Virginia Medicaid/FAMIS Client Appeals Frequently Asked Questions

FILING AN APPEAL

The Virginia Department of Medical Assistance Services (DMAS) has a portal to make it easier for you to file an appeal. The portal is called the Appeals Information Management System (AIMS). The AIMS portal is easy to use and includes step-by-step instructions to walk you through the entire appeals process. The AIMS portal allows you the convenience of filing your appeal, submitting documents and monitoring the status of your appeal online throughout the process.

While DMAS encourages you to use the AIMS portal, we will continue to accept appeals by email, fax, mail and phone. To register for the AIMS portal, go to: https://appeals-registration.dmas.virginia.gov/client. To log in to the AIMS portal, go to https://login.vamedicaid.dmas.virginia.gov/.

DMAS Appeals Division				
Email	**Fax**	**Phone**	**Mail**	**AIMS Portal**
appeals@dmas.virginia.gov	(804) 452-5454	804-371-8488	DMAS Appeals Division 600 E. Broad Street Richmond, VA 23219	https://www.dmas.virginia.gov/appeals

BEFORE YOU FILE AN APPEAL

Virginia's two medical assistance programs are Medicaid and the Family Access to Medical Insurance Security plan, which is known as FAMIS.

The Virginia Department of Medical Assistance Services (DMAS) administers the Medicaid and FAMIS programs. Eligibility determinations for these programs are the responsibility of local departments of social services under the supervision of the Virginia Department of Social Services (VDSS). Cover Virginia also processes certain applications for medical assistance, including referrals from the Federal Health Insurance Marketplace.

The DMAS Appeals Division is separate and apart from operational divisions within and outside of DMAS. The DMAS Appeals Division provides a neutral forum for appeals, by providing an impartial Hearing Officer to conduct fair hearings for issues regarding eligibility for medical assistance and medical services. The DMAS Appeals Division also hears appeals related to actions for services provided by a nursing facility, in accordance with § 1919(b)(3)(F) or 1919(e)(7)(B) of the Social Security Act.

What are appeal rights?

You have the right to request an appeal in response to notices of action regarding your eligibility for Medicaid and FAMIS coverage. This includes:

- Denial of your application for Medicaid or FAMIS coverage
- Denial, suspension, reduction or termination, in whole or in part, for a medical service
- The effective date of your Medicaid coverage

- Actions to terminate, suspend, or reduce benefits
- Delayed processing of your application for medical assistance
- A decision that benefits have been paid in error and must be repaid
- The amount of your Medicaid spenddown, or amount of your patient pay obligation to be paid to a health care facility
- The agency takes action or proposes to take action to recover applicable Medicaid payments from the estate of a person who has died
- A determination made by a nursing facility to transfer or discharge a resident
- Any other action that affects your receipt of medical assistance

What is an appeal?

An appeal is a written or verbal request for a fair hearing before an impartial representative of the DMAS Appeals Division to determine whether the action taken or proposed by the agency is correct.

The DMAS Appeals Division only hears appeals for medical assistance programs and related services (Medicaid and FAMIS), and nursing facility discharges. The DMAS Appeals Division does not hear appeals that relate to other benefit programs, such as Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Auxiliary Grants, Child Care Applications and Energy Assistance (EA); these are administered by the VDSS. The DMAS Appeals Division does not hear appeals related to Social Security Administration disability determinations or Medicare determinations; those are administered by their respective federal agencies. For information about those programs or to learn how to file an appeal, please contact the appropriate agency.

What is a fair hearing?

A fair hearing is an informal procedure conducted by a DMAS Appeals Division Hearing Officer. All hearings are *de novo* hearings, which means the Hearing Officer considers your appeal "from the new," or from the beginning. All documentation submitted by either you or the Agency for this appeal, along with the testimony taken at the hearing, will be used by the Hearing Officer to determine if you qualify for the requested coverage. At the hearing, the Hearing Officer asks questions, and listens to the agency representative's explanation of the action taken on your case. They also listen to your explanation why you do not agree with the agency's action. The Hearing Officer reviews documents provided by the agency, as well as documents that you provided in support of your appeal. Afterwards, the Hearing Officer evaluates the evidence presented at the hearing, and decides whether you qualify for the requested coverage based on the applicable law, regulation and policy.

