6003-I ARIZONA LONG TERM CARE SERVICES APPEAL PROCESS

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EFFECTIVE DATE: July 31, 1993
REFERENCES: A.A.C. R9-34-209, R9-34-216

Definitions

AHCCCS means the Arizona Health Care Cost Containment System (AHCCCS) Administration as defined in A.R.S. § 36-2901.

Appeal means a request for review of an adverse benefit determination.

Administrative Services Subcontractors (AdSS) means an organization or entity that has a capitated contract with the Division to provide goods and services to its members either directly or through subcontracts with providers, in conformance with contractual requirements, state statutes and rules, and Federal law and regulations.

Adverse Benefit Determination means any of the following:

A. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

B. The reduction, suspension, or termination of a previously authorized service;

C. The denial, in whole or in part, of payment for a service;

D. The failure to provide services in a timely manner, as defined by the State;

E. The failure to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals;

F. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a member's request to exercise the right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or

G. The denial of a member's request to dispute a financial liability, including cost sharing, co- payments, premiums, deductibles, coinsurance, and other member financial liabilities.

Arizona Revised Statutes (A.R.S.) means the statutory laws in the state of Arizona.

Arizona Administrative Code (A.A.C.) means the official publication of Arizona's codified rules.

Department means the Arizona Department of Economic Security.

Division means the Division of Developmental Disabilities within the Department.

Day means calendar day unless otherwise specified.

Enrollee means a person eligible for AHCCCS under A.R.S. Title 36, Chapter 29 and who is enrolled with an AHCCCS AdSS.

Filed means the date the AdSS or the Division, whichever is applicable, receives the request

as established by a date stamp on the request or other record of receipt.

Limited Authorization means a service authorization that falls short of the original request with respect to the duration, frequency, or type of service requested.

Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR Part 438 and that is [42 CFR 438.2]:

A. A Federally qualified HMO that meets the advance directives requirements of subpart I of 42 CFR Part 489; or

B. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:

1. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

2. Meets the solvency standards of 42 CFR 438.116.

Member means an individual enrolled with the Division.

Notice of Appeal Resolution means a written notice that includes the results of the resolution process per A.A.C. R9-34-216.

Notice of Adverse Benefit Determination means a notice that, per A.A.C. R9-34-205, explains:

A. The benefit determination the Division or AdSS has taken or intends to take;

B. The reasons for the benefit determination;

C. The enrollee's right to file an appeal with the Division or the AdSS;

D. The procedures for exercising the rights specified in Article 2 of A.A.C., Title 9, Chapter 34;

E. The circumstances under which an expedited resolution is available and how to request it; and

F. The circumstances under which an enrollee has a right to have services continue pending resolution of the appeal, how to request that services be continued, and the circumstances under which the enrollee is liable for the costs of services.

OAR means the Office of Administrative Review, which is the business unit within the Division of Developmental Disabilities responsible for processing member's appeals.

Prior authorization means a process used to determine in advance of provision whether a prescribed procedure, service, or medication will be covered.

Qualified Clinician means a behavioral health professional who is licensed or certified under A.R.S. Title 32 or a behavioral health technician who is supervised by a licensed or certified professional.

Recovering Costs means when the state fair hearing decision upholds the decision of the Division or the AdSS, the entities may initiate cost recovery for the service or services provided pending the outcome of the hearing decision. 42 CFR 431.230(b).

Representative means an individual authorized in writing by the responsible person to represent the member during the appeal process.

Responsible Person means the same as in A.R.S. § 36-551.

Rural means the same as in A.R.S. § 36-2171.

Seriously Mentally Ill (SMI) means persons who, as a result of a mental disorder as defined in section 36-501, exhibits emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, the mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment, and recreation as in A.R.S. § 36-550.

Suspension of Service means a decision to temporarily stop providing a service that was previously authorized or approved.

Termination of Service means a decision to stop providing a covered service that was previously authorized or approved.

