

 <b>WRAPAROUND MILWAUKEE Policy &amp; Procedure</b>	Date Issued: <b>10/1/06</b>	Reviewed: <b>12/6/10</b> By: <b>PE</b> Last Revision: <b>12/8/10</b>	Section: <b>ADMINISTRATION</b>	Policy No: <b>058</b>	Pages: <b>1 of 2</b> (1 Attachment)
	<input checked="" type="checkbox"/> Wraparound <input checked="" type="checkbox"/> Wraparound-REACH <input type="checkbox"/> FISS <input checked="" type="checkbox"/> Project O-Yeah	Effective Date: <b>1/1/11</b>	Subject: <b>NOTICE OF ACTION TO ENROLLEES</b>		

## I. POLICY

It is the policy of Wraparound Milwaukee or its subcontractors (Care Coordination Agencies), denies, terminates, suspends, limits or reduces a **Medicaid-Related** service (including services authorized by the County that the enrollee was previously enrolled in or services received by the enrollee on a Medicaid Fee-for-Service basis), **affecting the identified enrollee**, Wraparound Milwaukee shall notify the affected enrollee(s) of such action in writing.

## II. NOTICE OF ACTION DEFINITION OF TERMS

1. **Identified Enrollee** – the youth that has been enrolled into the Wraparound Milwaukee program. This does NOT include siblings, caregivers, etc.
2. **Medicaid-Related** – see listing of applicable services below.
3. **Deny** – to refuse services.
4. **Reduce** – to lower or diminish in length, (time) quantity, (units) services.
5. **Terminate** – to end or to finish services.
6. **Suspend** – to stop services temporarily, and then start services again.
7. **Limit** – to limit the length or quantity of services.

### **Wraparound Medicaid-Related Services include:**

Code 5001A – AODA Assessment  
 Code 5173 – AODA Day Services  
 Code 5121 – AODA Group Counseling  
 Code 5101 – AODA Individual/Family Counseling  
 Code 5103 – AODA Lab and Medical Services  
 Code 5182A – Assessment Services – Nursing  
 Code 5000A – Assessment – M.D.  
 Code 5303 – Crisis Stabilization/Supervision Services  
 Code 5172 – Day Treatment – Medicaid  
 Code 5120 – Group Counseling and Therapy  
 Code 5132 – High Risk Counseling and Therapy  
 Code 5163 – Home-Based Behavioral Management – Lead  
 Code 5165 – Home-Based Behavioral Management - Aide  
 Code 5164 – Home-Based Behavioral Management - Technician  
 Code 5161 – In-Home Case Aide  
 Code 5160 – In-Home Lead – Medicaid  
 Code 5100 – Individual/Family Therapy – Office Based  
 Code 5111A – Individual/Family Therapy – Ph.D. – Office Based  
 Code 5355 – Psychiatric Hospital – ER Visit  
 Code 5350 – Psychiatric Hospital  
 Code 5050 – Psychiatric Reviews/Meds.  
 Code 5051 – Psychiatric Reviews/Meds – with Therapy  
 Code 5180A – Psychological Evaluation Services – Ph.D.  
 Code 5130 – Special Therapy (*Occupational Therapy ONLY*)

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Code 5131 – Special Therapy – Group (*Occupational Therapy ONLY*)  
Code 5577 – Transportation (*Medicaid-Reimbursable transports ONLY*)

**III. PROCEDURE**

**A. For Wraparound Milwaukee Administrative/Quality Assurance Initiated Service Changes ONLY.**

When Wraparound Milwaukee denies, terminates, suspends, limits or reduces services for an identified enrollee, **Wraparound Milwaukee shall notify the affected enrollee(s) of this action in writing at least 10 days before the date of the action.**

The period of advance notice is shortened to 5 days, if probable enrollee fraud has been verified or by the date of the action of the following:

1. In the death of an enrollee (when the County is made aware of the death).
2. A signed, written enrollee statement requesting service termination or giving information requiring termination or reduction of services (where the enrollee understands that he/she must be the result of supplying that information).
3. The enrollee's admission to an institution where he/she is ineligible for further services.
4. The enrollee's address is unknown and mail directed to him/her has no forwarding address.
5. The enrollee has been accepted for Medicaid services by another local jurisdiction.
6. The enrollee's physician prescribe the change in the level of mental health/medical care.

***NOTE: In the circumstances referenced above, notification will often be referenced in the disenrollment documentation, as several of the situations lend themselves to the enrollee being disenrolled from the program.***

The "Notice of Action" form (*see Attachment*) will be the means in which the enrollee will be informed.

