CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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CHAPTER II

The Virginia Medicaid Program covers Psychiatric Services in both inpatient and outpatient settings. This chapter describes provider requirements for Psychiatric Services. All providers of psychiatric services are responsible for adhering to all DMAS policies, this manual, available on the DMAS website portal, their provider contract with the Managed Care Organization (MCOs) and the Behavioral Health Services Administrator (BHSA), and state and federal regulations.

MANAGED CARE ORGANIZATIONS

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted MCOs and their network of providers. All providers must check Medicaid member eligibility (Refer to Chapter 3) prior to rendering services to confirm whether an individual is enrolled in a Medicaid MCO and which particular MCO. To provide psychiatric services to an individual enrolled in a Medicaid MCO, providers need to be credentialed with the MCO that an individual is enrolled in to provide services to that individual.

There are several different managed care programs (Medallion 3.0, Medallion 4.0 (effective 8/1/2018), and Commonwealth Coordinated Care (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:

- http://www.dmas.virginia.gov/#/med3 (Medallion 3.0)
- http://www.dmas.virginia.gov/#/cccplus (CCC Plus) and
- http://www.dmas.virginia.gov/#/med4 (Medallion 4.0)
- http://www.dmas.virginia.gov/#/longtermprograms (PACE)

Even if the individual is enrolled with an MCO, some services may continue to be covered by Medicaid Fee-for-Service (FFS). Providers must follow the FFS rules in these instances where services are "carved-out." The carved-out services vary by managed care program. For example, Early Intervention is carved-out of the Medallion 3.0 program and covered by FFS Medicaid but covered by the CCC Plus and the Medallion 4.0 programs. Refer to each program's website for detailed information and the latest updates.

Commonwealth Coordinated Care (CCC) Plus

CCC Plus is a mandatory integrated care initiative for certain qualifying individuals, including dual eligible individuals and individuals receiving long term services or supports (LTSS). The CCC Plus program includes individuals who receive services through Nursing

Facility (NF) care, or from one of the Department's home and community-based services (HCBS) 1915(c) waivers.

At this time, individuals enrolled in a Medicaid waiver 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) are enrolled in CCC Plus for their non-waiver services only; the individual's DD waiver services continue to be covered through the Medicaid FFS program.

Medallion 4.0

Medallion 4.0 is a new Medicaid Managed Care Program effective August 1, 2018. Individuals enrolled in Medallion 3.0 will transition by region into Medallion 4.0. The Medallion 3.0 program will end on December 31, 2018. Several services, including Community Mental Health Rehabilitative Services (CMHRS) and Early Intervention, that were not included in the Medallion 3.0 contract will be included in the Medallion 4.0 contract. Additional information is available on the DMAS website http://www.dmas.virginia.gov/#/med4 and in Medicaid Memos to providers dated January 8, 2018 and June 11, 2018 available on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

PACE

The Program of All-inclusive Care for the Elderly (PACE) was established to help adults ages 55+ who are living with chronic healthcare needs and/or disabilities receive community-based healthcare services and supports. By providing flexibility in how participants' healthcare needs are met, PACE is often able to assist persons meeting functional nursing home level of care to reside within their own homes and communities longer than would have otherwise been possible.

For additional information, visit: http://www.dmas.virginia.gov/#/longtermprograms.

MAGELLAN OF VIRGINIA

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and direction of the FFS behavioral health benefits program under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

Providers under contract or who have questions about credentialing/contracting process with Magellan of Virginia should consult Magellan's National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider. Magellan of Virginia works with DMAS to improve access to quality behavioral health services and improve the value of behavioral health services purchased by the Commonwealth. Magellan of Virginia administers a comprehensive care coordination model, which is expected to reduce unnecessary expenditures. Other benefits of the Magellan of Virginia model include:

- Comprehensive care coordination including coordination with Medicaid/FAMIS managed care plans;
- Promotion of more efficient utilization of services;
- Development and monitoring of progress towards outcomes-based quality measures;
- Management of a centralized call center to provide eligibility, benefits, referral and appeal information;
- Provider recruitment, issue resolution, network management, and training;
- Service authorization;
- Member outreach, education and issue resolution; and
- Claims processing and reimbursement of behavioral health services that are currently carved out of Medicaid/FAMIS managed care.

