Provider Participation Requirements (PP)

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Provider Participation Requirements (PP)

Updated: 6/30/2022

Managed Care Enrolled Members (PP)

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, prior 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.

Effective April 4, 2022 all newly enrolling providers seeking to participate with one or more of DMAS's MCO(s) must be screened and enrolled with DMAS prior to enrolling with the MCO(s).

Effective April 4, 2022, all newly enrolling providers seeking to participate with the DMAS Behavioral Health Services Administrator (BHSA) must be screened and enrolled with DMAS.

After DMAS screens and approves a provider's enrollment application, it will be forwarded to the MCO(s) requested by the provider along with any required supporting documents. Any provider of services must be enrolled with DMAS prior to billing for services rendered to eligible individuals, including individuals enrolled with an MCO.

CARVED OUT SERVICES

Some services are "carved out" of the managed care system and are paid directly by DMAS using fee-for-service methodology regardless of the individual's MCO enrollment. Providers must follow the fee-for-service rules in these instances.

Individuals who receive services under one of the three 1915(c) Developmental Disability Home and Community-Based Services (HCBS) Waivers, including the Building Independence, Community Living, and Family and Individual Supports Waivers, are enrolled in CCC Plus 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.

There are two different managed care programs (Medallion 4.0, and Commonwealth Coordinated Care Plus (CCC Plus). DMAS has different MCOs participating in these programs. For providers to participate with one of the DMAS-contracted managed care organizations/programs, they must be credentialed by the MCO and contracted in the MCO's network.

For more information on participation with the Medallion 4.0 and/or Commonwealth Coordinated Care Plus (CCC Plus) programs, and the DMAS BHSA please visit the DMAS website at https://www.dmas.virginia.gov.

Participating Provider

A participating provider is a person who has a current, signed participation agreement with the Department of Medical Assistance Services.

PROVIDER ENROLLMENT (PP)

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.

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.

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. (Reference Healthcare Information Portability and Accountability Act (HIPAA) of 1996.)

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.

Provider Screening Requirements

All providers must undergo a federally mandated comprehensive screening as part of their enrollment process. An abbreviated screening is also performed on a monthly basis for any provider who participates with the Virginia Medicaid Program. The full screening is conducted at the time of revalidation, and providers are required to revalidate at least every 5 years.

The requirement for screening is in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid Program agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers' categorical risk levels are defined as "limited", "moderate" or "high".

Limited Risk Screening Requirements

The following screening requirements apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or 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

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. 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 submission of 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. This includes 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. Please refer to the table at the end of this chapter for more information on provider types that may be charged an application fee.

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 be made to CMS pursuant to 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers with a primary servicing address located outside of the Virginia border and, due to their provider risk-level, require a site visit, must have a site visit conducted by either their state's Medicaid program or by CMS prior to enrollment in DMAS. If the application is received by DMAS prior to the completion of the site visit, as required in the screening provisions of the Affordable Care Act (42 CFR

455 Subpart E), the application will be pended for proof this information.

Revalidation Requirements

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via our web portal.

Registration into the Virginia Medicaid Web Portal will be required to access and use the online enrollment and revalidation system.

All enrolled providers in the Virginia Medicaid program will be notified in writing of a revalidation date and informed of the new provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

Ordering, Referring, and Prescribing (ORP) Providers

Code of Federal Regulations 42 CFR 455:410(b) states that State Medicaid agencies must require all ordering or referring 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 ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

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

Please go to Chapter V of this provider manual to review the new billing procedures related to the implementation of these new screening requirements.

Participation Requirements

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

- Immediately notify Provider Enrollment Services in writing of any change in the information that the provider previously submitted to DMAS.
- Ensure freedom of choice to individuals who are eligible for medical assistance under the

Virginia Medicaid Program (eligible individuals) in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required service(s) and participating in the Virginia Medicaid Program at the time the service was performed.

