DAVID Y. IGE
GOVERNOR

PANKAJ BHANOT
DIRECTOR

CATHY BETTS
DEPUTY DIRECTOR

STATE OF HAWAII
**DEPARTMENT OF HUMAN SERVICES**
Med-QUEST Division
Health Care Services Branch
Quality and Member Relations Improvement Section
P.O. Box 700190
Kapolei, Hawaii 96709-0190

October 16, 2018

MEMORANDUM

MEMO NO.
CCS-1803

TO: 'Ohana Community Care Services (CCS)

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: REVISED TEMPLATES FOR DENIAL OF PAYMENT, DENIAL OF SERVICE AUTHORIZATION AND DENIAL OF SERVICE

The Department of Human Services, Med-QUEST Division (MQD) is issuing this memorandum to provide 'Ohana Community Care Services (CCS) with revised templates for denial of payment, denial of service authorization and denial of service that were distributed on July 9, 2014. Recent changes to 42 CFR §438 have modified required language and timeframes for denials that occur in the CCS program.

The revisions include the following:
1) Title was changed from Notice of Action to Notice of Adverse Benefit Determination (42 CFR §438.404);
2) Timeline for member to file a standard appeal was changed from thirty (30) days to sixty (60) days (42 CFR §438.402); and
3) Timeline to resolve an expedited appeal was changed from three (3) business days to seventy-two (72) hours (42 CFR §438.408) for the denial of service authorization and denial of service.

The attached templates are to be implemented effective immediately and include both the letter and memo formats to be used at your discretion.

Please contact Jon Fujii via e-mail at jfujii@dhs.hawaii.gov or call him at 692-8083 should you have any questions.

Attachments:
6A Notice of Adverse Benefit Determination – Denial of Payment Template – Letter
6B Notice of Adverse Benefit Determination – Denial of Payment Template – Memo
11A Notice of Adverse Benefit Determination – Denial of Service Template – Letter
11B Notice of Adverse Benefit Determination – Denial of Service Template – Memo
12A Notice of Adverse Benefit Determination – Denial of Service Authorization – Letter
12B Notice of Adverse Benefit Determination – Denial of Service Authorization – Memo

# NOTICE OF ADVERSE BENEFIT DETERMINATION
# DENIAL OF PAYMENT
# [health plan logo]

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Notice of Adverse Benefit Determination – Denial of Payment

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you our decision about whether to pay for a service you received.

We _____

recently received a claim for <<service(s)>> _____

_____

_____

_____

provided to you by <<provider name>> _____

on <<date(s) of service(s)>> _____ .

We will not pay for <<service(s)>> _____

_____

_____

_____

Because (Insert appropriate reason: "The request did not meet the established medical necessity criteria or guidelines at this time." "The service is not a covered service under Medicaid/The Plan." or other reason)

_____

_____

_____

_____

You may request a copy at no cost to you of the [criteria, benefit provisions, guidelines, or other information] that the decision was based upon.
We have also told <<provider>> that we will not pay for (Insert appropriate term: this, these) <<service(s)>>.

**(Notice only – This is not a bill)**

Signature: (Medical Director)
cc: Member (when applicable)

[Language block at end of document]

# IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

**What if I Don't Agree With This Decision?**

**You have the right to appeal.**

File your appeal in writing within 60 days after the date of this notice.

**Who May File An Appeal?**

You may file an appeal. If you don't want to file an appeal yourself, you may name a relative, friend, advocate, attorney, doctor, or someone else to act as your representative. You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____ .

If you want someone to act for you during your appeal, you and your representative must sign, date and send us a statement naming that person to act for you.

**What Do I Include With My Appeal?**

Your written request should include:
your name, address, member number, the reasons you disagree with our decision, and any other information you wish to attach.

You may send supporting medical records, doctors' letters, or other information that explains why we should pay for the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give this information to us in person. You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

**How Do I File An Appeal?**

Mail, fax, or deliver your written appeal to the address below:

Address:

Fax:
Toll-Free Phone:
TDD/TTY:

If you ask for an appeal by telephone, you must also send in a written request.

