

PIMA HEALTH SYSTEM
STANDARD AND PROCEDURE

SUBJECT: Member Appeal of Action	Administration
APPLICABLE TO: Acute Care, Long Term Care Members	Grievance System
EFFECTIVE DATE: 07/09 APPROVED BY: <i>Patricia Alvarez by signature</i>	GA-I-001
SUPERSEDES: 10/18/05; 1/30/02 Member Grievance and Request for Hearing; 12/1/03; 2/23/04, Member Appeal of Action 5/25/07, 6/28/04, 04/08, 06/24/09	

I. STATEMENT OF PURPOSE:

This Standard and Procedure establishes a process for members to file an appeal of an action taken by Pima Health System (PHS). This Standard and Procedure does not apply to decisions affecting a member’s eligibility, decisions that reduce a member’s benefits as a result of changes in state or federal law, or to actions arising from the non-Arizona Health Care Cost Containment System (AHCCCS) programs or other non-Medicaid programs administered by PHS.

Statutory Basis: BBA Medicaid Managed Care Regulations 42 CFR 438 Subpart F Grievance System; and AHCCCS Administrative Code,¹ and policies.

II. DEFINITIONS:

Action means the:

- denial or limited authorization of a requested service, including the type or level of service;
- reduction, suspension, or termination of a previously authorized service;
- denial of payment for a service not covered by AHCCCS;²
- failure to provide a service in a timely manner;
- failure of PHS to resolve a grievance or appeal within the timeframes provided in this Standard and Procedure; or
- denial of a rural enrollee’s request to obtain services outside the PHS network when PHS is the only program contractor in the rural area;³
- denial of a member’s request to reduce or waive a lien on a third party liability claim.⁴

Appeal means a request either orally or in writing, from a member or provider on behalf of a member for review of an action made within 60 days from the date on the Notice of Action.

Standard appeal an appeal processed within 30 days from the date of receipt.

Expedited appeal: An appeal that is supported with documentation from the member’s healthcare provider that indicates the standard resolution timeframe could seriously jeopardize

¹ In accordance with Chapter 34 AHCCCS Grievance System, Article 2 Appeal, Grievance and Hearing for An Enrolled Person.
² In accordance with AHCCCS Policy and Procedure: Member Notice for Non-Covered Services, effective 10/1/03.
³ Unless excepted by AHCCCS, subject to the requirements in 42 CFR 438.52 (b)(2)(ii). Rural has the same meaning as in A.R.S. 36-2171.
⁴ Action appealable, as recommended by Pima County Deputy County Attorney. Lien actions are not subject to notice requirements as provided in this Standard and Procedure.

the member's life, health, or ability to attain, maintain, or regain maximum function. An expedited resolution shall be no later than three business days⁵ following the receipt of the expedited appeal request unless an extension is in effect.

Appeal Specialist: the person responsible for resolution of appeals, claim disputes and grievances.

Grievance Manager: the person responsible for the management of the Grievance Department.

Grievance Department: The department responsible for resolution and oversight of member appeals, member grievances and provider claim disputes.

Days mean calendar days unless otherwise specified in the text.⁶

Director's Decision means the final administrative decision under ARS 41-1092(5).

Filed means the date that PHS receives the request as established by a date stamp on the written document or other record of receipt.

Member means a person eligible for and enrolled in the Arizona Health Care Cost Containment System (AHCCCS) and/or the Arizona Long Term Care System (ALTCS). In the context of this Standard and Procedure, the member's health care decision maker as defined by A.R.S. § 12-2291 is treated with the same rights and authority to amend, receive, or access the member's health information unless prohibited or excepted by state law or the Privacy Rule.⁷

Notice of Action means a written statement of the intended action taken by PHS, provided to the member. The written notice states the factual and legal basis for the action.⁸

The Notice of Action explains:

- the action PHS has taken or intends to take;
- the reason for the action, including the relative laws, rules and policies of the decision; the member's right to file an appeal with PHS;
- the procedures for exercising these rights;
- circumstances when an expedited resolution is available and how to request it; and
- the member's right to request continued services pending resolution of the appeal, how to request continued benefits and the circumstances under which the member may be required to pay for the cost of these services.

Notice of Appeal Resolution: the written notice provided to the member, which explains the appeal decision. The Notice includes, in easily understood language:

5 Business day means a Monday, Tuesday, Wednesday, Thursday, or Friday; unless a legal holiday falls on one of those days or a legal holiday falls on Saturday or Sunday and PHS is closed for business the prior Friday or following Monday. Business days and working days in the context of this Standard and Procedure are used interchangeably.

6 As defined by AHCCCS computation of time for calendar day begins the day after the act, event, or decision and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday. Business day begins the day after the act, event or decision and includes all business days (Monday through Friday except for when those days fall on an observed holiday).

7 State law may prohibit or except access to medical records by additional statutes. The Privacy Standard prohibits or excepts access to records in 45 CFR§164.524.

8 Although the federal requirement does not include the legal authority for the action, AHCCCS maintains this requirement as an internal check that the action is justified and to assist the fact finder in the adjudication process.

- the statutory and legal basis for the decision of the appeal;
- the date the appeal was competed; and
- how to file a State Fair Hearing.

Office Support Staff: the person responsible for the intake support of the Grievance Department.

Service Authorization Request is a member's request for the provision of a service. A service authorization request can be either standard or expedited.

Standard authorization request is a request for a service authorization that requires a decision by PHS as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the request.

Expedited authorization request is a request for a service authorization that requires an accelerated decision because a delay in the decision could seriously jeopardize the member's life, health, or the ability to attain, maintain, or regain maximum function. An expedited decision provides a Notice of Action to the member no later than three working days following the receipt of the expedited authorization request.

State Fair Hearing means an administrative hearing under A.R.S. Title 41, Chapter 6, Article 10.

III. STANDARDS:

A. ASSISTANCE AND INFORMATION PROVIDED TO MEMBERS AND PROVIDERS:

1. Members are provided with information in accordance with Pima Health System Standard and Procedure: Member Handbook, MS-I-0004 and MS-I-0005.
2. The Member Handbook, translated in the prevalent non-English language and in an easily understood format,⁹ provides the member with information about:
 - a. the member's rights;
 - b. the process, requirements and timeframes to file an appeal, with telephone numbers including a toll free number that the member may use to file an appeal by telephone; and
 - c. the availability of free oral interpretation services in any language and how a member may obtain this information.
3. Written documents, including, but not limited to, the Notice of Action and Extension of Notice of Action, are translated into Spanish and contains information in a prominent location on the first page in the secondary prevalent non-English language advising the member that oral interpretation of the document is available.
4. The Notice to Acknowledge Receipt of Appeal, Notice of Appeal Resolution and Extension of Appeal Resolution are translated into Spanish if information is received by the Appeals Manager either orally or in writing, indicating that the member has a limited English proficiency in that language. The notices are orally translated into any other

⁹ In accordance with AHCCCS policy and procedure: Cultural Competency.

language when requested by the person receiving a notice who has limited English proficiency.

5. PHS makes reasonable assistance available in the process of filing an appeal or requesting a State Fair Hearing, including but not limited to, interpreter services and toll free numbers with adequate TTY/TTD capabilities.
6. PHS provides this Standard and Procedure to all providers and subcontractors at the time of contract in accordance with Pima Health System Standard and Procedure: Provider Communication, PS-I-0007.
7. Significant changes in this Standard and Procedure are provided to the member at least 30 days before the intended effective date of the change.
8. PHS does not discriminate against an eligible person or member because of race, color, creed, religion, ancestry, limited English proficiency, marital status, sexual preference, national origin, age, sex, or physical or mental disability, in accordance with Title VI of the U.S. Civil Rights Act of 1964.

B. NOTICE OF ACTION:

1. A Notice of Action (Exhibit A) is provided by PHS to the member within established timeframes for the:
 - a. termination, suspension, or reduction of a previously authorized AHCCCS covered service;
 - b. denial of a covered AHCCCS service¹⁰ authorization request or the reduction of a service authorization request
2. A Notice of Action (Exhibit C) is provided to the member within established timeframe for an action affecting a claim when there has been a denial of payment for a non-covered AHCCCS service (Attachment C).
3. PHS notifies the requesting provider of the decision to deny or reduce a service authorization request. The notice to the provider need not be written.
4. An Extension of Notice of Action (Exhibit B) is provided to the member when PHS extends the timeframe for a standard or expedited authorization decision. The member has the right to file a grievance in accordance with Pima Health System Standard and Procedure: Member Grievance, GA-I-002 if the member disagrees with the reason PHS intends to extend the timeframe.
5. For service authorization decisions not reached within the maximum timeframe, in this Standard and Procedure, the authorization shall be considered denied on the date that the time frame expires.

¹⁰ Referral requests for non-covered AHCCCS services are processed in accordance with PHS Standard and Procedure: Prior Authorization Process, UM-MM-III-001.