- Ensure the eligible individual's freedom to reject medical care and treatment.
- Comply with 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 ground of race, color, or national origin.
- Provide services, goods, and supplies to eligible individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Rehabilitation Act requires reasonable accommodations for certain persons with disabilities.
- 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 for submission of charges.
- Maintain and retain business and professional records sufficient to 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. (Refer to the section titled "Documentation of Records," page 4.)
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to eligible individuals.
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding eligible individuals. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health

benefits or the data are necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUAL 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 physician 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, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by the Virginia Medicaid Program may be subject to overpayment liability as well as civil monetary penalties.

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

- Screen all new and existing employees and contractors to determine whether any of them have been excluded from participation in Medicaid or Medicare.
- 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. See below for information on how to search the LEIE database.
- 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, Ste 1300
Richmond, VA 23219
-or-
E-mailed to: providerexclusions@dmas.virginia.gov

Special Participation Requirements

All providers enrolled with DMAS must adhere to the conditions of participation outlined in their individual provider participation agreements. The paragraphs that follow outline special participation conditions which must be agreed to by certain types of providers.

Licensed Physicians

Physicians currently licensed in the Commonwealth of Virginia (or in the state in which they practice) to practice as doctors of medicine (M.D.) or doctors of osteopathy (D.O.) may apply for participation in the Virginia Medicaid Program by signing the authorized Participation Agreement. Acceptance for participation is based upon the needs of the Medicaid Program, pursuant to Section 32.1-325 of the *Code of Virginia*. Physicians who, in any of the 50 states, have relinquished or have had revoked their license to practice medicine will have their applications considered on a case-by-case basis, taking into consideration the needs of the Virginia Medicaid Program. The agreement(s) must be in effect at the time services are rendered in order for claims to be paid. Each physician will be assigned a provider identification number. DMAS can pay only for services performed by the participating treating physician or under their direct, personal supervision. Records must fully disclose a sufficient amount of information to indicate the extent and nature of the physician's overall supervision and participation in the care and treatment of the patient.

In inpatient teaching settings, the Virginia Medicaid Program will cover the services of an attending physician (other than an intern or resident) to an eligible individual, when the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of the individual. In the case of major surgical procedures or other complex or dangerous procedures or situations, such personal direction must include supervision in person by the attending physician. Payment will be made for the services of an attending physician who involves interns and residents in the care of his or her patient only if such services to the patient are of the same nature, in terms of responsibilities to the patient that are assumed and fulfilled, as the service rendered to other paying patients.

In ambulatory teaching and non-teaching settings, as evidence that a covered service was rendered under the attending physician's supervision, the medical record must contain the attending physician’s signed or countersigned notes which show that the attending physician personally reviewed the individual's medical history, gave a physical examination, confirmed or revised the diagnosis, and visited the individual. Exceptions to this requirement are outlined below:

I. When the following conditions are met, as evidence that a covered ambulatory visit was rendered by a resident physician under the attending physician’s supervision, the medical record must contain the attending physician’s signed or countersigned notes which show that the attending physician reviewed and confirmed the diagnosis and treatment plans, and the extent of their participation in the direction of services furnished to the patient:

- The resident physician has completed at least 6 months of training; and
- The degree of supervision for resident physicians is appropriate for the skill level, experience and level of training of the resident physician and the complexity and

severity of the patient's condition, consistent with Accreditation Council for Graduate medical Education (ACGME) standards; and

- The attending physician is on-site and immediately available to supervise services provided by resident physicians and billed to DMAS; and
- The attending physician is not supervising more than 4 residents in any clinic session; and
- Supervision of resident physicians is the attending physician’s primary responsibility at the time services are furnished by residents; and
- The attending reviews the care furnished by resident physicians during, or immediately after, each visit, including a review of the patient’s medical history and diagnosis, the resident physician’s findings on physical examination, and the treatment plan (e.g., tests and therapies ordered); and
- The service is furnished under the attending physician’s overall direction and control; and
- The attending maintains primary medical responsibility for patients cared for by resident physicians and ensures that the care furnished is medically indicated; and
- The care required by the eligible individual does not constitute the evaluation or management of an acute or chronic illness or injury that poses a threat to life or bodily function.

