# LTSS SCREENING

## 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

There are two types of appeals – client and provider. In a client appeal, the patient, their parent or guardian, or an authorized representative has the right to appeal for services not yet rendered. Please refer to Chapter III for more details on the client appeal process. In a provider appeal, a provider or its authorized representative has the right to appeal.

An appeal is an independent review of an adverse decision taken by DMAS, a DMAS contractor, or another agency on behalf of DMAS. For provider appeals, an adverse action can be:

1. Any negative action on payment for a service the provider has already given to the patient. A negative action can be: (a) a termination, suspension, reduction, or denial of authorization; (b) a claim denial; or (c) an audit determination.
2. Denial or termination of enrollment as a DMAS participating provider.

Appeals are processed in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*., Code of Virginia § 32.1-325.1, and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

## PROVIDER APPEALS: NON-STATE-OPERATED PROVIDERS

The following procedures apply to all providers not operated by the Commonwealth.

### Before the Appeal: Reconsideration Requirements

If an MCO, Acentra, or DentaQuest took the adverse action, the provider must exhaust the reconsideration process with that contractor **before** the provider can appeal with DMAS. DMAS will dismiss appeal requests made before the final reconsideration. If the reconsideration is final, the notification letter will state so and include instructions on how to request an appeal with DMAS.

If DMAS took the adverse action, the provider must request reconsideration if the action involves a DMAS claim under the Enhanced Ambulatory Patient Grouping (EAPG) payment methodology or a ClaimCheck denial. The deadline to request reconsideration for these claims is 30 days from when the provider received written notice of the adverse action. The provider must include all supporting documentation with the reconsideration request.

Address the EAPG or ClaimCheck reconsideration request to the Program Operations Division at the following address:

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

The Program Operations Division will review the reconsideration request and provide a written response.

If the reconsideration partially or completely upholds the adverse action, or reconsideration is not required, the provider may request an informal appeal with the DMAS Appeals Division.

Stages of Provider Appeals

There are two stages of provider appeals: informal and formal. For informal appeals, an informal appeals agent conducts an impartial review of the adverse action.

For formal appeals, a hearing officer is selected from a list maintained by the Supreme Court of Virginia. That hearing officer sends a recommended decision to the Agency Director, who then makes the final decision. An informal appeal decision must be issued before a provider can request a formal appeal.

## Appeal Requests

How to Request an Appeal

Providers must request an appeal in writing. To request an appeal, providers may:

1. Use the Appeals Information Management System ("AIMS") portal. The portal is at www.dmas.virginia.gov/appeals.
2. Email the appeal request to appeals@dmas.virginia.gov.
3. Fax the appeal request to DMAS at (804) 452-5454.
4. Mail or bring the appeal request to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

Address the appeal request to the DMAS Appeals Division. Do not address the request to an MCO, DMAS contractor, or other DMAS division.

Required Information

The Appeals Division has an appeal request form at:
https://dmas.virginia.gov/appeals/provider-appeals-resources/

If a provider does not use AIMS or the DMAS appeal request form to request an appeal, the provider must include the same information, in writing, with its appeal request. Providers must identify their submission as an appeal request.

All appeal requests must include:

- The provider's name
- A contact name, phone number, and mailing address. An email address is also helpful, but not required
- An explanation of what adverse action the provider is appealing
- The provider's National Provider Identification (NPI) number

An appeal request must also include the following, if applicable:

- The member/patient's name
- The claim number
- The service authorization number
- The enrollment termination letter
- The patient's Medicaid ID Number
- The date or dates of service at issue
- The final denial notice, if available

The Appeals Division will only process appeal requests that contain all of the required information listed above. The Appeals Division will not process requests that only include medical records and/or claim forms. The Appeals Division will not accept appeal requests submitted through digital media, such as CDs, flash drives, or memory cards.

Multiple Appeal Requests

If a provider submits more than one appeal request at the same time, the provider must separate or organize the requests using one of the following methods:

- Tabs
- Rubber bands
- Binder clips
- Tables of contents
- Staples
- Paper clips
- Indexes

The Appeals Division will only process the action identified on the first document of the group appeal unless the appeal requests are separated or organized using one of these methods.

Filing Date

A provider's appeal request is filed when the DMAS Appeals Division date stamps the request. DMAS currently accepts items transmitted by United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission, including AIMS. When DMAS or a provider uses AIMS, AIMS will electronically date stamp an item when it completes transmission to the Appeals Division.

When a provider uses email or facsimile, the Appeals Division date stamps an item on the date and time of transmission.

