Provider Participation Requirements (CCC Plus Waiver)

Last Updated: 09/07/2022

Table of Contents

Provider Participation Requirements (CCC Plus Waiver)

Updated: 8/1/2022

Managed Care Enrolled Members (CCC Plus Waiver)

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted Managed Care Organizations (MCOs) and their network of providers. All providers must check eligibility (Refer to Chapter 3) prior to rendering services to confirm which MCO the individual is enrolled. The MCO may require a referral or prior authorization for the member to receive certain services. However, all MCO's follow the program rules for CCC Plus Waiver services as defined in this manual. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations.

Even if the individual is enrolled with a MCO, some of the services may continue to be covered by Medicaid Fee-for-Service. Providers must follow the Fee-for-Service rules in these instances where services are "carved out." The carved-out services are the same for both managed care programs. Members who are enrolled in managed care and the CCC Plus Waiverwill be moved to the CCC Plus MCO benefit, which has the responsibility of covering long-term supports and services. Refer to each MCO program's website for detailed information and the latest updates.

There are several different managed care programs (Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE) for Medicaid individuals. 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. The credentialing process can take approximately three (3) months to complete. Go to the websites below to find which MCOs participate in each managed care program in your area:

- https://www.dmas.virginia.gov/for-providers/managed-care/ccc-plus/ (CCC Plus)
- https://www.dmas.virginia.gov/for-providers/managed-care/medallion-40/ (Medallion 4.0)
- https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care/ (PACE)

At this time, individuals enrolled in the three HCBS waivers that specifically serve individuals with intellectual and developmental disabilities (DD) (the Building Independence (BI) Waiver, the Community Living (CL) Waiver, and the Family and Individual Supports (FIS) Waiver) will be enrolled in CCC Plus for their non-waiver services only; the individual's DD waiver services will continue to be covered through the Medicaid fee-for-service program.

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, MCO enrollment, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going

to: https://vamedicaid.dmas.virginia.gov/. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

Provider Participation Requirements (CCC Plus Waiver)

PARTICIPATING PROVIDER

A participating provider is an institution, facility, agency, partnership, corporation, or association that is certified by the Virginia Department of Health and/or other licensing agencies and that has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

Freedom of Choice (Hospital)

The patient shall have freedom of choice in the selection of a provider of services. Generally, however, payments are limited under the Medical Assistance Program to providers who are qualified to participate in the Program under Title XVIII and who have signed a written agreement with DMAS.

Provider Enrollment (CCC Plus Waiver)

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid individuals. All providers must sign the appropriate Participation Agreement via electronic signature on the online enrollment application or sign the paper enrollment application and return it to the Provider Enrollment and Certification Unit. The authorized agent of the provider must sign an agreement for a group practice, hospital, or other agency or institution. The Virginia Medical Assistance Program must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

The Medicaid Participation Agreement may be time-limited depending on the licensing required. All participating Medicaid providers are required to complete a new application and agreement with Provider Enrollment Services as a result of any name change or change of ownership.

Upon the receipt of the signed contract, and the approval with signature by DMAS, a ten-digit Atypical Provider Identifier (API) or National Provider Identifier (NPI) number will be assigned as the provider identification number to each provider category (i.e., case

management, private duty nursing, and personal/respite care). **DMAS will not reimburse the provider for any services rendered prior to the assigning of this provider identification number to your file.** This number must be used on all billing invoices and correspondence submitted to DMAS or Provider Enrollment Services.

Requests for Enrollment (CCC Plus Waiver)

All providers who wish to participate with Virginia Medicaid are directed to complete their request via the online enrollment through our Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to https://vamedicaid.dmas.virginia.gov/ to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at.

If you have any questions regarding the online or paper enrollment process, please contact Provider Enrollment Services toll free at: 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.

Provider Responsibilities to Identify Excluded Individuals and Entities (CCC Plus Waiver)

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid 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 Medicaid

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 Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps on a monthly basis to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.
2. Search the 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.
3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Suite 1300

Richmond, VA 23219

-or-

E-mailed to: providerexclusions@dmas.virginia.gov

Participation Requirements (CCC Plus Waiver)

Requirements for providers approved for participation include, but are not limited to, the following:

- Immediately notify Provider Enrollment Services Unit by logging into the Virginia Medicaid Web Portal and click on the Provider Participation System, or in writing, whenever there is a change in any of the information that the provider previously submitted.

- Obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid individuals.

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

- Ensure the 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 individuals in full compliance with the requirements of § 504 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 Act requires reasonable accommodations for certain persons with disabilities.

- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public.

- Charge DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public.

- Not require, as a precondition for admission, any period of private pay or a deposit from the patient or any other party.

- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission.

- Accept as payment in full the amount established by DMAS. 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 individual for a covered service regardless of whether the provider received payment from the state. A provider may not seek to collect from a Medicaid individual, or any financially responsible relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered. The provider may not bill DMAS or individuals for broken or missed appointments. Example: If a third party payer reimburses $5 out of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference from Medicaid, the individual, a spouse, or a responsible relative;

- Reimburse the patient or any other party for any monies contributed toward the patient's care from the date of eligibility. The only exception is when a patient is spending down excess resources to meet eligibility requirements.

- Accept assignment of Medicare benefits for eligible Medicaid 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. Such records must be retained for a period of not less than six (6) 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 in this manual on documentation of records.)

- 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 individuals of medical assistance.

- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding individuals. A provider shall disclose information in his or her possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of the DMAS. DMAS shall not disclose medical information to the public.

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.

Utilization of Insurance Benefits (CCC Plus Waiver)

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical Assistance 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) - Virginia Medicaid will pay the amount of any deductible or coinsurance 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 Medicaid program payments shall be made for a patient covered by Workers' Compensation.

