disABILITY LAW CENTER OF VIRGINIA
Protection & Advocacy for Virginians with Disabilities

1512 Willow Lawn Dr. Ste. 100, Richmond, VA 23230 T:800-552-3962
www.dLCV.org F:804-662-7431

Medicaid Managed Care Denials and Appeals: FAQs

1. **What do I do if I receive an adverse benefits decision from my Managed Care Organization (MCO)?**

If your MCO decides to deny, reduce, or revoke a Medicaid service, they must inform you of their decision in writing. This decision is sometimes called an "adverse benefits decision." The written notification of this decision must explain the action that the MCO intends to take, the reasons for that action, the laws or policies that support their intended action, and how you can appeal their decision if you disagree with it. You should review the MCO's written notification carefully. It will include important information, including how to file an appeal, the deadline for submitting an appeal, and information about your rights during the appeals process.

2. **What happens after I request an internal appeal?**

The first step to appealing an adverse benefits decision is to request an internal appeal. During an internal appeal, a different doctor from the one who made the initial decision will look at your request. In cases where your MCO is revoking or reducing previously approved benefits, you may be able to ask your MCO to continue providing the services during the appeal. Note However, if you are unsuccessful in your appeal, your MCO can recover the costs of those services. Generally, the MCO is required to make this decision within 30 days of the initiation of the appeal. A member may request an expedited appeal when the standard appeal timeframe would seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. If an expedited appeal is granted, then the MCO must resolve the appeal within seventy-two (72) hours of their receipt of the appeal.

3. **What if my internal appeal is denied?**

If your MCO denies your internal appeal, and you wish to appeal this decision, you may request a Medicaid state fair hearing with the Department of Medical Assistance Services. You must request a state fair hearing within 120 days from the MCO's final internal appeal decision. In some circumstances, you may be able to keep your benefits during the appeal process if they were continued during the internal appeal. In order to do so, you must request your state fair hearing within 10 days of the MCO's internal appeal decision. And as noted above, if you are unsuccessful in your appeal, and your benefits were continued, then your MCO can recover the cost of the services provided during the appeals process.

4. **What happens after I request a state fair hearing?**

After you request a state fair hearing, a DMAS hearing officer will be assigned to your case. The hearing officer will set a date for your hearing and instruct the MCO to send to both you and the

hearing officer a summary of your case and the MCO's case file. You can submit any additional documents relevant to your case, such as medical records, letters from your doctors, or other relevant evidence, up to the day of your hearing. The sooner you submit evidence, the better.

Most DMAS state fair hearings are held via telephone, but you can request an in-person hearing if you prefer. On the day of the hearing, the hearing officer will ask the MCO's representative to explain the decision that they made and the reasons that they made that decision. After the MCO has explained their case, you may ask them questions, and then you will have an opportunity to present your case. The hearing officer will also likely ask clarifying questions of you and the MCO's representatives.

5. Who can help me with my appeal?

You can choose to appoint someone to act as your authorized representative for your appeal. Your authorized representative may be a family member, close friend, case manager, advocate, or attorney. It should be someone whom you trust to act on your behalf and who is knowledgeable about your case.

Although dLCV is only able to directly represent a small number of Medicaid members each year, you may find it helpful to speak with a dLCV advocate or attorney about the Medicaid appeals process. Should you wish to do so, you may submit a Get Help request on dLCV's website: https://www.dlcv.org/get-help; or you may call us toll free at 1-800-552-3962 or 804-225-2042, on Mondays, Wednesdays, or Fridays between 8:30am and 4:00pm.

6. Where can I get more information?

For more information, you may find the following resources helpful:

disAbility Law Center of Virginia, Medicaid Resources, Last Accessed September 18, 2022. https://www.dlcv.org/medicaid-eligibility-overview

Department of Medical Assistance Services, Applicant & Member Appeals, Last Accessed September 18, 2022. https://www.dmas.virginia.gov/appeals/applicant-member-appeals/

Virginia Poverty Law Center, A Guide to Medicaid Appeals in Virginia, April 2021. https://vplc.org/wp-content/uploads/2021/06/Medicaid-Guide.pdf