

**CHAPTER M16**  
**APPEALS PROCESS**

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**CHAPTER 16**

### M16 Changes

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## **M1600.00 APPEALS PROCESS**

### **M1610.100 PURPOSE AND SCOPE**

#### **A. Legal Base**

The Social Security Act requires that the State Plan for Medical Assistance provide individuals affected by the administration of the Medical Assistance Program an opportunity for a fair hearing. The act establishes the right of any individual to appeal and receive a fair hearing before the administering agency, the Department of Medical Assistance Services (DMAS), when DMAS or any of its designated agents:

- takes an action to terminate, deny, suspend, or reduce benefits,
- fails to take an application for medical assistance,
- fails to act on an application for medical assistance with reasonable promptness, or
- takes any other action that adversely affects receipt of medical assistance.

The State law governing the State/Local Hospitalization (SLH) program requires that DMAS use the Medicaid applicant/enrollee appeals and hearings procedures for SLH applicants and enrollees. The procedures in this Chapter also apply to SLH appeals.

#### **B. Participants**

The DMAS Appeals Division provides the Hearing Officer who makes arrangements for the fair hearing. The Appeals Division is separate and apart from operational divisions and units within and outside of DMAS. The Division provides a neutral forum for appeals. The Hearing Officer is an impartial decision-maker who will conduct hearings, decide on questions of evidence, procedure and law, and render a written final decision. The Hearing Officer is one who has not been directly involved in the initial adverse action which is the issue of the appeal.

**The local agency taking the action being appealed, including Disability Determination Services (DDS) disability decisions,** and the appellant (the individual appealing some aspect of his entitlement to medical assistance or its scope of services) or his representative must participate in the hearing. Most hearings will be conducted by telephone.

*Appeals that result from a self-directed application in the eligibility and enrollment system are handled by the local department of social services (LDSS) that houses the application.*

#### **C. Ex Parte Communication**

**Ex parte communication with the Hearing Officer is strictly prohibited.** Ex parte communication is any off-the-record communication (oral or written) between the Hearing Officer and an interested party outside the presence of the other parties to the proceeding during the life of the appeal proceeding.

The Hearing Officer cannot discuss the substantive issues of an appeal with anyone outside of the hearing. Therefore, it is not appropriate to contact the Hearing Officer to discuss the agency's action prior to or after the hearing.

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*Any information provided to the Hearing Officer must be provided to all parties of the proceeding. However, as noted in M1620.100, it is appropriate to notify all parties to the appeal when an action is taken by an agency to resolve the issue of the appeal. Communication is also allowed for procedural issues such as scheduling hearings, canceling hearings, and indicating a desire to withdraw an appeal.*

**D. Notification and Rights**

At the time of application or redetermination, and at the time of any action or proposed action affecting eligibility for medical assistance, medical services or patient pay, every applicant for and *enrollee* of medical assistance shall be informed in writing of his right to a hearing. He shall also be notified of the method by which he may obtain a hearing, and of his right to represent himself at the hearing or to be represented by an authorized representative such as an attorney, relative, friend, or other *spokesperson*.

**M1620.100 LOCAL AGENCY CONFERENCE**

**A. Time Limits**

A dissatisfied applicant or *enrollee* must be given the opportunity to request a local agency conference. *If a conference is requested, it must be scheduled within 10 working days of receiving the request.*

**B. Conference Procedures**

At the conference, the applicant/*enrollee* must be:

- given an explanation of the action.
- allowed to present any information to support his disagreement with the action.
- allowed to represent himself or be represented by an authorized representative such as a legal counsel, friend, or relative.