Magellan of Virginia is responsible for enrollment and credentialing of FFS behavioral health providers based upon DMAS regulatory requirements.

Magellan of Virginia Call Center has a centralized contact number **(1-800-424-4046)** for Medicaid/FAMIS members and providers. The Call Center is located in Virginia and is available 24 hours a day, 365 days a year. Staff include bilingual/multi-cultural representatives who speak English and Spanish. Interpreter services, TDD/TTY and relay services are available for individuals with a hearing impairment. The TDD number is 1-800-424-4048.

All calls related to the fee for service behavioral health services should go to Magellan of Virginia Call Center. Magellan of Virginia staff are available to assist callers with:

- service authorizations,
- clinical reviews,
- member eligibility status,
- referrals for services,
- provider network status,
- claims resolution, and
- grievances and complaints.

Enrolled providers are encouraged to integrate Magellan of Virginia's requirements and procedures into their day-to-day operations as a Medicaid provider.

Verifying Eligibility

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility and MCO enrollment. 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: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. 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.

RECOVERY AND RESILIENCY

DMAS encourages the provider network to integrate principles into their practices and service delivery operations including providing high quality, consumer-focused, recovery-based behavioral health services for individuals enrolled in Virginia Medicaid. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations (https://www.samhsa.gov/recovery).

A person's recovery is built on his or her strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members. Because recovery is a highly individualized process, recovery services and supports must be flexible to ensure cultural relevancy.

Resilience refers to an individual's ability to cope with adversity and adapt to challenges or change. Resilience develops over time and gives an individual the capacity not only to cope with life's challenges but also to be better prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resilience and the process of recovery.

A recovery focus is also a preventive approach that simultaneously supports building resiliency, wellness, measureable recovery and quality of life.

CULTURAL AND LINGUISTIC COMPETENCY

DMAS encourages providers to demonstrate an understanding and respect for each individual's health-related beliefs and cultural values through the establishment of policies, practices and allocation of resources that support culturally and linguistically appropriate

services. Culture has a significant impact on how people of different backgrounds express themselves, seek help, cope with stress and develop social supports. It also affects every aspect of an individual's life, including how they experience, understand, and express, mental and emotional distress, illness and conditions.

Development of cultural and linguistic competency means that providers have the ability to value diversity, adapt to diverse populations, obtain any needed education and training in order to enhance cultural knowledge, work within values and beliefs that may be different from their own, and be capable of evolving over extended periods of time as cultures change.

Providers licensed by the Department of Behavioral Health and Developmental Services (DBHDS) should refer to DBHDS for guidance in this area.

PARTICIPATION REQUIREMENTS

To be a network provider of behavioral health services in the Virginia Medicaid/FAMIS programs, providers must be credentialed and enrolled according to DMAS standards with the BHSA and/or a Medicaid MCO. Providers are subject to applicable licensing requirements. Additionally, any licensed practitioner joining a contracted group practice or a contracted organization adding a newly licensed location must also become credentialed with the BHSA and/or a Medicaid MCO prior to rendering services.

All participating Medicaid providers are required to complete a new contract agreement as a result of any name change or change of ownership. Upon completion of the enrollment process, a ten-digit Atypical Provider Identifier (API) will be assigned as the provider identification number for non-healthcare providers. Healthcare providers are required to submit their National Provider Identifier (NPI) number. The API or NPI number must be used on all claims and correspondence submitted to DMAS or its contractor.

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

For any additional questions about FFS credentialing and contracting with Magellan of Virginia, providers may contact a Magellan of Virginia Provider Network Coordinator at 1-800-424-4536, or send an email to VAProviderQuestions@MagellanHealth.com. For additional questions about contracting with a Medicaid MCO, providers should contact the MCO directly. Medicaid Managed Care information is available under "Managed Care Benefits" at http://www.dmas.virginia.gov/#/index.