II. When the following conditions are met, as evidence that an office-based ambulatory procedure was rendered by a resident physician under the attending physician’s supervision in accordance with the scope and supervisory guidelines of the Accreditation Council for Graduate Medical Education, the medical record must contain the attending physician’s signed or countersigned notes which show that the attending physician reviewed and confirmed the appropriateness of the procedure, and the extent of the attending physicians’ participation in the direction of the procedure furnished to the patient:

- All of the conditions outlined in section I above have been met; and
- The resident physician has been deemed competent by their training program to independently perform the procedure.

Physician Assistants

As of September 1, 2021 qualified Physician Assistants (PA) practicing in accordance with 18VAC85-50-101 may enroll with the Department of Medical Assistance Services (DMAS) as fee-for-service participating provider class type “Physician Assistant” and claim reimbursement for providing covered services to Medicaid and FAMIS-eligible individuals within their scope of practice. Physician Assistants who are not enrolled may continue to bill for Medicaid covered services within their scope of practice through their supervising Physician’s National Provider Identifier, as long as the Physician is enrolled in the Virginia Medicaid program.

Telemedicine Services

Please reference the Telehealth Services Supplement to this manual.

Locum Tenens Arrangement

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) provides that physicians may bill for the services of a substitute physician. Therefore, DMAS will allow for billing by the absent physician in cases where an informal reciprocal agreement exists between the physicians. This reciprocal agreement is limited to a period of 14 days with at least one-day elapsing before the beginning of another 14-day period.

Certification and Recertification (PP)

The Virginia Medicaid Program is dependent upon the participation and cooperation of physicians who provide or order health care services. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with community standards of medical practice.

Physicians, General

Medicaid recognizes the physician as the key figure in determining utilization of health services. The physician decides upon admission to a hospital; orders tests, drugs, and treatments; and determines the length of stay. The Program calls for substantiation of certain physician decisions as an element of proper administration and fiscal control. Payment for certain covered services may be made to a provider of services only if there is a physician's certification concerning the necessity of the services furnished, and, in certain instances, only if there is a physician's recertification to the continued need for the covered services.

- The institutional provider of services is responsible for obtaining the required physician certification and recertification statements and for retaining them on file for verification, when needed, by the intermediary or by the State Agency.
- Each provider of services determines the method by which the required physician certification and recertification statements are obtained. Use of specific procedures or specific forms is not required, so long as the approach adopted by the provider permits verification that required physician certification and recertification statements are entered on or included in forms, notes, or other records a physician normally signs in caring for a patient; a separate form may be used for this purpose. Each certification and recertification statement must be separately signed and dated at the time it is signed by a physician, except as otherwise specified in this section.
- The requirements for recertification (and for certification for inpatient hospital services furnished) set forth in this section specify certain information that must be included in the physician's statement. This required information need not be repeated in a separate statement if, for example, it is contained in the physician's progress notes. The physician's statement may merely indicate that the required information is contained in the patient's medical record, if this is so.
- Providers of services are expected to obtain timely certifications and recertifications. However, delayed certifications and recertifications can be honored when, for example, the patient was unaware of his or her eligibility for the benefits when he or she was treated. Delayed certifications and recertifications must include or be

accompanied by an explanation for the delay, including any medical or other evidence the physician or provider considers relevant for explaining the delay. A delayed certification and one or more delayed recertifications may appear in one signed statement.

Inpatient Hospital Services

Certification

Federal regulation 42 CFR 456.60 requires a physician certification that inpatient hospital services are necessary for each hospitalized member. A physician must certify the need for inpatient care at the time of admission. The certification must be in writing and signed or initialed by an individual clearly identified as a doctor of medicine (M.D.) or doctor of osteopathy (D.O.). The certification must be dated at the time it is signed.

