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CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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CHAPTER II

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 PROVIDER

A participating provider is an institution, facility, agency, partnership, corporation, or association that is licensed by the Virginia Department of Social Services and includes a specialty care unit designation and that has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

FREEDOM OF CHOICE

The individual shall have freedom of choice in the selection of a provider of services. Generally, payments are limited under the Medical Assistance Program to providers who are qualified to participate in the Program under Title XVIII and who have signed a written agreement with DMAS.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid program prior to billing for any services provided to Medicaid individuals. All providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment/Certification Unit. An original signature of the individual provider is required.

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. All providers must sign the appropriate Participation Agreement via electronic signature on the online enrollment application or sign the paper enrollment application and return it to the Provider Enrollment and Certification Unit. The authorized agent of the provider must sign an agreement for a group practice, hospital, or other agency or institution. The Virginia Medical Assistance Program must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

Note: Certification by the Virginia Department of Social Services, Division of Licensing Programs; the Division of Licensure and Certification of the Virginia Department of Health; or the Department of Behavioral Health and Developmental Services, does not constitute enrollment as a Medicaid provider.

Upon the receipt of the signed participation agreement, and the approval with signature by DMAS, a ten-digit Atypical Provider Identifier (API) number will be assigned as the provider identification number to each Alzheimer's Assisted Living (AAL) Facility provider. **DMAS will not reimburse the provider for any services rendered prior to assignment of this provider identification number.** The API number must be used on all billing invoices and correspondence submitted to DMAS or its provider enrollment contractor.

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 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 attachment 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.

PARTICIPATING ALZHEIMER'S ASSISTED LIVING WAIVER PROVIDER

A participating Alzheimer Assisted Living (AAL) Facility services provider must meet the Virginia Department of Social Services (VDSS) licensing standards, must meet the standards and requirements set forth by the Virginia Department of Medical Assistance Services (DMAS), and must have a current, signed participation agreement with DMAS.

Maintenance of Good Standing with VDSS Division of Licensing Programs

The assisted living facility (ALF) must be in good standing with the VDSS Division of Licensing Programs and in compliance with the VDSS licensure requirements for assisted living facilities (22VAC40-71-10 *et seq*.). DMAS and VDSS will share with each other information on facilities which are not in compliance with program requirements of either state agency.

This chapter specifies the requirements for approval to participate as a Medicaid provider. Any provider contracting with DMAS to provide services agrees as part of the provider participation agreement to adhere to all the policies and procedures in this provider manual in addition to federal and state regulations.

DMAS will contract only with ALFs licensed by VDSS to provide Alzheimer Assisted Living (AAL) Services and in compliance with VDSS licensure requirements for ALFs and must ensure that all applicants and residents have been assessed in accordance with the VDSS assessment and case management regulations. (22VAC40-745-10 *et seq*.)

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 continued 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 REQUIREMENTS

Requirements for providers approved for participation include, but are not limited to, the following:

- Immediately notify the Contractor's Provider Enrollment Services Unit, in writing, whenever there is a change in any of the information that the provider previously submitted.
- Obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid individuals.
- Ensure freedom of choice to individuals seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed.
- Ensure the individual's individual freedom to reject medical care and treatment.
- 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 § 504 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 individuals of the same quality and in the same mode of delivery as provided to the general public.

- Charge DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public.

- Not require, as a precondition for admission, any period of private pay or a deposit from the individuals or any other party.

- Accept Medicaid payment from the first day of eligibility if the provider was aware that a individual's application for Medicaid eligibility was pending at the time of admission.

- Accept as payment in full the amount established by DMAS. 42 CFR § 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 an individual for a covered service regardless of whether the provider received payment from the state. A provider may not seek to collect from a Medicaid individual, or any financially responsible relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered. The provider may not bill DMAS or individual for broken or missed appointments.

- Reimburse the individual or any other party for any monies contributed toward the individual's care from the date of eligibility. The only exception is when an individual is "spending down" excess resources to meet eligibility requirements.

- Accept assignment of Medicare benefits for eligible Medicaid individual.

- Use DMAS-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. 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. (Refer to Chapter VI of this manual on record documentation requirements)

- 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 individuals of medical assistance.

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

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act, as amended (29 U.S.C. § 794), provides that no individual with a disability 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 his or her program activities.

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

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, state, or local programs; coverage provided under federal or state law; other insurance; or third-party liability.

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- Title XVIII (Medicare) - Virginia Medicaid will pay the amount of any deductible or coinsurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.

- Workers' Compensation - No Medicaid program payments shall be made for an

individual covered by Workers' Compensation.

• Other Health Insurance - When an individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

• Liability Insurance for Accidental Injuries - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid individuals who receive medical care as the result of the negligence of another. If a individual is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to enforce its lien established under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability, or if the individual reports a third-party responsibility (other than those cited on his Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the provider is requested to forward the DMAS-1000 to:

Third-Party Liability Casualty Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION

All physician or other health care professionals' documentation, including certifications, must be signed with the initials, last name, and title. DMAS will allow the use of rubber stamps for physician signatures when the use is consistent with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation requirements and physician documentation. When a rubber stamp is used, the individual whose signature the stamp represents must provide DMAS, upon request, with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. All rubber-stamped signatures are also required to be accompanied by the initials of the physician. **The signature waiver form must be received 30 days prior to the date of the anticipated use of the rubber stamp.** All documentation must be completely dated with the month, day, and year.

