[Instructions for Health plan: (Do not include bracketed instructions in letters to members.)

Document Title: Appeal Resolution Letter Template (HMO Adverse Benefit Determination Upheld)

This notice is intended to notify members when the health plan has upheld the initial adverse benefit determination. (See Article I or 42 CFR 438.400 for definitions.) The notice of appeal resolution must be postmarked on or before the 30th calendar day after receiving the appeal, or 44th calendar day if there has been an extension. (See Article IX or 42 CFR 438.408 for timelines.)

## **How to use this notice template**

* Health plans may modify the format of this letter as needed to ensure readability and accessibility for members. However, all information must remain in the letter unless otherwise noted in these instructions.
* When sending the Appeal Resolution letter, health plans should include **Option 1** if the member had requested benefits continue during the appeal or **Option 2** if the member did not request that benefits continue during the appeal.
* Only include the **Continuing your services during a state fair hearing** section if the member had requested benefits continue during the appeal.
* The health plan should include a copy of the Wisconsin Division of Hearings and Appeals (DHA) fair hearing request form with the letter to the member. Find PDFs of this form on the [Wisconsin DHA “Requesting a Hearing” webpage](https://doa.wi.gov/Pages/LicensesHearings/DHAWFSRequestingaHearing.aspx).]

# **Your Appeal Decision**

<Mailing Date>

|  |  |
| --- | --- |
| <Member’s Name> | <Member MA ID Number> |
| <Member/Authorized Representative’s Address> |  |

**You may need to take action**

See <Page X> about actions you may want to take today.

Dear <First Name > <Last Name>,

The <Health Plan Name>’s Grievance and Appeal Committee has decided on your appeal about <insert service or benefit in question>. <You participated/You and your representative participated/Your representative participated/You chose not to participate> in the meeting on <date>. After reviewing your case, **the <Health Plan Name> Grievance and Appeal Committee has decided to <description of the decision>**.

The reason for this decision is <Must include specific explanation for why the original decision was upheld>. This decision is based on <Cite specific contract language, federal provisions, state laws, FH topics, clinical guidelines, etc.>.

If you disagree with this decision, you can ask for a state fair hearing with the Wisconsin Division of Hearings and Appeals. Your health care benefits will not be affected, and we won’t treat differently than other members.

**Continuing your services** [Choose one]

[Option 1. Standard continued benefits]

You asked to keep getting <describe continued services> during the appeal process. **Based on the <Health Plan Name> Grievance and Appeal Committee’s decision, we will <reduce/terminate/etc.> your <describe continued services> on <effective date of intended action – no earlier than 10 calendar days after the mailing date of this letter>.** If you choose to ask for a state fair hearing, you can ask to keep getting your benefits during the process.

[Option 2. Benefits were not continued]

Your services were not continued during the <Health Plan Name> appeal. If you choose to ask for a state fair hearing, your services cannot be continued during the process.

## **Asking for a state fair hearing**

A state fair hearing is a chance for you to explain to an administrative law judge why you think our decision is wrong. The hearing may be over the phone. You can be represented at the hearing, and you can bring a friend or family member. You can also to bring witnesses and send new evidence for the judge to consider when reviewing your case. The judge will hear from you and us before they decide. After the hearing, the judge will send you and us a letter with their decision.

**To ask for a state fair hearing, use the form included with this letter or send a written request with your signature to the address or fax below by <date the health plan received the appeal + 30 calendar days + number of additional extension days + 90 calendar days*>*. Include a copy of this letter with your request.**

Department of Administration

Division of Hearings and Appeals

P.O. Box 7875

Madison, WI 53707-7875

Fax: 608-264-9885

If you have questions about the state fair hearing process, call the Division of Hearings and Appeals at 608-266-7709. You can also get more information at [doa.wi.gov/RequestAHearing](https://doa.wi.gov/Pages/LicensesHearings/DHAWFSRequestingaHearing.aspx) (https://doa.wi.gov/Pages/LicensesHearings/DHAWFSRequestingaHearing.aspx.)

Once you ask for a state fair hearing, the Division of Hearings and Appeals has 90 calendar days to hold your hearing and give you a written decision, unless you requested a fast appeal from us.

## **Your fair hearing rights**

You can get a free copy of all the paperwork related to our appeal decision. This includes any medical information and policies that we needed for the decision. You can get this information even if you don’t appeal. If you do appeal, you can get a free copy of any new information we gather during your appeal.

## **Continuing your services during a state fair hearing**

You can ask to keep getting <insert service or benefit in question> until a decision has been made on the state fair hearing. **You must send a request for a state fair hearing to the Division of Hearings and Appeals and also ask them to continue your benefits by <insert appropriate date – 10 calendar days from the mailing date or the intended effective date, whichever is later>.**

If the administrative law judge decides that the <Health Plan Name>’s Grievance and Appeal Committee is correct, you may need to repay the cost of the services you received while your appeal was being processed.

## **Getting help**

If you have questions, need help asking for a state fair hearing, or want records, call our member advocate at <phone number>.

To talk to someone outside of <Health Plan Name>, call the BadgerCare Plus and Medicaid SSI ombuds at 800-760-0001. An ombud is a person who helps solve problems members have with care or services they get through BadgerCare Plus and Medicaid SSI. If you are enrolled in a Medicaid SSI plan, you can also call an SSI managed care advocate at 800-928-8778 for help.

<Signature block>