Working day means Monday, Tuesday, Wednesday, Thursday, or Friday from the hours of 8:00 a.m. to 5:00 p.m., unless:

A. A legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday; or

B. A legal holiday falls on Saturday or Sunday and the Division or AdSS is closed for business the prior Friday or following Monday.

Applicability

This policy applies to a decision made by the Division or its Administrative Services Subcontractors (AdSS) regarding:

A. Timely provision, approval, or authorization of a requested service or continuation of a covered service, benefit, or associated copayments including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

B. For members with SMI only, this also includes:

1. SMI Eligibility determination decisions

2. A PASRR determination related to a preadmission screening or an annual resident review which adversely affects member

3. Clinical Team findings regarding member's competency, capacity to make decisions, need for guardianship/other protective services or need for special assistance Planning Document or Inpatient Treatment and Discharge Plan (ITDP) service goals, objectives, or timelines and long-term views

4. Recommended services identified in assessment reports, Planning Documents, or ITDPs

5. Application of procedures and timeframes for developing a Planning Document or

ITDP

6. Sufficiency or Appropriateness of an Assessment

7. Access to or prompt provision of services identified in the Planning Documents or ITDPs

8. Denial of request to review outcome of, modification to, or failure to modify or termination of a Planning Document, ITDP or portion thereof

9. Decision to provide service planning including provision of an assessment or case management to a person who is refusing such services or a decision not to provide such services to the member

10. Decision regarding a person's fee assessment or the denial of a request to waive fees

11. Denial of payment of claims

12. Failure of the Division, AdSS, or AHCCCS to act within established Appeal timeframes

Non-Applicability

For members with SMI this procedure does not apply to:

A. Determinations of categorical eligibility/ineligibility for Title XIX or Title XXI services

B. Title XIX Appeals of an adverse determination affecting services that are subject to Prior Authorization for individuals eligible for Title XIX/XXI covered services, (See RHBA Contract Exhibit-14)

C. Adverse Determinations that are a result of changes in state or federal law requiring an automatic change or in order to avoid exceeding the legislatively appropriated state funding for program services and benefits

D. Allegations of rights violations made by members with SMI (See ACOM Policy 446)

E. Decisions involving a request for a service that requires a physician's order and the physician's refusal to order the service

Reasonable Entity for Appeals Process

The Division has delegated appeals to the AdSS for the following services:

A. Physical Health Care (i.e., prescription medications, DME, dental services, etc.)Behavioral Health Services

B. Seriously Mentally Ill (SMI) Services

C. Nursing Facility (NF) Services

D. Habilitative Physical Therapy for Members 21 Years of Age or Older

E. Emergency Alert System (EAS)

Filing an Appeal (Non-SMI)

When a Notice of Adverse Benefit Determination is given by the Division or the Administrative Services Subcontractors (AdSS) with whom the member/responsible person/representative does not agree, he/she may file an appeal. An authorized representative, including a service provider, may file an appeal on the member's behalf, with written consent from the member/responsible person/representative.

Neither the Division nor the AdSS will take punitive action against a member/authorized representative or service provider who exercises the right to appeal or supports a member's request for a resolution of the appeal.

Neither the Division nor AdSS allows punitive action against a provider for requesting expedited review of a member's appeal.

Filing an Appeal (SMI)

A member with SMI or the member's authorized representative may also appeal in writing or orally without prior receipt of a Notice of Adverse Benefit Determination when he/she is appealing any denial, decision, finding or recommendations outlined in the **Applicability** section of this policy pertaining to members with SMI only.

An authorized representative includes a legal guardian, guardian ad litem, designated representative or attorney, parent with legal custody, a court-appointed guardian ad litem or attorney of a member under 18 years, or a state or government agency that has executed an Intergovernmental/Interagency Service Agreement (IGA/ISA) with the Division for the provision of behavioral health services but which does not have legal custody or control of the member.

Neither the Division nor the AdSS will take punitive action against a member/authorized representative or service provider who exercises the right to appeal or supports a member's request for a resolution of the appeal.

Appeal Filing Timeframes

Any member/responsible person/representative must file an appeal within **60 calendar days** after the date of the Notice of Adverse Benefit Determination either orally or in writing.

