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NOTICE OF DECISION ON A CONTINUING REQUEST FOR MEDICAID SERVICES

September 16, 2010

To the Parent/Legal Representative/Authorized Representative of
Josh A Smith
122 Pincrest Road
Durham, NC 27705

The Hughes Center For Exceptional Children
1601 Franklin Turnpike
Danville, VA 24540

RE: Josh A Smith
MID#: [redacted]

Dear Parent/Legal Representative/Authorized Representative:

The above named provider requested prior approval for 30 days of PRTF services for the period September 9, 2010 through October 8, 2010. After reviewing the documentation submitted by the provider, Medicaid reduced this request to 6 days for the reasons set forth below. Pursuant to Section 10.15A.(h1)(2) of Session Law 2008-118, Medicaid is required to give 10 days notice of this denial of prior approval. This denial is effective 10 days from the date this notice was mailed. Medicaid will pay claims for additional days of PRTF services in excess of the 6 days which have been approved during the 10 day notice period. However, payments for services not specifically approved shall be subject to recoupment. This letter explains why the decision was made and tells you how to appeal if you disagree.

It is also important to note that you **may** also be eligible for other Medicaid services. Please check with your physician, other licensed clinician, or provider to determine if other Medicaid services are appropriate for you.

As the recipient is under 21 years of age, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) apply. EPSDT makes services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver OR for adults (recipients over 21 years of age). Specifically, the service limitations on scope, amount, duration, frequency, and other specific criteria described in DMA's clinical coverage policies may be exceeded or may not apply if

documentation submitted by the provider shows that all EPSDT criteria are met. The services must be prescribed by the recipient's physician, therapist, or other licensed practitioner.

When a recipient is under 21 years of age, the provider's request for service is evaluated under the applicable Medicaid clinical coverage policies as well as the EPSDT criteria. If the request cannot be approved under the clinical coverage policy criteria, all of the EPSDT criteria must be met to approve the request.

Based on the information submitted by the provider, the recipient does not meet medical necessity because:

Per NC Medicaid Criteria a,b,c,d, or e, in addition to f and g, are sufficient for discharge from this level of care:

- The child/adolescent can be safely treated at an alternative level of care.

As the recipient is under 21 years of age, the request was also evaluated under the EPSDT criteria. Medicaid reduced this request because the criterion/criteria specified below was/were not met:

• The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner.

The decision is based on the authority granted to the North Carolina Department of Health and Human Services and its contractors by the Code of Federal Regulations, Chapter 42 Part 431, Subpart E, N.C.G.S. §108A-25(b) and §108A-54, as well as the law(s) and policy(ies) specified below.

- Psychiatric Residential Treatment Facility Services Clinical Coverage Policy 8D-1, 3.3 A - G (http://www.ncdhhs.gov/dma/mp/)
- American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters and Guidelines (www.aacap.org)
- North Carolina Administrative Code 10A NCAC 22O .0301
- United States Code 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]

Medicaid's clinical coverage policies and EPSDT policy can be found at the websites listed below.

http://www.ncdhhs.gov/dma/mp/mpindex.htm
http://www.ncdhhs.gov/dma/EPSDTprovider.htm

YOU HAVE THE RIGHT TO APPEAL THIS DECISION. If you decide to appeal the decision, you must file for an evidentiary hearing with the Office of Administrative Hearings. **YOU HAVE 30 DAYS FROM THE DATE THIS DECISION LETTER WAS MAILED TO FILE THE REQUEST FOR HEARING.**

To learn more about the hearing process or to speak with a Medicaid clinical policy analyst about this decision, call the Appeals Unit, Division of Medical Assistance at 919-855-4260. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030** and request that your call be transferred. The enclosed general information sheet also explains the hearing process.

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THE HEARING PROCESS AND FILING THE REQUEST:

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed hearing request form to Clerk, Office of Administrative Hearings **AND** General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed**. As the mailing date is located on the envelope, **please keep the envelope containing this decision letter**.
- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.
- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the hearing process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.
- If a continuing request for services is denied and you submit a request for a hearing within 30 days of the date this decision letter was mailed and as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. This right to receive services applies even if you change providers. Services will be provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations.
- If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

Free legal aid may be available to assist with your appeal. Contact your nearest Legal Aid of North Carolina office or call 1-919-856-2564 or toll-free at 1-866-369-6923 to obtain the telephone number of the office that serves your community.

Sincerely,

ValueOptions, Inc.
(888)-510-1150/(jr)

Enclosure: Recipient Hearing Request Form, DMA 2003
(Only the recipient may appeal the decision).

cc: Provider

Appeals Unit, Division of Medical Assistance
Office of Administrative Hearings

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FOR YOUR INFORMATION ONLY
DO NOT SEND THIS PAGE WITH A COMPLETED HEARING REQUEST FORM
GENERAL INFORMATION ABOUT THE HEARING PROCESS

UNDERSTANDING THE APPEAL PROCESS: If you choose to appeal, you may represent yourself during the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you. Your case will begin as soon as the completed recipient hearing request form that you were sent in this mailing is **received and filed** with the Office of Administrative Hearings (OAH) **AND** the Department of Health and Human Services (DHHS). You will be contacted by the Office of Administrative Hearings or the Mediation Network of North Carolina to discuss your case and to be offered an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina. If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing and will be heard by an administrative law judge with the Office of Administrative Hearings. You will be notified by mail of the date, time, and location of your hearing. The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision. If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court. The hearing process must be completed within 90 days of receipt of your completed Recipient Hearing Request Form. For more information about the hearing process, visit the websites indicated below.

