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, Commonwealth Coordinated Care (CCC), Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (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 PRIVATE DUTY NURSING SERVICE PROVIDERS

The Department of Medical Assistance Services (DMAS) reimburses for private duty nursing rendered to individuals authorized for the service through the technology assisted waiver and the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) private duty nursing program. A participating provider for private duty nursing services must be licensed or certified as a Home Health agency by the Virginia Department of Health (VDH) for Medicare/Medicaid participation, must meet any additional standards and requirements set forth by DMAS, and must have a current, signed agreement with DMAS to provide private duty nursing services.

PRIVATE DUTY NURSING AGENCIES

Private duty nursing is defined as either continuous nursing provided as primary care for an individual or respite care nursing services designed to relieve the primary caregiver. Private duty nursing agencies provide professional nursing services to individuals in a home- or community-based setting in lieu of institutional care. DMAS must preauthorize Medicaid payment for private duty nursing for individuals who have been assessed and determined to require in-home nursing in order to safely remain in the home. Nurses employed by the private duty nursing agency will administer medications, treatments, and care according to a preauthorized plan of care which specifies the amount and type of care to be rendered. Private duty nursing must be provided by a registered nurse (RN) or licensed practical nurse (LPN) employed by a DMAS-approved private duty nursing provider. The policies in this manual apply to both continuous private duty nursing and respite care when provided by

nurses through a private duty nursing agency. Chapter IV of this manual contains a definition of both services.

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 the 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

42 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.

PROVIDER IDENTIFICATION NUMBER

Upon receipt of the above information, a ten-digit Atypical Provider Identifier (API) number will be assigned as the provider identification number is **assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.**

The provider will be sent a copy of the agreement upon approval of enrollment. DMAS will not reimburse the provider for any private duty nursing services rendered prior to the approval of enrollment in the Virginia Medicaid program.

PROVIDER PARTICIPATION STANDARDS

In order to be approved for a private duty nursing agreement with DMAS, the provider agency must:

- be licensed or certified as a home health agency by the Virginia Department of Health;
- meet the general requirements stated in this chapter; and
- employ nursing staff meeting the special participation requirements in this chapter.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply

program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive provider manuals or Medicaid memoranda because he or she has access to the publications as part of a group practice. To suppress the receipt of this information, the Xerox – Provider Enrollment Services Unit requires the provider to complete the Mail Suppression Form and return it to:

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

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Upon receipt of the completed form, Xerox PES will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

REVIEW OF PROVIDER PARTICIPATION AND RENEWAL OF CONTRACTS

Private duty nursing providers are continually assessed to ensure conformance with Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, high-quality care to a population in need of nursing home or hospital level of care.

Information used by DMAS to make this assessment includes DMAS' review of documentation submitted by the provider, as well as review of provider files and visits to recipient's homes. The DMAS assessment of the provider is based on a comprehensive evaluation of the provider's overall performance in the following areas:

- Consistency and continuity of care;
- Adherence to the plan of care;
- The plan of care;
- Progress notes;
- Quality of care;
- Health and safety needs of the recipient;
- Billing; and
- Supervisory visits

DMAS will review the provider's performance in all the areas of assessment to determine the provider's ability to achieve high quality of care (i.e., consistency and continuity) and conform to DMAS policies (e.g., supervisory visits, plans of care, etc.). The purposes of this assessment are to determine the frequency and level of review activity which will be conducted by DMAS and to provide feedback to the provider regarding those areas which may need improvement. All providers receive on-site reviews during which the analyst will review recipient files and conduct home visits to assess the quality of care and continued appropriateness of private duty nursing services.

Provider agreements are reviewed and renewed by DMAS every five years. DMAS staff will periodically review provider participation standards and conduct ongoing recipient utilization review.

GENERAL REQUIREMENTS

Providers approved for participation must perform all of the following activities, as well as any others specified by DMAS:

- Immediately notify Xerox-PES, in writing, of any change in the information that the provider previously submitted;
- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other 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;
- Accept referrals for services only when staff is available to initiate services;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin;
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;
- Provide services and supplies to recipients of the same quality and in the same mode of delivery provided to the general public;
- Charge DMAS 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 Medicaid payment from the first day of eligibility;
- Accept as payment in full the amount established by DMAS. 42 CFR § 447.15 requires 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 state. A 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 of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference.

The provider may not bill the recipient or DMAS for broken or missed appointments;

- 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 shall be maintained in a designated business office from which all private duty nursing provider agency business is conducted.

In general, such records must be retained for a period of not less than five years from the last date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. Records of minors must be kept for at least five (5) years after such minor has reached the age of 18 years.

Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS must be notified in writing of storage, location, and procedures for obtaining records for review should the need arise. The agent or trustee should be located within the Commonwealth of Virginia;

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

- Disclose, as requested by DMAS, 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 Medicaid;

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

- Employ and supervise professionally trained staff (meeting the requirements stated in this chapter) to provide private duty nursing services;
- Assure that no processing of bankruptcy or financial insolvency has been adjudicated or is pending in state or federal court and agree to inform DMAS of any action instituted with respect to financial solvency; and
- Have operated as a health care service provider prior to application for Medicaid private duty nursing provider status.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS 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

ADHERENCE TO PROVIDER CONTRACT AND SPECIAL PARTICIPATION CONDITIONS

In addition to the above, 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 private duty nursing providers. A key component of service programs is the continuous monitoring and re-evaluation activity provided by an agency contracted with DMAS to assure efficient and effective service delivery for waiver individuals. For Technology Assisted Waiver, this activity is performed by the Health Care Coordinator within DMAS' Long Term Care Division.

RECIPIENT CHOICE OF PROVIDER AGENCIES

If private duty nursing services are authorized, and there is more than one approved provider agency in the community, the individual will have the option of selecting the provider agency of his or her choice.

NURSING REQUIREMENTS

RN supervisors shall be currently licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience which may include work in an acute care hospital, long stay hospital, rehabilitation facility, or specialized care nursing facility. The RN supervisor's previous experience shall be documented in his/her agency personnel file.

The private duty nurse must either be a licensed practical nurse (LPN) or a registered nurse (RN) with a current and valid Virginia license. The decision to assign a registered or licensed practical nurse must be based on the needs of the recipient and the nurse's license restrictions. A licensed practical nurse cannot be assigned to perform activities which fall outside the nursing practices allowed and which should be performed by a registered nurse.

RN applicants do not meet the Medicaid requirement of having a valid Virginia nursing license.

In addition, each private duty nurse must demonstrate specialized experience and proficiency with delivery of nursing care to any population which has specialized needs (e.g., a ventilator-dependent individual) prior to assignment to such an individual.

All RNs and LPNs who provide skilled private duty nursing (PDN) services shall have either:

1) A minimum of six months of clinical experience related to the care needs of the assigned tech waiver individual such as ventilator, tracheostomy, nasogastric tube,

etc. (documented in their personnel file), that may include work in acute care hospitals, long stay hospitals, rehabilitation facilities, or specialized care nursing facilities; **or**

2) Have completed a provider training program related to the care and technology needs of the assigned tech waiver individual.

Nursing agencies that do not have a training program that meets the DMAS training program criteria shall continue to provide nurses with at least six (6) months of previous experience in the skills applicable to TW individuals to provide safe care (trachs, ventilators, etc.).

Training programs established by providers shall include, at a minimum, the following:

1. Trainers (RNs or Respiratory Therapists (RT) shall have at least six months clinical (hands on) successful experience in the areas they are providing training in such as ventilators, tracheostomies, peg tubes, nasogastric tubes. This experience must be documented in their personnel file or training records

2. Training shall include classroom time as well as direct clinical (hands on) demonstration of mastery of these skills by the trainee.

3. The training program shall include the following subject areas as they relate to the care to be provided by the TW nurse:

    a. Human Anatomy and Physiology
    b. Medications frequently used by technology dependent individuals
    c. Emergency management of equipment and individuals
    d. The operation of the relevant equipment.

4. Providers shall assure the competency and mastery of the above skills necessary to successfully care for TW individual by the nurses **prior** to assigning them to a TW individual. Documentation of successful completion of such training course and mastery of these skills shall be maintained in the provider's personnel records. The documentation shall be provided to DMAS upon request.

Training programs are not approved by DMAS but shall be included as part of provider reviews.

Documentation of the private duty nurse's knowledge, skills, and experience in the care of individuals with special needs and current CPR certification must be included in the nurse's personnel file. This is recorded on a skills checklist (DMAS-259) signed by the nurse

supervisor prior to the assignment of that nurse to a waiver recipient. The skills checklist may be one developed by the provider (approved by DMAS prior to its use) or the DMAS 259 developed by DMAS.

For a newly admitted individual, the orientation and skills checklist (DMAS 259) must be completed by the nursing supervisor for all nurses assigned to the case. When a recipient has been receiving services and a new nurse is assigned, the primary nurse can complete the orientation if he or she is an RN. If the primary nurse is a LPN, the nursing supervisor is responsible for the orientation.

Nurses providing skilled PDN/RC services cannot be parents (natural, adoptive, foster, legal guardians), spouses, siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual for the purpose of Medicaid reimbursement under the waiver.

Note: Documentation in personnel files (e.g., nursing license, CPR, skills checklist [DMAS 259]) must be maintained and available for five (5) years.