For members with SMI, an appeal may also be filed at any time even when there is no Notice of Adverse Benefit Determination when a member contests/disagrees with any denial, decision, finding or recommendation outlined in the **Applicability** section of this policy as referenced above.

For appeals from DDD Tribal Health Program members or appeals related to Long Term Services and Supports (LTSS) delivered by the Division to its members the appeal must be filed with the Division's Office of Administrative Review (OAR) at:

DDD Office of Administrative Review

4000 North Central Avenue
3rd Floor, Suite 301, Drop 2HE5
Phoenix, Arizona 85012
602-771-8163 or 1-844-770-9500

For appeals from members who are enrolled with an AdSS, member appeals must be filed to the

AdSS address specified in each Notice of Adverse Benefit Administration delivered to the member by the AdSS when it made its decision to deny, reduce, suspend or terminate a service. For appeals from **members with SMI who are enrolled with an AdSS**, appeal must be filed to the AdSS address or phone number listed in the Member's Handbook or communicated through the Health Plan Customer Services who will transmit this appeal request to the appropriate Appeals unit of the respective AdSS.

Each appeal receipt will be acknowledged in writing within **five calendar days**. At the time the appeal is filed, the member/responsible person/authorized representative may request an expedited appeal.

Late appeals will be accepted from an SMI member or his/her authorized representative only upon showing of good cause. If the Division or AdSS refuses to accept a late appeal or determines that a service may not be appealed, the Division or AdSS will inform the member/authorized representative, in writing that he/she may request an Administrative Review of the decision with AHCCCS within 10 business days. AHCCCS will issue a final decision on a timely request for Administrative Review within 15 calendar days of the request.

If the final day of any timeframe falls on a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a holiday.

The Division will assist the member/responsible person/representative with the completion of forms and other procedural steps, upon request. The member/responsible person/representative may present information to the Division in person or in writing at any time during the appeal process. The member/responsible person/representative may review the member's records and other documents considered before and during the appeal process, not protected from disclosure by law. The Division ensures the member/responsible person/representative is included as a party to the appeal process.

Appeal Notifications and Documents (SMI)

Notices and written documents will be available in each prevalent non-English language spoken within geographic service area. These will be made available in alternative formats such as Braille, large font, enhanced audio and other special communication devices and methods necessary to understand information. When needed, Oral interpretation services will be made available to members to explain written content contained in notices and written documents.

Member/authorized representative will not be made financially liable for all types of communication assistance provided.

All notices and appeal decisions will be personally delivered or mailed by certified mail to the required party at their last known residence or place of work or as specified in member/authorized representative's oral or written appeal.

Copies of notices will be maintained in the Division's official files using a unique docket number for each appeal filed. which will be referenced in all appeal correspondence generated. All records will be maintained in a secure and locked place in compliance with HIPAAA standards and requirements. The member/authorized representative will have the right to examine those documents and records maintained in member's docket file that will be used in informal conferences or Administrative Hearings upon request. The Division or AHCCCS may DENY access to Appeal case docket records when permitted by State and Federal law.

Continuation of SMI Services

If an appeal relates to the modification or termination of a behavioral health service, the service under Appeal will continue pending the resolution of the appeal through the Division's decision unless:

A. A Qualified Clinician (see definition) determines that the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the person or another individual or

B. The member or guardian, if applicable, agrees in writing to the modification or termination.

Appeal Resolution Process for Members with SMI

When the appealing member with SMI is enrolled with THP, the appeals process will be followed by the Division's OAR Appeals Unit. When the appealing member with SMI is enrolled with an AdSS, the Appeals Unit within each respective AdSS will follow the same appeal resolution process outlined below.

A. Division Informal Conference

1. Within seven days of receipt of an oral or written appeal, the Division or AdSS will hold an informal conference with the member/authorized representative. If member has been identified as needing special assistance and does not have an assigned Advocate, the Division or AdSS will contact AHCCCS Office of Human Rights to request for an advocate to be present during the informal conference or any part of the appeal process.

