

BROADCAST DMAS-54

DATE : October 15, 2020

TO: LDSS Directors and Eligibility Staff and Cover Virginia Staff

FROM: Cindy Olson, Director, Eligibility and Enrollment Services Division, Department of
Medical Assistance Services (DMAS)
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SUBJECT: Medicaid Appeals Changes – De Novo Review

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The purpose of this broadcast is to inform local agencies of changes regarding the appeal process. These policies and procedures are effective for appeals submitted on or after October 15, 2020. The changes to Chapter M16 of the Medical Assistance Eligibility Manual are attached to this broadcast.

DMAS offers appellants the opportunity to have their cases reviewed *de novo*, meaning the appellant is permitted to provide additional information through the entire appeal process. Appellants who wish for additional documentation to be reviewed may submit it with their appeal request, prior to the scheduled hearing, or after the hearing if the hearing officer agrees to hold the record open for submission of additional documentation.

Local DSS and Cover Virginia staff shall follow the procedures below:

1. Review documentation submitted with appeal request, even if it had not been previously submitted. If a resolution is possible considering all documents, issue a new notice and advise the hearing officer of the resolution. If the information does not meet criteria for approval, explain why not in the appeal summary.
2. LDSS or Cover Virginia will receive a copy of any new documentation that has been submitted to DMAS. Review all new documentation submitted during the appeal (can be up to and including the hearing itself) and determine if that documentation resolves the issue in the appellant's favor. If a resolution is possible, issue a new notice and advise the hearing officer of the resolution. If the information does not resolve the issue, be prepared to discuss at the hearing what policy/criteria is still not met.
3. Responsibility for appeals has not changed, so there shall be a need for additional communication between local agencies and Cover Virginia, depending on who is responsible for the appeal and subsequent evaluations.
4. If staff does not re-evaluate the case prior to the hearing based on additional documentation, or does not provide the updated NOA to the hearing officer prior to the hearing, the hearing officer shall render a decision based on the evidence provided in the hearing.

Please contact Michael Puglisi at michael.puglisi@dmas.virginia.gov should you have questions regarding this broadcast or the updated policies.

M16 Changes

Changed With	Effective Date	Pages Changed
N/A	10/15/20	Pages 3, 8 Page 8a was added as a runover page.
TN DMAS-12	4/1/19	Page 7
TN #DMAS-8	4/1/18	Page 7
TN #DMAS-4	4/1/17	Page 7 Pages 8-10 are runover pages.
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Page 1
TN #100	5/1/15	Page 3
Update #9	4/1/13	Page 8

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date October 15, 2020
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1630.100	Page 3

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 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.

B. Appeal Request

An applicant may submit an appeal using a "Virginia Medicaid/FAMIS Appeal Request Form," which is available from DMAS at www.dmas.virginia.gov/#/appealsresources. The applicant may also write his or her own letter to request an appeal. The Appeals Division also accepts telephonic appeal requests.

C. How to File an Appeal Request

- 1. Electronically.** Email an appeal request to appeals@dmas.virginia.gov
- 2. By fax.** Fax an appeal request to DMAS at (804) 452-5454
- 3. By mail or in person.** Send or bring an appeal request to:
Department of Medical Assistance Services
Appeals Division
600 East Broad Street
Richmond, Virginia 23219
- 4. By phone.** Call the Appeals Division at (804) 371-8488 (TTY: 1-800-828-1120).

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.

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date October 15, 2020
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1680.100	Page 8

- 1. 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.

- 2. 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.

- 3. De Novo Review** *DMAS offers appellants the opportunity to have their cases reviewed de novo by a DMAS hearing officer. That means that the DMAS hearing officer will issue an entirely new eligibility determination based upon evidence that may not have been available to the Agency or Contractor at the time the appealed eligibility determination was made. The DMAS hearing officer will review all information and testimony that was submitted for the initial eligibility determination as well as any information that is submitted during the appeal process. Appellants who wish for additional documentation to be reviewed may submit it with their appeal request, prior to the scheduled hearing, or after the hearing if the hearing officer agrees to hold the record open for submission of additional documentation.*

Agencies and Contractors will receive a copy of any new documentation that has been submitted for review, and must review it to determine whether it is possible to approve MA coverage. If the Agency or Contractor determines that it is appropriate to approve coverage, then they shall issue a new Notice of Action on Benefits and provide it to all parties to the appeal. The hearing officer must then decide whether it is appropriate to resolve the appeal based upon the new Notice of Action on Benefits.

If the new documentation would not result in a finding of MA eligibility, then the Agency or Contractor must produce an appeal summary explaining why the new documentation did not result in a finding of eligibility and should attend the hearing prepared to explain why the Agency or Contractor maintains its position on the appeal.

After the hearing, the DMAS hearing officer will issue a decision as to whether or not the appellant is approved for coverage based upon the new documentation.

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date October 15, 2020
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1680.100	Page 8a

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: