approval or denial of your appeal, we'll also include information about your right to a state fair hearing and external medical review. You must wait until after our decision to ask for a state fair hearing and external medical review.

Need Help?

You or your representative can call us at <MCO and/or MCO Member Advocate toll free telephone number> to learn more about your appeal rights.

If you have more questions about the health plan appeal process, call an HHSC ombudsman at 866-566-8989 or complete the online form at hhs.texas.gov/managed-care-help.

Aviso número 1B: Notificación al beneficiario de la determinación negativa sobre beneficios. Folleto

Apelaciones al plan médico

Los procesos descritos en este folleto se aplican a todas las apelaciones a un plan médico, incluidas las apelaciones de emergencia.

Puede solicitar una apelación al plan médico de una de las maneras siguientes:

- Llenando el "Formulario de solicitud de apelación al plan médico" anexo y enviándolo por correo o por fax a la dirección o número de fax que aparecen en la parte superior del formulario;
- Llamando por teléfono al <MCO phone number>; o bien
- Enviando un correo electrónico a <MCO email address>.

Deberá solicitar una apelación antes del <60 días después de la fecha de envío de este aviso>.

Si tiene una razón justificada, por ejemplo, que haya recibido nuestro aviso demasiado tarde, es probable que podamos aceptar su solicitud de apelación después de la fecha mencionada.

Cómo seguir recibiendo los servicios mientras dura el proceso de apelación a un plan médico

- Usted podría seguir recibiendo los servicios mientras dura el proceso de apelación al plan médico. Haga la solicitud marcando "Sí" donde dice: "¿Desea que sus servicios continúen?", en el Formulario de solicitud de apelación al plan médico. También puede llamar a <MCO name> al <MCO phone number> y decirles que desea seguir recibiendo los servicios durante el proceso de apelación.

Deberá hacer esta solicitud antes del <la fecha debe ser la más lejana de las siguientes: 10 días después de la fecha de envío de este aviso o de la fecha en que los servicios cambiarán>.

Si pierde la apelación al plan médico, es probable que tenga que reembolsar a su plan médico los servicios que se le prestaron durante el proceso de apelación. [insert MCO's name] no puede pedirle a usted que reembolse el dinero por servicios recibidos que no hayan sido autorizados por la HHSC.

Si no solicita la apelación al plan médico y la continuación de sus servicios antes del **<la fecha debe ser la más lejana de las siguientes: 10 días después de la fecha de envío de este aviso o de la fecha en que los servicios cambiarán>**, usted no seguirá recibiendo los servicios, pero aún tendrá tiempo para pedir una apelación al plan médico. Deberá presentar su apelación al plan médico a más tardar el **<60 días después de la fecha de envío de este aviso>.** Si tiene una razón justificada, podríamos aceptar su solicitud de apelación después de esta fecha. Una razón justificada podría ser que haya recibido demasiado tarde nuestro aviso y no haya tenido tiempo suficiente para solicitar una apelación.

Apelaciones de emergencia al plan médico

Si cree que su salud se verá gravemente perjudicada por tener que esperar una decisión sobre su apelación al plan médico, usted o su médico pueden solicitar una apelación de emergencia al plan médico. Revisaremos su caso y determinaremos si reúne los requisitos para una apelación de emergencia al plan médico. Deberemos entonces decidir si aprobamos o denegamos su apelación en las 72 horas siguientes a la fecha en que usted haya presentado su solicitud. Si no reúne los requisitos para una apelación de emergencia, se lo comunicaremos a usted. Procesaremos su apelación según el plazo estándar que se detalla a continuación. Si no está de acuerdo con nuestra decisión de denegar su solicitud de apelación de emergencia al plan médico, puede presentar una queja.

Sus derechos durante el proceso de apelación al plan médico

- Deberemos enviarle a usted una carta informándole que recibimos su solicitud de apelación al plan médico en un plazo de cinco días laborables a partir de la fecha en que recibimos su solicitud.
- Deberemos tomar una decisión sobre su apelación al plan médico y enviársela por escrito en un plazo de 30 días naturales a partir de la fecha de su solicitud.
- Usted puede pedirnos cualquiera de los datos que hayamos utilizado para tomar nuestra decisión. Si solicita esta información, se la enviaremos gratuitamente, antes de la fecha de su apelación, y a más tardar cinco días naturales después de la fecha de su solicitud.
- Usted, su médico o su proveedor médico pueden enviar sus comentarios escritos, documentos u otra información sobre su apelación al plan médico, ya sea por correo, fax o correo electrónico. Si necesita más tiempo para enviarnos información que podría ser útil para su apelación, puede pedirnos que retrasemos la fecha de su apelación hasta un máximo de 14 días naturales.
- Puede representarse a sí mismo o elegir a un familiar, amigo, abogado u otra persona para que lo represente durante la apelación al plan médico. En caso de que se carguen honorarios por representarle, tendrá que pagarlos usted. Para encontrar ayuda legal gratuita en su zona, vea la lista anexa de proveedores de asistencia legal incluida en esta carta y un directorio en www.texaslawhelp.org.
- Cuando le enviemos nuestra decisión sobre la aprobación o denegación de su apelación, también incluiremos información sobre su derecho a una audiencia imparcial estatal y a una revisión médica externa. Deberá esperar hasta después de nuestra decisión para solicitar una audiencia imparcial estatal y una revisión médica externa.

¿Necesita ayuda?

Usted o su representante pueden llamarnos al <número de teléfono gratuito de la MCO o de la persona que defiende al beneficiario de la MCO> para obtener más información sobre sus derechos de apelación.

Si tiene más preguntas sobre el proceso de apelación al plan médico, llame a un ombudsman de la HHSC al 866-566-8989 o complete el formulario en línea en hhs.texas.gov/managed-care-help.

Notice #1C: Member Notice of Adverse Benefit Determination – Form

Health Plan Appeal Request Form

To ask for a health plan appeal, you can call us at <MCO telephone number>, email us at <MCO email address>, or you can fill out this form and mail or fax it to us.

Mail: <MCO address>
Fax: <MCO fax number>

You must request an appeal by <date 60 Days from the date this notice is mailed>.