- Other Health Insurance - When an individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the 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 - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid individuals who receive medical care as the result of the negligence of another. If an individual is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to enforce its lien established under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability, or if the 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 hospital is requested to forward the DMAS-1000 to:

Third-Party Liability Casualty Unit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Use of Rubber Stamps for Physician Documentation

[Effective Date: 1/23/92]

All physician or other health care professionals' documentation, including certifications, must be signed with the initials, last name, and title. DMAS will allow the use of rubber stamps for physician signatures when the use is consistent with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation requirements and physician documentation. 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.

The signature waiver form must be received 30 days prior to the date of the anticipated use of the rubber stamp. (See "Exhibits" at the end of this chapter for a sample of this form.) All documentation must be completely dated with the month, day, and year.

Electronic Signatures (CCC Plus Waiver)

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 must 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, must 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 must be maintained and available at the provider's location.

Additionally, the use of electronic signatures must 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. For guidance on billing, please refer to Chapter V of this manual.

Addendum or Corrections to Medical Record Documentation

If an addendum or additional documentation is needed in a medical record, standard medical practice is to note the additional documentation as an "addendum", and sign and fully date the addendum documentation at the time of the additional entry.

If a correction is needed to a medical record entry that is discovered as an error, the standard medical practice is for the responsible staff member to strike through the error, note the correction and either sign or initial the correction, and fully date the correction.

There is a difference between an addendum and correction to a medical record and an alteration to a medical record. Providers cannot alter existing documentation. For example, once an audit has been initiated, a document cannot be altered as a result of a DMAS audit in order to correct any identified deficiencies found during the audit. This action is falsifying medical documentation and is prohibited. Another example is a staff individual signing and dating orders or documentation for a physician. Only the physician can sign and date his/her orders or medical record entries. All signatures, titling, and dating of record entries must be done at the time the documentation is written and not backdated or photocopied signatures. Alteration of medical record documentation can result in a referral to the Medicaid Fraud Control Unit at the State Attorney General's Office for further investigation.

Documentation of Records

The Provider Agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. The following elements are a clarification of Medicaid policy regarding documentation for medical records:

- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible licensed participating provider. Care rendered by personnel under the direct personal supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in

the record.
- The record must indicate the progress at each visit, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written for every office, clinic, or hospital visit billed to Medicaid.

Review and Evaluation

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services of providers and by recipients. This function is handled by the Virginia Medical Assistance Program's Prepayment and Postpayment Review Sections.

Provider and recipient utilization patterns to be reviewed are identified either from computerized exception reports or by referrals from agencies or individuals. To ensure a thorough and fair review, trained professionals review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Providers will be required to refund Medicaid if they are found to have billed Medicaid contrary to policy, failed to maintain records to support their claims, or billed for medically unnecessary services. Due to the provision of poor quality services or of any of the above problems, Medicaid may limit, suspend, or terminate the provider's participation agreement.

Providers selected for review will be contacted directly by personnel with detailed instructions. This will also apply when information is requested about a recipient or when a recipient is restricted to the physician or pharmacy, or both, of his or her choice because of misutilization of Medicaid services.

Additional information on hospital utilization review activities and on physician certification of the need for care may be found in Chapter VI, Utilization Review and Control.

Fraud (CCC Plus Waiver)

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain an item of value for services rendered or supposedly rendered to individuals under Medicaid. It includes any act that constitutes fraud under applicable federal or state law. A provider participation agreement will be terminated or denied in cases where a provider is found guilty of fraud.

Investigation of allegations of provider fraud is the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General of Virginia. Provider records are to be made available to personnel in this unit for investigative purposes. Further information on submission of fraudulent claims may be found in Chapter V of this manual.

Termination of Provider Participation (CCC Plus Waiver)

A participating provider may terminate participation in Medicaid at any time; however,

written notification must be provided to the DMAS Director and the Provider Enrollment Services Unit thirty (30) days prior to the effective date. The addresses are:

Director

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia Medicaid – PES Unit

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 individuals subsequent to the date specified in the termination notice.

Termination of a Provider Contract Upon Conviction of a Felony

Section 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Medicaid Program Information (DD)

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing information is associated with the provider number on the enrollment file, which assures that each assigned provider receives program information. Providers enrolled at multiple locations or who are individuals of a group using one central office may receive multiple copies of updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing a written request to the Contractor – Provider Enrollment Services at the address provided in "Requests for Participation" earlier in this chapter.

All Medicaid provider manuals are available on-line on the DMAS MES website at https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library (Provider Risk table – see page 18)

Areas of Service

The provider applicant notes on the application what localities (cities and counties) the provider wishes to serve. The provider must be able to adequately staff and supervise staff in any locality served by the provider's office. The provider may maintain separate provider agencies.

The provider should submit a provider application for each separate office which, upon approval, will be issued a separate provider identification number and will be expected to maintain all files related to individuals served by the office and to bill for those individuals from the office.

A differential rate is established for providers that are providing services to individuals residing in the Northern Virginia localities to reflect the higher cost of operating in these localities (both higher capital and wage costs).

Provider Mailings

Providers may choose to have their payments sent to one location and their other mailings, such as memorandums or letters, sent to another location within their organization. Please visit the DMAS website or contact the Provider Enrollment Services Unit if this is an option you would like to explore.

Direct Marketing

All participating Medicaid providers are prohibited from performing all types of direct marketing activities to Medicaid individual. "Direct marketing" means directly or indirectly conducting door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; mailing directly; paying "finder's fees"; offering financial incentives, rewards, gifts, or special opportunities to eligible individuals as inducements to use their services; continuous, periodic marketing activities to the same prospective individual (e.g., monthly, quarterly, or annual giveaways) as inducements to use their services; or engaging in marketing activities that offer potential customer rebates or discounts in conjunction with the use of their services or other benefits as a means of influencing individuals' use of providers' services.

