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.

PROVIDER PARTICIPATION REQUIREMENTS (PSYCH)

The psychiatric services included in this manual include psychiatric services in both inpatient and outpatient settings. This chapter provides general provider participation requirements and provider specific requirements for psychiatric services.

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, Mental Health Services Manual, and Residential Treatment Services Manual located on the DMAS website at: Provider Manuals Library | MES (virginia.gov)

All providers of psychiatric services are responsible for adhering to all DMAS policies, this manual, available on the DMAS website, their provider contract with the Managed Care Organization (MCOs) and related state and federal regulations.

ADVERSE OUTCOMES

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

RECOVERY AND RESILIENCY

DMAS encourages the provider network to integrate principles into their practices and service delivery operations including providing high quality, consumer-focused, recovery-based behavioral health services for individuals enrolled in Virginia Medicaid. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines

recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations: Recovery and Recovery Support | SAMHSA

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, measurable 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 QUALIFICATIONS

In addition to the criteria stated above, providers must meet the following requirements:

Inpatient Hospital

For provider enrollment requirements, please go to https://virginia.hppcloud.com/providerenrollment/enrollmentcreate and enter your information to obtain an Enrollment Pre-Checklist.

Outpatient Psychiatric Services

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

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

Outpatient psychiatric services must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S or school psychologist as defined below:
"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.

"School psychologist" means the same as defined in § 54.1-3600, licensed by the Virginia Board of Psychology as a School Psychologist (does not include school psychologists with a school psychologist-limited license).

Direct Supervision of Residents and Supervisees

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

- Therapy or counseling sessions rendered by a LMHP-R, LMHP-RP or LMHP-S must be provided under the direct, personal supervision of a licensed, qualified, Medicaid enrolled provider.
- The therapy session must contain at a minimum the dated signature of the LMHP-R, LMHP-RP or LMHP-S rendering the service but also include the dated signature of the qualified, Medicaid enrolled, licensed supervising provider.
- Each therapy session must contain the dated co-signature of the supervising provider within one business day from the date the service was rendered indicating that they have reviewed the note. The direct supervisor can be the licensed program supervisor/manager for the agency.

Physician Requirement for Mental Health Clinics

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

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

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

"As stipulated by section 1905 (a)(9) of title XIX of the Social Security Act, this requirement does not mean that the physician must necessarily be an employee of the clinic, or be utilized on a full-time basis or be present in the facility during all the hours that services are provided. However, each patient's care must be under the supervision of a physician directly affiliated with the clinic. To meet this requirement, a physician must see the patient at least once, prescribe the type of care provided, and, if the services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when his/her patient is receiving covered services, the physician must assume professional responsibility for the services provided and assure that the services are medically appropriate. Thus, physicians who are affiliated

with the clinic must spend as much time in the facility as is necessary to assure that patients are getting services in a safe and efficient manner in accordance with accepted standards of medical practice. For a physician to be affiliated with a clinic there must be a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided to the clinic's patients. Some clinics will require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement."

The requirement for physician supervision of all patient care in the clinic is a condition of participation with Medicaid and as a mental health clinic. The patient care protocols for treatment of individuals enrolled with Medicaid must reflect the role of the physician, and the patient's medical records must document that the physician has ordered the plan of care and is periodically reviewing the need for continued care. This requirement must be met for all clinic services billed to Medicaid by any employee of the mental health clinic.

Services Provided Under Arrangement and Medically Necessary EPSDT Services in an Inpatient Psychiatric Facility

The 21st Century Cures Act (Cures Act) requires that states must make available any services coverable under 1905(a) of the Act and the EPSDT benefit for youth under age 21 residing in an inpatient psychiatric facility and who are determined to need the service in order to correct or ameliorate health conditions, regardless of whether such services are identified in the youth's plan of care. These services may be provided by the inpatient psychiatric facility, under arrangement with a qualified non-facility provider, and/or by a qualified provider in the community not affiliated with or under arrangement with the facility. As the Cures Act requires that youth in inpatient psychiatric facilities are guaranteed full access to the full range of EPSDT services, a plan of care is not necessary to authorize any other medically necessary services and Medicaid services may be provided by community practitioners not affiliated with the facility.

Services Provided Under Arrangement

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

for members under age 21 residing in a psychiatric unit located within an acute care hospital or a freestanding psychiatric hospital.

Services Provided Under Arrangement	Private Freestanding Psychiatric Hospitals and Psychiatric Units located within Acute Care Hospitals	State Freestanding Psychiatric Hospitals
Physician Services	Yes	No
Other medical and psychological services including those furnished by licensed mental health professionals and other licensed or certified health professionals (i.e. oral surgeons, nutritionists, podiatrists, respiratory therapists, substance abuse treatment practitioners)	Yes	No
Outpatient Hospital Services	Yes	No
Pharmacy services	No	Yes
Physical therapy, occupational therapy and therapy for individuals with speech, hearing or language disorders	Yes	No
Laboratory and radiology services	Yes	No
Durable medical equipment (including prostheses/orthopedic services and supplies and supplemental nutritional supplies)	No	No
Vision services	Yes	No
Dental and orthodontic services	Yes	No

Non-Emergency Transportation services	Yes	No
Emergency services (including outpatient hospital, physician and transportation services)	Yes	Yes

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

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

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

Requirements for Direct Reimbursement to Providers of Services Provided Under Arrangement

DMAS or its contractors will reimburse services provided under arrangement separately from the per-diem rate paid to inpatient psychiatric provider only if the provider meets all of the following requirements:

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

Each initial and comprehensive plan of care must include, within one (1) calendar day of the initiation of the service provided under arrangement, any service that the individual needs while residing in the inpatient psychiatric setting, and that is furnished to the member by a provider of services under arrangement. Physicians may implement the

change to the plan of care by telephone, provided that the documented change is signed by the physician as soon as possible, and not later than the next 30-day plan review. Services provided under arrangement must be included in the plan of care -- documentation in the assessment, progress notes, or elsewhere in the medical record will not meet this requirement.

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

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

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

The contract must include the following:

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

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

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

Each inpatient psychiatric provider must maintain medical records from the provider of services under arrangement in the individual's medical record at the facility. These may include admission and discharge documents, treatment plans, progress notes, treatment

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

If there is the potential for retroactive Medicaid eligibility, the inpatient psychiatric provider should comply with these requirements so that the provider of services under arrangement can bill Medicaid after eligibility is confirmed. The provider must follow special billing instructions described in Chapter V.

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

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

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

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

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

Some providers are affiliated with hospitals but provide outpatient services as a separate billable item from the hospital charge (such as radiologists, pathologists, anesthesiologists, etc.). The acute-care hospital shall be responsible for providing the

referral NPI of the inpatient psychiatric provider to these “hidden” providers. These “hidden” providers must be addressed in the contract between the inpatient psychiatric provider and the hospital that provides the emergency services.

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

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

If the inpatient psychiatric provider fails to comply with any one of the requirements listed above, DMAS or its contractor may retract the per diem reimbursement made to the inpatient psychiatric provider on behalf of a member during the period of non-compliance.

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

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

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