If you want to continue your services during your appeal, you must make your request by **<date must be the later of the following: date 10 Days from the date this notice is mailed or the date services will change>**.

Mark the appeal you want:

Only select one.

___ Health Plan Appeal
___ Emergency Health Plan Appeal*

*Emergency health plan appeals should only be requested if you believe your health will be seriously harmed by waiting for your health plan appeal decision.

<Denial Reference Number: Number>

Do you want your services to continue? ___ Yes ___ No

You must request for your services to continue by **<date must be the later of the following: date 10 Days from the date this notice is mailed or the date services will change>**.

You can make this request by phone. Call us at <MCO telephone number> if you think this form will not reach us by mail before the deadline.

Your Personal Information*

Member name:	Parent or authorized representative:
Member Medicaid ID andsubscriber number:	Preferred phone number:

*If any of your contact information has changed, call the enrollment broker at 800-964-2777 or<MCO> at <MCO telephone number>.

Your Authorized Representative's or Parent's Informatio

You can represent yourself. If you would like someone to represent you, such as, parent, relative or friend, complete the following information. By completing this section, you are authorizing your designated representative to appeal and obtain information on your behalf.

Name:
Address:
Phone number:

Reason for the Appeal

This section is optional. You can fill it out to tell us about your services under appeal and why you think they're needed.

Services under appeal:
Why you need them:

Sign this form:
By signing this form, you or your authorized representative are requesting an appeal and giving your health plan, <MCO>, authorization to get your medical records and to contact your appeal representative if you listed one.

_____

Member/Authorized representative signature

_____

Printed name

_____

Date

Aviso número 1C: Notificación al beneficiario de una determinación negativa sobre beneficios. Formulario

Formulario de solicitud de apelación al plan médico

Para solicitar una apelación a un plan médico, puede llamarnos al <MCO telephone number>, enviar un correo electrónico a <MCO email address>, o puede completar este formulario y enviárnoslo por correo o por fax.

Por correo: <MCO address>
Fax: <MCO fax number>

La apelación debe solicitarse a más tardar el <60 días a partir de la fecha de envío de esta notificación>.

Si desea seguir recibiendo los servicios durante el proceso de apelación, deberá hacer la solicitud a más tardar el **<la fecha debe ser la más lejana de las siguientes: 10 días a partir de la fecha de envío de este aviso o la fecha en que los servicios cambiarán>.**

Marque el tipo de apelación que desea:

Seleccione solo una.

___ Apelación al plan médico
___ Apelación de emergencia al plan médico*

*Las apelaciones de emergencia al plan médico solo deben solicitarse si cree que su salud se verá gravemente perjudicada al tener que esperar el resultado de la decisión sobre la apelación al plan médico.

<Número de referencia de la denegación: Número>

¿Desea seguir recibiendo los servicios? ___ Sí ___ No

Debe solicitar la continuación de sus servicios antes del **<la fecha debe ser la más lejana de las siguientes: 10 días a partir de la fecha de envío de este aviso o de la fecha en que los servicios cambiarán>.**

Puede hacer esta solicitud por teléfono. Llámenos al <número de teléfono de la MCO> si cree que este formulario no nos llegará por correo antes de la fecha límite.

Los datos personales de usted*

Nombre del beneficiario:	Padre, madre o representante autorizado:
ID de Medicaid del beneficiario o número de asegurado	Teléfono de preferencia:

*Si alguno de sus datos de contacto ha cambiado, llame al agente de inscripción al 800-964-2777 o a <MCO> al <MCO telephone number>.

Información del representante autorizado o los padres

Usted puede representarse a sí mismo. Si desea que alguien le represente, por ejemplo, un padre, un familiar o un amigo, complete la siguiente información. Al llenar esta sección, usted autoriza a su representante designado a presentar apelaciones y obtener información en su nombre.

Nombre:
Dirección:
Número de teléfono:

Motivo de la apelación

Esta sección es opcional. Puede llenarla para informarnos sobre los servicios que son objeto de la apelación y por qué cree que los necesita.

Servicios objeto de la apelación:
Por qué los necesita:

Firme este formulario:
Al firmar este formulario, usted o su representante autorizado están solicitando una apelación y dando a su plan médico, <MCO>, la autorización para obtener sus expedientes médicos y ponerse en contacto con su representante para la apelación, si lo tiene.

_____

Firma del beneficiario/representante autorizado

_____

Nombre en letra de molde

_____

Fecha

IV. Notice #2 Content: Member Notice of MCO Internal Appeal Decision

Overview

Notice #2 includes three documents: a letter, flyer, and form. The MCO must send all three documents to the Member for each MCO Internal Appeal decision. All three documents must be sent to the Member after an appeal of an Adverse Benefit Determination. In this section, the letter will be known as "Notice #2A"; the flyer will be known as "Notice #2B"; and the form will be known as "Notice #2C". HHSC does not expect MCOs to use these titles or numbering system in their notices of Adverse Benefit Determination to the Member.

For each Adverse Benefit Determination, the MCO is required to send the following two notices: 1) notice to the Member that contains the elements identified in this chapter; and 2) notice to the provider that meets the requirements detailed under "Medical or legal reason(s) for the Adverse Benefit Determination." The member notice and provider notice must explain, in sufficient detail, the medical and legal reasons for a medical denial, as described in the "Medical or legal reason(s) for the Adverse Benefit Determination." The notices to providers should not be reduced to a 4th-6th grade reading level if the language is needed to detail the rationale for the Adverse Benefit Determination.

The MCO's notices of MCO Internal Appeal decision must include the following elements:

- The MCO must make notices person-centered by removing any language from the notice template that do not apply to the Member's Adverse Benefit Determination.
- The MCO must enter the relevant information applicable to the Member and service into applicable areas identified by "<" and ">"
- The MCO must use plain language (i.e., 4th-6th grade reading level) in each notice, unless HHSC has prescribed specific language.

- The MCO must use formatting to ensure the form/flyer/letter is easily readable. This could include: size 11 or 12 Sanserif fonts, bolding, and paragraph breaks, as appropriate.