Will I receive notice of my right to a hearing?

Within 10 calendar days, the agency is required to mail a written notice before they take a new action regarding your benefits or services. Examples of when the agency must send a notice include:

- Approvals of benefits and/or medical services
- Denials, terminations, suspensions, or reductions of benefits and/or medical services
- Delays in processing your application
- A decision has been made that benefits were paid in error and must be repaid
- When a request for re-evaluation of an application in spenddown status has been completed

The agency must process your Medicaid application within 45 days of receipt, or within 90 days of receipt for cases of Medicaid disability determinations. If the agency denies your application for medical assistance, or denies your request for medical services, they must mail you a written notice.

What will the notice say?

The written notice must have the following information:

- The action taken or proposed by the agency;
- The reasons for the intended action;
- The law, regulation or policy that supports the intended action;
- An explanation of your right to a hearing, as well as the methods and time limits for requesting a hearing;
- The circumstances under which your benefits may be continued by timely requesting a hearing; and
- The right to have representation at the hearing.

Is there a time limit for filing an appeal?

Yes, the time limit for filing an appeal is noted on the written notice of action from the agency. **In most cases**, the time limit is **30 days** from the date you receive the written notice of action from the agency. It is presumed that you will receive the notice five days after the agency mails the notice, unless you can show that you did not receive the notice within the five-day period. The date of filing an appeal will be determined by the postmark date, or the date it was faxed or hand-delivered to DMAS. If you are appealing an unreasonable delay in processing your application, you may file your appeal at any time until the agency has acted on your application.

How do I claim good cause for filing an untimely appeal?

The DMAS Appeals Division may grant an extension of the time limit for filing an appeal if the reason for failing to meet the time limit is due to a good cause. There is a Good Cause Questionnaire section in the Virginia Medicaid and FAMIS Appeal Request Form that allows you to provide information about why you filed an untimely appeal. Please complete this entire section. You may also submit this electronically via the AIMS portal. A DMAS Hearing Officer will evaluate your response and make a determination whether your untimely filing was due to good cause. You may also receive a letter from the DMAS Appeals Division requesting an explanation of your good cause reason for untimely filing. If you file your appeal within the allowed timeframe, you do not need to complete the Good Cause Questionnaire section.

What is an MCO Appeal?

If you are in the Medicaid program and receive services from one of the Managed Care Organizations (MCO) that are part of the Medicaid program, different rules apply to the timeframe of appeals and there are certain other procedures that must be followed. Examples of MCOs in the Medicaid program include:

- Aetna Better Health of Virginia
- Anthem Healthkeepers, Inc.
- Magellan Complete Care of Virginia, LLC
- Optima Health Plans
- UnitedHealthcare of the Mid-Atlantic, Inc.
- Virginia Premier Health Plan

The key difference with MCO decision appeals is that you may only appeal a **final** adverse determination from an MCO. This means you have to exhaust your appeal rights with the MCO that took the action before you file an appeal with DMAS. You must file an appeal with DMAS within 120 days of receiving a final decision from the MCO (as opposed to 30 days) and the 120 days cannot be extended.

Who can file an appeal?

Either you or your authorized representative may file an appeal on your behalf. The authorized representative may be an attorney, friend, relative, a patient advocate, or any other adult you choose. Use the following guidelines when submitting your appeal and authorized representative documents:

Spouse, Family Member, or Other Designee

In cases where a spouse, family member, or other designated person is representing an adult appellant, the representative must have authorization in writing which must be signed by the appellant. A Power of Attorney authorizing the representative to act on the appellant's behalf during the appeal will be accepted.