**What Happens Next?**

If you appeal we will review our decision again. We will give you a decision no later than 30 days after we receive your appeal request. After you get our decision, if you still disagree with the decision you will have further appeal rights. You will be notified of those appeal rights if this happens.

**Contact Information:**
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone:
TDD/TTY:

# NOTICE OF ADVERSE BENEFIT DETERMINATION
# DENIAL OF PAYMENT
# [health plan logo]

**Date:** **Member number:**

**Name:** **Reference/Case number:**

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you our decision about whether to pay for a service you received.

We _____ ,

recently received a claim for <<service(s)>> _____

_____

_____

_____

provided to you by <<provider name>> _____

on <<date(s) of service(s)>> _____ .

We will not pay for <<service(s)>> _____

_____

_____

_____

_____

Because (Insert appropriate reason: "The request did not meet the established medical necessity criteria or guidelines at this time." "The service is not a covered service under Medicaid/The Plan." or other reason)

_____

_____

_____

You may request a copy at no cost to you of the [criteria, benefit provisions, guidelines, or other information] that the decision was based upon.
We have also told <<provider>> that we will not pay for (Insert appropriate term: this, these) <<service(s)>>.

**(Notice only- This is not a bill)**

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Toll-Free Phone:
TDD/TTY:

# NOTICE OF ADVERSE BENEFIT DETERMINATION
# DENIAL OF SERVICE
# (health plan logo)

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Notice of Adverse Benefit Determination – Denial of Service

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about a decision we made about services you are receiving. We have (Insert appropriate term: stopped, reduced, suspended) coverage of the following medical services or items that you have been receiving:

_____
_____
_____
_____

We will make this change to your services on (EFFECTIVE DATE OF CHANGE).

[Your transition plan to (insert appropriate term: stop, reduce, suspend) services is (insert information about transition plan).]

We made the decision to (Insert appropriate term: stop, reduce, suspend) this service because:

_____
_____
_____
_____
_____

## What If I Don't Agree With This Decision?

**You have the right to ask (health plan name) for an appeal.** File your appeal in writing within 60 days after the date of this notice. If you want your services to continue during the appeal, all of the following must be met:

- You must ask for services to continue when you give us your appeal;
- Your appeal must be filed within 10 calendar days of this Notice of Adverse Benefit Determination or by the date services will be changed, whichever is later;
- Your appeal must involve stopping, reducing or suspending services or treatments that were already approved;
- The services must have been ordered by an authorized provider;

- The original authorization period cannot have ended yet.

## Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____ .

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

Signature: (Medical Director)
cc: PCP, Service Provider, and Service Coordinator (when applicable)

[Language Block at end of document]

# IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

**There are two kinds of appeals you can file:**

**Standard (60 days) –** You can ask for a standard appeal. If you ask for this appeal by telephone, you must also send in a written request. We will give you a decision no later than 30 days after we get your appeal request. (We may take more time, up to 14 more days, if you request more time, or if we need additional information and taking more time to make our decision benefits you.)

**Fast (72 hours) –** You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 days for a decision. We will decide on a fast appeal no later than 72 hours after we get your appeal request. (We may take more time, up to 14 more days, if you request more time, or if we need additional information and taking more time to make our decision benefits you.)

- **If your doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor says that waiting for 30 days could seriously harm your health, **we will give you a fast appeal.**
- If you ask for a fast appeal without information from your doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 days.

**What do I include with my appeal?**
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a fast appeal you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

**How Do I File An Appeal?**

**For a Standard Appeal:** Mail, fax, or deliver your written appeal to the address below:

Address:

Fax:
Toll-Free Phone:
TDD/TTY:

**For a Fast Appeal:** Contact us by telephone or fax:

Toll-Free Phone:
TDD/TTY:
Fax:

**How Do I Request for Services to Continue During My Appeal?**
**ALL of the following must be met:**

- You must ask for services to continue when you give us your appeal;
- Your appeal must be filed within 10 calendar days of this Notice of Action or by the date services will be changed, whichever is later;
- Your appeal must involve stopping, reducing or suspending services or treatments that were already approved;
- The services must have been ordered by an authorized provider;
- The original authorization period cannot have ended yet.