**C. Failure to Request a Conference**

*The applicant's or enrollee's failure to request a conference does not affect his right to appeal within 30 days and does not affect his right to continued eligibility if he appeals prior to the effective date of the action.*

**D. The Conference & Right to Appeal**

*The local agency conference must not be used as a barrier to the individual's right to a fair hearing.*

**E. Decision Notification**

*The local agency conference may or may not result in a change in the agency's decision to take the action in question, however an agency can reverse its decision at any time between making the original decision and when a decision is rendered by the Hearing Officer.*

*If the agency's decision is not to take the adverse action indicated on the notice, the applicant or enrollee must be informed in writing. The agency must send a new notice regarding the changed action. A copy of the new notice must be sent to the DMAS Appeals Division.*

If the agency's decision is to stand by its action, the applicant/*enrollee* must be *informed*, but written notice of this decision is not required.

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- F. Conference Decision** If the applicant/enrollee is not satisfied with the agency action following the conference and wants to request a fair hearing, he must be given that opportunity. See M1630.100 C. below. The applicant/enrollee may request an appeal before or after the conference. Participation in a conference does not extend the 30 day time limit for requesting an appeal.

## **M1630.100 APPEAL REQUEST PROCEDURES**

- A. Appeal Definition** An appeal is a request for a fair hearing. The request must be a clear, written expression by an applicant or enrollee, his legal representative (such as a guardian, conservator, or person having power of attorney), or his authorized representative acting at his request, of a desire to present his case to a higher authority. It may be a letter or a completed "Medicaid/SLH/FAMIS Appeal Request Form."
- B. Where to File an Appeal** Appeals must be sent to the:
- Department of Medical Assistance Services  
Appeals Division  
600 East Broad Street  
Richmond, Virginia 23219
- Appeals may also be faxed to (804) 452-5454.
- C. Assuring the Right to Appeal** The right to appeal must not be limited or interfered with in any way. When requested to do so, the agency must assist the applicant/enrollee in preparing and submitting his request for a fair hearing.
- D. Appeal Time Standards** A request for an appeal must be made within 30 days of receipt of notification that Medicaid coverage or medical services has been denied, terminated, reduced, adversely affected, or that it has not been acted upon with reasonable promptness.
- Notification is presumed received by the applicant/enrollee within three days of the date the notice was mailed, unless the applicant/enrollee substantiates that the notice was not received in the three-day period through no fault of his/her own.
- An appeal request shall be deemed to be filed timely if it is mailed, faxed, or otherwise delivered to the DMAS Appeals Division before the end of last day of filing (30 days plus 3 mail days after the date the agency mailed the notice of adverse action). The date of filing will be determined by:
- the postmark date,
  - the date of an internal DMAS receipt date-stamp, or
  - the date the request was faxed or hand-delivered.

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*In computing the time period, the day of the act or event from which the period of time begins to run shall be excluded, and the last day included. If the time limit would expire on a weekend or state or federal holiday, it shall be extended until the next regular business day.*

The DMAS will, at its discretion, grant an extension of the time limit for requesting *an appeal* if failure to comply with the time limit is due to a good cause such as illness of the appellant or his representative, failure to have been notified of the right to appeal, delay due to the postal service or to an incorrect address, or other unusual or unavoidable circumstances.

## **M1640.100 CONTINUED COVERAGE PENDING APPEAL DECISION**

### **A. Appeal Validation**

Following receipt of a written request for a hearing, the DMAS Appeals Division will determine whether the request *is valid*. A *valid* appeal is one that *involves* an action over which the DMAS has hearing authority, and that is received within the required time limit or extended time limit. During the process of validating an appeal request, a representative of the DMAS may contact the agency to request a copy of the notice of the adverse action. Upon receipt of such a request, the agency must immediately send a copy of the notice to the DMAS Appeals Division.

*When an appeal is determined to be valid, the DMAS will send official notification to the agency and identify the issue and Hearing Officer.*

### **B. Coverage May Continue**

When an appeal is received and validated, the DMAS Appeals Division decides if Medicaid coverage must continue and notifies the agency. The agency should not continue coverage due to the appeal until it has been contacted by the Appeals Division. Upon being informed, by telephone or correspondence, that the *enrollee* is eligible to receive continued coverage, the agency must reinstate coverage immediately.

