PerformCARE®	Policy and Procedure
Name of Policy:	Approval/Denial Process and Notifications
Policy Number:	CM-013
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Clinical Department
Related Stakeholder(s):	All Departments
Applies to:	Clinical Department
Original Effective Date:	03/25/02
Last Revision Date:	11/01/24
Last Review Date:	01/16/25
OMHSAS Approval Date:	01/16/25
Next Review Date:	01/01/26

Policy: PerformCare will follow Pennsylvania Department of Human Services requirements regarding prior authorization approval/denial process and notifications per Appendix AA of PSR.

Purpose: Outline procedure for prior authorization approval/denial process and sending approval/denial notifications.

Definitions: **Act 146:** Pennsylvania General Assembly passed in November 2022 Act 146 which supersedes June 1998 Act 68.
Appendix AA: Prior authorization approval/denial process and notifications requirements per Pennsylvania Department of Human Services (DHS) HealthChoices Behavioral Health, Program Standards and Requirements.
Appendix H: Complaint, Grievance and Fair Hearing Processes per Pennsylvania Department of Human Services (DHS) HealthChoices Behavioral Health, Program Standards and Requirements.

Acronyms: **ASAM:** American Society of Addiction Medicine
BH-MCO: Behavioral Health-Managed Care Organization
CCM: Clinical Care Manager
DHS: Pennsylvania Department of Human Services
EMR: Electronic Medical Record
LOC: Level of Care
MNG: Medical Necessity Guidelines
NCQA: National Committee for Quality Assurance
PA: Psychiatrist/Psychologist Advisor
PSR: Program Standards and Requirements

Procedure:

1. PerformCare follows all Appendix AA standards when issuing an authorization or a denial of services.
2. Annual Appendix AA and denial letter narrative training is provided to all CCM, CCM Supervisors & PA.
3. When a Member or Provider requests prior authorization for Behavioral Health Services, a PerformCare Associate completes verification of PerformCare eligibility, collects relevant demographic information, documents in the Member's Electronic Medical Record, and notifies the Clinical Care Manager (CCM) of the request.
4. Initial and continued stay authorizations requests for a Behavioral Healthcare Services must meet Pennsylvania Department of Human Services (DHS) HealthChoices medical necessity as determined by application of DHS HealthChoices Behavioral Health Program, Program Standards and Requirements, Appendix S and T HealthChoices Behavioral Health Medical Necessity Guidelines (MNG), ASAM or PerformCare OMHSAS approved MNG for in lieu of services.
5. Prior Authorization Time frames for Notice of Decisions.
   - 5.1. PerformCare is required to process each request for Prior Authorization (prospective utilization review) of an initial request for service and ensure that the Member is notified of the decision as expeditiously as the Member's health condition requires, at least verbally within two (2) business days of receiving the request, unless additional information is needed. If no additional information is needed, PerformCare must mail written notice of the decision to the Member and the prescribing Provider within two (2) business days after the decision is made.
   - 5.2. The decision for concurrent review (reauthorization- continued stay requests) must be communicated within one (1) business day of the receipt of all supporting information reasonably necessary to complete the review.
   - 5.3. If additional information is needed to make the decision, PerformCare must request the additional information from the Provider within forty-eight (48) hours of receipt of the request and allow up to fourteen (14) days for the Provider to submit the additional information. PerformCare must accept supplemental information from a member of the Provider's clinical staff.
   - 5.4. PerformCare must provide written notice to the Member that additional information has been requested on the date the additional information was requested using the Notice of Request for Additional Information template. PerformCare must also include the Non-Discrimination Notice and Language Assistance Services templates when it sends the request for additional information. PerformCare must use the templates supplied by the Department, which are available in DocuShare. PerformCare may not modify the template.

5.5. If the requested information is provided within fourteen (14) days, then PerformCare must make the determination to approve or deny the service and notify the Member verbally, within two (2) business days of receipt of the additional information. PerformCare must mail written notice of the decision to the Member and the prescribing Provider within two (2) business days after the decision is made. If the additional information is not received within fourteen (14) days, the decision to approve or deny the service must be made based upon the available information and the Member notified verbally within two (2) business days after the additional information was to have been received. PerformCare must mail written notice of the decision to the Member and the prescribing Provider within (2) two business days after the decision is made.

5.6. In all cases, if the Member does not receive written notification of the decision to approve or deny a covered service within twenty-one (21) days from the date PerformCare received the request, the service is automatically approved. To satisfy the twenty-one (21) daytime period, PerformCare may mail written notice to the Member and the prescribing Provider on or before the eighteenth (18th) day from the date the request is received. If the notice is not mailed by the eighteenth (18th) day after the request is received, then PerformCare must hand deliver the notice to the Member, or the request is automatically authorized (i.e., deemed approved).

5.7. If the Member is currently receiving a requested service, the written notice of denial must be mailed to the Member at least fifteen (15) days prior to the effective date of the denial of authorization for continued services. If probable Member fraud has been verified, the period of advance notice is shortened to five (5) days. For acute inpatient services, the effective date on a denial of a continuation of services must be at least one (1) day after the date of the notice. If the Member wishes to have services continued as previously approved, the Member must file a Grievance before the effective date of the denial as indicated on the denial notice.

6. The CCM is responsible for reviewing/responding to the request and documenting all relevant clinical information in the Member's EMR.
7. The CCM will approve the initial or concurrent (reauthorization-continued stay) requests if Medical Necessity is met per the CCM scope of practice and qualifications and will generate a notification and authorization per Appendix AA requirements.
8. CCMs are responsible for submitting all Level of Care (LOC) requests that may not meet Medical Necessity to a PerformCare Psychiatrist//Psychologist Advisor (PA) for review and final determination of approval or denial of services.

8.1. CCMs are not permitted to deny a request for service, only a PerformCare PA (in accordance with Appendix AA requirements) may issue a denial within the scope of their license and practice.

9. When a PA is consulted for a Medical Necessity review, the PerformCare PA will document the Medical Necessity determination rationale in the Member's Electronic Medical Record.
   9.1. The PA is responsible for writing the narrative section of the denial letter.
      9.1.1. When PerformCare denies a request for services, a written denial notice must be issued to the Member using the appropriate denial notice template. PerformCare must also include the Non-Discrimination Notice and Language Assistance Services templates when it sends the denial notice. PerformCare must use the templates supplied by the Department, which are available in DocuShare.
      9.1.2. The Clinical Department's Documentation Audit Tool monitors compliance of the determinations per *CM-060 Denial Letter Review & Auditing Procedures*.
   9.2. Requests for service will not be denied for lack of medical necessity unless a physician or other health care professional with appropriate clinical experience or expertise in treating the Member's condition or disease determines:
      9.2.1. that the prescriber did not make a good faith effort to submit a complete request, or
      9.2.2. that the service or item is not medically necessary, after making a reasonable effort to consult the prescriber.
   9.3. If the Member is under 21 years of age the reasonable efforts to consult with the prescriber must include a request that the Member, parent, or authorized representative of the Member, if the Member has an authorized representative, contact the prescriber to request that the prescriber contact PerformCare. If a Member is under 21 years of age, PerformCare must document its attempts to reach the prescriber, including its request that the Member, parent, or authorized representative of the Member, if the Member has an authorized representative, contact the prescriber to request that the prescriber contact PerformCare.