SCHEDULING AND SUPERVISION OF NURSING SERVICES

The nursing agency must designate a registered nurse to select and supervise the nursing staff providing direct care. A supervising RN must be available 24 hours per day to address concerns that may arise with TW individuals. The nursing supervisor is responsible for:

- Assessing the patient's status and needs;
- Reviewing the plan of care for appropriateness and recommending revisions when needed;
- Assuring that the assigned nurses have the necessary licensure and skills to provide safe care (skills checklist [DMAS 259]);
- Evaluating the quality of care provided by the agency nurses and recommending staffing changes where needed;
- Identifying any factors in the home environment that threaten the individual's ability to receive safe and appropriate care; and
- Communicating changes in the patient's status or plan of care to the health care coordinator, case manager, other services providers, family, and DMAS.

SUBSTITUTE NURSING SERVICES

The provider agency is responsible for ensuring that services are provided in accordance with the plan of care. Substitute nurses may be secured from another nursing provider agency for a temporary, short-term period (not to exceed two weeks). The provider agency having case responsibility must ensure that:

- All DMAS requirements continue to be met, including documentation requirements of services rendered and the qualifications of the nurses providing the care;
- Copies of the substitute nurses' licenses, training, and experience, as well as the daily log sheets, are obtained for the individual's record and the agency file;
- Nursing supervision will continue to be provided according to DMAS policies; and
- Services provided by the substitute nurse are billed to DMAS according to policy. (The two provider agencies involved are responsible for determining the financial arrangement for paying the substitute nurses.)

The Health Care Coordinator must be notified any time the provider is unable to staff a waiver service recipient and a qualified substitute nurse cannot be obtained. If another provider can be identified, the case should be transferred to that agency. The Health Care Coordinator must be notified immediately to assist with the transfer

PROVISION OF NURSING SERVICES OUTSIDE OF THE STATE

TW services may not be provided to an individual who resides or travels outside of the physical boundaries of the Commonwealth of Virginia, with the exception of brief periods of time as pre-approved by DMAS. Brief periods may include vacation, family emergencies/illness or medical appointments and are limited to the same skilled PDN hours approved for home based skilled PDN.

NURSING DOCUMENTATION REQUIREMENTS

Nursing documentation must clearly reflect the recipient's status and needs to enable an ongoing evaluation of the appropriateness of services and provide adequate accountability for all private duty nursing services rendered. The nursing documentation required by DMAS for private duty nursing services consists of the following:

- Daily Nursing Log

The nursing staff members providing direct care are responsible for recording in a daily nursing log the number of hours of service provided. This information can be recorded on a flow sheet indicating the dates, the time in and time out, special treatments, medications, vital signs, services by other providers, and pertinent information pertaining to the individual's condition. This verification of time must be signed by a caregiver or other person not employed by the nursing agency.

The nursing provider is required to maintain the last 2 weeks of nursing logs in the recipient's home each month for the Health Care Coordinator to review. Once removed from the home, nursing logs must be retained at the provider agency in

an orderly manner which facilitates review by the Health Care Coordinator and DMAS.

- Technology Assisted Waiver Supervisory Monthly Summary (DMAS 103)

The nursing supervisor is responsible for completing a home visit at least every 30 days and more frequently when indicated to provide oversight for all TW services in the home. The nursing supervisor must submit a report for each month (DMAS 103) to DMAS, completed in its entirety, within 5 days after the end of the month reported. A copy of the Technology Assisted Waiver Supervisory Monthly Summary (DMAS 103) is found in Appendix B.

- Nursing and Respite Care Revision

Services are authorized by DMAS and rendered according to a Plan of Care CMS-485 (POC-485) certified by a physician as medically necessary to enable the individual to remain at home rather than in a hospital or nursing facility. The type of service to be provided for an individual whose medical needs require nursing care and supervision will not differ whether offered through private duty nursing or respite care.

- OASIS (if required by the agency) or other reports

NOTE: All documentation must be maintained and available for at least five (5) years.

CHANGE OF OWNERSHIP

When ownership of the provider agency changes, DMAS must be notified within fifteen (15) calendar days. A new contract, notice of organizational structure, statements of financial solvency and service comparability, and full disclosure of all information required by this chapter relating to ownership and interest will be required.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no disabled individual shall, solely by reason of the disability, 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 is responsible for making provision for individuals with disabilities in its program activities.

In the event a discrimination complaint is lodged, DMAS is required to provide to the federal Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

TERMINATION OF PROVIDER PARTICIPATION

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.

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.) (the "APA"), the State Plan for Medical Assistance provided for in § 32.1-325 et seq. of the Code of Virginia and the DMAS appeal regulations at 12 VAC 30-20-500 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.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Subsection (c) of § 32.1-325 of the Code of Virginia 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 DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.