Appeal Template for <u>We were denied ABA because of our child's age or severity.</u>

This appeal can be filed by the family and the Medicaid-approved ABA provider who is serving the child.

Directions:

First, copy the below template and insert your individual information where you see "XX." Secondly, send your appeal request to your managed care plan. See the contact information below the template.

Appeal Template:

I am filing an appeal for my Medicaid-eligible child, (name and Medicaid number XX). My child was diagnosed with autism spectrum disorder (ASD) by a licensed professional and prescribed applied behavior analysis (ABA) therapy. My child received a denial from my managed care plan based on my child's XX (age or level of severity). The Medicaid standard is an individualized standard and must view my child as an individual. Medicaid needs to apply the generally accepted standards of care (GASC) for ABA therapy in treating ASD. The public GASC resource published by the Council of Autism Service Providers is "Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers." The EPSDT federal mandate provides early, periodic, screening, diagnosis, and treatment and applies and requires the state Medicaid agency to cover and ensure my child receives this medically necessary care. Prompt treatment is essential and every day without treatment threatens current and future functioning. We are requesting authorization for ABA therapy as prescribed and based on medical necessity from the standards of care without quantitative (age) or non-quantitative (severity) treatment limitations being applied. -Family Contact Information XX (Name, Address, Phone, Email, Child name, and Medicaid number)

Contact Information for managed care plans: If no email is listed, consider faxing your appeal.

Aetna Better Health of IL - Email: ILAppealandgrievance@aetna.com, Tel: 866-329-4701, Fax: 877-668-2076, Mail: Aetna Better Health of IL, Attn: Appeals Dept., P.O. Box 81139, Cleveland, OH 44181. Formerly Illinicare Health.

Blue Cross Blue Shield Community Plan – Email: unknown, Tel: 877-860-2837, Fax: 866-643-7069, Mail: BCBS, Attn: Grievance and Appeals Unit, P.O. Box 27838, Albuquerque, NM 87125-9705.

CountyCare (HealthChoice) Health Plan – Email: unknown, Tel: 312-864-8200, Fax: 866-200-5031, Mail: CountyCare Health Plan, Attn: CCH A&G Department, P.O. Box 21153, Eagan, MN 55121. Cook County only.

Humana Health Plan – Email: unknown, Tel: 1-800-787-3311, Fax: 1-855-336-6220, Mail: Attn: Grievance and Appeal Dept., PO Box 14546, Lexington, KY 40512-4546

Meridian Health Plan – Email: unknown, Tel: 866-606-3700, Fax: 312-508-7255, Mail: Meridian Health, Attn: Grievance Coordinator or Appeals, Coordinator, PO box 44287, Detroit, MI 48226.

Molina Healthcare of Illinois - Email: MHI.IL.Appeal@MolinaHealthCare.Com, Tel: 855-687-7861, Fax: 855-502-5128, Mail: Molina of Illinois, Attn: Grievance and Appeals Dept., 1520 Kensington Road Suite 212, Oak Brook, IL 60523.

Youthcare –Contact the case worker with the Illinois Department of Child and Family Services.

Medicaid Only – A Medicaid member not enrolled in managed care can file an appeal at DHS.BAH@Illinois.gov.