10. Denial of Service
   10.1. A determination made by PerformCare in response to a Provider's or Member's request for approval to provide a service of a specific amount, duration, and scope which:
      10.1.1. Disapproves the request completely, or
      10.1.2. Approves provision of the requested service(s), but for a lesser amount, scope or duration than requested, or
      10.1.3. Approves provision of the requested service(s), but by a Network Provider, or

10.1.4. Disapproves provision of the requested service(s), but approves provision of an alternative service(s), or

10.1.5. Reduces, suspends, or terminates a previously authorized service.

10.2. A The denial notice must include the following:

10.2.1. Specific reasons for the denial with references to the program provisions.

10.2.2. A description of alternative services recommended on the basis of the medical necessity guidelines.

10.2.3. A description of the Member's right to file a complaint or grievance.

10.2.4. Information for the Member describing how to file a complaint or grievance.

10.2.5. An offer by PerformCare to assist the Member in filing a Complaint or Grievance.

11. PerformCare follows all requirements for Emergency Inpatient Admission: Prior Authorization, Admission and Documentation per Appendix AA.

11.1. If a Member seeks Emergency Services and the emergency provider determines that Emergency Services are necessary, the provider shall initiate necessary intervention to evaluate and, if necessary, stabilize an Emergency Medical Condition of the Member without seeking or receiving authorization from PerformCare. PerformCare may not require a provider to submit a request for Prior Authorization for Emergency Services or emergency inpatient admissions.

11.2. The provider is required to notify PerformCare of the provision of Emergency Services and the condition of the Member within 10 Days following the presentation for Emergency Services. PerformCare may not refuse to cover Emergency Services because the emergency department provider, hospital or fiscal agent did not notify PerformCare of the Member's screening and treatment within 10 Days of presentation for Emergency Services.

11.3. Continued stay after stabilization of the emergency may be subject to concurrent review and Prior Authorization. The review procedures used by PerformCare shall be consistent with the involuntary commitment processes set forth in the Mental Health Procedures Act, 50 P.S. §§ 7101 et seq. If a request for continued stay after stabilization cannot be reviewed because it is uncertain if the individual is eligible for Medical Assistance, PerformCare must review the request within seven (7) Days of the eligibility issue being resolved and no later than one hundred and eighty (180) Days of the date of service. PerformCare must use the same time frame to review authorizations for continued stay for Network Providers and Out-of-Network Providers.

11.4. If at any time after requesting Prior Authorization, the provider determines the Member's medical condition requires Emergency Services, the Emergency Services must be provided in accordance with Appendix AA.

12. Closely Related Services.
    12.1. If a Provider performs a closely related service, PerformCare may not deny a claim for the closely related service for failure of the Provider to seek or obtain prior authorization, if the Provider notifies PerformCare of the performance of the closely related service no later than three (3) business days following completion of the service but prior to the submission of the claim for payment. The submission of the notification shall include the submission of all relevant clinical information necessary for PerformCare to evaluate the medical necessity and appropriateness of the service.
    12.2. PerformCare's retrospective utilization review of medical necessity and appropriateness of the closely related service and the need for verification of the Member's eligibility for coverage is not limited by the requirement that PerformCare may not deny a claim for closely related services if the conditions in 12.1 are met.
13. Peer-to-Peer
    13.1. Peer-to peer review.
        13.1.1. In the case of a denied prior authorization request, PerformCare-MCO will make available a peer-to-peer review discussion to the requesting provider. The peer-to-peer reviewer provided by PerformCare shall meet the standards specified in section(C)(3) of Appendix AA and have the authority to modify or overturn PerformCare's prior authorization decision.
        13.1.2. The procedure for requesting a peer-to-peer review discussion, including contact information for PerformCare is available on PerformCare's website and the provider portal.
        13.1.3. A provider may request a peer-to-peer review discussion during normal business hours (Monday to Friday 8:30am to 4:30pm) or outside normal business hours, PerformCare will make every effort to accommodate after hours requests based on availability of qualified staff or coordinate the peer-to-peer as soon as feasible to the Provider and PerformCare.
    13.2. Peer to Peer proxy.
        13.2.1. A Provider may designate, and PerformCare shall accept, another licensed member of the Provider's affiliated or employed clinical staff with knowledge of the Member's condition and requested service as a qualified proxy for purposes of completing a peer to-peer discussion.
        13.2.2. Individuals eligible to receive a proxy designation shall be limited to licensed providers whose actual authority and scope of practice is inclusive of performing or prescribing the

requested service. Authority may be established through a supervising provider consistent with applicable State law for nonphysician practitioners.

13.2.3. PerformCare must accept and review the information submitted by other members of a provider's affiliated or employed staff in support of a prior authorization request.

13.2.4. PerformCare may not limit interactions with clinical staff solely to the requesting provider.

13.3. Peer to Peer review timeline.

13.3.1. PerformCare will make a peer-to-peer review discussion available to a requesting Provider from the time of a prior authorization denial occurs until the internal grievance process commences.

13.3.2. If a peer-to-peer review discussion is available prior to the PerformCare making a decision on the prior authorization request, then PerformCare will offer the peer-to-peer review discussion within the timelines specified in section (C)(1) of Appendix AA.

14. Denial letters for Mental Health Inpatient and all Substance Use Residential Level of Care will be faxed to the Member at the BH IP or SUD IP Provider the same day or no later than within 24 hours of the denial.
15. The Member has the right to file a Grievance or a Complaint per Appendix H and *QI-044 Grievance Policy*.
16. PerformCare also complies with all timeliness decision and notification requirements per Act 146 and NCQA. The most stringent time frame is followed per *Attachment 4 UM Decision Timeframes*.