The certification may be either a separate form to be included with the patient's records or a stamp stating "Certified for Necessary Hospital Admission" which is to be made an **identifiable** part of the physician orders, history and physical, or other patient records. This certification must be signed and dated by the physician at the time of admission or, if an individual applies for assistance while in the hospital, before payment is to be made by the State Agency.

Federal regulation 42 CFR 456.80 requires that a written plan of care be established at the time of admission or before payment for care can be authorized for each member. The plan must be an identifiable part of patient records and must include:

- Diagnosis, symptoms, complaints, and complications indicating the need for admission;
- A description of the functional level of the individual;
- Any orders for medication, treatment, restorative or rehabilitative services, activities, social services, and diet;
- Plans to continue care as appropriate; and
- Plans for discharge.

Recertification

A physician, physician assistant, or nurse practitioner, acting within the scope of practice as defined by State law and under the supervision of a physician, must recertify at least 60 days after certification for each member that inpatient hospital services are needed.

This required information need not be repeated in a separate statement if, for example, it is contained in the physician's progress notes. The physician's statement may merely indicate that the required information is contained in the patient medical record, if this is so.

Long-Term Care Facilities

(Effective Date: Revised October 1, 1990)

Physician Certification and Recertification

In each case for which payment for inpatient nursing facility services or inpatient mental hospital services is made under the State Plan:

- In a nursing facility, a physician must approve a recommendation that an individual be admitted. The nursing home preadmission screening shall serve as the physician's admission or initial recommendation if the date of the screening occurred within 30 days of the date of the admission to a nursing facility. Recertification is not required for nursing facility residents.

- In a facility for the mentally retarded, the physician or nurse practitioner or clinical nurse specialist who is not employed by the facility and who is working in collaboration with a physician must recertify that patients continue to require the specific level of care at least once every 365 days.

- In mental hospitals, recertifications are required in intensive psychiatric units and in hospital areas (medical-surgical units) at least every 60 days. In nursing facility areas, units, or buildings on the grounds of State mental hospitals, the certification requirements are the same as for nursing facilities, based on the certification of the unit.

Note: The initial certification for either level of care must be dated and signed within 30 days prior to or at the time of admission. The date of the next recertification is computed from the date the initial certification was actually signed.

- Certification is not considered a pro forma act but rather a medical decision based on the professional evaluation of the patient's needs. The certification must justify the reasons for nursing facility placement and be signed (name and title) and dated (month, day, and year) by the attending physician or nurse practitioner or clinical nurse specialist as qualified on the preceding page. (Rarely would a diagnosis alone be acceptable as justification for nursing facility care.)

- For purposes of determining compliance, a recertification shall be considered to have been completed on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required if the physician or other person making the certification provides a written statement showing good cause why the recertification did not meet the schedule. The statement of good cause must be filed in the patient's record and be made available to the Department of Medical Assistance Services staff when audits for compliance are made. In the absence of clarifying regulations, the agency has not defined "good cause." Therefore, any

statement made by the physician purporting to show good cause will be accepted if made in writing by the physician, nurse practitioner, or clinical nurse specialist responsible for making such recertification and filed in the patient's record.

- The Department of Medical Assistance Services accepts recertifications written and signed by nurse practitioners or clinical nurse specialists. Private-pay patients who apply for Medical Assistance must have their certification signed by the physician or other qualified health professional at the time an application is made for Medicaid eligibility determination.
- Certification reflecting the need for nursing home placement and the physician's progress note of the observed medical condition may be contained in the same note. However, these are two separate requirements, and one cannot be substituted for the other.

NOTE: All physician or other health care professionals' documentation, including certifications, must be signed with the initials, last name, and title. All documentation must be completely dated with the month, day, and year. Mailing in certifications, orders, or progress notes is prohibited.

Physician's Plan of Care and Orders

A physician must approve a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. All residents must be seen by a physician, and orders must be renewed at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter (effective April 1, 1992). The most current page of the physician's orders must be the first page of the physician's order section in the medical record. "Renew orders" is acceptable if all current orders are on the same page of the physician's order sheet.

