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Important Changes to Fair Hearing Rights

Beginning May 1, 2018, we will see a major change related to appeals and fair hearing rights affecting Medicaid Managed Care enrollees. To dispute a plan's adverse determination (ie. denials, reductions, or inadequacy), enrollees must "exhaust" the plan's internal appeal process BEFORE requesting a fair hearing. 42 C.F.R. 438.402(c)

How to Request an Internal Appeal

An Initial Adverse Determination (IAD) is the plan's initial decision, on which the member may request an internal appeal. The IAD notice should include an Appeal Request Form. Members or advocates should fax the Appeal Request Form to the fax number listed on the notice. Note: plans require the written consent of the member

to have a representative request an internal appeal on their behalf. The written consent requires a statement, signature and date. To avoid delay, advocates working with Medicaid Managed Care members may want to have their client sign a designation form as part of routine file maintenance in case an appeals request is needed later. You can find a sample Authorization Form here: http://www.wnylc.com/health/download/646/.

Once the internal appeal has been requested, the member or advocate should request the case file from the plan. The case file is the internal appeal equivalent to the fair hearing evidence packet; it provides all of the information and evidence the plan will rely on to makes its case. Reviewing the case file in advance will help the member or advocate prepare their counter-argument for the appeal and fair hearing.

What about Aid Continuing?

The member has up to 60 days after the date of the Initial Adverse Determination to request an internal appeal, but they must request the internal appeal within ten days of the date on IAD notice to receive aid continuing. Aid continuing will keep your services the same while your appeal is pending. This request must be made before the effective date of the notice, and the ten days includes mailing time, weekends and holidays. Thus, with such a limited timeline, it may be critical to obtain the signed designation form in advance. If the request is made within ten days, then aid continuing is automatic.

Similarly, while the enrollee has up to 120 days after the Final Adverse Determination (FAD) to request a fair hearing, they must request the fair hearing within ten days of the date on the FAD notice to receive aid continuing. Note, the member may request aid continuing after the FAD even if they did not request it during the internal appeal. A Final Adverse Determination is the plan's final decision after the internal appeal.

What is "Deemed Exhaustion"?

Deemed Exhaustion is an exception to the exhaustion requirement and allows the member to request a fair hearing without receiving an FAD. If the plan fails to comply with notice requirements, the member is deemed to have exhausted internal appeals. Examples of failed compliance include the following:

- No written IAD notice
- IAD notice lacks information regarding aid continuing and how to request an appeal
- IAD lacks necessary alternative formats (ie. translation, accessible format, etc.)
- FAD not provided within 30 days from the member's appeal request (or 72 hours from receipt of request if expedited appeal request)

Step-by-Step

Step 1: Obtain a written consent designation form from member

Step 2: Request the internal appeal within 10 days of the date on the IAD (or

within 60 days if no aid continuing)

Step 3: Request the Case File from the plan

Step 4: Request a fair hearing within 10 days of the date on the FAD (or within 120 days if no aid continuing) or request a fair hearing if you do not receive a FAD within 30 days from date of appeals request

Ultimately, the new exhaustion rules may complicate due process and the member's opportunity for aid continuing. It is crucial that members and advocates are mindful of the sequence and timelines to request the internal appeal and external fair hearing. It is also important to understand the reason for changes in the member's services. For example, if the member receives homecare through a Managed Long Term Care plan and the homecare assistance stops, the member or advocate will need to determine whether it discontinued due to a plan determination or because the member's Medicaid coverage ended. If it was due to a plan determination, the member should receive the IAD and request an Internal Appeal. If it was because the member lost Medicaid coverage, they should request a fair hearing immediately against their local district of social services. For more information, go to http://www.wnylc.com/health/news/80/

Last updated on May 01, 2018.

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