C. FILING AN APPEAL:

1. A member,¹¹ or a provider on behalf of the member, with the member's written consent, has the right to file an appeal in accordance with this Standard and Procedure for the following actions:
 - a. the denial or limited authorization of a request for an AHCCCS covered service including the type or level of service;
 - b. the reduction, suspension, or termination of a previously authorized AHCCCS covered service;
 - c. the denial of payment for a non-covered AHCCCS service;
 - d. the failure of PHS to provide services in a timely manner;
 - e. the failure of PHS to comply with the timeframes for disposition of grievances and appeals; and
 - f. the denial of a rural member's request to obtain services outside the PHS network when PHS is the only provider in the rural area; or
 - g. denial of a member's request to reduce or waive a lien on a third party liability claim.¹²
2. Appeals must be filed with the PHS Appeals Manager within 60 days from the date on the Notice of Action, or within 60 days from another action not requiring a Notice of Action.¹³
3. An appeal submitted by a member must be filed either orally [Member Request to File an Oral Appeal form (Exhibit D)] or in writing.
4. Appeals submitted by a provider on behalf of a member must be in writing. Written consent from the member is required on all provider submitted appeals, except requests for expedited appeals.
5. No punitive action shall be taken against a provider who requests an expedited resolution or supports a member's appeal.
6. An appeal is considered filed upon PHS' receipt of either an oral or written appeal and is considered a standard appeal unless an expedited appeal¹⁴ is requested and the request qualifies the appeal as an expedited appeal.
7. PHS may deny a request for an expedited appeal resolution where there is insufficient documentary evidence from the member's health care provider that the 30-day timeframe for a standard resolution would seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

¹¹ In the context of this Standard and Procedure, "member" is used for simplicity and includes the member enrolled with PHS or the member's legal representative with all the rights and obligations under the law to act on behalf of the member.

¹² Action appealable, as recommended by Pima County Deputy County Attorney. Lien actions are not subject to notice requirements as provided in this Standard and Procedure.

¹³ Actions not requiring a Notice of Action are: a) the failure to provide services in a timely manner; b) the failure of PHS to comply with the timeframes for disposition of grievances and appeals; or (c) the denial of a rural member's request to obtain services outside the PHS network when PHS is the only provider in the rural area.

¹⁴ This requires a health care provider's statement or records showing that the member's health condition would be jeopardized unless a decision is made within three business days.

8. PHS makes a reasonable effort to give the member prompt oral notice and provide written notice within two business days of the denial of expedited resolution.
9. A standard appeal is acknowledged in writing within five business days of its receipt.
10. An expedited appeal is acknowledged orally within one business day of its receipt.
11. The member, upon written request, may withdraw an appeal at any time prior to the resolution of the appeal.
12. A member's failure to submit an appeal in a timely manner is determined to be a failure to exhaust administrative remedies required as a condition to seeking judicial relief.

D. EXTENSION OF BENEFIT REQUEST:

1. The member may request continued benefits pending resolution of the appeal if:
 - a. the member requests a continuation of benefits when filing an appeal;
 - b. the appeal is filed before the later of 10 days from the mailing of the Notice of Action or the intended date of PHS action;
 - c. the appeal involves termination, suspension, or reduction of a previously authorized course of treatment;
 - d. the benefit was ordered by an authorized provider; and
 - e. the original period covered by the original authorization has not expired.
2. PHS continues or reinstates benefits originally provided to the member until one of the following occurs:
 - a. the member withdraws the appeal;
 - b. the appeal resolution has been rendered adverse to the member;
 - c. the member has not specifically requested to continue benefits upon filing a State Fair Hearing within 10 days from the mailing of the Notice of Appeal Resolution (Exhibit H); by PHS;
 - d. 10 following the time AHCCCS Administration issues a State Fair Hearing decision on behalf of the member, or
 - e. the time period or service limits of a previously authorized service have been met.

E. RESOLUTION OF APPEAL:

1. PHS provides the member and/or his representative the opportunity before and during the appeal process to examine the appeal file, including medical records and other documents, unless protected by law, considered during the appeal process. Parties of the appeal may include the member, the member's legal representative, or the legal representative of a deceased member's estate.
2. PHS provides the member, or member's representative, a reasonable opportunity to present evidence and allegations of fact or law in person or in writing. PHS orally informs the member of the limited time available in cases involving expedited resolution.

3. Individuals who make decisions regarding grievances or appeals are individuals not involved in any previous level of review or decision making. Individuals who make decisions regarding 1) appeals of denials based on lack of medical necessity, 2) a grievance regarding denial of expedited resolution of an appeal, or 3) appeals involving clinical issues are health care professionals¹⁵ with the appropriate clinical expertise in treating the member's condition or disease.
4. If PHS denies a request for expedited appeal resolution, the appeal is transferred to the 30-day timeframe for a standard appeal resolution. PHS notifies the member through prompt oral notice and follow-up within two business days with a written notice of the denial of expedited appeal.
5. An expedited appeal that is approved shall be resolved no later than three business days from the date PHS receives the appeal, unless an extension is in effect. PHS makes a reasonable effort to provide oral notice to a member regarding an expedited resolution appeal.
6. A standard appeal is resolved no later than 30 days from the date of receipt of the appeal, unless an extension is in effect.
7. An Extension of Appeal Resolution (Exhibit G) is provided to the member when PHS extends the timeframe up to 14 days for a standard or expedited resolution of the appeal and includes the reason for the decision to extend the timeframe.
8. PHS provides a written Notice of Appeal Resolution (Exhibit H or H-1) to the member or the representative of a deceased member's estate within the allowable timeframe. The notice contains the resulting decision of the appeal and the date it was completed.
9. If a Notice of Appeal Resolution is not sent to the member within the allowable timeframe for an appeal resolution, the member has the right to file a grievance with PHS in accordance with PHS Standard and Procedure: Member Grievances, GA-I-002.
10. For appeals not resolved wholly in favor of the member, the Notice of Appeal Resolution (Exhibit H) contains:
 - a. the legal citations or authorities supporting the determination;
 - b. the member's right to request a State Fair Hearing no later than 30 days from the date of Notice of Appeal Resolution and how to do so;
 - c. the right to receive benefits pending the State Fair Hearing and how to request continuation of benefits, if applicable; and
 - d. information explaining that the member shall be held liable for the cost of benefits received during the appeal or hearing process if the hearing decision upholds PHS' decision.

¹⁵ As defined in 42 CFR 438.2

F. REQUEST FOR STATE FAIR HEARING:

1. The member may request a State Fair Hearing by submitting a request for a State Fair Hearing to the PHS Grievance Department in writing within 30 days following receipt of PHS' Notice of Appeal Resolution.
2. The member may request to withdraw a request for a State Fair Hearing by written request. If the AHCCCS Notice of Hearing has not been mailed, the request is made to PHS. If the Notice of Hearing has been mailed, the written request to withdraw the appeal shall be sent to the AHCCCS Office of Administrative Hearing.
3. If PHS, or the Director's Decision, reverses a PHS decision to deny, limit, or delay benefits not furnished while the appeal was pending, PHS authorizes or provides the benefits promptly and as expeditiously as the member's health condition requires.
4. If PHS, or the Director's Decision, reverses a PHS decision to deny authorization of benefits and the disputed services were received pending appeal, PHS shall pay for those benefits, as specified in policy and/or regulation.
5. If PHS, or the Director's Decision, upholds a PHS decision to deny authorization of benefits and the disputed benefits were received pending appeal, PHS may recover the cost of those benefits from the member for the period until the appeal was decided by the Director if the services were furnished solely because of the requirements in this Standard and Procedure.

G. RECORD MAINTENANCE:

1. An appeal is considered closed:
 - a. on the day the member voluntarily withdraws the appeal or State Fair Hearing request; or
 - b. 30 days following the PHS appeal resolution when no State Fair Hearing is filed; or
 - c. 35 days following the AHCCSA Director's Decision.
2. Member files are stored alphabetically by the member's last name and separated by programs (either long-term care or acute care).
3. The appeal file, which includes all notices, forms, and documents pertaining to the appeal or a request for a State Fair Hearing, are maintained and stored in a secure, designated file cabinet by the Grievance Department for a period of one year. The file is then transferred to Pima County Storage and Archives for a period of five years.
4. Member information is safeguarded and released only upon authorization by the member, except as provided by law¹⁶ and in accordance with PHS Standard and Procedure: Uses and Disclosure of Member's Health Information, AD VIII-0010.

¹⁶ As incorporated in PHS Standard and Procedure: Compliance with Privacy of Member's Health Information; AD-VIII-0006; Uses and Disclosure of Member's Health Information; AD-VIII-0010; and Administrative Procedures to Protect Client Health Information AD-I-0015.

III. PROCEDURES:

A. NOTICE OF ACTION FOR SERVICE AUTHORIZATION REQUEST:

1. The PHS Prior Authorization Division staff, responsible for reviewing service authorization requests, mails a Notice of Action to the member for the denial or limited authorization of a requested AHCCCS covered service, including the type or level of service:¹⁷
 - a. within 14 days from receipt of a request for a standard service authorization that has been denied or reduced, unless an extension is in effect;
 - b. as expeditiously as the member's health condition requires, but no later than three (3) business days from receipt of an expedited service authorization request unless, an extension is in effect;
 - c. within 14 days for either a standard or expedited authorization request when an extension of a decision of the authorization request requires additional time.
2. PHS may elect to mail the Notice of Action no later than the date of action when:
 - a. PHS receives notification of the death of the member,¹⁸
 - b. the member is admitted to an institution where he/she is ineligible for further services;
 - c. the member's address is unknown, and mail directed to the member has no forwarding address; or
 - d. the member has been accepted for Medicaid in another local jurisdiction.
3. If a member, or a provider acting on behalf of a member, requests an extension, the service authorization request decision may be extended up to 14 days for either a standard or expedited authorization request. A written request is attached to the authorization request for documentation purposes.
4. If PHS requests an extension to make the service authorization decision, the Prior Authorization Division staff mails the Extension of Notice of Action form to the member and the provider. The reason for an extension requested and why it is in the best interest of the member is stated in easily understood language.
5. The Notice of Action is prepared with all relevant fields completed, including the legal basis for the reason for the decision and possible recommendations for alternative services as appropriate.
6. The Notice of Action is sent to the member by certified mail. A copy of the Notice is kept on file by the PHS Prior Authorization Division for a period of five years from the date of the Notice.