The plan of care must include diagnoses, symptoms, complaints, and complications, and any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and plans for discharge. Orders must be specific for individual needs, and all orders must be complete (i.e., the medication orders must include the medication name, dosage, frequency, and route of administration; restraint orders must include the specific times in which the restraint may be applied, the type of restraint to be used, and the periods of time in which restraint will be removed for resident exercise).

A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required. The initial physician visit must be made by the physician personally. Subsequent required physician visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner under the physician's supervision.

In facilities for the mentally retarded, the physician must also review the use of psychotropic drugs on at least a quarterly basis for adverse side effects and record the review in the medical records of residents receiving a psychotropic drug. If psychotropic drugs are utilized, there must be a behavioral

program for that resident.

Progress Notes

It is expected that the physician will visit the resident and write progress notes, which reflect the observed medical condition of the resident. Physician progress notes should record any significant change between visits or record or elaborate when the resident's condition is unchanged. The record must indicate the progress at each visit, any change in the diagnosis or treatment, and the resident's response to treatment.

Progress notes must be written for every nursing facility visit to a member and at least every 90 days. If a physician chooses to delegate the alternate patient visits (as described above), the physician assistant or nurse practitioner must write the progress notes for visits in which he or she was involved. Significant changes or problems in the patient's condition must be immediately reported to the physician.

DMAS will accept documentation written by an alternate physician, such as the Medical Director.

Home Health Services

Home health services include periodic nursing care under the direction of a physician. Such services are provided by participating home health agencies and can be used effectively by the physician for post-hospital care and periodic nursing care.

To be eligible for home health services, the patient must be essentially homebound. While this does not mean bedridden, the patient must meet at least one of the following conditions to be considered homebound:

- The patient's physical condition is such that there exists a normal inability to leave home without the assistance of others or the use of special equipment;
- The patient has a mental or emotional problem which is manifested in part by refusal to leave his or her home environment or is of such a nature that it would not be considered safe for him or her to leave home unattended;
- The patient is ordered to restrict his or her activity by the physician due to a weakened condition following surgery or heart disease of such severity that stress and physical activity must be avoided; or
- The patient has an active communicable disease, and the physician restricts the patient to prevent exposing others to the disease.

In addition, under the following conditions, Medicaid will reimburse for home health services when a patient is not essentially homebound when:

- The combined cost of transportation and medical treatment exceeds the cost of a home health services visit;
- The patient cannot be depended upon to go to a physician or clinic for the required treatment; as a result, he or she would, in all probability, have to be admitted to a hospital or nursing facility because of complications arising from the lack of treatment;
- The visits are for a type of instruction to the patient which can better be accomplished in the home setting; or
- The duration of the treatment is such that rendering it outside of the home is not practical.

When home health services are provided because of one of the above reasons, an explanation must be included on the Home Health Certification and Plan of Treatment (HCFA 485, 486, and 487 forms.

Certification (PP)

The required physician's statement should certify that:

- The home health services were required because the individual was confined to his or her home (as described above) or when the conditions for when a patient is not essentially homebound.
- The individual needed skilled nursing care or home health aide services on an intermittent basis, or he or she needed physical or occupational therapy or speech-language pathology services.
- A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician.
- These services were furnished while the individual was under the care of a physician. The physician may be the patient's private physician or a physician on the staff of the home health agency or a physician working on an arrangement with the institution which is the patient's residence or, if the agency is hospital-based, a physician on the hospital or agency staff.

Recertification

A recertification is required at intervals of at least once every two months, should be signed by the physician who reviews the plan of treatment, and should preferably be obtained at a time when the plan of treatment is reviewed. The recertification statement should indicate the continuing need for services and should estimate how long home health services will be needed.

Certification and Recertification for Member Who Receives Services Prior to Entitlement

If any individual receives services before his or her entitlement to Medicaid benefits, the timing of certification and recertification will be determined as if the date of entitlement was the date of admission. For example, if any individual is admitted to a hospital before entitlement, the date of entitlement will determine the timing of certification and recertification, not the date of admission.