Business Office

The provider must operate from a business office, which is staffed and provides accessible staff space, files, business telephones for the individual to contact the provider when necessary, and an address for receipt of mail and forms.

Individual Choice of Provider

If services are authorized and there is more than one approved provider in the community, the individual will have the option of selecting the provider of his or her choice.

At the time individuals are approved for services, the Long Term Services and Supports (LTSS) Hospital or Community Screening Team must inform the individual of available service providers and (1) that they have the option of selecting their providers and (2) provide a list of service providers from which to choose.

Advance Directives (CCC Plus Waiver)

At the time of their admission to services, all providers participating in the Medicare and Medicaid programs must provide adult individuals with written information regarding each individual's right to make medical care decisions as outlined in this section. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and relating to the provision of such care when the individual is incapacitated. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require individuals to execute an advance directive.

Under the law, providers must:

> Provide all adult individuals with written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment, and the right to execute advance directives, as well as the

provider’s written policies respecting the implementation of such rights;

Inform individual about the provider’s policy on implementing advance directives;

Document in the individual’s medical record whether he or she has signed an advance directive;

Not discriminate against an individual based on whether he or she has executed an advance directive; and

Provide staff and community education on advance directives.

Criminal Background Checks

In accordance with Virginia Code § 32.1-162.9:1, any licensed home care organization as defined in § 32.1-162.7 or any home care organization exempt from licensure under subdivision 3 a or b of § 32.1-162.8 or any licensed hospice as defined in § 32.1-162.1, shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in Code of Virginia § 32.1-162.9:1 or an original criminal history record from the Central Criminal Records Exchange. However, no employee shall be permitted to work in a position that involves direct contact with a patient until an original criminal record clearance or original criminal history record has been received, unless such person works under the direct supervision of another employee for whom a background check has been completed in accordance with the requirements of § 32.1-162.9:1 of the Code of Virginia.

Subsection C. of Virginia Code § 32.1-162.9:1 states as follows: "A person who complies in good faith with the provisions of this section shall not be liable for any civil damages for any act or omission in the performance of duties under this section unless the act or omission was the result of gross negligence or willful misconduct." Accordingly, this provision does not apply to audits or administrative actions by DMAS to recover a Medicaid overpayment made to a provider.

Participating Agency-Directed Personal/Respite Care Provider

A participating personal/respite care provider is an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed Participation Agreement with DMAS. The duties and responsibilities of the provider are the same for both services. Each service requires a separate Participation Agreement and provider identification (ID) number. The term "personal/respite care" is used throughout this manual wherever procedures and policies are alike for both services. A provider may, however, choose to offer only one of the two services.

Personal/respite care providers provide services designed to prevent or reduce institutional care by providing eligible individuals with personal care aides who perform basic health-related services. This chapter sets forth the requirements for approval to participate as a Medicaid provider of personal/respite care as a part of the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The personal/respite care provider will be reimbursed according to the fee schedule (available on the DMAS website (www.dmas.virginia.gov). Any provider contracting with Medicaid to provide these services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

Provider Participation Standards for Agency-Directed Personal/Respite Care Services

A participating personal/respite care provider is an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed Participation Agreement with DMAS. The duties and responsibilities of the provider are the same for both services. Each service requires a separate Participation Agreement and provider identification (ID) number. The term "personal/respite care" is used throughout this manual wherever procedures and policies are alike for both services. A provider may, however, choose to offer only one of the two services.

Personal/respite care providers provide services designed to prevent or reduce institutional care by providing eligible individuals with personal care aides who perform basic health-related services. This chapter sets forth the requirements for approval to participate as a Medicaid provider of personal/respite care as a part of the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The personal/respite care provider will be reimbursed according to the fee schedule (available on the DMAS website (www.dmas.virginia.gov). Any provider contracting with Medicaid to provide these services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

In order to be enrolled as a Medicaid provider for the personal care or respite service, the provider must be licensed or accredited by one of the following:

- Accreditation Commission for Health Care, Inc. Certification (ACHC)
- Centers for Medicare and Medicaid Services (CMS) Certification
- Community Health Accreditation Program Certification (CHAP)
- Joint Commission on Accreditation for Health Care Organizations (JCAHO)
- Virginia Department of Health (VDH) Home Care Organization (HCO) License

Nursing Qualifications for Private Duty Nursing Services

RN Supervisors

- RN supervisors shall be verified as currently licensed to practice nursing in the Commonwealth;
- Have at least one year of verified related clinical nursing experience which may include work in an acute care hospital, long stay hospital, rehabilitation facility, or specialized care nursing facility; and
- Previous nursing experience shall be documented in his/her agency personnel file.

Private Duty Nurse – RN or LPN

- The private duty nurse (PDN) must either be a licensed practical nurse (LPN) or a registered nurse (RN) with a current and valid Virginia license;
- The decision to assign a RN or LPN must be based on the needs of the individual and the nurse's license restrictions;
  - A LPN cannot be assigned to perform activities which fall outside the nursing practices allowed and which should be performed by a RN;
- RN "applicants" do not meet the Medicaid requirement of having a valid Virginia nursing license; and
- A private duty nurse must demonstrate specialized experience and proficiency with delivery of nursing care to any population which has specialized needs (e.g., a ventilator-dependent individual) prior to assignment to such an individual.

All RNs and LPNs who provide skilled private duty nursing (PDN) services shall have either:

1. A minimum of six months of clinical experience related to the care needs of the assigned waiver individual such as ventilator, tracheostomy, nasogastric tube, etc. (documented in their personnel file), that may include work in acute care hospitals, long stay hospitals, rehabilitation facilities, or specialized care nursing facilities; or

2. Have completed a provider training program related to the care and technology needs of the assigned waiver individual; and

3. Have a completed TB test and current CPR certification.

Nursing agencies that do not have a training program that meets the DMAS training program criteria shall continue to provide nurses with at least six (6) months of previous experience in the skills applicable to CCC Plus waiver individuals to provide safe care (tracheostomies, ventilators, etc.).