Parent or Legal Guardian

A parent may file an appeal on behalf of their minor child. If the parent wishes to appoint a representative, the representative must have authorization in writing and be signed by the parent. If you are appealing as a child's legal guardian, proof of guardianship is needed.

Physically Unable to Sign

If an appellant is physically unable to sign a written authorization, the person acting on their behalf must provide written authorization and describe the physical reason why the appellant cannot sign the form.

Mentally Unable to Sign

If an appellant is mentally unable to sign a written authorization, proof of guardianship is needed.

Deceased Appellant

If an appellant is deceased, you must submit evidence from a court that you qualified as the Executor or the Administrator of the appellant's estate. A Power of Attorney or Last Will and Testament is not acceptable proof of representation.

The Virginia Medicaid and FAMIS Appeal Request Form includes an Authorized Representative Form. Complete this form if you wish to have an authorized representative file an appeal on your behalf. You and your representative may also receive a letter from the DMAS Appeals Division, with instructions and an Authorized Representative Form, if the form is not submitted at the same time as your appeal request. A Power of Attorney authorizing your representative to act on your behalf during the appeal will be accepted. If the appellant is deceased, then proof of guardianship needs to be submitted. If you wish to have an attorney or a paralegal working under the supervision of an attorney represent you, a signed statement by the attorney or paralegal that he or she is authorized to represent you prepared on the attorney's letterhead, will be accepted as representation. You may also submit a request for another individual or organization to represent you electronically ivia the AIMS portal.

How do I file an appeal?

The AIMS portal allows you the convenience of filing your appeal, submitting documents, and monitoring the status of your appeal online throughout the process. While DMAS encourages you to use the AIMS portal, we also accept appeals by email, fax, mail, and phone. Your request should explain the reason for your appeal, the action by the agency you are appealing, and a copy of the notice of action you are appealing.

You may submit a written appeal by letter or by using the Virginia Medicaid and FAMIS Appeal Request Form, available at https://www.dmas.virginia.gov/appeals and your local department of social services. Send the Virginia Medicaid and FAMIS Appeal Request Form or appeal request letter and related documents, including the notice of action you are appealing to DMAS using the information below:

DMAS Appeals Division				
Email	**Fax**	**Phone**	**Mail**	**AIMS Portal**
appeals@dmas.virginia.gov	(804) 452-5454	804-371-8488	DMAS Appeals Division 600 E. Broad Street Richmond, VA 23219	https://www.dmas.virginia.gov/appeals

Can the DMAS Appeals Division deny my request for a hearing?

Yes, your request for a hearing can be denied for any of the following reasons:

- You filed an untimely appeal, unless you had good cause
- The appeal request was not made by you or by your authorized representative
- Your representative did not provide proper authorization
- The issue is not appealable
- The issue was resolved by the agency
- The issue was previously decided through the hearing process

If your appeal request is denied, you will receive a written notice. You have the right to appeal DMAS' decision to the Circuit Court.

What happens to my benefits if I appeal?

You may request to have your coverage continued during the appeal process if you file your appeal request before the date coverage is terminated or within 10 days of the date stated on the notice of action you are appealing. This is known as continued coverage. Not all cases qualify for continued coverage. Should any of the following situations occur, your continued coverage will end:

- Your appeal is invalidated
- You withdraw your appeal
- You abandon your appeal
- The Hearing Officer agrees with the agency decision
- The Hearing Officer determines that no facts are disputed and the sole issue of the appeal is a disagreement with existing state or federal law or policy

If the Hearing Officer agrees with the decision of the local agency, or any of the above situations occur, you may have to pay back the costs of medical care received during the period of continued coverage. Requesting continued coverage is optional. If not requested, your benefits will not be continued during the appeal process.

What is a pre-hearing conference for Medicaid and FAMIS eligibility cases?

A pre-hearing conference is an opportunity for you to discuss your Medicaid and FAMIS eligibility case with a representative from your local department of social services. This could potentially resolve the agency's action. If your action is resolved, you may not need to move forward with a DMAS appeal. Your local department of social services must schedule a pre-hearing conference within 10 working days of your request.

