Provider Participation Requirements (Early Intervention)

Last Updated: 09/07/2022

Table of Contents

Provider Participation Requirements (Early Intervention)

Updated: 1/19/2022

Managed Care Enrolled Members

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 services. 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 an 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 vary by managed care program. For example, where one program (Medallion 3.0) carves out Early Intervention, the CCC Plus program has this service as the responsibility of the MCO. Refer to each program's website for detailed information and the latest updates.

There are several different managed care programs (Medallion 3.0, Commonwealth Coordinated Care (CCC), Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE) for Medicaid individuals. DMAS has different MCOs participating in these programs. For providers to participate with one of the DMAS-contracted managed care organizations/programs, they must be credentialed by the MCO and contracted in the MCO's network. 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:

Ø Medallion 3.0:

http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
Ø Commonwealth Coordinated Care (CCC):
http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
Ø Commonwealth Coordinated Care Plus (CCC Plus):
http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
Ø Program of All-Inclusive Care for the Elderly (PACE):
http://www.dmas.virginia.gov/Content_atchs/ltc/WEB%20PAGE%20FOR%20PACE%20Sites%20in%20VA.pdf

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: www.virginiamedicaid.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 (Early Intervention)

All provider agencies and individuals who provide early intervention services must be certified to provide Early Intervention services. Certification is administered by the Department of Behavioral Health and Developmental Services (DBHDS). For information about provider certification through DBHDS, please contact the Infant & Toddler Connection at 804-786-3710 or on the web at www.infantva.gov.

Participating Provider (EI)

A participating provider is an agency, program, or person that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and that has a current, signed Participation Agreement with DMAS. Participating providers must also meet the practitioner qualifications set forth under Part C, abide by the Infant & Toddler Connection of Virginia Practice Manual and adhere to statutes and regulations governing Part C of IDEA.

Medicaid Program Information (EI)

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information. Providers enrolled at multiple locations or who is a member of a group using one central office may receive multiple copies of manuals, 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 Xerox/Provider Enrollment Unit (Xerox/PEU) at the address given under “Provider Enrollment” below.

Provider Enrollment (EI)

Any provider of services must be enrolled with the Department of Medical Assistance Services (DMAS) prior to billing for any services provided to individuals who are enrolled in Medicaid/ Family Access to Medical Insurance Security Plan (FAMIS) Plus or FAMIS. A copy of the provider agreement with

instructions on how to complete the forms can be found at the DMAS website, www.dmas.virginia.gov or by calling the Provider Enrollment Unit at 1-888-829-5373 (in state, toll-free), 1-804-270-5105 (Richmond area and out-of-state long distance), or via toll free fax at 888-335-8476. All providers must sign and complete the entire application and submit it to the Provider Enrollment/Certification Unit at:

Xerox State Healthcare,
LLC EDI
Coordinator

Virginia Medicaid Fiscal Agent

P.O. Box 26228
Richmond, Virginia
23260-6228

An original signature of every individual provider is required. 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 as a result of any name change or change of ownership.

Healthcare providers are required to submit their National Provider Identifier (NPI) number, which must be used on all claims and correspondence submitted to DMAS.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

Requests for Enrollment

All providers who wish to participate with Virginia Medicaid are being 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 www.virginiamedicaid.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 www.virginiamedicaid.dmas.virginia.gov.

If you have any questions regarding the online or paper enrollment process, please contact the Provider Enrollment Services at toll free 1-888-829-5373 or local 1-804-270-5105.

Provider Screening Requirements

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

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

Limited Risk Screening Requirements

The following screening requirements apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type; (2) Verification that a provider or supplier meets applicable licensure requirements; and (3) Verification that a provider or supplier has not been excluded from providing services in federally funded programs. The verification process includes a review of applicable federal and state databases checks and is completed on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening.

Application Fees

Institutional providers may be required to pay a federally-required fee at the time of application for enrollment, re-enrollment or reactivation. This includes when adding new locations. If a provider is required to pay an application fee, it will be outlined in the provider enrollment application and/or revalidation notice. Please refer to the table at the end of this chapter for more information on provider types that may be charged an application fee.

CMS determines the application fee each year. This fee is not required to be paid to DMAS if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request for CMS approval with their enrollment application. If CMS does not approve the hardship request, then providers have 30 calendar days from the date of the CMS notification to pay the application fee or the application for enrollment will be rejected.

An appeal of a hardship exception determination must be made to CMS pursuant to 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers with a primary servicing address located outside of the Virginia border and, due to their provider risk-level, require a site visit, must have a site visit conducted by either their state’s Medicaid program or by CMS prior to enrollment in DMAS. If the application is received by DMAS prior to the completion of the site visit, as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E), the application will be pended for proof this information.