Related Policies: *CM-004 Physician Advisor -Psychologist Advisor Consultation*
CM-007 Service Denial- Behavioral Health Inpatient Services
CM-011 Clinical Care Management Decision Making
CM-012 Authorization of Psychological and Neuropsychological Testing
CM-015 Inter-Rater Reliability Monitoring of Medical Necessity
CM-028 Requests for Prior-Authorized Substance Use Disorder Services
CM-029 Authorization Requests for Drug and Alcohol Hospital and Non-Hospital Based Detoxification
CM-034 Emergency Services-Coverage/Reimbursement
CM-043 Requests for Prior-Authorized Mental Health Services
CM-045 Requests for Initial, Continuation and Maintenance for Electroconvulsive Therapy
CM-047 Authorization and Delivery of Music Therapy Services
CM-053 Requests for Initial and Continued Stay Assertive Community Treatment Services
CM-054 Requests for Mobile Mental Health Intellectual Disability Service
CM-055 Requests for Transcranial Magnetic Stimulation
CM-060 Denial Letter Review & Auditing Procedures

CM-CAS-042 Initial & Re-Authorization Requirements for Individual Intensive Behavioral Health Services (IBHS) – BC/MT/BHT & ABA Services
CM-CAS-043 Initial & Re-Authorization Requirements for Intensive Behavioral Health Services (IBHS) – Group/Evidenced-Based Therapy/Other Individual Services
CM-CAS-051 Procedure for Prior Authorization for Family Based Mental Health Services
CM-CAS-053 CRR-HH Initial and Re-authorization Process
CM-CAS-054 RTF Initial and Re-authorization Process
PR-001 Service Authorization Procedures and Standards for Out-of-Network Providers
QI-044 Grievance Policy

Related Reports: *NCQA Standard UM-5 and Act 146.*

Source Documents and References: *Department of Human Services Prior Authorization Requirements for Participating Behavioral Health Managed Care Organizations in the Behavioral Health HealthChoices Program, Appendix AA and H, Complaints and Grievances.*
Pennsylvania Department of Human Service HealthChoices Behavioral Health Program, Program Standards and Requirements, Appendix S, T, American Society of Addiction Medicine (ASAM) Criteria, HealthChoices Behavioral Health Services Guidelines for Mental Health Medical Necessity Criteria.

Superseded Policies and/or Procedures: None

My Attachments: *Attachment 1 Notice of request for additional information*
Attachment 2a Complete Denial
Attachment 2b Approved Other Than Requested
Attachment 2c Approved Different Service
Attachment 2d Denial or Partial Approval Multiple IBHS
Attachment 3a Non-Discrimination notice
Attachment 3b Language Assistance Services
Attachment 4a Denial Decision Partial Change Due to Peer to Peer
Attachment 4b Denial Decision Change Due to Peer to Peer
Attachment 5 UM Decision Timeframes

Approved by:

_____

Primary Stakeholder

ATTACHMENT 1

Notice of Request for Additional Information

[Date letter mailed (date additional information was requested from Provider)]

[Member Name or Parent/Guardian Name]
[Address]
[County]

Member ID: *********

Subject: Request for Additional Information from your Provider

Dear **[Member or Parent/Guardian Name]**:

This is an important notice about your requested service(s). Read it carefully. Call **[BH-MCO Name]** at **[BH-MCO Phone# & Toll-free TTY/PA RELAY#]** if you have any questions or need help.

[BH-MCO Name] received a request for **[describe specific services/frequency/level/duration]** from **[provider name]** on **[date received]**.

In order to decide if this service is medically necessary for you, **[BH-MCO Name]** needs more information. **[BH-MCO Name]** has asked your provider to send us the following information by **[date]**:

[list specific information requested]

[BH-MCO Name] will make a decision on the requested services within 2 business days after getting the information from your provider. **[BH-MCO Name]** will tell you the decision in writing within 2 business days after making its decision.

If we do not receive the additional information within 14 days, **[BH-MCO Name]** will make the decision to approve or deny the service based on the information it already has. **[BH-MCO Name]** will tell you the decision in writing within 2 business days after it should have received the additional information.

If you have any questions, please contact Member Services at **[BH-MCO Phone# & Toll-free TTY/PA RELAY#]**.

Sincerely,

[BH-MCO Name]

cc: **[Prescribing Provider]**

ATTACHMENT 2a

STANDARD DENIAL NOTICE FOR REQUESTS THAT ARE DENIED COMPLETELY

[DATE] [This MUST be the date the notice is mailed]

[Member Name or Parent/Guardian Name]
[Address]
[County]

RE: [Member's name, DOB, and Member or Denial Identifier]

Dear **[Member or Parent/Guardian Name]**:

This is an important notice about your requested service(s). Read it carefully. Call **[BH-MCO Name]** at **[BH-MCO Phone# & Toll-free TTY/PA RELAY#]** if you have any questions or need help.

[BH-MCO Name] has reviewed the **[initial, continued, OR amended]** request for **[identify SPECIFIC service with amount, frequency, and dates of service (if applicable)]** submitted by **[prescriber's name and credentials]** for **[member name]** on **[date]**. The review was completed by **[name and credentials]**.

After **[physician] [psychologist] (select the most appropriate description)** review, the request is:

Denied completely because: **[Explain at a 6th grade reading level in detail every reason for denial. In addition to the explanation for the decision, include specific references to approved Medical Necessity guidelines, rules, or protocols on which the decision is based, in easily understood language. If under the age of 21, denial must be based on medical necessity. If a member under the age of 21 is denied because of insufficient information to determine medical necessity, it must be clear that a medical necessity determination could not be reached with the available information and all information needed to render a decision must be listed. If denied because of insufficient information and 21 or older, identify all additional information needed to render decision.]**

[If the ASAM criteria was used in this determination include the following: "The use of the American Society of Addiction Medicine's ASAM Criteria for Addictive, Substance-Related, and Co-Occurring Conditions criteria to review your request does not mean that the American Society of Addiction Medicine was part of [BH-MCO] review of the request."]

This decision will take effect on [date].

[If the service(s) requested were previously authorized, in any amount, include the following:]

The **[identify SPECIFIC service]** you have been getting will end on **[date services will end]** unless you file a Complaint or Grievance by **[DATE+1 or 15]**. If you file a Complaint or Grievance by **[DATE+1 or 15]**, your services will continue until a decision is made on your Complaint or Grievance.

1) What if I disagree with the decision to deny my request for services?

- You may file a Complaint or Grievance with **[BH-MCO Name]** by **[DATE+60].**
- You may ask for the Medical Necessity guidelines or other rules **[BH-MCO Name]** used to make this decision, at no cost to you. To ask for a copy of Medical Necessity guidelines or other rules that **[BH-MCO Name]** used to make the decision, call **[BH-MCO Name]** at **[BH-MCO Phone# & Toll-free TTY/PA RELAY#]** or write a letter.
- You may get a second opinion from another provider in **[BH-MCO Name]**'s network. Call **[BH-MCO Name]** at **[BH-MCO Phone# & Toll-free TTY/PA RELAY#]** to get a referral for a second opinion. Asking for a second opinion will not give you more time to file a Complaint or Grievance. It will not continue any service that you have been getting.

2) How do I file a Complaint or Grievance?

You can file a Complaint or Grievance by phone, or by writing a letter.

To file a Complaint or Grievance:

- By Phone: Call **[BH-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY#]**
- **[Include if available]** By Fax: Fax a letter to **[BH-MCO Fax #]**; or
- By Mail: Mail a letter to the following address:

BH-MCO address for filing Complaints or Grievances

3) How long will it take to decide my Complaint or Grievance?

[BH-MCO Name] will send you a written notice of the decision on your Complaint or Grievance within **[30 days; unless the BH-MCO uses a shorter timeframe to provide notice of 1st level decisions]** from when **[BH-MCO Name]** received your Complaint or Grievance.

4) How do I ask for an early decision on my Complaint or Grievance?

