FLORIDA HEALTH JUSTICE PROJECT

How to File an Appeal with Your Medicaid Managed Care Plan

You have the right to appeal a denial, reduction, or termination of health care services by your Medicaid Managed Care Plan. With some exceptions described below, internal appeals should be filed directly with your health plan; you can request a Medicaid Fair Hearing with the Agency for Health Care Administration (AHCA) if the internal appeal with the plan is unfavorable.

You have a right to file an appeal

➔ How do I file an appeal?

- If your health care services are denied, reduced, or terminated by your Medicaid Managed Care Plan, the plan must provide a **Notice of Adverse Benefit Determination (NABD)**. You will receive a NABD if:
  - The plan denies a requested service.
  - The plan reduces, stops, or suspends previously authorized services.
  - The plan fails to provide services in a timely manner.
  - The plan denies your request to dispute copayments.

- Once you receive a NABD, you have **60 days** from the date of the notice to file an appeal orally or in writing.
  - The plan is required to assist in filing the appeal.
  - We recommend you always follow up in writing if you file an appeal by phone.
  - The plan must confirm receipt of a written appeal within 5 days. If the appeal is filed orally, the plan may follow up in writing within 10 days.

- Services must continue pending the outcome of the appeal, known as **Aid Paid Pending**, if all of the following conditions are met:
  - Previously authorized services were denied, reduced or stopped.
  - The authorization period has not expired.
  - The appeal is filed within 10 days after the plan sends the NABD.

- If the standard appeal timeframe could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function, you can file an **Expedited Appeal**.
  - If the plan grants your expedited appeal request, the appeal must be resolved within **48 hours**.

- ➢ If the plan denies your expedited appeal request, the plan must provide you with written notice of denying your request to expedite the appeal within **48 hours** and transfer your appeal to a normal processing time.

➔ What happens after I file my appeal?

- ❖ The plan is required to reach a resolution within 30 calendar days of your appeal request. You can agree to the plan's request for an extension if there is a need for additional information, and it is in the enrollee's best interest.

- ❖ The plan will issue the outcome of the appeal in a **Notice of Plan Appeal Resolution (NPAR)**. The NPAR contains the appeal results as well as the right to request a fair hearing, instructions on how to request a hearing, and the right to continued benefits.

You have a right to request a fair hearing

➔ How do I request a hearing?

- ❖ If the NPAR is not in your favor, you can request a **Fair Hearing** with the Medicaid Hearing Unit at the Agency for Health Care Administration (AHCA).
  - ➢ You are generally required to file an appeal with the plan and receive an NPAR before you can request a state fair hearing (see exceptions below).

- ❖ **You must request a Fair Hearing** within 120 days of receiving the NPAR.
  - ➢ To have continued benefits, you must request a hearing within 10 days from the date of the NPAR.

- ❖ You can ask for a Fair Hearing orally or in writing by contacting the Agency for Health Care Administration Office of Fair Hearings, using any of the following ways:
    - Phone: 877-254-1055
    - MedicaidHearingUnit@AHCA.myflorida.com
    - Fax: 239-338-2642
  - ➢ The request must include your name, the name of who the hearing is for, their Medicaid ID number, phone number, mailing address, email (if available), and details about the services that were denied, reduced or stopped.

- ❖ *Exceptions to a plan appeal*. You can immediately request a hearing with the state if one of the following occurs:
  - ➢ The plan fails to adhere to the resolution deadlines described above.
  - ➢ The plan fails to provide an NABD or NAPR within the deadlines described above.
  - ➢ The plan fails to provide services requested by the enrollee with reasonable promptness (~90 days) and subsequent failure to issue an NABD.

➔ <u>What happens after I request a hearing?</u>

- ❖ You will receive an acknowledgement of the hearing request from the Agency for Health Care Administration Office of Fair Hearings.

- ❖ You will later receive a Notice of Hearing (NOH) with a date, time, and method of attending a hearing.
  - ➢ Unless you select the option for video or in-person hearing, the hearing will be conducted by telephone.

- ❖ You can have someone else request or attend a Fair Hearing for you.
  - ➢ To do this, you must send a Designated Authorized Representative form signed by you to AHCA.

- ❖ The plan is required to submit the entire case file to the hearing office and to you, the enrollee, free of charge within 10 days of the NOH.
  - ➢ The file should include all medical records and any other documents and records considered or relied upon by the plan regarding the plan appeal.

- ❖ You must provide evidence to the Hearing Officer no less than 10 days before the hearing.
  - ➢ Additional evidence may include a letter of medical necessity from your doctor or other supporting medical records and documents.

➔ <u>What if I can't make it to the hearing or have not found an attorney?</u>

- ❖ The Hearing Officer may grant a continuance (postponement) of a fair hearing for "good cause" or agreement of the parties.
  - ➢ "Good cause" may include your inability to attend the hearing through no fault of your own, a party's good faith need for more time to conduct discovery, or a good faith need for more time to find representation.

- ❖ Except in cases of emergency, you must request a continuance at least five days prior to the date noticed for the hearing.

- ❖ You are required to confer with the other party and state in your written motion (request) for continuance whether there were any objections to the continuance.

➔ <u>What happens at the hearing?</u>

- ❖ A Hearing Officer will conduct the hearing which is only open to you, the plan's representatives, and any witnesses introduced by either party.

- The hearing is conducted "de novo" which means that the Hearing Officer will look at the case from the beginning and can consider any new evidence that was introduced prior to the hearing.

- The hearing officer will swear in witnesses and take their testimony under oath.

➔ What happens after the hearing?

- Unless extended, the hearing officer will issue the decision/Final Order within 90 days of the Fair Hearing request.

- If the decision is not in your favor, within 30 days from the date on the Final Order, you have the right to appeal through the District Court of Appeal.

If you need legal assistance because you were denied services, you can contact Florida Health Justice Project via our website at: Online Intake (legalserver.org)