INSTRUCTIONS FOR MANAGED CARE ORGANIZATIONS (MCOs) FILLING IN A STANDARDIZED FAMILY CARE NOTICE OF ADVERSE BENEFIT DETERMINATION (F-00232)

Completion and use of this Notice of Adverse Benefit Determination is mandatory according to Wis. Stat. § 46.287 (2)(c), "Information regarding the availability of advocacy services and notice of adverse actions taken and appeal rights shall be provided to a client by the resource center or care management organization in a form and manner that is prescribed by the department by rule." **Note: Family Care Partnership and PACE MCOs should use the standard CMS-approved Notice of Denial form available online at www.dhs.wisconsin.gov/familycare/mcos/noa.htm.**

How to use this form

1. Read these instructions before completing the form.
2. Shaded areas on the form signify fields for information that the MCO should insert into the Notice of Adverse Benefit Determination.
3. MCOs may insert their logo and agency information on the top of the first page.

Personal Information

Under Wis. Stat. § 49.45(4), personally identifiable information must be kept confidential and may only be used for the direct administration of the Family Care program.

Information to enter in Notice of Adverse Benefit Determination (pages 1–3)

1. Date of Notice Adverse Benefit Determination
   a. The <<Date notice mailed>> is the **mailing date**. The MCO must mail the Notice of Adverse Benefit Determination on this date.
   b. In situations involving a termination, suspension, or reduction in services, the MCO should mail the notice 15 calendar days prior to the effective date of the intended action. The 15 calendar days begins to run on the day after the mailing date.
      i. For example, if the MCO mails the notice on July 1, the first of the 15 calendar days begins the day after it was mailed (July 2). For this notice, the effective date of the intended action would have to be no earlier than July 16.
2. Member Contact Information
   a. Enter the member's name. This name will automatically fill in all other references to the member's name.
   b. The MCO should mail the Notice of Adverse Benefit Determination to the member's last known mailing address.
   c. If the member has a legal decision-maker, the MCO should send this information to *both* the member and the legal decision-maker. If the member and legal decision-maker live at the same address, duplicate mailing is optional.
3. <<Member's ID or MCI Number>> Enter the member's ID or MCI number. This is for the Division of Hearing and Appeals (DHA) to identify the case and process the request.
4. **For all adverse benefit determinations except denials of provider claims**, keep the text described directly below under 4.a–4.c. and delete the provider claim denial specific text under 5.a–5.c.

4.a. This notice confirms our discussion on <<insert date>>. Enter the date of the last discussion you had with the member regarding the service or support in question.

4.b. The service or support in question is <<open field>>. Use this field to describe the service or support in question. For example, request for supportive home care, request for a power wheelchair, etc.

4.c. After reviewing the options with you using the Resource Allocation Decision (RAD) process, we have decided to:

5. **For denials of provider claims only**, keep the text described below under 5.a–5.c. Delete the text above under 4.a–4.c.

5.a. <<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 <<Provider name>> cannot be paid for its claim. Enter the name of the provider whose claim is being denied.

5.b. It's not your fault the claim was denied. You are **not** responsible for paying any amount to us, <<Provider name>>, or anyone else. Enter the name of the provider whose claim is being denied.

5.c. The details about this denial are as follows:

6. Select the 'Decision'. The decision choices are in bold. Fill in the appropriate additional information.
    - **Terminate current service.** Select this box if currently authorized services are being completely ended.
        a. Effective Date of the Intended Action. Insert the *actual date* of the intended action.
            i. For example, if the service will stop on September 1, 2019, the MCO should insert "September 1, 2019" in the spaces indicated on the template.
    - **Reduce current service.** Select this box if currently authorized services are being reduced from the currently authorized amount.
        a. Effective Date of the Intended Action. Insert the *actual date* of the intended action.
        b. Description of current level. Enter a description of the service at issue in detail. If applicable, include the amount of authorized time or units for the current level of service.
            i. For example, "Two 45-minute weekly acupuncture appointments"
        c. New level after reduction. Enter description of the change(s) to the service in detail. If applicable, include the amount of time or units for the reduced level or service.
            i. For example, "Reducing to one weekly 45-minute acupuncture appointment"
    - **Suspend current service**. Select this box if currently authorized services are being temporarily ended.
        a. Effective Date of the Intended Action. Insert the *actual date* of the intended action.
        b. Expected date service will resume. If it is expected that the service will resume on a specific date, insert the date. If the resumption of services is not contingent upon a date but rather the occurrence of a certain event or circumstance (for example, using up accumulated taxi vouchers) insert "see below" and describe the event/circumstance upon which services will resume under "team explanation of decision."
    - **Deny request for new service or support**. Select this box if denying the authorization of a service or item requested by the member, including a decision to deny a level increase of a currently authorized service.