PROVIDER QUALIFICATIONS

Inpatient Hospital

All individuals enrolled in Medicaid may receive inpatient psychiatric care in a psychiatric unit located within an acute care hospital. Individuals over the age of 65 may also receive services in a freestanding psychiatric hospital. Individuals under the age of 21 may also receive psychiatric services in a freestanding psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The facility must also meet state licensure requirements.

Services Provided Under Arrangement

The inpatient psychiatric services benefit shall include services provided under arrangement when furnished by Medicaid enrolled providers other than the inpatient psychiatric facility, as long as the inpatient psychiatric facility (i) arranges for and oversees the provision of all services, (ii) maintains all medical records of care furnished to the individual, and (iii) ensures that the services are furnished under the direction of a physician. Services provided under arrangement shall be documented by a written referral from the inpatient psychiatric facility. For purposes of pharmacy services, a prescription ordered by an employee or contractor of the facility who is licensed to prescribe drugs shall be considered the referral. See the chart below for services provided under arrangement with the treating facility that may be billed separately from the per diem for each provider type, provided that the requirements discussed in this section are met. No other services may be billed separately from the inpatient psychiatric per diem for members under age 21 residing in a psychiatric unit located within an acute care hospital or a freestanding psychiatric hospital.

Services Provided Under Arrangement	Private Freestanding Psychiatric Hospitals and Psychiatric Units located within Acute Care Hospitals	State Freestanding Psychiatric Hospitals
Physician Services	Yes	No
Other medical and psychological services including those furnished by licensed mental health professionals and other licensed or certified health professionals (i.e. oral surgeons, nutritionists, podiatrists, respiratory therapists, substance abuse treatment practitioners)	Yes	No

Outpatient Hospital Services	Yes	No
Pharmacy services	No	Yes
Physical therapy, occupational therapy and therapy for individuals with speech, hearing or language disorders	Yes	No
Laboratory and radiology services	Yes	No
Durable medical equipment (including prostheses/orthopedic services and supplies and supplemental nutritional supplies)	No	No
Vision services	Yes	No
Dental and orthodontic services	Yes	No
Non-Emergency Transportation services	Yes	No
Emergency services (including outpatient hospital, physician and transportation services)	Yes	Yes

In order for DMAS to reimburse these services separately from the per-diem rate paid to providers of inpatient psychiatric services, the Centers for Medicare and Medicaid Services (CMS) requires that the provider:

1. arrange for and oversee the provision of all services;
2. maintain all medical records of services provided under arrangement furnished to the member while receiving inpatient psychiatric services;
3. ensure that each member receiving inpatient psychiatric services has a comprehensive plan of care that includes services provided under arrangement; and
4. ensure that all services, including services provided under arrangement, are furnished under the direction of a physician.

If these requirements are not met, DMAS or its contractor will not reimburse for these services and providers may not charge members directly. These requirements apply to both in-state providers and out-of-state providers. These requirements also apply across all contractors who administer claims on behalf of DMAS and reimburse for inpatient psychiatric services.

Requirements for Direct Reimbursement to Providers of Services Provided Under Arrangement

DMAS or its contractors will reimburse services provided under arrangement separately from

the per-diem rate paid to inpatient psychiatric provider only if the provider meets all of the following requirements:

1. As required by regulations (42 CFR 441.155; 42 CFR 456.180; and 12 VAC 30-50-130), each initial and comprehensive plan of care must be specific to meet each child's medical, psychological, social, behavioral and developmental needs.

   Each initial and comprehensive plan of care must include, within one (1) calendar day of the initiation of the service provided under arrangement, any service that the individual needs while residing in the inpatient psychiatric setting, and that is furnished to the member by a provider of services under arrangement. Physicians may implement the change to the plan of care by telephone, provided that the documented change is signed by the physician as soon as possible, and not later than the next 30-day plan review. Services provided under arrangement must be included in the plan of care -- documentation in the assessment, progress notes, or elsewhere in the medical record will not meet this requirement.

2. Each initial and comprehensive plan of care must document the prescribed frequency and circumstances under which the services provided under arrangement shall be sought.