2. The Division or AdSS will schedule the informal conference at a convenient time and place and notify all participants in writing, at least two days prior to the scheduled conference listing date, time, location, and the option to participate by telephone or teleconference when preferred and the member's right to be represented by a designated representative of his/her choice.

3. The Informal Conference will be chaired by the designated representative of the Division or AdSS with authority to resolve the issues under appeal and who will seek to mediate and resolve the issues in dispute. The Division may designate a staff from its Behavioral Health Unit, Quality Management Unit, or Support Coordination to represent OAR during an informal conference.

4. During the informal conference the Division's designated representative will record a statement of the nature of the appeal, the issue presented, any resolution(s) agreed upon and the date(s) of implementation. Any unresolved issues will be identified for further appeal.

5. Upon a satisfactory resolution of member's appeal, the Division or AdSS will issue a dated written notice to all parties that contains the statement of the nature of the appeal, the issue addressed, the resolution(s) achieved, and the resolution implementation dates agreed upon.

6. If member's appeal is not resolved to member's satisfaction and the appeal issue does NOT relate to the member's eligibility for behavioral health services/SMI services, the member and other representative present during the Informal conference (member's designated representative/authorized representative, Advocate) will be informed that the appeal will be forwarded to AHCCCS for a

second informal conference. The procedure for requesting a waiver of the AHCCCS informal conference will be communicated to member/designated representative at this time.

7. If member's appeal is not resolved to member's satisfaction and the appeal issue relates to the member's eligibility for behavioral health services/SMI services, or the member has requested a waiver from the AHCCCS informal conference in writing, the Division or AdSS will:

   a. Provide a written notice to the member/authorized representative of the process to request an Administrative Hearing.

   b. Determine during the informal conference if the member/authorized representative or Advocate is requesting an Administrative Hearing. If so, the Division will file a request with AHCCCs within three business days of the informal conference.

   c. Send a copy of the Appeal, informal conference results, and written notice of the process to request an administrative hearing and notice of an Administrative hearing to the AHCCCS Office of Human rights for members in need of Special Assistance whether the member has an assigned Advocate who attended the informal conference or not.

8. For all appeals that are unresolved after an informal conference, the Division will forward the Appeal case record to AHCCCS within three days from the conclusion of the informal conference.

9. If the member fails to attend the scheduled informal conference and fails to notify the Division or AdSS, another informal conference will be rescheduled following written notification requirements followed previously.

10. If the member fails to attend the rescheduled informal conference and fails to notify the Division or AdSS prior to conference, the Division or AdSS will close the Appeal docket and send written notice of the closure to the member/authorized representative.

11. If the member requests the appeal to be re-opened due to failure to receive the informal conference notification and/or due to other good cause, the Division or AdSS may re-open the appeal and proceed with another informal conference.

B. Expedited Appeals Requests (SMI)

1. At the time an Appeal is initiated, the member may request an expedited Appeal in writing. The Division or AdSS will accept requests to expedite an Appeal for good cause, and for the following:

   a. A Denial of admission to or the termination of a continuation of inpatient services, or

   b. A Denial or termination of crisis or emergency services.

2. Within one day of receipt of a request for an expedited Appeal, the Division or AdSS will:

a. Inform the member in writing that the Appeal has been received and of the time, date, and location of the expedited informal conference; or

b. Issue a written decision stating that the Appeal does not meet criteria as an expedited Appeal; and

c. Inform the member that he/she may, within three days of the Division or AdSS's decision, request an Administrative Review of the Division or AdSS's decision from AHCCCS.

3. Within two days of receipt of a written request for an expedited Appeal, the Division or AdSS will hold an informal conference to mediate and resolve the issues in dispute.

4. If the member requests an Administrative Review on a timely basis, AHCCCS will complete the review and issue a written decision within one day from the date of receipt. The decision of AHCCCS will be final.

C. AHCCCS Informal Conference

1. AHCCCS will hold another informal conference within 15 days of the notification from the Division that the Appeal was unresolved unless the member/authorized representative waives an informal conference with AHCCCS, or the appeal relates to eligibility for SMI services.