Training programs established by providers shall include, at a minimum, the following:

1. Trainers (RNs or Respiratory Therapists (RT) shall have at least six months clinical ("hands-on") experience in the areas they are providing training in such as ventilators, tracheostomies, peg tubes, and nasogastric tubes. This experience must be documented in their personnel file or training records.

2. Training shall include classroom time as well as direct clinical ("hands-on") demonstration of mastery of these skills by the trainee.

3. The training program shall include the following subject areas as they relate to the care to be provided by the PDN nurse:

    a. Human Anatomy and Physiology
    b. Medications frequently used by technology dependent individuals
    c. Emergency management of equipment and individuals
    d. The operation of the relevant equipment.

4. Providers shall assure the competency and mastery of the above skills necessary to successfully care for the CCC Plus waiver individual by the nurses prior to assigning them to the individual. Documentation of successful completion of such training course and mastery of these skills shall be maintained in the provider's personnel records. The documentation shall be provided to DMAS or its contractors, upon request.

Documentation of the PDN's knowledge, skills, abilities and experience in the care of individuals with special needs and current CPR certification must be included in the nurse's personnel file. This information is recorded on the "CCC Plus Waiver Private Duty Nursing Skills Checklist" (DMAS 259) which must be fully completed, signed and fully dated by the nurse supervisor prior to the assignment of a PDN to a waiver individual. The DMAS-259 Skills Checklist is recommended for use by all PDN providers and can be located on the Medicaid Web Portal under *the MES Forms*

Library. A skills checklist may be developed by the provider which contains all of the components of the DMAS-259 form.

For a newly admitted waiver individual, the DMAS 259 must be completed by the nursing supervisor for all nurses assigned to the individual. When a waiver individual has been receiving services and a new nurse is assigned, the primary nurse can complete the orientation if he or she is an RN. If the primary nurse is a LPN, the nursing supervisor is responsible for the orientation and completion of the DMAS-259.

Nurses providing skilled PDN or respite care services cannot be parents (i.e.: natural, step-parent, adoptive, foster, or legal guardians), spouses, siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual for the purpose of Medicaid reimbursement under the CCC Plus waiver.

Participating Adult Health Care (ADHC) Provider

A participating Adult Day Health Care (ADHC) provider is a facility that is licensed by the Virginia Department of Social Services (DSS) as an adult day care center, meets the standards and requirements set forth by DMAS, and has a current, signed Participation Agreement with DMAS.

ADHCs offer community-based day programs providing a variety of health, therapeutic, and social services designed to meet the specialized needs of older adults and individuals who have a physical disability. ADHC services enable individual to remain in their communities and to function at the highest level possible by augmenting the social support system already available to the individual, rather than replacing the support system with more expensive institutional care. The ADHC is reimbursed according to the fee schedule available on the DMAS website (www.dmas.virginia.gov). Any provider contracting with Medicaid to provide these services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this provider manual.

Provider Participation Standards For Adult Day Health Care (ADHC) Services

Licensing Requirement

To be enrolled as a Medicaid Adult Day Health Care (ADHC) provider, the ADHC Center must be an Adult Day Care Center licensed by the Virginia Department of Social Services (VDSS). A copy of the current license must be available to the Provider Enrollment Services Unit for verification purposes prior to enrollment as a Medicaid provider. DMAS will notify VDSS when an ADHC agreement is issued to a licensed center. VDSS will notify DMAS

whenever a change to the ADHC's status as a licensed Adult Day Care Center is made by VDSS.

Each ADHC Center participating with Medicaid is responsible for adhering to the VDSS Adult Day Care Center standards. The DMAS special participation conditions included here are standards imposed in addition to VDSS standards, which must be met to perform Medicaid ADHC services.

HCBS Settings Compliance

Home and Community-Based Services (HCBS) Waivers provide Virginians enrolled in Medicaid long-term services and supports the option to receive community based services as an alternative to an institutional setting. Per federal regulations (42 CFR 441.301), provider operated or controlled settings must have the following characteristics:

- The setting must be integrated in and supports full access to the greater community. This includes opportunities to engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- The setting must ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- The setting must optimize, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- The setting must facilitate individual choice regarding services and supports, and who provides them.
- Use the information and resources provided to critically evaluate each setting's compliance with these standards and to develop strategies to ensure individual's rights are supported and achieved.

Prior to ADHC enrollment, providers must complete a HCBS Provider Self Assessment. The provider can get access to the assessment and further instructions by emailing hcbssettings@dmas.virginia.gov. Once completed, the assessment is reviewed and compliance is verified by DMAS staff. Once the ADHC is determined compliant, they will receive a DMAS Compliance Letter. The ADHC will send a copy of the letter to DMAS Provider Enrollment Services Unit when applying for the NPI number.

Individual Staff Requirements

The number of staff required for an ADHC Center depends upon the level of care required by its participants. Each ADHC Center is required to employ sufficient interdisciplinary staff to adequately meet the health, maintenance, and safety needs of each individual. The following staffing guidelines are required by DMAS. However, DMAS reserves the right to require an ADHC Center to employ additional staff, if, on review, DMAS staff find evidence of unmet individual needs.

"Staff" is defined as professional and aide staff.

"Professional staff" is defined as the Director, Activities Director, RN, Therapist, Social Worker, or LPN.

Adult Day Health Care (ADHC) Minimum Staffing Requirements

1. The ADHC Center will always maintain a minimum staff-individual ratio of one staff member to every six individuals (Medicaid and other participants).

2. There shall be at least two (2) staff persons at the ADHC Center at all times when there are Medicaid individuals in attendance.

