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| [Insert MCO logo here] |

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| **FAMILY CARE****NOTICE OF ADVERSE BENEFIT DETERMINATION** |
| Mailing Date: Insert Date Notice Mailed |
| Member Name | Member ID: Member's ID or MCI Number |
| Member/Legal Decision Maker's Street Address |
| City, State Zip Code |
| Dear Member Name, |

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| **<<Use the three sentences below for all adverse benefit determinations except denials of provider claims. Then delete the provider claim denial specific language and these instructions.>>**This notice confirms our discussion on insert date.The service or support in question is: insert service in questionAfter reviewing the options with you using the Resource Allocation Decision (RAD) process, we have decided to:**<<For denials of provider claims, delete the three sentences above and use the following six sentences in their place. Then delete these instructions.>>**Insert 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 decided that Insert provider name cannot be paid for its claim.It is not your fault the claim was denied. You are **not** responsible for paying any amount to us, <<insert provider name>>, or anyone else.The details about this denial are as follows: |

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| [ ]  **Terminate current service.** |
| Effective date of intended action: |       |  |
| [ ]  **Reduce current service.** |
| Effective date of intended action: |       |  |
| Description of current level: |       |
| New level after reduction: |       |
| [ ]  **Suspend current service.** |
| Effective date of intended action: |       |  |
| Expected date service will resume: |       |  |
| [ ]  **Deny request for service or support.** |
| Date of request: |       |  |
| [ ]  **Limit request for service or support.** |
| Date of request: |       |  |
| Description of requested level: |       |
| Authorized level of service or support: |       |
| [ ]  **Deny payment for service or support (member request).** |
| Date of request: |       |  |
| Date(s) service provided: |       |  |
| Provider or supplier: |       |  |
| Payment amount being denied: | $       |  |
| **[ ]  Deny payment for service or support (provider claim).** |
| Service or support: |       |  |
| Date(s) of denial(s): |       |  |
| Date(s) of claims(s): |       |  |
| Provider/Supplier: |       |  |
| **The reason for our decision is that**: [ ]  The service or support is not an effective way to support your outcome(s).[ ]  You do not need this service or level of service or support to support your outcome.[ ]  We are already supporting your outcome in another way.[ ]  The service or support you received was not authorized.[ ]  An informal support has been identified and has agreed to provide this service or support for you.[ ]  The service or support is being performed by a member of your household and the service or support benefits the other individuals residing in the household with you.[ ]  Other:       |
| Explanation of the decision: This detailed explanation is for the member. The rationale used to make the decision should always be included along with any recommended alternative(s). |
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| If you disagree with this decision, the following pages describe your options. |
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| Sincerely,care manager namecare manager titlephone number RN care manager nameRN Care Manager titlephone number |
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| **Appeal Rights** |
| 1. **How to appeal this decision**
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| **<<Include the paragraph directly below for denials of provider claims and delete these instructions. If the adverse benefit determination is unrelated to a denial of a provider’s claim, delete the paragraph below and these instructions>>**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. |

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| If you disagree with this decision, write, call, fax, or email:MCO nameMCO addressappropriate contact phone numberappropriate fax numberappropriate email addressYou can get the Appeal Request form online at [www.dhs.wisconsin.gov/familycare/mcoappeal.htm](http://www.dhs.wisconsin.gov/familycare/mcoappeal.htm), or by calling one of the independent ombudsman agencies listed at the end of this notice.**Include a copy of this notice with the completed request form or letter.**  |
| 1. **Grievance and Appeal Committee**

After MCO name receives your request, we will set up a meeting with our Grievance and Appeal Committee. The committee is made up of MCO name representatives and at least one person who is also receiving services from us (or represents someone who does). You have the right to appear in person if you choose. You may bring an advocate, friend, family member, or witnesses. You may also present evidence and testimony to this committee.You will receive a written decision on your appeal. If you do not agree with the Grievance and Appeal Committee’s decision, you can request a state fair hearing. See the “state fair hearing” section below for more information. |

