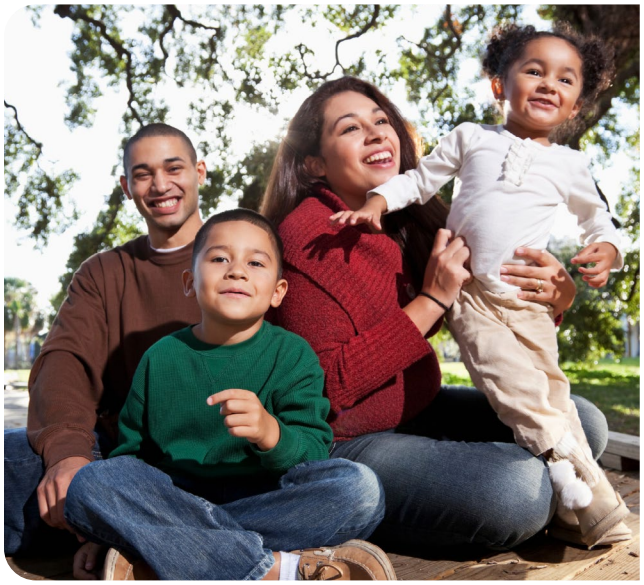
A Guide to Medicaid Appeals in Virginia:

Medical Service Denials, Terminations and Reductions

April 2021



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Medicaid Appeals for Medical Service Denials, Terminations and Reductions

Medicaid Managed Care in VA

The Department of Medical Assistance Services (DMAS) is responsible for the Medicaid program in Virginia. DMAS contracts with six health plans, called Managed Care Organizations, or MCOs, to provide health care benefits to most Medicaid members in Virginia. All MCOs participate in two Medicaid programs. CCC Plus serves people 65 and older, people with disabilities, and the medically frail. Medallion 4.0 serves families and adults. Members can select an MCO when they first enroll, change during their annual open enrollment period, or change at any point during the year if they have "good cause" that is approved by DMAS. Medicaid members receive a blue-and-white Medicaid card and a card from their MCO. Both should be brought to all doctors' appointments.

Because of this system, appeals must begin with the member's Medicaid MCO. If the member disagrees with the MCO decision, they can appeal to DMAS.

What is an Appeal?

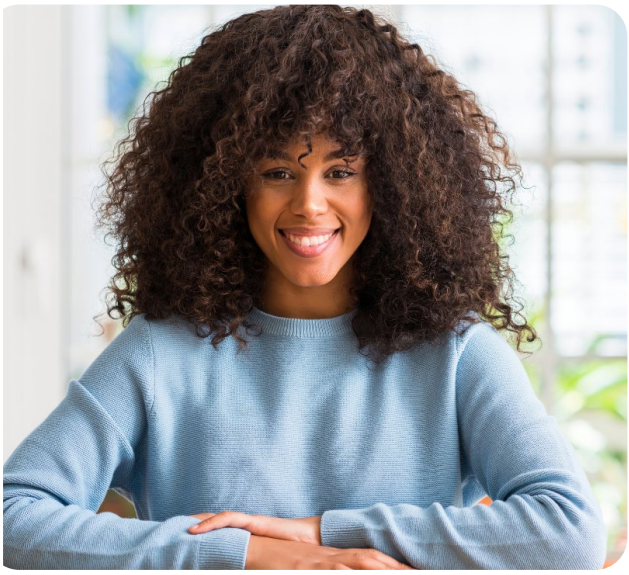
An appeal is a **request that your MCO or DMAS review a negative decision that was made about a Medicaid covered service**, such as medical treatment, assistive technology, prescription medication, or behavioral health.

You can appeal other issues, such as Medicaid eligibility, but this document will discuss appeals about services and benefits only.

What can be appealed?

- The MCO will not cover a service requested or prescribed by a provider;
- A service or benefit you are getting is reduced. For example, the MCO will cover fewer hours of physical therapy, personal care, or ABA therapy than you were getting before; or
- The MCO stops covering services that you are getting.

