* As required by 42 CFR 422.633(f)(4), plans must send a notice when denying a member’s plan-level integrated appeal. This is a model notice that meets regulatory requirements.
* Instructions to plans appear in *blue italicized text and brackets [ ]* and are only for plan use. Plans must ensure that no blue text remains in the letter that plans send to members.
* Plans must revise references to “Medicaid” to use the state-specific name for the program throughout the letter. If the state-specific name does not include the word “Medicaid,” plans should add “(Medicaid)” after the first reference of the state-specific name.
* Plans may modify the letter as needed to describe the plan’s rules and benefits.
* Plans may modify the language in the letter, as applicable, to address state-specific Medicaid benefits and procedures.
* Where the template instructs inclusion of a phone number, plans should insert the most appropriate plan number. Only the plan’s Member Services phone and TTY numbers are required to be toll-free.
* If plans do not use the term “Member Services,” plans should replace it with the term they use.
* Plans must revise references to “Fair Hearing” to use the state-specific name for the program throughout the letter.
* Plans should ensure plan-customized text is in plain language.
* Plans may place a hyperlink or a QR code in the letter where appropriate to provide an option for members to go online.

Appeal Decision

<Date of Letter>

[*Insert Member name*]

Member Health Plan ID: [*Insert member ID*]

Service/item this letter is about: [*Insert name of service/item]*

**Service Subject to Notice:** Insert Service in Question **Date of Service:** Click here to enter text.

**Effective Date of Intended Action:** Enter Date **Provider Name: (optional)** Enter Provider Name

<Plan name> is called “our plan” or “we” in this letter. We are a health plan that contracts with Medicare and Family Care Partnership (Medicaid) to provide coverage for both programs. Our plan coordinates your Medicare and Family Care Partnership services and your doctors, hospitals, pharmacies, and other health care providers.

**Our plan <denied** *or* **partially denied>the appeal we got on <date appeal received> for the [*insert if applicable:* payment for] <service** *or* **item> listed above.**

Our plan made this decision because [*Provide a specific denial reason and a concise explanation of why the service/item was denied. Include citations of applicable state and federal rule, law, and/or regulation that support the decision. The plan may also include Evidence of Coverage/Member or Enrollee Handbook provisions and plan policies/procedures or assessment tools used to support the decision. Write the explanation in plain language and give, at a minimum, a basic explanation of the reasoning behind the action in the simplest language possible without losing meaning; do not include coding or technical terms, nomenclature, or other system-based or otherwise internal plan designations without appropriate explanation of the terms.*].

**Our plan will** [*include one of the following as applicable:*

**limit the number of <hours** *or* **days> authorized for your [*insert name of service or item*] to [*insert number of hours or days*] <hours** *or* **days>, on [*insert effective date*].**

*[OR]*

**reduce the [*insert name of service or item*] you’re getting from [*insert number of hours or days*] <hours** *or* **days> to [*insert number of hours or days*] <hours** *or* **days>, on [*insert effective date*].**

*[OR]*

**stop the [*insert name of service or item*] you’re getting, on [*insert effective date*].**

*[OR]*

**not cover [*insert name of service or item*].**

*[OR]*

**suspend****[*insert name of service or item*], on [*insert effective date*].**

*[OR]*

**[*insert explanation of action*], on [*insert effective date*.**]

# You can appeal again

If you appeal again, this is called a **level 2 appeal**. Share this letter with your <doctor *or* health careprovider> and ask about next steps.

You can also call <plan phone number for appeal requests> (TTY: <TTY number>) or email <plan email address for appeal requests> to ask us for a free copy of the information we used to make our decision. This may include health records, guidelines, and other documents. You should show this information to your <doctor *or* health care provider> to help you decide if you should appeal again.

# How the level 2 appeal process works

[*Insert one of the following sets of paragraphs as applicable:*]

[*Insert for a* ***Medicare-only*** *covered service or item:* You don’t need to do anything. Our plan will **automatically** send your case to the Medicare Independent Review Entity (IRE) for a level 2 appeal. The IRE is an organization that isn’t connected to our plan. The IRE will contact you so you can give them more information about your appeal. **The IRE will mail you an answer within 30 calendar days from when it gets your appeal. In some cases, it may be sooner.**]

*[OR]*

*[Insert for a Medicaid-only covered service or item:* You can ask the State of Wisconsin for a level 2 appeal, called a state fair hearing. If you ask for a state fair hearing, you will have a hearing with an independent administrative law judge. You may bring an advocate, friend, family member, or witnesses. You may also present evidence and testimony at the hearing.

<Plan 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 letter or online at [www.dhs.wisconsin.gov/library/f-00236.htm](http://www.dhs.wisconsin.gov/library/f-00236.htm).