¹⁷ In accordance with PHS Standard and Procedure: Prior Authorization Process, UM-MM-III-001; Chief Medical Officer's Role in Medical Management, UM-MM-III-001.

¹⁸ PHS Standard and Procedure: Notification to Members Regarding Denial, Reduction, Suspension or Termination of Case Manager Authorized ALTCS Services, CM-GEN-III-0005 includes exceptions to advance notice when there is a confirmation of the member's death.

B. NOTICE OF ACTION FOR CHANGE IN PREVIOUSLY AUTHORIZED SERVICE:

1. The assigned PHS Long Term Care Case Manager,¹⁹ the Behavioral Health Case Manager, or the Prior Authorization staff for Acute Care Services members mails a Notice of Action to the member for any termination, suspension, or reduction of previously authorized services:
 - a. at least 10 days before the date of the termination, suspension, or reduction of previously authorized AHCCCS covered services;
 - b. at least five days before the date of action in the case of suspected fraud.
2. The Notice of Action may be sent no later than the date of action when:
 - a. PHS receives notification of the death of the member;²⁰
 - b. the member is admitted to an institution where he/she is ineligible for further services;
 - c. the member's address is unknown and mail directed to the member has no forwarding address;
 - d. the member signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information); or
 - e. the member has been accepted for Medicaid in another local jurisdiction.
3. The Notice of Action is prepared with all relevant fields completed, including the legal basis for the reason for the decision and possible recommendations for alternative services as appropriate.
4. The Notice of Action is sent to the member by certified mail. A copy of the Notice of Action is included in the member's case record and retained for five years.

C. NOTICE OF ACTION FOR DENIAL OF PAYMENT:

1. The PHS Office of Corporate Compliance mails a Notice of Action (Exhibit C) to the member at the time of any action affecting a claim when there has been a denial of payment for a benefit not covered by AHCCCS.
2. A report showing claims denied for non-covered services is prepared weekly by the PHS Information Systems Division and forwarded to the PHS Compliance Office. The Compliance Office reviews the report and prepares the Notice of Action by completing all fields including the legal or statutory basis for the denial in easily understood language.
3. The Notice of Action is sent to the member by certified mail. A copy of the Notice is filed in a confidential file to document the notice to the member and maintained for five years from the date on the Notice.

¹⁹ In accordance with PHS Standard and Procedure: Notification to Members Regarding Denial, Reduction, Suspension, or Termination of Case Manager Authorized ALTCS Services, CM-GEN-III-0005.

²⁰ PHS Standard and Procedure: Notification to Members Regarding Denial, Reduction, Suspension or Termination of Case Manager Authorized ALTCS Services, CM-GEN-III-0005 includes exceptions to advance notice when there is a confirmation of the member's death.

D. APPEAL FILED:

1. Upon receipt of an appeal, the Grievance Department Office Support staff:
 - a. date stamps the written or oral request for appeal at time of receipt;
 - b. verifies the timeliness of the appeal request;
 - 1.) if the member's appeal was received past the date allowed for filing an appeal, a Denial of Appeal Notice (Exhibit F) is sent to the member within two working days of receipt of the appeal.
 - c. verifies the authority of the person requesting the appeal, if other than the member;
 - 1.) If the appellant is a provider and the appeal request is for a standard resolution, or the appeal request is from some other person who does not have authority to represent the member, the Office Support Staff sends an Appointment of Representative (AOR) letter with an AOR form to the member and provider requesting the AOR form be signed and returned. The appeal will be processed upon receipt of signed permission from the member.
 - 2.) If the appellant is a provider who is requesting an expedited appeal the appeal is processed as an expedited appeal, in accordance with Procedure E.
 - 3.) If the member's identity or member's representative's legal authority cannot be verified within the allowed filing limit for an appeal, the Office Support Staff sends a Denial of Appeal Notice to the person who filed the appeal.
 - d. Verifies appeal type:
 - 1.) Standard Appeal
 - 2.) Expedited Appeal
 - 3.) Requests for continued benefits during the appeal process
 - f. Enters the appeal information into the Grievance Database including, but not limited to (and log is updated, as necessary, until the appeal is closed):
 - 1.) Date received;
 - 2.) Date of acknowledgement;
 - 3.) Date of resolution;
 - 4.) Appeal status;
 - 5.) Appeal type, in accordance with AHCCCS reporting requirements:
 - a.) Reduction, suspension or termination of a previously authorized service;
 - b.) Denied service;
 - c.) Failure to provide services timely;
 - d.) Failure of a contractor to act timely;
 - e.) Denial of out of network services;
 - f.) Claim denial.
 - 6.) Assigns a number for identification and reporting purposes in accordance with the following coding scheme:

Example: M-00-A-101900-01

M = Member

00=Contract Year

A= Program (A = Acute; L = LTC)

101900 = Month, Day, Year Received

01 = The number, in order, of appeals received for the date
 - g. Creates a member appeal file, containing all relevant information regarding the appeal.

E. STANDARD (30-day) APPEAL FILED:

1. The Office Support Staff:
 - a. Sends a Notice to Acknowledge Receipt of Appeal (Exhibit E) to the member or member's representative acknowledging receipt of the appeal in writing within five days of receipt of the appeal;
 - b. Forwards case to assigned Appeal Specialist.

2. The Appeal Specialist:
 - a. Requests medical records or other documentation, if available, to assist in a thorough investigation into the matter of the appeal using applicable statutory, regulatory and contractual provision, PHS standards and procedures, and collects all facts from all parties pertinent to the appeal;
 - b. Refers all medical issues for investigation and recommendation in accordance with PHS Standard and Procedure: Chief Medical Officer's Role in Medical Management, UM-MM-III-001, or to the Utilization Management Manager or the Corporate Compliance Officer for review.
 - c. Sends the Notice of Appeal Resolution to the member and the member's representative, or the representative of a deceased member's estate, which provides a written explanation to the resolution of the appeal.
 - 1.) If the decision is not in favor of the member, sends the Notice of Appeal Resolution by certified mail.
 - 2.) If the decision is in favor of the member, the Appeal Specialist facilitates the appeal decision.

3. Forwards the case to the Office Support Staff for closure in the Grievance Database and filing.

4. The Office Support Staff tracks the file until either a State Fair Hearing is requested by the member within 30 days from the date the Notice of Appeal Resolution was received by the member, or when no State Fair Hearing is filed within the timeline to file a hearing, and updates the Grievance Database.

E. EXPEDITED (three day) APPEAL FILED:

1. Upon receipt of an expedited appeal, the Office Support Staff:
 - a. evaluates the evidentiary documentation to support an expedited appeal resolution;
 - 1.) If the expedited appeal request is filed by a provider, the expedited appeal request is granted and processed as an expedited appeal.
 - 2.) If an expedited appeal is filed by the member, the request is referred to the Medical Director for review in accordance with PHS Standard and Procedure: Chief Medical Officer's Role in Medical Management, UM-MM-III-001;
 - a.) If the Medical Director determines the request meets expedited appeal criteria, the appeal is processed as an expedited appeal.
 - b.) If the Medical Director determines the request does not meet expedited appeal criteria:
 - i. The Office Support Staff promptly telephones the member of the denial for a request for expedited appeal if the reason for the expedited appeal resolution is not substantiated;

- ii. Follows up the oral notice of denial for a request for an expedited appeal with a written notice;
 - iii. Processes the appeal as a standard appeal.
- 2. Expedited Appeal approved:
 - a. The Office Support Staff:
 - 1.) creates a member's appeal file containing all relevant information regarding the appeal;
 - 2.) Sends a Notice to Acknowledge Receipt of Appeal (Exhibit E) to the member or member's representative acknowledging receipt of the appeal in writing within five days of receipt of the appeal;
 - 3.) Forwards the case to the assigned Appeal Specialist and notifies the Appeal Specialist of the expedited appeal status.
 - b. The Appeal Specialist:
 - 1.) requests medical records or other documentation from the member's medical provider, if time allows, to assist in a thorough investigation into the matter of the appeal using applicable statutory, regulatory and contractual provisions; PHS standards and procedures; and collects all facts from all parties pertinent to the appeal;
 - 2.) The Appeal Specialist refers all medical issues for investigation and recommendation in accordance with PHS Standard and Procedure: Chief Medical Officer's Role in Medical Management, UM-MM-III-001; or to the Utilization Management Manager or Corporate Compliance Officer for review.
 - 3.) Telephones the member or member's representative, within three business days, with an explanation to the resolution of the appeal. If the decision is not in favor of the member, the member is told in easily understood terms the statutory and the legal basis for the decision of the appeal and how to file a State Fair Hearing;
 - 4.) Sends the Notice of Appeal Resolution to the member or the member's representative, which provides a written explanation to the resolution of the appeal as provided orally. If the decision is not in favor of the member, sends the notice by certified mail. The notice includes in easily understood language the statutory and the legal basis for the decision of the appeal and how to file a State Fair Hearing;
 - 5.) Forwards the case to the Office Support Staff for closure in the Grievance Data Base, and filing.
 - c. The Office Support Staff tracks the file until either a written request for State Fair Hearing is received, or the 30-day time frame from the date the Notice of Appeal Resolution to file a State Fair Hearing has been exceeded, and updates the Grievance Database.