2. At least five days prior to the date of the AHCCCS-scheduled informal conference, AHCCCS will notify the participants in writing of the date, time, and location of the conference.

3. The informal conference will be chaired by a representative of AHCCCS who will seek to mediate and resolve the issues in dispute.The AHCCCS representative will record a statement of the nature of the Appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented and identify any unresolved issues for further Appeal.

4. If the issues in dispute are resolved to the satisfaction of the member, AHCCCS will issue a dated written notice to all parties, which will include a statement of the nature of the Appeal, the issues involved, the resolution achieved, and the date by which the resolution will be implemented.

5. For a person in need of Special Assistance, AHCCCS will send a copy of the informal conference report to AHCCCS Office of Human Rights.

6. If the issues in dispute are not resolved to the satisfaction of the member, AHCCCS will:

a. Provide written notice to the member of the process to request an administrative hearing;

b. Determine at the informal conference whether the member is requesting AHCCCS to request an administrative hearing on behalf of the member and, if so, file the request within three days of the informal conference;

c. For a person in need of Special Assistance, send a copy of the notice to AHCCCS Office of Human Rights.

7. If the member requests an **expedited** AHCCCS Informal Conference, AHCCCS will hold an informal conference to mediate and resolve the issue in dispute, within two days of notification from the Division or AdSS, unless the member/authorized representative waives the informal conference, in which case the Appeal will be forwarded within one day to AHCCCS to schedule an administrative hearing.

8. If the AHCCCS informal conference is not waived, and AHCCCS fails to resolve the Appeal, the Appeal will be forwarded to AHCCCS to schedule an administrative hearing within one day of the informal conference.

9. If the member/authorized representative fails to attend the AHCCCS informal conference and fails to notify AHCCCS of this, AHCCCS may issue a written notice, within three working days of the scheduled conference, which contains a description of the decision on the issue under appeal and advises the member/authorized representative of his/her right to request an Administrative hearing.

10. In the event the member requests the Appeal be re-opened due to not receiving the informal conference notification and/or due to other good cause, AHCCCS may re-open the Appeal and proceed with the informal AHCCCS conference.

D. Requests for Administrative Hearing

1. In the event a request for administrative hearing is filed with the Division or AdSS, the Division or AdSS will ensure that the written request for hearing, Appeal case record, and all supporting documentation is received by AHCCCS within three days from such date. A written request for hearing filed by the Division or AdSS with AHCCCS will contain the following information:

   a. Name of the member and person receiving services (if different),

   b. Member's case docket number,

   c. The decision being Appealed,

   d. The date of the decision being Appealed, and

   e. The reason for the Appeal.

2. Administrative Hearings will be conducted and decided pursuant to A.R.S. § 41-1092 et seq.

Standard Appeal Resolution Timeframe

The Division will respond to the standard appeal filed as a result of receipt of a Notice of Adverse Benefit Determination and mail the written Notice of Appeal Resolution to the member/responsible person/representative within 30 calendar days after the date the Division receives the appeal. The Division will extend the 30-day timeframe up to an additional 14 calendar days upon request by the member/responsible person/representative. The Division may request a 14-calendar day extension of the 30-day time frame if additional information is needed and the extension is in the best interest of the member. The OAR will provide the member/responsible person/representative written notice of the reason for the decision to extend the 30-day timeframe.

Appeal Notice Requirements

All notices and appeal decisions will be personally delivered or mailed by certified mail to the required party at their last known residence or place of work. In the event that it may be unsafe to contact the member/authorized representative at his/her home address, or the person indicated that he/she does not want to receive mail at home, the alternate communication methods specified by the member/authorized representative will be used.

Notices and written documents generated through the Appeals process will be available in alternative format such as Braille, large font, or enhanced audio and take into consideration the special communication needs of members.