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| **<<Delete the “3. Continuation of services” section in its entirety for situations involving a request for a new service, a member request for payment of a service/support, or a denial of a provider’s claim. Keep the section for reductions, suspensions, or terminations of a current service. After deciding whether to include or exclude the section, delete these instructions.>>** 1. **Continuation of services**

If you are getting benefits and you ask for an appeal before your benefits change, you can keep getting the same benefits until the Grievance and Appeal Committee makes a decision on your appeal. If you want to keep your benefits during your appeal, **your request must be postmarked, faxed, or emailed on or before** **insert effective date of intended action**. If the Grievance and Appeal Committee decides that MCO name, decision was right, you may need to repay the extra benefits that you received between the time you asked for your appeal and the time that the Grievance and Appeal Committee makes a decision. However, if it would cause you a large financial burden, you might not be required to repay this cost. |

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| 1. **Deadline to file your appeal with MCO name**

You should file your appeal as soon as possible.Your appeal to MCO name must be postmarked, faxed, or emailed no later than 60 calendar days from the mailing date on page one of this notice. **Important**: If you would like your benefits to continue during your appeal, your appeal must be postmarked, faxed, or emailed **insert effective date of intended action.** |
| 1. **Speeding up your appeal with MCO name**

You may ask MCO name to speed up your appeal. If MCO name decides that taking the standard amount of time could seriously harm your health or ability to perform your daily activities, we will grant you a faster appeal called an “expedited appeal.” This means you will receive a decision on your case within 72 hours of your request. If you want to learn more about an expedited appeal, contact MCO name at MCO phone number. |
| 1. **State fair hearing**

You have the right to ask for a state fair hearing if you do not agree with the Grievance and Appeal Committee’s decision on your appeal. If you ask for a state fair hearing, you will have a hearing with an independent Administrative Law Judge (ALJ). You may bring an advocate, friend, family member, or witnesses. You may also present evidence and testimony at the hearing. MCO name’s member rights specialist can assist you with filing a fair hearing request. To contact a member rights specialist, call Member Rights Specialist phone number. You can also get the hearing form from one of the independent ombudsman agencies listed at the end of this notice or online at [www.dhs.wisconsin.gov/library/f-00236.htm](http://www.dhs.wisconsin.gov/library/f-00236.htm).Send the completed request form or a letter asking for a hearing and a copy of this notice to: Family Care Request for Fair HearingWisconsin Division of Hearings and AppealsPO Box 7875Madison, WI 53707-7875Fax: 608-264-9885**Important Note:** You cannot request a state fair hearing until you have received the Grievance and Appeal Committee’s decision on your appeal or MCO name fails to send you a written decision within 30 calendar days of receiving your appeal. You have 90 calendar days from the date you receive the Grievance and Appeal Committee’s written decision on your appeal to request a state fair hearing. If MCO name fails to send you a written decision within 30 calendar days of receiving your appeal, the 90 days starts the day after the 30 calendar day period ends.  |
| 1. **Who can help you understand this notice and your rights?**
	1. MCO name’s member rights specialist can inform you of your rights, try to informally resolve your concerns, and assist you with filing an appeal. The member rights specialist **cannot** represent you at a meeting with our Grievance and Appeal Committee or at a state fair hearing. To contact a member rights specialist, call Member Rights Specialist phone number.
	2. Anyone receiving Family Care services can get free help from an **independent ombudsman**. The following agencies advocate for Family Care members:
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| **For members age 18 to 59:**Disability Rights Wisconsin Toll Free: 800-928-8778TTY: 711 |
| **For members age 60 and older:**Wisconsin Board on Aging and Long Term Care Toll Free: 800-815-0015TTY: 711 |
| **Copy of your case file** You have the right to a free copy of the information in your case file related to this decision. Information means all documents, medical records, and other materials related to this decision. If you decide to appeal this decision, you have the right to any new or additional information MCO name gathered during your appeal. To request a copy of your case file, contact appropriate contact at phone number. |