



DUE PROCESS FOR COVERED AND NON-COVERED SERVICES

**Jane Plaskie, RN, MS
Manager, Appeals Unit
Division of Medical Assistance
919-855-4260**

OBJECTIVES

- Describe the importance of due process.
- Describe how due process impacts prior approval.
- Explain how non-covered services may be requested.
- Explain the Medicaid recipient appeal process.

DEVELOPING THE REQUEST

- Must be developed and submitted by a provider in accordance with DMA's published procedures.

DEVELOPING THE REQUEST

CON'T.

- It is the responsibility of the provider to document medical necessity.
- Requests for prior approval of Medicaid services should be fully documented by the provider and treating clinicians to demonstrate medical necessity.

DEVELOPING THE REQUEST

CON'T.

- Providers are encouraged to supplement the information requested on prior approval forms and plan of care forms with other recent clinical information the provider believes will document medical necessity if the provider believes the information requested on the form is not sufficient to fully document medical necessity for the requested service.

DEVELOPING THE REQUEST

CON'T.

- This additional documentation may include recent evaluation reports from clinicians, recent treatment records, and letters signed by treating clinicians which explain why the service is medically necessary.

DEVELOPING THE REQUEST

CON'T.

- For children under the age of 21, documentation must also show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem] as well as meet all other EPSDT criteria.

DEVELOPING THE REQUEST

CON'T.

- This includes:
 - documentation showing that policy criteria are met;
 - documentation to support that all EPSDT criteria are met; and
 - evidence-based literature to support the request, if available.

DEVELOPING THE REQUEST

CON'T.

- EPSDT criteria are found on the DMA website

<http://www.dhhs.state.nc.us/dma/provider/epsdthealthcheck.htm>.

SUBMITTING THE REQUEST

- Requests must be submitted to the appropriate vendor or Medicaid based on the service type and in accordance with Medicaid's published clinical coverage policies and procedures.
- In an effort to assure that needed information is submitted and to expedite the review, providers may use program specific forms to request prior approval.

SUBMITTING THE REQUEST

CON'T.

- Must request re-authorization of service **14 days PRIOR to end of current authorization period** for payment authorization to continue without interruption until the effective date of the notice (10 days from date notice is mailed).
- Must submit the re-authorization request **PRIOR to the end of the current authorization period** in order for services to continue.

REVIEWING THE REQUEST

- Requests will be reviewed under the clinical coverage policy criteria as well as the EPSDT criteria.
- Medicaid will fully comply with these requirements.
(NOTE: EPSDT does not cover habilitative services).
- Medicaid will consider all relevant information that is submitted, regardless of whether it is included on a particular form.

REVIEWING THE REQUEST

CON'T.

- Medicaid will:

- Make medical necessity decisions based on the individual facts of each prior authorization request.
- Use available utilization review and best practice standards.

PROPER PA REQUEST

- See the clinical coverage policies and the PA section of the Basic Medicaid Billing Guide on DMA's website at:
 - **Policies:** <http://www.ncdhhs.gov/dma>
 - **Guide:** <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

PROPER PA REQUEST

CON'T.

■ Medical and Dental Services

- Recipient's name and address, MID number, and date of birth
- Provider contact information, including signatures, if required
- Date of service
- Service requested

■ MH/SAS/DD

- Medical and dental requirements
- <http://www.dhhs.state.nc.us/MHDDSAS/servicedefinitions/servdefupdates/index.htm>

IMPROPER PA REQUEST

- If the request is missing required information, it will be considered improper.
- The request will be returned to provider.

IMPROPER PA REQUEST

CON'T.

- The recipient will be notified by the provider submitting the request that:
 - The request was returned.
 - No further action is required by DMA or the vendor/contractor.

ACTING UPON A REQUEST

- Acting upon a request means:
 - Approving the request
 - Denying an initial request (DMA 2001/2001E)
 - Reducing/terminating a concurrent request (DMA 2002/2002E)
 - Requesting additional information (DMA 3501/3501E)

ACTING UPON A REQUEST

CON'T.

- DMA staff and vendors or contractors must act upon a request no later than 15 business days of receipt of the request, unless there is a more stringent requirement.
- An emergent request must be reviewed and acted upon within two business days of receipt of the request, unless there is a more stringent requirement.

