<IPA logo>

NOTICE OF ACTION – TERMINATE
About Your Treatment Request

<<Date>>

<<Member Name>>
<<Address Line 1>> <<Address Line 2>>
<<City>>, <<ST>> <<Zip>>

<<Treating Provider's Name>>
<<Address>>
<<City,>> <<State>> <<Zip>>

Identification Number: <<Member ID Number>>; Case #: <<Insert case number>>

RE: <<Service to be terminated>>

You are currently getting *[service to be terminated].* This care is no longer approved. *[Service to be terminated]* will end on *[date]*. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

<IPA> will stop paying for this care on *[date].*

You can get free copies of all information used to make this decision. To get this, please call <IPA> at <IPA Contact Information>.

You may appeal this decision. The enclosed "Your Rights" information letter tells you how. It also tells you how you can get free help. This can be free legal help. You can send in any information that could help your case. The "Your Rights" letter tells you the last day you can ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at **1-888-452-8609**. You can also get help from your doctor or call <IPA Contact> at <IPA phone number and hours of operations>. TTY users should call **1-800-718-4347**.

This letter does not change your other Medi-Cal care.

[Medical Director's Name or Reviewer's Name]

IF YOU DO NOT AGREE WITH THE DECISION YOUR HEALTH PLAN MADE FOR YOUR HEALTH CARE, YOU CAN ASK YOUR HEALTH PLAN FOR AN APPEAL.

HOW DO I ASK FOR AN APPEAL?

You have 60 days from the date of this Notice of Action letter to ask for a standard or expedited appeal. If your health plan decided to reduce, suspend or terminate a service(s) you are getting now, you may be able to keep getting the service(s) until your appeal is decided. This is called Aid Paid Pending. To qualify for Aid Paid Pending, you must ask your health plan for an appeal within 10 days from the date of this Notice of Action letter, or before the date your health plan says the change to your service(s) will happen. Even though your health plan must give you Aid Paid Pending when you ask for an appeal within these timelines above, you should let your health plan know when you ask for an appeal that you want to get Aid Paid Pending until your appeal is decided.

If you miss the 10-day period to request an appeal OR do not ask for an appeal before the date the change to your service(s) will happen, you still have 60 days from the date of this Notice of Action letter to ask for an appeal. However, you will not get Aid Paid Pending while your appeal is being decided.

You can ask for an appeal yourself. Or, you can have someone like a relative, friend, advocate, doctor, or attorney to ask for one for you. This person is called an Authorized Representative. Your health plan can provide a form for you to identify your Authorized Representative. You, or your Authorized Representative, can send in anything you want your health plan to look at to make a decision on your appeal. A doctor who is different from the doctor who made the first decision will look at your appeal.

You can file a standard or expedited appeal by phone, in writing, or electronically:

- By phone: Contact IEHP Member Services Monday–Friday, 7am–7pm, and Saturday–Sunday, 8am–5pm by calling 1-877-273-4347. If you cannot hear or speak well, please call TTY: 1-800-718-4347.

- In writing: Fill out an appeal form or write a letter and send it to:
  IEHP Grievance Department, P.O. Box 1800, Rancho Cucamonga, CA 91730-5987

  Your doctor's office will have appeal forms available. Your health plan can also send a form to you.

- Electronically: Visit your health plan's website. Go to *https://www.iehp.org/*.

When you appeal, you must give your plan:

- Your name

- Your address or an address where we should send information about your appeal (if you don't have a current address, you can still appeal)
- Your member number with your plan
- The reason(s) you're appealing your plan's decision
- If you want a standard or a fast appeal. (For a fast appeal, tell your plan why you need one.)
- Anything you want your plan to look at that shows why you need the service. For example, you can send them:
    - Medical records from your health care provider,
    - Letters from your health care provider (such as a statement from your health care provider that says why you need a fast appeal), or
    - Other information that says why you need the service

WHEN WILL MY APPEAL BE DECIDED?

For Standard Appeals, your health plan must respond to your appeal in writing within 30 days. If you think waiting 30 days will hurt your health, you may be able to get a decision in 72 hours. When you ask for an appeal with your health plan, say why waiting will hurt your health. Make sure you ask for an Expedited Appeal.