Grievances v.s. Appeals



If you have an issue with your MCO and it is not something you can appeal, you can file a grievance, or complaint, with the MCO. For example, if you were treated poorly by an MCO staff member or physician in the MCO network. The MCO must have a plan to take and respond to your complaint and must help you complete all steps to file the grievance. The MCO must also respond to you within 30 days of when you filed the complaint. Member complaints made with an MCO are shared with DMAS. Your MCO's member handbook will include information on their grievance process.

You can also file a grievance with DMAS, the Department of Health and Human Services/Office of Civil Rights, or the Long-Term Care Ombudsman, depending on your situation and the issue.

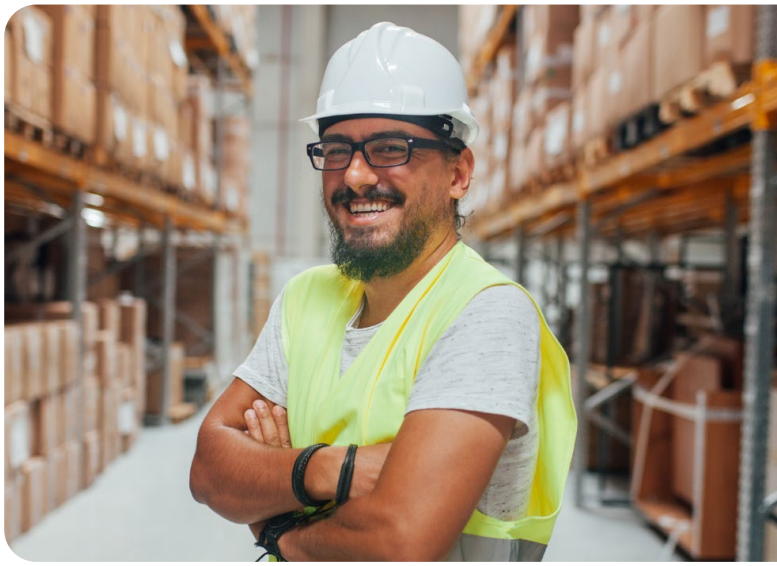
Who can file an appeal?

- **Individual** or their parent if they are a minor.
- **Authorized Representative** – The representative must have written authorization signed by the individual or, if they are a minor, their parent. A Power of Attorney authorizing the representative to act on the appellant's behalf during the appeal is also accepted.
- **Guardian**- A guardian can file an appeal on behalf of a Medicaid enrolled, but proof of guardianship must be submitted at each step of the appeal process.
- **Legal Counsel**- Legal counsel can be requested at any step in the process as well. Many legal aid programs will provide free advice or representation, depending on your circumstance and their eligibility criteria. Even if you are not eligible for their services, they may refer you to an attorney willing to help for little or no cost.

  Find your local legal aid here: https://www.valegalaid.org/find-legal-help or call the Legal Aid Helpline at (866) 552-7977.

Medical Necessity

MCOs are required to cover "medically necessary" services. This is defined as "appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are nor provided only as a convenience. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. For children under 21, medical necessity review must fully consider federal EPSDT guidelines." Using this phrase and language in your appeal can be helpful since it is what is legally required of the MCO.



Special Considerations for Children: Early Periodic Screening, Diagnosis & Treatment (EPSDT)

EPSDT Basics

Children and young adults enrolled in Medicaid under age 21 are guaranteed access to many important health care services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement. EPSDT requires that Medicaid provide medical, behavioral, dental, vision, and hearing screenings.

Early – Assessing and identifying problems early, starting at birth.
Periodic- Checking children's health at periodic, age-appropriate intervals.
Screening – Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
Diagnostic- Performing diagnostic tests to follow up when a risk is identified.
Treatment- Treating the problems found.

Treatment must be provided to "correct or ameliorate" (make better or stop from getting worse) any medical condition discovered through these screenings. EPSDT allows children to access many services that are not covered for adults enrolled in Medicaid.

EPSDT covered services include, but are not limited to:

- Assistive technology;
- Durable medical equipment;
- Private duty nursing;
- ABA therapy;
- Personal care;
- Medical formula and nutritional supplements;
- Eyeglasses;
- Hearing aids; and,
- Dental services and orthodontics.

