CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PROVIDER ENROLLMENT

A participating provider is a person or organization who has a current, signed participation agreement with DMAS.

Effective April 4, 2022 all newly enrolling providers seeking to participate with Medicaid managed care or fee-for-service (FFS) must be screened and enrolled with DMAS.

DMAS's online provider enrollment process may be accessed through the Provider Enrollment link located on the DMAS Medicaid Enterprise System (MES) Provider Resources site at https://vamedicaid.dmas.virginia.gov/provider.

1. As a part of the enrollment process, providers must complete a Participation Agreement applicable to their provider type. In the case of a group practice, hospital, or other agency or institution, the authorized agent of the provider institution must sign the agreement. For group practice, hospital, or other agency or institution, DMAS must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

2. A National Provider Identifier (NPI) number must be obtained from the National Plan and Provider Enumeration System (NPPES) and provided with the enrollment application. An enrolled provider's NPI is used by MES to manage provider information across functions. For example, this number must be used on all claims submitted to DMAS.

Provider NPIs may be disclosed to other Covered Healthcare Entities pursuant to Centers for Medicaid and Medicare Services (CMS) regulations requiring the disclosure of NPIs as a part of HIPAA-compliant standard transactions. (Please reference the Healthcare Information Portability and Accountability Act (HIPAA) of 1996.)

3. Providers must have an active license from the relevant state licensing authority and provide proof of licensure during the enrollment process.

4. The provider must be successfully screened according to the requirements detailed in the next section (titled "Provider Screening Requirements").

5. Providers may be denied enrollment for any of the following reasons:
   - failing to submit any of the requested information;
   - conviction of a felony;
   - conviction of health care fraud;
   - if there are past licensure actions or actions related to privileges, enrollments, educational tenure, board certifications, authorizations, participation in health care programs, malpractice actions, liability actions, or other actions or information indicating that the individual may pose a risk to the health, safety or welfare of Medicaid members.

6. Providers who are located in another state but within 50 miles of the Virginia border may be permitted to enroll if all other qualifications are met, but are required to submit claim documentation to DMAS during the enrollment process.

7. Providers will be notified of the enrollment decision by email notice or letter mailed to the address entered into the provider enrollment portal. For denied applications, information about filing an appeal is included in the notice or letter.

8. The enrollment effective date will begin the 1st day of the month in which the application is received, unless a retroactive effective date is approved for documented extenuating circumstances.

If you have any questions regarding the enrollment process, please email Provider Enrollment Services at VAMedicaidProviderEnrollment@gainwelltechnologies.com or phone toll free 1-888-829-5373 or local 1-804-270-5105.

PARTICIPATION IN MANAGED CARE AND FEE FOR SERVICE (FFS)

Any provider of services must be enrolled with DMAS prior to billing for services rendered to eligible individuals, including individuals enrolled in either FFS or Medicaid managed care.

Most individuals who are eligible for Medicaid or Family Access to Medical Insurance Security (FAMIS) benefits are enrolled with one of the Department of Medical Assistance Services' (DMAS') contracted Managed Care Organizations (MCOs) and receive services from the MCO's network of providers. All participating providers must confirm the individual's MCO enrollment status prior to rendering services. The MCO may require a referral, service authorization or other action prior to the start of services. All providers are responsible for adhering to state and federal requirements, their MCO provider contract(s) (as applicable), and the applicable DMAS provider manual. For providers to participate with one of DMAS' contracted MCOs, they must also become a participating provider in the MCO's network.

Please visit the DMAS website at https://vamedicaid.dmas.virginia.gov/provider for more information on participation with the Medicaid FFS and managed care programs

Carved-Out Services

Regardless of an individual's MCO enrollment, some services are "carved-out" of the managed care program and are paid directly by DMAS using FFS methodology. Providers must follow the FFS rules in these instances.