F. EXTENSION OF BENEFITS REQUEST BY MEMBER:

- 1. If the member requests continuation of benefits during the appeal and it is within the timeframe allowed for the request, the Appeals Specialist:
 - a. records the request in the member's appeal file;
 - b. reviews the request for continuation of benefits for appropriateness in accordance with this Standard and Procedure.

2. The Appeals Specialist notifies the following PHS associates when the member requests an extension of benefits, either at the time of filing an appeal, or if the member files a State Fair Hearing and has requested an extension of the benefits within the allowable 10-day timeframe:
 - a. the assigned Long Term Care Case Manager of the request from an ALTCS Long Term Care member;
 - b. the assigned ALTCS Behavioral Health Case Manager of the request from an ALTCS Behavioral Health member;
 - c. the PHS Prior Authorization Manager of the request for continued medical services.

3. The Appeals Specialist notifies the PHS associate as in F.2 in writing to discontinue the benefits:
 - a. when the member withdraws the appeal;
 - b. when the member, who was receiving extended benefits during the appeal, failed to file a State Fair Hearing and 10 days have lapsed from the date of the mailing of the Notice of Appeal Resolution; or
 - c. upon receipt of the Director's Decision following a State Fair Hearing when the decision is adverse to the member.

4. If the request to extend the benefits does not meet the standard for continuation of services, the Appeals Specialist:
 - a. informs the member by telephone within one working day of the request of the reason for the denial;
 - b. notifies the Long Term Care Case Manager; the Behavioral Health Case Manager or Prior Authorization Manager by telephone of the denial for continued benefits;
 - c. documents the member's appeal file accordingly.

G. EXTENSION TO RESOLUTION REQUEST:

1. If the Appeals Specialist extends the timeframe for the resolution of standard or expedited appeal, the Appeals Specialist provides the member with a written notice of Extension of Appeal Resolution stating the reason for the delay and updates the member's file to indicate the extension request.

2. If the member or member's representative requests an extension, the Appeals Specialist updates the member's file to indicate the extension request.

3. The Appeals Specialist completes the procedure for a standard or expedited appeal within the extended timeframes.

4. The Office Support Staff logs the extension into the Grievance database upon closure of the case.

H. STANDARD (30-day) STATE FAIR HEARING FILED:

1. Upon receipt of a written request to file a State Fair Hearing, the Office Support Staff:
 - a. date stamps the written request at time;

- b. verifies the timeliness of the request; if the request is deemed untimely it is forwarded with the notation that the issue to be heard is the timeliness of the request.
 - c. verifies the authority of the person requesting the hearing, if other than the member;
 - d. logs the request for State Fair Hearing into the Grievance database indicating the date received. The log is updated, as necessary, until the hearing is closed;
 - e. updates the Member's appeal file.
2. The Office Support Staff forwards the request for a State Fair Hearing and all supporting documents to AHCCCS Administration Office of Administrative Legal Services within five business days from the date the request for hearing was received, including:
 - a. a cover letter describing the matter of the appeal and a summary of relevant facts of the PHS decision; the name, address, phone number and AHCCCS ID number of the member; a dated copy of the member's written request for hearing;
 - b. a copy of the entire file, including the investigations, and/or medical records;
 - c. a copy of the PHS Notice of Appeal Resolution;
 - d. any other information used by PHS to resolve the appeal that would be necessary for AHCCCS to resolve the issue.
 3. Upon receipt of the notice of date and time of the hearing scheduled by OLA with the Office of Administrative Hearing (OAH), the Office Support Staff:
 - a. notifies the PHS Medical Director and all other parties to the hearing of the date, time and place set for the hearing;
 - b. notifies the Pima County Deputy Attorney if the matter of the hearing requires legal representation for PHS;
 - c. prepares the room for a telephonic hearing;
 - d. prepares copies of all documents needed to conduct the hearing;
 - e. coordinates the participation of the Grievance Manager, Appeals Specialist, Office Support Staff, Medical Director, and other PHS representatives, as necessary, in the hearing.
 4. Following the State Fair Hearing, the Office Support Specialist:
 - a. updates the Grievance data base; and
 - b. updates the member's appeal file.
 5. Upon receipt of the AHCCCS Director's Decision letter, the Appeals Manager;
 - a. documents the closure of the member's appeal;
 - b. notifies all parties of the hearing of the decision by the Director;
 - c. notifies the parties in writing involved in the hearing to carry out any directive in favor of the member following the Director's decision;
 - d. documents in the member's appeal file how the Director's decision was carried out;
 - e. forwards the case to the Office Support Staff for closure in the Grievance database and filing.

I. EXPEDITED STATE FAIR HEARING FILED:

1. Upon receipt of a written request to file an expedited State Fair Hearing, the Office Support Staff:
 - a. date stamps the written request at time of receipt;

- b. verifies the timeliness of the request; if the request is deemed untimely it is forwarded with the notation that the issue to be heard is the timeliness of the request;
 - c. verifies the authority of the person requesting the hearing, if other than the member;
 - d. verifies the request qualifies for an expedited State Fair Hearing (the request may only be expedited if the appeal was expedited);
 - e. logs the request for State Fair Hearing into the Grievance and Appeals database indicating the date received. The log is updated, as necessary, until the hearing is closed;
 - f. updates the member's appeal file;
 - g. completes the AHCCCS approved "Expedited Hearing Cover Sheet" (Attachment A);
 - h. forwards the completed form to AHCCCS Office of Administrative Legal Services by fax to 602-253-9115 within one business day of receipt of the member's request.
2. Appeal processed as outlined in H3 through H5.

J. WITHDRAWAL OF REQUEST FOR STATE FAIR HEARING:

1. Upon receipt of a written request from the member to withdraw a request for hearing:
 - a. Before the notice of AHCCCS Notice of Hearing is issued, the Office Support Staff forwards the written request to AHCCCS.
 - b. After the Notice of Hearing was issued, the Office Support Staff forwards the members written request to withdraw directly to AHCCCS Office of Administrative Hearing.
2. The Office Support Staff tracks the file for the AHCCCS Director Decision, Grievance Log is updated, case closed and filed.

K. MONTHLY REPORT TO AHCCCS:

1. The Grievance & Appeals Manager submits a monthly Appeal Report to AHCCCS using the mandated Authorization Request and Appeal Report format (Attachment B).
2. The Monthly Report is sent to AHCCCS by the first business day of the second month following the month being reported. The report is submitted to the following address:

Compliance Officer
AHCCCS Division of Health Care Management
701 East Jefferson
(MD #6500 for Acute MD #6100 for ALTCS)
Phoenix, AZ 85034

3. The report includes a summary of the findings, including trending information and any corrective or process improvement actions taken.
4. A copy of the report is maintained by the Grievance and Appeals Manager and is reviewed at the Quality Management/Process Improvement Quarterly Committee

Meeting and by the Compliance Officer. Member appeals are reviewed to identify trends and conditions that could determine changes in standards and procedures. Any changes implemented as a result of trending information are evaluated for effectiveness, and a Process Improvement Project (PIP) report is completed and submitted to the Quality Management Manager.

G:/Corporate/Standards & Procedures/Administration-HR/Member Appeal of Action.doc (Dev. by MN)(rev 05/25/07-kah)(Rev 04/08 VR)(Rev 06/09 kaw)

PHS

Always Here For You

Pima Health System

3950 S. Country Club, Suite #400 Tucson, Arizona 85714 (520) 243-8000 (520) 243-8035

NOTICE OF ACTION

If you cannot read this information, we can translate it into your language. Call: 243-8033.

Если Вы не можете прочитать эту информацию, мы переведем ее на Ваш родной язык. Справки по телефону: 243-8033.

Si usted no puede leer este aviso, nosotros podemos traducirlo en su idioma. Usted puede llamar al: (520) 243-8030 or 1-800-423-3801

DATE OF THIS NOTICE: _____

TO: Member Name: _____ name and address of representative, if relevant

Address: _____

_____ Zip _____

AHCCCS ID: _____

NEW SERVICE REQUESTS:

1. You have asked Pima Health System to approve:

We have reviewed your request and decided that:

3. Our decision is based on the following reasons:

4. We recommend that you:

CHANGE OF EXISTING SERVICES:

Service affected: _____

Your services will be reduced from _____ to _____ Effective _____

Your services will be suspended effective _____

Your services will be terminated effective _____

1. Our decision is based on the following reason:

We recommend that you:

You may ask us to look into our decision again. **THIS IS CALLED AN APPEAL.** If you want to appeal, you can contact us in writing or by phone. You must do this by _____ which is within 60 calendar days from the date of this notice.

TO FILE AN APPEAL:

You can fill out the Request to File An appeal With Pima Health System form attached to this Notice and send it to:

Appeals Manager, Pima Health System
3950 South Country Club Road, Suite #400
Tucson, AZ. 85714

You can call: 520-243-8006

You can fax: 520-243-8314

You can use our toll free number: 1-800-423-3801

You may have someone help you with your appeal. Your health care provider can appeal for you if you write telling us so.

AFTER YOU FILE AN APPEAL:

Before we make our decision, you can give us any information that you think will be helpful. Before you do that, you can ask to see your case file, including medical records or other information about your appeal. You can give us this information in writing. You can ask to set up a meeting to talk to us in person.