Revalidation Requirements

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

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

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

Ordering, Referring, and Prescribing (ORP) Providers

Code of Federal Regulations 42 CFR 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

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

Early Intervention Provider Requirements

Congress enacted Early Intervention legislation in 1986 as an amendment to the Education of Handicapped Children's Act (1975) to ensure that all children with disabilities from birth through the age of two would receive appropriate Early Intervention (EI) services. This amendment formed Part H of the Act, which was re-authorized in 1991 and renamed the Individuals with Disabilities Education Act (IDEA). When the IDEA was re-authorized in 1998, Part H became Part C of the Act. Virginia's statewide EI system is called the Infant & Toddler Connection of Virginia.

Providers must be enrolled with DMAS to perform and bill for EI services provided to Medicaid or FAMIS enrollees. Please note that providers who are already enrolled with DMAS in a provider category that is required to bill using the UB-04 claims form must re- enroll as an EI provider in order to be reimbursed for EI services as described in Chapter IV of this manual. More information about enrollment as a DMAS EI provider can be found above under the EI Provider Enrollment section of this chapter.

Providers of EI services must either be a Local Lead Agency (LLA) or must be affiliated by contract or memorandum of agreement with a LLA in order to provide EI services. “Local lead agency” means an agency under contract with the Department of Behavioral Health and Developmental Services (DBHDS) to facilitate implementation of a local EI system as described in Chapter 53 of Title 2.2 (§ 2.2-5304.1) of the Code of Virginia.

A DMAS provider of EI services must have the administrative and financial management capacity to meet state and federal requirements, and have the ability to document and maintain individual case records in accordance with state and federal requirements.

All EI service providers participating in the Virginia Medicaid Medical Assistance Services Program and Managed Care Organizations (MCOs) must adhere to the requirements and provide services in accordance with State and Federal laws and regulations governing the provision of Early Intervention services, as well as both of the Early Intervention Practice Manuals (DMAS and DBHDS Part C).

Early Intervention Provider Enrollment

Early Intervention Individual Practitioners

All individual practitioners providing EI services must be certified to provide EI services. Certification is administered by the DBHDS. For information about practitioner certification through DBHDS, please contact the Infant & Toddler Connection at 804-786- 3710, or visit www.infantva.gov for more information.

Qualified individuals listed in Appendix G of this manual who wish to receive their Early Intervention Certification in order to enroll as an EI provider can find information on the certification process at www.infantva.gov or they may contact:

Infant & Toddler Connection of Virginia
Office of Child and Family Services

DBHDS

1220 Bank Street

Richmond, VA 23218

804-786-3710

Certified EI Professionals who provide supervision of certified EI Specialists must document their ongoing clinical supervision of services provided by the EI Specialist and must maintain that documentation for at least three (3) years. If an EI professional observes an EI specialist during a service session, then both the EI professional and the EI specialist must sign the contact note.

All EI providers must be enrolled with DMAS for reimbursement of EI services. Providers who are currently enrolled with DMAS as a Community Services Board, Outpatient Rehabilitation Agency, Home Health Agency, Private Duty Nursing, will need to complete an Early Intervention Attestation Letter and submit to:

Virginia Medicaid Provider Enrollment
Services PO Box 26803

Richmond, VA 23261-6803

888-335-8476 (Fax)

A sample EI Attestation Letter may be located online, under Early Intervention:
http://dmasva.dmas.virginia.gov/Content_pgs/mch-home.aspx.

Providers other than a Community Services Board, Outpatient Rehabilitation Agency, Home Health Agency, Private Duty Nursing must complete the Early Intervention Provider Enrollment application and submit to Virginia Medicaid

Provider Enrollment Services listed above. The Provider Enrollment applications may be located online at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderEnrollment.

Early Intervention Targeted Case Management

LLAs are designated by DBHDS to be responsible for either providing or contracting with another entity to provide the EI Target Case Management (also referred to as EI Service Coordination) for each locality in the Commonwealth. If a LLA subcontracts this service to another entity, it is the responsibility of the LLA to ensure that the EI Service Coordination agency meets all provider qualifications to provide EI services. This includes the service coordinator's qualifications to render EI Service Coordination services. Providers interested in providing EI Service Coordination should contact the LLA in their area for more information on providing this service.

