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.

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. If a provider is outside of the 50-mile border of Virginia and considered an out of state provider, then a claim or supporting documentation is required to necessitate their enrollment.

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

7. 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 five (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 five (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 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 five (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 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 waiver services or medical care from any institution, pharmacy, provider, 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 supports, 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.

- The provider shall submit all other available third-party payment sources prior to submitting a claim to DMAS or the MCO, as applicable. Notwithstanding this, the Provider shall not request, pursue (e.g., assignment of rights by member or member's representative) or accept payment for medical services from any tortfeasors or their carrier arising from a bodily injury claim (for example, motor vehicle, or homeowner's insurance).

- The provider and its vendors must submit claims for medically necessary, Medicaid-covered services to DMAS or the MCO, as applicable, provided that the member has supplied information to verify the member's Medicaid enrollment at least 21 days before the claim submission deadline. A provider that does not comply with this requirement agrees not to bill the member for such services or assert any contractual assignments, benefits, rights to reimbursement, or statutory liens against the member.

- 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 the nature, scope, and details of the health care services 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 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 is 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 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 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 individuals with disabilities 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 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 termination's 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 after 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 and issues the informal appeal decision. An informal appeal decision must be issued before a provider can request a formal appeal.

For formal appeals, a hearing officer is selected from a list maintained by the Supreme Court of Virginia. The hearing officer sends a recommended decision to the Agency Director, who then issues the final agency decision.

Appeal Requests

How to Request an Appeal

Effective November 5, 2026, all providers must request appeals through the Appeals Division's online portal, the Appeals Information Management System ("AIMS"). Providers must have an AIMS account to request an appeal.

Provider registration requests must be reviewed before the account is created. As a result, providers will not have an AIMS account immediately after registering. Providers are encouraged to register for AIMS even if they do not need to file an appeal.

Providers can register for and access AIMS at www.dmas.virginia.gov/appeals.

Exception to the Portal Filing Requirement

Providers who are unable to file an appeal request through AIMS can request an exception. The request must have a subject of "Exception Request for Portal Filing." For emails, this must be in the subject line. For delivered requests, this must be underneath the address block on the cover letter. The request must be filed prior to the appeal request deadline.

Exceptions will be granted for good cause shown. Examples of good cause include:

1. The infrastructure necessary to support electronic submission is not available in the provider's geographic region;
2. The disability of all members of a provider's staff prevents their use of AIMS; or
3. The provider cannot transmit documents through AIMS due to unusual or unavoidable circumstances.

Providers can request an exception using any of the following methods:

1. Email the exception request to appeals@dmas.virginia.gov.
2. Mail or bring the exception request to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

If the DMAS Appeals Division grants an exception to the portal filing requirement, the provider must file an appeal request through email, postal mail, or hand delivery, prior to the appeal request deadline. See 12VAC30-20-520 for more information.

Multiple Appeal Requests

Providers must submit a new appeal request for each appealable notice received.

Filing Date

A provider's appeal request is filed when it completes transmittal to AIMS.

If the DMAS Appeals Division grants an exception to the portal filing requirement, the provider's appeal request is filed when it is date-stamped by the DMAS Appeals Division. See 12VAC30-20-520 for more information.

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

Providers must upload all documents, correspondence, and other items to AIMS. The Appeals Division will not accept items a provider sends through any other method unless the Appeals Division granted the provider's request for an exception from the portal filing requirement.

The Appeals Division will send all documents and correspondence through AIMS. 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; for security reasons, the email will only contain a link to log in to AIMS to review the documents. The Appeals Division presumes the point of contact receives all items when the Appeals Division sends the email notification to the point of contact.

For technical assistance with AIMS, contact AIMS Help at aimshelp@dmas.virginia.gov or 804-486-2865.

If the Appeals Division grants an exception to the portal filing requirement, the Appeals Division will send all documents and correspondence to the postal mail address listed in the provider's exception request. The provider may transmit items through email, mail, or hand delivery. See 12VAC30-20-520 for more information on filing documents after an exception request is granted.

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 formal appeal request 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 formal appeal request 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.

EMERGENCY AND NON-EMERGENCY AIR AND GROUND AMBULANCE, AND NEONATAL TRANSPORT PROVIDER ENROLLMENT

Virginia Emergency And Non-Emergency Air And Ground Ambulance, Neonatal Transport Providers Must Be Enrolled With The Department Of Medical Assistance Services (DMAS) Prior To Billing For Any Services Provided To Medicaid Members. In Order For Air, Ground, And Water Ambulance Providers To Bill For Members Enrolled With An MCO Plan Providers Must Also Be Enrolled With That MCO Plan. Contact The MCO Plan For Enrollment Requirements.

He Air Ambulance, Emergency And Non-Emergency Ground Ambulance, And Neonatal Transport Provider Participation Agreement And Enrollment Packet For All Ambulance Services Can Be Found At:
Https://Www.Dmas.Virginia.Gov/For-Providers/Medicaid-Enterprise-System/Fee-For-Service-Providers/.

The Transportation Manual Consists Of Six Chapters. Specific Chapters In The Manual Contain Instructions For Billing And Specific Details Concerning The Medicaid Program. Providers Must Comply With All Sections Of This Manual To Maintain Continuous Participation In The Medicaid Program. The Transportation Manual Link Is:
Https://Vamedicaid.Dmas.Virginia.Gov/Manuals/Transportation-Manual.

