CHAPTER M16

APPEALS PROCESS

M16 Changes

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N/A	10/15/20	Pages 3, 8 Page 8a was added as a runover page.
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TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Page 1
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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, its local offices, the Department of Medical Assistance Services, Cover Virginia, and agents *or contractor(s)*.

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 *the* processed 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.

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 *(also known as the 'pre-hearing 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:

- *explain at the outset that the Local Agency Conference is an informal discussion between the local agency representative and the applicant/enrollee that does not involve the DMAS Appeals Division;*
- *state that the purpose is to describe the reason for the action, give the individual the opportunity to discuss their position/ask questions, and allow the individual to submit documents if they choose;*
- allow the applicant/enrollee to represent themselves or be represented by an authorized representative such as a legal counsel, a friend, or a relative.
- give the applicant/enrollee an explanation of the action;
- allow the applicant/enrollee to present any information to support their disagreement with the action;
- *make clear at the conclusion of the Local Agency Conference that if the applicant/enrollee disagrees with the results of the Local Agency Conference, the standard appeal process remains available;*
- *tell applicants/enrollees who have not yet filed an appeal that the appeal filing timeframes are applicable (30 days from the date of the notice with an additional allowance of five days for mailing – 35 days total from the date of the originating written notice of action) and inform them of the methods to request an appeal; and*

- *tell applicants/enrollees who have already requested an appeal that they may continue the standard appeal process, can submit additional documents directly to DMAS, and should monitor their correspondence for notification of a hearing date.*

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. *The Agency may proactively offer a Local Agency Conference at any point prior to a scheduled hearing, but the applicant/enrollee is not required to participate.*

C. The Conference and Right to Appeal

The Local Agency Conference must not be used as a barrier to the *applicant/enrollee's* right to a fair hearing. Participation in a conference does not extend the *35*-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 *coverage* if the appeal is *submitted* to the DMAS Appeals Division prior to the effective date of the action.

E. Agency Case Review

An Agency representative should review the case before contacting the applicant/enrollee for a Local Agency Conference:

- *If errors are identified, the Agency representative should correct the case, re-determine eligibility, send a new notice of action to the applicant/enrollee, and upload the notice of action to the Appeals Information Management System portal.*

- *If no errors are identified the Agency representative should be prepared to provide an explanation for the adverse action during the Local Agency Conference.*

F. 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 *applicant/enrollee* in writing. The Agency must send a new notice of action regarding the changed action *to the appellant/enrollee. The Agency must upload the new notice of action to the Appeals Information Management System portal.*

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

Applicant/enrollees are encouraged to file and appeal request through the DMAS appeals portal at **https://www.dmas.virginia.gov/appeals/**. *It is also acceptable to file an appeal by other means,* using the "Virginia Medicaid/FAMIS Appeal Request Form," which is available from DMAS at **https://www.dmas.virginia.gov/appeals/**.

The appeal request should identify the action under appeal, the reason for the appeal, and include a copy of the notice of action. The submission should also include acceptable proof of authorization to act on behalf of an applicant or enrollee if an authorized representative is filing on their behalf. Appeals filed more than 35 days after the date on the notice of action should include a good cause statement explaining the reason for filing an untimely appeal. Finally, appellants and their representatives may include any other documentation that they wish the hearing officer to consider.

***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 *35* days of the *notice of action (thirty days from the date of the notice with an additional allowance of five day for the mailing – 35 days total from the date of the originating written notice of action).* that Medicaid coverage or medical services has been denied, terminated, reduced, adversely affected, *or that an application or request for coverage* 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 *their* own.

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, *filing the appeal with another government agency in good faith,* 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*, or when the appeal is requested after the effective date but within 10 days of the *Notice of Action.*

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.

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 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 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 *the appropriate* 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.

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. *Appellants or authorized representatives who have established access to the Appeals Information Management System portal may withdraw their appeal electronically within the portal. Otherwise,* 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 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

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 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 *conducted by telephone* unless the appellant requests a face-to-face hearing. Appellants may request to participate in their hearing at the local Agency rather than appearing telephonically.

Hearings regarding actions taken *by other agents* or contractors will be conducted telephonically.

B. Confirmation Letter

The schedule letter is mailed to the appellant and representative, and a copy is *provided* to the Agency *via the Appeals Information Management System Portal.*

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 *medical assistance* 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 *transmit* 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 *and in the following manner:*

- Department of Medical Assistance Services, Appeals Division - Electronically via the *Appeals Information Management System* at portal at www.dmas.virginia.gov/appeals. Use of the *Appeals Information Management System* portal is the *required* method for filing the appeal summary with DMAS.

- The appellant or their authorized representative, if the appellant has designated a representative for the appeal, *via U.S. Mail.*

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.

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.

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.

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* 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.*

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."

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.

2. Agency Action - Remanded Cases

The Agency must take action to close the case in the Medicaid system using cancel reason "015" effective the date the Agency receives the decision.

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.

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.