If you or your **[doctor] [psychologist] [prescriber] (select the most appropriate description)** thinks that waiting **[30 days; unless the BH-MCO uses a shorter timeframe]** for a decision could harm your health, call **[BH-MCO Name]** at **[Phone # & Toll-free TTY/PA RELAY#]** to ask for an early decision on your Complaint or Grievance.

You should also ask your **[doctor] [psychologist] [prescriber] (select the most appropriate**

description) to fax a signed letter to **[BH-MCO Fax#]** within 72 hours of when you asked for an early decision on your Complaint or Grievance. The letter should explain why waiting **[30 days; unless the BH-MCO uses a shorter timeframe]** for a decision could harm your health.

[BH-MCO Name] will tell you the decision within 48 hours from when **[BH- MCO Name]** gets your **[doctor's] [psychologist's] [prescriber's] (select the most appropriate description)** letter, or within 72 hours from when you asked **[BH-MCO Name]** for an early decision, whichever is sooner, unless you ask **[BH-MCO Name]** to take more time to decide your Complaint or Grievance. You may ask **[BH-MCO Name]** to take up to 14 more days to decide your Complaint or Grievance.

5) <u>What happens after I file my Complaint or Grievance?</u>

[BH-MCO Name] will hold a meeting within **[30 days; unless the BH-MCO uses a shorter timeframe]** of when you filed your Complaint and Grievance to review your Complaint or Grievance. You may attend the meeting either in person or by telephone [**OR if video conference is available:** You may attend the meeting either in person, by telephone or by video conference.] You may also bring a family member, friend or lawyer to help you during the meeting.

Once you have completed **[BH-MCO Name]**'s internal process, if you disagree with **[BH-MCO Name]**'s decision on your Complaint or Grievance, you may ask for an external review or a Fair Hearing or you may ask for both an external review and a Fair Hearing. Information about external reviews and Fair Hearings can be found in the member handbook.

6) <u>How can I get help with my Complaint or Grievance?</u>

If you need help filing a Complaint or Grievance, you can call **[BH-MCO Name]** at **[BH-MCO Phone# & Toll-free TTY/PA RELAY#]**.

To ask for free legal help with your Complaint or Grievance, you can contact:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org); or
- Pennsylvania Legal Aid Network at 1-800-322-7572 (https://palegalaid.net)

Sincerely,

[BH-MCO Name]

cc: **[*Prescribing Provider*]**

ATTACHMENT 2b

STANDARD DENIAL NOTICE FOR REQUESTS THAT ARE APPROVED OTHER THAN REQUESTED

[DATE] [This MUST be the date the notice is mailed]

[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member's name, DOB, and Member or Denial Identifier]

Dear **[Member or Parent/Guardian Name]**:

This is an important notice about your requested service(s). Read it carefully. Call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]** if you have any questions or need help.

[BH-MCO Name] has reviewed the **[initial, continued, OR amended]** request for **[identify SPECIFIC service with amount, frequency, and dates of service (if applicable)]** submitted by **[prescriber's name and credentials]** for **[member name]** on **[date]**. The review was completed by **[name and credentials]**.

After **[physician] [psychologist] [master's level staff if denial was due to out-of-network provider] (select the most appropriate description)** review, the request is:

Approved other than as requested as follows**:**

[Describe the level, frequency, and duration of service approved.]

[Describe the level, frequency, and duration of service denied, or describe the level, frequency, and duration of service approved or denied. If services are denied because the provider is not in the BH-MCO network, include an instruction to contact the BH-MCO to find an in-network provider.]

The service is not approved as requested because: **[Explain at a 6th grade reading level in detail every reason for denial. In addition to the explanation for the decision, include specific references to approved Medical Necessity guidelines, rules, or protocols on which the decision is based, in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]**

[If the ASAM criteria was used in this determination include the following: "The use of the American Society of Addiction Medicine's ASAM Criteria for Addictive, Substance-Related,

and Co-Occurring Conditions criteria to review your request does not mean that the American Society of Addiction Medicine was part of [BH-MCO] review of the request."]

This decision will take effect on [date].

[If the service(s) requested were previously authorized, in any amount, include the following:]

The **[identify SPECIFIC service]** you have been getting will end on **[date services will end]** unless you file a Complaint or Grievance by **[DATE+1 or 15]**. If you file a Complaint or Grievance by **[DATE+1 or 15]**, your services will continue until a decision is made on your Complaint or Grievance.

1) <u>What if I disagree with the decision to deny my request for services?</u>

- You may file a Complaint or Grievance with **[BH-MCO Name]** by **[DATE +60].**
- You may ask for the Medical Necessity guidelines or other rules **[BH-MCO Name]** used to make this decision, at no cost to you. To ask for a copy of Medical Necessity guidelines or other rules that **[BH-MCO Name]** used to make the decision, call **[BH-MCO Name]** at [**BH-MCO Phone # & Toll-free TTY/PA RELAY#]** or write a letter.
- You may get a second opinion from another provider in **[BH-MCO Name]**'s network. Call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]** to get a referral for a second opinion. Asking for a second opinion will not give you more time to file a Complaint or Grievance. It will not continue any service that you have been getting.

2) **<u>How do I file a Complaint or Grievance?</u>**

You can file a Complaint or Grievance by phone, or by writing a letter.

To file a Complaint or Grievance:

- By Phone: Call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]**;
- **[Include if available]** By Fax: Fax a letter to **[BH-MCO Fax #]**; or
- By Mail: Mail a letter to the following address:

BH-MCO address for filing Complaints or Grievances

3) <u>How long will it take to decide my Complaint or Grievance?</u>

[BH-MCO Name] will send you a written notice of the decision on your Complaint or Grievance within **[30 days; unless the BH-MCO uses a shorter timeframe to provide notice of 1st level decisions]** from when **[BH-MCO Name]** received your Complaint or Grievance.

4) <u>How do I ask for an early decision on my Complaint or Grievance?</u>

If you or your **[doctor] [psychologist] [prescriber] (select the most appropriate description)** thinks that waiting **[30 days; unless the BH-MCO uses a shorter timeframe]** for a decision could harm your health, call **[BH-MCO Name]** at **[Phone # & Toll-free TTY/PA RELAY#] to** ask for an early decision on your Complaint or Grievance.

You should also ask your **[doctor] [psychologist] [prescriber] (select the most appropriate description)** to fax a signed letter to **[BH-MCO Fax #]** within 72 hours of when you asked for an early decision on your Complaint or Grievance. The letter should explain why waiting **[30 days; unless the BH-MCO uses a shorter timeframe]** for a decision could harm your health.

[BH-MCO Name] will tell you the decision within 48 hours from when **[BH-MCO Name]** gets your **[doctor's] [psychologist's] [prescriber's] (select the most appropriate description)** letter, or within 72 hours from when you asked **[BH-MCO Name]** for an early decision, whichever is sooner, unless you ask **[BH-MCO Name]** to take more time to decide your Complaint or Grievance. You may ask **[BH-MCO Name]** to take up to 14 more days to decide your Complaint or Grievance.

