~~CHAPTER II~~

~~PROVIDER PARTICIPATION REQUIREMENTS~~

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MANAGED CARE ENROLLED MEMBERS

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted Managed Care Organizations (MCOs) and their network of providers. All providers must check eligibility (Refer to Chapter 3) prior to rendering services to confirm which MCO the individual is enrolled. The MCO may require a referral or prior authorization for the member to receive services. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations.

Even if the individual is enrolled with an MCO, some of the services may continue to be covered by Medicaid Fee-for-Service. Providers must follow the Fee-for-Service rules in these instances where services are "carved out." The carved-out services vary by managed care program. For example, where one program (Medallion 3.0) carves out Early Intervention, the CCC Plus program has this service as the responsibility of the MCO. Refer to each program's website for detailed information and the latest updates.

There are several different managed care programs (Medallion 3.0, CCC, CCC Plus, and PACE) for Medicaid individuals. DMAS has different MCOs participating in these programs. For providers to participate with one of the DMAS-contracted managed care organizations/programs, they must be credentialed by the MCO and contracted in the MCO's network. The credentialing process can take approximately three (3) months to complete. Go to the websites below to find which MCOs participate in each managed care program in your area:

- Medallion 3.0:
  http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC):
  http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Commonwealth Coordinated Care Plus (CCC Plus):
  http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- Program of All-Inclusive Care for the Elderly (PACE):
  http://www.dmas.virginia.gov/Content_atchs/ltc/WEB%20PAGE%20FOR%20PACE%20Sites%20in%20VA.pdf

At this time, individuals enrolled in the three HCBS waivers that specifically serve individuals with intellectual and developmental disabilities (DD) (the Building Independence (BI) Waiver, the Community Living (CL) Waiver, and the Family and Individual Supports (FIS) Waiver) will be enrolled in CCC Plus for their non-waiver services only; the individual's DD waiver services will continue to be covered through the Medicaid fee-for-service program.

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, MCO enrollment, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating provider is a person who has a current, signed participation agreement with the Department of Medical Assistance Services.

PROVIDER ENROLLMENT

Any provider of services must be enrolled and have a current participation agreement with the Virginia Medicaid Program prior to billing for any services provided to Medicaid recipients. Continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of the provider license. Failure to renew the license through the licensing authority shall result in the termination of the Medicaid Participation Agreement.

Upon receipt of the above information, the ten-digit National Provider Identifier (NPI) number that was provided with the enrollment application is **assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.**

DMAS is informing the provider community that NPIs may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share your NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR ENROLLMENT

All providers who wish to participate with Virginia Medicaid are being directed to complete their request via the online enrollment through our Virginia Medicaid web-portal. If a

provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web portal and follow the instructions for submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov.

If you have any questions regarding the online or paper enrollment process, please contact the Xerox Provider Enrollment Services at toll free 1-888-829-5373 or local 1-804-270-5105.

PROVIDER SCREENING REQUIREMENTS

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved by DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as "limited", "moderate" or "high". Please refer to the table at the end of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state

~~database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.~~

~~Moderate Risk Screening Requirements~~
~~The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.~~

~~High Risk Screening Requirements~~
~~In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the "high" level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.~~

~~Application Fees~~
~~All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and revalidation process.~~ **~~The application fee requirements are also outlined in Appendix section of this provider manual.~~**

~~The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.~~

~~Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied.~~

~~An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.~~

~~Out-of-State Provider Enrollment Requests~~
~~Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit~~

previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

REVALIDATION REQUIREMENTS

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via our web portal.

Registration into the Virginia Medicaid Web Portal will be required to access and use the online enrollment and revalidation system.

All enrolled providers in the Virginia Medicaid program will be notified in writing of a revalidation date and informed of the new provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

Please go to chapter V of this provider manual to review the new billing procedures related to the implementation of these new screening requirements.

PARTICIPATION REQUIREMENTS

~~Providers approved for participation in the Medical Assistance Program must perform the following activities as well as any other specified by DMAS:~~

- ~~Immediately notify the Department of Medical Assistance Services, in writing, of any change in the information which the provider previously submitted to the Department.~~
- ~~Assure freedom of choice to recipients in seeking medical care from any Medicaid enrolled provider qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed.~~
- ~~Assure the recipient's freedom to reject medical care and treatment or services.~~
- ~~Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, creed, or national origin.~~
- ~~Provide services and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973 requiring that all necessary accommodations are made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, and disabilities of coordination (refer to section regarding the Rehabilitation Act).~~
- ~~Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.~~
- ~~Charge the Department for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.~~
- ~~Accept as payment in full the amount established by the Department to be reasonable payment. 42 CFR, Section 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the Medicaid Program, providing that the recipient was Medicaid eligible at the time service was rendered. The provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. For example: If a third party payer reimburses $5.00 out of an $8.00 charge, the provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative.~~
- ~~Accept assignment of Medicaid benefits for eligible Medicaid recipients.~~
- ~~Use Program-designated billing forms for submission of charges.~~
- ~~Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.~~

- Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to section regarding documentation for medical records.)

