CHAPTER II

CHAPTER II

TABLE OF CONTENTS

LOCAL EDUCATION AGENCY (LEA) PROVIDERS AND MEDICAID DELIVERY SYSTEMS

Most of the services covered through Virginia's Medicaid and FAMIS programs are furnished through the Department of Medical Assistance Services' (DMAS') contracted MCOs and their networks of providers; however, there are exceptions. Covered services provided by Local Education Agency (LEA) providers to member students are carved out of managed care and administered by DMAS, and those providers must follow DMAS fee-for-service (FFS) and other policies and procedures as set out in the LEA Provider Manual.

LEA PARTICIPATING PROVIDER

For purposes of this manual, a "local education agency" (LEA) refers to a school division that operates local public primary and secondary schools in Virginia, as well as the Virginia School for the Deaf and Blind (VSDB). A participating LEA provider (also referred to as "LEA billing provider" or "billing provider") is a local education agency that has a current, signed Business Associate Agreement on file with DMAS and is enrolled with DMAS as a participating provider.

LEA providers must complete the Business Associate Agreement as required in 45 CFR § 160.103 of the Final Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. More information about the Business Associate Agreement may be found on the web at https://www.dmas.virginia.gov/about-us/procurements/.

LEA PROVIDER ENROLLMENT

For purposes of the LEA Provider Manual, DMAS distinguishes the following terms used to describe those responsible for providing LEA services:

Term	Definition	Requirements
LEA provider	The LEA or school division. Also known as the billing provider and facility provider.	The LEA provider must enroll with DMAS in order to bill for services.
Qualified provider of school-based services	A licensed healthcare professional rendering school-based services, or supervising another direct services provider rendering school-based services, within their licensed scope of	The qualified provider must be employed or contracted by the LEA provider. The qualified provider is accountable for ensuring that services are provided according to state and federal rules.

	practice according to Virginia law.	
Ordering, referring or prescribing (ORP) provider	The ORP provider is a licensed healthcare professional that is allowed to refer for school-based services according to their licensed scope of practice and according to Virginia law.	An ORP provider must enroll with DMAS and may or may not render school-based services, and may or may not supervise others in rendering school-based services.
Direct service provider	The LEA-employed or contracted staff member rendering direct services to the student.	This includes qualified providers that render direct services. It also includes unlicensed staff rendering care under the supervision of a qualified provider.

LEA (billing) providers must be currently enrolled with DMAS in order to submit claims for services provided to Medicaid or FAMIS-enrolled members.

NATIONAL PROVIDER IDENTIFIER (NPI) AND LEA/ORP PROVIDER ENROLLMENT

HIPAA mandates that the Secretary of Health and Human Services use a standard unique identifier for health care providers that participate in Medicaid billing. LEA providers, and providers that order, refer or prescribe DMAS-covered services for Medicaid and FAMIS members must obtain a National Provider Identifier (NPI) and submit the NPI to DMAS at the time of enrollment.

NPIs may be disclosed to other entities that need the health care provider's NPI in order to carry out HIPAA standard transactions, as defined in 45 CFR Part 16, HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers; Final Rule (NPI Final Rule).

This manual contains information about provider qualifications and specific details concerning the DMAS reimbursable services for LEAs. To maintain continuous participation in the DMAS program, LEA providers and their associated direct service providers and ORP providers must comply with all sections of this manual and must practice in accordance with the requirements of the applicable licensing board within the Department of Health Professions or the Department of Education.

PROVIDER REQUESTS FOR ENROLLMENT

Providers seeking to enroll with DMAS as a LEA provider or ORP provider may do so at https://virginia.hppcloud.com/.

For assistance with the provider enrollment process, contact the Virginia Medicaid Provider Enrollment Helpdesk by phone at 804-270-5105 or 888-829-5373, or email VAMedicaidProviderEnrollment@gainwelltechnologies.com.

PROVIDER SCREENING REQUIREMENTS

LEA and ORP providers must undergo a federally mandated comprehensive screening as part of the DMAS enrollment process. 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

LEA providers and their associated ORP providers are categorized as limited risk providers. Prior to enrollment, DMAS must verify that the provider or supplier meets applicable federal and state legal requirements, including applicable Virginia licensure requirements, and verify that the provider is not excluded from providing services in federally funded programs.