3. In the absence of the Director, a professional staff member shall be designated to supervise the program.

4. Volunteers shall be included in the staff-individual ratio only when they meet the qualifications and training requirements of paid staff, and, for each volunteer, there shall be at least one paid employee also included in the staff-individual ratio.

5. Any ADHC Center that is co-located with another facility shall count only its own separate identifiable staff in the Center's staff-individual ratio.

6. The ADHC Center must employ staff sufficient to meet the needs of the individuals.

These staff include the:

Director - Responsible for the overall management of the ADHC Center's programs and employees. This individual is the provider contact person for the service authorization contractor and is responsible for participation agreements and receiving and responding to communication from DMAS. The Director is responsible for ensuring the initial development of the Plan of Care (DMAS-301) for individuals;

Personal Care Aides - Responsible for overall care and assistance to the individual (assistance with activities of daily living, recreational activities, and other health and therapeutic related activities); and

Registered Nurse (RN) - Responsible for administering and monitoring the health needs of the individual. The RN is responsible for the planning, organization, and management of a Plan of Care (POC) involving multiple services where specialized health care knowledge must be applied in order to attain the desired result. The RN must be present a minimum of 8 hours each month at the ADHC Center. The nurse must be available to meet the nursing needs of all individuals receiving Medicaid ADHC individual services. DMAS does not require that the nurse be a full-time staff position, but the nurse's schedule must be arranged so that each individual is seen every month. There must be a RN available by telephone at a minimum to the ADHC Center's staff and individuals receiving ADHC services during all times the ADHC Center is in operation. The ADHC Center may contract with either an individual or agency to provide these services, but the ADHC Center must ensure quality service delivery and coordination of the Plan of Care.

The ADHC Center may use one person to fill more than one professional position as long as the requirements for both positions and other staffing

requirements are met. The ADHC Center may employ staff as either full-time or part-time as long as the person hired can fulfill the duties of the position and meet the needs of the individuals receiving services. DMAS will enter into Participation Agreements only with ADHC Centers employing a sufficient number of staff whose employment status (full-time, part-time, or contracted RN services) is determined to be sufficient based on the number of individuals in the ADHC Center and the overall functional level or specialized needs of those individual.

7. The Director will assign a professional staff member to act as ADHC Coordinator for each individual. The identity of the ADHC Coordinator must be documented in the individual's file. The ADHC Coordinator is responsible for management of the individual's Plan of Care and reviews the individual's Plan of Care with the program aides. In cases where the individual only receives ADHC and PERS the ADHC Coordinator is responsible for ensuring the continued appropriateness of PERS.

8. All staff must be 18 years of age or older.

It is the ADHC Coordinator's responsibility to inform the program aides of changes in the Plan of Care and give instruction and direct supervision with any new tasks. If the individual's Plan of Care requires a particular task a program aide is not familiar with, any professional staff available is expected to provide the aide with instruction and direct supervision of the task.

Each professional staff member is responsible for providing input to the Plan of Care, sharing expertise with other staff members through in-service training, providing direct supervision to aides or providing direct care to the individuals, or both.

A multi-disciplinary approach to problem identification, individual goal setting, development and implementation of the Plan of Care and supervision of nonprofessional staff is essential to ensure the provision of quality ADHC services. However, the Center Director has the ultimate responsibility for directing the ADHC Center program and supervision of its staff.

Minimum Qualifications of Adult Day Health Care Staff

I. Personal Care Aide

Each program aide hired must be evaluated by the provider to ensure compliance with minimum qualifications required by DMAS. Basic qualifications for ADHC personal care aides include:

- Ability to read and write in English to the degree necessary to perform the expected tasks;
- Physically able to do the work; and
- Special training in the needs of the elderly and individuals with disabilities through the completion of a minimum 40-hour training program consistent with DMAS requirements. The provider must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements.
- DMAS requirements may be met in one of the following ways:

1. Registration as a Certified Nurse Aide: The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration, which contains a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as an ADHC Aide. A copy of the state certification must be maintained in the aide's personnel record. If the certification has expired and the aide has not renewed the certification, the provider must contact the Board of Nursing to ensure that the aide's certification was not revoked for disciplinary reasons. DMAS does not require Board of Nursing Nurse Aide Certification in order to perform ADHC aide services; it is merely one type of certification that meets DMAS requirements.

2. Graduation from an Approved Educational Curriculum: The Board of Nursing has an approved list of educational curricula offered by educational institutions throughout the Commonwealth of Virginia which award certificates qualifying the graduate as a Nursing Assistant, Geriatric Assistant, or Home Health Aide. If an aide has successfully completed one of the Board of Nursing-approved courses, the provider must obtain a copy of the applicant's certificate, verify that it is from a Board of Nursing-accredited institution, and maintain the documentation in the aide's personnel file for review by DMAS staff.

3. Training from an Educational/Medical Institution: Numerous hospitals, nursing facilities, and educational institutions provide nursing assistant training that is not Board of Nursing-approved (e.g., out-of-state curricula). This type of nursing assistant training is acceptable to meet DMAS requirements for personal care aides. Providers must obtain documentation from the educational or medical institution confirming the personal care aide successfully completed the course. This must be done prior to offering employment for Medicaid-reimbursed services.

4. Provider-Offered Training: A provider may develop and offer a 40 hour training program incorporating all the following elements:

   Goals of Personal Care, Prevention of Skin Breakdown, Physical and Biological Aspects of Aging, Physical and Emotional Needs of Older Adults, Physical Disabilities, Personal Care and Rehabilitative Services, Body Mechanics, Safety and Accident Prevention, Policies and Procedures Regarding Accidents and Injuries, Food Nutrition, and Meal Accommodation, Care of Personal Belongings, Documentation Requirements for Medicaid Individuals.

   This training must be conducted by a registered nurse who meets the RN staffing requirements for personal care/respite providers. ALL graduates from the 40-hour provider training program must have a certificate of completion with the RN instructor's signature, printed name, and date of course completion.