Your written request must include:

* Your name
* Address
* Member number
* Reasons for requesting a fair hearing
* Any evidence you want, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Send the completed request form or a letter asking for a hearing and a copy of this letter to:

Family Care Partnership Request for Fair Hearing

Wisconsin Division of Hearings and Appeals

PO Box 7875

Madison, WI 53707-7875

Fax: 608-264-9885

* Your request for a state fair hearing must be postmarked or faxed no later than 90 calendar days after you receive this notice.] [Insert for a service or item covered by both Medicare and Medicaid: The <service or item> listed on the first page of this letter can sometimes be covered by both Medicare and Family Care Partnership. Medicare and Family Care Partnership have different rules about when they cover your <service or item>. Our plan doesn’t review level 2 appeals, so two different organizations not connected to <plan name> can review your case. Carefully read the information these organizations send you. Their reviews can happen at the same time:
* **The Medicare Independent Review Entity (IRE):** Because Medicare may cover your <service *or* item>, our plan will **automatically** send your case to the Medicare IRE for a level 2 appeal. The IRE will contact you so you can give them more information about your appeal. **The IRE will mail you an answer within 30 calendar days from when it gets your appeal. In some cases, it may be sooner.**
* **The State of Wisconsin:** Because Family Care Partnership may cover your <service *or* item>, you can also ask the State of Wisconsin for a level 2 appeal, called a state fair hearing. If you ask for a state fair hearing, you will have a hearing with an independent administrative law judge. You may bring an advocate, friend, family member, or witnesses. You may also present evidence and testimony at the hearing.

<Plan 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).

Your written request must include:

* Your name
* Address
* Member number
* Reasons for requesting a fair hearing
* Any evidence you want, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Send the completed request form or a letter asking for a hearing and a copy of this notice to:

Family Care Partnership Request for Fair Hearing

Wisconsin Division of Hearings and Appeals

PO Box 7875

Madison, WI 53707-7875

Fax: 608-264-9885

Your request for a state fair hearing must be postmarked or faxed **no later than 90 calendar days** after you receive this notice.]

To get more information about a level 2 appeal, call <plan phone number for appeal requests> (TTY: <TTY number>) or email <plan email address for appeal requests>. You can also find more information in our plan’s [*insert Evidence of Coverage, Member or Enrollee Handbook, or other term plan uses*],[*p*lans may insert chapter and/or section reference, as applicable]. An up-to-date copy of the [*insert* *Evidence of Coverage, Member or Enrollee Handbook, or other term plan uses*] is always available on our website at <web address> or by calling our plan.

# What happens to your <service *or* item> during your level 2 appeal

[*Insert one of the following sets of paragraphs as applicable:*]

[*Insert for a* ***Medicare-only*** *covered service or item:* You **won’t** keep getting this <service *or* item> through our plan during the level 2 appeal process with the IRE, even if you kept getting your <service *or* item> while our plan reviewed your first appeal.]

[OR]

[*Insert for a service or item covered* ***by Medicaid or by both Medicare and Medicaid****:* You

may be able to keep getting your <service *or* item> during your level 2 appeal if both of the following apply:

* You qualified to keep getting your <service *or* item> while our plan reviewed your first appeal.
* You ask for a state fair hearing and ask to keep getting the <service or item> during your fair hearing on or before **[*insert the effective date from page 1 of this letter in month, date, year format. Insert deadline date in bold text***.]

If your <service *or* item> continues during your level 2 appeal, you can keep getting the <service *or* item> until one of the following happens:

* You withdraw your appeal.
* All of the organizations that got your appeal deny it.

If you ask for a state fair hearing and ask to keep getting the <service *or* item> during the fair hearing:

* **You won’t have to pay** for the <service *or* item> you received while our plan reviewed your appeal.
* **Our plan must pay** for the <service *or* item> you got during the state fair hearing process if you win your fair hearing.
* **You may have to pay** for the <service *or* item> you got during the state fair hearing process if you lose your fair hearing.

# Get help and more information

* **<Plan name> Member Rights Specialist:** Call <member rights specialist phone number> (TTY: < TTY number>). The member rights specialist can answer your questions and help you submit a request for a state fair hearing.
* **Independent Ombudsman:** Anyone receiving Family Care Partnership services can get free help from an independent ombudsman. The following agencies advocate for Family Care Partnership members:

**For members age 18 to 59:**

**Disability Rights Wisconsin**

Toll Free: 800-928-8778

TTY: 711

[www.disabilityrightswi.org/learn/family-care-and-iris-ombudsman-program/](http://www.disabilityrightswi.org/learn/family-care-and-iris-ombudsman-program/)

**For members age 60 and older:**

**Wisconsin Board on Aging and Long Term Care**

Toll Free: 800-815-0015

TTY: 711

http://longtermcare.wi.gov/section\_detail.asp?linkcatid=1953&linkid=1014&locid=123

* **Wisconsin State Health Insurance Assistance Program (SHIP):** Call 800-242-1060 (TTY: 711). Medigap Helpline counselors can help you with Medicare issues, including how to request a state fair hearing. They aren’t connected with any insurance company or health plan. Their services are free. <http://longtermcare.wi.gov/category.asp?linkcatid=1958&linkid=1014&locid=123>
* **Medicare:** Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users can call 1-877-486-2048). Or, visit [Medicare.gov](http://www.Medicare.gov).
* **Medicaid Member Services:** Call 1-800-362-3002.
* **Medicare Rights Center:** Call 1-800-333-4114, or visit [www.medicarerights.org](http://www.medicarerights.org/).
* **Eldercare Locator:** Call 1-800-677-1116, or visit [www.eldercare.acl.gov](https://www.eldercare.acl.gov/) to find help in your community.
* **Aging and Disability Resource Center (ADRC):** Visit [www.dhs.wisconsin.gov/adrc/consumer/index.htm](http://www.dhs.wisconsin.gov/adrc/consumer/index.htm) to find the ADRC nearest to you.

You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY numbers, days and hours of operation>. The call is free.

[*Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, visit* [*www.hhs.gov/civil-rights/for-individuals/section-1557*](http://www.hhs.gov/civil-rights/for-individuals/section-1557).]