Application Fees

The Centers for Medicare and Medicaid Services (CMS) sets an application fee amount to be collected by DMAS on an annual basis. DMAS does not collect this fee if the provider has already paid the fee to another state Medicaid program or to Medicare, or has been granted a hardship exception by Medicare.

LEA providers and ORP providers enrolling for purposes of LEA-based services are not charged an enrollment fee.

LEA ENROLLMENT REVALIDATION REQUIREMENTS

LEA and ORP providers must undergo a revalidation of their enrollment information at least every five years. LEA and ORP providers will be notified in writing of a revalidation

due date and informed of new or revised provider requirements in the revalidation notice. They will be notified via email or mail, depending on their preference indicated at the time of enrollment, and provided with instructions on completing the revalidation process.

REQUIREMENTS FOR MAINTAINING LICENSES

ORP providers licensed through the Virginia Department of Health Professions (VDHP) or the Virginia Department of Education (VDOE) must follow the licensing policies and procedures of their respective licensing agency and maintain a valid, up-to-date license on file with DMAS. DMAS' provider enrollment data system is linked to the VDHP system, so providers licensed through VDHP do not have to take any additional action when their license information is changed or renewed. Providers holding licenses administered by VDOE, however, must ensure that any updated license information is forwarded to DMAS by fax, email or mail:

Virginia Medicaid Provider Enrollment Services
P.O. Box 26803
Richmond, Virginia 23261-6803
Phone: 804-270-5105 or 1-888-829-5373
Fax: 804-270-7027 or 1-888-335-8476

ORDERING, REFERRING, AND PRESCRIBING (ORP) PROVIDERS

Federal law requires state Medicaid programs to screen and enroll providers that order, refer or prescribe Medicaid-covered services. This includes individual providers that do not themselves participate directly in Medicaid billing. These providers are referred to as ordering, referring and prescribing (ORP) providers.

ORP providers must enroll with DMAS to meet CMS program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid-eligible individuals originate from appropriately licensed practitioners who have not been excluded from participation in Medicare or Medicaid.

Billing providers that submit claims for services that were ordered, referred or prescribed by an ORP provider must ensure that the ORP provider is enrolled with DMAS as of the date of service billed and that the NPI of the ORP provider is submitted as part of the billing claim. The ORP provider must also be enrolled as of the date the claim is adjudicated by DMAS. (See Chapter V of this provider manual for more detail on billing procedures.)

PROVIDER PARTICIPATION REQUIREMENTS

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.

- 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.

- Use DMAS-designated billing forms to submit claims.

- Maintain and retain business and professional records sufficient to fully and accurately document 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.

- 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 ensure that Federal and Virginia Medicaid Program integrity requirements are met:

- 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 (HHSOIG) 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

PARTICIPATION REQUIREMENTS SPECIFIC TO LEAS

The following paragraphs outline the special participation conditions for LEA billing providers and their associated ORP and direct service providers. Direct service providers must meet all qualifications and requirements for their specialty as defined in Virginia law, and they must be employed by or contracted by the billing LEA provider.

DMAS covers the following school-based services. (Service conditions are covered in Chapter IV of this manual.)

- Well child visits and health-related screenings,
- Physical therapy,
- Occupational therapy,
- Speech-language therapy,
- Audiological services,
- Nursing,
- Behavioral health, including adaptive behavior treatment and substance use disorder treatment,
- Personal care,
- Medical evaluation,
- Specialized transportation*

*Specialized transportation is covered only when authorized by a special education individualized education program (IEP) plan.

Qualified Providers That May Enroll as ORP Providers

The following qualified providers of LEA school-based services holding a valid license from the VDHP or the VDOE must enroll with DMAS as ORP providers in order to refer for billed services within the program:

Audiologists	Physician Assistants
Clinical Psychologists	Professional Counselors
Clinical Social Workers	School Psychologists
Marriage and Family Therapists	School Social Workers
Nurse Practitioners	School Counselors
Occupational Therapists	Behavior Analysts
Physical Therapists	Speech-Language Pathologists
Physicians	Substance Abuse Treatment Practitioners

