

CHAPTER M16

APPEALS PROCESS

M16 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Table of Contents Pages 1-10 Pages 11 and 12 were added.
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 July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with TOC	Page i

TABLE OF CONTENTS

M16 APPEALS PROCESS

	Section	Page
Purpose and Scope	M1610.100	1
Local Agency Conference.....	M1620.100	2
Appeal Request Procedures	M1630.100	3
Continued Coverage Pending Appeal Decision.....	M1640.100	4
Pre-hearing Actions	M1650.100	5
Scheduling the Hearing	M1660.100	7
Agency Appeal Summary.....	M1670.100	8
The Hearing Procedure	M1680.100	9
Recovery of Benefits Paid During Appeal	M1690.100	12

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1610.100	Page 1

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.

This chapter applies to client appeals resulting from eligibility determinations made by the Virginia Department of Social Services, as well as its local offices. It also applies to eligibility determinations made by the Department of Medical Assistance Services and its agents, including Cover Virginia.

Many Medicaid members are enrolled with a Managed Care Organization (MCO). The MCO appeals process differs from the Eligibility appeals process and the procedures contained within this chapter do not apply to MCO 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 *Agency or Contractor* taking the action being appealed and the appellant (the individual appealing some aspect of entitlement to medical assistance or its scope of services) or their 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 *processed* 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.

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1620.100	Page 2

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.

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 *administrative* reasons 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 the right to a hearing. Appellants shall also be notified of the method by which they may obtain a hearing, and of their right to represent themselves 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. Definition and Scope

The Local Agency Conference is an informal process outside of the standard appeal process and does not involve the DMAS Appeals Division. At the conference, the Agency must:

- *give the applicant/enrollee an explanation of the action;*
- *allow the applicant/enrollee to present any information to support their disagreement with the action; and*
- *allow the applicant/enrollee to represent themselves or be represented by an authorized representative such as a legal counsel, a friend, or a relative.*

B. 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 business days of receiving the request.

C. The Conference and Right to Appeal

The Local Agency Conference must not be used as a barrier to the individual's right to a fair hearing. Participation in a conference does not extend the 30-day time limit for requesting an appeal.

D. Failure to Request a Conference

The applicant's or enrollee's failure to request a conference does not affect the right to appeal within 30 days of the Notice of Action on Benefits and does not affect the right to continued eligibility if the appeal is requested to the DMAS Appeals Division prior to the effective date of the action.

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1630.100	Page 3

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 may reverse its decision at any time between making the original decision and when a decision is rendered by the Hearing Officer.*

If the Agency decides not to take the adverse action indicated on the notice, the Agency must inform the appellant in writing. The Agency must send a new notice regarding the changed action. The Agency must send a copy of the new notice 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.

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, their legal representative (such as a guardian, conservator, or person having power of attorney), or authorized representative acting at *their* request, of a desire to present their 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 <https://www.dmas.virginia.gov/appeals/>. Applicants may also write their own letters to request an appeal. The DMAS Appeals Division also accepts telephonic appeal requests.

C. How to File an Appeal Request

- 1. Electronically. Via the Appeals Information Management System (AIMS) portal at <https://www.dmas.virginia.gov/appeals/> or 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 a request for a fair hearing. *The Agency may not discourage an applicant/enrollee from requesting an appeal and may not pressure an appellant to withdraw an appeal that they have already filed.*

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 five days of the date the notice was mailed, unless the applicant/enrollee demonstrates that the notice was not received in the five-day period through no fault of his/her own.

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1640.100	Page 4

An appeal request shall be deemed to be filed timely if it is mailed, faxed, electronically transmitted, or otherwise delivered to the DMAS Appeals Division before the end of last day of filing (30 days plus five mailing 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.

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 Appeals Division 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 their 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 Appeals Division 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 Appeals Division 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 Appeals Division 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 *Notice of Action on Benefits*, or when the appeal is requested after the effective date but within 10 days of the *Notice of Action on Benefits*.

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.

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1650.100	Page 5

- C. When Continued Coverage Does Not Apply** Coverage **will not** continue *through the date of the appeal decision* when:
- *an appeal hearing is requested after the effective date of action, or more than 10 days after the Notice of Action on Benefits if the appellant is given less than 10 days of advanced notice; or*
- the sole issue under appeal is one of Federal or State law or policy, and the Agency promptly informs the appellant that services will be terminated or reduced pending the appeal hearing decision.*
- D. Recovery of Continued Coverage Costs** When the Hearing Officer determines that the appellant is not eligible for coverage, the cost of medical care received during the period of continued coverage may be recovered by DMAS, to the extent they were furnished solely by reason of this section. (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. *The Hearing Officer shall issue a final decision.*
- 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 *and the Hearing Officer will issue the appropriate final decision.*
- 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 *and the Hearing Officer will issue the appropriate final decision.*
- B. Administrative Dismissal** A request for an appeal may be administratively dismissed without a hearing if the appellant has no right to a hearing. *The Hearing Officer shall issue a final decision.*
- 1. No Adverse Action Taken** If DMAS learns that no adverse action was taken prior to the date of the appeal request, *the Hearing Officer will issue a final decision dismissing the appeal.*