Providers must be enrolled with DMAS as an EI Service Coordination provider to be reimbursed for EI Service Coordination services provided to Medicaid or FAMIS enrollees. The following two steps are necessary to become enrolled as a DMAS EI Service Coordination provider:

- Complete a new Early Intervention provider application and select "Case Management", and submit it to Virginia Medicaid Provider Enrollment Services as instructed on the application; and
    - Have the LLA in the provider's locality complete and submit an Early Intervention Targeted Case Management Provider Information form (DMAS-57) to:

Virginia Medicaid Provider Enrollment
Services PO Box 26803

Richmond, VA 23261-6803

888-335-8476 (Fax)

Both of the forms mentioned above may be obtained from the DMAS website at: www.virginiamedicaid.dmas.virginia.gov. The DMAS-57 is also located in

Appendix I of this Manual.

Early Intervention Service Coordination Qualifications

There are three parts to the EI Service Coordinator qualifications.

1. (a) A minimum of a bachelor's degree in any of the following fields:

    - Allied health, including rehabilitation counseling, recreation therapy, occupational therapy, physical therapy, or speech or language pathology;
    - Child and family studies;
    - Counseling;
    - Early childhood;
    - Early childhood growth and development;
    - Early childhood special education;
    - Human development;
    - Human services;
    - Nursing;
    - Psychology;
    - Public health;
    - Social work;
    - Special education – hearing impairments;
    - Special education – visual impairments;
    - Other related field or interdisciplinary studies approved by the State Lead Agency;

or

b. An associate degree in a related field such as occupational therapy assistant, physical therapy assistant, or nursing;

or

c. A high school diploma or general equivalency diploma, or an undergraduate degree in an unrelated field, **plus** three years' full-time experience coordinating direct services to children and families and implementing individual service plans. Direct services address issues related to developmental and physical disabilities, behavioral health or educational needs, or medical conditions. Experience may include supervised internships, practicums, or other field placements. Parents' experience coordinating their child's services in Part C EI and in Part B early childhood special education will be considered to meet the requirement for full-time experience, and both the time coordinating their child's services in Part C and in Part B will count toward the requirement for three years' experience.

- Three years means 36 months or more.
- Full-time means 32 hours/week.

2. Completion of the Infant & Toddler Connection of Virginia online certification training modules, passing the competency test for each with at least 80% accuracy:

3. Completion of EI case manager certification process through DBHDS. For more information on the EI case manager certification, go to www.infantva.org or call, 804-786-3710.

EI Service Coordination Responsibilities

EI Service Coordination allowable activities include but are not limited to:

1. Coordinating the initial intake and assessment of the child and planning services and supports, including gathering background information from parents/guardians, gathering information from other sources, and participation in the development of Individualized Family Service Plans (IFSP), including initial IFSPs, periodic IFSP reviews, and annual IFSPs. This does not include performing medical assessments, but may include referral for such assessment;

2. Coordinating services and supports planning with other agencies and providers;
3. Assisting the child and family directly for the purpose of locating, developing, or obtaining needed services and resources;
4. Enhancing community integration through increasing the child and family's community access and involvement;
5. Making collateral contacts to promote implementation of the IFSP and allow the child/family to participate in activities in the community. Collateral contacts are defined as contacts with the child's significant others to promote implementation of the service plan and community participation, including family, non-family, health care entities and others related to the implementation and coordination of services;
6. Monitoring implementation of the IFSP through regular contacts with service providers, as well as periodic face-to-face visits, such as the development of the IFSP, annual IFSPs, as well as IFSP reviews;
7. Developing a supportive relationship with the family that promotes implementation of the IFSP and includes coaching the family in problem-solving and decision- making to enhance the child's ability to participate in the everyday routines and activities of the family within natural environments where children live, learn, and play;
8. Coordinating the child/family's transition from EI services; and
9. Making contacts (face to face, phone, email, text) with the family.

Provider Responsibilities to Identify Excluded Individuals and Entities

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 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. See below for information on how to search the LEIE database.

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, Ste 1300

Richmond, VA 23219

-or-

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

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

Virginia Medicaid is a "last pay" program. Benefits available under Medicaid shall be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or State law; other insurance; or third-party liability.

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** – The Virginia Medicaid Program will pay the amount of any deductible or coinsurance up to the Medicaid limit for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- **Workers' Compensation** - No payments shall be made for a patient covered by Workers' Compensation.
- **Other Health Insurance** - When an eligible individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), the Virginia Medicaid Program requires that these benefits be used first. Supplementation shall be made by the Virginia Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.
- **Liability Insurance for Accidental Injuries** - DMAS will seek repayment from any settlements or judgments in favor of eligible individuals who receive medical care as the result of the negligence of another. If an eligible individual is treated as the result of an accident, DMAS should be notified promptly so action can be initiated to establish a lien as set forth in the Virginia Code Section 8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing DMAS.

