Health Plan Logo with contact information



(CCC Plus Logo Optional)

# INTERNAL APPEAL DECISION

<Date>

|  |  |
| --- | --- |
| Name | <Medicaid Number> |
| Address |  |
| City, State Zip |  |

Dear <First\_Name> <Middle\_Initial> <Last\_Name>:

On <date> we received a request for a <standard or expedited> appeal about our denial of <service/item/date of service/date of request>.

A doctor who did not make the original denial decision has reviewed your information. <Name/Title/Specialty of Provider> has decided to <uphold/reverse> the <denial/partial denial> of coverage because <reason/criteria>.

[include a specific discussion of the reason for any adverse benefit determination specific to the member and request, including citations to the policies, procedures and authority that supports the decision. If this is for a denial or reduction of a previously authorized service, include what has changed since the last authorization to support the denial or reduction]

<The effective date of this appeal decision is < > . This date is beyond the established deadline for the appeal decision because of an extension that was requested by < > *(use only if applicable)*.

This decision has exhausted your appeal rights with us. If you disagree with this decision, you can request a State Fair Hearing with the Department of Medical Assistance Services (“DMAS”), which will be conducted in accordance with the requirements of 42 CFR Part 438, Subpart F, as well as DMAS’ client appeal regulations at 12 VAC 30-110-10 *et seq*. You must request your State Fair Hearing within 120 calendar days of the date of this letter. Please see the information attached to this letter that explains your rights and the process to request a State Fair Hearing.

[<At the plan’s discretion, insert any additional NCQA language here in order to ensure compliance with NCQA guidelines. >]

If you would like a copy of the documents we used to make our decision, please call us at <insert phone> <TTY>. There is no charge for us to send them to you.

Sincerely,

[Health Plan]

Attachments

Non-discrimination notice

Multi-language insert

# Appeal to DMAS - State Fair Hearing Request Information

## Your Right to Appeal our Decision

You or your authorized representative have the right to appeal our decision to the Department of Medical Assistance Services (“DMAS”). This is called a State Fair Hearing. You can have an attorney represent you, or you can have someone like your doctor, provider, friend, or family member be your authorized representative. You must give written permission for anyone other than an attorney to help you with your State Fair Hearing request.

## Deadline to File the State Fair Hearing Request

An appeal request must be filed with DMAS within 120 calendar days from the date on this letter.

## How to File the State Fair Hearing Request

You or your representative acting on your behalf can file the appeal request any of the following ways:

1) **Electronically.** Online at https://www.dmas.virginia.gov/appeals or by email to appeals@dmas.virginia.gov

2) **By fax.** Fax your appeal request to DMAS at (804) 452-5454

3) **By mail or in person.** Send or bring your appeal request to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219

4) **By phone.** Call DMAS at (804) 371-8488 (TTY: 1-800-828-1120)

To help you prepare your appeal, an appeal request form is available from DMAS at <https://www.dmas.virginia.gov/appeals/>or by calling (804) 371-8488. You can also write your own letter. Include a full copy of our final denial letter when you file your appeal with DMAS. Also include any documents you would like DMAS to review during your appeal.

## Expedited or Standard State Fair Hearing

### Expedited Appeal

You or your doctor can ask that your request be reviewed under an expedited (fast) process if you believe your health condition requires it. Your doctor will need to explain how a delay will cause harm to your physical or behavioral health.

If you want your State Fair Hearing to be handled quickly, you must write “EXPEDITED REQUEST” on your appeal request. You must also ask your doctor to send a letter to DMAS that explains why you need an expedited appeal.

Hearings for expedited decisions are usually held within one or two days of DMAS receiving the letter from your doctor. DMAS will give you an answer within 72 hours of receiving your doctor’s letter.

### Standard Appeal

If your request is not an expedited appeal, or if DMAS decides that you do not qualify for an expedited appeal, DMAS will give you a decision within 90 days from the date you filed your MCO appeal, not including the number of days you took to file for a State Fair Hearing.

## Continuation of Benefits

You may be able to continue services that are scheduled to end or be reduced or suspended if you ask for an appeal: (1) within ten (10) calendar days of being told that your request is denied or your care is changing; or, (2) on or before the date the change in the service is scheduled to occur. If you meet these requirements and want the benefits to continue, state that you want your services to continue during the appeal on your appeal request.

It is important to know that if your appeal to DMAS results in your denial being upheld, you may have to pay for any of the continued benefits received while the appeal was being handled if the services were provided solely because you requested the benefits to continue.

## After You File Your State Fair Hearing Appeal

DMAS will notify you of the date, time, and location of the scheduled hearing if you qualify for one. A hearing is a meeting between you, someone from our organization, and a DMAS hearing officer. Before the hearing, we will send you a copy of the information that will be used at the hearing. This is called the appeal summary. You also have the right to ask us for a full copy of your file. Most hearings can be conducted by telephone, but you can ask to participate in a hearing in person.

To get ready for your hearing, you can:

* Review the appeal summary before the hearing.
* Bring someone with you to the hearing, like a friend, relative, lawyer, or come alone.
* Bring information or witnesses to the hearing to show why you think we made a mistake.

## Help from an Advocate

You can get help with your appeal through the Office of the State Long-Term Care Ombudsman, Department for Aging & Rehabilitative Services. If you would like to speak to an independent advocate with that office, please call

1-800-552-5019 or TTY toll-free 1-800-464-9950.

***Additional information on this process is available in your Member Handbook available on our website at* (health plan should insert URL to member handbook).**