*An enrollee's Medicaid coverage must continue until a final appeal decision is made when an appeal hearing is requested prior to the effective date of the action stated on the "Advance Notice of Proposed Action". In the case of a patient pay adjustment, the patient pay obligation must return to the amount that was effective prior to the change shown on the "Notice of Obligation for Long Term Care Costs" that is the subject of the appeal.*

### **C. When Continued Coverage Does Not Apply**

*Coverage will not continue when:*

- an appeal hearing is requested on or after the effective date of action;
- an *enrollee* does not dispute the facts used by the local agency, but is appealing the policy on which the agency based its action;
- at the hearing, the Hearing Officer determines that the sole issue of the appeal is disagreement with existing State or Federal policy or law and that no facts are disputed. The Hearing Officer will *promptly* notify

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the *enrollee* or his representative and the agency in writing that continued Medicaid coverage must terminate immediately. The agency *must* terminate the *enrollee's* Medicaid immediately, using cancel reason "015" effective the date of the hearing.

- D. Recovery of Continued Coverage Costs**      *When the Hearing Officer upholds the agency's action, the cost of medical care received during the period of continued coverage may be recovered by the DMAS. (See M1670.100)*

## **M1650.100 PRE-HEARING ACTIONS**

- A. Invalidation**      *A request for an appeal may be invalidated if it was not filed within the time limit imposed or if it was not filed by the applicant/enrollee or an authorized representative.*
- 1. Appeal Not Filed Timely**      *If DMAS determines that the appellant has failed to file a timely appeal, DMAS shall notify the appellant or the appellant's representative of the opportunity to show good cause for the late appeal.*
- If there is no response, or if after evaluating the response, the Hearing Officer determines that the reason for failing to file a timely appeal does not meet good cause criteria, the appeal request will be considered invalid.*
- 2. Factual Dispute of Timeliness**      *If a factual dispute exists about the timeliness of the request for an appeal, the Hearing Officer shall receive testimony and evidence at the hearing prior to receiving testimony and evidence about the substantive issue of the appeal. A decision on the timeliness issue will be made prior to a determination of whether to make a decision about the substantive issue of the appeal.*
- 3. When Individual Filing Appeal Is Not the Appellant**      *If the individual filing the appeal is not the appellant or an authorized representative of the appellant, DMAS will request that the appellant and/or representative provide proof of authorization to represent the appellant. If proof is not provided, the appeal request will be considered invalid.*
- B. Administrative Dismissal**      *A request for an appeal may be administratively dismissed without a hearing if the appellant has no right to a hearing. DMAS will administratively close an appeal case in the following situations:*
- 1. No Adverse Action Taken**      *If DMAS learns that no adverse action was taken prior to the date of the appeal request, the appeal will be closed.*
- 2. Disability Decision Rescinded By DDS**      *If the appellant's Medicaid application is returned to a pending status because the Disability Determination Services analyst rescinds the denial of disability, the appeal will be closed.*
- 3. Withdrawn**      *If the appellant requests that the appeal be withdrawn, the appeal will be closed by the DMAS Appeals Division.*

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- *The appellant must sign a statement clearly indicating that he wishes to withdraw his appeal. The statement or form must be mailed or faxed to the DMAS Appeals Division. Verbal notification to the LDSS by the appellant to withdraw an appeal is **not** sufficient.*
- *The Hearing Officer will close the appeal and send a letter to the appellant with a copy to the LDSS.*

**4. Abandoned**

*If the appellant or his representative fails to appear at the scheduled hearing, and does not reply within 10 days to the Hearing Officer's request for an explanation that meets good cause criteria, or if the appellant does reply and the Hearing Officer decides that the reply does not meet good cause criteria, the appeal will be closed as "abandoned."*

**5. Administratively Resolved**

*If, upon reevaluation by the LDSS, the appellant's coverage is reinstated to the full amount of coverage that was in effect prior to closure or reduction of benefits, the appeal will be closed as administratively resolved.*

**NOTE:** *The agency should not assume that a reinstatement automatically ends the appeal. The Appeals Division will decide whether to terminate the appeal. The agency will receive a copy of final letters for administrative closures.*

**C. Judgment on the Record**

*If the Hearing Officer determines from the record that the agency's action was clearly in error and that the case should be resolved in the appellant's favor, he shall issue a judgment on the record instead of holding a hearing. The Hearing Officer will provide the local agency with a clear explanation of the reason(s) for issuing a judgment on the record and which actions must be taken by the local agency to correct the case. The decision to issue a judgment on the record is at the Hearing Officer's discretion.*

**D. Remand to the Agency Prior to the Hearing**

*If the Hearing Officer determines from the record that the case might be resolved in the appellant's favor if the agency obtains and develops additional information, documentation, or verification, he may remand the case to the agency for action consistent with the Hearing Officer's written instructions. The agency must complete the remand evaluation within 30 days or 45 days as applicable.*

**M1660.100 SCHEDULING THE HEARING**

**A. Scheduling and Location**

*The Hearing Officer will select a date and time for the hearing. Typically, hearings are scheduled three weeks in advance.*

*For eligibility issues, hearings will be held at the local agency. The applicant/enrollee will be at the agency. The Hearing Officer will conduct the hearing by telephone unless the appellant requests a face-to-face hearing.*

**B. Confirmation Letter**

*The schedule letter is mailed to the appellant or representative, and a copy is mailed to the agency.*

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*The schedule letter contains information about summary due dates and other pertinent information.*

*If the agency representative can not be available on the date and time selected by the Hearing Officer, he/she must notify the DMAS as soon as possible and request an alternate date and time for the hearing.*

## **M1670.100 LOCAL AGENCY APPEAL SUMMARY**

### **A. Agency Appeal Summary Form**

*Once a hearing has been scheduled, the agency must complete an “Agency Appeal Summary,” form #032-03-805 available at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.*

### **B. Send to Appeals Division and Appellant**

*At least ten days prior to the hearing, the agency must send one copy of this form to each of the following:*

- Department of Medical Assistance Services  
Appeals Division, 11<sup>th</sup> Floor  
600 East Broad Street  
Richmond, Virginia 23219.
- The appellant or his authorized representative.

*The agency must keep a copy of the appeal summary and all relevant documentation, including applications and notices, for its records.*

## **M1680.100 THE HEARING PROCEDURE**

### **A. Hearing Procedure**

*The hearing will be conducted in an informal manner. Formal rules of evidence do not apply in these proceedings. The appellant is entitled to guarantees of fair hearings established in Goldberg v. Kelly, 397 US 245 (1970). The proceedings will be governed by the following rules:*

#### **1. Record**

*The Hearing Officer will swear-in all hearing participants who will be presenting evidence or facts and will record the hearing proceedings.*

#### **2. Appellant**

*The appellant will present his own case or have it presented by an authorized representative. He will be allowed to bring witnesses, establish all pertinent facts and circumstances, advance any testimony or evidence, and question witnesses.*

#### **3. Agency Representatives**

*The local DSS agency worker who took the action being appealed and/or the worker’s supervisor should be present at the hearing. The local agency may be represented by its county or city attorney. The agency has the authority to ask its county or city attorney to attend the hearing.*

*When the action being appealed is a disability decision made by the DDS, a representative from DDS must be present at the hearing. When the action being appealed is a denial of a medical or dental covered service, a representative from DMAS or its contractor who made the decision must be present at the hearing.*



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- 4. Opportunity to Examine Documents** The appellant or his representative must be given the opportunity to examine all documents and records to be used at the hearing, at a time before the hearing or during the hearing. Copies of case record information must be made available free of charge to the appellant at his request.

**B. Hearing Officer Evaluation and Decision**

- 1. Evaluation** Following the hearing, the Hearing Officer prepares a decision taking into account the summary prepared by the agency or medical provider involved, evidence provided by the appellant or his representative, and additional information provided by the agency. The Hearing Officer evaluates all evidence, researches laws, regulations and policy, and decides on the accuracy of the agency’s action.