3. Each provider must document a written referral for each service provided under arrangement, and must maintain a copy of the referral in the member's medical record at the facility. The provider of the service under arrangement must also maintain a copy of the referral in the member's medical record. The referral must be consistent with the plan of care. A physician order will meet the requirement for a referral. For pharmacy services, the referral is the prescription. The prescribing provider must be employed or have a contract with the facility. Referrals must be documented when the provider has accepted the referral. A referral should not be documented when the provider does not accept the referral.

4. Providers of services under arrangement must either be employees of the inpatient psychiatric provider or, if they are not employees of the inpatient psychiatric provider, they must have a fully executed contract with the inpatient psychiatric provider prior to the provision of the service, with the exception of emergency services. For emergency services, the contract must be executed before the provider of emergency services bills DMAS for the emergency services.

   The contract must include the following:

   a. if the provider of services under arrangement accepts a referral, it agrees to include the NPI of the referring inpatient psychiatric provider on its claim for payment; and

b. the provider of services under arrangement agrees to provide medical records related to the member residing in the inpatient psychiatric provider upon request by the inpatient psychiatric provider.

A fully executed contract requires that a representative of the inpatient psychiatric provider and a representative of the provider of services under arrangement signs the contract and includes their name, title, and date. A letter of understanding or letter of agreement will meet the requirement for a contract, provided that both the inpatient psychiatric provider and provider of services under arrangement sign and date the letter.

5. Each inpatient psychiatric provider must maintain medical records from the provider of services under arrangement in the individual's medical record at the facility. These may include admission and discharge documents, treatment plans, progress notes, treatment summaries and documentation of medical results and findings. These records must be requested in writing by the inpatient psychiatric provider within seven (7) calendar days of discharge from or completion of the service provided under arrangement. If the records are not received from the provider of services under arrangement within 30 days of the initial request, they must be re-requested or DMAS or its contractor may retract the per diem reimbursement made to the IPF on behalf of a member during the period of non-compliance.

If there is the potential for retroactive Medicaid eligibility, the inpatient psychiatric provider should comply with these requirements so that the provider of services under arrangement can bill Medicaid after eligibility is confirmed.

The provider must follow special billing instructions described in Chapter V.

The requirements above are in addition to all other existing requirements for services. For example, providers of services under arrangement must still obtain service authorization for services that otherwise require service authorization.

Special Instructions for Dental, Pharmacy, Emergency Services, Non-Emergency Transportation and Inpatient Acute Care Services

Dental services for Medicaid members are provided through Smiles for Children and are reimbursed by the Department's Dental Benefits Administrator (DBA), DentaQuest. Inpatient psychiatric providers that currently arrange for dental services should continue to do so based on the member's Plan of Care. Inpatient psychiatric providers must have a contract with a Smiles for Children participating dentist and must provide a referral to that dentist's office when the appointment is made for one of their residents/patients. The inpatient psychiatric provider shall provide the name of its contracted dentist to the Department or DentaQuest upon request.

Pharmacies must have a contract with the inpatient psychiatric provider. DMAS will use the prescribing NPI as the referral NPI. The prescription can serve as the referral document. The prescribing provider must be an employee or contractor of the inpatient psychiatric provider.

Inpatient psychiatric providers should include emergency services in the plan of care and contract in advance with the usual providers of emergency services. If the inpatient psychiatric provider uses a non-contracted provider for emergency services, the inpatient psychiatric provider may contract with the emergency services provider after the fact. The emergency services provider must have a contract in place with the inpatient psychiatric provider provider prior to billing DMAS. A referral is required for emergency services, and the emergency services provider must include the NPI of the IPF in the referring provider locator on the claim for payment.

Some providers are affiliated with hospitals but provide outpatient services as a separate billable item from the hospital charge (such as radiologists, pathologists, anesthesiologists, etc.). The acute-care hospital shall be responsible for providing the referral NPI of the inpatient psychiatric provider to these "hidden" providers. These "hidden" providers must be addressed in the contract between the inpatient psychiatric provider and the hospital that provides the emergency services.