Notice #2A: Member Notice of MCO Internal Appeal Decision - Letter

<MCO letterhead>

Date of Notice: <Date Notice is Mailed>

<Member/Parent/Guardian Name and Address>

Member Name: <Member Name>
Member Identification Number: <Medicaid ID and Subscriber Number>
Date of Birth: <Date>
<Denial Reference Number: Number, if applicable>
<Authorization Number: Number, if applicable>

Subject Line: **Notice of Health Plan Appeal Decision**

Service(s) Affected: <Service>
Date of <Denial/Partial Denial/Reduction/Suspension/Termination>
Determination: <Date>
Date Appeal Requested: <Date>
Appeal Decision Date: <Date>

Dear <Member Name>

<The MCO must apply the relevant minimum language requirements for various service scenarios here and as noted below.>

For network health care provider transfer denials and terminations

[Denial or termination sustained]:

We did not change our decision to deny your request.

You or <health care provider> requested a transfer of care to <health care provider> on <date>. You appealed this decision on <date>.

After reviewing the provided information, we denied the request.

[Denial or termination overturned]:

We approved your previously denied request. You can begin getting services from <health care provider> on <date>.

You or <health care provider> requested a transfer of care to <provider> on <date>. We denied this request on <date>. You appealed this decision on <date>.

After reviewing the provided information, we decided to approve your request to transfer your care.

<Additional Information, if applicable>

For one-time service request denials and terminations

[Denial sustained]:

We did not change our decision to deny your request.

You or <health care provider> asked for <service or treatment> on <date>. We denied this request on <date>. You appealed this decision on <date>.

After reviewing the provided information, we denied the request.

[Termination sustained]:

We did not change our decision to deny your services.

We previously denied <service or treatment> on <date>. After reviewing the provided information, we decided you don't need this service. Starting <date>, you will no longer get <service or treatment>.

[Partial denial or denial overturned]:

We approved your previously denied services. Starting <date>, you may get <service or treatment>.

You or <health care provider> asked for <service or treatment> on <date>. We denied this request on <date>. You appealed this decision on <date>.

After reviewing the provided information, we decided you need these services.

[Partial denial or denial overturned-Dental]:

We approved your previously denied services. you may contact your provider to receive <service or treatment>.

You or <health care provider> asked for <service or treatment> on <date>. We denied this request on <date>. You appealed this decision on <date>.

After reviewing the provided information, we decided you need these services.

[Termination overturned]:

We approved your previously denied services. Starting <date>, you may get <service or treatment>.

We previously changed your services on <date>, and you appealed this decision. We reviewed your needs on <date> and decided your services shouldn’t have changed.

[Termination overturned-Dental]:

We approved your previously denied services. Starting <date>, you may contact your provider to receive <service or treatment>.

We previously changed your services on <date>, and you appealed this decision. We reviewed your needs on <date> and decided your services shouldn’t have changed.

For all other service denials, suspensions, reductions, and terminations

[Partial denial sustained, partial denial overturned, or denial overturned]:

We changed our previous decision about your services.

You or <health care provider> asked for <# units, if applicable> <per week or month, if applicable> of <service or treatment> on <date>. We denied this service request on <date>. You appealed this decision on <date>.

After reviewing the provided information, we decided you will start getting <# units> <per week or month> of <service or treatment> on <date>.

[Reduction, suspension, or termination sustained while Member is receiving continued benefits]:

We did not change our previous decision about your services.

Your <service or treatment> <is or are> going to change. We are <reducing/stopping> the services you get. Right now, you get <# units> hours per <week or month> of <service or treatment>. Starting <date>, you'll get <# units> per <week or month> of <service or treatment>.

We reviewed your needs on <date> and decided that you don't need the same services.

[Reduction, suspension, or termination sustained while Member is not receiving continued benefits]:

We did not change our previous decision to change your services.

You used to get <# units> per <week or month> of <service or treatment>. Starting <date>, you will get <# units> per <week or month> of <service or treatment>.

We reviewed your request on <date> and decided you don't need the same services.

[Reduction, suspension, or termination overturned while Member is receiving continued benefits]:

We changed our decision about your services. You'll keep getting <#units> per <week or month> of <service or treatment>.

We previously changed your services on <date>, and you appealed this decision. We reviewed your needs on <date>, and decided your services shouldn't have changed.

[Reduction, suspension, or termination overturned while Member is not receiving continued benefits]:

We changed our decision about your services. Starting <date>, you will get <# units> per <week or month> of <service or treatment>.

We previously changed your services on <date>, and you appealed this decision. We reviewed your needs on <date>, and decided your services shouldn't have changed.

[Denial sustained]:

We did not change our decision to deny your request.

You or <health care provider> asked for <service or treatment> on <date>. We denied this request on <date>. You appealed this decision on <date>.

After reviewing the provided information, we denied the request.

For all letters

We made this decision because:

<An explanation of the reasons for the MCO's decision. Clear and concise information about the provisions of the Texas Medicaid Provider Procedures Manual, the relevant managed care contract, managed care handbook or

manual or MCO approved clinical criteria that support the Adverse Benefit Determination.>

<If the decision is based on state or federal laws, the MCO must explain how the law applies to the Member's request and supports the MCO's action. The MCO must refer to the specific subsection of the rule if there is more than one reason on which the denial can be based. The MCO must explain how the laws apply to the Member's request and support the MCO's action. For example, if the basis for a decision is that the requested service is not Medically Necessary for the Member, the Medically Necessary criteria must be stated and must explain why that specific Member does not meet the criteria. The MCO must: 1) explain the medical basis for the decision, applying the MCO's policy or accepted standards of medical practice to the Member's particular medical circumstances; 2) explain how the requested service does not meet one or more of the criteria for medical necessity, as set forth in the managed care contract's definition of "Medically Necessary;" and (3) identify the specific provision of the Texas Administrative Code the MCO maintains is not met and provide the factual basis for this determination. For example, a general reference to the rule without further detail does not suffice. Listing the following TAC citations, "1 TAC 353.2(69), 1 TAC 363.309, and 1 TAC 363.311" would not be a sufficient explanation of the basis for the denial. Referencing a guideline (e.g., McKesson, InterQual, MCG), protocol, or other document without explanation as to why it is not Medically Necessary is not sufficient for Medically Necessary Adverse Benefit Determinations.>

<For Members 21 years of age and older, if the basis for a decision is that the requested service is not a Covered Service the MCO must explain in detail that the service is excluded from coverage or does not fit within one of the categories of Covered Services for adults under the State Plan or applicable waiver(s). However, a request for durable medical equipment (DME), including medical supplies, through the home health benefit for Members 21 years of age or older cannot be denied on the basis that the requested DME item of medical supply is not a Covered Service. If the

request identifies the DME item or medical supply as Medically Necessary, the request must go through the home health exceptional circumstances process outlined here.