- 2. Hearing Officer Decision** Examples of the Hearing Officer’s decisions include, but are not limited to:

**a. Sustain**

When the Hearing Officer’s decision upholds the agency’s action, the decision is “sustained.”

**b. Reverse**

When the Hearing Officer’s decision overturns the agency’s action, the decision is “reversed.”

**c. Remand**

When The Hearing Officer sends the case back to the agency for additional evaluation, the decision is “remanded.” The Hearing Officer’s decision will include instructions that must be followed when completing the remand evaluation.

- 3. Failure to Provide Requested Information** If the local department of social services denies an application *or terminates coverage* because of failure to provide requested information, *the hearing officer can hold the hearing open for a period of time to allow the appellant to submit additional information.* The hearing will address:

- whether or not the applicant was given appropriate notification of what was needed for the eligibility determination; and
- whether or not the applicant was given sufficient time to submit the information requested.

**a. Sustained**

If the local department of social services followed correct procedures (see M0130.200) and the applicant brings the requested information to the hearing, the action of the local department of social services will be sustained and the applicant will be required to file a new application.

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***b. Remanded***

If the Hearing Officer determines that the local department of social services did not follow appropriate procedures, the case may be remanded for appropriate action.

If the Hearing Officer determines that the local department of social services did not follow correct procedures, and the applicant brings the relevant information to the hearing, the case may be remanded for an eligibility determination using the original application date.

**C. Local Agency Action**

The decision of the Hearing Officer is the final administrative action taken on the appeal. The local agency must comply with the Hearing Officer's decision.

**1. Agency Action - Sustained Cases**

*If the Hearing Officer's decision is to sustain the agency's action, and coverage was continued during the appeal process, the case must be closed without an additional notice to the enrollee from the local agency. The Hearing Officer's decision letter to the appellant is the appropriate official notice of cancellation.*

The local agency must take action to close the case in the Medicaid computer using cancel reason "015" effective the date the agency receives the decision.

**2. Agency Action - Remanded Cases**

***a. Do Not Send Documents to Hearing Officer***

If the Hearing Officer's decision is to remand the case to the local agency, the local agency must not send documentation of the evaluation or a copy of the remand notice to the Hearing Officer.

***b. Enrollment Actions***

If the Hearing Officer's decision is to remand the case for further evaluation and coverage was continued during the appeal process, coverage must be continued until the local agency completes the evaluation and makes a new decision.

If the remand evaluation results in the appellant's continuous eligibility, the local agency must notify the appellant of his/her continuing eligibility for coverage.

If the remand evaluation results in the appellant's continuous eligibility and coverage was NOT continued during the appeal process, the local agency must reinstate coverage back to the original termination date (no break in coverage) and notify the appellant of his continued eligibility.

If the remand evaluation results in the appellant's ineligibility and coverage was continued during the appeal process, the *enrollee's coverage* must be *cancelled* at the completion of the evaluation, and the appellant must be notified.

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*c. Take Action in 30-45 Days*

*The agency must complete the remand evaluation within 30 days or 45 days as applicable.*

**3. Agency Action-Reversed Cases**

Following a Hearing Officer's decision to reverse an agency's action to deny, reduce, or terminate coverage, the agency must reinstate coverage retroactive to the date of closure or month of application (including retroactive coverage months, if applicable).

***M1690.100 RECOVERY OF BENEFITS PAID DURING APPEAL***

**A. Applicable Circumstances**

The Medicaid Program may recover expenses paid on behalf of appellants whose Medicaid coverage was continued during the appeal process, when the agency's proposed action is upheld by the Hearing Officer.

DMAS will be responsible for recovering these expenses from the appellant, not the service provider. The appellant will be notified, after the hearing decision is made, of how much money if any is owed to the Medicaid Program.

**B. Recovery Period**

Medicaid expenditures for services received from the original effective date of the proposed adverse action (as stated on the notice) until the actual cancellation of Medicaid coverage or payment will be recovered.