STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM

Managed Care Organization Transmittal No. 44

September 15, 2003

TO: Managed Care Organizations

FROM: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

RE: Denial/Appeal Letter Template

The purpose of this transmittal is to provide managed care organizations (MCOs) with a template letter for notifying recipients of adverse actions regarding covered benefits. Adverse actions include denials of pre-service coverage requests as well as reduction of services currently being provided to enrollees by the MCO or its subcontractors.

This template complies with the components of Federal regulations 42 CFR §438.10 and the eleven State required elements evaluated by the Department's External Quality Review Organization (EQRO) vendor during the annual Systems Performance Review (SPR). Every MCO is required to include all eleven elements in its adverse action letters. Appropriate use of the enclosed template will ensure your compliance with this component of the SPR.

If you have any questions about your adverse action letter and the SPR, contact James Gardner, Chief, Division of HealthChoice Management and Quality Assurance at 410-767-1482. If you have any questions about sending copies of adverse action letters to the Complaint Resolution Unit, contact Nadine Smith, Chief, Division of Outreach and Care Coordination at 410-767-6750.

This transmittal includes the Denial/Appeal Template Letter (Attachment 1) and the eleven State required elements evaluated by the Department's EQRO vendor (Attachment 2).

Attachments

Attachment 1

Denial Letter Template

ORGANIZATIONAL LETTER HEAD

Date

[Enrollee Name or Legal Guardian]
[Enrollee Address]
[City, State, Zip Code]

Patient's Name:
DOB:
Medicaid ID NO:

Three identifiers to confirm correct enrollee

Dear [Member's Name or Legal Guardian]:

You or your doctor has asked [MCO name] to provide [1][Specify medical services or treatment]
A [MCO's name] doctor has reviewed your case and decided:

The services requested are not a covered benefit.

The services requested are not medically necessary.

The services requested are no longer medically necessary.

Other: [Describe reason]

[3]This decision is based on a [MCO's name] doctor reviewing your case using nationally recognized medical standards. [2][Provide clear, full, and factual explanation of the reasons for denial, reduction or termination]

If you disagree with this decision, you have several options. You can:

- Ask your doctor to provide us with: [4][Description of Information]; or
- [6]Call the Statewide HealthChoice Enrollee Action Line (HEAL) at 1-800-284-4510 to learn about your appeal rights. You can also ask them to review the MCO's decision. [10]If they cannot resolve your case within 10 days of your call, you will receive information from the State of Maryland about how to file an appeal and obtain a fair hearing on your case; or
- You may appeal to [MCO's name] directly. You have 30 days from the date on this letter to contact [MCO's name]. To contact your MCO, call [MCO phone #]or write to:

[Person or Department]
[MCO]
[Street, Suite]
[City, State, Zip Code]

[7]If you currently are receiving previously authorized services that are being denied or reduced, you may have the right to continue receiving these services during the appeal process through [MCO name] by calling the HealthChoice Enrollee Action Line (HEAL) at 1-800-284-4510 within 10 days from receipt of this letter.

Throughout the appeal process, [8]you have the right to represent yourself or to select someone else to represent you such as legal counsel, a relative, or friend. Your appeal will not affect your ability to receive other services through [MCO]. [5]You also can request a copy of your medical records by calling [MCO phone number].

[9]We will assume that you received this letter within 5 days from the date above. If you have questions about this information, you can call the HealthChoice Enrollee Action Line (HEAL) at 1-800-284-4510 or [MCO name] at [MCO phone #].

Sincerely,

Physician's Signature

cc: [11]Primary Care Provider
HealthChoice Complaint Resolution Unit

Attachment 2

Denial Letter Review Criteria

There must be documented policies and procedures for provider and enrollee appeals. Such policies and procedures must address all 11 required letter components for denial of care and/or services. The required denial letter components include:

1. Explanation of the requested care, treatment, or service.
2. Clear, full and complete factual explanation of the reasons for the denial, reduction or termination in understandable language.
   a. Conclusive statements such as "services included under another procedure"; and "not medically necessary"; are not legally sufficient. (note: The Department will be providing the MCOs with examples of how to comply with this component over the next few weeks.)
3. Clear explanation of the criteria, standards and interpretive guidelines the MCO used to make the decision. The use of the phrase "nationally recognized medical standards" is acceptable.
4. Description of any additional information MCO needs for reconsideration.
5. Statement that the enrollee has access to his/her medical records.
6. Direction to the enrollee to call the HealthChoice Enrollee Action Line to discuss the enrollees right to appeal if he/she disagrees with the MCO decision. This direction should appear prior to any direction to call the MCO.
7. Explanation to the enrollee that if he/she calls the HealthChoice Enrollee Action Line within 10 days of receiving the adverse action letter, he/she may continue to receive the on going services the he/she is currently receiving.
8. Statement that the enrollee may represent self or use legal counsel, a relative, a friend, or other spokesperson.
9. An explanation that it is assumed an enrollee receives the letter 5 days after it is dated unless he shows evidence otherwise.
   An explanation that the HealthChoice Enrollee Action Line staff will investigate and notify the enrollee 10 days after receiving his complaint about the status of the investigation and how to request a fair hearing.
   There is evidence that the letter is copied to the PCP and the HealthChoice Complaint Resolution Unit

Note: Review criteria numbering matches labeling of *Denial Letter Template*