Individuals who receive services under one of the three 1915(c) Developmental Disabilities Home and Community-Based Services (HCBS) Waivers, including the Building Independence, Community Living, and Family and Individual Supports Waivers,

are enrolled in managed care for their non-waiver services (e.g., acute, behavioral health, pharmacy, and non-waiver transportation services). The individual's waiver services benefits are carved-out and managed directly by DMAS.

PROVIDER SCREENING REQUIREMENTS

The 21st Century Cures Act (Cures Act)114 P.P.255 requires all states to screen Medicaid providers, both those in Medicaid fee-for-service (FFS) and managed care organizations (MCOs) upon enrollment. An abbreviated screening is also performed on a monthly basis for any provider who participates with the Virginia Medicaid Program. The full screening is conducted at the time of revalidation, and providers are required to revalidate at least every 5 years.

The requirement for screening is in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid Program 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."

Limited Risk Screening Requirements

The following screening requirements apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations and State requirements for the provider or supplier type; (2) Verification that a provider or supplier meets applicable licensure requirements; and (3) Verification that a provider or supplier has not been excluded from providing services in federally funded programs. The verification process includes a review of applicable federal and state databases checks and is completed on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

Moderate Risk Screening Requirements

In addition to the screening requirements applicable to the limited risk provider category listed above, unannounced pre-and/or post-enrollment site visits apply to moderate risk providers. 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 submit 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.

Application Fees

Institutional providers may be required to pay a federally-required fee at the time of application for enrollment, re-enrollment or reactivation, and when adding new locations. If a provider is required to pay an application fee, it will be outlined in the provider enrollment application and/or revalidation notice.

CMS determines the application fee each year. This fee is not required to be paid to DMAS 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 for CMS approval with their enrollment application. If CMS does not approve the hardship request, then providers have 30 calendar days from the date of the CMS notification to pay the application fee or the application for enrollment will be rejected.

An appeal of a hardship exception determination must may be made to CMS pursuant to 42 CFR 424.514.

Out-of-State Provider Screening

Prior to enrollment in DMAS, providers with a primary servicing address located outside of the Virginia border must have a site visit conducted by either their state’s Medicaid program or by CMS due to their provider risk-level. Pursuant to 42 CFR 455 Subpart E, an application will be pended for proof of this information if it is received by DMAS prior to the completion of the site visit.

Revalidation Requirements

All participating providers are required to revalidate at least every 5 years. Providers are notified in writing of their revalidation due date and of any new or revised provider screening requirements. (Providers will indicate their preferred mode of notification, i.e., email or USPS, at the time of enrollment.) DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements if a provider is enrolled as a Medicare provider at the time of revalidation.

ORDERING, REFERRING, AND PRESCRIBING (ORP) PROVIDERS

42 CFR 455.410(b) states that state Medicaid agencies must require all ordering, or referring, and prescribing 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 ORP providers to enroll to meet new program integrity requirements designed to ensure that all orders, prescriptions or referrals for items or services for Medicaid members originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. There is one exception: the provider enrollment requirements do not apply to physicians who order or refer services for a Medicaid member in a risk-based managed care plan.

If a provider does not participate with Virginia Medicaid currently but may order, refer, or prescribe to Medicaid members, they must 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.

PARTICIPATION REQUIRMENTS

Providers approved for participation in the Virginia Medicaid Program must perform the following activities, as well as any other activities specified by DMAS:

- Immediately notify Provider Enrollment Services in writing of any change in the information that the provider previously submitted to DMAS.
- Ensure freedom of choice to individuals who are eligible for medical assistance under the Virginia Medicaid Program (eligible individuals) in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required service(s) and participating in the Virginia Medicaid Program at the time the service was performed.
- Ensure the eligible individual's freedom to reject medical care and treatment.
- Provide services and supplies to eligible individuals in the same mode of delivery and of the same quality and as provided to the general public.
- Charge DMAS for the provision of services and supplies to eligible individuals in amounts not to exceed the provider's usual and customary charges to the general public.
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 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 eligible individual for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from an eligible individual, or any financially responsible

relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered. A provider may not charge DMAS or an eligible individual for missed or broken appointments.