5. Completion of the VADSA (Virginia Adult Day Services Association) Aide Note: An aide who has completed the VADSA training does not meet the qualifications as an aide for in-home personal/respite care services.

6. Completion of the most current National Adult Day Services Association curriculum. (Information for this curriculum can be accessed by mailing a request in writing to the address below or by checking their website at:

The National Adult Day Services Association

11350 Random Hills Road, Suite 800
Fairfax, VA 22030
Email: info@nadsa.org
memberservices@nadsa.org
Phone: 1-877-745-1440

Regardless of the method of training received, documentation must be present indicating the training has been received prior to assigning an aide to individuals receiving ADHC services. The provider must verify all information on the employment application prior to hiring an ADHC program aide. It is important that the minimum qualifications be met by each hired aide to ensure the health and safety of individuals.

The aide must have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. If the aide has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable.

Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia*

regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The personal care aide must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. **The provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the *Code of Virginia* or has a founded complaint confirmed by the CPS Central Registry.** The provider must have documentation proving that a criminal background check and central registry check if applicable was obtained. This documentation must be made available to DMAS staff or its contractors, upon request.

Providers shall obtain references from the educational facility, vocational school, or institution where the aide's training was received, if possible. Documentation of the date of the reference check, the individual contacted and his or her relationship to the aide (friend, co-worker, supervisor), and the content of the reference check must be maintained in the employee's personnel record. These qualifications must be documented and maintained in the provider personnel files for review by DMAS staff or its contractors.

II. Registered Nurse (RN)

The RN must:

- Be registered and currently licensed to practice nursing in the Commonwealth of Virginia;

- Have one year of related clinical experience as an RN. Clinical experience may include work in an acute care hospital, rehabilitation hospital, public health clinic, home health agency, or nursing facility; and

- The RN must have a satisfactory work history as evidenced by documentation of two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the RN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or

older adult is be acceptable.

- Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia or has a founded complaint confirmed by the CPS Central Registry.

- Documentation of both license and clinical experience must be maintained in the provider's personnel file for review by DMAS staff or its contractors. A copy of the RN's current license must be in the personnel record.

III. Director

The Director must meet the qualifications of the Director as specified in the VDSS standards for Adult Day Care Centers.

Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The Director must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. The provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia or has a founded complaint confirmed by the CPS Central Registry.

Provider Participation Standards For Personal Emergency Response Systems (PERS) and Medication Monitoring Systems

A participating Personal Emergency Response System (PERS) and Medication Monitoring provider is a certified home health or personal care agency, a Durable Medical Equipment (DME) provider, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS

monitoring. The PERS provider must meet the standards and requirements set forth by DMAS, and have a current, signed Participation Agreement with DMAS. All PERS providers must enroll as DME providers in order to provide this service to Medicaid individual and to receive reimbursement from Medicaid. Enrollment as a DME provider does not obligate the PERS provider to provide any other DME services. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

In addition to meeting the general conditions and requirements for home- and community-based care participating providers, PERS providers, which provide PERS and Medication Monitoring, must also meet the qualifications described below.

PERS and Medication Monitoring services are designed to prevent or reduce inappropriate institutional care by providing eligible individuals with services that will allow them to live independently while having access to emergency services. This chapter specifies the requirements for approval to participate as a Medicaid provider of the PERS and Medication Monitoring services as a part of the CCC Plus Waiver. The provider will be reimbursed according to the fee schedule available on the DMAS website (www.dmas.virginia.gov). Any provider contracting with Medicaid to provide services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

The PERS provider must provide an emergency response center staff with fully trained operators who are capable of receiving signals for help from an individual's PERS equipment 24 hours a day, 365, or 366 as appropriate, days per year; determining whether an emergency exists; and notifying an emergency response organization or an emergency responder that the PERS individual needs emergency help.

The PERS provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.

- The PERS provider must properly install all PERS equipment into a PERS recipient's functioning telephone line and must furnish all supplies necessary to ensure that the system is installed and working properly.

- The PERS provider must maintain all installed PERS equipment in proper working order.

- The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from the individual's PERS equipment.

The monitoring agency's equipment must include the following: a primary receiver and a back-up receiver, which must be independent and interchangeable; a back-up information retrieval system; a clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test; a back-up power supply; a separate telephone service; a toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and a telephone-line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

The monitoring agency must maintain detailed technical and operation manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures.

In addition to the above, all PERS providers enrolled in the Virginia Medicaid program must adhere to the conditions outlined in their individual Participation Agreements.

Participation Services Facilitation (SF) Provider

A participating Consumer-Directed (CD) Services Facilitator (SF) is a facility, agency,

person, partnership, corporation, or association that meets the standards and requirements set forth by DMAS and has a current, signed Participation Agreement with DMAS.

Services facilitation agencies provide supportive services designed to prevent or reduce inappropriate institutional care by offering assistance to eligible waiver individuals for the hiring, training, supervising, and firing responsibilities of the CD attendants, who perform basic health-related services. This chapter specifies the requirements for approval to participate as a Medicaid provider of services facilitation services. The services facilitation provider will be reimbursed according to the fee schedule available on the DMAS website (www.dmas.virginia.gov). Any provider contracting with Medicaid to provide services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

Provider Participation Standards For Services Facilitation

In addition to meeting the general conditions and requirements for home- and community-based care participating providers, services facilitation providers must meet the following special participation conditions:

1. CD Services Facilitator (SF) Requirements

The CD Services Facilitator (SF) provides ongoing supervision of the individual's Service Plan. SFs employed after January 11, 2016 shall possess, at a minimum, either an associate's degree or higher from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in the Commonwealth of Virginia. The SF must be 18 years of age or older. The SF must possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults; or possess a bachelor's degree or higher in a non-health or human services field and have a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults.