If the DMAS Appeals Division receives the item through other means, such as United States mail or hand delivery, the Appeals Division will physically stamp the item upon receipt.

The Department of Medical Assistance Services' normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern Time. If a provider submits documents or correspondence to the DMAS Appeals Division after 5:00 p.m., DMAS will date stamp the document or correspondence on the next day the Department is officially open. If a provider sends a document to the DMAS Appeals Division after 5:00 p.m. on the deadline date, it is untimely.

## Communication Options

The Appeals Division will send all documents and correspondence to the last known

point of contact associated with the appeal. A provider may change its point of contact using the same communication methods allowed for appeal requests.

Providers who use AIMS have the choice to receive correspondence from the Appeals Division through mail or email. Providers who do not use AIMS will only receive correspondence from the Appeals Division through mail.

Email

If a provider chooses to receive email notifications, the provider must register for an AIMS account. The Appeals Division will send an email notification to the provider's point of contact when an item is ready to review in AIMS. The Appeals Division will not directly email electronic copies of documents or correspondence to the provider's point of contact. The Appeals Division presumes the point of contact receives all items when the Appeals Division sends the email notification to the point of contact.

If a provider has trouble using AIMS, call the AIMS Help Desk at 804-486-2865.

Mail

If a provider chooses to receive correspondence through mail, the Appeals Division will send all correspondence and documents to the provider's point of contact through United States mail. The Appeals Division presumes the point of contact receives all documents and correspondence within three days after transmission through mail. The correspondence and documents will also be available to review in AIMS.

## Administrative Dismissals

Informal Appeals

The Appeals Division will administratively dismiss an informal appeal if:

- A provider fails to request an informal appeal before the applicable deadline.
- DMAS requests proof that an individual or entity is authorized to pursue the appeal and the provider does not return the required paperwork by the deadline.
- A provider has not exhausted the DMAS or contractor's reconsideration, review, or internal appeal process, if the process is required before filing a DMAS informal appeal.

An administrative dismissal is an informal appeal decision dismissing the informal appeal without any further proceedings. If a provider's informal appeal results in an administrative dismissal, the provider will have the right to appeal the dismissal.

Formal Appeals

The Appeals Division cannot administratively dismiss formal appeals.

## Appeal Request Timeframes

Informal Appeals

The informal appeal request timeframe begins when a provider receives notice of the

adverse action. The appeal request deadline depends on the type of appeal the provider requests.

The deadline to request an appeal of a DMAS provider agreement termination is **15 calendar days**.
The deadline to request an appeal of adjustments to a cost report is **90 calendar days**.

The deadline is **30 calendar days** for:

- Any payment-related action that does not involve adjustments to a cost report.
- Any other adverse action not stated above.

Formal Appeals

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division. The formal appeal request must identify the informal case(s) that are being appealed. The deadline is **30 calendar days** from the provider's receipt of the DMAS informal appeal decision. 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.

Circuit Court 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 the Supreme Court of Virginia.

**Repayment**

Virginia Code § 32.1-325.1 requires DMAS to collect identified overpayments. Repayment must be made upon demand unless DMAS agrees to a repayment schedule. If a provider does not repay DMAS in a lump sum cash payment, DMAS will add interest on the declining balance at the statutory rate, pursuant to Va. Code § 32.1-313.1. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates a financial hardship warranting extended repayment terms. The provider must demonstrate the hardship to the satisfaction of DMAS.

DMAS and associated contractors (e.g. MCOs) cannot collect repayment or apply interest during the administrative appeal.

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

## PROVIDER APPEALS: STATE-OPERATED PROVIDERS

The following procedures apply to all Medicaid-enrolled providers operated by DMAS.

Reconsideration

A state-operated provider has the right to request a reconsideration of any issue that the State Plan allows a non-state operated provider to appeal. This is the sole procedure

available to state-operated providers.

The reconsideration process has three steps:

1. An informal review by the Division Director.
2. A review by the DMAS Agency Director.
3. A Secretarial review.

1. Informal Review

For Step One, the state-operated provider must submit written information specifying the nature of the dispute and the relief sought to the appropriate DMAS Division Director. DMAS must receive this request 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 provider seeks a reimbursement adjustment, the written information must include the nature of the adjustment, the amount of the adjustment, and the reason(s) for seeking the adjustment. Upon request by either party, DMAS may arrange an informal meeting to discuss a resolution.

The Division Director or a designee will review the information and request additional information if necessary. The designee will then recommend to the Division Director whether relief is appropriate under applicable laws and regulations. The Division Director shall consider any recommendation of the designee and render a decision.