- Accept assignment of Medicare benefits for eligible individuals.

- Use DMAS-designated billing forms to submit claims.

- Maintain and retain business and professional records sufficient to fully and accurately 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 not less than six 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.

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

- As requested by DMAS, 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 eligible individuals.

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

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

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

Payments cannot be made for items or services furnished, ordered, or prescribed by an excluded provider 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 payment itself is made to another provider, practitioner, or supplier that is not excluded, but is 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 the Virginia Medicaid Program may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to meet Federal and Virginia Medicaid program integrity requirements:

- Screen all new and existing employees and contractors to determine whether any of them have been excluded from participation in Medicaid or Medicare. (Go to https://oig.hhs.gov/exclusions/)

- Search the Health and Human Services Office of the Inspector General (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.

- 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, Suite 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 disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, all Medicaid providers are responsible for making provisions for disabled individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. 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.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

All providers of care and suppliers of services under contract with DMAS must comply with the requirements of 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 basis of race, color, religion, sex, or national origin.

UTILIZATION OF INSURANCE BENEFITS

Virginia Medicaid is a "payer of last resort" program. Benefits available under Medicaid 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) – The Virginia Medicaid Program will pay the amount of any deductible or coinsurance up to the Medicaid limit 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 payments shall be made for a patient covered by Workers' Compensation.

- Other Health Insurance - When an eligible individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), the Virginia Medicaid Program requires that these benefits be used first. Supplementation shall be made by the Virginia 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 - DMAS will seek repayment from any settlements or judgments in favor of eligible individuals who receive medical care as the result of the negligence of another. DMAS should be notified promptly if an eligible individual is treated as the result of an accident, DMAS should be notified promptly so action can be initiated to establish a lien as set forth in the Code of Virginia §8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing DMAS.

In the case of an accident in which there is a possibility of third-party liability or if the eligible 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 physician is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Casualty Unit, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219. The form can also be sent electronically to TPLcasualty@dmas.virginia.gov

DOCUMENTATION REQUIREMENTS

The Virginia Medicaid Program provider participation agreement requires that medical records fully disclose the extent of services provided to all Medicaid members. Medical records must clearly document the medical necessity for covered services. This documentation must be written at the time the service is rendered and the description of the services rendered must be clear. All documentation must be signed (name and title) and dated (month, day, year) on the date of service delivery.

ELECTRONIC SIGNATURES

An electronic signature that meets the following criteria is acceptable for clinical documentation:

- Identifies the individual signing the document by name and title;
- Assures that the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and
- Provides for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

Use of the electronic signatures for clinical documentation purposes shall be deemed to constitute a signature and will have the same effect as a written signature on a document. Providers shall have written policies and procedures in effect regarding use of electronic signatures. In addition to complying with security policies and procedures, providers who use electronic signatures shall sign a statement assuring that they alone will have access to and use the key or computer password. The policies and procedures and statements of exclusive use shall be maintained and available at the provider's location.

Additionally, the use of electronic signatures shall be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies. These requirements for clinical documentation apply only to Medicaid claims, and do not preclude other state or federal requirements.

An original written signature is still required on provider enrollment forms and for medical consents. This clarification does not apply to electronic claims submission or the electronic sharing or transmission of clinical records.

TERMINATION OF PROVIDER PARTICIPATION

The provider participation agreement is time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to DMAS 30 days prior to the effective date. The written notification should be sent to the following address:

DMAS Provider Enrollment Services
PO Box 26803
Richmond, Virginia 23261-6803

DMAS may terminate a provider's participation agreement. DMAS must provide written notification 30 days prior to the termination's effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

Pursuant to §32.1-325 (D) of the Code of Virginia, the DMAS Director of Medical Assistance Services is authorized to:

Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

Appeals of Provider Termination or Enrollment Denial: A provider has the right to appeal in any case in which a Virginia Medicaid Program provider agreement or contract is terminated or denied pursuant to Virginia Code §32.1-325(D). The provider may appeal the decision in accordance with the Administrative Process Act (Code of Virginia §2.2-4000 et seq.) and the Provider Appeals regulations (12 VAC 30-20-500 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division within 15 calendar days of the receipt of the notice of termination or denial.