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by the Program, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.

- Hold confidential and use for authorized department purposes only all medical assistance information regarding recipients. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state or federal agency. The state agency shall not disclose medical information to the public.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUAL AND ENTITIES

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.

2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.
3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS
Attn: Program Integrity/Exclusions
600 E. Broad St, Ste 1300
Richmond, VA 23219
-or-
E-mailed to: providerexclusions@dmas.virginia.gov

PARTICIPATION CONDITIONS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. The paragraphs which follow outline special participation conditions which must be agreed to by licensed podiatrists.

Licensed Podiatrists

Any podiatrist licensed to practice in the Commonwealth of Virginia (or in the state in which he/she practices) may apply for participation in the Virginia Medicaid Program by signing the authorized Participation Agreement, DMAS-101 (see "Exhibits" at the end of this chapter). The agreement must be in effect at the time services are rendered in order for them to be considered for payment. Each podiatrist will be assigned a Virginia Medicaid provider identification number. Medicaid can pay only for services performed by the participating podiatrist or under his direct, personal supervision; however, a podiatrist may not bill for services provided by another podiatrist.

CERTIFICATION

The Virginia Medicaid Program is dependent upon the participation and cooperation of providers who provide or oversee **all categories** of health care. The provider is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with excellence in medical practice and economic considerations.

Providers, General

A podiatrist who admits a patient to a hospital may order tests, drugs, and treatments; and determine the length of stay. The Program calls for substantiation of certain provider decisions as an element of proper administration and fiscal control. Payment for certain covered services may be made to a provider of services only if there is certification concerning the necessity of the services furnished, and, in certain instances, only if there is recertification to the continued need for the covered services.

- The provider of services is responsible for obtaining the required certification and recertification statements and for retaining them on file for verification, when needed, by DMAS.
- Use of specific procedures or specific forms is not required, so long as the approach adopted by the provider permits verification that required certification and recertification statements are entered on or included in forms, notes, or other records a practitioner normally signs in caring for a patient; a separate form may be used for this purpose. Each certification and recertification statement must be

separately signed by a practitioner, except as otherwise specified in this section.

- The requirements for recertification (and for certification for inpatient hospital services furnished) set forth in this section specify certain information that must be included in the statement. This required information need not be repeated in a separate statement if, for example, it is contained in the progress notes. The statement may merely indicate that the required information is contained in the patient's medical record, if this is so.

- Providers of services are expected to obtain timely certifications and recertifications. However, delayed certifications and recertifications can be honored when, for example, the patient was unaware of his eligibility for the benefits when he was treated. Delayed certifications and recertifications must include or be accompanied by an explanation for the delay, including any medical or other evidence the physician or provider considers relevant. A delayed certification and one or more delayed recertifications may appear in one signed statement.

Inpatient Hospital Services

The certification and recertification statement should contain the following information:

- The reason for continued hospitalization of the patient for medical treatment or for medically required inpatient diagnostic study

- The estimated period of time the patient will need to remain in the hospital

- Any plans, where appropriate, for post-hospital care

Certifications and recertifications should be signed by the provider responsible for the case, by another provider having knowledge of the care who is authorized to sign by the responsible provider, or by the hospital's medical staff.

A separate recertification statement is not necessary when the requirements for a second or subsequent recertification are satisfied through utilization review. The Utilization Review Committee records are sufficient if they show that consideration was given to the reasons for continued hospitalization, estimated time the patient will need to remain in the hospital, and plans for the post-hospital care.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 provides that no handicapped individual shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for handicapped individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. A compliance notice is printed on the back of checks issued to providers, and, by endorsement, the provider indicates compliance with Section 504 of the Rehabilitation Act.

DOCUMENTATION OF RECORDS

The provider agreement requires that medical records fully disclose the extent of services provided to Medicaid recipients. Medical records must clearly document the medical necessity for covered services. This documentation is to be written at the time service is rendered, and be legible and clear in the description of the services rendered.

Pre-existing written protocols with contemporaneous medical record documentation may be considered in addition to the medical record to satisfy the documentation requirements. Sufficient information must be present in the medical record to support the medical necessity for the billed service. The protocol is not acceptable as a replacement for appropriate medical record documentation. A copy of the written protocol must be present in the patient's chart to be considered in any audit.