Timing Requirements for Provider Signatures

[Effective Date: 7-13-2017]

All physician services provided shall be documented in the medical record at the time they are rendered, whether in-person or via telehealth. All patient medical records, whether paper-based or electronic, shall be signed with the first initial, and last name and title and dated (month, day, and year) no later than 14 calendar days from the date of service delivery. The 14-day signature requirement shall apply in all cases, except where a federal or state signature deadline requires a time frame different than 14 days.

Use of Rubber Stamps for Physician Documentation

[Effective Date: 1-23-92]

When a rubber stamp is used, the individual whose signature the stamp represents must provide DMAS with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. All rubber-stamped signatures are also required to be accompanied by the initials of the physician and the date (month, day, year) at the time the rubber stamp is used.

The signature waiver form must be received 30 days prior to the date of the anticipated use of the rubber stamp. All documentation must be completely dated with the month, day, and year. Mailing in certifications, orders, or progress notes is prohibited.

Requirements of the 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 provision 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 DMAS under the contract with DMAS must comply with the requirements of Title VI of the Civil Rights Act of 1964 which requires that services be provided to Medicaid-eligible individuals without regard to race, color, religion, sex, or national origin.

Utilization of Insurance Benefits

Virginia Medicaid is a "last pay" 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. 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 Virginia Code Section 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, Virginia Medical Assistance Program, 600 East Broad Street, Richmond, Virginia 23219.

Documentation (PP)

The Virginia Medicaid Program provider participation agreement requires that the 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 must be legible and clear in the description of the services rendered. All documentation must be signed (name and title) and dated (month, day, year) on the date of service delivery. Dates may not be typed onto medical records in advance of the signature.

The provider is to select from the *Physicians' Current Procedural Terminology, Fourth Edition* (CPT) the procedure code which most appropriately describes the service rendered and documented. Please pay particular attention to the definitions and descriptions regarding classifications of the evaluation and management (E/M) services for new and established patients as contained in the introduction to the CPT. These same definitions and descriptions will be used to evaluate the documentation during Program audits of medical records.

A pre-existing written protocol, defined as a narrative explanation of an office or examination procedure, with contemporaneous medical record documentation may be considered in addition to the medical record to satisfy the documentation requirements. The protocol is not acceptable as a replacement for appropriate medical record documentation.

Specific points to be recorded in the medical records to meet the documentation requirements should include the following as appropriate:

- The present complaint;
- A history of the present complaint, the past medical history applicable to the complaint, and the family history when applicable to the complaint;
- The positive and negative physical examination findings pertinent to the present complaint;
- The diagnostic tests ordered, if any, and the positive and negative results;
- The diagnosis(es);
- The treatment, if any, including referrals. Any drugs prescribed as part of the treatment must have quantities and the dosage entered in the medical record;
- The observed medical condition of the patient, the progress at each visit, any change in the diagnosis or treatment, and the response to the treatment. Progress notes must be written for every office, clinic, nursing facility, hospital, or psychotherapy visit billed to Medicaid;
- The length of time and type of therapy (i.e., individual or group) for psychotherapy.
- The provider in solo practice must have a method of identifying the member and the treating physician for each service. However, entries from covering physicians must be signed by the covering physicians.
- In group practices, providers must have a verifiable method of identifying the member and the treating physician for each service.
- The documentation for care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.
- Signature (name and title) and date (month, day, year) on the date of service delivery. Dates may not be typed onto medical records in advance of the signature.

Examples of Medical Record Documentation

Office Visit with Follow-Up Visit

John Doe

Jan. 20, 1989 BP 120/70 T 98.6
C/O itching over back and legs x 2 wks.

Macular excoriated eruptions over back and lower legs. None on chest or abdomen. HEENT WNL. Chest clear, heart regular.

Dermatitis, non-specific
Zone A Forte BID & HS
Prednisone 5 mg. TID #12
Chlorofed q12h rtn 2 wks
Bob Roe, M.D.