APPEALS OF ADVERSE ACTIONS

An appeal is a request for a review of an adverse decision taken by DMAS, a DMAS contractor, or another agency on behalf of DMAS. There are two types of appeals – a provider appeal, which may be filed by a provider or their authorized representative, and a client appeal, which may be filed by an individual or an authorized representative on the individual's behalf. The provider appeals process is described below. The client appeals process is described in Chapter III.

PROVIDER APPEALS

Definitions

Administrative Dismissal –the dismissal of a provider appeal 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.

Adverse Action – means, for services that have already been rendered, the termination, suspension, or reduction in covered benefits or the denial or retraction, in whole or in part, of payment for a service. An adverse action may also include the denial or termination of enrollment as a DMAS participating provider.

Appeal – means:

1. A request made by an MCO provider (in-network or out-of-network) to review the MCO's reconsideration decision of an adverse action in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a DMAS-enrolled 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

2. For fee-for-service ("FFS") services, a request made by a provider to review DMAS' adverse action or a DMAS Contractor's reconsideration decision of an adverse action 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 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*.

Reconsideration – means a provider's reconsideration request 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.

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

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. Many adverse actions require a provider to request reconsideration with DMAS or the DMAS Contractor before appealing to the DMAS Appeals Division. Read the denial notice carefully to determine if reconsideration is required, as the reconsideration process is a pre-requisite to filing an appeal with the DMAS Appeals Division. Failure to exhaust a required reconsideration process will result in the appeal to the DMAS Appeals Division being deemed premature.

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. For EAPG and ClaimCheck actions, 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 reconsideration rights with an MCO must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO. A reconsideration may also be required by other DMAS contractors before appealing to DMAS.

For services that have been rendered and any applicable reconsideration 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 decision. There are two case types that have other timeframes to file appeals: (1) 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; and (2) providers appealing adjustments to a cost report are required to file the informal appeal within 90 calendar days of the provider's receipt of the notice of program reimbursement.

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 adverse action being appealed. To ensure that the appeal is efficiently processed, include: the provider name, national provider identification number (NPI), recipient name(s) and Medicaid ID# *[if applicable]*, date(s) of service *[if applicable]*, claim or service authorization number *[if applicable]*, and the reason for the appeal. Also include a copy of the adverse action and a contact name, phone number, and address for appeal correspondence.

Failure to file a written notice of informal appeal within the prescribed timeframe or that

does not identify the action being appealed 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.

<u>Repayment of Identified Overpayments</u>

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 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 must 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 must be final.

PROVIDER PARTICIPATION REQUIREMENTS – RESIDENTIAL SERVICES

The residential treatment services covered in this manual include Therapeutic Group Home (TGH) and Psychiatric Residential Treatment Facilities (PRTF). This chapter provides general provider participation requirements and provider specific requirements for TGHs and PRTFs.

Provider requirements for additional Behavioral Health services covered by the Department of Medical Assistance Services (DMAS) are located in the Addiction and Recovery Treatment Services (ARTS) Manual, Psychiatric Services Manual, and Mental Health Services Manuals located on the DMAS website at:
https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

Providers are responsible for adhering to all DMAS policies, this manual, available on the DMAS website portal, their provider contracts with the Medicaid Managed Care Organization (MCOs) and the fee for service (FFS) contractor, and related state and federal regulations.

BEHAVIORAL HEALTH FFS CONTRACTOR

Magellan of Virginia currently serves as the Behavioral Health FFS contractor and is responsible for the management and direction of the fee for service (FFS) behavioral health benefits program under contract with DMAS.

Magellan of Virginia is authorized to train a FFS 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.

