

# An Overview of the Medicaid Provider Appeals Process in Virginia

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The Virginia Medicaid agency—the Virginia Department of Medical Assistance Services (DMAS)—has been extremely active of late in auditing providers for overpayments and seeking recovery of such overpayments. This activity is likely to increase as the number of Medicaid enrollees increases under federal healthcare reform and as additional federal dollars are provided for such audit activity. In light of these actions, it is important for healthcare providers in Virginia to understand how the DMAS appeals process operates in the event the agency seeks to recover an alleged overpayment from a provider.

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## Step 1: The Demand Letter

Initially, DMAS sends the provider a letter requesting that the provider repay DMAS the amount of the alleged overpayment. This is referred to as “the Demand Letter.” Under Virginia law, DMAS is only permitted to seek recovery for a period of four years from the date a decision is reached in an informal fact finding conference, otherwise known as an informal hearing. To do this, DMAS will estimate the time when the informal hearing will take place and a decision will be rendered, and will calculate back four years from such date.

## Step 2: The Informal Appeal

Once a demand letter is received, the provider has 30 days to request an informal appeal. If the provider is filing a cost report, it has 90 days to request an informal appeal. There are no detailed requirements that should be included in the notice of appeal for the informal hearing. Depending on the facts of the case, less information included in the notice may be the better.

Within 30 days of the filing of the notice of the informal appeal, DMAS must file a written case summary meeting the requirements of the regulations. The informal hearing will be held within 90 days of filing the notice of informal appeal. The informal hearing may be conducted by way of written submissions, although the provider is entitled to a face-to-face hearing at the DMAS headquarters in Richmond. An informal “appeals agent,” who is a DMAS employee, decides the appeal. The informal hearing is not transcribed and is not adversarial in nature. Nonetheless, it is important for the provider to be represented by counsel at the informal hearing because issues and information developed at the hearing may serve as the basis for the provider’s formal appeal.

The provider may file additional information following the informal hearing

within the time frame specified by the informal appeals agent. The informal appeal decision must be issued within 180 days of the notice of informal appeal.

## Step 3: The Formal Appeal

If the provider is dissatisfied with the informal appeal decision, the provider may request a formal hearing, which is held at DMAS’ headquarters in Richmond. This request must be made within 30 days of the provider’s receipt of the informal appeals decision. The appeal is handled by an independent hearing officer who is an attorney.

The formal appeal is a new hearing on the issues raised by the provider in their Notice of Formal Appeal. It is extremely important that the provider specify in detail in the Notice of Formal Appeal the issues being appealed. Documentary evidence must be submitted within 21 days of the filing of the Notice of Formal Appeal and objections to admissibility of documentary evidence must be filed within seven days of the filing of the documentary evidence. A hearing officer will rule on any objections within seven days of the filing of the objection. The hearing officer conducts the hearing within 45 days of the filing of the Notice of Formal Appeal. Given the short time frame for preparing for the formal appeal, it is important to have counsel involved at the earliest possible time in the matter.

In the formal appeal hearing, the provider will be permitted to put on its case. The provider is entitled to subpoena witnesses, and, often witnesses from DMAS will need to be subpoenaed. A decision must be issued within 120 days of the filing of the request for a formal appeal. Once the hearing officer makes a recommended decision, the DMAS director notifies the provider and DMAS that written exceptions may be filed within 30 days of receipt of the notification from the DMAS director. The DMAS director then has 60 days to issue a final agency decision. The provider may appeal this decision to the Circuit Court.



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