The Health Insurance Portability And Accountability Act Of 1996 (HIPAA) Mandated That The Secretary Of Health And Human Services Adopt A Standard Unique Health Identifier For Healthcare Providers. Providers Of Medical And Health Services For Medicaid Members Must Obtain A National Provider Identifier (NPI) And Submit The NPI To DMAS. The NPI Replaces All Previously Assigned Medicaid Provider Numbers And Must Be Included On All Claims And Correspondence Submitted To Medicaid.

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) PROVIDER ENROLLMENT

DMAS Has Contracted With A Broker To Manage The Fee-For-Service (FFS) Non-Emergency Medical Transportation Program (NEMT) For The Commonwealth Of Virginia. All FFS Non- Emergency Transportation Providers Must Enroll With The FFS NEMT Broker. The FFS NEMT Broker Provider Enrollment Contact Telephone Number Is 1-866-810-8305 X2645. DMAS Does Not Enroll NEMT Providers Directly. NEMT Providers Must Enroll With The FFS Broker, MCO Broker(S) Or MCO Plan Internal Transportation Program For NEMT Provider Enrollment. In Order To Transport Members NEMT Provider

Must Meet FFS Or MCO Provider, Driver, And Vehicle, Driver Requirements. FFS NEMT Provider, Driver, And Vehicle Requirements Can Be Found At: Https://Www.Dmas.Virginia.Gov/Media/3090/Dmas-Nemt-Ffs-And-Mco-Provider-Enrollment.Pdf .

Managed Care Organizations (MCO) Either Contract With A Transportation Broker Or Have Internal Transportation Services. Please Contact The MCO For Information On Contacting With Their Broker Or Internal Transportation Services. The Information Can Be Found At:
Https://Www.Dmas.Virginia.Gov/Media/3090/Dmas-Nemt-Ffs-And-Mco-Provider-Enrollment.Pdf.

All NEMT Providers And Volunteer Drivers Must Have An NPI And Taxonomy Code Prior To Enrollment. The Seven Types Of Transportation Providers In The NEMT Program Are:

- Sedan/Taxi For Ambulatory
- Wheelchair Transportation
- Non-Emergency Ambulance
- Stretcher Van
- Non-Emergency Neonatal Transports
- Volunteer Drivers
- Transportation Network Companies (TNC - DMAS Type 1 And Type 2)

Volunteer Driver For Non-Emergency Medical Transportation

DMAS Has Contracted With A Broker To Manage Non-Emergency Medical Transportation. The Broker Has A Volunteer Driver Program In Which “Certified” Volunteers Receive Mileage Reimbursement For Transporting Medicaid Eligible Members To Medicaid Covered Services. Volunteer Drivers Must Complete The Volunteer Driver Training Program And Have Their Vehicles Inspected By The Broker Prior To Transporting Medicaid Members. All Volunteer Driver Trips Are Assigned And Paid For By The Broker.

For Information On Being A FFS Volunteer Driver Please Contact The FFS NEMT Broker At 1-866-810-8305 X2645.

MANAGED CARE ORGANIZATION (MCO) TRANSPORTATION PROVIDER ENROLLMENT

Virginia Medicaid Enrolls Eligible Medicaid Members In Managed Care Organizations (MCO). Eligible FFS And MCO Members Receive Emergency Air And Ground Ambulance And Non-Emergency Transportation Services Through Either MCO Transportation Broker, MCO Internal Transportation Service Or Directly Through The MCO. Please Contact The MCO For Transportation Questions MCO Contacts Can Be Found At:

Https://Www.Dmas.Virginia.Gov/Media/3090/Dmas-Nemt-Ffs-And-Mco-Provider-Enrollment.Pdf.

All FFS And MCO Air Ambulance, Emergency Ground, And Non-Emergency Ground Ambulance Providers Must Enroll With DMAS Prior To Enrolling With A MCO Or Transporting Members. DMAS Ambulance Provider Enrollment Information Can Be Found At:
Https://Vamedicaid.Dmas.Virginia.Gov/Providernemt Providers That Want To Do Business With Mcos Must Contact The MCO Directly For MCO Provider Enrollment.

DMAS Does Not Enroll NEMT Providers Directly. Please Contact The FFS Broker, MCO Broker(S) Or MCO Plan Internal Transportation Program For NEMT Provider Enrollment.

PARTICIPATION CONDITIONS (TRANSPORT)

All Providers Enrolled In The Virginia Medicaid Program Must Adhere To The Conditions Of Participation Outlined In Their Individual Provider Agreements. The Paragraphs, Which Follow Outline Special Participation Conditions, Which Must Be Agreed To By Certain Types Of Providers.

Emergency Air And Emergency Ground Ambulance Service Providers

Emergency And Non-Emergency Ambulance Operators Who Are Certified By The Office Of Emergency Medical Service (OEMS) Of The State Department Of Health Become Enrolled As Participating Providers By Executing An Agreement With The Department Of Medical Assistance Services.

All Emergency Air Ambulance, Emergency And Non-Emergency Ground Ambulance Providers Must Sign An Agreement With Medicaid. Other Applicable Requirements Are As Follows:

- A Copy Of The Office Of Emergency Medical Services Certification Is Required For A Ground Ambulance And Neonatal Transport Services.

- A Copy Of The FAA 135 Air Ambulance Certification Is Required For Emergency Air Ambulance Services.

Upon Receipt Of The Required Documents, The Provider Will Use Their NPI And Taxonomy Code Numbers When Submitting Claims.

Not All FFS Non-Emergency Ground Ambulance Services Are Billed Directly To DMAS. However, Non-Emergency Ambulance Providers Must Meet DMAS Requirements Before Enrolling With The FFS Broker, MCO Broker(S) Or Internal Transportation Services.