The pre-hearing conference is less formal than the DMAS appeal hearing. At the conference, your eligibility worker will explain the agency's action and you will have an opportunity to present any information to support your disagreement with the action. You are allowed to have a representative at the conference. If the agency decides not to take the action, you will be notified in writing or if the agency decides to proceed with the action, you will be informed of the agency's decision.

The pre-hearing conference is separate from the fair hearing appeal process with the DMAS Appeals Division. To protect your appeal rights, file an appeal within the timeframe stated on your notice of action if you want to request an appeal hearing.

Can I file a new application if my benefits have been stopped or denied, even if I appeal?

Yes, you can file a new application. If your circumstances change during your appeal, such as a change in income or household size, be sure to notify your local agency to reapply.

AFTER YOU FILE AN APPEAL

What happens after I file my appeal?

When the DMAS Appeals Division receives your appeal request, you will receive a letter acknowledging receipt of your appeal. Your appeal request will then be reviewed to see if a hearing can be granted, or if more information is needed.

If you submit your appeal after the deadline, which **in most** cases is **30 days**, and do not give a good reason for your late appeal, you will receive a letter with instructions on how to provide a reason for the delay, called "good cause." Whether there is "good cause" for a late appeal will be decided by a Hearing Officer, based upon regulations. If an appeal is filed on your behalf without proper authorized representation, a letter will be sent with instructions on how to provide authorization.

If you submit documents to the DMAS Appeals Division without a clear explanation of your intent to appeal or what action you are appealing, you will receive a letter with instructions on how to properly file your appeal request and what information you need to include.

The DMAS Appeals Division will close your appeal if it is determined that no adverse action was taken on your case or the agency re-evaluates your case and resolves the action you are appealing. You will receive a written notice if your appeal is closed without a hearing.

Once the DMAS Appeals Division determines that your appeal request is eligible for a hearing, your hearing will be scheduled with the agency that took the action. You will be notified in writing of the date, time, and location of your hearing.

What if I no longer want to appeal?

If you no longer want to continue with your appeal, you may withdraw your appeal request. The easiest way to withdraw your appeal is via the AIMS portal. You may also submit your withdrawal request in writing to the DMAS Appeals Division via email, fax, or mail, or call the DMAS Appeals Division and explain that you want to withdraw your appeal. The contact information for the DMAS Appeals division is below. After you submit your withdrawal and it is reviewed by the DMAS Appeals Division, your case will be closed and you will receive a letter confirming your withdrawal.

DMAS Appeals Division				
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What happens at a hearing?

The hearing is an informal proceeding. The DMAS Hearing Officer will begin the hearing, state the action that is being appealed, and allow each side to present its case. The DMAS Hearing Officer will swear-in all hearing participants who are presenting testimony and record the hearing proceedings. All hearings are *de novo* hearings, which means the Hearing Officer considers your appeal "from the new," or from the beginning. All documentation submitted by either you or the Agency for this appeal, along with the testimony taken at the hearing, will be used by the hearing officer to determine if you qualify for the requested coverage.

During the hearing, the DMAS Hearing Officer will allow the agency representative to explain the agency's action, and will ask the agency representative and witnesses relevant questions. You will be allowed to ask questions of the agency representative and witnesses. You can also let it be known if you disagree with any of the testimony and evidence presented.

The DMAS Hearing Officer will then allow you and/or your authorized representative to express your disagreement with the agency's action and present evidence. You will be allowed to bring witnesses to testify on your behalf and present documents to support your case. The DMAS Hearing Officer may also ask you and your witnesses questions.

You will have the opportunity to examine all of the documents being used by the agency before and during the hearing.

The Hearing Officer will allow you and the agency representative to make closing remarks. At the end, the Hearing Officer closes the hearing, and explains when you can expect the hearing decision. The Hearing Officer evaluates the evidence presented at the hearing, and decides whether your case was properly evaluated based on the applicable law, regulation and policy.