ACTING UPON A REQUEST

CON'T.

- Providers and recipients will not be asked to withdraw or modify a request for prior approval of Medicaid services in order to accept a lesser number of hours, or less intensive type of service, or to modify a SNAP score or other clinical assessment.

ACTING UPON A REQUEST

CON'T.

- When a proper request for prior approval may be made verbally and it can be approved, the caller will be notified that the request for prior approval:
 - is approved effective the date of the call contingent upon receipt of the written request within 15 business days of the call, unless there is a more stringent requirement, and
 - will be denied if the written request is not received within 15 business days of the call, unless there is a more stringent requirement.

ADDITIONAL INFORMATION

- The provider will be notified in writing or verbally if additional information is required.

If requesting additional information **verbally**:

- The caller will read a statement indicating that additional information is being requested verbally and that this is not an attempt to have the provider withdraw or modify the request but an opportunity to provide additional information.
- Most often, additional information requested verbally can be provided verbally at the time of the call.

This should not be construed to prevent clinical or treatment discussions or educational discussions about Medicaid services.

ADDITIONAL INFORMATION

CON'T.

- If additional information is requested in writing:
 - The provider will be allowed 15 business days from the date of the request to submit the additional information or to request an extension of time (verbally or in writing).

ADDITIONAL INFORMATION

CON'T.

- DMA staff and vendors/contractors must act upon the written request within 15 business days of receipt of the additional information, unless there is a more stringent requirement.
- If there is no response, the recipient will be notified in writing that the request was denied for insufficient information.

DUE PROCESS NOTICES

- If a recipient's service is denied, reduced, or terminated, the recipient must receive a written explanation that **specifically**:
 - states why the service was denied, reduced, or terminated,
 - identifies citation(s) and website(s) supporting the adverse action,
 - describes how to appeal the decision,

DUE PROCESS NOTICES

CON'T.

- states the effective date (initial and concurrent request),
- states alternate services and amount approved or willing to approve, and
- includes the telephone number of a contact person who can answer questions about the reasons for the decision in this case.

EFFECTIVE DATES OF NOTICES

- Initial Request (services not authorized during the 10 days prior to the request): date notice mailed
- Concurrent Request (services authorized on the day immediately preceding the adverse decision): 10 days from the date notice mailed

CITATION SOURCES

- Federal or state law
- Federal or state rules
- Waivers
- Promulgated Policies
- State Medicaid Plan

MAILING NOTICES

- Recipient notices are mailed via trackable mail to the last known address filed by the recipient with his/her county DSS.
- Notices should be mailed at least 10 days before the effective date of an adverse decision.
- Date on the notice and appeal request form is the date the notice was mailed.

Mailing contains notice, information and instruction sheet, appeal form.

MAILING NOTICES

CON'T.

- For recipients under 21 years of age or recipients who have been adjudicated incompetent and if the provider has knowledge that the parent or legal guardian does not reside at the address shown on the notice, they are required to forward the notice to the address they have on file for the parent or legal guardian or assist them to contact Medicaid for a duplicate notice.

MAILING NOTICES

CON'T.

- A copy of the recipient notice is mailed via USPS first class mail to the last known provider address filed by the provider with Provider Services.

Mailing contains notice and information and instruction sheet.

MAILING NOTICES

CON'T.

- If the notice is returned undelivered and it was properly addressed to the latest address on file in EIS, a copy of the notice shall be forwarded to the recipient's county Department of Social Services (DSS) so that DSS can take appropriate action.

MAILING NOTICES

CON'T.

- Any recipient who believes he or she did not receive notice of a decision on a request for prior approval should contact the CARELINE (1-800-662-7030) between the hours of 7:00 a.m. and 11:00 p.m.

DUPLICATE NOTICES

- Duplicate copies of notices may be obtained by calling:

Appeals Unit

Division of Medical Assistance

919-855-4260

DUPLICATE NOTICES

CON'T

- Should Medicaid make an error in the mailing, for example by addressing the mailing to the wrong person or address, a new notice with an updated date will be issued.
- If the notice is returned undeliverable and it was properly addressed, a duplicate notice will be issued but the date will not be updated.

