Virginia Medicaid Informal Provider Appeals: At-A-Glance

DMAS or its contractor takes an adverse action and sends the provider a notice that includes appeal rights to DMAS.

Typically, providers have 30 days from the date on the adverse action to file an appeal; however, different time frames apply to provider enrollment (15 days to appeal) and cost reporting (90 days to appeal). The appeal is deemed filed when it is received by the DMAS Appeals Division, including using the online appeal portal. Any submission received by the DMAS Appeals Division after 5:00 pm is considered as received on the next business day.

If all required reconsiderations with a DMAS contractor have been exhausted and the appeal is timely filed, DMAS or its contractor complete a case summary that explains the basis for the action. The case summary deadline is 30 days after the appeal was received by DMAS. It is filed with the DMAS Informal Appeals Agent (IAA), with a copy sent to the Provider.

If requested by the provider or deemed necessary by the IAA, an Informal Fact Finding Conference (IFFC) is held within 90 days from the DMAS Appeals Division's receipt of the informal appeal request. If an IFFC is not requested, the provider may submit additional written information within a timeframe set by the IAA. Any written submission is forwarded to DMAS or its contractor for review and response. The period for submission and response is within 90 days from the filing of the notice of appeal.

If an IFFC is held, both parties may submit additional information to the IAA for up to 30 days.

The DMAS Appeals Division issues a written decision within 180 days from when the informal appeal request was filed. The provider has the right to appeal the decision to a formal administrative hearing.