

Insert Your Logo Here

[Send this notice in all cases where, after considering both Medicare and Medicaid coverage, an MMP denies, or partially denies, a service, item, Part B drug, or Medicaid drug. If an MMP determines that a service, item, Part B drug, or Medicaid drug is covered, for example, under Medicaid but not under Medicare and thus is provided to the member as requested by the member, do NOT send this notice. Under the terms of the three-way contract, such a situation does not constitute a denial or partial denial.]

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed toward the end under “Get help & more information.” You can also refer to Chapter 9 of the *Member Handbook* for information about how to make an appeal.

Notice of Denial of Medical Coverage

Date: _____ **Member number:** _____

Name: _____

Reference number: _____

<Insert other identifying information, as necessary (e.g., provider name, enrollee’s Medi-Cal number, service subject to notice, date of service).>

Your request was denied

We’ve *<denied, stopped, reduced, suspended>* the Part B drug listed below requested by you or your provider:

Why did we deny your request?

We *<denied, stopped, reduced, suspended>* the Part B drug listed above because *<Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage (Member Handbook) provisions to support decision>*:

<Where the plan has determined that the drug is covered under Medicare Part D, insert the following text: This request was denied under your Medicare Part B benefit; however, coverage/payment for the requested drug(s) has been approved under Medicare Part D. <Insert, as applicable, an explanation of the conditions of approval in a readable and understandable format>. If you think Medicare Part B should cover this drug for you, you may appeal.>

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) to review our decision by asking us for a Level 1 Appeal (sometimes called an “internal appeal” or “plan appeal”). In special cases, you can also ask for an Independent Medical Review (IMR) without first appealing to our plan. You cannot ask for an IMR if you have already had a State Hearing on the same issue. If you get an IMR and you are not satisfied with the result, you can still ask for a State Hearing.

Ask IEHP DualChoice for a Level 1 Appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. Refer to the section titled “How to ask for a Level 1 Appeal with IEHP DualChoice” for information on how to ask for a plan level appeal.

How to keep your services while we review your case: If we’re stopping or reducing a service, you can keep getting the service while your case is being reviewed. **If you want the service to continue, you must ask for an appeal within 10 calendar days** of the date of this notice or before the service is stopped or reduced, whichever is later.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-877-273-IEHP (4347). 8am-8pm (PST), 7 days a week, including holidays to learn how to name your representative. TTY users call 1-800-718-4347. Both you and the person you want to act for you must sign and date a statement saying this is what you want. You’ll need to mail or fax this statement to us. Keep a copy for your records.

There are 2 kinds of Level 1 appeals with IEHP DualChoice

Standard Appeal – We’ll give you a written decision on a standard appeal within **7 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If your appeal is for payment of a Part B drug you’ve already received, we’ll give you a written decision within **60 calendar days**.

Fast (Expedited) Appeal – We’ll give you a decision on a fast appeal as quickly as your condition requires, and always within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting for a decision on a standard appeal.

We’ll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within **7 calendar days**.

How to ask for a Level 1 Appeal with IEHP DualChoice

Step 1: You, your representative, or your provider must ask for an appeal within **60 calendar days** of getting this notice.

Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Whether you want a standard or fast appeal (for a fast appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters (such as a doctor's supporting statement if you request a fast appeal), or other information that explains why you need the Part B drug. Call your doctor if you need this information.

We recommend keeping a copy of everything you send us for your records.

You can ask to look at the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal or call us.

For a Standard Appeal:	Mailing Address:	IEHP DualChoice P.O. Box 1800 Rancho Cucamonga, CA 91729-1800
	Phone:	1-877-273-IEHP (4347)
	TTY Users Call:	1-800-718-4347
	Fax:	909-890-5748

If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter confirming what you told us. The letter will tell you how to make any corrections.

For a Fast Appeal:	Phone:	1-877-273-IEHP (4347)
	TTY Users Call:	1-800-718-4347
	Fax:	909-890-5748

What happens next?

If you ask for a Level 1 Appeal and we continue to deny your request for a service, we'll send you a written decision.

If the service was originally a Medicare service or a service covered by both Medicare and Medi-Cal, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

If the service was a Medi-Cal service, you can ask for an **Independent Medical Review (IMR)** or a **State Hearing**. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

How to ask for an Independent Medical Review (IMR)

You can ask for an Independent Medical Review (IMR) for Medi-Cal covered services and items from the California Department of Managed Health Care (Department). You can ask for an IMR if you disagree with IEHP DualChoice's Level 1 Appeal decision or if IEHP DualChoice has not resolved your Level 1 Appeal after 30 days. In special cases, you can also ask for an Independent Medical Review (IMR) without first appealing to our plan.

In most cases, you must file a Level 1 Appeal with IEHP DualChoice before requesting an IMR; however, you may be able to have an IMR without appealing to IEHP DualChoice first if:

- Your problem is urgent and involves an immediate and serious threat to your health.
- IEHP DualChoice denied a Medi-Cal service or treatment because it is experimental or investigational.

You cannot ask for an IMR if you have already had a State Hearing on the same issue. If you get an IMR and you are not satisfied with the result, you can still ask for a State Hearing.

How to ask for an IMR. Fill out the online Independent Medical Review/Complaint Form available at www.dmhc.ca.gov/fileacomplaint/submitanindependentmedicalreviewcomplaintform.aspx or you can fill out the hard copy IMR application form that is included with this notice and send it to:

Help Center
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
FAX: 916-255-5241

If you choose to do so, you may attach copies of letters or other documents about the service or item that was denied. If you do, send copies of documents, not originals. The Department Help Center may not be able to return all original documents.

You or your representative must ask for an IMR within **6 months** after we send you a written decision. However, the Department may extend the 6-month deadline for good reasons such as you had a medical condition that prevented you from asking for the IMR within 6 months or you did not get adequate notice of the IMR process.

Call the **California Department of Managed Health Care (DMHC) toll-free at 1-888-466-2219** for free help.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-877-273-IEHP (4347)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

What happens next?

If you qualify for an IMR, the DMHC will review your case and send you a letter within 7 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 30 calendar days. You should receive the IMR decision within 45 calendar days of the submission of the completed application.

If your case is urgent and you qualify for an IMR, the DMHC will review your case and send you a letter within 2 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 3 calendar days. You should receive the IMR decision within 7 calendar days of the submission of the completed application.

An IMR can take longer if the DMHC does not receive all of the medical records needed from you or your treating doctor. If you are using a doctor who is not in your health plan's network, it is important that you get and send us your medical records from that doctor. Your health plan is required to get copies of your medical records from doctors who are in the network.

Doctors who are not part of IEHP DualChoice will review your case. The DMHC will send you a letter explaining the decision. If the IMR decision is in your favor, IEHP DualChoice must give you the service or treatment you asked for. If you do not agree with the decision, you can ask for a State Hearing as long as you have not had a State Hearing on the same issue.

If you do not qualify for an IMR, your issue will be reviewed through DMHC's standard complaint process. You will receive a written notice of the decision within 30 days. If you decide not to use the IMR process, you may be giving up your rights under California law to pursue legal action against IEHP DualChoice about the service or treatment you are asking for.

How to ask for a State Hearing

If the service was a Medi-Cal covered service or item, you can ask for a State Hearing. You can only ask for a State Hearing after you have appealed to our health plan and received a written decision with which you disagree. Please note that if you have a State Hearing, you will not be able to ask for an Independent Medical Review (IMR).

Step 1: You or your representative must ask for a State Hearing within **120 days** of the date of our notice to you that the adverse benefit determination (Level 1 appeal decision) has been upheld. Fill out the "Form to File a State Hearing" that will be provided with your appeal decision notice. Make sure you include all of the requested information.

Step 2: Send your completed form to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
FAX: 916-651-5210 or 916-651-2789

You can also request a State Hearing by calling 1-800-952-5253 (TTY: 1-800-952-8349). If you decide to make a request by phone, you should be aware that the phone lines are very busy.

What happens next?

The State will hold a hearing. You may attend the hearing in person or by phone. You'll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision that will explain if you have additional appeal rights.

A copy of this notice has been sent to: <insert PCP name/requesting Provider name>.

Get help & more information

- Call **IEHP DualChoice** at 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays. TTY users call 1-800-718-4347. You can also visit our website at www.iehp.org.
- Call the **California Department of Managed Health Care** for free help in understanding your rights and information about the complaint and Independent Medical Review (IMR) process at 1-888-466-2219.
- Call the **Health Consumer Alliance** for free help with your health care at 1-888-804-3536.
- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. They can talk with you about how to make an appeal and what to expect during the appeal process. The phone number is 1-855-501-3077.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Call the **Medicare Rights Center** at 1-800-333-4114.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- You can also refer to **Chapter 9 of the *Member Handbook*** for information about how to make an appeal.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays. TTY users call 1-800-718-4347. The call is free.