

OASIS · AT A GLANCE

Appealing denials without losing what you still have

A denial notice has a clock hidden inside it. Miss it and you lose the service while you fight. Catch it and the service keeps running until someone actually rules on your case.

BY JIM PALASTY · 11 MIN READ · AID PAID PENDING, EXPLAINED PLAINLY

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DAYS TO REQUEST AN APPEAL

File before the effective date on the notice and federal rules require your current services to keep running while the appeal is pending.

How it works

THREE STEPS

STEP 1

The denial notice arrives

Buried in the letter is an effective date and an appeal deadline. Both matter more than the reason given.



STEP 2

You file before that date

Requesting a hearing before the effective date triggers continued benefits while the appeal is pending.



STEP 3

You write a focused rebuttal

Answer the agency's own stated criteria, point by point, not a general complaint about fairness.

The appeal safeguards

Timely filing	Request the hearing before the notice's effective date
Aid paid pending	Ask explicitly, in writing, for continued services during the appeal
Focused rebuttal	Answer the agency's own criteria, point by point
Written record	Every request submitted in writing, with proof of delivery

THE LINE SHE ALMOST MISSED

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Patricia read her son's denial notice twice before she found the sentence stating services would end in nine days. She filed her appeal on day eight, in writing, and explicitly requested continued services pending the hearing. His day program kept running for the four months her appeal took to resolve. She won.

ONE SENTENCE IN A DENSE LETTER WAS THE ENTIRE DIFFERENCE BETWEEN FOUR MONTHS OF CONTINUED CARE AND FOUR MONTHS OF NOTHING.

What matters, at a glance

Timely filing deadline

A short, strict window to request a hearing. Miss it and you may have to reapply from scratch instead of appealing.

Aid paid pending

Federal Medicaid rules require continued services during a timely appeal, but only if you request it explicitly, in writing.

A rebuttal that misses the target

Arguing that a decision feels unfair loses to an agency's own written medical necessity criteria almost every time.

Answer their own criteria

Pull the exact standard the agency used to deny you and rebut each point specifically. Generic appeals rarely win.

Never rely on a phone call

Verbal appeal requests get lost. A written, dated, delivered request is what protects your continued services.

Keep everything

Copies of the notice, your appeal letter, proof of delivery, and the criteria document you're rebutting.

BRING THESE · CHECK AS YOU GO

- | | |
|---|--|
| ☐ The original denial notice with effective date circled | ☐ A written, dated appeal request letter |
| ☐ An explicit continued-services request | ☐ The agency's own written eligibility criteria |
| ☐ A point-by-point rebuttal document | ☐ Proof of delivery for every submission |

YOUR MOVE

When a denial notice lands, here is the exact sequence

- 1 Find the effective date on the notice immediately.
- 2 File your appeal in writing before that date.
- 3 Explicitly request continued services in the same letter.
- 4 Request the agency's written medical necessity criteria.
- 5 Write a rebuttal answering each criterion specifically.
- 6 Keep copies of everything, with proof of delivery.

The deadline is not a formality. It is the entire hinge the rest of your case swings on.

RESOURCES NAMED IN THIS POST

healthlaw.org · <https://healthlaw.org>
 bazelon.org · <https://www.bazelon.org>

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ABOUT THE AUTHOR

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Jim Palasty

Jim Palasty is the founder of OASIS for Autism and a single father of an adult autistic daughter in Michigan.