For Expedited Appeals, your health plan will give you a decision within 72 hours after receiving your appeal and must try to give you an oral notice of its decision. For both Standard and Expedited appeals, your health plan will mail you a Notice of Appeal Resolution letter. This letter will tell you what your health plan decided on your appeal.

CAN I ASK FOR AN INDEPENDENT MEDICAL REVIEW AND A STATE HEARING?

An Independent Medical Review is where a doctor(s) that is not related to the health plan will review your case. A State Hearing is where a judge will review your case.

If you disagree with your health plan's decision regarding your service(s), you can ask your health plan for an appeal. If you still disagree with your health plan's decision on your appeal, or it has been at least 30 days since you filed your appeal with your health plan, you can request an Independent Medical Review with the Department of Managed Health Care (DMHC). DMHC staff will determine whether your issue qualifies for an Independent Medical Review.

In most instances, you are not eligible to request a State Hearing until you have first completed your health plan's internal appeal process. However, there are times when you can directly request a State Hearing. This can happen if your health plan did not notify you correctly or timely about your service(s). This is called Deemed Exhaustion. Here are some examples of Deemed Exhaustion:

- The health plan did not make this Notice of Action letter available to you in your preferred language.
- The health plan made a mistake that affects any of your rights.
- The health plan did not give you a written Notice of Action letter informing you of its intended action regarding your service(s).
- The health plan made a mistake in its written Notice of Appeal Resolution letter.

- The health plan did not decide your appeal within 30 days and send you a Notice of Appeal Resolution letter.
- The health plan decided your case was urgent, but did not respond to your appeal within 72 hours and send you a Notice of Appeal Resolution letter.

Sometimes, you can ask for both an Independent Medical Review and a State Hearing at the same time. You can also ask for one before the other to see if one will resolve your problem first. For example, if you ask for an Independent Medical Review first, and you do not agree with what was decided, you can ask for a State Hearing. But, if you ask for a State Hearing first, and your hearing has already taken place, you cannot ask for an Independent Medical Review. In this case, the State Hearing has the final say.

You will not have to pay for an Independent Medical Review or a State Hearing.

HOW DO I REQUEST AN INDEPENDENT MEDICAL REVIEW?

The paragraph below provides you with information on how to request an Independent Medical Review with DMHC.[1] Note that the term grievance is talking about both complaints and appeals:

"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 1-800-440-IEHP (4347), Monday–Friday, 7am–7pm, and Saturday–Sunday, 8am–5pm. TTY users should call 1-800-718-4347, 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 **http://www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online."

HOW DO I REQUEST A STATE HEARING

As stated above, you may be eligible to request a State Hearing.

You can ask for a State Hearing in the following ways:

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[1] Health and Safety Code (HSC) Section 1368.02(b). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/home.xhtml.

- Online at www.cdss.ca.gov

- By phone: Call 1-800-743-8525. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.

- In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:

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

  Fax: (916) 309-3487 or toll-free at 1-833-281-0903

  A State Hearing Form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number and/or CIN number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell the State Hearings Division what language you speak. You will not have to pay for an interpreter. The State Hearings Division will get you one. If you have a disability, the State Hearings Division can get you special accommodations free of charge to help you participate in the hearing. Please include information about your disability and the accommodation you need.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think that waiting 90 days will hurt your health, you can request an Expedited Hearing. If the State Hearings Division approves your request for an Expedited Hearing, you may be able to get a hearing decision within 3 days from the date it receives your case file from your health plan.

You can ask for an Expedited Hearing by calling the State Hearings Division at the number above. Or, you can send the State Hearing form or a letter to the State Hearings Division. You must explain how waiting for up to 90 days for a decision will harm your life, health or ability to get or keep maximum function. You can also get a letter from your doctor to help show why you need an Expedited Hearing.

You can speak for yourself at the State Hearing. Or, you can have someone like a relative, friend, advocate, doctor, or attorney speak for you. If you want someone else to speak for you, then you must sign a form telling the State Hearings Division that the person can speak for you. This person is called an Authorized Representative.