For Members under 21 years of age, the MCO cannot deny the service on the basis that the requested service is not a Covered Service. Any Adverse Benefit Determination against a Member under 21 years of age must clearly explain the factual basis for the MCO's contention that the requested service will not correct or ameliorate the Member's medical condition or disability, in accordance with 42 U.S.C. § 1396d(r)(5). The requirements of 42 U.S.C. § 1396d(r)(5), also known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, apply regardless of whether the Medicaid-covered service is covered under the state plan. Experimental services are not covered at this time. However, an MCO can provide experimental services on a case-by-case basis.>

If an item, requested by a provider, qualifies as DME (including medical supplies) under the home health benefit, the MCO cannot deny the item on the basis that the requested service is not a Covered Service for the Member (children and adults). For example, informing a Member that a requested item of DME is "not allowed by your plan" or "is not a payable code" is the same as denying the item on the basis of non-coverage. If an item, requested by a provider, qualifies as DME (including medical supplies), then the denial must be based on medical necessity. The notice must clearly explain the factual basis for the MCO's contention that the requested service is not Medically Necessary, in accordance with 42 C.F.R. §440.70(b)(3)(v), and 1 TAC §354.1039(a)(4)(D). The fact that Medicare may not provide the requested item is not determinative of the question of Medicaid coverage. >

<If the basis for a decision is based on lack of supporting documentation from a health care provider, the MCO must identify the provider and describe the supporting documentation that needs to be submitted. The identification of missing information must be specific to the Member and the actual documentation that was submitted on the Member's behalf.>

You or your provider can talk with us about this decision by calling us at <MCO telephone number>. You can also get a free copy of the information, including criteria and guidelines, as well as records used to make this decision by calling us at <MCO telephone number>, emailing us at <MCO email address>, writing to us at <MCO mailing address>, or utilizing our secure portal located at <MCO web address>.

For all Mental Health Targeted Case Management or Mental Health Rehabilitative Services

We used the Texas Resiliency and Recovery Utilization Management Guidelines: Adult Mental Health Services to make this decision. You can see them here:

https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-adult.pdf.

If you do not have access to the internet, contact us at <MCO telephone number> to get a free copy of the guidelines.

You might still be eligible to get outpatient or other types of mental health services through community resources:

<list mental health services through community resources, if applicable.>

For Value-added Services

[Include the following passage if the MCO offers Value-added Services applicable the Member's condition or situation.]

You may be able to get these services:

We offer extra services for members, such as <list related/relevant value-added services and benefit parameters such as dental cleaning, one exam with x-rays, etc.>.

You can request these services by emailing us at <MCO email address>, calling us at <MCO telephone number>, or writing to us at <MCO mailing address>.

For Members age 20 and younger, if the MCO finds nursing requested services do not meet the criteria to be delivered by a licensed nurse, but documentation might support authorization of PCS, the MCO must add:

[For all Members except STAR Members]:

You may be able to get personal care services.

Personal care services can help you with daily tasks like bathing, eating, getting dressed, preparing your meals and housekeeping. To learn more about getting personal care services, call us at <MCO telephone number>.

[For STAR Members only]:

You may be able to get personal care services.

Personal care services can help you with daily tasks like bathing, eating, getting dressed, preparing your meals and housekeeping. To learn more about getting personal care services, call us at <MCO telephone number>or call the Texas Health and Human Services Commission at 888-276-0702.

For Medicaid Members under 21 years of age, if the MCO finds requested private duty nursing visits are more appropriately provided on a per-visit basis through home health skilled nursing visits, the MCO must add*:

You may be able to get home health skilled nursing visits.

home health skilled nursing visits can help you with short-term nursing needs. To learn more about getting home health skilled nursing visits, call us at <MCO telephone number>. STAR members may also contact the Texas Health and Human Services Commission at 888-276-0702.***Informing the Member of the option to receive home health skilled nursing visits**

does not release the MCO from their contractually required services coordination responsibilities to ensure that the Member receives needed services.

For all letters

[If applicable, add]:

<Information about accessing case management services (such as the case management services identified in the contract's provisions regarding managed care service coordination Services, Managed Care Service Management, Case Management for Children and Pregnant Women, or Noncapitated Service).>

[If applicable, add]:

We approve <# units> per <week or month> of <service or treatment starting <**date**>.

[For all Medicaid Members]:

This decision was made by:

Title: <Title - Medical Director for Medical Necessity or Utilization Management Reviewer for all other decisions>
Delegated Reviewer(s): <Add additional delegated reviewing agent or URA entity, if applicable>
Specialization: <Specialty, if applicable>
Phone: <MCO telephone number>
Fax: <MCO fax number>
Email: <MCO email address>

If you disagree with our decision, you have the right to ask for a state fair hearing with or without an external medical review.

If you kept receiving services during your health plan appeal, you may be able to continue your services during your state fair hearing.

If you want your services to continue, you must make your request by <date must be the later of the following: date 10 Days from the date this notice is mailed or the date services will change>.

For more important dates and details, see the attached documents "State Fair Hearings and External Medical Reviews" and "State Fair Hearing and External Medical Review Request Form."