EPSDT Secondary Review

The goal of EPSDT is to find and treat conditions as early as possible to stop them from negatively affecting the child's growth and development. Before any service is denied, reduced, or ended by the MCO – they must review it using EPSDT "correct or ameliorate" requirements. This is called a "secondary review".

When filing an appeal for a Medicaid enrollee under 21, it is important to check that the MCO reviewed the service using EPSDT criteria.

This is true if the person under age 21 is enrolled in any full-benefit Medicaid category including, children's Medicaid, Medicaid for Pregnant Women, Medicaid for Expansion Adults, and Medicaid through a long-term care waiver.

The appeals process has many steps and can be confusing. It is important to understand where you are in the process and your rights and responsibilities at each step!

Remember: An EPSDT Secondary Review must be completed at each step.

Notice of Adverse Benefit Determination → **Internal MCO Appeal** → **DMAS Fair Hearing** → **Circuit Court**

Internal MCO appeals must be filed within 60 days of getting the negative decision.

To keep benefits that are being reduced or ended, you must file within **10 days OR before the change happens**.

MCOs must make a decision within 30 days for a standard appeal, 3 days for an expedited appeal.

DMAS Fair Hearing appeals must be filed within **120 days** of the negative Internal Appeal decision.

To keep benefits that are being reduced or ended, you must file within **10 days** of losing the Internal Appeal.

You have **30 days** from the date of the Fair Hearing Decision to file a "Notice of Appeal", letting DMAS know that you are planning on appealing, and then 30 days from the "Notice of Appeal" to file a Petition in Circuit Court.

It is recommended that you seek legal assistance if you plan on taking this step!

The Appeals Process

1. Notice of Adverse Benefit Determination

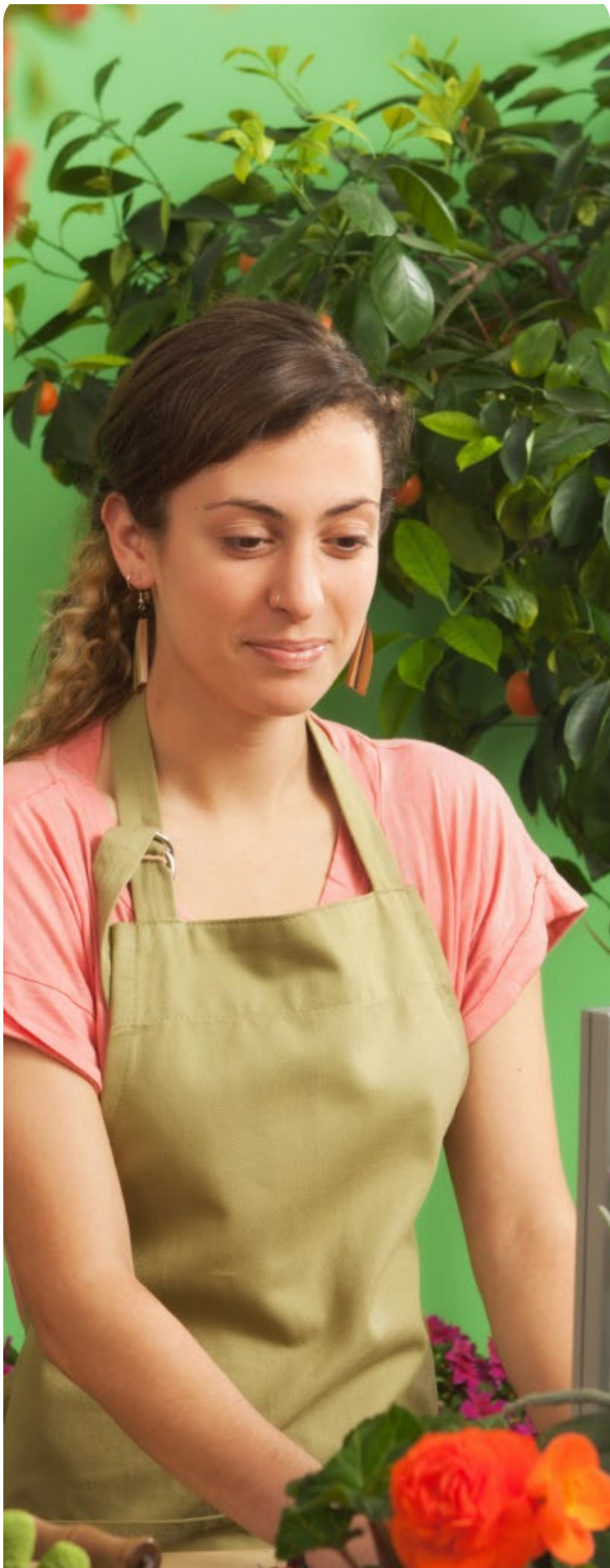
An adverse benefit determination is a denial, reduction, or ending of services. When this happens, your MCO will must send you written notice with information on why the negative decision was made; the contact name, address and telephone number for the person who made the decision; and how to appeal it. This is called the "notice of adverse benefit determination".

The MCO must provide a detailed and specific reason for denying, reducing, or ending the service. They cannot use the same language for everybody or say that the service is not "medically necessary" without providing information on why it is not "medically necessary". If reducing or ending a service, they must explain what changed since the last service approval to merit the reduction or ending.

They must also tell you about your right to appeal through the MCO and a DMAS Fair Hearing once the MCO appeal process has been completed; to get, free of charge, documents used by the MCO to make their decision; to file an expedited appeal for a faster decision; and how to keep your benefits during the appeal.

In most cases, the MCO must inform you at least **10 days before** they reduce, suspend, or end a service that you are currently getting. DMAS allows for an additional 5 days for mailing, or more if you can verify that you received it later than that. For example, the postmark on the envelope is after the date on the letter.

It is important to **begin the appeal process as soon as you get notice of the adverse benefit determination.**



The Appeals Process *(cont.)*

2. Internal Appeal (MCO Appeal)

The first step of the appeals process is to file an appeal with the MCO, called an internal appeal. **This must be filed within 60 days of getting the adverse benefit determination, but you should file an appeal as soon as you receive the denial, reduction or termination.**

An attorney or authorized representative may also submit the appeal for you. The MCO must help you complete the forms and provide interpretation services if you need this type of help.

You may request an appeal over the phone or in writing. Phone requests must be followed up with a written request unless it is an expedited appeal.

The MCO must decide the appeal within 30 days. You can request an extra 14 days if you need it to gather and submit extra information or documents.

The MCO must consider all additional information you provide when deciding your appeal, even if they did not have this information when they made their original decision. This includes information on new conditions. It is important for you and your provider to submit all information that supports your need for the service that is being denied, reduced, or ended.

You may also request an expedited appeal if you believe that a delay will harm your physical or behavioral health.

Your doctor will need to provide additional information to prove the need for an expedited appeal. If an expedited appeal is granted and the MCO has all the information they need, the MCO has only 3 business days to decide.

The MCO then has 14 days to send a written notice with their decision. They must try to provide oral notice within 3 days of the appeal.

What to Say When You Request an Appeal

Below are examples of verbal appeal requests.

A Reduced or Ended Service
"I would like to appeal this adverse benefit determination because I still require the same number of (reduced service) that I have been receiving. These services are medically necessary and I ask that you note my appeal now. Please send me all records and the criteria used to make this adverse decision."

To **keep your services during the appeal** you can include the following statement in your appeal request:

"I also request a continuation of my services at the current level during this internal appeal process and through the DMAS fair hearing, should I require one."

A Denied Service
"I would like to appeal this adverse benefit determination because (denied service) is medically necessary. I ask that you note my appeal now. Please send me all records and the criteria used to make this adverse decision."

Remember, you must follow up a verbal request with a written request unless an expedited appeal is requested. Your MCO member handbook will tell you how to submit the written appeal request.

Keeping Your Services During an Appeal

If the MCO decision reduces or ends services you are getting, you can request to keep getting them at the current level while the appeal is being processed. This is sometimes called "benefits pending appeal" or "continuation of benefits". **You must act fast!**

- **The appeal must be made within 10 days of the adverse benefits decision OR before the date the change is scheduled to take place.** The 10 days starts on the notice date, DMAS allows an additional 5 days for mailing or more if you can verify that you got the notice more than 5 days after the date on the notice.
- You may have to pay for the cost of the benefits that you received while the appeal is being determined if your appeal results in another denial.