APPEALING THE DECISION

- Recipient and/or legal guardian must:
 - Request a hearing within 30 days of the date of the notice was mailed.
 - Mail or fax the request to the Office of Administrative Hearings (OAH).

Clerk of Court
6714 Mail Service Center
Raleigh, NC 27699-6714
FAX: 919-431-3000

APPEALING THE DECISION

CON'T.

- A recipient or legal guardian may request an in-person hearing in Raleigh, telephone hearing, or video conference hearing.
- If requesting an in-person hearing other than Raleigh, the recipient or legal guardian must enclose a short letter with the appeal request form stating why they wish to have an in-person hearing and why coming to Raleigh is a hardship on them.

UNDERSTANDING THE HEARING PROCESS

- **Fair Hearing Process (OAH and Final Agency Decisions)**—completed in 90 days from the date hearing request received by OAH

Three Phases

- **OAH Proceeding**—completed within 55 days of receipt of hearing request by OAH
- **Mediation (voluntary)**—completed within 25 days of receipt of hearing request by OAH
- **Final Agency Decision**—completed within 20 days of receipt of case from OAH

UNDERSTANDING THE HEARING PROCESS

CON'T.

- **Superior Court**

Final agency decision may be appealed to Superior Court within 30 days of the date the final agency decision was mailed.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

MEDIATION

- Informal process to explore options for a mutually acceptable resolution to the recipient's appeal.
- Voluntary and may be accepted or declined by the recipient.
- Free and may resolve the case more quickly than a fair hearing.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- Case referred to the Mediation Network of North Carolina.
- The recipient will be contacted by the mediator within five days of receipt of case from OAH.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- The mediator serves as a neutral party whose role is to guide the mediation process, facilitate communication, and assist the parties to generate and evaluate possible outcomes.
- The recipient and their representatives may participate in person or by telephone. Medicaid staff/vendors participate by phone.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- The recipient may invite anyone to participate in the mediation as long as all parties involved in the mediation agree.
- New evidence may be presented at the mediation that has not been seen or heard by the Medicaid agency before. Medicaid representatives may need a recess to review and respond to the new information.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- The recipient does not have to accept any offer made during mediation.
- If recipient agrees to mediation and if mediation resolves the case, the appeal will be dismissed, and services will be provided as agreed to during the mediation.
- Mediation must be completed within 25 days of receipt of appeal request by OAH.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- If the recipient does not accept the offer of mediation or if the mediation does not succeed and the recipient still wishes to proceed with a hearing, the case will be scheduled for hearing.
- Mediator must report to OAH that the case was not resolved, recipient rejected the offer of mediation, or recipient failed to appear.
- **Mediation is confidential and legally binding.**

UNDERSTANDING THE APPEAL PROCESS

CON'T.

FAIR HEARING

- OAH will not hold a hearing until the recipient has had an opportunity to resolve the case through mediation. (*Completed within 55 days of receipt of hearing request by OAH and includes 25 days for mediation*)

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- The hearing will be held by an administrative law judge (ALJ).
- Recipient may represent himself/herself or may hire an attorney or use a legal aid attorney, or ask a relative, friend, or other spokesperson (including provider or case manager) to speak for them.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- ALJ may allow brief extensions of the timeline on fair hearings for **good cause** to ensure the record of the proceeding is complete.

SL 2008-118 defines **good cause** to include delays from untimely receipt of documentation to render a decision and other unavoidable and unforeseen circumstances.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- Continuances will not be granted on the day of the hearing except for **good cause** (*not defined by the SL 2009-118*).
- If hearing properly noticed by OAH and petitioner fails to make appearance, hearing will be immediately dismissed.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- The hearing will be held by telephone unless the recipient specifically requests an in-person or videoconference hearing.
- An in-person hearing will be held at OAH in Wake County (Raleigh) unless the recipient can show **good cause** why he/she cannot come to Wake County for the hearing.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- If a hearing is held outside of Raleigh, it will be held at one of the OAH sites listed below that is closest to the recipient's county of residence.
 - Newton/Asheville
 - Charlotte
 - High Point
 - Fayetteville
 - Wilmington
 - Elizabeth City/Halifax
 - New Bern

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- To have a videoconference hearing, the recipient must have access to a computer with a camera and videoconference software (such as Skype).
- If the recipient chooses a telephone hearing, OAH can call the recipient's witnesses and representative at different telephone numbers to participate in the hearing. Even if the recipient has an in person hearing, he/she can ask that a witness such as their physician participate by telephone.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- The recipient can request an in person hearing in their county of residence even if they filed the appeal form asking for a telephone hearing. To do so, the recipient needs to contact OAH.

UNDERSTANDING THE APPEAL PROCESS

CON'T

■ Burden of Proof

- **Initial Request:** Petitioner has burden of proof to show entitlement to requested benefit or service when request denied.
- **Concurrent Request:** Medicaid has burden of proof when decision is to reduce, terminate, or suspend previously requested benefit or service.

UNDERSTANDING THE APPEAL PROCESS

CON'T

- The recipient may present new evidence at the hearing. This includes medical records and written reports (even if obtained after Medicaid made its decision), testimony from physicians and other providers about why the recipient needs the service, and testimony by family and friends.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- If new evidence is submitted at the hearing that Medicaid has not reviewed, Medicaid may request additional time for review.
- The administrative law judge shall continue or recess the hearing for a minimum of 15 days and a maximum of 30 days to allow for Medicaid's review.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- The recipient has a right to review all of the documents in Medicaid's file about his/her case **before the hearing date.**
- Copies of these documents should be given to the assistant attorney general so that they can be mailed by trackable mail to the recipient.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- The hearing date will be postponed only in accordance with OAH rules and will not be granted on the day of the hearing, except for good cause shown.
- If the recipient and/or legal guardian fails to appear at the hearing, OAH will dismiss the appeal.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- DHHS will be represented by an assistant attorney general.

- Two or more DHHS witnesses will testify at the hearing.
 - The Medicaid witness will discuss the clinical coverage policy.
 - The vendor witness will discuss the clinical decision.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- The assistant attorney general will ask questions of the Medicaid and vendor witnesses as well as the recipient or legal guardian and his/her witnesses.
- The recipient has the right to ask questions of his/her witnesses and to ask questions of the witnesses who testify for the Medicaid agency.
- The judge can also ask questions.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- After the hearing, the administrative law judge will make a decision within 20 days of the date of completion of the hearing and will send that decision to the recipient and to the Medicaid agency.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

■ Fair Hearing Decision (Not to be acted on)

Judge must decide if Medicaid:

- Exceeded its authority or jurisdiction
- Acted erroneously
- Failed to use proper procedure
- Acted arbitrarily or capriciously or
- Failed to act as required by law or rule

UNDERSTANDING THE APPEAL PROCESS

CON'T.

■ FINAL AGENCY (MEDICAID) DECISION

- The Medicaid agency will make the final agency decision within 20 days of receipt of the case from OAH.
- Each party is given an opportunity to provide written exceptions by telling why they agree/disagree with the decision made by the ALJ.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- If the final agency decision reverses the OAH decision, the decision must provide information that supports reversal of the decision.
- The final agency decision will be mailed to the recipient by trackable mail.

UNDERSTANDING THE APPEAL PROCESS

CON'T.

■ **Decisions That Uphold Agency Decision**

A final agency decision that upholds the agency action shall be implemented no later than **three business days from the date the decision was mailed** to the recipient and/or the legal guardian at the correct, current address filed by the recipient with his/her county Department of Social Services.

UNDERSTANDING THE APPEAL PROCESS CON'T.

- **Decisions that Reverse the Agency Decision in Part or in Full**
 - Payment for the services approved in the final agency decision will be authorized as specified in the decision (usually 20 calendar days after the date of the decision).
 - The final agency decision also states when the next service request must be submitted (usually 15 business days from decision). ⁶⁶

UNDERSTANDING THE APPEAL PROCESS

CON'T.

- The final agency decision may be appealed to Superior Court within 30 days of the date of the final agency decision.
- The recipient or legal guardian must file a Petition for Judicial Review with Clerk of Superior Court, Civil Division, Wake County or county of residence.