Aviso número 2A: Notificación al beneficiario de la decisión interna de la MCO sobre la apelación. Carta

<MCO letterhead>

Fecha de la notificación: <Date Notice is Mailed>

<Member/Parent/Guardian Name and Address>

Nombre del beneficiario: <Member Name>
Número de identificación del beneficiario: <Medicaid ID and Subscriber Number>
Fecha de nacimiento: <Date>
<Denial Reference Number: Number, if applicable>
<Authorization Number: Number, if applicable>

Asunto: **Notificación de la decisión sobre la apelación al plan médico**

Servicios afectados: <Service>
Fecha de la <Denial/Partial Denial/Reduction/Suspension/Termination> Determinación: <Date>
Fecha en que se solicitó la apelación: <Date>
Fecha de la decisión sobre la apelación: <Date>

Estimado <Member Name>

[Denial or termination sustained]:

No hemos cambiado nuestra decisión de denegar su solicitud.

Usted o <proveedor médico> solicitaron la transferencia de la atención a <proveedor médico> el <date>. Usted apeló esta decisión el <date>.

Después de revisar la información proporcionada, hemos denegado la solicitud.

[Denial or termination overturned]:

Hemos aprobado su solicitud que previamente fue denegada. Puede comenzar a recibir servicios de <proveedor médico> el <date>.

Usted o <proveedor médico> solicitaron la transferencia de la atención a <proveedor> el <date>. Denegamos esa solicitud el <date>. Usted apeló esta decisión el <date>.

Después de revisar la información proporcionada, decidimos aprobar su solicitud para transferir la atención.

<Additional Information, if applicable>

For one-time service request denials and terminations

[Se mantiene la denegación]:

No hemos cambiado nuestra decisión de denegar su solicitud.

Usted o <proveedor médico> solicitaron <servicio o tratamiento> el <date>. Hemos denegado esa solicitud el <date>. Usted apeló esa decisión el <date>.

Después de revisar la información proporcionada, hemos denegado la solicitud.

[Se mantiene la terminación de los servicios]:

No hemos cambiado nuestra decisión de denegar los servicios.

Anteriormente, denegamos <servicio o tratamiento> el <date>. Después de revisar la información proporcionada, hemos decidido que usted no necesita este servicio. A partir del <date>, usted ya no recibirá <servicio o tratamiento>.

[Partial denial or denial overturned]:

Hemos aprobado los servicios que previamente fueron denegados. A partir del <date>, podrá recibir <servicio o tratamiento>.

Usted o <proveedor de atención médica> solicitaron <servicio o tratamiento> el <fecha>. Hemos denegado esta solicitud el <fecha>. Usted apeló esta decisión el <fecha>.

Después de revisar la información proporcionada, hemos decidido que necesita estos servicios.

[Partial denial or denial overturned-Dental]:

Hemos aprobado los servicios que previamente fueron denegados. Puede comunicarse con su proveedor para recibir <servicio o tratamiento>.

Usted o <proveedor médico> solicitaron <servicio o tratamiento> el <date>. Denegamos esta solicitud el <date>. Usted apeló esta decisión el <date>.

Después de revisar la información proporcionada, hemos decidido que usted necesita estos servicios.

[Termination overturned]:

Hemos aprobado sus servicios previamente denegados. A partir del <date>, usted puede recibir <servicio o tratamiento>.

Anteriormente cambiamos sus servicios el <date>, y usted apeló esta decisión. Hemos revisado sus necesidades el <date> y decidimos que sus servicios no deberían haberse cambiado.

[Termination overturned-Dental]:

Hemos aprobado los servicios que previamente fueron denegados. A partir del <date>, puede comunicarse con su proveedor para recibir <servicio o tratamiento>.

Anteriormente cambiamos sus servicios el <date>, y usted apeló esta decisión. Hemos revisado sus necesidades el <date> y decidimos que sus servicios no deberían haberse cambiado.

For all other service denials, suspensions, reductions, and terminations

[Partial denial sustained, partial denial overturned, or denial overturned]:

Hemos cambiado nuestra decisión anterior sobre sus servicios.

Usted o <proveedor médico> solicitaron <número de unidades, si corresponde> <por semana o por mes, si corresponde> de <servicio o tratamiento> el <date>. Denegamos esta solicitud el <date>. Usted apeló esta decisión el <date>.

Después de revisar la información proporcionada, hemos decidido que empezará a recibir <número de unidades> <por semana o por mes> de <servicio o tratamiento> el <date>.

[Reduction, suspension, or termination sustained while Member is receiving continued benefits]:

No hemos cambiado nuestra decisión anterior sobre sus servicios.

Su <servicio o tratamiento> <va o van> a cambiar. Vamos a <reducir/suspender> los servicios que recibe. Actualmente, usted recibe <número de unidades> horas por <semana o mes> de <servicio o

tratamiento>. A partir del <date>, usted recibirá <número de unidades> por <semana o mes> de <servicio o tratamiento>.

Hemos revisado sus necesidades el <date> y hemos decidido que ya no necesita esos servicios.

[Reduction, suspension, or termination sustained while Member is not receiving continued benefits]:

No hemos cambiado nuestra decisión previa de cambiar los servicios que recibe.

Usted recibía <número de unidades> por <semana o mes> de <servicio o tratamiento>. A partir del <date>, recibirá <número de unidades> por <semana o mes> de <servicio o tratamiento>.

Hemos revisado su solicitud el <date> y hemos determinado que usted ya no necesita esos servicios.

[Reduction, suspension, or termination overturned while Member is receiving continued benefits]:

Nuestra decisión sobre sus servicios ha cambiado. Usted seguirá recibiendo <número de unidades> por <semana o mes> de <servicio o tratamiento>.

Anteriormente hicimos cambios en sus servicios el <date>, y usted apeló esta decisión. Hemos revisado sus necesidades el <date>, y decidimos que sus servicios no deberían haberse cambiado.

[Reduction, suspension, or termination overturned while Member is not receiving continued benefits]:

Nuestra decisión sobre sus servicios ha cambiado. A partir del <date>, usted recibirá <número de unidades> por <semana o mes> de <servicio o tratamiento>.

Anteriormente hicimos cambios en sus servicios el <date>, y usted apeló esta decisión. Hemos revisado sus necesidades el <date>, y hemos decidido que sus servicios no deberían haberse cambiado.