Who may represent me at a hearing?

You may represent yourself, or have an authorized representative at the hearing. The authorized representative may be an attorney, friend, relative, a patient advocate, or any other adult you choose. If you do not plan to attend the hearing yourself and your authorized representative will attend on your behalf, provide the DMAS Appeals Division with your written authorization of representation prior to the hearing. You may authorize an authorized representative via the AIMS portal or the "Virginia Medicaid and FAMIS Client Appeal Authorized Representative Form" available at https://www.dmas.virginia.gov/appeals. Use the guidelines outlined in the "Who can file an appeal?" section in this document when submitting your authorized representative documents.

Who will be at my hearing?

Attendance at the hearing will include the following:

- The DMAS Hearing Officer, usually participating by telephone;
- The agency representative;
- You and/or your authorized representative.

There may also be witnesses participating on behalf of the agency, as well as any witnesses you bring to the hearing. You are allowed to have an attorney present, but you are not required to obtain legal representation. The agency may have the local city or county attorney attend the hearing.

How do I prepare for the hearing?

Review the schedule letter from the DMAS Appeals Division carefully for the location, date, and time of your hearing. If your hearing is scheduled to be conducted by telephone, make sure that the DMAS Appeals Division has the correct telephone number to reach you, and that you will be available to participate by telephone at the date and time specified on the schedule letter.

Prior to your hearing, think about the points you would like to make during the hearing and any questions that you may have for the agency.

Review all of the documents you have received from the agency, and have them available to reference on your scheduled hearing date. You can also request to review your case file with the agency prior to your hearing.

If there are any documents you want the DMAS Hearing Officer to review for the hearing, submit them via the AIMS portal or email, mail or fax them to the DMAS Appeals Division and the agency that took the action several days before the hearing.

What is an appeal summary?

An appeal summary is a document from the agency that explains the reasons for the agency's action, including relevant facts and applicable policy. The appeal summary should also include any supporting documentation for the agency's action.

The agency will send you and the DMAS Appeals Division a copy of the appeal summary before the hearing. The agency should send the appeal summary by the deadline written on the schedule letter.

If you do not receive the appeal summary before the hearing, let the agency know and call the DMAS Appeals Division so that we may work to have your hearing take place on time.

Will I be able to submit documents before or during the hearing?

Yes, you may submit documents that you would like the DMAS Hearing Officer to consider before the hearing via the AIMS portal or by email, fax, or mail at the following addresses:

DMAS Appeals Division				
Email	**Fax**	**Phone**	**Mail**	**AIMS Portal**
appeals@dmas.virginia.gov	(804) 452-5454	804-371-8488	DMAS Appeals Division 600 E. Broad Street Richmond, VA 23219	https://www.dmas.virginia.gov/appeals

Also, send copies of the documents to the agency that took the action you are appealing. The Hearing Officer may also consider documents that you bring to the hearing when making a decision about your appeal.

During the hearing, the Hearing Officer may decide to "leave the record open" for a limited amount of time to permit you to submit additional documentation that was not available for the hearing. If this happens, the Hearing Officer will provide instructions during the hearing.

If the Hearing Officer does not "leave the record open," any documentation that you submit after the hearing will not be considered by the Hearing Officer when making a decision about your appeal.

Where will my hearing be held?

Most eligibility appeal hearings will take place at the local department of social services. Appeal hearings regarding medical issues are usually conducted by telephone. Reference your schedule letter for the hearing location.

Can I request a telephone hearing?

Yes, if you are unable to attend the hearing at the scheduled location, you may contact the DMAS Appeals Division to request to participate by telephone. The Hearing Officer will call you on the scheduled hearing date and time at the telephone number you provide to the DMAS Appeals Division.

What if I need an interpreter?

If you need an interpreter at the hearing, you can ask for one in your appeal request, or by contacting the DMAS Appeals Division prior to your hearing. The DMAS Appeals Division will provide an interpreter for your hearing.

Will my hearing be recorded?