In the case of an accident in which there is a possibility of third-party liability or if the eligible individual reports a third-party responsibility (other than those cited on his Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Casualty Unit, Virginia Medical Assistance Program, 600 East Broad Street, Richmond, Virginia 23219.

Termination of Provider Participation (EI)

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and Xerox-PEU 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

P.O. Box 26803
Richmond, VA 23261-6803

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

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 §32.1-325D 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.

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.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

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

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

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

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

Appeal – means:

1) A member appeal is:

   a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

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

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

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

2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

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

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

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

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

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

MEMBER APPEALS

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

PROVIDER APPEALS

Non-State Operated Provider

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

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a

ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

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

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

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

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

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

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

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;

- Email to appeals@dmas.virginia.gov; or
- Fax to (804) 452-5454.

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

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

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

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

Repayment of Identified Overpayments

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

State-Operated Provider

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

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

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30

calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

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

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

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

Client Appeals

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

Provider Risk Category Table

Application	Rule Risk Category	App Fee Requirement Yes (Y) or No (N)
Comprehensive Outpatient Rehab Facility (CORF)	Moderate	Y
Hospital	Limited	Y
Hospital Medical Surgery Mental Health and Mental Retarded	Limited	Y
Hospital Medical Surgery Mental Retarded	Limited	Y
Hospital TB	Limited	Y
Long Stay Hospital	Limited	Y
Long Stay Inpatient Hospital	Limited	Y
Private Mental Hospital(inpatient psych)	Limited	Y
Rehab Outpatient	Limited	Y
Rehabilitation Hospital	Limited	Y
Rehabilitation Hospital	Limited	Y
State Mental Hospital(Aged)	Limited	Y
State Mental Hospital(less than age 21)	Limited	Y
State Mental Hospital(Med-Surg)	Limited	Y
Audiologist	Limited	N
Baby Care	Limited	N
Certified Professional Midwife	Limited	N
Chiropractor	Limited	N
Clinical Nurse Specialist - Psychiatric Only	Limited	N
Clinical Psychologist	Limited	N
Licensed Clinical Social Worker	Limited	N
Licensed Marriage and Family Therapist	Limited	N
Licensed Professional Counselor	Limited	N
Licensed School Psychologist	Limited	N
Nurse Practitioner	Limited	N
Optician	Limited	N
Optometrist	Limited	N
Physician	Limited	N
Physician	Limited	N
Physician	Limited	N
Podiatrist	Limited	N
Psychiatrist	Limited	N
Psychiatrist	Limited	N
Substance Abuse Practitioner	Limited	N
Ambulance	Moderate	Y
Ambulance	Moderate	Y
Durable Medical Equipment (DME)	Moderate - Revalidating High - Newly Enrolling	Y
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate - Revalidating High - Newly Enrolling	Y
Home Health Agency - Private Owned	Moderate - Revalidating High - Newly Enrolling	Y
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate - Revalidating High - Newly Enrolling	Y
Renal Unit	Limited	Y
Adult Day Health Care	Limited	N
Private Duty Nursing	Limited	N
Federally Qualified Health Center	Limited	Y
Health Department Clinic	Limited	N
Rural Health Clinic	Limited	Y
Developmental Disability Waiver	Limited	N
Alzheimer's Assisted Living Waiver	Limited	N
Treatment Foster Care Program	Limited	N
Qualified Medicare Beneficiary (QMB)	Limited	N
ICF-Mental Health	Limited	Y
ICF-MR Community Owned	Limited	Y
ICF-MR State Owned	Limited	Y
Intensive Care Facility	Limited	Y
Skilled Nursing Home	Limited	Y
SNF-Mental Health	Limited	Y
SNF-MR	Limited	Y
Psych Residential Inpatient Facility	Limited	Y
Consumer Directed Service Coordination	Limited	N
Personal Care	Limited	N
Respite Care	Limited	N
Personal Emergency Response System	Moderate - Revalidating High - Newly Enrolling	Y
Case Management DD Waiver	Limited	N
CMHP Transition Coordinator	Limited	N
Transition Coordinator	Limited	N
PACE	Limited	N
Family Caregiver Training	Limited	N
Mental Retardation Waiver	Limited	N
Mental Health Services	Moderate - Revalidating High - Newly Enrolling	Y - only for Mental Health Clinics
Early Intervention	Limited	N
Group Enrollment	Limited	N
Group Enrollment	Limited	N
Ambulatory Surgical Center	Limited	Y
Ordering, Referring, or Prescribing Provider	Limited	N