REQUESTING NON-COVERED SERVICES FOR RECIPIENTS UNDER 21 YEARS OF AGE

- The provider may submit a Non-Covered Services Request for Recipients **under 21 Years of Age** form on behalf of the recipient to:

Assistant Director for Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: 919-715-7679

REQUESTING NON-COVERED SERVICES FOR RECIPIENTS UNDER 21 YEARS OF AGE

CON'T.

- The Non-Covered State Medicaid Plan Services for Recipients under 21 Years of Age Request form may be found on DMA's website at:

<http://www.dhhs.state.nc.us/dma/forms.html>

REQUESTING NON-COVERED SERVICES FOR RECIPIENTS UNDER 21 YEARS OF AGE

CON'T.

- All due process procedures apply in their entirety.
- The recipient is notified in writing if the request is denied or if more information is requested from the provider.

MAINTENANCE OF SERVICES

- If the recipient appeals within **10 days of the date the notice was mailed**, payment for services and service provision will not be interrupted.
- If the recipient appeals within **30 days of the date the notice was mailed** and services were stopped or reduced, services will be reinstated.

As long as the recipient remains otherwise Medicaid eligible, unless he/she gives up this right

MAINTENANCE OF SERVICES

CON'T.

- Services will be provided at the same level the recipient was receiving the day before the decision or the level requested by the provider, whichever is less.
- If the recipient elects to continue services for the pendency of the appeal, the provider must render services at a rate and frequency that is medically necessary to meet the recipient's individual needs.

MAINTENANCE OF SERVICES

CON'T.

- Services must be provided in accordance with all DMA (Medicaid), licensure and certification, and all other applicable federal and state statutes and rules requirements.
- **IF THE RECIPIENT LOSES HIS/HER APPEAL, HE/SHE MAY BE REQUIRED TO PAY FOR THE SERVICES RECEIVED BECAUSE OF THE APPEAL.**

AUTHORIZATIONS

- If a decision on a timely reauthorization request cannot be made **at least 10 days before the end of the previously approved period**, the authorization for payment at the current level or the level requested by the provider, whichever is less, **MUST** be extended before it expires in order to assure that authorization in the computer continues without interruption until 10 days after the Change Notice is mailed.

AUTHORIZATIONS

CON'T.

- Within five (5) business days after DMA is notified of the filing of a Hearing Request with OAH that occurs within 10 days after the date the Change Notice is mailed, authorization for payment in the computer system must be entered and must continue without interruption until the UR contractor is notified that the appeal has been resolved, either through mediation, dismissal, or a final agency decision, as long as the recipient does not give up this right and as long as he/she remains otherwise eligible for the service.

AUTHORIZATIONS

CON'T.

- Within five (5) business days after DMA is notified of the filing of a Hearing Request with OAH that occurs within 30 days of the date the Change Notice is mailed, authorization for payment must be reinstated, retroactive to the day after the expired authorization period. Authorization for payment must be at the level provided on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.

AUTHORIZATIONS

CON'T.

- When a recipient changes providers during the appeal process, authorization for payment must be transferred to the new provider within five (5) business days of notification by the new provider to the appropriate utilization review vendor. Such authorization must be retroactive to the last date of service for which the previous provider was paid or to the first date services were provided by the new provider, whichever comes last.

CHANGING PROVIDERS DURING CURRENT AUTHORIZATION PERIOD

- For Medicaid services with an authorization period of 90 days or less and the provider has gone out of business, authorization for payment will be transferred to the new provider within five days of receipt by the appropriate vendor. See required items.
- For CAP-MR/DD services with an authorization period of more than 90 days and if a Medicaid recipient changes providers for any reason, authorization for payment will transfer to the new provider within five days of receipt by the appropriate vendor. See required items.

CHANGING PROVIDERS DURING CURRENT AUTHORIZATION PERIOD

CON'T.

- Such authorizations shall be retroactive to the date that the new provider submits a copy of the written attestation.

CHANGING PROVIDERS DURING CURRENT AUTHORIZATION PERIOD

CON'T.

- Required Items For **Written Attestation** that New Provider Must Submit When Recipient Changes Providers
 - provision of the service meets Medicaid policy
 - and
 - the recipient's condition meets coverage criteria

CHANGING PROVIDERS DURING CURRENT AUTHORIZATION PERIOD

CON'T.