5) <u>What happens after I file my Complaint or Grievance?</u>

[BH-MCO Name] will hold a meeting within **[30 days; unless the BH-MCO uses a shorter timeframe]** of when you filed your Complaint or Grievance to review your Complaint or Grievance. You may attend the meeting either in person or by telephone **[OR if video conference is available:** You may attend the meeting either in person, by telephone or by videoconference.**]** You may also bring a family member, friend, or lawyer to help you during the meeting.

Once you have completed **[BH-MCO Name]**'s internal process, if you disagree with **[BH-MCO Name]**'s decision on your Complaint or Grievance, you may ask for an external review or a Fair Hearing or you may ask for both an external review and a Fair Hearing. Information about external reviews and Fair Hearings can be found in the member handbook.

6) <u>How can I get help with my Complaint or Grievance?</u>

If you need help filing a Complaint or Grievance, you can call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#].**

To ask for free legal help with your Complaint or Grievance, you can contact:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org)**;** or
- Pennsylvania Legal Aid Network at 1-800-322-7572 (https://palegalaid.net)

Sincerely,

[BH-MCO Name]

cc: **[*Prescribing Provider*]**

ATTACHMENT 2c

STANDARD DENIAL NOTICE FOR REQUESTS THAT ARE DENIED AS REQUESTED BUT HAVE APPROVED DIFFERENT SERVICES

[DATE] [This MUST be the date the notice is mailed]

[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member's name, DOB, and Member or Denial Identifier]

Dear **[Member or Parent/Guardian Name]**:

This is an important notice about your requested service(s). Read it carefully. Call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]** if you have any questions or need help.

[BH-MCO Name] has reviewed the **[initial, continued, OR amended]** request for **[identify SPECIFIC service with amount, frequency, and dates of service (if applicable)]** submitted by **[prescriber's name and credentials]** for **[member name]** on **[date]**. The review was completed by **[name and credentials]**.

After **[physician] [psychologist] (select the most appropriate description)** review, the request is:

Denied as requested, but the following service is approved: **[describe the specific service approved, including the level, frequency, and duration of service].**

A different service is approved because: **[Explain at a 6th grade reading level in detail every reason for denial. In addition to the explanation for the decision, include specific references to approved Medical Necessity guidelines, rules, or protocols on which the decision is based, in easily understood language. If under the age of 21, denial must be based on medical necessity. If a member under the age of 21 is denied because of insufficient information to determine medical necessity, it must be clear that a medical necessity determination could not be reached with the available information and all information needed to render a decision must be listed. If denied because of insufficient information and 21 or older, identify all additional information needed to render decision.]**

[If the ASAM criteria was used in this determination include the following: "The use of the American Society of Addiction Medicine's ASAM Criteria for Addictive, Substance-Related, and Co-Occurring Conditions criteria to review your request does not mean that the American Society of Addiction Medicine was part of [BH-MCO] review of the request."]

This decision will take effect on [*date*].

[If the service(s) requested were previously authorized, in any amount, include the following:]

The **[identify SPECIFIC service]** you have been getting will end on **[date services will end], unless you file a Complaint or Grievance by [DATE+1 or 15]**. If you file a Complaint or Grievance by **[DATE+1 or 15]**, your services will continue until a decision is made on your Complaint or Grievance.

1) <u>What if I disagree with the decision to deny my request for services?</u>

- You may file a Complaint or Grievance with **[BH-MCO Name]** by **[DATE +60].**
- You may ask for the Medical Necessity guidelines or other rules **[BH-MCO Name]** used to make this decision, at no cost to you. To ask for a copy of Medical Necessity guidelines or other rules that **[BH-MCO Name]** used to make the decision, call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]** or write a letter.
- You may get a second opinion from another provider in **[BH-MCO Name]**'s network. Call **[BH-MCO Name] at [BH-MCO Phone # & Toll-free TTY/PA RELAY#]** to get a referral for a second opinion. Asking for a second opinion will not give you more time to file a Complaint or Grievance. It will not continue any service that you have been getting.

2) <u>How do I file a Complaint or Grievance?</u>

You can file a Complaint or Grievance by phone, or by writing a letter.

To file a Complaint or Grievance:

- By Phone: Call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]**;
- **[Include if available]** By Fax: Fax a letter to **[BH-MCO Fax #]**; or
- By Mail: Mail a letter to the following address:

BH-MCO address for filing Complaints or Grievances

3) <u>How long will it take to decide my Complaint or Grievance?</u>

[BH-MCO Name] will send you a written notice of the decision on your Complaint or Grievance within **[30 days; unless the BH-MCO uses a shorter timeframe to provide notice of 1st level decisions]** from when **[BH-MCO Name]** received your Complaint or Grievance.

4) <u>How do I ask for an early decision on my Complaint or Grievance?</u>

If you or your **[doctor] [psychologist] [prescriber] (select the most appropriate description)** thinks that waiting **[30 days; unless the BH-MCO uses a shorter timeframe]** for a decision could harm your health, call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]** to ask for an early decision on your Complaint or Grievance.

You should also ask your **[doctor] [psychologist] [prescriber] (select the most appropriate description)** to fax a signed letter to **[BH-MCO Fax #]** within 72 hours of when you asked for an early decision on your Complaint or Grievance. The letter should explain why waiting **[30 days; unless the BH-MCO uses a shorter timeframe]** for a decision could harm your health.

[BH-MCO Name] will tell you the decision within 48 hours from when **[BH-MCO Name]** gets your **[doctor's] [psychologist's] [prescriber's] (select the most appropriate description)** letter, or within 72 hours from when you asked **[BH-MCO Name]** for an early decision, whichever is sooner, unless you ask **[BH-MCO Name]** to take more time to decide your Complaint or Grievance. You may ask **[BH-MCO Name]** to take up to 14 more days to decide your Complaint or Grievance.

5) <u>What happens after I file my Complaint or Grievance?</u>

[BH-MCO Name] will hold a meeting within **[30 days; unless the BH-MCO uses a shorter timeframe]** of when you filed your Complaint or Grievance to review your Complaint or Grievance**.** You may attend the meeting either in person or by telephone **[OR if video conference is available:** You may attend the meeting either in person, by telephone or by videoconference.**]** You may also bring a family member, friend, or lawyer to help you during the meeting.

Once you have completed **[BH-MCO Name]**'s internal process, if you disagree with **[BH-MCO Name]**'s decision on your Complaint or Grievance, you may ask for an external review or a Fair Hearing or you may ask for both an external review and a Fair Hearing. Information about external reviews and Fair Hearings can be found in the member handbook.