Qualified Providers That Do Not Enroll as ORP Providers

The following qualified providers are also licensed through the VDHP, but are not allowed to “refer” members for covered services for purposes of fulfilling the ORP requirement for billing claims and, therefore, do not enroll with DMAS as ORP providers of LEA school-based services:

- Registered nurses, licensed practical nurses
- Occupational therapy assistants
- Physical therapy assistants
- Assistant behavior analysts

Unlicensed Direct Services Providers

Direct services providers also include unlicensed staff providing services under the supervision of a qualified provider. These persons are not "qualified" in the sense that they are not able to render billed services without supervision. These include persons performing personal care, psychological testing technician and adaptive behavior treatment by protocol services. These unlicensed providers do not enroll with DMAS as ORP providers of LEA school-based services.

Personal Care Services Provided by a Student's Family Member(s)

Family members providing personal care services to a student in accordance with DMAS policies outlined at the Legally Responsible Individuals page of the DMAS website (https://www.dmas.virginia.gov/for-providers/long-term-care/waivers/legally-responsible-individuals/) and in the CCC+ Waiver Manual and the DD Waiver Manual must be employed by or under contract with the LEA and must meet all DMAS-required provider qualifications.

Requirements for Providing Clinical Supervision According to Board Licensing Requirements

In addition to the requirements listed in the LEA Provider Manual, qualified providers providing clinical supervision to professionals according to Virginia licensing board requirements must follow their individual licensing-related laws and regulations regarding supervision requirements as detailed in the Code of Virginia and Virginia Administrative Code, as applicable. This includes requirements for clinical supervision.

If the individual licensing requirements do not include specific time periods regarding supervisory visits (e.g., every 30 days) then the supervising provider shall complete supervisory visits with the supervisee at least every 90 days, to ensure both the quality and appropriateness of the services provided, and to make any needed adjustments to the treatment plan. Supervision may be provided via telephone if allowed under the applicable licensing authority. The supervisor must document supervisory activities as described in Chapter VI of this manual.

Supervision of Personal Care Assistants

Any licensed practitioner who meets requirements as a qualified provider as defined in this chapter may supervise an unlicensed personal care assistant (PCA) within the scope of the supervising provider's licensing requirements. In cases where a single PCA is providing personal care services to a student based on multiple service-specific plans of care, the PCA's work must be supervised by multiple licensed practitioners representing each of the service-specific disciplines involved.

PROVIDER QUALIFICATIONS FOR SPECIFIC SERVICES

Physical Therapy Services

Physical therapy services must be performed by the following:

- A physical therapist (PT) licensed by the Virginia Board of Physical Therapy; or
- A physical therapy assistant (PTA) licensed by the Virginia Board of Physical Therapy under the supervision of a PT.

Occupational Therapy Services

Occupational therapy services must be performed by the following:

- An occupational therapist (OT) licensed by the Virginia Board of Medicine; or
- An occupational therapy assistant (OTA) licensed by the Virginia Board of Medicine under the supervision of a licensed occupational therapist.

Speech-Language Therapy Services

Speech-language therapy services must be performed by:

- A speech-language pathologist (SLP) licensed by the Virginia Board of Audiology and Speech-Language Pathology;
- A school SLP licensed by the Virginia Board of Audiology and Speech-Language Pathology; or
- A SLP provisionally licensed by the Virginia Board of Audiology and Speech Language Pathology.

Audiological Services

Audiological services must be provided by an audiologist licensed by the Virginia Board of Audiology and Speech-Language Pathology.

Nursing Services

Nursing services must be provided by:

- A Registered Nurse (RN) licensed by the Virginia Board of Nursing or through another state participating in the Nursing Licensing Compact as allowed under Virginia law; or
- A Licensed Practical Nurse (LPN) licensed by the Virginia Board of Nursing or through another state participating in the Nursing Licensing Compact as allowed under Virginia law.

Behavioral Health Services

The following definitions are useful in understanding DMAS qualifications needed for performing school-based behavioral health services:

"Licensed assistant behavior analyst" or **"LABA"** means an individual who is licensed as an Assistant Behavior Analyst by the Virginia Board of Medicine as defined in 18VAC85-150-10 et seq. These professionals are often referred to as Board Certified Assistant Behavior Analysts or BCABAs.