The enrollee has the right to Appeal the service change within 45 days of the date of the Notice of Action. They may Appeal to the Wraparound Milwaukee Quality Assurance Department, the State of Wisconsin Medicaid/BadgerCare Plus Ombuds (1-800-760-0001) or in writing to:

State of Wisconsin  
Division of Hearings & Appeals  
P.O. Box 7875  
Madison, WI 53707

This notice requirement does not apply when the County, Wraparound Milwaukee or its subcontractors, triages an enrollee to a proper health care provider or when an individual health care provider determines that a service is medically unnecessary.

**B. For Child & Family Team (includes Care Coordinator from Respective Care Coordination Agency), Enrollee or Caregiver Initiated Service Changes ONLY.**

When a change in service occurs as a result of a Child & Family Team, enrollee or caregiver decision, this change will be noted in the appropriate area of the applicable Plan of Care (POC). The POC Signature Sheet that the enrollee and caregiver signs will serve as acknowledgment of the service change. The Signature Sheet references the enrollee's or caregiver's right to Appeal the decision, if they disagree with the service changes within the Plan.

Reviewed & Approved by: Bruce Kamradt

Bruce Kamradt, Director



## Notice of Action

**Purpose:**

To notify Wraparound enrollees if a service is denied, reduced, terminated, discontinued, suspended or limited.

**Enrollee Name:**

Date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Relationship:**

**RE:**

Dear ,

Please be advised that the request to authorize [ENTER SERVICE] services provided to [ENTER YOUTH NAME] at [ENTER AGENCY] has been [ENTER ACTION]. [INSERT REASON].

Please work with your Care Coordinator to obtain another provider for the requested services for [ENTER YOUTH NAME].

**Action Taken:**

Denied  Reduced  Terminated  Suspended  Limited

If you have any questions call Pamela Erdman, Wraparound Quality Assurance Director at (414) 257-7608.

If you do not agree with this decision, please see the attached process to appeal.

**Interpreter Services:**

English – For help to translate or understand this, please call your Care Coordinator.

Spanish – Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono Su Coordinador de Cuidado.

Hmong – Yog xav tau kev pab txhais cov ntaub ntauv no kom koj totaub, hu rau Koj saib xyaus Kevpab

Russian – Если вам не всё понятно в этом документе, позвоните по телефону  
Ваш координатор заботы!

Sincerely,

Jeannine P. Maher  
Provider Network Coordinator

cc: Pamela Erdman – Director, Quality Assurance  
Janet Friedman – Administrator, Finance  
(Care Coordinator)

If you do not agree with this decision you have the right to:

1. Look at the information Wraparound used to make its decision.
2. File a grievance with Wraparound **within 45 days** of the date of this letter if you disagree with the decision.
  - a. If you were not receiving the service before this decision Wraparound Milwaukee does not have to provide or pay for the service while you grieve.
  - b. If Wraparound Milwaukee authorized and paid for the service before this decision, Wraparound Milwaukee must continue to provide the same level of service while you grieve, but if our decision does not change you may have to pay for the services you received while you were grieving.
3. Request that your grievance be handled in an urgent manner, i.e. – within 2 working days, if the decision could result in illness or injury or if the delay in services could affect the enrollees health **as determined by a medical provider.**
4. Meet in person with Wraparound Administration to present more information about your grievance.
5. Bring a friend, family member or representative with you to the meeting.
6. Have an interpreter at the meeting if needed, free of charge.
7. Have the right to appeal to the State of Wisconsin Department of Health Services (DHS) if you do not agree with our decision.

To file a grievance with Wraparound Milwaukee, call the Wraparound Quality Assurance Dept. at **(414) 257-7608**



**If you want to appeal to DHS you can call the BadgerCare Plus Ombuds at 1-800 760-0001.**

8. You also have the right to appeal to the State of Wisconsin Division of Hearings and Appeals (DHA) for a Fair Hearing. You must send an appeal **within 45 days** of the date of this letter if you disagree with the decision. If you appeal this action to DHA before the effective date, the service may continue. You may need to pay for the cost of services if the hearing decision is not in your favor.



**If you want a Fair Hearing, send a written request to:**

Department of Administration  
Division of Hearings and Appeals  
P.O. Box 7875  
Madison, WI 53707-7875



**If you need help writing a request for a Fair Hearing, please call the:**

BadgerCare Plus Ombuds at (800) 760-0001  
**OR**  
Wraparound Milwaukee Quality Assurance  
Department at (414) 257-7608