HOW TO GET THE SERVICES YOU NEED WHEN YOUR AHCCCS HEALTH PLAN TELLS YOU “NO”

(HOW TO APPEAL AN AHCCCS DENIAL OF SERVICES)

Arizona Center for Disability Law
5025 E. Washington Suite 202
Phoenix, Arizona 85034-2005
(602) 274-6287 (Voice/TTY)
1-800-927-2260 (toll free)
(602) 274-6779 (Fax)

100 North Stone Avenue Suite 305
Tucson, Arizona 85701
(520) 327-9547 (Voice/TTY)
1-800-922-1447 (toll free)
(520) 884-0992 (Fax)

www.azdisabilitylaw.org
center@azdisabilitylaw.org

Step 1: ASK FOR THE SERVICE
Health plan has 14 days to make a decision

Step 2: READ THE FIRST DECISION
You have 60 days to appeal

Step 3: SEND IN APPEAL
Health plan has 30 days to make a decision

Step 4: READ THE APPEAL DECISION
You have 30 days to ask for fair hearing

Step 5: ASK FOR A FAIR HEARING
Hearing usually set within 20-40 days

Step 6: FAIR HEARING
Final decision within 30 days of Judge’s decision

Step 7: AHCCCS FINAL DECISION
(May be appealed to Superior Court)

OVERVIEW OF AHCCCS APPEALS PROCESS

The “Notice of Fair Hearing” from AHCCCS will tell you the date, time and place of the hearing. You must appear at the hearing by telephone or in person. The hearing takes place at the Office of Administrative Hearings (OAH). For more information about fair hearings, see guide “How to Represent Yourself at an Administrative Hearing.”

WHAT IF I AM ALREADY RECEIVING A SERVICE AND THE HEALTH PLAN STOPS MY SERVICE?
If you are receiving a service and your health plan wants to stop the service, they must send you a “Notice of Intended Action.” The Notice must be sent at least 10 days before the date your health plan wants to stop the service. The Notice must tell you how you may be able to continue the service. For information on having your service continued while you appeal, contact the Arizona Center for Disability Law.

STEP 6: FAIR HEARING

STEP 7: AHCCCS FINAL DECISION
(May be appealed to Superior Court)
The health plan has 30 days after they receive your appeal letter to mail you an answer. The health plan’s decision on your appeal must be made by a health care professional who knows about treating your medical condition. The letter you get will be called a “Notice of Appeal Resolution.” If the service is denied, the notice will tell you why the decision was made. It will also tell you how to ask for a fair hearing. If you disagree with the decision, go to Step 5.

If your appeal is denied, you have the right to go to a fair hearing. A fair hearing is the chance for you to tell a judge why you need the service or equipment that your health plan will not provide. The letter asking for a fair hearing must be received by the health plan no later than 60 days of the date of their decision to you. Check that date and be aware of the deadline. You may appeal by calling the health plan, but it is better to put your appeal in writing. The health plan will send you a letter saying that they have received your appeal.

Your appeal letter should state why you do not agree with their decision. It should directly respond to the reason for the denial. If the reason for denial is that the service is not “medically necessary” then you should get a letter of medical necessity. Include this letter and any medical records that make your point with the appeal. If the reason for denial is not medical necessity, contact us.

**STEP 1: ASK IN WRITING FOR THE SERVICE**

The first step is to ask the health plan for the health care service that you need. You or your doctor can request the service. It is better for your doctor to directly request the service. Ask the doctor to put in the request the reason that the service or treatment is needed. (See insert on letters of medical necessity.) Be sure your doctor gives you a copy of the request.

**Important Tip to Protect Yourself**

When asking for services, appealing a denial, or requesting a fair hearing, it is important to:
- Put it in writing.
- Keep a copy for yourself
- Get proof of when, where and what you sent.

For mailing, you should send letters by “certified mail, return receipt” which means that you will get a receipt that says the letter was received by the health plan. You can also fax letters directly to the health plan; make sure to keep your fax confirmation sheet.

**STEP 2: READ THE FIRST DECISION**

Your health plan must mail you a written answer within 14 days of receiving your request for services. The letter should tell you:
- Whether the health plan said “yes” or “no” to the service.
- If the answer is “no”, the reason for the denial.
- Your right to appeal and how long you have to appeal.

If the health plan doesn’t mail you an answer within 14 days, you can consider their answer to be “no” and go to step 3.

**STEP 3: SEND IN A WRITTEN APPEAL**

If your health plan said “no”, you can send a written letter to appeal their decision. The appeal letter must be received by the health plan within 60 days of the date of their decision to you. Check that date and be aware of the deadline. You may appeal by calling the health plan, but it is better to put your appeal in writing. The health plan will send you a letter saying that they have received your appeal.

Your appeal letter should state why you do not agree with their decision. It should directly respond to the reason for the denial. If the reason for denial is that the service is not “medically necessary” then you should get a letter of medical necessity. Include this letter and any medical records that make your point with the appeal. If the reason for denial is not medical necessity, contact us.

**STEP 4: READ THE APPEAL DECISION**

The health plan has 30 days after they receive your appeal letter to mail you an answer. The health plan’s decision on your appeal must be made by a health care professional who knows about treating your medical condition. The letter you get will be called a “Notice of Appeal Resolution.” If the service is denied, the notice will tell you why the decision was made. It will also tell you how to ask for a fair hearing. If you disagree with the decision, go to Step 5.

**STEP 5: ASK IN WRITING FOR A FAIR HEARING**

If your appeal is denied, you have the right to go to a fair hearing. A fair hearing is the chance for you to tell a judge why you need the service or equipment that your health plan will not provide. The letter asking for a fair hearing must be received by the health plan no later than 30 days after the date the health plan mailed the “Notice of Appeal Resolution.” Calendar this deadline.

If you do not ask for a hearing by the deadline, the health plan’s decision is final. You must ask for a fair hearing in writing. After AHCCCS receives your letter, they will mail you a “Notice of Fair Hearing.” The hearing should take place within 20 - 40 days.

AHCCCS (Arizona Health Care Cost Containment System) is Arizona’s public health care (Medicaid) program. While on AHCCCS, you receive health care from one of several health managed care plans such as Mercy Care or Cigna. This guide tells you how to ask for the health services you need. It advises what to do if your AHCCCS health plan says “no” to your request or if your health plan stops providing a service. Please read this guide along with the guide “How to Make Your Health Insurance Work for You.”