- When a recipient changes providers for any reason, regardless of the length of the authorization and regardless of whether the previous authorization was transferred, the procedures regarding services during the appeal process apply to the new provider's request for authorization if received at least 14 calendar days before the previous authorization period ends.

FEDERAL CITATIONS

- **42 C.F.R. 431.200 - .250 (42 C.F.R. Subpart E)**
Medicaid applicants and recipients are entitled to a fair hearing when an adverse decision is made.
- **42 U.S.C. 1396a(a)(3)**
State plan for medical assistance must grant an opportunity for a fair hearing.
- **42 C.F.R. Subpart J**
Regulations regarding applications for Medicaid

STATE CITATIONS

(Citation) S.L. 2008-118 s. 3.13(a), effective July 01, 2008 (former HB 2438 Section 10.15A(h1) specifies:

- types of adverse decisions that may be appealed
- service of notice
- who can appeal the adverse determination
- content requirement of notice
- when and how appeal should be filed
- format of the appeal request form
- final agency decision and timeline

STATE CITATIONS

CON'T.

(Citation) S.L. 2008-118 s. 3.13(b), effective July 01, 2008 (former HB 2438 Section 10.15A(h2-h6) addresses the following:

- (h2): application of the law, simplified OAH procedures, mediation, burden of proof, and decision
- (h3): transference of DHHS funds to OAH for the conduct of the appeals process
- (h4): discontinuance of DHHS recipient informal appeal process effective October 01, 2008
- (h5): performance of DHHS informal review prior to issuing notice of adverse determination
- (h6): required reports from DHHS and OAH to the General Assembly re costs, effectiveness, and efficiency of the Medicaid appeals process on March 10, 2009, October 01, 2009, and March 01, 2010, and expiration of the law on July 01, 2010.

Additional procedures for conducting a hearing are found in the North Carolina Administrative Procedure Act (N.C.G.S. §§ 150B-22 to -52).

STATE CITATIONS

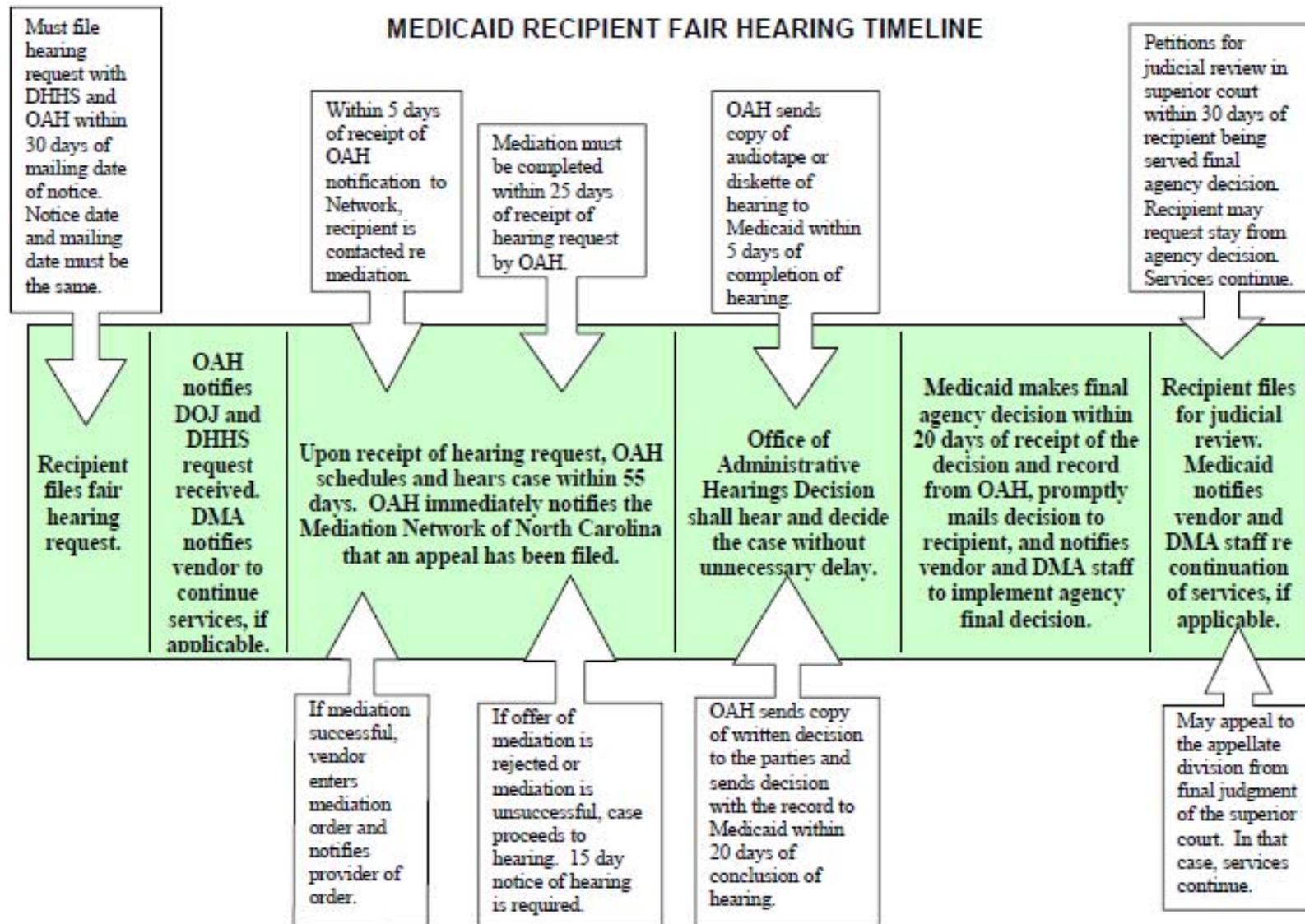
CON'T.