The Appeals Process *(cont.)*

Tips for Preparing Your Appeal

- It is important to provide as much additional information as you can to support your appeal. This is the best time in the appeals process to submit additional information to prove that you need the service! A detailed letter from your doctor can be especially helpful. The letter should include:
  - o The health condition or diagnosis the services are addressing and your medical needs.
  - o Detailed explanation of why you need the services and why the services are "medically necessary."

- Request medical records from your doctor's office to submit with the appeal.

- Ask the MCO for your case file, medical records, and the criteria used to make their decision. They must give this to you for free. These records will tell you what information the MCO is basing their decision on and what information they may be missing. They will also provide you more information on who is making the decision.

- **MCOs are required to have appropriate medical professionals making these decisions.** If, for example, a cardiologist denied a behavioral health service, you can argue that the physician did not have the appropriate credentials to make that decision and the denial should be overturned.

- Make sure that the MCO has the correct diagnosis in their records.

- Don't forget: **Children and young adults under 21 have special rights under EPSDT!** One of these is that the service request or change must undergo a secondary review using EPSDT criteria.

- If you are appealing a reduction or ending of Personal Care or Private Duty Nursing hours, ask your service facilitator to check that all forms (DMAS-7, DMAS-7A, and DMAS-99) are filled out properly and ask them to provide additional documentation on your need for the specific number of hours requested.

- If you are appealing a reduction or ending of any kind, submit documentation that your condition has not improved and that your needs have not changed since the last approval. MCOs are required to accept previous approvals as proof of "medical necessity" and explain what has changed or why the last decision was wrong before they can reduce or end a service.

The Appeal Decision Notice

The MCO will send you a written notice with their decision. This notice must include:

- Detailed information on how they made their decision including a response to any additional information or documents you provided during the appeal process.
- The date the appeal was received.
- The date of the decision.
- If the appeal was not decided in your favor, the notice must also include:
  - o Information about the DMAS State Fair Hearing process and your rights to receive benefits during the State Fair Hearing process.
  - o A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
  - o Your right to be represented by an attorney or other individual.
  - o If applicable, information on how to contact the Office of the State Long-Term Care Ombudsman, Department for Aging and Rehabilitative Services.
- If the appeal decision reverses an adverse benefit determination, the MCO must approve the services promptly.

The Appeals Process *(cont.)*

3. DMAS State Fair Hearing

If the MCO appeal process is over and your service is still denied, reduced, or ended, you can appeal to DMAS through the State Fair Hearing process. You have 120 days after the MCO makes their final internal appeal decision to request a State Fair Hearing, but you should file quickly after receiving the final decision from the MCO.

Note: You can file for a State Fair Hearing before the MCO decision is made if the MCO did not make a decision within the proper time frame.

This is 30 days for an internal appeal.

If you kept your services during the MCO appeal and wish to keep them during the State Fair Hearing, you must request a State Fair Hearing within 10 days of the MCO appeal decision. Include in your DMAS appeal that you kept your services during the MCO appeal and want to keep them during the State Fair Hearing process. If your appeal is denied, you might be responsible for paying for the services you received during the appeal.

DMAS appeals are generally decided within 90 days from the date that you file the appeal. You may request your DMAS appeal be handled more quickly if the standard timeframe could jeopardize your life, health, or ability to attain, maintain, or regain maximum function. To do this, write "EXPEDITED REQUEST" on your appeal to request. **You must do this even if you and were granted an expedited appeal by the MCO**. If DMAS approves the expedited appeal request, they will issue a decision within 72 hours.

After you file your appeal, DMAS will notify you of the date, time, and location of the hearing. Most hearings are done by telephone, you can request an in-person hearing. If you cannot attend an in-person hearing or one is not granted, you can submit pictures and videos so the hearing officer can see the full extent of your medical condition.

If you did not request all records including the criteria the MCO used to deny, end, or reduce the service from the MCO during the internal appeal process, do it now.

MCOs are required to provide this information to you for free. You can then check that:

- The MCO considered all the applicable evidence including new evidence submitted during the internal appeal and, in the case of a service reduction or ending, prior approvals.
- An appropriate person made the decision.
- A secondary EPSDT review was made for those under 21.
- The reason the MCO decided that the service was not "medically necessary" and the criteria they used to make that decision.

The hearing is an informal hearing that will be overseen by a State Fair Hearing officer, not a judge. The MCO will likely be represented by one of their attorneys. You will have the opportunity to present your case, submit additional evidence or testimony to support your claim, call witnesses, ask questions of DMAS and MCO representatives, and respond to the hearing officer's questions. You can appoint an authorized representative to represent you during the appeal. You can also seek legal assistance. DMAS must provide language assistance if it is needed.

Remember, the hearing is all about the medical necessity of the services you are seeking. This includes EPSDT considerations for children under 21.

You can get the Virginia Medicaid and FAMIS Medicaid Appeal Request Form in online at www.dmas.virginia.gov/#/appeals resources or a paper copy at 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 by:

- Email: **appeals@dmas.virginia.gov**
- Online Appeal Portal: **www.dmas.virginia.gov/appeals/appeals-portal-login/**
- Fax: (804) 452-5454
- Mail or in person:
  Appeals Division, Department of Medical Assistance Services
  600 E. Broad Street, Richmond, VA 23219
- Phone: (804) 371-8488 (TTY: 1-800-828-1120)

