VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AUDITS: WHAT YOU NEED TO KNOW

December 15, 2020

While the pandemic seems to have decreased the number of Virginia Department of Medical Assistance Services (DMAS) audits this year as a result of a suspension of onsite audits and use of desk audits only, providers are likely to see an uptick in audits in early 2021. While DMAS provided some leeway during audits in 2020, we anticipate less flexibility going forward.

Audit requests and demand letters can catch providers off guard, especially if they do not realize there are strict rules about materials that will be considered, the process moves surprisingly fast, and many deadlines cannot be extended.

DMAS AUDIT BASICS

Post-payment audits can originate with either DMAS itself or managed care organizations (MCOs) such as Anthem, Optima, or Virginia Premier. If a provider receives a notice of an audit, it is imperative to ensure all relevant documentation is timely provided. In both the audit and any subsequent appeals, DMAS will **only** consider documentation submitted by the provider during the course of the audit. See Medicaid Memo dated 11/12/15.[1] If overpayments are identified during the audit, DMAS or the MCO will send a provider a "demand letter" or "overpayment letter" requesting repayment.

INFORMAL APPEAL

Once a demand letter is received, a provider generally has 30 days to request an Informal Appeal. An Informal Appeal is a request for a hearing officer to review the action taken by DMAS or an MCO. The burden of proof is on the provider to show the decision made by DMAS or its MCO was wrong.

The timeline to request an appeal is fast. A letter is "presumed" to have been received by the provider within 3 days of mailing. If a letter is sent by email or facsimile, it is "deemed" received the same day it was sent. A document is only considered to be filed with DMAS when it is date stamped by the DMAS Appeals Division in Richmond. A document must be filed before 5:00 pm on the due date to be considered timely. Extensions to file an appeal are not permitted.

[1] The memo references *1st Stop Health Services v. DMAS*, 63 Va. App., 756 S.E.2nd 183 (2014).

Within 30 days of filing the notice of informal appeal, DMAS must file a written case summary. An informal hearing is held within 90 days of the date a provider files a notice of informal appeal. Many informal appeals are conducted through written submissions, but providers ordinarily have the right to a face-to-face hearing at DMAS headquarters in Richmond.[2] DMAS elected Informal Appeals Agents, who are employees of the DMAS Appeals Division, conduct the appeals and preside over Informal Fact-Finding Conferences. The informal appeal decision must be issued within 180 days of the notice of informal appeal.

FORMAL APPEAL

If the provider is dissatisfied with the informal appeal decision, the next step is to request a formal appeal. A provider must file a Notice of Formal Appeal within 30 days of receipt of the informal appeal decision. The Notice of Formal Appeal is not considered filed until it is date stamped by the DMAS Appeals Division. The Notice must detail the specific issues being appealed. There are specific deadlines for submitting evidence for consideration at the Formal Appeal. Typically, a Formal Appeal is held within 45 days of filing the Notice of Formal Appeal.

The formal appeal is typically held at DMAS headquarters in Richmond. A Hearing Officer presides over the formal hearing. Hearing Officers are assigned by the Executive Secretary of the Virginia Supreme Court on a rotating basis and are typically licensed, practicing attorneys. DMAS is represented at a formal appeal hearing by a Formal Appeal Representative.

During a formal appeal hearing, the Hearing Officer will typically make opening remarks and swear in witnesses. Witnesses offer testimony through direct examination and cross examination. The parties also typically have an opportunity to make closing arguments. After a transcript of the hearing is prepared, the provider will file an opening brief and has the opportunity to file a reply to DMAS's opening brief. The hearing officer must issue a decision within 120 days of the filing of the Notice of Formal Appeal. After reviewing the briefs, testimony, and evidence presented, the Hearing Officer submits a Recommended Decision to the DMAS Director. The DMAS Director must accept the Recommended Decision unless the recommendation contains an error of law or policy.

A Final Agency Decision is issued by the DMAS Director and sent to the provider. It must be issued within 60 days of the Hearing Officer's Recommended Decision. The provider may appeal the decision to Circuit Court by filing a Notice of Appeal with the DMAS Director within 30 days and filing a petition for appeal with the court within 30 days of filing a Notice of Appeal. DMAS will not need to provide evidence or testimony in court.

PREPARING FOR AN AUDIT OR AUDIT APPEAL

DMAS appeals move quickly and require methodical attention to document production and deadlines. If you receive a Demand Letter or Overpayment letter from DMAS or an MCO, consider reaching out to any attorney who specializes in reimbursement to assist with the process. A member of our Reimbursement team would be pleased to speak with you.

[2] At times during the pandemic, DMAS elected to use online platforms for hearings.