All SFs shall complete required training and competency assessments with a score of 80% prior to working as a SF. Satisfactory competency assessment results shall be kept in the service facilitator's record. The training and competency assessment can be accessed at:

http://www.vcu.edu/partnership/servicesfacilitators/index.html.

All SFs must possess the following knowledge, skills, and abilities:

A. Knowledge of:

a. Types of functional limitations and health problems that may occur in older adults or individuals with disabilities,

as well as strategies to reduce limitations and health problems;

b. Physical assistance typically required by people who have physical disabilities or older adults, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

c. Equipment and environmental modifications that are commonly used and required by people who have physical disabilities or older adults which reduce the need for human assistance and improve safety;

d. Various long-term services and supports program requirements, including nursing facility level of care criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance and respite services;

e. DMAS consumer-directed personal care attendant and respite services program requirements, as well as the administrative duties for which the individual will be responsible;

f. Conducting assessments (including environmental, psychosocial, and functional factors) and their uses in services planning;

g. Interviewing techniques;

h. The waiver individual's right to make decisions about, direct the provisions of, and control his or her services, including hiring, training, managing, approving time sheets, and firing a personal care aide;

i. The principles of human behavior and interpersonal relationships; and

j. General principles of record documentation.

B. Skills in:

a. Negotiating with individuals and service providers;

b. Assessing, supporting observing, recording, and reporting behaviors;

c. Identifying, developing, and providing services to individuals who have disabilities or older adults; and

d. Identifying services within the established services system to meet the individual's needs.

C. Ability to:

a. Report findings of the assessment or onsite visit, either in writing or in an alternative format for persons who have visual impairments;

b. Demonstrate a positive regard for individuals and their families;

c. Be persistent and remain objective;

d. Work independently, performing position duties under general supervision;

e. Communicate effectively both orally and in writing; and

f. Develop a rapport and communicate with individuals from diverse cultural backgrounds.

Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The SF must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. The provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia or has a founded compliant confirmed by the CPS Central Registry.

If the services facilitator is not an RN, then the services facilitator shall inform the primary health care provider for the individual who is enrolled in the waiver that services are being provided within 30 days from the start of such services and request consultation with the primary health care provider, as needed. This shall be done after the services facilitator secures written permission from the individual to contact the primary health care provider. The documentation of this written permission to contact the primary health care provider shall be retained in the individual's medical record. All contacts with the primary health care provider shall be documented in the individual's medical record.

Consumer Directed (CD) Personal Care Attendant Requirements

It is the individual’s or their chosen Employer of Record (EOR) individual’s responsibility to hire, train, supervise, and, if necessary, fire the personal care attendant. The EOR is

considered the employer and can be the waiver individual or someone chosen by the individual to represent them. Each personal care attendant hired by the EOR/individual must be evaluated by the EOR/individual to ensure compliance with the minimum qualifications as required by DMAS.

Basic qualifications for personal care attendants include:

- 18 years of age or older;
- Ability to read and write in English to the degree necessary to perform the expected tasks and possess basic math skills;
- Have the required skills to perform care as specified in the individual's Plan of Care;
- Have a valid Social Security Number;
- Submitting to a criminal history record check and a child protective services central registry check for attendants that provide services care for minor children. The personal care attendant will not be compensated for services provided to the individual once the records check verifies the personal care attendant has been convicted of any of the crimes that are described in § 32.1-162.9:1 .
- Attend or receive training at the EOR's/individual's/family's request; and
- Understand and agree to comply with the consumer-directed personal/respite services requirements.

A personal care attendant cannot be the parent (natural, step-parent, adoptive parent, foster parent, legal guardian) of the minor child or the spouse of the individual receiving waiver services. Payment may be made for services rendered by other family members or caregivers living under the same roof as the individual receiving waiver services only when there is written, objective documentation as to why no other attendant is able to provide services for the individual. The family member or caregiver providing personal care services must meet the same requirements as other personal care attendants.

- Personal care attendants are prohibited from also serving as the EOR for the individual receiving waiver services.

SFs are not directly responsible for finding personal care attendants for the individuals; however, they are required to support the individual by providing hiring resources. SFs are also not responsible for verifying personal care attendants' qualifications; this is the responsibility of the EOR.

Assistive Technology (AT) and Environmental Modification (EM) Provider Qualifications

- AT and EM providers must be a durable medical equipment (DME) provider enrolled with DMAS in order to bill for these services for a waiver individual.

- Providers of AT and EM services cannot be spouses, parents (natural, step-parent, adoptive parent, foster parent, legal guardian), of individuals requesting services.

- Providers who supply AT and EM to waiver individuals shall not perform assessments/consultations or write AT or EM specifications for such individuals.

- Providers who supply AT or EM for a waiver individual may not perform design or inspect AT or EM.

Utilization Review and Quality Management Review

Utilization Reviews (UR) conducted by the Program Integrity Division, and Quality Management Reviews (QMR) are conducted periodically by DMAS QMR staff. DMAS Review Analysts, will review provider compliance with participation standards during Utilization Review/QMR. DMAS may retract funds based on documentation reviewed. (See Chapter VI for more information about Utilization Review/QMR.)

Annual Level-Of-Care-Reviews

DMAS will conduct annual level-of-care (LOC) reviews of each individual according to established procedures described in Appendix F of this manual.

If during an annual level of care review, it is determined that an individual who is using consumer-directed services no longer meets the established criteria for waiver services, the SF must inform the individual and EOR. It is the responsibility of the individual and EOR to ensure that the personal care attendants are made aware that the individual no longer meets the level of care criteria to be eligible for CCC Plus waiver services. Payment to attendants on behalf of individuals who no longer meet criteria for waiver services will not continue and any additional payments will be the responsibility of the individual/EOR. The notification from the SF must be made in writing to the individual/EOR within 10 days (plus 3 days for mailing) of receipt of official notification by DMAS.