Inpatient psychiatric providers that use the Fee for Service (FFS) Non-Emergency Medical Transportation (NEMT) broker for medical transportation must have a contract with the FFS NEMT broker which allows non-emergency transportation to be provided as a service provided under arrangement. When the member receiving inpatient psychiatric services needs transportation, the IPF should contact the FFS NEMT broker reservation number (866-386-8331) or use the FFS NEMT broker online request system https://transportation.dmas.virginia.gov in order to arrange transportation services prior to the date transportation is required. Please make the members FFS NEMT reservations five business days in advance. This request for transportation will be considered the "referral". Inpatient psychiatric providers enrolled with the FFS NEMT broker must 1) inform the FFS NEMT broker that they are an inpatient psychiatric provider; and 2) provide the transportation contractor with the inpatient psychiatric provider name and if needed the NPI number to use as an assigned provider. The inpatient psychiatric provider's NPI will be used by the broker on the transportation encounter that is submitted to DMAS.

Inpatient admissions to acute care hospitals for treatment of acute care conditions do not require a referral or arrangement from the inpatient psychiatric provider. However, the inpatient psychiatric provider must report all patient discharges from their facility to Magellan or the MCO within one business day. Failure to notify Magellan or the MCO will result in any claims associated with the inpatient acute care stay being denied.

If the inpatient psychiatric provider fails to comply with any one of the requirements listed above, DMAS or its contractor may retract the per diem reimbursement made to the inpatient

psychiatric provider on behalf of a member during the period of non-compliance.

An inpatient psychiatric provider may arrange for services for members with providers who are not enrolled with DMAS. As long as these services are included in the plan of care, the inpatient psychiatric provider is in compliance. The inpatient psychiatric provider should not arrange for services with a DMAS enrolled provider without either an employee relationship or an executed contract as this could result in a retraction to the per diem during an audit.

For information on services provided under arrangement to individuals under the age of 21 in Psychiatric Residential Treatment Facilities (PRTFs), please refer to the Residential Treatment Services Manual.

Additional information related to billing for services under arrangement is located in Chapter V of this manual.

Psychiatric Residential Treatment

As of June 30, 2017, Psychiatric Residential Treatment Facility services are defined in the Residential Treatment Services manual.

Treatment Foster Care Case Management

As of August 1, 2018, Treatment Foster Care Case Management services are defined in the Community Mental Health Rehabilitative Services Manual.

Enrolled Psychiatric Services Providers

Only facilities, licensed individuals, Mental Health Clinics, Federally Qualified Health Centers, and Rural Health Clinics enrolled as Medicaid providers may bill Virginia Medicaid for outpatient psychiatric services.

Community Services Boards (CSBs) can provide outpatient psychiatric services where qualifying providers bill under the facility NPI and are not required to operate under the physician-directed model for all services. CSBs can also bill as a mental health clinic for physician-directed services.

Provider Qualifications for Outpatient Psychiatric Services

Outpatient psychiatric services includes an array of therapeutic services designed to provide necessary support and address mental health and behavioral needs in order to diagnose, prevent, correct, or minimize the adverse effect of a psychiatric or substance use disorder.

Outpatient psychiatric services may be provided by:

- "Licensed mental health professional" or "LMHP" means the same as defined in 12VAC35-105-20.

- "LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling.

- "LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology.

- "LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

Providers should consult with the Medicaid MCOs to determine if they recognize unlicensed providers (LMHP-R/RP/S) in outpatient psychiatric settings prior to providing services.

Direct Supervision of Residents and Supervisees

When plans of care and psychotherapy or counseling services are provided by a LMHP-R, LMHP-RP or LMHP-S, to support the billing of these services, the licensed supervisor must ensure that:

- Therapy or counseling sessions rendered by a LMHP-R, LMHP-RP or LMHP-S must be provided under the direct, personal supervision of a licensed, qualified, Medicaid enrolled provider.
- The therapy session must contain at a minimum the dated signature of the LMHP-R,

LMHP-RP or LMHP-S rendering the service but also include the dated signature of the qualified, Medicaid enrolled, licensed supervising provider.

- Each therapy session must contain the dated co-signature of the supervising provider within one business day from the date the service was rendered indicating that he or she has reviewed the note. The direct supervisor can be the licensed program supervisor/manager for the agency.

Physician Requirement for Mental Health Clinics

This section only applies to providers enrolled with Medicaid as a Mental Health Clinic provider type. Code of Federal Regulations (CFR) §42.440.90 define clinic services as: "Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

a) Services furnished at the clinic by or under the direction of a physician or dentist.

b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address."