6) <u>How can I get help with my Complaint or Grievance?</u>

If you need help filing a Complaint or Grievance, you can call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#].**

To ask for free legal help with your Complaint or Grievance, you can contact:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org)**;** or
- Pennsylvania Legal Aid Network at 1-800-322-7572 (https://palegalaid.net)

Sincerely,

[BH-MCO Name]

cc: **[*Prescribing Provider*]**

ATTACHMENT 2d

STANDARD DENIAL NOTICE FOR REQUEST FOR MULTIPLE IBHS

[DATE] [This MUST be the date the notice is mailed]

[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member's name, DOB, and Member OR Denial Identifier]

Dear **[Member or Parent/Guardian Name]**:

This is an important notice about your requested service(s). Read it carefully. Call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]** if you have any questions or need help.

[BH-MCO Name] has reviewed the **[initial, continued, OR amended]** request for **[identify SPECIFIC service/item along with amount, frequency, and dates of service (if applicable)]** submitted by **[prescriber's name and credentials]** for **[member name]** on **[date]**. The review was completed by **[name and credentials]**.

After **[physician] [psychologist] (select the most appropriate description)** review, the following services are:

Approved (IF APPLICABLE):
[Type of service(s), amount, frequency, authorized dates]

Approved other than as requested (IF APPLICABLE):
[Type of service(s), amount, frequency, authorized dates]

Denied:
[Type of service(s), amount, frequency, denied dates]

The reason for this decision is: **[Explain at a 6th grade reading level in detail every reason for denial. In addition to the explanation for the decision, include specific references to approved Medical Necessity guidelines, rules, or protocols on which the decision is based, in easily understood language. If under the age of 21, denial must be based on medical necessity. If a member under the age of 21 is denied because of insufficient information to determine medical necessity, it must be clear that a medical necessity determination could not be reached with the available information and all information needed to render a decision must be listed. If denied because of insufficient information and 21 or older, identify all additional information needed to render decision.]**

[If the ASAM criteria was used in this determination include the following: "The use of the American Society of Addiction Medicine's ASAM Criteria for Addictive, Substance-Related, and Co-Occurring Conditions criteria to review your request does not mean that the American Society of Addiction Medicine was part of [BH-MCO] review of the request."]

This decision will take effect on [*date*].

[If the service(s)requested were previously authorized, in any amount, include the following:]

The **[identify SPECIFIC service]** you have been getting will end on **[date services will end] unless you file** a Complaint or Grievance by **[DATE+15]**. If you file a Complaint or Grievance by **[DATE+15]**, your services will continue until a decision is made on your Complaint or Grievance.

1) What if I disagree with the decision to deny my request for services?

- You may file a Complaint or Grievance with **[BH-MCO Name]** by **[DATE +60]**
- You may ask for the Medical Necessity guidelines or other rules that **[BH-MCO Name]** used to make this decision at no cost to you. To ask for a copy of Medical Necessity guidelines or other rules that **[BH-MCO Name]** used to make the decision, call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]** or write a letter.
- You may get a second opinion from another provider in **[BH-MCO Name]**'s network. Call **[BH-MCO Name] at [BH-MCO Phone # & Toll-free TTY/PA RELAY#]** to get a referral for a second opinion. Asking for a second opinion will not give you more time to file a Complaint or Grievance. It will not continue any service that you have been getting.

2) How do I file a Complaint or Grievance?

You can file a Complaint or Grievance by phone, or by writing a letter.

To file a Complaint or Grievance:

- By Phone: Call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]**;
- **[Include if available]** By Fax: Fax a letter to **[BH-MCO Fax #]**; or
- By Mail: Mail a letter to the following address:

BH-MCO address for filing Complaints or Grievances

3) How long will it take to decide my Complaint or Grievance?

[BH-MCO Name] will send you a written notice of the decision on your Complaint or Grievance with **[30 days; unless the BH-MCO uses a shorter timeframe to provide notice of 1st level decisions]** from when **[BH-MCO Name]** received your Complaint or Grievance.

4) How do I ask for an early decision on my Complaint or Grievance?

If you or your **[doctor] [psychologist] [prescriber] (select the most appropriate description)** thinks that waiting **[30 days; unless the BH-MCO uses a shorter timeframe]** for a decision could harm your health, call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]** to ask for an early decision on your Complaint or Grievance.

You should also ask your **[doctor] [psychologist] [prescriber] (select the most appropriate description)** to fax a signed letter to **[BH-MCO Fax #]** within 72 hours of when you asked for an early decision on your Complaint or Grievance. The letter should explain why waiting **[30 days; unless the BH-MCO uses a shorter timeframe]** for a decision could harm your health.

[BH-MCO Name] will tell you the decision within 48 hours from when **[BH-MCO Name]** gets your **[doctor's] [psychologist's] [prescriber's] (select the most appropriate description)** letter, or within 72 hours from when you asked **[BH-MCO Name]** for an early decision, whichever is sooner, unless you ask **[BH-MCO Name]** to take more time to decide your Complaint or Grievance. You may ask **[BH-MCO Name]** to take up to 14 more days to decide your Complaint or Grievance.

5) <u>What happens after I file my Complaint or Grievance?</u>

[BH-MCO Name] will hold a meeting within **[30 days; unless the BH-MCO uses a shorter timeframe]** of when you filed your Complaint or Grievance to review your Complaint or **Grievance.** You may attend the meeting either in person or by telephone **[OR if video conference is available:** You may attend the meeting either in person, by telephone or by videoconference.**]** You may also bring a family member, friend, or lawyer to help you during the meeting.

Once you have completed **[BH-MCO Name]**'s internal process, if you disagree with **[BH-MCO Name]**'s decision on your Complaint or Grievance, you may ask for an external review or a Fair Hearing or you may ask for both an external review and a Fair Hearing. Information about external reviews and Fair Hearings can be found in the member handbook.

6) <u>How can I get help with my Complaint or Grievance?</u>

If you need help filing a Complaint or Grievance, you can call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#].**

To ask for free legal help with your Complaint or Grievance, contact:

- Pennsylvania Health Law project at 1-800-274-3258 (www.phlp.org); or
- Pennsylvania Legal Aid Network at 1-800-322-7572 (https://palegalaid.net)

Sincerely,

[BH-MCO Name]

cc: **[*Prescribing Provider*]**

Attachment 3a

Non-Discrimination Notice

[BH-MCO] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

[BH-MCO] does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

[BH-MCO] provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

[BH-MCO] provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact **[BH-MCO Name]** at **[BH-MCO phone# & Toll-free TTY/PA RELAY#].**

If you believe that **[BH-MCO]** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

[BH-MCO Name],
[BH- MCO Mailing Address for Complaint/Grievances],
[Address line]
[Address line]
[Telephone number], [TTY/PA Relay number],
[Fax], or
[Email]

The Bureau of Equal Opportunity,
Room 223, Health and Welfare Building,
P.O. Box 2675,
Harrisburg, PA 17105-2675,
Phone: (717) 787-1127, TTY/PA Relay 711,
Fax: (717) 772-4366, or
Email: RA-PWBEOAO@pa.gov

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, [BH-MCO] and the Bureau of Equal Opportunity are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW.,
Room 509F, HHH Building,
Washington, DC 20201,
1-800-368-1019, 800-537-7697 (TDD).
OCRMail@hhs.gov

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Attachment 3b

Language Assistance Services

Taglines in the top fifteen (15) prevalent languages in Pennsylvania, in addition to English tag line in large print, for all large significant publications and communications.