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1650.100	Page 6

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 Hearing Officer will issue a final decision dismissing the appeal.*

C. Withdrawal If the appellant requests that the appeal be withdrawn, *the Hearing Officer will send the appellant a letter acknowledging the withdrawal and no further action will be taken on the appeal. A copy of the letter will be sent to the Agency.*

- *The appellant must provide the Appeals Division with a statement clearly indicating that they wish to withdraw their appeal. The statement or form must be mailed, e-mailed, or faxed to the DMAS Appeals Division.*
- *In lieu of a written statement, the appellant may make a recorded verbal statement clearly indicating that they wish to withdraw their appeal by calling the Appeals Division at (804) 371-8488. Verbal notification to the LDSS by the appellant to withdraw an appeal is **not** sufficient.*

D. Failure to Appear If the appellant or their 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,” *and the Hearing Officer will issue a final decision.*

E. Administrative Resolution 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, *and the Hearing Officer will issue a final decision.*

NOTE: *The Agency should not assume that any new Notice of Action on Benefits automatically ends the appeal. The Agency must send any new Notices to the Appeals Division, and the Appeals Division will decide whether the appeal is administratively resolved. The Agency will receive a copy of final letters for administrative closures.*

F. 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 Agency with a clear explanation of the reason(s) for issuing a judgment on the record and which actions must be taken by the Agency to correct the case. The decision to issue a judgment on the record is at the Hearing Officer’s discretion*

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1660.100	Page 7

G. 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, they 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.

H. Defective Notices

If the appealed Notice of Action on Benefits is defective on its face, the Hearing Officer may remand the appeal to the Agency for the issuance of a legally compliant Notice.

For Notices reducing or terminating existing coverage or services, the Hearing Officer will issue a decision that finds in favor of the appellant by ordering the Agency/contractor to reinstate the existing level of coverage or services at issue for a period of at least 30 calendar days; and

Requires the Agency/contractor to issue a new compliant notice prior to the end of the 30 calendar day period by reviewing the same application or service authorization request. If the Agency/contractor requires additional information to process the application or service authorization request, they must ensure that the information is requested and obtained in order to timely issue the new compliant notice.

For Notices concerning new applications for eligibility or requests for new services, the Hearing Officer may issue a decision remanding the Notice to the entity that issued it and order that, within a reasonable period determined by the Hearing Officer, a new compliant Notice be issued to the member on the same eligibility application or service authorization request. If the Agency/contractor requires additional information to process the application or service authorization request, they must ensure that the information is requested and obtained in order to timely issue the new compliant notice. Alternatively, the appellant will be given the option to waive the deficient notice and continue with the State Fair Hearing process.

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 at least three weeks in advance.

Hearings will be held at the local Agency if a local department of social services office is responsible for the action. The applicant/enrollee will be at the Agency. The Hearing Officer will participate in any hearing by telephone unless the appellant requests a face-to-face hearing. Appellants may also request to participate in their hearing telephonically, rather than appearing at the local Agency.

Hearings regarding actions taken by Contractors will be conducted telephonically.

B. Confirmation Letter

The schedule letter is mailed to the appellant and representative, and a copy is mailed to the Agency.

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1670.100	Page 8

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

If the Agency representative cannot be available on the date and time selected by the Hearing Officer, he/she must notify the DMAS Appeals Division as soon as possible and request an alternate date and time for the hearing.

M1670.100 AGENCY APPEAL SUMMARY

A. Agency Appeal Summary Form

Upon notification that a fair hearing has been requested, the Agency must complete an Agency Appeal Summary. There is a form for the Agency Appeal Summary (form #032-03-805) available on *Fusion*.

When preparing the Agency Appeal Summary, the Agency must consider all documents submitted up until that point, even if the information/documents were submitted for the first time during the appeal process, as discussed below at M1680.100 (A)(5). The Agency Appeal Summary must thoroughly explain the facts, policy, and other relevant information that support the Agency's position on the appeal. The Agency must submit all documents relevant to the Agency's determination with the Agency Appeal Summary.

If new documentation submitted by the appellant during the appeals process 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.

B. Send to Appeals Division and Appellant

The Agency must send one copy of the Agency Appeal Summary and all relevant documentation to the following parties by the due date specified by the Appeals Division at the time of the notification:

- *Department of Medical Assistance Services, Appeals Division*
 - *Electronically via the AIMS portal at www.dmas.virginia.gov/appeals. Use of the AIMS portal is the preferred method for filing the appeal summary with DMAS.*
 - *Via USPS: 600 East Broad Street, Appeals Division
Richmond, Virginia 23219*
 - *Via email: appeals@dmas.virginia.gov*
 - *Via fax: 804-452-5454*
- *The appellant or their authorized representative, if the appellant has designated a representative for the appeal.*

The Agency must keep a copy of the Agency Appeal Summary and all relevant documentation, including applications, notices, and DMAS appeal decisions for its records.

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1680.100	Page 9

- C. Deadline for Submission** *In most cases, the Agency Appeal Summary must be submitted to the DMAS Appeals Division and the appellant or their authorized representative within 21 days after the Agency or Contractor is notified of the appeal. The only exception is when the Appeals Division certifies an expedited appeal*

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 *their* own case or have it presented by an authorized representative. *They* will be allowed to bring witnesses, establish all pertinent facts and circumstances, advance any testimony or evidence, and question witnesses called on *their* own behalf and by the Agency.
 - 3. Agency Representatives** *The worker at the Agency* who took the action being appealed and/or the worker's supervisor should be present at the hearing, and must be prepared to explain the Agency's action. The 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.
 - 4. Opportunity to Examine Documents** The appellant or *their* 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 *their* request.
 - 5. De Novo Hearing** *The DMAS state fair hearing is a de novo hearing in front of a DMAS Hearing Officer. That means that the DMAS Hearing Officer will issue an entirely new determination based upon all relevant evidence that the appellant offers during the appeal process. This includes 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 that was submitted for the initial eligibility determination, as well as any additional documentation and testimony 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, during the hearing itself, or after the hearing if the Hearing Officer agrees to hold the record open for submission of additional documentation.*

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1680.100	Page 10

Further, a de novo hearing is a hearing that starts over from the beginning. This means the Hearing Officer must allow the appellant to develop the record fully. The record will consist of any relevant evidence, documentation, and testimony, regardless of whether it was available at the time of the adverse determination. The Hearing Officer’s decision will be based solely on the record developed during the de novo hearing process, and it will include an explanation of how the facts apply to the relevant laws, regulations, and policies.

Agencies and Contractors will receive a copy of any new documentation that has been submitted to the DMAS Appeals Division during the appeal process to determine whether it is possible to approve MA coverage. If the Agency or Contractor receives new documentation from the appellant independently during the appeal process, copies of such documentation must be sent to the DMAS Appeals Division. The Agency or Contractor can use new documentation to determine that the appellant is eligible for coverage. If the Agency or Contractor determines that the appellant is eligible, 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 submitted by the appellant 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 must 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 all of the documentation, evidence, and testimony provided by the appellant and the Agency or Contractor.

B. Hearing Officer Evaluation and Decision

1. Evaluation

Following the hearing, the Hearing Officer will prepare a decision taking into account the Agency Appeal Summary, evidence provided by the appellant or their representative, testimony, and additional information provided by the parties. The Hearing Officer *will evaluate* all evidence, research laws, regulations and policy, and *will decide* if the applicant or recipient is *approved for coverage*.

2. Hearing Officer Decision

Examples of the Hearing Officer’s decisions include:

a. Sustain

When the Hearing Officer’s decision *is consistent with the Agency’s action*, the decision is “sustained.”

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1680.100	Page 11

b. Reverse

When the Hearing Officer’s decision *overturns the Agency’s action, including when the Hearing Officer finds the appellant eligible for Medical Assistance under the de novo hearing process*, 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 *Agency* denies an application or terminates coverage because of failure to provide requested information, the *Hearing Officer* can hold the hearing record open for a period of time to allow the appellant to submit additional information *to receive a de novo eligibility determination. The Hearing Officer may decide to reconvene the hearing if appropriate.*

C. Local Agency Action

The decision of the Hearing Officer is the final administrative action taken on the appeal. The local *Agency or Contractor* 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 Agency. The Hearing Officer's decision letter to the appellant is the appropriate official notice of cancellation.

The 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 Agency must notify the appellant in writing of *their* 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 their continued eligibility.

Manual Title Virginia Medical Assistance Eligibility	Chapter M16	Page Revision Date July 2021
Subchapter Subject M16 APPEALS PROCESS	Page ending with M1690.100	Page 12

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

c. Take Action in 30 or 45 Days

The Agency must complete the remand evaluation within 30 days or 45 days *according to the Hearing Officer's instructions in the decision.*

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) *according to the Hearing Officer's instructions in the decision.*

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.