[Denial sustained]:

Nuestra decisión de denegar su solicitud no ha cambiado.

Usted o <proveedor médico> solicitaron <servicio o tratamiento> el <date>. Hemos denegado esa solicitud el <date>. Usted apeló esta decisión el <date>.

Después de revisar la información proporcionada, hemos denegado la solicitud.

[For all Medicaid Members]:

Esta decisión fue tomada por:

Título: <Title - Medical Director for Medical Necessity or Utilization Management Reviewer for all other decisions>
Examinador delegado: <Add additional delegated reviewing agent or URA entity, if applicable>
Especialización: <Specialty, if applicable>
Teléfono: <MCO telephone number>
Fax: <MCO fax number>
Correo electrónico: <MCO email address>

Si no está de acuerdo con nuestra decisión, tiene derecho a solicitar una audiencia imparcial estatal con o sin una revisión médica externa.

Si siguió recibiendo los servicios durante el proceso de apelación al plan médico, es probable que pueda seguir recibiendo los servicios durante el proceso de la audiencia imparcial estatal.

Si desea que sus servicios continúen, debe hacer la solicitud antes del <la fecha debe ser la más lejana de las siguientes: 10 días a partir de la fecha de envío de esta notificación o de la fecha en que los servicios cambiarán>.

Para más fechas y detalles importantes, vea los documentos anexos "Audiencia imparcial estatal y revisiones médicas externas" y "Formulario de solicitud de audiencia imparcial estatal y revisión médica externa".

Notice #2B: Member Notice of MCO Internal Appeal Decision - Flyer

State Fair Hearings and External Medical Reviews

The Processes outlined in this flyer apply to both non-emergency and emergency State Fair Hearings and External Medical Reviews.

A state fair hearing is when the Texas Health and Human Services Commission (HHSC) directly reviews our decisions with your medical care.

If you ask for a state fair hearing, you can also ask for an external medical review where independent healthcare experts review your request to receive services. This review is an optional, extra step you can take to get your case reviewed for free before your state fair hearing. It doesn't change your right to a state fair hearing.

Request a state fair hearing and external medical review by either:

- Filling out the attached State Fair Hearing and External Medical Review Request Form and mailing or faxing it to us using the address or fax number at the top of the form.
- Calling us at <MCO telephone number>;
- Emailing us at <MCO email address>

You must make a request for a state fair hearing with or without an external medical review by <date 120 Days from the date this notice is mailed>.
If you don't ask for the state fair hearing with or without an external medical review by this date, you may lose your right to a state fair hearing. If you have a good reason, like receiving our notice late, we may be able to accept your appeal request after this date.

If you kept receiving services during your health plan appeal, you may be able to continue your services during your state fair hearing.

Make a request to continue getting services by **< date 10 Days from the date this notice is mailed>** only if you got services during your health

plan appeal. If you don't ask for a state fair hearing and to keep your services by then, you will not continue to get your services, but you still have until **<date 120 Days from the date this notice is mailed>** to ask for a state fair hearing with or without an external medical review.

To make the request, call us or check "Yes" on the State Fair Hearing and External Medical Request Form where it says, "Do You Want Your Services to Continue?".

If you lose your state fair hearing, you may have to pay your health plan back for services provided to you during the fair hearing process. [insert MCO's name] cannot ask you to pay them back for services you received without permission from HHSC.

What to Expect After You Request a State Fair Hearing

When you ask for a state fair hearing with or without an external medical review, a hearings officer will be placed in charge of your case.

You'll get a Notice of Hearing in the mail **within 10 calendar days** of your request for a state fair hearing. It will tell you the date, time, and location of your hearing.

If you ask for an external medical review, it will happen before your state fair hearing. An external medical review doesn't affect when your state fair hearing will be scheduled.

About the External Medical Review
• HHSC will give your information to independent healthcare experts who will review your case. • Only the information submitted for your health plan appeal will be used. You won't be able to give new information for the review. • The experts can agree with or change our decision. Their external medical review decision will be mailed to you **in 15 calendar days or less.** • After you get your external medical review decision, you can choose if you

want to also have the state fair hearing you requested.

- If you want to have your state fair hearing, the external medical review decision will be considered as evidence during your state fair hearing.

About the State Fair Hearing

- Most hearings are held by phone, but if you have a good reason, you can request to hold it in person.
- You have the right to see any information your health plan will use at the hearing. We're required to send you this information within 10 calendar days from the date you requested a hearing.
- You can submit new facts about your case to HHSC. This information will be shared with your health plan prior to the State Fair Hearing.
- HHSC can agree with or change our decision in a state fair hearing decision. But, if you had an external medical review, the state fair hearing decision will not reduce your benefits below the external medical review decision.
- The written state fair hearing decision will be mailed to you within 90 calendar days of the date you asked for a state fair hearing.
- The decision will explain your right to have the case reviewed by an HHSC attorney if you disagree with the decision made about your services.

Emergency State Fair Hearings and External Medical Reviews

You can ask for an emergency state fair hearing if you feel your health will be seriously harmed by waiting for a decision. HHSC will review your case and determine if you qualify for an emergency state fair hearing. If your doctor supports your request, they should submit the support in writing to HHSC.

If you get an emergency state fair hearing, your hearing will be scheduled, and you will get a decision within three business days of your request.

If you request an emergency external medical review with your emergency State Fair Hearing, you'll get the external medical review decision within two business days. You can choose whether you want to have the state fair hearing you requested.

Need Help?

You or your representative can call us at <MCO and/or MCO Member Advocate toll free telephone number> to learn more about a state fair hearing and an external medical review.

If you have more questions about the state fair hearing process, call an HHSC ombudsman at 866-566-8989 or complete the online form at hhs.texas.gov/managed-care-help.

Aviso número 2B: Notificación al beneficiario de la decisión de la MCO sobre la apelación interna. Folleto

Audiencias imparciales estatales y revisiones médicas externas

Los procesos descritos en este folleto se aplican a las audiencias imparciales estatales y a las revisiones médicas externas, tanto de emergencia como de no emergencia

Se realiza una audiencia imparcial estatal cuando la Comisión de Salud y Servicios Humanos de Texas (HHSC) revisa directamente nuestras decisiones sobre la atención médica que usted recibe.