- **Adults:** http://www.ncdhhs.gov/dma/Forms/abd.pdf,
- **Children:** http://www.ncdhhs.gov/dma/Forms/famchld.pdf.

SERVICES DURING THE APPEAL PROCESS: If a **continuing** request for services is denied and you submit a request for hearing within **30 days of the date the notice was mailed and** as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if you change providers.** The service will be provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations. If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

FILING A RECIPIENT HEARING REQUEST FORM WITH OAH AND DHHS: Complete the enclosed Recipient Hearing Request Form if you decide to appeal Medicaid's decision to deny, terminate, reduce (change), or suspend the services requested by your provider. Hearing requests must be served on **BOTH** OAH and DHHS. The request must be filed by mail or fax within **30 days of the date the notice was mailed**. The mailing addresses and telephone and fax numbers for OAH and DHHS appear below.

For questions concerning the decision Medicaid made about your provider's request for service, please contact Medicaid. Should you have questions about the appeal process, please contact OAH. You may also contact the Appeals Unit, Division of Medical Assistance (Medicaid) if you have questions.

AGENCY	MAILING ADDRESS	OFFICE NUMBER	FAX NUMBER
Office of Administrative Hearings (OAH)	Clerk 6714 Mail Service Center Raleigh, NC 27699-6714	919-431-3000	Clerk 919-431-3100
Division of Medical Assistance (Medicaid)	Appeals Unit Clinical Policy and Programs 2501 Mail Service Center Raleigh, NC 27699-2501	919-855-4260 Toll-free: 1-800-662-7030 Ask for your call to be transferred to the DMA Appeals Unit, Clinical Policy and Programs.	Appeals Unit 919-733-2796

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RECIPIENT HEARING REQUEST FORM

COMPLETE THIS FORM IF YOU WISH TO APPEAL MEDICAID'S DECISION

Date: September 16, 2010 **Period: September 9, 2010 to October 8, 2010**
Decision made by: [ ] DMA [ ] ACS [ ] CCME [ ] EDS [ ] Murdoch [ ] PBH [X] VO
Type of Request: [ ] Initial/No Service in Place [X] Continuing/Concurrent
Type of Notice Issued: [ ] 2001 [ ] 2001A [ ] 2001E [ ] 2001NCS [ ] 2002 [X] 2002E

SEND COPY OF FORM TO:
Office of Administrative Hearings (OAH)
Attention: Clerk
6714 Mail Service Center
Raleigh, NC 27699-6714
Telephone: 919-431-3000
Fax: 919-431-3100

SEND COPY OF FORM TO:
Department of Health and Human Services
Attention: Appeals
2501 Mail Service Center
Raleigh, NC 27699-2501
Telephone: 919-855-4260
Fax: 919-733-2796

Josh A Smith (MID # 946134832L)
122 Pincrest Road
Durham, NC 27705

DIRECTIONS: Please complete the Recipient Hearing Request Form if you decide to appeal Medicaid's decision to reduce services. Send the completed request form by mail or fax to OAH **AND** DHHS at the addresses or fax numbers in the above boxes. The hearing request form must be received within **30 days of the date this notice was mailed**. You may represent yourself during the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to represent you. By signing this form, you authorize the person(s) listed below to represent you during the appeal, to discuss your case, and to release any and all medical records or other documents and confidential information that pertain to the hearing. You also attest that **BOTH** OAH and DHHS have been served.

I would like to appeal the reduction of 30 days of PRTF services for the period September 9, 2010 through October 8, 2010 to 6 days of PRTF services for the period September 9, 2010 through September 14, 2010.

Please check one.

☐ I will represent myself.

☐ I will be represented by someone else other than myself. If yes, please provide the information requested below.

Name of Representatives	Relationship to Recipient	Address	Telephone Number
			( ) -
			( ) -

I understand if a **continuing** request for services is denied **and** I submit a request for hearing within **30 days of the date this notice was mailed and** as long as I remain otherwise Medicaid eligible, unless I give up this right, I am entitled to receive services during the pendency of the appeal. **This right to receive services applies even if I change providers.** Services will be provided at the same level I was receiving the day before the decision or the level requested by my provider, whichever is less. The services that continue must be based on my current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations. If I lose my appeal, I understand that I may be required to pay for the services that continue because of the appeal.

_____ _____ (_____)_____
Signature of Medicaid Recipient/Applicant or Legal Representative Date Telephone Number

Print Name of Medicaid Recipient/Applicant or Legal Representative: _____
Full Mailing Address: _____