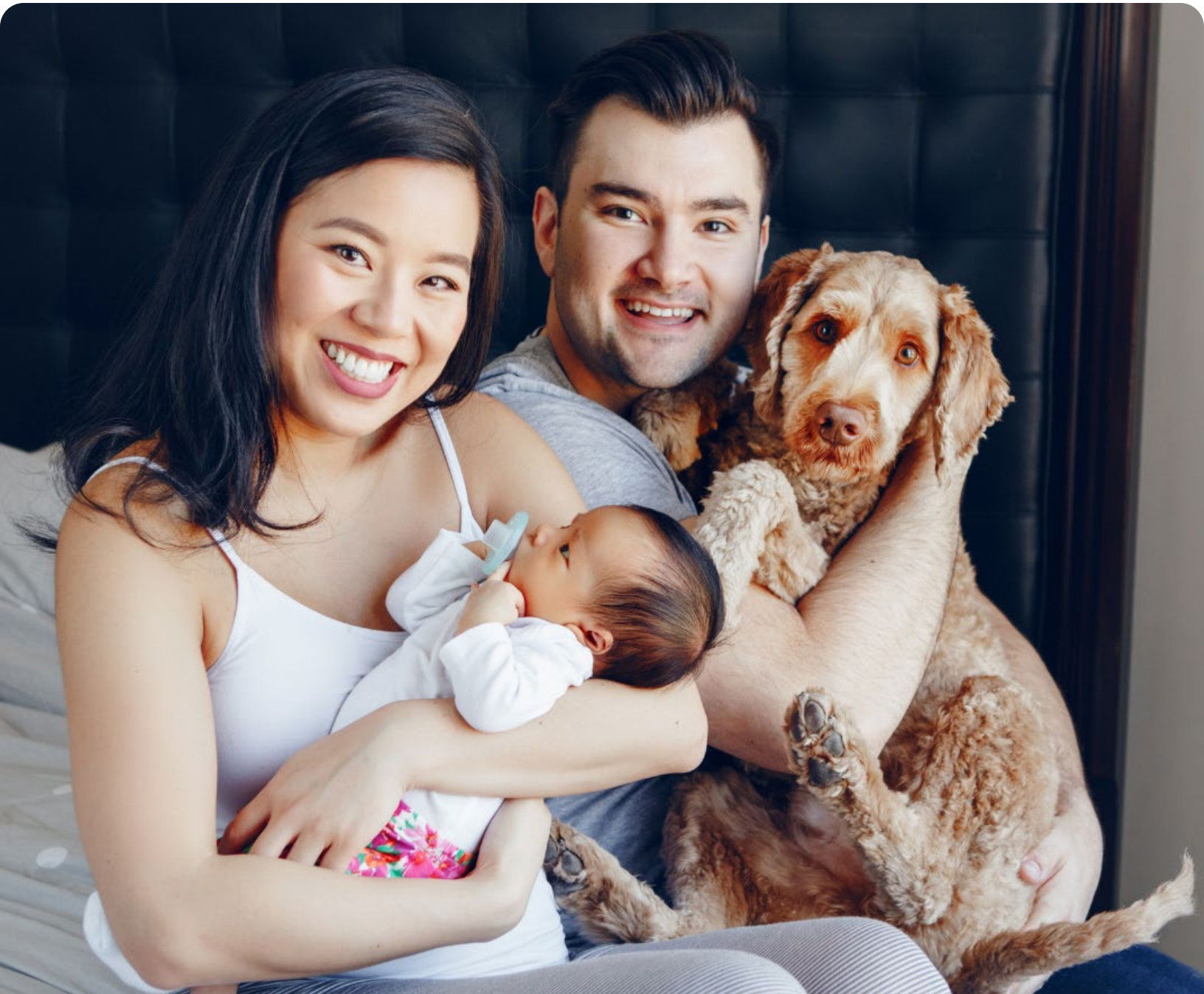
The Appeals Process *(cont.)*

4. The Circuit Court

If you disagree with the State Fair Fearing decision you can appeal to your local Circuit Court. **We recommend that you seek legal help if you want to take the appeal to this level.** You have 30 days from the date of the fair hearing decision to file a "Notice of Appeal", letting DMAS know that you plan to appeal, and then 30 days from the "Notice of Appeal" to file a Petition in Circuit Court. The Circuit Court decision is based on the record established at the State Fair Hearing. The judge will not take new evidence into consideration but will determine if the State Fair Hearing decision complies with the law.

Find Legal Help

Many legal aid programs will provide free advice or representation, depending on your circumstance and their eligibility criteria. Even if you are not eligible for their services, they may refer you to an attorney willing to help for little or no cost. Find your local legal aid here: https://www.valegalaid.org/find-legal-help or call the Legal Aid Helpline at (866) 552-7977.



Additional Resources

MCO Resources

Aetna Better Health of Virginia
Phone: 855-652-8249
Fax: 866-669-2459
Attn: Grievances/Appeals,
9881 Mayland Drive
Richmond, VA 23233
www.aetnabetterhealth.com/Virginia

Medallion 4.0 Member Handbook:
https://www.aetnabetterhealth.com/virginia/members/medicaid/medicaid-handbook
CCC Plus Member Handbook:
https://www.aetnabetterhealth.com/virginia/members/ccc-plus/ccc-handbook

Anthem HealthKeepers Plus
Phone: 855-323-4687
Fax: 800-359-5781
Central Appeals Processing,
HealthKeepers Plus
P.O. Box 62429,
Virginia Beach, VA 23466-2429
www.anthem.com/vamedicaid

Medallion 4.0 Member Handbook:
https://mss.anthem.com/va/benefits/medicaid-plans.html
CCC Plus Member Handbook:
https://mss.anthem.com/va/benefits/ccc-plus-medicaid.html

Magellan Complete Care of Virginia
Phone: 800-424-4524
No Fax
Attn: Appeals Specialist
3829 Gaskins Road
Richmond, VA 23233-1437
www.mccofva.com

Medallion 4.0 Member Handbook:
https://www.mccofva.com/medallion/for-members/member-handbook-and-directories/member-handbook/
CCC Plus Member Handbook:
https://www.mccofva.com/ccc-plus/for-members/my-plan/member-handbook/

Optima Health Community Care
Phone: 888-512-3171
Fax: 866-472-3920
TTY 844-552-8148
Appeals: 844-434-2916
Optima Health Community Care Appeals
P.O. Box 62876
Virginia Beach, VA 23466-2876
www.optimahealth.com/communitycare

Medallion 4.0 Member Handbook:
https://www.optimahealth.com/documents/plan/general/optima-family-care-members-guide-medallion-4.pdf
CCC Plus Member Handbook:
https://www.optimahealth.com/documents/plan/general/optima-health-community-care-members-handbook.pdf

