Medicaid Appeal Procedure

Members or their appointed representatives (including providers) may request an appeal of an adverse benefit determination (denied authorization). For a provider to file an appeal on behalf of the member for a denied service, the member must provide their written consent. Please follow the instructions below.

Note: The appeal process outlined below applies before a claim is submitted for payment. **Once a claim is processed, providers should follow the Provider Reconsideration Process.**

Filing an Appeal of an Adverse Benefit Determination

Types of Appeals?

- Standard appeals are resolved within 30 calendar days of receipt.
- Expedited appeals may be requested if it is determined that following the standard processing timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function. Expedited appeals are resolved within 72 hours of receipt.

- **Who Can File?**
  - A member or their authorized representative (including their provider or an attorney).
  - **For a provider to file an appeal on behalf of the member for a denied service, the member must provide their written consent.** If the service has been rendered, the provider may submit the claim for the services and follow the Provider Reconsideration (Post-Claim) process outlined below if the claim is denied or partially denied.

- **When to File?**
  - Within 60 days from the date on the Adverse Benefit Letter (ABDL)

- **What to Include?**
  - A request for appeal
  - Any relevant documentation supporting the appeal (e.g., medical records, denial letters)
  - The member's written consent for the provider to appeal on their behalf

- **Need Help?**
  - Contact Sentara Health Plans Appeals and Grievances Department at 1-844-434-2916.

Medicaid Appeal Procedure

Sentara Health Plans

How to Submit Your Appeal

Mail:
Sentara Medicaid
Appeals and Grievances
P.O. Box 62876
Virginia Beach, VA 23466
Fax: 1-866-472-3920
Phone: 1-844-434-2916
Email: memberappeals@sentara.com
Hand Delivery:
1300 Sentara Park
Virginia Beach, VA 23464

What Happens Next

- You will receive an acknowledgement letter within 5 calendar days of appeal submission for standard appeals.
- If the appeal is received without the member's written consent, the Appeals Department will make attempts to contact the member and obtain their written consent. If the member's written consent is not received within 30 calendar days, the appeal will be closed as invalid.
- An appeals coordinator will review the case, gathering all necessary documentation. You may submit additional documentation to support the appeal within 10 calendar days of submission.
- A decision is made within 30 calendar days for standard appeals and within 72 hours for expedited appeals.
- A written notice of the decision will be sent to both the member and provider.

FAMIS Members Only – Optional External Medical Review

FAMIS members have the option of requesting an external medical review from Acentra Health (formerly KEPRO). All external reviews requested by members must be submitted in writing within 30 days of receiving the unfavorable appeal decision letter. It is not required that you request an external medical review to file a State Fair Hearing appeal request with DMAS. Additionally, if you request an external medical review and would like a State Fair Hearing appeal, you **must** still file the State Fair Hearing appeal as outlined below, including the deadline to file the appeal.

The external medical review request, should you choose to request one, must be submitted to Acentra Health (formerly KEPRO) directly using one of the options below. When you file your external medical review request, please include a full copy of our final denial letter and any documents you would like included in the external medical review of your denial.

You or your representative acting on your behalf can file the external medical review request in the following ways:

Electronically: Online https://atrezzo.kepro.com/ExternalReview.aspx by clicking the external appeal link. Please include your name and ID number, your phone number with area code, and copies of any relevant notices or information.

Mail: FAMIS External Review, c/o Acentra (formerly KePro),
6802 Paragon Place, Suite 440., Richmond, VA 23230.

DMAS State Fair Hearing and External Reviews

You can file an appeal to the Department of Medical Assistance Services (DMAS) through what is called the State Fair Hearing process after filing an appeal with Sentara Health Plans if you disagree with the final appeal decision you receive from Sentara Health Plans or Sentara Health Plans does not respond to your appeal in a timely manner. The appeal request must be filed with DMAS within 120 calendar days from the date of the internal appeal decision notice.

The member must provide their written consent for the provider to appeal to DMAS on their behalf. You may file the appeal in one of the following ways:

Electronically: Online at https://www.dmas.virginia.gov/appeals or by email to appeals@dmas.virginia.gov

Fax: Fax your appeal request to DMAS at 1-804-452-5454

Mail or in person: Send or bring your appeal request to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219

Phone: Call DMAS at 1-804-371-8488 (TTY: 1-800-828-1120)

You can ask if the appeal request be reviewed under an expedited (fast) process if the member's health condition requires it. You will need to explain how a delay will cause harm to the member's physical or behavioral health. If you want your State Fair Hearing to be handled quickly, you must write "EXPEDITED REQUEST" on your appeal request.

Hearings for expedited decisions are usually held within one or two days of DMAS receiving the request, and a decision is rendered within 72 hours of receipt.

If your request is not an expedited appeal, or if DMAS decides that the member does not qualify for an expedited appeal, DMAS will render a decision within 90 days from the health plan (1st level) appeal was filed, not including the number of days it took to file for a State Fair Hearing.