a. Date of Request. Enter the date the member requested the service and whether the request was verbal or written.

- **Limit request for service or support**. Select this box for a partial denial to authorize a service or item requested by the member.
    a. Date of Request. Enter the date the member requested the service, whether the request was verbal or written.
    b. Description of requested level. Describe the time or units of requested service.
        i. For example, "The member requested ten hours of supportive home care per week."
    c. Authorized level of service or support. Describe the amount of services the MCO will authorize (service and amount).
        i. For example, "We are authorizing eight hours of supportive home care per week."
- **Deny payment for service or support (member request)**. Select this box for denying a member's request for payment or reimbursement for a non-authorized service or support.
    a. Date of Request. Enter the date the member requested the service and whether the request was verbal or written.
    b. Date(s) service provided. Enter the date(s) that non-authorized service or support was provided to the member.
    c. Provider/Supplier. List the name of the provider/supplier of the service or support for which the payment is being denied.
    d. Payment amount being denied. Enter the dollar amount of the denial.
- **Deny payment for service or support (provider claim)**. Select this box if a provider's claim remains unpaid, in whole or in part, after the MCO and provider have completed the provider appeals process and the unpaid claim is a clean claim as defined under 42 CFR § 447.45(b).
    a. Service or Support. List the name(s) of the service(s) and/or support(s) for which payment is being denied.
    b. Date of Denial. Enter the date of the Department's appeal decision denying the provider's claim(s), in whole or in part.
    c. Date(s) of Claim(s). Enter the date(s) of the claim(s) for which payment was denied by the MCO.
    d. Provider/Supplier. List the name of the provider/supplier of the service or support for which the payment is being denied.

7. Reason for our decision – select all that apply.
    a. For **denials of provider claims, select "Other"** and enter the denial reason stated in the Department's appeal decision.
8. Explanation for the decision. This explanation is for the member and the MCO should include the rationale used to make their decision and/or what alternative is being recommended.
9. Signatures. Enter the Care Manager's and RN's name, title, and phone number.

Instructions for Adding Information on pages 3–5.

1. **How to appeal this decision.**

a. **For denials of provider claims only**, keep the following text: "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." Enter the name of the provider whose claim is being denied. For all adverse benefit determinations other than denials of provider claims, delete the above text.
b. Enter the MCO's name into the shaded box <<MCO name>>. Entering the MCO's name in this field will automatically fill in all other references to the MCO's name.
c. Enter the MCO's address into the shaded box <<MCO Address>>. Enter the complete mailing address (street address, city, state and zip).
d. Enter the phone number the member can call to file an appeal into the shaded box <<appropriate contact phone number>>.
e. Enter the fax number the member can use to file an appeal into the shaded box <<appropriate fax number>>.
f. Enter the email address the member can use to file an appeal into the shaded box <<appropriate email address>>.

2. **Continuation of Services**.
   a. Exclude the "Continuation of Services" section for all adverse benefit determinations except for reductions, suspensions, or terminations of a current service.
   b. Insert the effective date of the intended action. This date must be the same date entered under the relevant Decision Choice selected on page one of the notice. The effective date will automatically populate in the effective date of intended action in number 4, Deadline to file your appeal.
3. **Speeding up your appeal.** Insert the appropriate MCO phone number.
4. **State fair hearing.**

   Enter the Member Rights Specialist phone number in the <<Member Rights Specialist phone number >> field. The number will automatically fill in all other references to the Member Rights Specialist phone number.
5. **Copy of your case file.**

   Enter the appropriate name and phone number for the contact person designated to facilitate member access to his or her case file.