Si solicita una audiencia imparcial estatal, también puede pedir una revisión médica externa en la que especialistas médicos independientes revisan su solicitud de servicios. Esta revisión es una medida adicional y opcional que usted puede tomar para que su caso sea revisado sin costo alguno antes de su audiencia imparcial estatal. Esto no cambia su derecho a una audiencia imparcial estatal.

Puede solicitar una audiencia imparcial estatal y una revisión médica externa de una de las maneras siguientes:

- Completando el Formulario de solicitud de audiencia imparcial estatal y revisión médica externa anexo, y enviándolo por correo o por fax a la dirección o al número de fax que aparece en la parte superior del formulario.
- Llamando al <MCO telephone number>;
- Enviando un correo electrónico a <MCO email address>

Usted debe solicitar una audiencia imparcial estatal con o sin una revisión médica externa antes del <120 días a partir de la fecha de envío de este aviso>.
Si no solicita la audiencia imparcial estatal con o sin revisión médica externa antes de esa fecha, podría perder su derecho a una audiencia imparcial. Si tiene una razón justificada, por ejemplo, si recibió nuestro aviso demasiado tarde, es probable que aceptemos su solicitud de apelación después de esa fecha.

Si siguió recibiendo los servicios durante el proceso de apelación al plan médico, es probable que pueda seguir recibiendo los servicios mientras dure el proceso de audiencia imparcial estatal.

Solicite continuar recibiendo los servicios antes del **< 10 días a partir de la fecha de envío de este aviso>** solo si siguió recibiendo los servicios durante el proceso de apelación al plan médico. Si no solicita una audiencia imparcial estatal y no solicita que sus servicios continúen antes de esa fecha, no seguirá recibiendo esos servicios, pero aún tiene tiempo hasta el **<120 días a partir de la fecha de envío de este aviso>** para pedir una audiencia imparcial con o sin revisión médica externa.

Para solicitarla, llámenos o marque "Sí" en el formulario de Solicitud de audiencia imparcial estatal y revisión médica externa donde dice: "¿Desea que sus servicios continúen?".

Si pierde la audiencia imparcial estatal, es probable que tenga que reembolsar a su plan médico el importe de los servicios que le hayan

prestado durante el proceso de la audiencia imparcial. [inserte el nombre de la MCO] no puede pedirle a usted que devuelva el dinero por servicios recibidos que no hayan sido autorizados por la HHSC.

Qué sucede después de solicitar una audiencia imparcial estatal

Cuando solicite una audiencia imparcial con o sin revisión médica externa, un funcionario de audiencias se encargará de su caso.

Usted recibirá por correo un Aviso de audiencia **en un plazo de 10 días naturales contados a partir** de su solicitud de una audiencia imparcial. En el aviso se le indicará la fecha, la hora y el lugar de la audiencia.

Si solicita una revisión médica externa, esta se realizará antes de su audiencia imparcial estatal. Una revisión médica externa no afecta a la fecha en que se llevará a cabo su audiencia imparcial estatal.

Acerca de la revisión médica externa

- La HHSC entregará su información a especialistas médicos independientes que revisarán su caso.
- Solo se utilizará la información presentada para la apelación a su plan médico. Usted no podrá entregar nuevos datos para la revisión.
- Los especialistas podrían estar de acuerdo con nuestra decisión o podrían cambiarla. La decisión de la revisión médica externa se le enviará por correo en un plazo de **15 días naturales o menos.**
- Una vez que reciba la decisión de la revisión médica externa, puede elegir si quiere tener también la audiencia imparcial estatal que solicitó.
- Si quiere tener su audiencia imparcial estatal, la decisión de la revisión médica externa se considerará como prueba durante su audiencia imparcial estatal.

Acerca de la audiencia imparcial estatal

- La mayoría de las audiencias se realizan por teléfono, pero si tiene una razón justificada, puede solicitar que se realice en persona.
- Tiene derecho a ver la información que su plan médico utilizará en la audiencia. Estamos obligados a enviarle esta información en un plazo de 10 días naturales a partir de la fecha en que solicitó la audiencia.
- Usted puede presentar a la HHSC nuevos datos sobre su caso. Esta información se compartirá con su plan médico antes de que se lleve a cabo la audiencia imparcial.
- La HHSC podría estar de acuerdo con la decisión de la audiencia imparcial o podría cambiarla. Pero, si usted tuvo una revisión médica externa, la decisión de la audiencia imparcial no reducirá sus beneficios a una cantidad menor de lo que decida la revisión médica externa.
- La decisión por escrito de la audiencia imparcial estatal se le enviará por correo en un plazo de 90 días naturales a partir de la fecha en que solicitó la audiencia imparcial.
- En la decisión por escrito se le explicará su derecho a que un abogado de la HHSC revise el caso si no está de acuerdo con la decisión tomada sobre sus servicios.

Audiencias imparciales estatales de emergencia y revisiones médicas externas

Puede solicitar una audiencia imparcial estatal de emergencia si cree que su salud se verá gravemente perjudicada al tener que esperar una decisión. La HHSC revisará su caso y determinará si reúne los requisitos para una audiencia imparcial estatal de emergencia. Si su médico apoya su solicitud, este deberá presentar por escrito a la HHSC la confirmación de su apoyo.

Si obtiene una audiencia imparcial estatal de emergencia, se programará su audiencia y usted recibirá una decisión dentro de los tres días hábiles siguientes a su solicitud.

Si solicita una revisión médica externa de emergencia con su audiencia imparcial estatal de emergencia, obtendrá la decisión de la revisión médica

externa en un plazo de los dos días hábiles. Usted puede elegir si quiere tener la audiencia imparcial estatal que solicitó.

¿Necesita ayuda?

Usted o su representante legal pueden llamarnos al <MCO and/or MCO Member Advocate toll free telephone number> para obtener más información sobre una audiencia imparcial estatal y una revisión médica externa.