When we are finished with our review of your appeal, we will send you our decision in writing. This letter is called the Notice of Appeal Resolution. We will normally send the decision within 30 days from the date we received your appeal unless you asked for a faster review. We call this faster review an "expedited appeal".

You may ask for more time if you need it to help with your own appeal. This can be up to 14 days. We may also ask for more time if we need it to get together more information before we make our decision. We will write to you and tell you why we need more time.

TO REQUEST AN EXPEDITED APPEAL:

If your health care provider tells us your life or health could be in danger, or you may not be able to attain, maintain, or regain maximum function by waiting the normal 30 days for a decision on your appeal, we will make our decision within 3 working days after we receive your appeal. You may also ask us to expedite your appeal. If you ask us and we agree, we will make our decision within 3 working days. If you ask for an expedited appeal, tell us how your health will suffer if we take 30 days to decide your appeal. If we do not agree, we will write you within 2 days to let you know that your appeal will be decided within 30 days. We will also call you.

TO REQUEST CONTINUED SERVICES DURING THE APPEAL:

You may ask to have the services continue while we make our decision. If you want those services to continue, you must say so when you appeal. We can do this only if:

- you request it in writing;
- we are stopping, reducing, or temporarily suspending a service that we have already approved;
- the services were ordered by a doctor or other health care provider; and
- the original time period covered by the original authorization has not expired.

You must request it in writing within 10 days from the date this Notice was mailed to you or before the intended date of the action. We will continue your service unless you did not request it within the time frame allowed. We will stop the services if you withdraw your appeal, or our decision to the appeal is against you. If you want your services continued while you file a State Fair Hearing, you must request it again. We will stop the services if we win the appeal after a State Fair Hearing decision; or if the service authorization has expired.

If you do not win your appeal, you may be responsible for paying for the services you received during your appeal.

TO ASK FOR ASSISTANCE:

If you have any questions about filing an appeal or if you need help, you may call the PHS Appeals Manager at 520-243-8006. Our office hours are 8:00 a.m. to 5:00 p.m. Monday through Friday.

Name, Title

MEMBER REQUEST TO FILE AN APPEAL WITH PIMA HEALTH SYSTEM
If you cannot read this information, we can translate it into your language. Call: 243-8033.

Если Вы не можете прочитать эту информацию, мы переведем ее на Ваш родной язык.
Справки по телефону: 243-8033.

Si usted no puede leer este aviso, nosotros podemos traducirlo en su idioma. Usted puede llamar al: (520) 243-8030 o 1-800-423-3801

PLEASE PRINT

Name _____ Phone Number _____

Address _____ Message or other phone _____

_____ AHCCCS ID # _____

City, State, Zip Code

The date on the Notice of Action is: _____

I am requesting a review of Pima Health System’s decision as stated on the Notice of Action that I received for: Check the box of the one that applies:

- A new service was denied or limited.
- My current service was reduced, suspended, or terminated.

Please explain your reason for asking us to review our decision below:

If you need more room, you can use the back of this form or add another sheet.

Signature _____ Date signed _____

If signed by someone other than the PHS Member, please attach your written authority to act on behalf of the member.

Send this form to: Appeals Manager, Pima Health System
3950 South Country Club Road, Suite #400
Tucson, AZ. 85714

or fax to 520-243-8314

PHS

Always Here For You

Pima Health System

3950 S. Country Club, Suite #400 Tucson, Arizona 85714 (520) 243-8000 (520) 243-8035

AVISO DE ACCIÓN

FECHA DE ESTE AVISO: _____

PARA: Nombre del Miembro: _____
nombre y dirección del representante, si es relevante

Dirección: _____ Código Postal _____

Numero de Identificación de AHCCCS: _____

SOLICITUD PARA SERVICIOS NUEVOS:

1. Usted solicitó que Pima Health System autorice:

2. Revisamos su solicitud y decidimos que:

3. Nuestra decisión se hizo por las siguientes razones:

4. Le recomendamos que usted

CAMBIO DE SERVICIOS ACTUALES:

Servicio afectado: _____

Sus servicios serán reducidos de _____ a _____ A partir de _____

Sus servicios serán suspendidos a partir de _____

1. Nuestra decisión está basada en las siguientes razones:

2. Le recomendamos que usted:

Usted puede pedir que revisemos nuestra decisión una vez más. A ESTO SE LE LLAMA APELACIÓN. Si usted desea apelar nuestra decisión, usted puede comunicarse con nosotros por escrito o por teléfono. Usted necesita hacer esto antes del _____, que son 60 días de la fecha de este aviso.

PARA SOLICITAR UNA APELACION:

Usted puede llenar la forma Petición para Solicitar una Apelación con Pima Health System incluida con este Aviso y mandarla a:

Appeals Manager, Pima Health System
3950 South Country Club Road, Suite #400
Tucson, AZ. 85714

Usted puede llamar al: 520-243-8030

Usted puede mandarlo por fax al: 520-243-8314

Usted también puede utilizar nuestra línea gratuita: 1-800-423-3801

Usted puede tener a alguien que le ayude con su apelación. Su proveedor de médico puede solicitar una apelación por usted, si usted nos avisa por escrito que lo va hacer.

DESPUES DE QUE USTED SOLICITE UNA APELACION:

Antes de tomar nuestra decisión, usted puede darnos cualquier información que usted piense que sea útil. Antes de hacer esto, usted puede solicitar ver su archivo del caso, incluyendo su archivo médico u otra información sobre su apelación. Usted puede darnos esta información por escrito. Usted puede solicitar una junta para hablar con nosotros en persona.

Cuando terminemos de revisar su apelación, nosotros le enviaremos nuestra decisión por escrito. Esta carta le llamamos Carta de Resolución de Apelación. Normalmente le enviaremos la decisión dentro de 30 días de la fecha que recibimos su apelación, a menos que usted pida que se revise su apelación mas rápidamente. A esto le llamamos una "apelación acelerada".

Usted puede solicitar mas tiempo si lo necesita para su apelación. Puede ser hasta 14 días. Nosotros también podemos solicitar mas tiempo si lo necesitamos para recolectar más información antes de tomar nuestra decisión. Nosotros le informaremos por escrito porque necesitamos mas tiempo.

PARA SOLICITAR UNA APELACION ACELERADA:

Si su proveedor médico nos informa que su vida o su salud pueden correr peligro, o que usted no podrá alcanzar, mantener o recuperar su función normal si espera 30 días para nuestra decisión, haremos una decisión dentro de 3 días hábiles después de recibir su apelación. Usted también puede solicitar una apelación acelerada. Si usted nos lo pide y nosotros estamos de acuerdo, tomaremos nuestra decisión dentro de 3 días de negocio. Si usted pide una apelación acelerada, díganos como su salud será afectada si tomamos 30 días para tomar nuestra decisión. Si nosotros no estamos de acuerdo, le informaremos por escrito dentro de 2 días que su apelación se decidirá dentro de 30 días. También le llamaremos.

PARA SOLICITAR QUE SUS SERVICIOS CONTINUEN DURANTE SU APELACION:

Usted puede solicitar que sus servicios continúen durante su apelación. Si usted desea que sus servicios continúen, usted necesita solicitarlo con su apelación. Nosotros solamente podemos continuar sus servicios si:

- usted lo solicita por escrito;
- nosotros estamos terminando, reduciendo o suspendiendo temporalmente un servicio que anteriormente aprobamos;
- los servicios fueron ordenados por un doctor u otro proveedor de cuidado médico; y
- el periodo original de la autorización no se ha vencido.

Usted debe solicitarlo por escrito dentro de 10 días de la fecha en que se le envió este Aviso o antes de la fecha en que está proyectado a tomarse la acción. Nosotros continuaremos su servicio al menos que usted no lo haya solicitado dentro de el tiempo permitido. Si usted retira su apelación, o si nuestra decisión de la apelación es contra usted, nosotros le cancelaremos los servicios. Si usted desea que sus servicios continúen durante el proceso de audiencia Estatal justa, usted debe solicitarlo una vez más. Nosotros le cancelaremos sus servicios si la decisión de la audiencia Estatal justa es a favor de nosotros; o si la autorización para el servicio se ha vencido.

Si usted no gana su apelación, usted puede ser responsable de pagar el costo de recibir sus servicios durante su apelación.

PARA PEDIR AYUDA:

Si usted tiene alguna pregunta sobre como solicitar una apelación o si necesita ayuda, usted puede llamarle al Gerente de Apelaciones de PHS al 520-243-8030. Nuestras horas de oficina son de 8:00 a.m. a 5:00 p.m., de lunes a viernes.

Nombre, Título

PHS

Always Here For You

Pima Health System

3950 S. Country Club, Suite #400 Tucson, Arizona 85714 (520) 243-8000 (520) 243-8035

EXTENSION OF NOTICE OF ACTION

If you cannot read this information, we can translate it into your language. Call: 243-8033.

Если Вы не можете прочитать эту информацию, мы переведем ее на Ваш родной язык. Справки по телефону: 243-8033.

Si usted no puede leer este aviso, nosotros podemos traducirlo en su idioma. Usted puede llamar al: (520) 243-8033 o 1-800-423-3801

DATE OF THIS NOTICE: _____

TO: Member Name: _____
name and address of representative, if relevant

Address: _____
_____ Zip _____

AHCCCS ID: _____

1. You have asked Pima Health System to approve:

A decision cannot be made at this time for your request. In your best interest, Pima Health System needs an additional 14 days to process your request because:

We will make our decision as soon as possible, but we will not go over the additional 14 days.

