NYLAG
New York Legal Assistance Group

Requesting Services from a Managed Care Plan (including MLTC plans)

Evelyn Frank Legal Resources Program - NYLAG

You or your doctor can request new or increased Medicaid services from your managed care plan at any time. Requests can be made in writing, and/or by speaking to Member Services, to your care manager, or at your periodic reassessment when a nurse comes to your home. If your managed care plan denies your request or does not respond within a specific timeframe, this can be appealed.

How to make a request for new or increased services: **Do it in writing and keep proof!**

- Give your written request to a nurse or care manager in person, keep a copy for yourself, and ask the nurse or care manager to sign to acknowledge receipt on your copy, **OR**
- Send your written request by certified mail or fax it to your care manager and keep the tracking number or fax confirmation with your copy so that you have proof of when the care manager receives the request.
- NOTE: Some managed care plans may require you to request home care service changes on a **specific form** completed by your doctor. In NYC, some plans use the M11Q: Medical Request for Home Care. [1] Ask your plan if you need a specific form before you make your request.
- **If you ask for an increase verbally**, by phone or to a plan employee, make a note of the ***date*** and ***who you talked*** to. Follow up with a letter via certified mail or fax and save the tracking number or fax confirmation. The letter should confirm all of the following:
  - That you made a request;
  - The date of the request;
  - The name of the person you spoke to; and
  - The nature of your request (i.e., What you are asking for, and if an increase in services, how much of an increase).

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[1] NYC M11q available at http://www1.nyc.gov/assets/hra/downloads/pdf/services/micsa/m_11q.pdf.
Fill-in-able version at http://www.wnylc.com/health/download/30/.
Outside NYC, in most counties the form at this link -- http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/10oltc-006att.pdf.

Tips for making requests for increased homecare hours or new services: Give details!

- Include a **letter from your doctor** explaining your need for services day and/or night. If it is urgent doctor should request that it be **expedited** – the doctor must explain why. See chart below for plan's timeframe for deciding expedited requests.
- Supplement this with **your own letter** specifying the amount of hours and reasons you need assistance. Though unpaid support is not required, if anyone in your life is committed to providing you with help that would substitute for homecare, explain exactly how much help your they have committed to providing, if any, including specific days and times.
- For both letters, instead of saying that you generally need supervision or safety monitoring, it is more helpful to specify *which* activities you need help with, *when* you need help, what *type* of help you need, and *why*. For the type of help, not everyone needs hands-on assistance. If you have dementia, you may need "cueing and prompting assistance," which means an aide must remind you to use your walker or to take your medication, etc. If you have weakness, an unsteady gait or poor balance from a past stroke or arthritis, you may need "contact guarding" assistance, which means an aide must be close by to ensure you use the walker safely, whenever you need to use the bathroom, get up, or walk.
- For both your letter and the doctor's letter, it can help to organize the letter using bullet points for each activity you need help with. The key activities for which people may need more than 8 hours/day are ambulation, toileting, and transfer (getting up or down).
- If seeking **24-hour care**, your doctor and you should specify how many times you need help from an aide each night and how frequently. Your request should state whether the needed assistance can be **scheduled** or **may occur at unpredictable times during the day or night** – especially the need for help with using the bathroom or having incontinent pads changed, help with walking and getting up and down ("transferring"). Ask a caregiver to keep a **night-time log** of the times you need help and how long it takes, over several nights, and submit that log.
- Standards the plan must use in order to assess your needs are explained in Department of Health Managed Long Term Care Policy 16.07, available http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-07.htm. This policy says the plan must assess your needs on an individual basis, not using standard "task times," and that you have a right to receive services at the time of day that your needs actually arise.

People in hospitals or rehab facilities may have special rights

- If you are in the hospital or inpatient rehab stay, and your plan refuses to reinstate the ***same services in the same amount*** you received before, this is not a request for new or increased services. This refusal to reinstate services is a discontinuance of services you are already authorized to receive. The plan should send you a letter that says at the top "INITIAL ADVERSE DETERMINATION NOTICE TO REDUCE, SUSPEND OR STOP SERVICES." This refusal to reinstate your services is immediately appealable.[2]
- If you are seeking an ***increase in services*** you had previously, to take effect following a hospital or rehab stay, this is a new request.

Timeframe for Plan to Respond to Your Request

Your managed care plan may send you a letter approving or denying your request. If the plan denies your request you should receive a letter in the mail that says at the top "INITIAL ADVERSE DETERMINATION DENIAL NOTICE."

But sometimes plans fail to decide requests altogether. When the plan does not issue a decision within the timeframe specified below, this is a **denial** of services. You can file a plan appeal.[2]

Type of Request	Plan Must Issue a Decision No Later than...
Expedited**	**3 business days from receipt of request**; can extend up to 14 calendar days if more info needed
Standard	**14 calendar days from receipt of request**; can extend up to 14 calendar days if more info needed
Medicaid covered home health care services following an inpatient admission	1 business day after receipt of necessary info; when request made the day before a weekend or holiday, **no more than 3 business days** after receipt of the request for services

The doctor can ask the plan to **expedite processing of your request by explaining why a delay would **seriously jeopardize your life, or your health, or your ability to attain, maintain, or regain maximum function.**

[2] See fact sheet on managed care & MLTC appeals at http://www.wnylc.com/health/download/654/.

Where to get help

ICAN – Independent Consumer Advocacy Program TEL: 844-614-8800
TTY Relay Service: 711 www.icannys.org e-mail ican@cssny.org

NYLAG

Evelyn Frank Program eflrp@nylag.org M, W 10-2 pm 212-613-7310
Public Benefits Unit M, W, Thurs 9:00 am – 3:00 pm 212-613-5000

Legal Services NYC 917-661-4500

The Legal Aid Society 888- 663-6880

Cardozo Bet Tzedek Legal Services 212-790-0240
JASA/ Queens Legal Services for the Elderly (Queens only) 718- 286-1500

More info online at www.nyhealthaccess.org

- All about MLTC http://www.wnylc.com/health/entry/114/
- MLTC Appeal Rights http://www.wnylc.com/health/entry/184/
- Fact Sheet on Appeals http://www.wnylc.com/health/download/654/
- Standards for assessing need for services
  - MLTC Policy 16.07: Guidance on Task–based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-07.htm
  - http://www.wnylc.com/health/entry/7/#5%20how%20much%20care? – More on assessing need for home care services

This Fact Sheet is Posted at http://www.wnylc.com/health/download/723/ - Check for updates

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Intake Monday, Wednesday 10 – 2 PM