Expedited Appeal

The member/responsible person/representative may request an expedited resolution of the appeal when the appeal is filed as a result of a Notice of Adverse Benefit Determination. The Division or AdSS will conduct an expedited appeal if it is determined that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The Division will conduct an expedited appeal if a request is received directly from a health care provider, with written authorization from the member/responsible person/representative, and the health care provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function.

If the request for an expedited appeal is denied, the Division's OAR or AdSS will promptly contact the member/responsible person/representative orally to advise him/her of the denial. It will send a written notice of the denial no later than two calendar days to the member/responsible person/representative. If a request for an expedited appeal is denied, the Division will follow the standard appeal resolution timeframe and the appeal will be resolved no later than 30 calendar days after the day the Division received the appeal.

If the request for an expedited appeal is granted, the Division's OAR or AdSS will promptly contact the member/responsible person/representative orally to advise him/her of the approval. The Division will adjudicate the appeal and mail the written Notice of Appeal Resolution to the member/responsible person/representative within 72 hours from the day the Division or AdSS receives the request for an expedited appeal. The Division or AdSS will extend the 72-hour timeframe up to an additional 14 calendar days upon request by the member/responsible person/representative. The Division or AdSS may request a 14-calendar day extension of the 72-hour timeframe if additional information is needed and the extension is in the best interest of the member. The Division or AdSS will provide the member/responsible person/representative written notice of the reason for the decision to extend the 72-hour timeframe.

Appeal Decisions and Timeframes

For standard and expedited appeals filed as a result of a Notice of Adverse Benefit Determination, the Division will ensure the person who makes a decision on an appeal was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will render a written Notice of Appeal Resolution to the member/responsible person/representative no later than 30 calendar days from the date the appeal was received. The Notice of Appeal Resolution will include the results of the resolution process and the date it was completed. If a Notice of Appeal Resolution is not rendered in 30 calendar days for a standard appeal or 72 hours for an expedited appeal, the member may consider the appeal denied. The

Notice of Appeal Resolution is issued to the member/responsible person/representative. If the appeal is not wholly resolved in favor of the member, the Notice of Appeal Resolution will include:

A. The member's right to request a fair hearing and how to do so;

B. In cases where the member requests the services continue, the member's right to receive services while the fair hearing is pending;

C. The factual and legal basis of the decision; and

D. The member/responsible person/representative's liability for the cost of the continued services if Arizona Health Care Cost Containment System (AHCCCS) upholds the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD or Division) decision.

If the Notice of Appeal Resolution is reversed, the Division or AdSS will notify Support Coordination and the other entity (Division or AdSS), as appropriate. Upon notification, services will be provided expeditiously as the member's health condition requires. If the Notice of Appeal Resolution is upheld, and services were requested to continue pending resolution of the appeal, the Division may recover the cost of services from the member.

The Division or AdSS will ensure the person who makes a decision on an appeal was not involved in any previous level of review or decision-making. The AdSS will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division or AdSS will render a written Notice of Appeal Resolution to the member/responsible person/representative no later than 30 calendar days from the date the appeal was received. The Notice of Appeal Resolution will include the results of the resolution process and the date it was completed. If a Notice of Appeal Resolution is not rendered in 30 calendar days for a standard appeal or within 72 hours for an expedited appeal, the member may consider the appeal denied. The Notice of Appeal Resolution is issued to the member/responsible person/representative and the Division through the Office of Administrative Review. If the appeal is not wholly resolved in favor of the member, the Notice of Appeal Resolution will include:

A. The member's right to request a fair hearing and how to do so;

B. In cases where the member requests the services continue, the member's right to receive services while the fair hearing is pending;

C. The factual and legal basis of the decision; and

D. The member/responsible person/representative's liability for the cost of the continued services if Arizona Health Care Cost Containment System (AHCCCS) upholds the AdSS decision.

If the Notice of Appeal Resolution is reversed, the AdSS or the Division of Developmental Disabilities, Office of Administrative Review by the other. Upon notification services will be provided expeditiously as the member's health condition requires. If the Notice of Appeal Resolution is upheld, and services were requested to continue pending resolution of the appeal, the Division or AdSS may recover the cost of services from the member.