VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact § 32.1-325.1 of the Code of Virginia, relating to Department of Medical Assistance Services; appeals of agency determinations.

[S 1237]

Approved

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325.1 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-325.1. Appeals of agency determinations.

A. *All providers enrolled with the Department that receive an adverse action or determination are afforded appeal rights. For provider appeals stemming from an action taken by a Department contractor, including managed care organizations, the provider shall exhaust the contractor's internal reconsideration process before appealing to the Department.*

B. The ~~Director~~ *Department* shall make an initial *appeal* determination ~~as to whether an overpayment has been made to a provider~~ in accordance with the state plan for medical assistance, the provisions of § 2.2-4019, and applicable federal law. The initial determination shall be issued within 180 days of the receipt of the appeal request. If the agency does not render a decision within 180 days, *or, in the case of a joint agreement to stay the appeal decision pursuant to subsection D, within the time after the stay expires and before the appeal timeframe resumes,* the decision is deemed to be in favor of the provider.

~~B.~~ *C.* An appeal of the ~~Director's~~ *Department's* initial determination concerning provider reimbursement shall be heard in accordance with § 2.2-4020 of the Administrative Process Act (§ 2.2-4020 et seq.) and the state plan for medical assistance provided for in § 32.1-325. The hearing officer appointed pursuant to § 2.2-4024 shall conduct the appeal and submit a recommended decision to the Director within 120 days of the agency's receipt of the appeal request, *unless the settlement provisions of this section apply*. The Director shall consider the parties' exceptions and issue the final agency case decision within ~~sixty~~ *60* days of receipt of the hearing officer's recommended decision. If the Director does not render a final agency case decision within ~~sixty~~ *60* days of the receipt of the hearing officer's recommended decision, the decision is deemed to be in favor of the provider. The Director shall adopt the hearing officer's recommended decision unless to do so would be an error of law or Department policy. Any final agency case decision in which the Director rejects a hearing officer's recommended decision shall state with particularity the basis for rejection. Prior to a final agency case decision issued in accordance with § 2.2-4023, the Director may not undertake recovery of any overpayment amount paid to the provider through offset or other means. Once a final determination of overpayment has been made, the Director shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial or the final determination of overpayment. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 from the date the ~~Director's~~ *Department's* determination becomes final. Nothing in § 32.1-313 shall be construed to require interest payments on any portion of overpayment other than the unpaid balance referenced herein.

~~C.~~ *D. The Department and the provider may jointly agree to stay the deadline for the informal appeal decision or for the formal appeal recommended decision of the hearing officer for a period of up to 60 days to facilitate settlement discussions. If the parties reach a resolution as reflected by a written settlement agreement within the 60-day period, then the stay shall be extended for such additional time as may be necessary for review and approval of the settlement agreement, unless the action stems from a managed care organization. If the action stems from a managed care organization, the settlement may occur between the provider and the managed care organization without additional approval.*

E. The burden of proof in informal and formal administrative appeals is on the provider. *If an action stems from a Department contractor, then such contractor shall represent itself during the informal and formal appeal proceedings.*

F. The agency shall reimburse a provider for reasonable and necessary ~~attorneys'~~ *attorney* fees and costs associated with an informal or formal administrative appeal if the provider substantially prevails on the merits of the appeal and the agency's position is not substantially justified, unless special circumstances would make an award unjust. In any case in which a provider has recovered ~~attorneys'~~ *attorney* fees and costs associated with an informal or formal administrative appeal, the provider shall not be entitled to recover those same ~~attorneys'~~ *attorney* fees and costs in a subsequent judicial proceeding.

~~D.~~ *G.* Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act (§ 2.2-4000 et seq.). In any case in which a final determination of overpayment has been reversed in a subsequent judicial proceeding, the provider shall be reimbursed that portion of the payment to which he is entitled plus any applicable interest, within ~~thirty~~ *30*

days of the subsequent judicial order.