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| --- |
| **PLAN ID: XXXXXXXXXXXXXXXXXXXX** |

<<DATE>>

<<ENROLLEE>> and/or

<<LEGAL REPRESENTATIVE>>

<<STREET ADDRESS>>

<<CITY, STATE ZIP>>

**NOTICE OF ADVERSE BENEFIT DETERMINATION**

Dear <<ENROLLEE/LEGAL REPRESENTATIVE>>:

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

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

We made our decision because:

*(Check all boxes that apply)*

We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: *(See Rule 59G-1.010)*

Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.

Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient’s needs.

Must meet accepted medical standards and not be experimental or investigational.

Must be able to be the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.

Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.

*(The convenience factor is not applied to the determination of the medically necessary level of private duty nursing (PDN) for children under the age of 21.)*

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

**Other authority** <<explain and cite authority>>

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

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

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

*Example from eQHealth*

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

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

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

**Right to Request a Plan Appeal**

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

**How to Ask for a Plan Appeal:**

You can ask for a plan appeal in writing or by calling us. Your case manager can help you with this, if you have one. We must receive the request *within 60 days* of the date of this letter. Here is where to call or send your request:

<<MCO>>

<<MAILING ADDRESS>>

<<PHONE>>

<<FAX>>

<<EMAIL>>

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

* Your name
* Your member number
* A phone number where we can reach you or your legal representative

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

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

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

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

You can ask for an “expedited plan appeal” if you think that waiting 30 days for a plan appeal decision resolution could put your life, health, or your ability to attain, maintain, or regain maximum function in danger. You can call or write us (see above), but you need to make sure that you ask us to *expedite* the plan appeal. We may not agree that your plan appeal needs to be expedited, but you will be told of this decision. We will still process your plan appeal under normal time frames. If we do need to expedite your plan appeal, you will get our plan appeal resolution within 72 hours after we receive your plan appeal request. This is true whether you asked for the plan appeal by phone or in writing.

**What to Do if You Disagree with the Plan Appeal Decision**

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

**How to Ask for a Review by the State:**

When you ask for a review, a hearing officer who works for the state reviews the decision made during the plan appeal. You may ask for a review by the state any time up to 30 days after you get the Notice of Plan Appeal Resolution. **You must finish your plan appeal process first.**

You may ask for a review by the state by calling or writing to:

Agency for Health Care Administration

Medicaid Hearing Unit

P.O. Box 60127

Ft. Myers, FL 33906

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

239-338-2642 *(fax)*

[MedicaidHearingUnit@ahca.myflorida.com](mailto:MedicaidHearingUnit@ahca.myflorida.com)

After getting your request, the Agency for Health Care Administration will tell you in writing that they got your request.

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

**Notice of Nondiscrimination**

<< INSERT NONDISCRIMINATION LANGUAGE>>

Sincerely,

<<NAME>>

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