(If you lose your appeal, you may have to pay for these services that you asked us to continue.)

**What Happens Next?**
If you appeal, we will review our decision again. If we decide to continue your services without any changes, you will receive services right away. If we decide again that your services should be stopped, reduced or suspended, and you still disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

**Contact Information:**
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone:
TDD/TTY:

# NOTICE OF ADVERSE BENEFIT DETERMINATION
# DENIAL OF SERVICE
# (health plan logo)

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Notice of Adverse Benefit Determination – Denial of Service

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about a decision we made about services you are receiving. We have (Insert appropriate term: stopped, reduced, suspended) coverage of the following medical services or items that you have been receiving:

_____
_____
_____
_____

We will make this change to your services on (EFFECTIVE DATE OF CHANGE).

[Your transition plan to (insert appropriate term: stop, reduce, suspend) services is (insert information about transition plan).]

We made the decision to (Insert appropriate term: stop, reduce, suspend) this service because:

_____
_____
_____
_____
_____

## What If I Don't Agree With This Decision?

**You have the right to ask (health plan name) for an appeal.** File your appeal in writing within 60 days after the date of this notice. If you want your services to continue during the appeal, all of the following must be met:

- You must ask for services to continue when you give us your appeal;
- Your appeal must be filed within 10 calendar days of this Notice of Adverse Benefit Determination or by the date services will be changed, whichever is later;
- Your appeal must involve stopping, reducing or suspending services or treatments that were already approved;
- The services must have been ordered by an authorized provider;

- The original authorization period cannot have ended yet.

## Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____ .

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

Signature: (Medical Director)
cc: PCP, Service Provider, and Service Coordinator (when applicable)

[Language Block at end of document]

# IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

**There are two kinds of appeals you can file:**

**Standard (60 days) –** You can ask for a standard appeal. If you ask for this appeal by telephone, you must also send in a written request. We will give you a decision no later than 30 days after we get your appeal request. (We may take more time, up to 14 more days, if you request more time, or if we need additional information and taking more time to make our decision benefits you.)

**Fast (72 hours) –** You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 days for a decision. We will decide on a fast appeal no later than 72 hours after we get your appeal request. (We may take more time, up to 14 more days, if you request more time, or if we need additional information and taking more time to make our decision benefits you.)

- **If your doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor says that waiting for 30 days could seriously harm your health, **we will give you a fast appeal.**
- If you ask for a fast appeal without information from your doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 days.

**What do I include with my appeal?**
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a fast appeal you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

**How Do I File An Appeal?**

**For a Standard Appeal:** Mail, fax, or deliver your written appeal to the address below:

Address:

Fax:
Toll-Free Phone:
TDD/TTY:

**For a Fast Appeal:** Contact us by telephone or fax:

Toll-Free Phone:
TDD/TTY:
Fax:

**How Do I Request for Services to Continue During My Appeal?**
**ALL of the following must be met:**

- You must ask for services to continue when you give us your appeal;
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- Your appeal must involve stopping, reducing or suspending services or treatments that were already approved;
- The services must have been ordered by an authorized provider;
- The original authorization period cannot have ended yet.

(If you lose your appeal, you may have to pay for these services that you asked us to continue.)

**What Happens Next?**
If you appeal, we will review our decision again. If we decide to continue your services without any changes, you will receive services right away. If we decide again that your services should be stopped, reduced or suspended, and you still disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

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Toll-Free Phone:
TDD/TTY:

# NOTICE OF ADVERSE BENEFIT DETERMINATION
# DENIAL OF SERVICE
# (health plan logo)

**Date:** **Member number:**

**Name:** **Reference/case number:**

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about a decision we made about services you are receiving. We have (Insert appropriate term: stopped, reduced, suspended) coverage of the following medical services or items that you have been receiving:

We will make this change to your services on (EFFECTIVE DATE OF CHANGE).