Federal law requires that each mental health clinic be physician-directed.

"As stipulated by section 1905 (a)(9) of title XIX of the Social Security Act, this requirement does not mean that the physician must necessarily be an employee of the clinic, or be utilized on a full time basis or be present in the facility during all the hours that services are provided. However, each patient's care must be under the supervision of a physician directly affiliated with the clinic. To meet this requirement, a physician must see the patient at least once, prescribe the type of care provided, and, if the services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when his/her patient is receiving covered services, the physician must assume professional responsibility for the services provided and assure that the services are medically appropriate. Thus, physicians who are affiliated with the clinic must spend as much time in the facility as is necessary to assure that patients are getting services in a safe and efficient manner in accordance with accepted standards of medical practice. For a physician to be affiliated with a clinic there must be a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided to the clinic's patients. Some clinics will require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement."

The requirement for physician supervision of all patient care in the clinic is a condition of participation with Medicaid and as a mental health clinic. The patient care protocols for treatment of individuals enrolled with Medicaid must reflect the role of the physician,

and the patient's medical records must document that the physician has ordered the plan of care and is periodically reviewing the need for continued care. This requirement must be met for all clinic services billed to Medicaid by any employee of the mental health clinic.

ADVERSE OUTCOMES

Providers must notify Magellan of Virginia or the appropriate MCO of member adverse outcomes within one business day following knowledge of the incident. Adverse outcomes are defined as: death; suicide or serious suicide attempt; an incident of violence initiated by the individual; or other incidents resulting in serious harm to the individual or others that includes but is not limited to serious complication from a psychotropic medication regimen that required medical intervention.

Providers must follow notification or reporting processes required by applicable Local, State and Federal regulatory bodies or contracts with the MCOs and BHSA.

FREEDOM OF CHOICE

The individual has the right to choose to receive services from any Medicaid-enrolled provider of services. However, payments under the Medical Assistance Program are limited to providers who meet the provider participation standards and who have signed a written agreement with the Department of Medical Assistance Services or its contractor.

OUT-OF-STATE FACILITIES

Inpatient Psychiatric facilities, including psychiatric units within an acute care hospital and freestanding psychiatric hospitals, that are out of state must be enrolled with DMAS or its contractor. Out of state providers must follow the requirements of both this manual, *Psychiatric Services* and of the *Hospital* Provider Manual regarding acute care hospitals providing inpatient psychiatric services.

Freestanding psychiatric hospitals and psychiatric units within an acute care hospital located out of state must abide by the *Psychiatric Services* manual.

SPECIFIC INFORMATION FOR OUT OF STATE PROVIDERS

Out of state providers are held to the same service authorization processing rules as in-state providers and must be enrolled with DMAS or its contractor prior to submitting a request for out of state services for an individual.

For FFS, if the provider is not enrolled as a participating provider, the provider is encouraged to submit the request to Magellan of Virginia as timeliness of the request will be considered in the review process. Magellan of Virginia will complete the service authorization review and

will request the completion of enrollment documentation. If Magellan of Virginia receives the information in response to the provider's enrollment, the request will be completed and the provider will be informed of the status of their enrollment to serve the individual member. If Magellan of Virginia does not receive the information to complete the processing of enrollment within 12 business days, Magellan of Virginia will reject the service authorization request and will not enroll the provider. It may take up to 10 business days to become a participating provider that is only serving a specific individual during the duration of admission.

For individuals enrolled in a Medicaid MCO, the provider should contact the MCO for information.

Out-of-State Provider Requests

Authorization requests for certain services may be submitted by out-of-state providers of freestanding psychiatric hospitals and psychiatric units within an acute care hospital. These specific procedures and/or services may be performed out of state only when it is determined that they cannot be performed in the Commonwealth of Virginia because of the indications below. This requirement is for services authorization requests that are only submitted to the BHSA.

Effective March 1, 2013 out of state providers are to determine and document evidence that one of the following items is met at the time the service authorization request is submitted to the service authorization contractor:

1. The medical services must be needed because of a medical emergency.
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is the general practice for recipients in a particular locality to use medical resources in another state.