2. Agency Director Review

Step Two permits a state-operated provider to request the DMAS Agency Director review the Division Director's decision. The state-operated provider must request the Agency Director's review within 30 days after receipt of the Division Director's decision. The DMAS Agency Director may appoint a designee to review the Division Director's decision. The DMAS Agency Director has the authority to take whatever measures the Agency Director deems appropriate to resolve the dispute.

3. Secretarial Review

Step Three occurs when the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider. Step Three permits the provider to request the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. The state-operated provider must request referral for Secretarial review within 30 days after receipt of the DMAS Agency Director's Decision. Any determination by such Secretary or Secretaries is final.

## PARTICIPATION CONDITIONS - MEDICAID LTSS SCREENING

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. The following paragraphs

outline special participation conditions for Medicaid Long Term Services and Supports (LTSS) screening providers.

## LOCAL COMMUNITY-BASED LTSS SCREENING TEAMS

Community-based teams (CBTs) are composed, at a minimum, of a physician, registered nurse, and family services specialist or social worker. The registered nurse and physician are required to be licensed or eligible to be licensed by the Commonwealth of Virginia to practice in the Commonwealth and must be employees of the local Department of Health. The family services specialist or social worker must be an employee of the local department of social services. Members of the CBT should have experience in geriatrics or adult services, care of persons with special health care needs and knowledge of care for persons living with disabilities.

For adults the screening process, including the home visit, must be completed jointly by both the registered nurse and family services specialist or social worker, and at a minimum the registered nurse must be a screener for children. Members of the Community-Based LTSS Screening Teams must be trained and certified .to conduct the Medicaid LTSS Screening and submit all screening in the electronic Medicaid LTSS Screening (eMLS) system.

The authorization or denial for Medicaid LTSS (DMAS-96 form) is signed and attested to by the certified screener(s). The certified physician must review all screening results, sign and date the Medicaid LTSS Authorization form (DMAS-96) in the electronic Medicaid LTSS Screening (eMLS) system. No other individual may sign or date for the physician signers.

## HOSPITAL SCREENING TEAMS

"Hospital screening team" means persons designated by the hospital who are responsible for conducting and submitting the LTSS screening for inpatients into the eMLS system. “Hospital” includes acute care hospitals, rehabilitation hospitals, a rehabilitation unit in an acute care hospital, or a psychiatric unit in an acute care hospital.

At a minimum the hospital team consists of a screener (preferably a Virginia licensed registered nurse) and a physician who can discern nursing and medical needs according the LTSS Screening regulations, assess the ability of the individual to conduct activities of daily living and assess the individual’s risk if LTSS is not provided. The screener may be a social worker or discharge planner. If the screeners is not a nurse, the screener must collaborate with a licensed registered nurse ~~licensed~~ or individual eligible to be licensed by the Commonwealth of Virginia to practice in the Commonwealth and is knowledgeable about the individual's medical needs prior to completion of the screening process. Hospitals must seek prior approval and exemption from the DMAS if a social

worker and/or nurse is not involved in the screening process. Members of the Hospital Screening Teams must be trained and certified to conduct the Medicaid LTSS Screening.

The authorization or denial for Medicaid LTSS (DMAS-96 form) is signed and attested to by the certified screener(s) and the certified physician must review all screening results, sign and date the Medicaid LTSS Authorization form (DMAS-96) in the electronic Medicaid LTSS Screening (eMLS) system. No other individual may sign or date for the physician signers.

## SKILLED NURSING FACILITY (NF) LTSS SCREENING TEAMS

"Nursing facility (NF) LTSS screening teams" are composed at a minimum of at least one registered nurse and a physician. The registered nurse and physician are required to be licensed or eligible to be licensed by the Commonwealth of Virginia to practice in the Commonwealth and must be employed by the nursing facility. NF LTSS Screening team members must be able to discern nursing and medical needs according the LTSS Screening regulations, assess the ability of the individual to conduct activities of daily living and assess the individual's risk if LTSS is not provided.

The nursing facility staff are responsible for performing LTSS screenings for non-Medicaid individuals who apply for or request LTSS while receiving skilled nursing/rehab services not covered by Medicaid (whole or in part) after discharge from a hospital. Members of the NF LTSS Screening team must be trained and certified to conduct the Medicaid LTSS Screening and submit all screening in the electronic Medicaid LTSS Screening (eMLS) system. The authorization or denial for Medicaid LTSS (DMAS-96 form) is signed and attested to by the certified screening nurse and physician in the electronic Medicaid LTSS Screening (eMLS) system. No other individual may sign or date for the physician signers.