<<PLACEHOLDER FOR MCE & HCPF CO-BRANDING>>

Must include Alt text, Cannot be inside Header

<<Month DD, YYYY>>

<<Name Of Member>>
<<Address>>
<<City, State, Zip>>

<<Denial/Partial Denial>> of service

Dear <<Member's Name/Parent Or Guardian Of Member's Name>>:

We are <<RAE>>, your Health First Colorado (Colorado's Medicaid program) regional organization. As your regional organization, we manage some of your behavioral health services.

On <<date>>, we received a request from <<requester (e.g., provider, you, etc., include name and title where possible>> for <<service description and amount/duration>>. After review, we decided to <<partially deny/deny>> the request on <<effective date of decision>>.

OPTIONAL-If partial denial, add the following section
Of the requested amount, we have approved <<insert description of the amount partially approved>>.

Important: This decision is only for the service listed in this letter. Your other health benefits are not changing.

If you disagree with our decision, you can appeal it. You must appeal it by <<calculate 60 calendar days from date on letter>>. See the "**If you disagree with this decision**" section in this letter for instructions and "**For help with your appeal or state fair hearing**" for help.

How we made our decision

Select ONE option based on SUD vs non-SUD service

NON-SUD REASON:
We review service requests using medical necessity criteria. After reviewing the information we received from your provider, we have <<partially denied/denied>> the request for <<service description - including amount/duration/dates of service requested>> because

<<provide relevant medical necessity criteria and provide explanation of how the member did not meet criteria and how that informed your decision in a manner that is easy for the member to understand.>>

***** OR *****

SUD REASON:
We review service requests using medical necessity criteria. After reviewing the information we received from your provider, we have <<partially denied/denied>> the request for <<service description - including amount/duration/dates of service requested>> because of the following American Society of Addiction Medicine (ASAM) criteria:

<<Using the ASAM criteria dimension table as reference, choose an option from each dimension and list here>>:

You can talk to your provider about other services you may qualify for. <<Describe services or level of care they may qualify for>>.

Services for members age 20 or younger

If you are age 20 or younger, your request was also reviewed for medical necessity under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) regulations at 10 C.C.R. 2505-10, Section 8.280. EPSDT provides comprehensive and preventive health care services for individuals age 20 or younger who are enrolled in Medicaid. <<MCE>> is responsible for coordinating EPSDT services even when the services are not covered by <<MCE>> and can help you.

If you have questions or need help

We can help coordinate or connect you to other health care options. We can also provide more information about this decision. You or your representative can ask us for a free copy of your file, including medical records, a copy of the guidelines, and other documents and information on why we made the decision in this letter. For help or more information, call <<MCE>>> at **<<Phone>>.** For callers with speech or hearing disabilities call **TTY << Phone>>**. This information will be provided at no cost.

Sincerely,

<<MCE>>

<<CC:>>

If you disagree with this decision

You have the right to appeal any decision about your health coverage.

First, appeal the decision with <<MCE>>

You must file your appeal with us no later than **60 calendar days** from the date of this letter. A health care professional at <<MCE>> will review your appeal. The reviewer will not be the same person who made the decision in this letter. The last day you can ask us for an appeal is <<calculate 60 calendar days from date on letter>>.

You can file your appeal in any of these ways:

- Send an email to <<MCE Email>>
- Call us at <<MCE Phone>> to tell us you want to appeal. TTY <<Phone>> State Relay 711 for callers with speech or hearing disabilities
- Send a letter to:

  <<MCE>>
  <<Address>>
  <<City, State, Zip>>

- Send a fax to <<Fax>>

Your appeal must include:

- Your name
- Your mailing address and phone number
- Your Health First Colorado Member ID
- A statement that says you are appealing a decision about your care
- Your signature (if you send a letter)

It is also helpful to include:

- Any documents that show why you disagree, like a letter from your provider
- A copy of the decision letter
- A request for an interpreter or other accommodations you need

If you need a faster appeal decision

If you or your provider thinks waiting 10 business days for a decision on your appeal might seriously put your life and health at risk, you can ask for a faster (expedited) appeal. When you file your appeal, tell us if you need a faster appeal, and why you need it. If we agree a faster appeal is necessary, we will contact you with our appeal decision within 72 hours of receiving your faster appeal request. If we do not agree that a faster appeal is necessary, we will contact you within 2 calendar days.

What happens after you ask for an appeal

<<MCE>> will confirm that we received your request within **2 business days** and give our decision within **10 business days**. You or the <<MCE>> can ask for an additional **14 calendar days** if necessary.

We will send you a letter and contact you by phone to let you know of our decision or any extensions. If you do not receive a decision within **10 business days**, or you disagree with the appeal decision you may ask for a state fair hearing. See "**How to ask for a state fair hearing**" for instructions.

Help from a designated representative

You can choose someone to file the appeal for you. It can be a friend, family member, provider, or anyone you trust. To designate someone as your representative, complete a "Designated Representative Form": <<instructions for finding the form>>.

You also may need to sign a "Release of Information Form" that allows us to share your health information with your designated representative. You may not need this form if your doctor or legal guardian is your representative. Call us at <<Phone>>/TTY<<Phone>> to ask if you need to sign this form. If you need to sign it, you can get a copy of the form online at <<link to Release of Information Form>>, or you can ask for the form to be sent to you.

If you disagree with an appeal decision about residential mental health treatment for a child, you can ask for a second review

If you are a parent or guardian of a child age 18 or younger and <<MCE>> denies your child residential mental health treatment, you have the right to request an objective third-party review. The Children and Youth Mental Health Treatment Act (C.R.S. 27-67-101) gives you this right.

Under the Children and Youth Mental Health Treatment Act, you have the right to ask for an objective third-party review through the Behavioral Health Administration. The Behavioral Health Administration will have an independent professional perform a free clinical review and provide a second opinion on your appeal. You must ask for this third-party review within **5 business days** after <<MCE>> makes our appeal decision. You may ask for this third-party review even if you do not request a State fair hearing about your appeal. This objective third-party review does not guarantee funding of services.

If you want to ask the Behavioral Health Administration to review the decision we made about your appeal, email, call, or write:

- Email: cdhs_bha@state.co.us
- Phone: 303-866-7400
- Behavioral Health Administration
  710 S. Ash St.,
  Denver, CO 80246

How to ask for a state fair hearing

If you disagree with the appeal decision or if we do not meet the appeal deadlines in this notice, you can request a state fair hearing with the Office of Administrative Courts no later than **120 calendar days** after <<MCE>>'s appeal decision date.

To ask the Office of Administrative Courts for a state fair hearing, please write, call, fax, email, or submit online:

Contact Method	**Contact Information**
Mail or In-person	Office of Administrative Courts 1525 Sherman St., 4th floor Denver, CO 80203
Phone	303-866-2000
Fax	303-866-5909 (10 pages or fewer; otherwise, mail your request)
Email	oac-gs@state.co.us
Online	Submit an online form using the Office of Administrative Courts e-filing system (registration required): **oac.colorado.gov/resources/oac-e-filing-system** Fill out the Request for State Level Hearing form. It is on the Office of Administrative Courts forms page under General Services Forms: **oac.colorado.gov/resources/oac-forms**

Your letter must include:

- Your name
- Your mailing address and phone number
- The decision you are appealing and the reason you are appealing it. You may include a copy of the letter, which has the decision you disagree with
- Your signature
- Health First Colorado member ID, if known
- A request for an interpreter or other accommodations you need

For help with your appeal or state fair hearing

- Contact the Behavioral Health Ombudsman (advocate)
  - Ombudsman: People who help settle grievances, appeals and other issues related to your health care
  - Call **303-866-2789** (State Relay: 711)
  - Email **ombuds@bhoco.org**
  - Website: https://behavioralhealthombudsman.colorado.gov/
- You can also call <<MCE>>: **<<MCE Phone>>**

What happens after you ask for a state fair hearing

After you ask for a state fair hearing, the Office of Administrative Courts will send you a letter explaining the process and set a date for your hearing. A judge will review your case and make the final decision.

What happens after a decision in your favor?

If the appeal, or state fair hearing decision is in your favor, <<MCE>> must quickly provide your services. This will happen no later than 72 hours after <<MCE>> receives notice of the favorable decision. <<MCE>> will let you know when you can continue to receive your services.

<<Place Holder For MCE Non-Discrimination Notice>>

<<Place Holder For Language Assistance Notice>>