The Magellan of Virginia Call Center has a centralized contact number (1-800-424-4046) for members and providers. The Call Center is located in Virginia and is available 24 hours a day, 365 days a year. Staff members include bilingual and 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 the Magellan of Virginia Call Center. Magellan of Virginia staff members are available to assist callers with:

- service authorizations
- clinical reviews
- member eligibility status

- referrals for services
- claims resolution
- reconsiderations
- grievances and,
- complaints

Providers can also visit the Magellan of Virginia provider website at https://www.magellanofvirginia.com/for-providers/ for service authorization and claims information or email Magellan of Virginia at VAProviderQuestions@magellanhealth.com.

CARVED-OUT SERVICES

Even if the individual is enrolled with an MCO, some services, such as therapeutic group home (TGH) services, continue to be covered by Medicaid Fee-for-Service (FFS). Providers must follow the Fee-for-Service rules in these instances where services are "carved-out." Refer to each program's website for detailed information and the latest updates. While youth residing in TGHs remain in managed care, youth who enter a psychiatric residential treatment facility (PRTF) are disenrolled from managed care.

ADVERSE OUTCOMES

Providers must follow notification or reporting processes for reporting adverse outcomes or critical incidents as required by applicable Local, State and Federal regulatory bodies and contracts with the MCOs and FFS contractor.

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 federal 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.

PROVIDER CREDENTIALS FOR RESIDENTIAL TREATMENT SERVICES

In addition to the criteria stated above, residential treatment service providers must meet the following requirements.

Provider Credentials for Residential Treatment Services Staff:

Residential treatment service providers (PRTFs and TGHs) must ensure that employed or contracted staff meet the service-specific staff requirements of all services rendered by the service provider. All provider sites must be credentialed by Magellan of Virginia, licensed by the Department of Behavioral Health and Developmental Services (DBHDS) and in compliance with all DMAS requirements as defined in the residential treatment service regulations.

"ADL Supervisor" means a child care supervisor with a baccalaureate degree in social work or psychology and two years of professional experience working with children one year of which must have been in a residential facility for children; or a high school diploma or General

Education Development Certificate (G.E.D.) and a minimum of five years professional experience working with children with at least two years in a residential facility for children; ADL supervisors shall work under supervision of the Program Director.

“ADL Technician” means a child care worker at least 21 years of age who has a baccalaureate degree in human services; has an associate’s degree and three months experience working with children; or is a high school graduate or has a G.E.D. and has six months of experience working with children. A trainee with a high school diploma or a G.E.D may gain experience working with children by working directly alongside a staff member who is, at a minimum, an ADL technician with at least one year of professional experience with children. These trainees must be within sight and sound of the supervising staff member and may not work alone. ADL technicians must be supervised by an ADL supervisor, QMHP-C, LMHP, LMHP-R, LMHP-RP or LMHP-S.

“Institution for Mental Disease” or “IMD” means a hospital, nursing facility, or other institution with more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

"Licensed assistant behavior analyst" or “LABA” means a person who has met the licensing requirements for an assistant behavior analyst as defined in 18VAC85-150-10 et seq. and holds a valid license issued by the Virginia Board of Medicine.

"Licensed behavior analyst" or “LBA” means a LMHP who has met the licensing requirements for a behavior analyst as defined in 18VAC85-150-10 et seq. and holds a valid license issued by the Virginia Board of Medicine.

"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.

“Program Director” means the same as defined in 12VAC35-46-350.

"Qualified mental health professional-child" or "QMHP-C” means the same as the term is defined in § 54.1-3500.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term “qualified mental health professional - trainee” as defined in § 54.1-3500.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in 12VAC35-105-20.

QMHP Requirements (RTS)

The QMHP-E staff must have at least one hour of supervision per week by a LMHP, LMHP-R, LMHP-S or LMHP-RP which must be documented in the employee file. Evidence of compliance with the QMHP-E criteria must be in the staff file.

Department of Health Professions Registration

For reimbursement purposes, DMAS requires QMHP-A, QMHP-C and QMHP-Trainee (QMHP-E) staff to be registered with the Board of Counseling. Applicants may apply for QMHP registration by submitting an online application, fee and supplemental documentation with the Board of Counseling. For more information please visit the Board of Counseling website: https://www.dhp.virginia.gov/counseling/counseling_QMHP.htm

SPECIFIC PROVIDER REQUIREMENTS (RTS)

Psychiatric Residential Treatment Facilities (PRTF)

PRTF services shall be covered for the purpose of diagnosis and treatment of mental health and behavioral disorders when such services are rendered by PRTFs. This section also applies to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) PRTFs. PRTFs must be:

- licensed by The Department of Behavioral Health and Developmental Services (DBHDS);

- accredited by the Joint Commission on Accreditation of Healthcare organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children or by any other accrediting organization with comparable standards that is recognized by the state; and

- fully in compliance with (i) the Code of Federal Regulations at 42 CFR Part 441 Subpart D, specifically 42 CFR 441.151 (a) and (b) and 441.152 through 441.156, and (ii) the Conditions of Participation in 42 CFR Part 483 Subpart G regarding the use of restraint and seclusion.

Each admission must be service authorized and the treatment must meet DMAS requirements for clinical necessity as outlined in Chapter IV of this manual.

Therapeutic Group Home (TGH)

TGH service providers shall be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46). Service Providers must be credentialed and contracted with Magellan of Virginia. Licensed practitioners providing professional services separately from the TGH per diem shall also be credentialed and contracted with the youth's MCO. This section also applies to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) TGHs.

- Room and board costs shall not be reimbursed. Facilities that only provide independent living services or non-clinical services that do not meet the requirements of this subsection are not eligible for reimbursement.

- DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds regardless of the funding source. DMAS shall not reimburse for TGH services provided in any facility that meets the definition of an Institution for Mental Disease (IMD).

- TGH services may only be rendered by a LMHP, LMHP-S, LMHP-R, LMHP-RP, a QMHP-C, a QMHP-E, a QPPMH, an ADL Supervisor or an ADL Technician.

- Treatment Team/Team Responsible for the Plan of Care must contain an LMHP, LMHP-R, LMHP-RP, or LMHP-S and a family member or legally authorized representative.

- The clinical director must be a LMHP. The caseload of the clinical director must not exceed 16 total clients including all sites for which the clinical director is responsible;

- The program director must be full time and meet the requirements for a program director as defined in 12VAC35-46-350.

- Assessment, treatment planning, crisis management, and individual, group and

family therapy must be provided by a LMHP, LMHP-S, LMHP-R, or LMHP-RP.

- Skills restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP- C, QMHP-E or QPPMH under the supervision of a QMHP-C or higher.

- ADL restoration must be provided by a: LMHP, LMHP-R, LMHP-RP, LMHP-S or QMHP-C; or, a QMHP-E, QPPMH, ADL Supervisor or ADL Technician under the supervision of a QMHP-C or higher.

- At least 50% of the direct care staff onsite at the group home must meet a minimum of DBHDS QPPMH criteria.

- Services provided by QPPMHs require supervision by a QMHP-C or higher. Supervision is demonstrated by the supervisor's review of progress notes, the member's progress towards achieving Comprehensive Individual Plan of Care (CIPOC) goals and objectives, and recommendations for change based on the youth's status. Supervision must occur and be documented monthly in the clinical record.

- Direct staff who do not meet the minimum QPPMH requirements may provide services for Medicaid reimbursement if they meet qualifications to be an ADL Supervisor or ADL Technician, are working directly with at least a QPPMH on-site and being supervised by a QMHP-C or higher. Supervision must include on-site observation of services, face-to-face consultation with the direct staff member, a review of the progress notes, the youth's progress towards achieving CIPOC goals and objectives, and recommendations for change based on the youth's status. Supervision must occur and be documented monthly in the clinical record.

- If any services are subcontracted, the subcontracted provider must meet the same qualifications as listed in this chapter for program operation and provider qualifications. The provider who subcontracts services is responsible for ensuring that the subcontracted employees meet all psychiatric service requirements and psychiatric services staffing requirements.