If you do not agree with this Notice for more time in order for us to make a decision, you have the right to file a grievance with the PHS Grievance Manager.

You can write to:

Grievance Manager, Pima Health System
3950 S. Country Club Rd., Suite #400
Tucson, AZ. 85714

Or you can call: 520-243-8006
Or you can fax: 520-243-8314
Or use our toll free number: 1-800-423-3801

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Pima Health System

3950 S. Country Club, Suite #400 Tucson, Arizona 85714 (520) 243-8000 (520) 243-8035

AVISO DE EXTENSION PARA ACCION

FECHA DE ESTE AVISO: _____

PARA: Nombre del Miembro: _____
nombre y dirección del representante, si es relevante

Dirección: _____
_____ Código Postal _____

Número de Identificación de AHCCCS: _____

1. Usted ha solicitado a Pima Health System que se le apruebe:

La decisión no puede llevarse a cabo en este momento para su petición. Por su propio bien, Pima Health System necesita 14 días adicionales para procesar su petición debido a:

Tomaremos nuestra decisión lo más pronto posible, en un plazo no mayor de 14 días.

Si usted no esta de acuerdo con este Aviso en el que nos llevará mas tiempo en tomar una decisión, usted tiene el derecho de solicitar un agravio con el PHS Grievance Manager.

You can write to:

Grievance Manager, Pima Health System
3950 S. Country Club Rd., Suite #400
Tucson, AZ. 85714

- O usted puede llamar al: 520-243-8030
- O enviar un fax al fax: 520-243-8314
- O utilizar nuestra línea gratuita: 1-800-423-3801

PHS

Always Here For You

Pima Health System

3950 S. Country Club, Suite #400 Tucson, Arizona 85714 (520) 243-8000 (520) 243-8035

NOTICE OF ACTION

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Если Вы не можете прочитать эту информацию, мы переведем ее на Ваш родной язык. Справки по телефону: 243-8033.

Si usted no puede leer este aviso, nosotros podemos traducirlo en su idioma. Usted puede llamar al: (520) 243-8033 or 1-800-423-3801

DATE OF THIS NOTICE: _____

TO: Member Name: _____

Address: _____

Zip

AHCCCS ID: _____

This notice is to let you know Pima Health System has denied payment to:

For: _____

Pima Health System denied payment for the following reasons: The service provided was not-an AHCCCS covered benefit.

The legal or statutory basis for the denial is: _____

You may ask us to look into our decision again. THIS IS CALLED AN APPEAL. If you want to appeal, you can contact us in writing or by phone. You must do this by _____, which is within 60 calendar days from the date of this notice.

TO FILE AN APPEAL:

You can fill out the Request to File An appeal With Pima Health System form attached to this Notice and send it to:
Grievance Manager, Pima Health System
3950 S. Country Club Rd. #400
Tucson, AZ 85714

You can call: 520-243-8006 You can fax: 520-243-8314
You can use our toll free number: 1-800-423-3801

You may have someone help you with your appeal. Your health care provider can appeal for you if you write telling us so.

AFTER YOU FILE AN APPEAL:

Before we make our decision, you can give us any information that you think will be helpful. Before you do that, you can ask to see your case file, including medical records or other information about your appeal. You can give us this information in writing. You can ask to set up a meeting to talk to us in person.

When we are finished with our review of your appeal, we will send you our decision in writing. This letter is called the Notice of Appeal Resolution. We will normally send the decision within 30 days from the date we received your appeal. The Notice of Appeal Resolution will also give you information on how you can file a State Fair Hearing if you are not happy with our decision.

You may ask for more time if you need it to help with your own appeal. This can be up to 14 days. We may also ask for more time if we need it to get together more information before we make our decision. We will write to you and tell you why we need more time.

TO ASK FOR ASSISTANCE:

If you have any questions about filing an appeal or if you need help, you may call the PHS Grievance Manager at 520-243-8006. Our office hours are 8:00 a.m. to 5:00 p.m. Monday through Friday.

Name, Title

MEMBER REQUEST TO FILE AN APPEAL WITH PIMA HEALTH SYSTEM

If you cannot read this information, we can translate it into your language. Call: 243-8033.

Если Вы не можете прочитать эту информацию, мы переведем ее на Ваш родной язык. Справки по телефону: 243-8033.

Si usted no puede leer este aviso, nosotros podemos traducirlo en su idioma. Usted puede llamar al: (520) 243-8030 or 1-800-423-3801

PLEASE PRINT

Name _____ Phone Number _____

Address _____ Message or other phone _____

_____ AHCCCS ID # _____

City, State, Zip Code

The date on the Notice of Action is: _____

I am requesting a review of Pima Health System's decision as stated on the Notice of Action that I received. This Notice stated payment to my provider for a non-covered AHCCCS service was denied.

Please explain your reason for asking us to review our decision below:

If you need more room, you can use the back of this form or add another sheet.

Signature _____ Date signed _____

If signed by someone other than the PHS Member, please attach your written authority to act on behalf of the member.

Send this form to: Appeals Manager, Pima Health System
3950 South Country Club Road, Suite #400
Tucson, AZ 85714

PHS

Always Here For You

Pima Health System

3950 S. Country Club, Suite #400 ¹ Tucson, Arizona 85714 ¹ (520) 243-8000 ¹ (520) 243-8035

AVISO DE ACCION

If you cannot read this information, we can translate it into your language. Call: 243-8033.

Если Вы не можете прочитать эту информацию, мы переведем ее на Ваш родной язык. Справки по телефону: 243-8033.

Si usted no puede leer este aviso, nosotros podemos traducirlo en su idioma. Usted puede llamar al: (520) 243-8030 or 1-800-423-3801

FECHA DE ESTE AVISO: _____

A: Nombre del Miembro: _____
 Dirección: _____
 _____ Código Postal
 Número de AHCCCS: _____

Este aviso es para avisarle que Pima Health System ha negado el pago a:

 Por: _____

Pima Health System ha negado el pago por las siguientes razones: El servicio proveído no era un beneficio cubierto por AHCCCS.

Esta negación se basa en el estatuto legal de: _____

Usted puede solicitarnos que revisemos una vez mas nuestra decisión. A ESTO SE LE LLAMA APELACION. Si usted desea una apelación, usted puede contactarnos por teléfono o por escrito. Usted tiene hasta _____ para hacer la apelación que viene siendo dentro de los 60 días de la fecha de este aviso.

PARA LLENAR UNA APELACION:

Usted puede llenar la solicitud de Petición para Una Apelación con Pima Health System que se encuentra adjunta con este aviso y enviarla al: Gerente de Apelaciones, Pima Health System
3950 S. Country Club Rd. #400
Tucson, AZ 85714

Usted puede llamar al: 520-243-8030 Puede mandar un fax al: 520-243-8035
Usted puede llamar a nuestra línea gratuita: 1-800-243-3801

Usted puede pedirle a alguien que lo ayude con su apelación. Su proveedor de cuidado puede apelar por usted si usted nos envía un aviso por escrito.

DESPUES DE SOLICITAR UNA APELACION:

Antes de que tomemos una decisión, usted puede darnos cualquier información que usted piense que nos sea útil. Antes de que usted haga esto, puede solicitar revisar su historial médico u otra información acerca de su apelación. Usted puede enviarnos esta información por escrito. Usted puede solicitar una junta para hablar con nosotros en persona.

Cuando terminemos con la revisión de su apelación, le enviaremos nuestra decisión por escrito. A esta carta se le llama Aviso de Resolución de Apelación. Por lo general enviamos nuestra decisión dentro de 30 días de la fecha en que recibimos su apelación. El Aviso de la Resolución de Apelación le proporcionará también información acerca de como puede solicitar una audiencia Estatal justa si usted no está satisfecho con nuestra decisión.

Usted puede solicitar mas tiempo si lo necesita para su apelación. Puede ser hasta 14 días. Nosotros también podemos solicitar más tiempo si lo necesitamos para recolectar más información antes de finalizar nuestra decisión. Nosotros le informaremos por escrito porque necesitamos mas tiempo.

PARA SOLICITAR AYUDA:

Si usted tiene preguntas acerca de como solicitar una apelación ó si necesita ayuda, puede llamar al Gerente de Apelaciones de PHS al 520-243-8033. Nuestro horario de oficina es de 8:00 a.m. a 5:00 p.m. de lunes a viernes.

Nombre, Título

SOLICITUD DE APELACION DEL MIEMBRO CON PIMA HEALTH SYSTEM

FAVOR DE LLENAR

Nombre _____ Número de teléfono _____

Dirección _____ Número telefónico para mensajes _____

_____ AHCCCS ID # _____

Ciudad, Estado, Código Postal

La fecha del Aviso de Acción es: _____

Estoy solicitando una revisión de la decisión de Pima Health System como se especifica en el Aviso de Acción que recibí. Este Aviso indicaba que el pago a mi proveedor por servicios no cubiertos por AHCCCS fue negado.

Favor de explicar su(s) razón(es) para solicitarnos que revisemos nuestra decisión:

Si necesita mas espacio, puede utilizar el reverso de esta forma o agregar otra hoja.

Firma _____ Fecha de la Firma _____

Si es firmada por alguien que no sea el Miembro de PHS, por favor incluya una autorización por escrito para actuar en representación del miembro.