“Licensed behavior analyst” or **“LBA”** means an individual who is licensed as a behavior analyst by the Virginia Board of Medicine as defined in 18VAC85-150-10 et seq. These professionals are often referred to as Board Certified Behavior Analysts or BCBAs.

"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. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"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. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

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

"Postgraduate Professional License" and “Pupil Personnel Services License” are VDOE-issued school personnel licenses as defined in 8VAC20-23-10. Licensure endorsement requirements for school counselors may be found in 8VAC20-23-670; for school psychologists in 8VAC20-23-690; and for school social workers in 8VAC20-23-700.

The following behavioral health services providers may provide school-based services within the scope of their individual professional license:

- Persons designated as LMHPs by the Virginia Department of Behavioral Health and Development Services, which includes the following professionals:

    - Physicians and LBAs licensed by the Virginia Board of Medicine;
    - Licensed clinical psychologists, licensed by the Virginia Board of Psychology;
    - Licensed clinical social workers (LCSWs) licensed by the Virginia Board of Social Work;
    - Licensed professional counselors (LPCs), licensed substance abuse treatment practitioners (LSATP) and licensed marriage and family therapists (LMFTs) licensed by the Virginia Board of Counseling;
    - Psychiatric clinical nurse specialists (CNSs) licensed by the Virginia Board of Nursing and certified by the American Nurses Credentialing Center;
    - Licensed psychiatric/mental health nurse practitioners licensed by the Virginia Board of Nursing;

- LABAs licensed by the Virginia Board of Medicine working under the supervision of a LBA.
- Professionals holding a postgraduate professional license or a pupil personnel service license issued by the Virginia Department of Education with an endorsement in school social work, school psychology or school counseling.
- Professionals holding a school psychologist license-limited issued by the Virginia Board of Psychology.

Residents/Supervisees

LMHP-Rs, LMHP-RPs and LMHP-Ss may provide services under supervision of a LMHP in accordance with the applicable VDHP Health Regulatory Board regulations.

Psychological Testing Technicians

A qualified psychologist acting within the scope of their license may utilize an unlicensed person to administer psychological tests, and bill for this service as part of psychological testing evaluation services. The person must have undergone specific training in the administration of standardized psychological testing procedures, and the qualified psychologist must provide supervision in accordance with their license requirements. Reference Chapter V of this manual for billing requirements for psychological testing technician services.

Adaptive Behavior Treatment Technicians

A licensed psychologist, LBA or LABA provider acting within the scope of their license may delegate adaptive behavioral treatment tasks and procedures to unlicensed persons based on a written protocol developed by the supervising (delegating) professional in accordance with Virginia law. This includes:

- Personnel under the supervision of a LBA or LABA in accordance with 18VAC85-150-10 et seq. of the Virginia Board of Medicine regulations; and
- Personnel under the supervision of a Licensed Clinical Psychologist in accordance with § 54.1-3614 of the *Code of Virginia*.

Reference Chapter V of this manual for billing requirements for adaptive behavior treatment services performed by unlicensed staff.

*Tasks performed by unlicensed personnel cannot constitute the practice of applied behavior analysis in accordance with 18VAC85-150-130. The definition of unlicensed personnel includes but is not limited to Registered Behavior Technicians (RBTs).

Personal Care Assistant Services

Basic qualifications for persons performing PCA services include:

- Ability to perform personal care tasks strictly in accordance with a plan of care/treatment plan developed for an individual student (or students in limited circumstances described in Chapter IV) under supervision* of a DMAS qualified provider.

*Supervision must be carried out according to licensing requirements of the supervising provider of the services as listed in the plan of care.

Medical Services

Qualified providers of medical services include:

- A physician licensed by the Board of Medicine;
- A physician assistant licensed by the Board of Medicine; or
- A nurse practitioner licensed by the Board of Nursing.

Specialized Transportation

Providers of specialized transportation services must be employed through the LEA or have a contract with the LEA and must meet applicable federal and state statutes and regulations for transporting students.

Note: Specialized transportation service is not covered by the VA Medicaid Non-Emergency Transportation (NET) Brokerage program. School-based specialized transportation arrangements and services are provided only by LEA providers.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. 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.

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 with DMAS 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
P.O. Box 26803
Richmond, Virginia 23261-6803

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

Pursuant to § 32.1-325(D) of the Code of Virginia, the DMAS Director 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.