United Healthcare Community Plan
866-622-7982
No Fax
Grievances and Appeals
P.O. Box 31364
Salt Lake City, Utah 84131-0365
www.uhccommunityplan.com

Medallion 4.0 Member Handbook:
https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/handbook/en/VA-Community-Plan-Handbook-EN.pdf
CCC Plus Member Handbook:
https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/handbook/en/VA-CCCPlus-Handbook-EN.pdf

Virginia Premier Health Plan
877-719-7358, Fax: 804-649-9647
Attn: Grievances and Appeals
P.O. Box 5244, Richmond, VA 23220-0307
www.vapremier.com

Medallion 4.0 Member Handbook:
https://www.virginiapremier.com/members/medicaid/member-resources/
CCC Plus Member Handbook:
https://www.virginiapremier.com/members/medicaid/ccc-plus/

Additional Resources *(cont.)*

Long-Term Care Ombudsman

An Ombudsman serves individuals in the CCC Plus MCO program. This includes elderly, disabled, such as those receiving care in nursing homes, assisted living facilities, and community based long-term care. A Long-Term Care Ombudsman helps individuals solve problems with their care, understand and exercise their rights and obtain needed assistance.

Contact the State Long-Term Care Ombudsman Program at (800) 552-5019.

DMAS Resources

DMAS's website includes a Client Appeal Frequently Asked Questions page, Client Appeal Overview, and the forms necessary to file an appeal.
http://dmasva.dmas.virginia.gov/appealsresources

Additional DMAS EPSDT Resoruces:
https://www.dmas.virginia.gov/#/maternalepsdt

MOMS in Motion

Moms in Motion is a Service Facilitator that works with Medicaid members who receive long-term care in the community. Their website has helpful information on how to access Personal Care through EPSDT.
https://momsinmotion.net/waivers-general-info-2/epsdt-process/

Special Rules During the COVID-19 Public Health Emergency

There are several appeal flexibilities due to the current public health crisis. These temporary changes give members more time to file appeals, ensure member's benefits are continued and modify hearing timelines.

1. Extended timeframe to file appeals. During the emergency, the 60-day timeframe for an internal appeal and the 120-day timeframe from a negative internal appeal decision to file an appeal with DMAS do not apply.

2. Delays in scheduling client appeal hearings and issuing client appeal decisions. DMAS may not be able to schedule hearings within the given timeframes. Your benefits should be automatically continued during this time without risk to you if you lose the appeal.

3. Verbal authorization for representation during the appeal. During the public health emergency, you can designate a representative through verbal authorization, not only in writing.

4. Benefits will be automatically continued during client appeals when the action involves a denial, reduction, or ending of existing eligibility or services. During the emergency, the coverage is automatically continued by the MCO during the internal appeal and by DMAS during the State Fair Hearing, with no financial impact to the member. When an appeal has been filed, the coverage will continue during the appeal at the previously approved level. Any new requests or request for additional services are not provided or continued during the appeal.

5. Requests reschedule hearings will be automatically granted and new hearings will be automatically scheduled when an appellant misses a hearing.

6. All hearings will be conducted via telephone.

Contact Information

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Email: sara@vplc.org
Phone: 804-332-1432

References

[i]Department of Medical Assistance Services, Medallion 4.0 Managed Care Services Agreement: Contract to Provide Managed Care Services for the Medicaid and Family Access to Medical Insurance Security (FAMIS) Programs, July 1, 2020 – June 30, 2021.
https://www.dmas.virginia.gov/files/links/5727/Medallion%204.0%20Contract%20SFY21v3.pdf.
Accessed 3/21/2021

[ii]Centers for Medicare and Medicaid Services, Early, Periodic, Screening, Diagnosis and Treatment
https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html.
Accessed 3/21/2021

[iii]Department of Medical Assistance Services, Medallion 4.0 Managed Care Services Agreement: Contract to Provide Managed Care Services for the Medicaid and Family Access to Medical Insurance Security (FAMIS) Programs, July 1, 2020 – June 30, 2021.
https://www.dmas.virginia.gov/files/links/5727/Medallion%204.0%20Contract%20SFY21v3.pdf.
Accessed 3/21/2021

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