(Citation) S.L. 2009-526, s. 2.(a) and (b)
effective August 26, 2009, made various
clarifying changes

to

S.L. 2009-118 s. 3.13(b), effective July 01,
2008.

MEDICAID RECIPIENT FAIR HEARING TIMELINE



RECIPIENT NOTICES

- DMA 2001(A,E, NCS)—Notice of Decision-Initial Request for Medicaid Service
 - Applies to services not authorized during 10 days prior to the request)
 - Must complete all shaded areas of notice.

RECIPIENT NOTICES

CON'T.

- DMA 2002(E)—Notice of Decision-Continuing Request for Medicaid Services
 - Applies to services that were authorized on the day immediately preceding the adverse decision.

 - Applies when a decision both denies authorization for payment for a **NEW** service and **CHANGES** authorization for payment of an existing service.

RECIPIENT NOTICES

CON'T.

DMA 2002(E) con't.

- Effective date: 10 from date notice is mailed
- If alternate services approved versus the one requested, notice will specify what service and how much is being approved or what service and how much Medicaid is willing to approve as an alternate to the requested service.

RECIPIENT NOTICES

CON'T.

DMA 2002(E) con't.

- The beginning date of the period for which the alternative or lower level services are approved must be the same date as this effective date.
- Must complete all shaded areas of notice.

RECIPIENT NOTICES

CON'T.

- DMA 2003(NCS)—Appeal Request Form
 - Complete the header and shaded areas.
 - Form:
 - ❖ **Must be one page.**
 - ❖ **Cannot be duplexed to another page.**
 - ❖ **Is mailed only to the recipient and/or his/her legal guardian.**

RECIPIENT NOTICES

CON'T.

- DMA 3501(E)—Additional Information
- DMA 3503—Return of Improper Request
- DMA 3504—Notice of Approval
- DMA 1059—Notice When Request Exceeds Policy Limits
- Additional Template Notices

LOCATION OF RECIPIENT NOTICES TEMPLATES

Shared Drive

All Users

DMA Templates

2009 Templates (adult, children, provider)

UPLOADING TO DOCUMENT MANAGEMENT SYSTEM

- Documentation management system is operated on behalf of the State by PCG.
- All DMA and vendor staff are required to upload adverse notices to the secure on-line document management system or to work out a transfer process with PCG.
- The upload process is a two step process.