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids also available free of charge. Call: **[BH-MCO phone number] (TTY: phone number).**

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **[BH-MCO phone number] (TTY: phone number)** o hable con su proveedor.

Chinese; Mandarin
注意：**如果您**说[**中文**]，**我**们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 **[BH-MCO phone number] (TTY: phone number) 文本**电话：**[BH-MCO phone number] (TTY: phone number)**）**或咨**询您的服务提供商。”

Nepali
सावधान: यिद तपाईं नेपाली भाषा बोल्नु□न्छ भनेतपाईंका लाि◌ग ि◌नःशु□ भाि◌षक सहायता सेवाह□ उपल□ छन्। प□ँ◌चयो□ ढाँचाह□मा जानकारी प्रदान गन□ उपयु□ सहायता र सेवाह□ पिन ि◌नःशु□ उपल□ छन्। **[BH-MCO phone number] (TTY: phone number)** मा फोन गनु□होस्वा आफ्नो प्रदायकसँग कुरा गनु□होस्।”

Russian
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **[BH-MCO phone number] (TTY: phone number)** или обратитесь к своему поставщику услуг.

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **[BH-MCO phone number] (TTY: phone number)** أو تحدث إلى مقدم الخدمة".

Haitian Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan **[BH-MCO phone number] (TTY: phone number)** oswa pale avèk founisè w la."

Vietnamese
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số **[BH-MCO phone number] (TTY: phone number)** (Người khuyết tật: **[BH-MCO phone number] (TTY: phone number)** hoặc trao đổi với người cung cấp dịch vụ của bạn."

Ukrainian
УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером **[BH-MCO phone number] (TTY: phone number)** або зверніться до свого постачальника».

Chinese; Cantonese
注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 **[BH-MCO phone number] (TTY: phone number)** 或與您的提供者討論。」

Portuguese
ATENÇÃO: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para **[BH-MCO phone number] (TTY: phone number)** ou fale com seu provedor."

Bengali
মেনাোযাগ িদন: যিদ আপিন বাংলা বেলন তাহেল আপনার জন িবনামূেল ভাষা সহায়তা পিরেষবাি উপল রেয়েছ। অ াে সেযাগ ফরম াে তথ দাে নর জন উপযু সহায়ক সহেযাগিতা এবং পিরেষবাি ও িবনামূেল উপল রেয়েছ। **[BH-MCO phone number] (TTY: phone number)** ন ের কল ক ন অথবা আপনার দানকারীর সাে থ কথা বলুন।"

French
ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **[BH-MCO phone number] (TTY: phone number)** ou parlez à votre fournisseur. »

Cambodian
សូមយកចិត□ទុក□ក់ៈ ប្រសិនេបើអ□កនិ□យ □□ែខ□រ
េសៀ□កម□ជំនួយ□□ឥតគិតៃថ□គឺ□នស្រ□ប់អ□ក។ ជំនួយ
និងេសៀ□កម□ែដល□□រួយដ៏សមរម្យ
ក□□ង□រផ□ល់ព័ត៌□ន□មទ្រមង់ែដល□ចចូលេប្រើ□ស់□ន
ក៏□ចរក□ន□េយឥតគិតៃថ□ជង្ហែដរ។ េ□ទូរសព□េ□ **[BH-MCO phone number] (TTY: phone number)** ឬនិ□យេ□□ន់អ□កផ□ល់េសៀ□របស់អ□ក។”

Korean
주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **[BH-MCO phone number] (TTY: phone number)** 번으로 전화하거나 서비스 제공업체에 문의하십시오."

Gujarati
ધ્યાન આપો: જો તમે□ુજરાતી બોલતા હો તો મફત ભાષાક□ય સહાયતા સેવાઓ તમારા માટ□ ઉપલબ્ધ છે. યોગ્ય ઓ□ક્ઝલર□ સહાય અનેએક્સેિસબલ ફોમ□ટમાંમા□હતી □ૂર□ પાડવા માટ□ની સેવાઓ પણ િવના □ૂલ્યે ઉપલબ્ધ છે. **[BH-MCO phone number] (TTY: phone number)** પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.”

ATTACHMENT 4a
Decision Notice After Peer-to Peer Review

[Use for Denials Partially Changed After Peer-to-Peer Consultation]

[Date the notice is mailed]

[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member Identifier]**

Subject: Partial Approval of Services After Peer-to-Peer Review

Dear **[Member or Parent/Guardian Name]**:

This is an important notice about your requested service(s). Read it carefully. Call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]** if you have any questions or need help.

Based on a review of information provided to **[BH-MCO Name]** during a discussion with your provider, **[BH-MCO Name]** has changed its decision to deny services requested for you

The following services have been authorized from **[include date services were requested to start]** until **[include date authorized services will end]**:

- **[list all approved services]**
- **[designate if a service was approved other than requested]**
- **[include each individual service approved in its own bullet]**
- **[include specifics of the services approved, including hours per week, service type, and dates requested]**

The following services have been denied:

- **[list all services denied]**
- **[include each individual service denied in its own bullet]**
- **[include specifics of the service denied, including hours per week, service type, and dates requested]**

The reason your services were not approved as requested is because:

[Explain at a 6th grade reading level in detail every reason for the decision. In addition to the explanation for the decision, include specific references to approved Medical Necessity guidelines,

rules, or protocols on which the decision is based, in easily understood language. If services are denied because of insufficient information, identify all additional information needed to render decision.]

[If the ASAM criteria was used in this determination include the following: "The use of the American Society of Addiction Medicine's ASAM Criteria for Addictive, Substance-Related, and Co-Occurring Conditions criteria to review your Grievance does not mean that the American Society of Addiction Medicine was part of the review of your Grievance."]

This decision will take effect on [date].

[If the service(s) requested were previously authorized, in any amount, include the following:]

The **[identify SPECIFIC service]** you have been getting will end on **[date services will end]**, unless you file a Complaint or Grievance by **[DATE+1 or 15]**. If you file a Complaint or Grievance by **[DATE+1 or 15]**, your services will continue until a decision is made on your Complaint or Grievance.

1) **What if I disagree with the decision to deny my request for services?**
   - You may file a Complaint or Grievance with **[BH-MCO Name]** by **[DATE+60].**
   - You may ask for the Medical Necessity guidelines or other rules **[BH-MCO Name]** used to make this decision, at no cost to you. To ask for a copy of Medical Necessity guidelines or other rules that **[BH-MCO Name]** used to make the decision, call **[BH-MCO Name]** at **[BH-MCO Phone# & Toll-free TTY/PA RELAY#]** or write a letter.
   - You may get a second opinion from another provider in **[BH-MCO Name]**'s network. Call **[BH-MCO Name]** at **[BH-MCO Phone# & Toll-free TTY/PA RELAY#]** to get a referral for a second opinion. Asking for a second opinion will not give you more time to file a Complaint or Grievance. It will not continue any service that you have been getting.

2) **How do I file a Complaint or Grievance?**
   You can file a Complaint or Grievance by phone, or by writing a letter.

   To file a Complaint or Grievance:

   - By Phone: Call **[BH-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY#]**
   - **[Include if available]** By Fax: Fax a letter to **[BH-MCO Fax #]**; or
   - By Mail: Mail a letter to the following address:

BH-MCO address for filing Complaints or Grievances

3) **How long will it take to decide my Complaint or Grievance?**

[BH-MCO Name] will send you a written notice of the decision on your Complaint or Grievance within **[30 days; unless the BH-MCO uses a shorter timeframe to provide notice of 1st level decisions]** from when **[BH-MCO Name]** received your Complaint or Grievance.

4) How do I ask for an early decision on my Complaint or Grievance?

If you or your **[doctor] [psychologist] [prescriber] (select the most appropriate description)** thinks that waiting **[30 days; unless the BH-MCO uses a shorter timeframe]** for a decision could harm your health, call **[BH-MCO Name]** at **[Phone # & Toll-free TTY/PA RELAY#]** to ask for an early decision on your Complaint or Grievance.

You should also ask your **[doctor] [psychologist] [prescriber] (select the most appropriate description)** to fax a signed letter to **[BH-MCO Fax#]** within 72 hours of when you asked for an early decision on your Complaint or Grievance. The letter should explain why waiting **[30 days; unless the BH-MCO uses a shorter timeframe]** for a decision could harm your health.

[BH-MCO Name] will tell you the decision within 48 hours from when **[BH- MCO Name]** gets your **[doctor's] [psychologist's] [prescriber's] (select the most appropriate description)** letter, or within 72 hours from when you asked **[BH-MCO Name]** for an early decision, whichever is sooner, unless you ask **[BH-MCO Name]** to take more time to decide your Complaint or Grievance. You may ask **[BH-MCO Name]** to take up to 14 more days to decide your Complaint or Grievance.

5) What happens after I file my Complaint or Grievance?

[BH-MCO Name] will hold a meeting within **[30 days; unless the BH-MCO uses a shorter timeframe]** of when you filed your Complaint and Grievance to review your Complaint or Grievance. You may attend the meeting either in person or by telephone [**OR if video conference is available:** You may attend the meeting either in person, by telephone or by video conference.] You may also bring a family member, friend or lawyer to help you during the meeting.

Once you have completed **[BH-MCO Name]**'s internal process, if you disagree with **[BH-MCO Name]**'s decision on your Complaint or Grievance, you may ask for an external review or a Fair Hearing or you may ask for both an external review and a Fair Hearing. Information about external reviews and Fair Hearings can be found in the member handbook.

6) How can I get help with my Complaint or Grievance?

If you need help filing a Complaint or Grievance, you can call **[BH-MCO Name]** at **[BH-MCO Phone# & Toll-free TTY/PA RELAY#]**.

To ask for free legal help with your Complaint or Grievance, you can contact:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org); or
- Pennsylvania Legal Aid Network at 1-800-322-7572 (https://palegalaid.net)

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**

[Provider]

ATTACHMENT 4b

Decision Notice After Peer-to-Peer Review

[Use for Denials Changed After a Peer-to-Peer Consultation]

[Date the notice is mailed]

[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member Identifier]**

Subject: Approval of Services After Peer-to-Peer Review

Dear **[Member or Parent/Guardian Name]**:

This is an important notice about your requested service(s). Read it carefully. Call **[BH-MCO Name]** at **[BH-MCO Phone # & Toll-free TTY/PA RELAY#]** if you have any questions or need help.

Based on a review of information provided to **[BH-MCO Name]** during a discussion with your provider, **[BH-MCO Name]** has changed its decision to deny the services requested for you and has approved all of the requested services.

The following services have been authorized from **[include date services were requested to start]** until **[include date authorized services will end]**:

- **[list all services approved, list must be the same as the list of services originally requested]**

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**

[Provider]

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UM DECISION TIMEFRAMES
HealthChoices, Act 146, and NCQA Comparison

TYPE OF REQUEST	HealthChoices		Act 146		NCQA	
	DECISION	NOTICE	DECISION	NOTICE	DECISION	NOTICE
Standard /Routine Non Urgent **(Pre-Service/ Prospective Utilization Review)**	At least verbally within 2 business days of receipt of request.	Written notice within 2 business days of decision.	Within 2 business days of the receipt.	Within 2 business days of communicating the decision.	Within 14 calendar days of receipt of request.	Electronic or written within 14 calendar days of request.
Standard / Routine Additional Information Extension **(Non-Urgent Pre-Service/ Prospective Utilization Review)**	Send additional information letter within 48 hours of receipt of request & allow up to fourteen (14) Days. The decision & verbal notice must be made within 2 business days from when the information is received or due date for information, whichever is sooner. Written notification must be within 2 business days of decision. Completed decision and notice must be received by Member within 21 days of receipt of request.		Request additional information within 48 hours of the request for service.		45 calendar days to provide additional information & 14 calendar days from receipt of information for decision & notice.	

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Urgent Prior Authorization **(Urgent Service Review)**	At least verbally within 2 business days of receipt of request.	Written notice within 2 business days of decision.	Within 2 business days of the receipt.	Within 2 business days of communicating the decision.	Within 72 hours of receipt of request.	Electronic or written notification of the decision with 72 hours of request.

Urgent Prior Authorization **(Pre-Service Review)** Additional Information Extension	If additional information is required for Urgent requests, PerformCare will notify the requestor immediately with what specific information is needed to make the decision, so that all urgent decisions are made within 24 hours of the receipt of an Urgent request. Peer-to-peer reviews when necessary are arranged and conducted so that all urgent decisions are made within 24 hours of the receipt of an Urgent request.		Request additional information within 48 hours of the request for service		Notify member of need for additional information within 24 hours of receipt of request. Allow 48 hours to provide information. Decision within 2 calendar days of receipt of information.	
Urgent Concurrent Review ** Non-Urgent Concurrent Review.	At least verbally within 1 business day of receipt of request. * At least verbally within 1 business day of receipt of request.	Written notice within 1 business day of receipt of request.	Within 1 business day of the receipt of all supporting information necessary to complete the review.	Written or electronic confirmation of the decision within 1 business day of communicating the decision.	Within 24 hours of receipt of request.	Electronic or written notification of the decision within 72 hours of request

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Post-service Review/ Retrospective	Within 30 calendar days of receipt of request. For PA Medicaid, post-service review only applies to 6 Criteria Dissatisfaction Complaints. A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or a denial of payment after a service has been delivered because the service is not a covered benefit.	Within 30 days of the receipt of all supporting information reasonably necessary to complete the review. Written or electronic confirmation of its decision with 15 business days of communicating the decision.	Within 30 calendar days of receipt of request.

NOTE: Most restrictive guideline must be used for all UM decision timeframes and notifications.