Envíe esta forma a: Gerente de Apelaciones, Pima Health System
3950 S. Country Club Rd. #400
Tucson, AZ 85714

o envíela por fax al 520-243-8314

MEMBER'S REQUEST TO FILE AN ORAL APPEAL
(completed by person taking the call)
PLEASE PRINT

Member Name _____ Phone Number _____
Address _____

_____ AHCCCS ID # _____
City, State, Zip Code _____

Date of Call _____ Time of Call _____

Person who made call: _____ Relationship to member: _____
Phone number _____

The date on the Notice of Action is: _____

The member is requesting a review of Pima Health System's decision as stated on the Notice of Action for:

- A new service was denied or limited. _____
- Member's current service was reduced, suspended, or terminated. _____

Member is requesting continued services. Member notified of possible reimbursement.

-

The caller is requesting a standard appeal.

The caller is requesting an expedited appeal. Approved Denied by Medical Director _____
Date

Member notified of denial _____

The request for appeal is denied as it exceeded the time limit of 90 days from date of action.

Statement by caller:

Signature _____
Name of person taking the call

PHS

Always Here For You

Pima Health System

3950 S. Country Club, Suite #400 ¹ Tucson, Arizona 85714 ¹ (520) 243-8000 ¹ (520) 243-8035

If you cannot read this information, we can translate it into your language. Call: 243-8033.

Если Вы не можете прочитать эту информацию, мы переведем ее на Ваш родной язык. Справки по телефону: 243-8033.

Si usted no puede leer este aviso, nosotros podemos traducirlo en su idioma. Usted puede llamar al: (520) 243-8030 or 1-800-423-3801

NOTICE TO ACKNOWLEDGE RECEIPT OF APPEAL

DATE OF THIS NOTICE _____

To: _____

Address:

Re: MEMBER NAME: _____

AHCCCS ID #: _____

PHS FILE NUMBER: _____

Dear _____:

Pima Health System received your appeal on _____ regarding _____
_____.

Pima Health System is looking into your appeal and will let you know of our decision as soon as possible but no later than 30 days. Please let me know if you want to see your appeal file or if you want to set up a time to meet to discuss your appeal. If you have any questions about the appeal process, please call me at (520) 243-8006.

Sincerely,

Name & Title

PHS

Always Here For You

Pima Health System

3950 S. Country Club, Suite #400 Tucson, Arizona 85714 (520) 243-8000 (520) 243-8035

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DENIAL OF APPEAL

DATE OF THIS NOTICE _____

To: _____

Address:

Re: MEMBER NAME: _____

AHCCCS ID #: _____

PHS FILE NUMBER: _____

Dear _____:

You filed an appeal with Pima Health System about

Pima Health System regrets to inform you that we cannot accept your appeal because

If you have any questions regarding this letter, please call me at (520) 243-8006.

Sincerely,

Name & Title

PHS

Always Here For You

Pima Health System

3950 S. Country Club, Suite #400 ¹ Tucson, Arizona 85714 ¹ (520) 243-8000 ¹ (520) 243-8035

EXTENSION OF APPEAL RESOLUTION

If you cannot read this information, we can translate it into your language. Call: 243-8033.

Если Вы не можете прочитать эту информацию, мы переведем ее на Ваш родной язык. Справки по телефону: 243-8033.

Si usted no puede leer este aviso, nosotros podemos traducirlo en su idioma. Usted puede llamar al: (520) 243-8030 or 1-800-423-3801

DATE OF THIS NOTICE _____

Member Name
Address

Re: MEMBER NAME: _____
AHCCCS ID #: _____
PHS FILE NUMBER: _____

Dear _____:

You filed an appeal with Pima Health System about

I am not able to give you our decision within the 30 days of your appeal because

You will get out answer in 14 days from the date on this notice. Your patience in this matter is appreciated. If you have any questions regarding this letter, please call me at (520) 243-8006.

Sincerely,

Appeals Manager

PHS

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**NOTICE OF APPEAL RESOLUTION
(WITH RIGHT TO STATE FAIR HEARING)**

DATE OF THIS NOTICE

Member Name:

Address:

Re: MEMBER NAME: _____

AHCCCS ID #: _____

PHS FILE NUMBER: _____

Dear _____:

You filed an appeal with Pima Health System about _____.

After a thorough investigation into the issue, Pima Health System has decided _____.

This decision is based on the following law, rule or regulation _____.

If you are not satisfied with our decision, you may ask for another review of your appeal. This is called a **STATE FAIR HEARING**. If you want to do this you must let us know in writing within 30 days from the date you receive this Notice of Appeal Resolution. Requests for State Fair Hearing received after 30 days will be heard only on the issue of the timeliness of the request.

TO FILE A STATE FAIR HEARING:

You can send your letter asking for a State Fair Hearing to:

Grievance Manager, Pima Health System
3950 S. Country Club Rd. #400
Tucson, AZ 85714

AFTER YOU FILE A STATE FAIR HEARING:

When Pima Health System receives your letter, we will send it to AHCCCS Administration. AHCCCS will send you a Notice of Hearing. This Notice will tell you about the issues to be decided at the hearing, the laws, rules or policies that affect the issues. It will also tell you the date and the time of the hearing and where the

hearing will take place. The Notice will give you more information about how the hearing will be done and how you can ask to have the hearing held by phone if you can't be there in person.

You can have someone you know help you with the hearing if you write AHCCCS telling them so. You, or anyone who is helping you with the hearing, can ask to see your case file, including medical records or other information that will be used at the hearing. You can bring witnesses to the hearing. You will be able to ask and answer questions.

THE STATE FAIR HEARING:

An Administrative Law Judge will listen to everything presented at the hearing. After the hearing, the Administrative Law Judge will send a letter to AHCCCS Administration. This letter is called a Recommended Decision. The AHCCCS Director will make a final decision and send you, and everyone who was part of the hearing, a letter. This letter is called the Director's Decision and lets you know if the AHCCCS Director accepts, changes, or rejects the Administrative Law Judge's recommendations. The Director's Decision letter tells you the facts of the hearing, rules or other laws that made up the decision and about any further appeal rights.

TO REQUEST CONTINUED BENEFITS DURING THE STATE FAIR HEARING:

You may ask to have the services listed in this letter continued during the hearing process. If you want those services to continue, you must say so when you request a State Fair Hearing. We can do this only if:

- you request it in writing;
- we are stopping, reducing, or temporarily suspending a service that we have already approved;
- the services were ordered by a doctor or other health care provider; and
- the original time period covered by the original authorization has not expired.

You must request it in writing, within 10 days from the date the Pima Health System Notice of Appeal Resolution was mailed to you, or before the intended date of the action.

We will continue your service unless you did not request it within the time frame allowed; or you withdraw your appeal; We will stop the services if we win the appeal after a State Fair Hearing decision; or if the service authorization has expired.

If the State Fair Hearing decision is against you, you may be responsible for paying for the services you received during the hearing process.

If you have any questions regarding the State Fair Hearing process, please call me at (520) 243-8006.

Sincerely,

Name/Title

Certified Mail # _____

PHS

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Pima Health System

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NOTICE OF APPEAL RESOLUTION

DATE OF THIS NOTICE _____

Member Name
Address

Re: MEMBER NAME: _____
AHCCCS ID #: _____
PHS FILE NUMBER: _____

Dear _____:

You filed an appeal with Pima Health System about

After a thorough investigation into the issue, Pima Health System has decided agree to your request for

Sincerely,

Appeals Manager

PHS

Always Here For You

Pima Health System

3950 S. Country Club, Suite #400 ¹ Tucson, Arizona 85714 ¹ (520) 243-8000 ¹ (520) 243-8035

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Справки по телефону: 243-8033.**

Si usted no puede leer este aviso, nosotros podemos traducirlo en su idioma. Usted puede llamar al: (520) 243-8030 or 1-800-423-3801

NOTICE OF APPEAL RESOLUTION (WITH RIGHT TO STATE FAIR HEARING)

DATE OF THIS NOTICE _____

TO: _____
Address

Re: MEMBER NAME: _____
AHCCCS ID #: _____
PHS FILE NUMBER: _____

Dear _____:

You filed an appeal with Pima Health System about

After a thorough investigation into the issue, Pima Health System has decided _____

This decision is based on the following law, rule or regulation _____

If you are not satisfied with our decision, you may ask for another review of your appeal. This is called a **STATE FAIR HEARING**. If you want to do this you must let us know in writing within 30 days from the date you receive this Notice of Appeal Resolution. Requests for State Fair Hearing received after 30 days will be heard only on the issue of the timeliness of the request

TO FILE A STATE FAIR HEARING:
You can send your letter asking for a State Fair Hearing to:
Appeals Manager, Pima Health System
3950 S. Country Club Rd. #400
Tucson, AZ 85714

AFTER YOU FILE A STATE FAIR HEARING:

When Pima Health System receives your letter, we will send it to AHCCCS Administration. AHCCCS will send you a Notice of Hearing. This Notice will tell you about the issues to be decided at the hearing, the laws, rules or policies that affect the issues. It will also tell you the date and the time of the hearing and where the hearing will take place. The Notice will give you more information about how the hearing will be done and how you can ask to have the hearing held by phone if you can't be there in person.

You can have someone you know help you with the hearing if you write AHCCCS telling them so. You, or anyone who is helping you with the hearing, can ask to see your case file, including medical records or other information that will be used at the hearing. You can bring witnesses to the hearing. You will be able to ask and answer questions.