Si tiene más preguntas sobre el proceso de una audiencia imparcial estatal, llame a un ombudsman de la HHSC al 866-566-8989 o complete en línea el formulario en hhs.texas.gov/managed-care-help.

Notice #2C: Member Notice of Internal Appeal Decision - Form

State Fair Hearing and External Medical Review Request Form

To ask for a state fair hearing and external medical review, you can call us at <MCO telephone number>, email us at <MCO email address>, or mail or fax this form to us.

Mail: <MCO address>
Fax: <MCO fax number>

You must request a state fair hearing by <date 120 Days from the date this notice is mailed>.

If you kept receiving services during your health plan appeal, you may be able to keep getting your services during your state fair hearing. Make your request by **<date must be the later of the following: date 10 Days from the date this notice is mailed, or the date services will change>** only if you kept services during your health plan appeal.

Mark the state fair hearing option you want:

Only select one.

___ State fair hearing

___ State fair hearing and external medical review

___ Emergency state fair hearing*

___ Emergency state fair hearing and emergency external medical review*

*Emergency state fair hearings and emergency external medical reviews should only be requested if you believe your health will be seriously harmed by waiting for your fair hearing or external medical review decisions.

<Denial Reference Number: Number>

Do you want your services to continue? ___ Yes ___ No

Your services can only be continued if they were also continued during your health plan appeal. If you want your services to continue, you must request a state fair hearing and ask to keep your services by **<date must be the later of the following: date 10 Days from the date this notice is mailed or the date services will change>**.

You can make this request by phone. Call us at <MCO telephone number> if you believe this form will not reach us by mail before the deadline.

Your Personal Information*

Member last name:	Member first name:
Parent or guardian last name:	Parent or guardian first name:
Member Medicaid ID and subscriber number:	Preferred phone number:

*If any of your contact information has changed, call the enrollment broker at 800-964-2777 and <MCO> at <MCO telephone number>.

Your Hearing Representative's or Parent's Information

You can represent yourself. If you would like someone to represent you, such as, parent, relative or friend, complete the following information. By completing this section, you are authorizing your designated representative to appeal and obtain information on your behalf.

Name:
Address:
Phone number:

Reason for the State Fair Hearing
This section is optional. You can fill it out to tell us about your services under appeal and why you think they're needed.

Services under appeal:
Why you need them:

Sign this form

By signing this form, you or your representative are requesting a state fair hearing and giving the Texas Health and Human Services Commission authorization to get your medical records and to contact a representative if you listed one.

Member/Authorized representative signature

_____

Printed Name

_____

Date

Aviso número 2C: Notificación al beneficiario de la decisión de apelación interna. Formulario

Formulario de solicitud de audiencia imparcial estatal y revisión médica externa

Para solicitar una audiencia imparcial estatal y una revisión médica externa, puede llamarnos al <MCO telephone number>, enviarnos un correo electrónico a <MCO email address>, o enviarnos este formulario por correo postal o por fax.

Correo postal: <MCO address>
Fax: <MCO fax number>

Deberá solicitar una audiencia imparcial estatal antes del <120 días a partir de la fecha de envío de este aviso>.

Si siguió recibiendo servicios durante su apelación al plan médico, es probable que pueda seguir recibiendo sus servicios mientras dure el proceso de audiencia imparcial estatal. Haga su solicitud antes del **<la fecha debe ser la más lejana de las siguientes: 10 días a partir de la fecha de envío de este aviso o la fecha en que los servicios cambiarán>** solo si continuó recibiendo los servicios durante el proceso de apelación al plan médico.

Marque la opción de audiencia imparcial estatal que desee:

Elija solo una.

___ Audiencia imparcial estatal

___ Audiencia imparcial estatal y revisión médica externa

___ Audiencia imparcial estatal de emergencia*

___ Audiencia imparcial estatal de emergencia y revisión médica externa de emergencia*

*Las audiencias imparciales estatales de emergencia y las revisiones médicas externas de emergencia solo debe solicitarlas si cree que su salud se verá gravemente perjudicada al tener que esperar las decisiones de su audiencia imparcial o la revisión médica externa.

<Número de referencia de la denegación: Número>

¿Desea que sus servicios continúen? ___ Sí ___ No

Sus servicios solo podrán continuar si también siguió recibiéndolos durante su apelación al plan médico. Si desea que sus servicios continúen, debe solicitar una audiencia imparcial estatal y pedir que sus servicios continúen antes del **<la fecha debe ser la más lejana de las siguientes: 10 días a partir de la fecha de envío de este aviso o de la fecha en que los servicios cambiarán>.**

Puede hacer esta solicitud por teléfono. Llámenos al <MCO telephone number> si cree que este formulario no lo recibiremos por correo antes de la fecha límite.

Sus datos personales*

Apellido del beneficiario:	Primer nombre del beneficiario:
Apellido del padre, madre o tutor:	Primer nombre del padre, madre o tutor:
ID de Medicaid del beneficiario y número de asegurado:	Teléfono de preferencia:

*Si alguno de sus datos de contacto ha cambiado, llame al agente de inscripción al 800-964-2777 y a <MCO> al <MCO telephone number>.

Datos del representante para la audiencia o de los padres de usted:
Usted puede representarse a sí mismo. Si desea que alguien lo represente, por ejemplo, uno de sus padres, un familiar o un amigo, complete la siguiente información. Al completar esta sección, usted autoriza a su representante designado a presentar apelaciones y obtener información en su nombre.

Nombre:
Dirección:
Número de teléfono:

Motivo de la audiencia imparcial estatal
Esta sección es opcional. Puede llenarla para informarnos sobre los servicios que son objeto de apelación y por qué cree que los necesita.

Servicios objeto de la apelación:
Por qué necesita los servicios:

Firme este formulario
Al firmar este formulario, usted o su representante están solicitando una audiencia imparcial estatal y dando autorización a la Comisión de Salud y Servicios Humanos de Texas para obtener sus expedientes médicos y ponerse en contacto con un representante si usted ha designado uno.

Firma del beneficiario/representante autorizado

_____

Nombre en letra de molde

Fecha