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

Document Title: Notice of Denial, Change, or Delay in Your Services Letter Template

This notice is intended to inform members when the health plan has made an adverse benefit determination. (See Article I or 42 CFR 438.400 for definitions). All notices of adverse benefit determination must be sent to members according to the timelines found in Article IX (also outlined in 42 CFR 438.404).

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

* Health plans may modify the format of this letter as needed to ensure readability and accessibility. However, all information must remain in the letter unless otherwise noted in these instructions.
* **Include only one of the adverse benefit determination types in the letter.** For example, if a prior authorization was denied, only include Option 1: “Deny your request for this service.” Do not include the full list of option types 2 through 11. Do not include the number shown before the adverse benefit determination types.
* If multiple types of adverse benefit determinations have been made for the same individual, the member should receive a notice for each one.
* Under the section **Your appeal rights,** the health plan may modify the Grievance and Appeal Committee language to align with internal processes. The default text reads, “we will schedule a meeting with you and our Grievance and Appeal Committee.” Some health plans automatically schedule committee meetings for members, while others will only schedule if a member requests a meeting.

If this text is changed for the latter situation, the resulting letter must:

* 1. Make clear that members have the option to request a meeting.
  2. Provide the process for requesting a meeting.
* Only include the **Continuing your services during an appeal** section if the adverse benefit determination is a termination, suspension, or reduction of previously authorized services.
* Use Option 6, Denial of Payment (member request), when a member purchases an item or service and is requesting reimbursement from the health plan.
* Use Option 7, Denial of Payment (provider claim) when a provider’s claim remains unpaid, in whole or in part, after the provider has completed the provider appeals process with the health plan and the Wisconsin Department of Health Services, and the unpaid claim is a clean claim as defined under 42 CFR § 447.45(b).

When using Option 7:

1. Replace the text under the salutation:

“This is an important letter about < service or benefit in question>. We decided to <adverse benefit determination type>:”

with:

“<Provider name> asked us to pay for a service or support that you received from them. This is called a “claim.” The Wisconsin Department of Health Services determined that <Provider name> cannot be paid for its claim. **It’s not your fault the claim wasn’t covered and you aren’t responsible for paying any amount to us, <Provider name>, or anyone else.** The details about this denial are as follows:”

1. Add this text immediately under “Your Appeal Rights:” **“You have the right to appeal the denial of <Provider name>’s claim but you are not required to do so. Whether you appeal or not, you are not responsible for paying any amount for this claim to us, <Provider name>, or anyone else.”**

* Option 9 applies only when the member is a resident of a rural area with only one HMO.
* When using Option 11, because the health plan failed to follow the grievance or appeal timeframe, remove the heading “How to appeal this decision if you disagree with it” and all of the language that follows until you reach the “Getting Help” section. Include all of the language that follows.

# **Notice of Denial, Change, or Delay in Your Services**

<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>,

This is an important letter about < service or benefit in question>. We decided to < adverse benefit determination type>: [Include only one option below per notice. Do not include the number shown before the adverse benefit determination types.]

**(1) deny your request for this service.**

Date of request: <Date>

**(2) limit your request for this service.**

Date of request: <Date>

Amount of service requested: <insert description>

Amount of service approved: <insert description>

**(3) end this service.**

When this service will end: <Date>

**(4) reduce this service.**

When this service will be reduced: <Date>

Current level of service: <insert description>

New level of service: <insert description>

**(5) suspend (temporarily stop) this service.**

When this service will stop: <Date>

When the service will start again: <Date>

**(6) deny payment for this service (member request).**

Date of request: <Date>

When the service was provided: <Date(s)>

Provider or supplier: <insert provider/supplier>

Payment amount being denied: <$ amount>

**(7) deny payment for this service (provider claim).**

Service or support: <List the name(s) of the service(s) and/or support(s) for which payment is being denied>

Date(s) of denial(s): <Enter the date of DHS’ appeal decision denying the provider’s claim(s), in whole or in part>

Date(s) of claim(s): <Enter the date(s) of the claim(s) for which payment was denied by the health plan>

Provider or supplier: <List the name of the provider/supplier of the service or support for which the payment is being denied>

**(8) deny your request to dispute a bill.**

Date of request: <Date>

**(9) deny your request to pick a service outside of our provider network.**

Date of request: <Date>

**(10) promptly tell you about a** **failure to provide services on time.**

Date of service request: <Date>

**(11) tell you about our failure to follow grievance and appeal timeframes.**

Date grievance or appeal received: <Date>

We decided this because <explanation of decision for the member that must include specific rationale used to make the decision and any recommended alternatives.>This decision is based on <Cite specific contract language, federal provisions, state laws, FH topics, clinical guidelines, etc.>

Your provider can talk to the people who made the decision by calling the <title/department> at <phone number>.

## **How to appeal this decision if you disagree with it**

If you don’t agree with this decision, you can appeal. When you appeal, we will take a second look at the decision. **You must appeal by <appeal filing deadline – 60 calendar days from mailing date>.** If you have an authorized representative, they can appeal for you. You must give them written permission.

To start the appeal process, call our member advocate at <phone number>. Or, you can write to:

<Health Plan Mailing Address>

Include your name, how to contact you, and the word “appeal” in your request.

We have 30 calendar days to give you a decision on your appeal. If our Grievance and Appeal Committee denies your appeal, you can ask for a state fair hearing with the Wisconsin Division of Hearing and Appeals. We will send you a letter about the appeal decision and how to ask for a state fair hearing. You must appeal to us and finish the appeal process with us before asking for a state fair hearing.

You can also ask for a state fair hearing if we don’t give you a decision within 30 days of getting your appeal, and the appeal is not extended.

## **Asking for a fast appeal**

You can ask for a faster decision on your appeal if you or your doctor think that waiting 30 days could seriously harm your health or ability to perform your daily activities. If we agree that you need a fast appeal, you will get a decision within 72 hours. If we decide you don’t need a fast appeal, we will let you know why and you will get a decision within 30 days. To ask for a fast appeal, call <title/department> at <phone number>.

## **Your appeal rights**

When you appeal, we will schedule a meeting with you and our Grievance and Appeal Committee. You can call in to this meeting or join in person. You can have someone represent you at the appeal meeting if you want. This can be anyone you choose, including an attorney. You can also bring a friend or family member. You can also bring new evidence and witnesses to this meeting.

You can get a free copy of all the paperwork related to our 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 appeal, you can get a free copy of any new information we gather during your appeal.

If you appeal, your other health care benefits won’t change, and we won’t treat you different from other members.

## **Continuing your services during an appeal**

You can ask to keep getting < service or benefit in question> until we give you a decision. To keep your benefits during your appeal, call our member advocate at <phone number> or send a letter to the mailing address on the first page of this letter. **To continue this service, you must ask on or before <insert appropriate date –10 days from the mailing date or the effective date of the action, whichever is later>.**

If our Grievance and Appeal Committee denies your appeal, you may need to repay the cost of the services you got during the appeal process.

## **Asking for more time**

We will always try to decide your appeal within 30 days of getting your appeal. Sometimes, it takes more time. If you need more time to resolve the appeal, you can ask us for a 14-day extension. If we need more time, we will call you and send you a letter to let you know we extended the appeal decision deadline. We cannot extend it more than 14 days.

## **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. If you have questions about the state fair hearing process, call the Division of Hearings and Appeals at 608-266-7709.

<Signature Block>