THE STATE FAIR HEARING:

An Administrative Law Judge will listen to everything presented at the hearing. After the hearing, the Administrative Law Judge will send a letter to AHCCCS Administration. This letter is called a Recommended Decision. The AHCCCS Director will make a final decision and send you, and everyone who was part of the hearing, a letter. This letter is called the Director's Decision and lets you know if the AHCCCS Director accepts, changes, or rejects the Administrative Law Judge's recommendations. The Director's Decision letter tells you the facts of the hearing, rules or other laws that made up the decision and about any further appeal rights.

TO REQUEST AN EXPEDITED FAIR HEARING:

If you have medical records from your provider that says that taking the time for a standard Fair state hearing could seriously endanger your life, or health, or ability to attain, maintain, or regain maximum function, you can ask for a faster review. In this case, the Director's Decision is made within 3 working days after AHCCCS receives the information from us. The Director will try to give you their decision by phone.

TO REQUEST CONTINUED BENEFITS DURING THE STATE FAIR HEARING:

You may ask to have the services listed in this letter continue during the hearing process. If you want those services to continue, you must say so when you request a State Fair Hearing. We can do this only if:

- you request it in writing;
- we are stopping, reducing, or temporarily suspending a service that we have already approved;
- the services were ordered by a doctor or other health care provider; and
- the original time period covered by the original authorization has not expired.

You must request it in writing within 10 days from the date the Pima Health System Notice of Appeal Resolution was mailed to you or before the intended date of the action.

We will continue your service unless you did not request it within the time frame allowed; or you withdraw your appeal; We will stop the services if we win the appeal after a State Fair Hearing decision; or if the service authorization has expired. If the State Fair Hearing decision is against you, you may be responsible for paying for the services you received during the hearing process.

If you have any questions regarding the State Fair Hearing process, please call me at (520) 243-8006.

Sincerely,

Name/Title

Certified Mail # _____



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Pima Health System

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Expedited Hearing Cover Sheet
Fax to Office of Administrative Legal Service
(602) 253-9115

From: Pima Health System Phone Number: 520-243-8006
Contact: Fax Number: 520-243-8314

Complainant: Name: Phone Number: Fax Number: Mailing Address:
Complainant: Name: Representative Phone Number: Fax Number: Mailing Address:

Requested Service:
Denial Reason:
Denial Date:
Legal Basis for Denial:

DO NOT SEND APPEAL FILE IN RESPONSE TO THIS FAX
BRING APPEAL FILE TO HEARING

Date appeal was filed with Health Plan:
Health Plan response to appeal: [] Approve [] Deny [] Other
Health Plan Response Date:
Request for Hearing Date:

THE INFORMATION IN THIS FACSIMILE COMMUNICATION IS CONFIDNETIAL AND IS INTENDED SOLEY FOR THE USE OF THE RECIPIENT NAMED ABOVE. IF YOU ARE NOT THE INTENDED RECIPIENT, OR A PERSON RESPONSIBLE FOR DELIVERING IT TO THE INTENDED RECIPIENT, ANY DISSEMINATION, DISTRIBUTION, COPYING OR OTHER USE OF THIS COMMUNICATION FOR ANY PURPOSE IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE TELEPHONE THE SENDER IMMEDIATELY AND MAIL THE COMMUNICATION TO THE SENDER AT THE ADDRESS SHOWN ABOVE.

SUMMARY OF AUTHORIZATION REQUESTS

		Total Number			
A1	Total Number of Authorization Requests Received During the Reporting Period				
A2	Total Number of Actions (denials, suspensions, terminations)				
	I. Not a Covered Benefit/Benefit Exhausted				
	II. Not Medically Necessary				
	III. Out of Network Provider				
	IV. Not Enough Information to Make a Decision				
	V. System/Program Issues, Including Coverage by Another Entity (BHS, CRSA, TPL)				
A3	Percentage of All Authorization Requests Resulting in an Action	%	<i>Formula will be built in</i>		

TYPES OF REQUESTS

		Total Number Received in the Reporting Period	Number Completed Within Timeliness Standard	Percentage Completed Timely	
B1	Standard Authorization Requests				
B2	Standard Authorizations Requiring Extension				
B3	Expedited Authorization Requests				
B4	Expedited Authorizations Requiring Extension				
B5	Expedited Authorizations Changed to Standard Requests				

STANDARD APPEALS

		≤ 30 Days	≤ 45 days	>45 days	Total Number
C1	Ending Inventory from Previous Month				
C2	Number of Member Appeals Received This Month				
C3	Number of Decisions Issued this Month				
C4	Number of Decisions Issued within 30-Days				
C5	Total Current Inventory as of End of Month				

		Total Number			
D1	Upheld Appeals				
D2	Untimely Appeals				
D3	Overtured Appeals				
	I. Overtured due to secondary review				
	II. Overtured due to additional information submitted				
D4	Partially Overtured Appeals				
	I. Partially Overtured due to secondary review				
	II. Partially Overtured due to additional information submitted				
D5	Extensions				
		Total Number			
E1	Hearing Requests Received During Reporting Period	0			
E2	Forwarded to AHCCCS within 5 days	0			
E3	Missed Forwarding Deadline	0			
E4	Total Number of Cancelled RFH	0			
	I. Those cancelled RFH due to Contractor Initiated Settlement Agreement	0			
E5	Director's Decisions Received in favor of the Member	0			
E6	Director's Decisions Received in favor of the Contractor	0			
EXPEDITED APPEALS					
		≤3 Days	>3 Days		Total Number
F1	Ending Inventory from Previous Month	0	0		0
F2	Number of Member Expedited Appeals Received This Month				0
F3	Number of Decisions Issued this Month				0
F4	Number of Decisions Issued within 3-Days				0
F5	Total Current Inventory as of End of Month	0	0		0
		Total Number			
G1	Upheld Expedited Appeals	0			
G2	Untimely Expedited Appeals	0			
G3	Overtured Expedited Appeals	0			
	I. Overtured due to incorrect handling	0			
	II. Overtured due to additional information submitted	0			
G4	Partially Overtured Expedited Appeals	0			
	I. Partially Overtured due to secondary review	0			
	II. Partially Overtured due to additional information submitted	0			
G5	Extensions Requested	0			

G6	Expedited Appeals Changed to Standard Appeals				
	EXPEDITED	Total Number			
H1	Hearing Requests Received During Reporting Period	0			
H2	Forwarded to AHCCCS timely	0			
H3	Missed Forwarding Deadline	0			
H4	Total Number of Cancelled RFH	0			
	I. Those cancelled RFH due to Contractor Initiated Settlement Agreement	0			
H5	Director's Decisions Received in favor of the Member	0			
H6	Director's Decisions Received in favor of the Contractor	0			

SERVICES NOT COVERED ACUTE CARE AND LONG TERM CARE TITLE XIX

Reference: Arizona Administrative Code, Article 2, R9-22

R9-22-201 General Requirements

10. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
- A service that is determined by the Chief Medical Officer to be experimental or provided primarily for the purpose of research;
 - Services or items furnished gratuitously; and
 - Personal care items; and
11. Medical or behavioral health services are not covered services if provided to:
- An inmate of a public institution;
 - A person who is in residence at an institution for the treatment of tuberculosis; or
 - A person age 21 through 64 who is in an IMD, unless provided under Article 12 of this Chapter.

R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services

2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
- Qualification for insurance;
 - Pre-employment physical evaluation;
 - Qualification for sports or physical exercise activities;
 - Pilot's examination for the Federal Aviation Administration;
 - Disability certification to establish any kind of periodic payments;
 - Evaluation to establish third-party liabilities; or
 - Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
3. Orthognathic surgery is covered only for a member who is less than 21 years of age;
4. The following services are excluded from AHCCCS coverage:
- Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
 - Pregnancy termination counseling services;
 - Services or items furnished solely for cosmetic purposes; and

R9-22-207. Dental Services

- Provision of dentures for cosmetic purposes is not a covered service;

R9-22-212. Medical Supplies, Durable Medical Equipment, and Orthotic and Prosthetic Devices

- Hearing aids are not covered for a member who is age 21 or older.
- Prescriptive lenses are not covered for a member who is age 21 or older unless they are the sole visual prosthetic device used by the member after a cataract extraction.

R9-22-215. Other Medical Professional Services

- C. The following services are excluded as covered services:
- Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;**** (Acute Care Only)
 - Physical therapy provided only as a maintenance regimen;
 - Abortion counseling; or
 - Services or items furnished solely for cosmetic purposes.

SERVICES NOT COVERED ACUTE CARE TITLE XXI

Reference: Reference: Arizona Administrative Code, Article 2, R9-31

R9-31-201. General Requirements

- A service that the Chief Medical Officer determines to be experimental or provided primarily for the purpose of research;
 - Services or items furnished gratuitously;
 - Personal care items; and
9. Medical or behavioral health services are not covered if provided to:
- An inmate of a public institution,
 - A person who is a resident of an institution for the treatment of tuberculosis, or
 - A person who is in an IMD at the time of application, unless provided under Article 12 of this Chapter.

R9-31-205. Attending Physician, Practitioner, and Primary Care Provider Services

2. A member's physical examination is not a covered service if the physical examination is to obtain one or more of the following:
- Qualification for insurance,
 - Pre-employment physical evaluation,
 - Qualification for sports or physical exercise activities,
 - Pilot's examination (Federal Aviation Administration),
 - Disability certification to establish any kind of periodic payments,
 - Evaluation to establish third-party liabilities, or
 - Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
3. The following services are excluded from AHCCCS coverage:
- Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgery;
 - Pregnancy termination counseling services;
 - A service or item furnished solely for cosmetic purposes;
 - Licensed midwife services for prenatal care and home birth.