<u>EPSDT PRTFs and TGHs</u>

For Applied Behavior Analysis (ABA) services delivered in EPSDT PRTFs and TGHs, the following requirements apply:

Applied Behavior Analysis (ABA) Services must be provided by either:

- An LMHP practicing within the scope of their practice as defined by the applicable Virginia Health Professions Regulatory Board or an agency that employs a LMHP, or

- An LBA meeting all requirements established by the Virginia Board of Medicine in 18VAC85-150-10 et seq. or an agency that employs a LBA.

Direct ABA interventions must be provided by either:

- A LMHP acting within the scope of their practice;
- A LMHP, LMHP-R, LMHP-RP or LMHP-S;
- A LBA;
- A LABA under the supervision of a LBA; or
- Personnel under the supervision of a LBA in accordance with 18VAC85-150-10 et seq. of the Virginia Board of Medicine regulations.

EPSDT PRTF and TGH providers practicing ABA must meet all requirements established by the Virginia Board of Medicine in 18VAC85-150-10 et seq.

INDEPENDENT ASSESSMENT, CERTIFICATION AND COORDINATION TEAMS (IACCT)

The independent certification team shall certify the need for PRTF or TGH services and issue a certificate of need document within the process and timeliness standards as approved by DMAS under contractual agreement with Magellan of Virginia.

The independent certification team shall be approved by DMAS through a Memorandum of Understanding with a locality or be approved under contractual agreement with Magellan of Virginia. The team shall initiate and coordinate referral to the FAPT (as defined in Va. Code 2.2-5207 and 2.2-5208) to facilitate care coordination and for consideration of educational coverage and other supports not covered by DMAS.

The independent certification team shall assess the individual's and family's strengths and needs in addition to diagnoses, behaviors, and symptoms that indicate the need for behavioral health treatment and also consider whether local resources and community-based care are sufficient to meet the individual's treatment needs, as presented within the previous 30 calendar days, within the least restrictive environment.

For additional information on the IACCT process and IACCT team requirements, please refer to the IACCT supplement to this manual.

SECLUSION AND RESTRAINT

As part of the supporting documentation for a PRTF provider, PRSS must receive a signed letter of attestation from the Chief Executive Officer (CEO) of the facility stating that the facility is in compliance with the federal condition of participation of restraint and seclusion in PRTFs (42 CFR §§ 483.350 – 483.376). If there is a change in CEOs, a new letter of attestation must be submitted. Letters are required at enrollment and annually thereafter. A sample letter of attestation can be found in the Exhibits section

at the end of this chapter. Letters are due by 5 PM on July 1 or the first business day thereafter each year.

Adherence to the regulations regarding restraint & seclusion, including the reporting of any serious incident involving any individual, is a condition of continued participation as a Medicaid provider. If the letter of attestation is not received by PRSS by the due date, approval of new authorizations will not occur. Also, DMAS Utilization Review Audits will monitor for compliance with the provider contract with this requirement.

For further information on requirements related to restraint and seclusion, refer to Chapter IV of this manual.

SAMPLE ATTESTATION LETTER

(Submit on Facility Letterhead)

This attestation must be signed by an individual who has the legal authority to obligate the facility.

Date

Name of the Psychiatric Residential Treatment Facility Address
City, State, Zip Code Telephone Number
Fax Number (if applicable) Provider Number/NPI

To the Virginia Department of Medical Assistance Services:

The above listed facility has [insert total number of facility beds]. As of the date of this attestation, the facility has [insert number of Medicaid residents in the facility]. Of this total, [insert number of residents for whom the psych under 21 is paid for by another state].
Below is a list of all states from whom the facility has ever received Medicaid payment for the provision of psych under 21 benefit:
[include list]

By this letter, I attest that this facility, a residential treatment facility providing inpatient psychiatric services to individuals under the age of 21, is in compliance with Part 483, Subpart G of CMS's standards governing the use of restraint and seclusion. In the event that there is a new facility director, the facility will submit a new attestation of compliance.

Sincerely,

Name of Individual

Facility Director [insert position name]