Individual Rights and Responsibilities

The provider must have a written statement of individual rights, which clearly states the responsibilities of both the provider and the individual in the provision of services. This statement of individual rights must be signed by the individual and the provider representative at the time services are initiated. This statement must be maintained in the individual's file, and a copy must be given to the individual.

The statement of individual rights must include the following:

- The provider's responsibility to notify the individual in writing of any action taken which affects the individual's services;

The provider's responsibility to render services according to acceptable standards of care;

The provider's procedures for patient pay collection;

The individual's obligation for patient pay, if applicable;

The provider's responsibility to make a good faith effort to provide care according to the scheduled Plan of Care and to notify the individual when unable to provide care;

The provider must inform the individual of his or her responsibility to have some planned back-up for times when the provider is unable to secure coverage and to identify which staff the individual should contact regarding schedule changes;

The provider's responsibility to treat the individual with respect, to respond to any questions or concerns about the care rendered, and to routinely check with the individual about his or her satisfaction with the services being rendered;

Offer the individual choice of provider agencies and waiver services;

The individual responsibility to notify the appropriate provider staff whenever the individual's schedule changes or assigned staff fail to appear for work; and

The individual's responsibility to treat provider staff with respect and to communicate problems immediately to the appropriate provider staff.

The Individual's Rights/Responsibilities Statement must include the following notification of the appropriate resources for complaint resolution:

"The DMAS (Medicaid) pays (provider name) to provide (type of service) to you. If you have a problem with these services you should contact (RN, Services Facilitator, ADHC Coordinator, Provider Director, or PERS provider) at (provider telephone)."

If the staff at the agency is unable or unwilling to help you resolve the problem, if you are a CCC Plus member, you may contact your Health Plan Care Coordinator to assist you. For fee for service (FFS) members, you may contact the DMAS Office of Community Living by e-mail at cccpluswaiver@dmas.virginia.gov or the DMAS Recipient Helpline by calling 1-804-786-6145, or by mail at the following address:

DMAS

Office of Community Living

600 East Broad Street, Suite 1300

Richmond, VA 23219

DMAS may terminate a provider from participating upon 30 days' written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to individuals after the date specified in the termination notice.

Termination of a Provider Contract Upon Conviction of a Felony (CCC Plus Waiver)

Subsection § 32.1-325 (D) of the *Code of Virginia* mandates that any Medicaid agreement or contract shall terminate upon conviction of the provider of a felony. A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a

provider pursuant to Virginia Code §32.1-325(D) and (E). The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code §2.2-4000 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.

Provider Reconsiderations and Appeals (MCO and FFS)

Non-State Operated Provider

For services that have been rendered, providers have the right to appeal adverse actions. However, before appealing to the Department, providers must first exhaust any MCO's or DMAS Contractor's reconsideration process. Providers in an MCO's network may not appeal enrollment or terminations decisions made by the MCO to the DMAS Appeals Division. Providers enrolled with DMAS through the DMAS Contractor may appeal enrollment or termination decisions made by the DMAS Contractor to DMAS once they have exhausted the reconsideration process with the DMAS Contractor.

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

All 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 the MCO's or DMAS Contractor's adverse reconsideration decision. 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 in the reconsideration decision being appealed. Failure to file a written notice of informal appeal within 30 calendar days of receipt of the MCO's or DMAS Contractor's reconsideration decision shall result in an administrative dismissal of the appeal. The notice of appeal must be transmitted to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Appeal requests may be faxed 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. shall 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 shall 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 shall result in dismissal of the appeal. The notice of appeal must be transmitted to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Appeal requests may be faxed to (804) 452-5454.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the Administrative Process Act at Va. Code § 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.

Member Appeals (CCC Plus Waiver)

Member Appeals (MCO)

Members or their authorized representatives have the right to appeal adverse benefit determinations to the Department. However, the MCO's internal appeal process must be exhausted or deemed exhausted, due to the failure of the MCO to adhere to the notice and timing requirements, prior to a member filing an appeal with the DMAS Appeals Division.

Any member or member's authorized representative wishing to appeal an adverse benefit determination must first file an internal appeal with the MCO **within 60 calendar days** from the date on the notice of adverse benefit determination. The internal appeal request may be submitted orally or in writing. If the member does not request an expedited appeal, the member must follow an oral appeal with a written, signed appeal. For individuals with special needs or who do not understand English, the appeal rights must be provided in such a manner as to make it understandable by the individual.

A member may request continuation of services during the MCO's internal appeal and DMAS' State fair hearing. If an appeal is filed before the effective date of the action or within 10 days of the date the notice of adverse benefit determination was mailed, services may continue during the appeal process. If the final resolution of the appeal upholds the MCO's action and services to the member were continued while the internal appeal or State fair hearing was pending, the MCO may recover the cost of the continuation of services from the member.

Member appeals to DMAS are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-370.

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals

of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal may be filed at any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. Appeal requests may be faxed to (804) 452-5454. If sent by mail, the appeal request should be mailed to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

Member Appeals (FFS)

Members receiving FFS services through a DMAS Contractor may be required to file an internal appeal with the DMAS Contractor before appealing to DMAS. Providers under contract with a DMAS Contractor seeking to file an appeal on behalf of their client should consult their contract with the DMAS Contractor.

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an authorized representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the adverse action is upheld by the hearing officer, the member will be expected to repay DMAS or the DMAS Contractor for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The DMAS Contractor will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, DMAS or the DMAS Contractor may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals may be requested orally or in writing. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. The member or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

Appeal requests may be faxed to (804) 452-5454.

If sent by mail, the appeal request should be mailed to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

APPEALS OF ADVERSE ACTIONS

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. must 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 must 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 must result in dismissal of

the appeal. The notice of appeal must be transmitted through AIMS or sent to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Formal appeal requests may also be faxed to (804) 452-5454.

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.