[Your transition plan to (insert appropriate term: stop, reduce, suspend) services is (insert information about transition plan).]

We made the decision to (Insert appropriate term: stop, reduce, suspend) this service because:

## What If I Don't Agree With This Decision?

**You have the right to ask (health plan name) for an appeal.** File your appeal in writing within
60 days after the date of this notice. If you want your services to continue during the appeal, all of the following must be met:

- You must ask for services to continue when you give us your appeal;
- Your appeal must be filed within 10 calendar days of this Notice of Adverse Benefit Determination or by the date services will be changed, whichever is later;
- Your appeal must involve stopping, reducing or suspending services or treatments that were already approved;
- The services must have been ordered by an authorized provider;
- The original authorization period cannot have ended yet.

## Who May File An Appeal?

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advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

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If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

Signature: (Medical Director)
cc: PCP, Service provider, and Service Coordinator (when applicable)

[Language Block at end of document]

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**Fast (72 hours) –** You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 days for a decision. We will decide on a fast appeal no later than 72 hours after we get your appeal request. (We may take more time, up to 14 more days, if you request more time, or if we need additional information and taking more time to make our decision benefits you.)

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- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

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Address:

Fax:
Toll-Free Phone:
TDD/TTY:

**For a Fast Appeal:** Contact us by telephone or fax:

Toll-Free Phone:
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**What Happens Next?**
If you appeal, we will review our decision again. If we decide to give you your services, you will receive services right away. If we decide again that your services should not be given to you and you still disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

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Toll-Free Phone:
TDD/TTY:

# NOTICE OF ADVERSE BENEFIT DETERMINATION
# DENIAL OF SERVICE AUTHORIZATION REQUEST
# (Health plan logo)

[Date]

[Name]
[Address of member]

Member number:
Reference/case number:

Re: Notice of Adverse Benefit Determination – Denial of Service Authorization Request

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about a decision we made about services you or your doctor requested. We have decided to deny the request for coverage of the following medical services or items:

_____
_____
_____
_____
_____
_____

We made the decision to deny this service because:

_____
_____
_____
_____
_____
_____

## What If I Don't Agree With This Decision?

**You have the right to ask (health plan name) for an appeal.** File your appeal in writing within 60 days of the date of this notice.

## Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

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Signature: (Medical Director)
cc: Member (when applicable)

[Language Block at end of document]

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Fax:
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Toll-Free Phone:
TDD/TTY:

# NOTICE OF ADVERSE BENEFIT DETERMINATION
# DENIAL OF SERVICE AUTHORIZATION REQUEST
# (Health plan logo)

---

**Date:** **Member number:**

**Name:** **Reference/Case number:**

---

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about a decision we made about services you or your doctor requested. We have decided to deny the request for coverage of the following medical services or items:

_____

_____

_____

_____

We made the decision to deny this service because:

_____

_____

_____

_____

## What If I Don't Agree With This Decision?

**You have the right to ask (health plan name) for an appeal.** File your appeal in writing within 60 days of the date of this notice.

## Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____ .

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[Language Block at end of document]

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- If you ask for a fast appeal without information from your doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 days.

**What do I include with my appeal?**
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a fast appeal you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

**How Do I File An Appeal?**

**For a Standard Appeal:** Mail, fax, or deliver your written appeal to the address below:

Address:

Fax:
Toll-Free Phone:
TDD/TTY:

**For a Fast Appeal:** Contact us by telephone or fax:

Toll-Free Phone:
TDD/TTY:
Fax:

**What Happens Next?**
If you appeal, we will review our decision again. If we decide to give you your services, you will receive services right away. If we decide again that your services should not be given to you and you still disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

**Contact Information:**
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone:
TDD/TTY: