The Virginia Medicaid Appeals Process: An Overview for Medicaid Providers

The Virginia Medicaid agency—the Virginia Department of Medical Assistance Services (DMAS)—has historically conducted post-payment audits of providers. In recent years, DMAS has contracted with managed care organizations (MCOs) to cover the Medicaid population in Virginia. These programs are known as Medallion 4.0 and CCC Plus. Audits under these programs by MCOs, such as Anthem and UnitedHealthcare, are conducted by the MCOs themselves. It is important for health care providers in Virginia to understand how the DMAS appeals process operates in the event they are subject to an audit by DMAS or an MCO.

Step 1: The Overpayment Letter

Following the audit the DMAS auditor or MCO 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" or "Overpayment Letter." Under Virginia law, DMAS is only permitted to seek recovery four years from before 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 from DMAS, or once the MCO's informal appeals process is exhausted, the provider has 30 days to request an informal appeal. A demand letter sent via U.S. mail is presumed to be received by the provider within three days after the letter was mailed by DMAS. A demand letter that is transmitted via email or facsimile, however, is deemed received by the provider on the date that the email or facsimile was sent. If the provider is filing a cost report, it has 90 days to request an informal appeal. It is very important the provider has evidence the appeal was received by DMAS in a timely manner. There are certain requirements that should be included in the notice of appeal for the informal hearing. In particular, the notice must indicate which retractions are being appealed. It is generally recommended to appeal all retractions at the informal stage.

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 the date a provider files a 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.

It is recommended the provider be represented by an attorney 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 timeframe 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 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 commences the hearing within 45 days of the filing of the Notice of Informal Appeal. Given the short timeframe 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/MCO 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 14 days of receipt of the notification from the DMAS director. The provider may appeal the Final Agency Decision to the Circuit Court. In certain cases, providers who prevail on appeal are entitled to recover their attorney's fees from DMAS.

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