Specific points to be recorded in the medical records to meet documentation requirements include the following:

- The present complaint.
- A history of the present complaint, past medical history applicable to the complaint, and the family history applicable to the complaint.
- The positive and negative physical examination findings pertinent to the present complaint.
- Diagnostic tests ordered, if any, and the positive and negative results.
- Diagnosis(es).
- Any systemic condition that results in severe circulatory embarrassment or areas of desensitization in the legs or feet which justifies the palliative trimming of toenails or other foot lesions. See Podiatry Manual, Ch. IV, page 10, "Covered Services and Limitations," subsection entitled "NON-COVERED SERVICES AND LIMITATIONS."
- Treatment, if any, including referrals. Any drugs prescribed as part of the treatment must have the quantities and the dosage entered in the medical record.
- The record must indicate the progress at each visit, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written and signed for every office, clinic, or hospital visit billed to Medicaid.
- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible licensed participating provider. The documentation for the care rendered by personnel under the direct, personal supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.

Examples of medical record documentation:

Initial Office Visit With Follow-Up (Please note that routine, uncomplicated post-operative care is included in the global surgical procedure and may not be billed separately.)

Jan. 20, 1989 C/O of knuckle on rt. big toe sticking out and pain on walking. Referred by family physician.
Gradual onset over 4 months with increasing pain. Unable to wear closed shoe.
No drug allergies.
No current meds.
No illnesses.
First MTPJ (rt) pain on ROM. Can't stand on ball of foot without pain. X-rays show rt. hallux with phalangeal deformity, displaced met. head.
Painful hallux valgus deformity rt. foot.
Patient informed of risks of surgery and alternative treatments.
Schedule for modified Austin bunionectomy rt.
Feb. 20 1989 2 wks. S/P mod. Austin bunionectomy rt.
Min. swelling around op. site. Incision clean and healing.
Pain controlled with Ibuprofen 200 mg. q4-6 hours

- All billed laboratory services must have documented results. Those laboratory tests listed as quantitative tests by the CPT must be documented by a numerical result. Qualitative tests must be documented as positive or negative. Those laboratory tests requiring descriptive results must be fully documented. Documentation examples are listed below:

Quantitative:
Glucose - 85 mg/dl
WBC - 7,000/mm^3

Qualitative:
Antistreptolysin screen - negative

Descriptive tests:
Urine microscopic - clear, yellow-brown, few WBC, rare renal epithelial cell
X-ray (left foot) - no abnormal findings

CLARIFICATION OF CURRENT PROCEDURAL TERMINOLOGY DEFINITIONS

Brief Level of Service - A documented abbreviated system evaluation. A brief office visit may indicate a recheck of a complaint for one system with previous treatment continued or discontinued if the problem is resolved.

Limited Level of Service - A documented limited or interval one system evaluation. Tests to support the diagnosis may be ordered with the results documented.

Intermediate Level of Service - A documented multiple systems review. One or more conditions may be new complaints or there may be one new complaint with a follow-up for a previously identified condition.

Extended Level of Service - History, diagnosis and treatment for two or more systems are

documented. There may be new or existing problems. The past medical history as well as history of the present medical complaint is done.

Comprehensive Level of Service – A complete history, diagnosis and treatment plan provided are documented. A comprehensive level of service may include a family history, past medical history, a personal history and a history of the chief complaint, or a complete systems review and physical exam.

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement is not time-limited, and will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed licensure/certification prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and Xerox – PES 30 days prior to the effective date. The addresses are:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Virginia Medicaid – PES
PO Box 26803
Richmond, Virginia 23261-6803

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

The Code of Virginia, Chapter 10, Department of Medical Assistance Services, Section 32.1-325(c), mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify the Program of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of State law.

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325D and E. The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code §2.2-4000 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division **within 15 calendar days** of the receipt of the notice of termination or denial.

APPEALS OF ADVERSE ACTIONS

Definitions:

Administrative Dismissal – means:

1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or
2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action – means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

   a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

   b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be

conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2) For services that have already been rendered, a provider appeal is:

a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration – means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

MEMBER APPEALS

Information for providers seeking to represent a member in the member's appeal of an adverse benefit determination is located in Chapter III.

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division
Department of Medical Assistance Services
600 East Broad Street,
Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated

~~provider. This is the sole procedure available to state-operated providers.~~

~~The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.~~

~~Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.~~

~~The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.~~

~~The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.~~

~~CLIENT APPEALS~~

~~For client appeals information, see Chapter III of the Provider Manual.~~