DOCUMENTATION OF MEDICAL RECORDS

The Provider Agreement requires that the medical records fully disclose the extent of services provided to Medicaid individual. The following elements are a clarification of Medicaid policy regarding documentation for medical records:

The medical record must identify the individual on each page.

- Entries must be signed and dated by the responsible licensed participating provider. 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.

- The medical record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.

- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the medical record.

- The medical record must indicate the individual's progress or lack thereof, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written for every office, clinic, or hospital visit billed to Medicaid.

For more detailed information regarding documentation of medical records, refer to Chapter VI of this manual.

REVIEW AND EVALUATION

Program Integrity Reviews:

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services of providers and by individuals. This function is handled by the Virginia Medical Assistance Division of Program Integrity Provider and individual utilization patterns to be reviewed are identified either from computerized exception reports or by referrals from agencies or individuals. To ensure a thorough and fair review, trained professionals review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Providers will be required to refund Medicaid if they are found to have billed Medicaid contrary to policy, failed to maintain records to support their claims, or billed for medically unnecessary services. Due to the provision of poor quality services or of any of the above problems, Medicaid may limit, suspend, or terminate the provider's participation agreement.

Providers selected for review will be contacted directly by personnel with detailed instructions. This will also apply when information is requested about an individual or when a individual is restricted to the physician or pharmacy, or both, of his or her choice

because of misutilization of Medicaid services.

Additional information on Program Integrity utilization review activities and on physician certification of the need for care may be found in Chapter VI of this manual.

Quality Management Reviews:

Quality management reviews are conducted annually. DMAS staff or another DMAS designees will review provider compliance with participation standards during quality management review. Refer to Chapter VI of this manual for more information detailing medical record documentation requirements.

Annual Level of Care Reviews:

DMAS in compliance with 1915(c) Centers for Medicare and Medicaid Services (CMS) Waiver Assurances conducts annual level of care reviews for each individual enrolled in the AAL waiver program. This review based on the documentation submitted by the AAL waiver provider and are performed to ensure that individuals receiving services in the AAL waiver continue to meet the criteria for the AAL waiver.

If during an annual level of care review, it is determined that an individual no longer meets the established criteria for the AAL waiver services, the ALF will inform the authorized representative for the individual. Notification by the ALF to the authorized representative must be made within 10 days (plus 3 days for mailing) of receipt of official notification by DMAS. Appeal rights are explained later in this chapter.

FRAUD

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or their agent to obtain or seek direct or indirect payment, gain, or item of value for services rendered or supposedly rendered to individuals under Medicaid. A provider participation agreement will be terminated or denied in cases where a provider is found guilty of fraud.

Investigation of allegations of provider fraud is the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General of Virginia. Provider records are to be made available to personnel in this unit for investigative purposes. Further information on submission of fraudulent claims may be found in Chapter V and Chapter VI of this manual.

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided the DMAS Director and Contractor – PES thirty (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 individuals 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 *Code of Virginia* §32.1-325D and E. The provider may appeal the decision in accordance with the Administrative Process Act (*Code of Virginia* §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.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Section 32.1-325(c) 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.

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 provider/program-specific program information. Providers enrolled at multiple locations or who are a member of a group using one central office may receive multiple copies of manuals, updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing a written request to the Contractor Provider Enrollment Services Unit at the address given under "Requests for Participation" stated earlier in this chapter.

AREAS OF SERVICE

The provider notes on the application what localities (cities and counties) the provider wishes to serve. The provider must be able to adequately staff and supervise staff in any locality served by the provider's office. The provider may maintain separate provider agencies/facilities.

The provider should submit a provider application for each separate location which, upon approval, will be issued a separate provider identification number and will be expected to maintain all files related to individuals served by the location and to bill for those individuals from the office.

A differential rate is established for providers that are providing services to individuals residing in the Northern Virginia localities to reflect the higher cost of operating in these localities (both higher capital and wage costs).

PROVIDER MAILINGS

Providers may choose to have their payments sent to one location and their other mailings, such as memorandums or letters, sent to another location within their organization. The provider may visit the DMAS website or contact the Contractor – Provider Enrollment Services Unit PES), if this is an option a provider would like to explore.

DIRECT MARKETING

All participating Medicaid providers are prohibited from performing all types of direct marketing activities to Medicaid individuals. "Direct marketing" means directly or indirectly conducting door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; mailing directly; paying "finder's fees"; offering financial incentives, rewards, gifts, or special opportunities to eligible individuals as inducements to use their services; continuous, periodic marketing activities to the same prospective individual (e.g., monthly, quarterly, or annual "give-aways") as inducements to use their services; or engaging in marketing activities that offer potential customer rebates or discounts in conjunction with the use of their services or other benefits as a means of influencing individuals' use of providers' services.