Services provided out of state for circumstances other than these specified reasons shall not be covered. Please refer to 12VAC30-10-120 and 42 CFR 431.52**.**

Should the provider not respond or is not able to establish items 1 through 4, the request can be administratively denied. This decision is also supported by 12VAC30-10-120 and 42 CFR 431.52**.**

PROVIDER SCREENING REQUIREMENTS

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved by DMAS or its contractor. 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 Virginia Medicaid web provider portal may be located here: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderEnrollmentLogin

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 the contracted MCO, the BHSA or DMAS.

Providers will receive written instructions from the MCOs, the BHSA or DMAS regarding the revalidation process, revalidation date and the provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, the MCOs, BHSA and DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require

all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

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

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

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

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

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements/contracts, provider contracts, manuals, and related state and federal regulations. Psychiatric Services providers approved for participation in the MCOs and BHSA provider network must perform the following activities as well as any others specified by DMAS:

- Immediately notify DMAS, the MCOs, and the BHSA in writing whenever there is a change in the information that the provider previously submitted. For a change of address, notify DMAS, the MCOs, and the BHSA prior to the change and include the effective date of the change;

- Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS, the MCOs, and the BHSA require, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.

- Use the MCOs, BHSA and DMAS designated methods for submission of charges;

- Assure freedom of choice to individuals in 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 is performed;

- Assure the individual's 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 grounds of race, color, or national origin;

- Provide services, goods, and supplies to individuals 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 individuals of the same quality and in the same mode of delivery as provided to the general public;

- Charge the MCOs, BHSA and 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 individual or any other party;

- Accept as payment in full the amount reimbursed 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". The provider should not attempt to collect from the individual or the individual's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example, if a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the individual, a spouse, or a responsible relative. The provider may not charge the MCOs, BHSA, DMAS or an individual for broken or missed appointments;

- Accept assignment of Medicare benefits for dual eligible Medicaid enrolled individuals;

- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;

- 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;

- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided;

- In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable federal and state laws, whichever period is longer. Providers who are contracted with managed care organizations must follow their contract requirements for record retention. 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;

- 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 Medicaid members;

- Hold information regarding Medicaid enrolled individuals confidential. A provider shall disclose information in his/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 the state agency. DMAS shall not disclose medical information to the public;

- Obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients; and

- Providers must comply with the Code of Virginia (§ 54.1-2400.4) mandate to inform their clients of the right to report misconduct to the Department of Health Professions.

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 person 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 person 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 the contracted MCOs and the BHSA any exclusion information discovered in accordance to the providers contract with the MCO and the BHSA. In addition, such information should be sent in writing and should include the person 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

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 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. Each Medicaid participating provider is responsible for making provisions for such disabled individuals in the provider's programs and activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. The provider's signature on the claim indicates their attestation of compliance with the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding non-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, and accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered individual. Supplementation of available benefits shall be as follows:

- Title XVIII (Medicare) - Virginia Medicaid will pay the amount of any deductible or coinsurance up to the Medicaid limits for covered health care benefits under Title XVIII of the Social Security Act (42 U.S.C. §§ 1395 through 1395ggg) for all eligible individuals 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, 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 enrolled individuals who receive medical care as the result of the negligence of another. If an 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 any lien that may exist under § 8.01-66.9:1 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 or her Medical Assistance Identification Card), and regardless of whether or not Medicaid is billed by the provider for rendered services related to the accident, the facility and/or provider is

requested to forward the DMAS-1000 to the attention of the Third-Party Liability Unit, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

ASSIGNMENT OF BENEFITS

If an individual enrolled in the Virginia Medical Assistance Program is the holder of an insurance policy which assigns benefits directly to the individual, the facility and/or provider must require that benefits be assigned to the facility or refuse the request for the itemized bill that is necessary for the collection of the benefits.

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION

A required physician signature for Medicaid purposes may include signatures, written initials, computer entries, or rubber stamps initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the *Physician Manual* issued by DMAS and review Chapter VI in this manual for information on medical record documentation and retention for psychiatric services.