Yes, your hearing will be recorded by the DMAS Hearing Officer to ensure an accurate and complete hearing record.

How do I postpone my hearing if needed?

If you will not be able to attend your hearing on the scheduled date and time, notify the DMAS Appeals Division before the day of the hearing. The hearing will then be rescheduled, and you will be notified of the new date and time. Your decision date will be extended based on your request to postpone your hearing. You will only be able to reschedule your hearing twice, unless you have a compelling reason for an additional reschedule request.

What if I miss my hearing?

The DMAS Hearing Officer will send you a letter with instructions, asking you for good cause why you missed your hearing. You will have 10 days to respond to the letter with your reason for missing the hearing.

If you do not respond to the good cause request letter by the deadline, or if the Hearing Officer determines that your reason for missing the hearing was not for good cause, your appeal will be closed and you will receive a written notice. You have the right to appeal this decision to the Circuit Court.

What happens after the hearing? When will I receive my decision?

Following your hearing, the DMAS Hearing Officer will review the testimony and the evidence presented at the hearing, and issue a written decision.

The Hearing Officer will make a decision within 90 days from the date you filed your appeal. If you requested that your hearing be postponed, or asked that the hearing record be held open to submit additional information, the Hearing Officer will have more time to issue the decision.

Delays requested or caused by you or your representative may extend the 90-day timeframe by the number of days as explained below.

If you ask to postpone the hearing:

- Within 30 days of your appeal request, the 90-day time limit will be extended by the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled;
- Within 31 to 60 days of your appeal request, the 90-day time limit will be extended by 1.5 times the number of days from the date when the most recent hearing was scheduled until the date to which the hearing is rescheduled;
- Within 61 to 90 days of your appeal request, the 90-day time limit will be extended by 2 times the number of days from the date when the most recent hearing was scheduled until the date to which the hearing is rescheduled; and
- If you ask to keep the record open after the hearing, the 90-day time limit will be extended by the number of days the record is left open.

For an MCO appeal, the 90-day decision period includes the combined MCO and DMAS appeal processing time. For more information on MCO appeals, refer to the “What is an MCO Appeal” section in this document.

What will the decision say?

The DMAS Hearing Officer’s written decision will include the following information:

- The issue or issues of your appeal;
- Findings of fact, which is an overview of the facts of your case;
- A description of the testimony and evidence presented at your hearing;
- Conclusions of law and policy, which is the analysis of your case; and
- The DMAS Hearing Officer’s decision.

The decision options a DMAS Hearing Officer can make about your appeal include:

- Sustaining the agency's action; finding the agency's action was correct
- Reversing the agency's action; finding the agency acted incorrectly
- Remanding the agency's action; sending your case back to the agency for further evaluation
- Sustain in Part and Remand in Part the agency's action; finding that the agency's action was correct but there is some additional evaluation that the agency must complete.
- Agency Error; determining that the action or failure to take action of the agency was in error and there is no further remedy.

The DMAS Hearing Officer's decision is the final decision in the administrative appeals process.

What if I disagree with the outcome of the decision?

If you disagree with the outcome of the decision, you may appeal to Circuit Court by using a two-step process as provided by Rules 2A:2 and 2A:4 of the Rules of the Supreme Court of Virginia. Information about how to appeal will be included in your decision.

Within 30 days from the date you receive the decision, you must file a Notice of Appeal with the Director of DMAS. The next step is to file a Petition for Appeal in Circuit Court within 30 days after the Notice of Appeal is filed.

Who do I contact for assistance?

- For questions about your case, contact the agency that took the action related to your benefits or services.
- For questions specific to the appeal process, contact the DMAS Appeals Division by calling 804-371-8488.
- For legal assistance, you may want to contact an attorney. Legal Aid can provide free civil legal assistance to low income individuals. For the Statewide Legal Aid Helpline, call 1-866-LEGL-AID, 1-866-534-5243, or visit http://www.valegalaid.org/. There are local Legal Aid organizations located throughout Virginia.

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