LEGAL HELP

You may be able to get free legal help. Call the *State Department of Consumer Affairs at 1-800-952-5210*. You may also call the local Legal Aid Office in your county at 1-888-804-3536.

FORM TO FILE A STATE HEARING FROM A MANAGED CARE DENIAL

You can ask for a State Hearing by calling: **1-800-743-8525**. **TDD users, call 1-800-952-8349**. You can also request a hearing in the following ways:

- You can request a hearing **ONLINE** at **WWW.CDSS.CA.GOV**
- You can fill out this form and **FAX** it to State Hearings at **916-309-3487**
- You can fill out this form and **EMAIL** it to **SCOPEOFBENEFITS@DSS.CA.GOV**
- **(Note:** If you send it by email, *please understand there is a risk that someone other than the State Hearings Division could intercept your email. Please consider using a more secure method of sending your request.)*
- You can also **MAIL** this State Hearing Request **to:**

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430

For free help filling out this form, call the legal help phone number listed on the attached 'Your Rights' Notice

I do not agree with the decision about my health care. State the treatment, drug, equipment, or service that the doctor requested. I disagree because:

_____
_____
_____
_____
_____

(If you need more space, use another piece of paper and attach it to this one.)

PLEASE PROVIDE THIS INFORMATION ABOUT THE BENEFICIARY
(This is the person who was denied medical benefits)

NAME: _____

DATE OF BIRTH: _____

ADDRESS (Where you can get mail): _____

TELEPHONE NUMBER: _____

Do we have your permission to communicate with you by email? [ ] YES [ ] NO

If Yes, what is your **EMAIL ADDRESS:** _____

Please provide your **Medi-Cal BIC Card Number and /or Social Security Number** if you have one: _____

Do you have Straight Medi-Cal (**Fee for Service**) or **Managed Care**?

_____

If **Managed Care**, what is the **name of your HEALTH PLAN**:

_____

PLEASE ANSWER EVERY QUESTION THAT APPLIES TO THE BENEFICIARY

My Doctor requested this health benefit on this date: _____

The Health Plan denied this health benefit on this date: _____

I have appealed the case to the Health Plan:
YES [ ] **On what date**? _____ NO [ ]

The Health Plan gave an answer to the appeal:
YES [ ] **On what Date?** _____ NO [ ]

Did you ask the Health Plan for an expedited (72 Hour) appeal? [ ] YES [ ] NO

Did the Health Plan decide the appeal in 72 Hours? [ ] YES [ ] NO

I NEED THESE FOR MY HEARING (Check these Boxes if they apply to you):

☐ **I need an Expedited Hearing because my situation is urgent**. My case must be decided very quickly and I cannot wait for up to 90 days. This is what will happen without a quick decision:

_____
_____
_____

EXPLAIN WHY YOU CANNOT WAIT UP TO 90 DAYS. **If you do not explain, your case will not be expedited and will be scheduled** on the normal calendar. You can submit a letter from your doctor or plan to show why you cannot wait.

☐ **Continued Services / Aid Paid Pending: Please continue my treatment** until the Judge decides my case. (Describe the treatment that you want to continue and say **what date the plan stopped it** or **is planning to stop it**):

_____
_____

☐ **I want a Free Interpreter**. My language or dialect is: _____

☐ **I have a disability and want a reasonable accommodation to help me participate in my hearing**. The accommodation(s) I want is:

_____

_____

☐ **I want someone else to speak for me (represent me) at the hearing.** She/he can see my medical records that relate to this hearing and come to the hearing. The person I have chosen to speak for me is:

Name: _____ Phone Number: _____

Address: _____

My signature: _____ Today's Date: _____

SEND THIS FORM WITH A COPY OF THE LETTER (NOTICE OF APPEAL RESOLUTION) YOU RECEIVED FROM YOUR PLAN IF YOU HAVE IT. (IF YOU WANT A COPY OF THIS FORM FOR YOURSELF, COPY IT BEFORE YOU SEND IT.)