FRAUD

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain, or items of value for services rendered or supposedly rendered to individuals reenrolled in Medicaid. A provider participation agreement or contract will be terminated or denied when a provider is found guilty of fraud.

Since payment of claims is made from both State and Federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either Federal or State Court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, United States Attorney General, or the appropriate law enforcement agency.

Further information about fraudulent claims is available in Chapter VI, “Utilization Review and Control” of this manual.

TERMINATION OF PROVIDER PARTICIPATION

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

termination notice. The MCOs have different rules for terminating providers and shall adhere to the contract rules regarding notification.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the all contracted MCOs, the BHSA, the DMAS Director and the DMAS Fiscal Agent – Provider Enrollment Services (PES) 30 days prior to the effective date. The addresses for the DMAS Director and the DMAS Fiscal Agent 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

Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a BHSA/Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325 (D) and (E). The provider may appeal the decision in accordance with the Administrative Process Act (APA) (Virginia Code §2.2-4000 et seq.), 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. This only applies to provider contracts with DMAS for fee-for-service or the BHSA. Providers denied or terminated from a MCO network do not have appeal rights with DMAS.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Section 32.1-325 (D) 2 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 , the MCOs, or the BHSA of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law. Providers must also adhere to their contract requirements with the individual MCO.

PROVIDER RECONSIDERATION OF ADVERSE ACTIONS

Service providers seeking to contest an adverse action issued by the MCO or BHSA must follow the MCO's or BHSA's policies and procedures for requesting reconsideration. For information regarding the reconsideration process, providers should consult their agreement

with the MCOs or the BHSA. The provider's exhaustion of the MCO's or BHSA's reconsideration process is a mandatory pre-requisite to filing an appeal with DMAS.

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

Member Appeals (MCO)

Members or their authorized representatives have the right to appeal adverse benefit determinations to the Department. However, the MCO's internal appeal process must be exhausted or deemed exhausted, due to the failure of the MCO to adhere to the notice and timing requirements, prior to a member filing an appeal with the DMAS Appeals Division.

Any member or member's authorized representative wishing to appeal an adverse benefit determination must first file an internal appeal with the MCO **within 60 calendar days** from the date on the notice of adverse benefit determination. The internal appeal request may be submitted orally or in writing. If the member does not request an expedited appeal pursuant to 42 CFR § 438.410, the member shall follow an oral appeal with a written, signed appeal. For individuals with special needs or who do not understand English, the appeal rights must be provided in such a manner as to make it understandable by the individual.

A member may request continuation of services during the MCO's internal appeal and DMAS' State fair hearing. If an appeal is filed before the effective date of the action or within 10 days of the date the notice of adverse benefit determination was mailed, services may continue during the appeal process. If the final resolution of the appeal upholds the MCO's action and services to the member were continued while the internal appeal or State fair hearing was pending, the MCO may recover the cost of the continuation of services from the member.

Member appeals to DMAS are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-370.

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal may be filed at any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. If sent by mail, the appeal request should be mailed to:

DMAS Appeals Division
600 East Broad Street
Richmond, VA 23219

The Department's final administrative appeal decision may be appealed to the appropriate circuit court by the member accordance with the Administrative Process Act at Virginia Code § 2.2-4025, *et seq*. and the Rules of Court.

Member Appeals (FFS)

Individuals (clients) receiving services through the BHSA may file an appeal directly with DMAS. Providers under contract with the BHSA seeking to file an appeal on behalf of their client should consult their contract with Magellan the Magellan National Provider handbook, the Magellan Virginia Provider handbook, or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@Magellanealth.com or visit the provider website at https://www.magellanofvirginia.com/for-providers/.

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the client. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the BHSA's action is upheld by the hearing officer, the client will be expected to repay DMAS for all services received during the appeal period. For this reason, the client may choose not to receive continued services. The BHSA will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, the BHSA may not terminate or reduce services until a decision is rendered by the hearing

officer.

An appeal may be requested by mail, telephone, email, in person, and through commonly available electronic means within 30 days of receipt of the notice of adverse action. If desired, the client or his authorized representative may complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

A written appeal request must be signed and mailed to the:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street 6th Floor
Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 452-5454

EXHIBITS