BUSINESS OFFICE

The provider must operate from a business office, which is staffed and provides accessible staff space, files, business telephones for the individual to contact the provider when necessary, and an address for receipt of mail and forms.

INDIVIDUAL CHOICE OF PROVIDER

At the time individuals are approved for services, the Pre-Admission Screening (PAS) Team must inform the individual of available service providers and (1) that they have the option of selecting their providers and (2) provide a list of service providers from which to

choose.

ADVANCE DIRECTIVES

At the time of their admission to services, all providers participating in the Medicare and Medicaid programs must provide adult individuals with written information regarding each individual's right to make medical care decisions as outlined in this section. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and relating to the provision of such care when the individual is incapacitated. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require individuals to execute an advance directive.

Under the law, providers must:

- Provide all adult individuals with written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives, as well as the provider's written policies respecting the implementation of such rights;
- Inform individuals about the provider's policy on implementing advance directives;
- Document in the individual's medical record whether he or she has signed an advance directive;
- Not discriminate against an individual based on whether he or she has executed an advance directive; and
- Provide staff and community education on advance directives.

ADULT PROTECTIVE SERVICES

Adult Protective Services (APS) are provided through the Department of Aging and Rehabilitation Services (DARS). Services are provided to prevent abuse, neglect, or exploitation of an adult or an individual with a disability. This includes an investigation to determine the need for protective services and provision of those activities, resources, and supports necessary to detect, reduce, prevent, or eliminate abuse, neglect, or exploitation. Services are provided across all long-term care settings including ALFs. Certain persons are mandated by the Code of Virginia to report all suspicion of abuse, neglect, or exploitation to the local department of social services APS unit. Mandated reporters include persons licensed to practice medicine or any of the healing arts, persons employed in the nursing profession, and persons employed by a public or private agency or facility working with adults. Reports of alleged abuse, neglect, or exploitation should be made to

the local department of social services' APS unit or to the statewide, 24-hour toll-free hotline at 1-888-83ADULT.

MEDICAID STAFF TO CONTACT WHEN QUESTIONS ARISE

When AAL waiver providers have questions regarding level-of-care decisions, completion of forms, or DMAS policies and procedures concerning AAL Services in ALFs they should contact the DMAS Provider Help Line at (888) 552-8627.

INDIVIDUAL RIGHTS AND RESPONSIBILITIES

As provided in §63.2-1805 of the Code of Virginia, the AAL services provider must establish written policies and procedures to ensure that, at a minimum, each person who becomes a resident of the ALF is fully informed, prior to or at the time of admission and during the resident's stay, of his or her rights and responsibilities. The statute further states that the residence must provide a copy of these rights to each resident and must include in them the name and telephone number of the VDSS regional licensing supervisor, the Virginia Long-Term Care Ombudsman Program, and the Virginia Office for Protection and Advocacy.

The provider must have a written statement of the individual rights, which clearly states the responsibilities of both the provider and the individual in the provision of care. This statement of individual rights must be signed by the individual and/or the authorized representative, and the provider representative at the time services are initiated. This statement must be maintained in the individual's medical record, and a copy must be given to the authorized representative. The statement of individual rights must include the following:

- The provider's responsibility to notify the individual, in advance, in writing of any action taken which affects the individual's services;
- The provider's responsibility to render services according to acceptable standards of care;
- The provider's procedures for patient pay collection;
- The individual's obligation for patient pay, if applicable;
- The provider's responsibility to make a good faith effort to provide care according to the scheduled plan of care and to notify the individual when unable to provide care;
- The provider's responsibility to treat the individual with respect, to respond to any questions or concerns about the care rendered, and to routinely check with the individual and/or his/her authorized representative about his/her satisfaction with the services being rendered;
- Offer the individual choice of provider agencies or services, when applicable; and
- The individual's authorized representative's responsibility to treat provider staff with respect and to communicate problems immediately to the appropriate provider staff.

APPEALS OF ADVERSE ACTIONS

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse actions that afford appeal rights to providers.

A provider may appeal an adverse decision where a service has already been provided, by filing a written notice for a first-level Informal Appeal with the DMAS Appeals Division **within 30 calendar days** of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 6th Floor
Richmond, VA 23219

If the provider is dissatisfied with the first-level Informal Appeal decision, the provider may file a written notice for a second-level appeal Formal Appeal, which includes a full administrative evidentiary hearing under the Virginia Administrative Process Act (APA), *Code of Virginia,* § 2.2-4000 et seq. The notice for a second-level Formal Appeal must be filed **within 30 calendar days** of receipt of the first-level Informal Appeal decision. The notice for second-level Formal Appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 6th Floor
Richmond, VA 23219

Administrative appeals of adverse actions concerning provider reimbursement are heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the *Code of Virginia*) (the APA), the State Plan for Medical Assistance provided for in §32.1-325 of the *Code of Virginia*. The DMAS appeal regulations at 12 VAC30-20-500 et. seq. Review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

If the provider is dissatisfied with the second-level Formal Appeal decision, the provider may file an appeal with the appropriate county circuit court, in accordance with the APA and the Rules of Court.

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall

be untimely.

The provider may not bill the individual 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.

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.

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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.