Feb. 3, 1989 BP 110/70 T 98.6
Itch has resolved. C/O headache
HEENT WNL, chest clear, heart regular, abd soft ext WNL.
Headache
Esgic tab #60 1-2 tab q4h prn
Bob Roe, M.D.

Pediatric Office Visit with Follow-Up Visit

Jimmy Doe

Jan. 20 1989

CC: coughing, worse at night. Pulling at ears T 99
TMs injected with fluid. Tonsils injected and red. Coarse rhonchi with squeaks.
HCT 27.4 Strep screen- pos.
Plt 381,000
WBC 6.6
Grans 30-46%
Lymphs 36-54%
Acute tonsillitis
BOM
Anemia
Slophyllin 80 1 tsp QID
Amoxicillin susp. 250 mg. TID
Return 10 days
Jane Roe, M.D.

Jan. 31, 1989 T 98.8

Still coughing. Not pulling at ears.
Tonsils less injected. TMs less injected. Coarse rhonchi.
Resolving tonsillitis
Resolving BOM
URI

Rondec syrup 1 tsp q 4h prn
Jane Roe, M.D.

Psychotherapy Visit

John Smith

10/2/89

Individual therapy one hour. Therapy focused on the anxiety Mr. Smith experiences when in public places such as a grocery store or shopping mall. Mr. Smith reported following through with recommendations made during last session in regards to increasing the amount of time spent in a store while practicing relaxation exercises. Plan is to continue relaxation training in office coupled with systematic desensitization along with increased exposure to feared situations outside the office.

Jack Brown, M.D.

Jane Jones

10/2/89

Individual therapy one hour. Ms. Jones continues to report depressed feelings surrounding the break up of her marriage. Therapy focused on identification of origins of these feelings in relation to other losses in her life. Encouraging alternative coping style and plan to use a more cognitively based approach to deal with negative thought patterns. Jack Brown, M.D.

All laboratory tests billed to the Program must have documented results. Those laboratory tests listed as quantitative tests by the CPT must be documented by a numerical result. Qualitative tests are to be documented by positive or negative. Those laboratory services requiring descriptive results are to be fully-documented. Documentation examples are listed below:

Quantitative tests:

WBC - 7,000/mm3
Glucose - 85 mg/dl

Qualitative tests:

Monoscreen - positive
Pregnancy test - negative

Descriptive tests:

Urine microscopy - clear, yellow-brown, few wbc, rare renal epithelial cell Urine culture - greater than 105/ml E. coli

Program Information

Federal regulations governing program operations require the Virginia Medicaid Program to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives Program information. Individual providers may request that publications not be mailed to them by completing a Mailing Suspension Request form and returning it DMAS Provider Enrollment Services (PES) at the address given on the form. The Mailing Suspension Request form must be completed and signed by each provider within the group who is requesting that Program information not be sent. The address is:

Virginia Medicaid - PES PO Box 26803
Richmond, Virginia 23261-6803
Phone: 804-270-5105 or 1-888-829-5373
Fax: 804-270-7027

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 address is:

DMAS Provider Enrollment Services

PO Box 26803

Richmond, Virginia 23261-6803

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

1.325(D." DMAS

In VAC Section 32.1-325 (D)3 **The**of the Virginia Administrative Code states that the Director of Medical Assistance Services is authorized to:

3. 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 (Virginia Administrative Code 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

Definitions:

Administrative Dismissal – means:

1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or

2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action – means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

    a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to

DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2) For services that have already been rendered, a provider appeal is:

a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration – means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

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

MEMBER APPEALS

Information for providers seeking to represent a member in the member's appeal of an adverse benefit determination is located in Chapter III.

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when

it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:

  - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;

  - Email to appeals@dmas.virginia.gov; or

  - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq*. and the Rules of Court.

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

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months

unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Client Appeals

For client appeals information, see Chapter III of the Provider Manual.

MEDICAID PROGRAM INFORMATION (PP)

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the Code of Virginia, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.