Provider Participation Requirements (Pharm)

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Provider Participation Requirements (Pharm)

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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.

Participating Provider (Pharm)

A participating provider is a pharmacy licensed by the Virginia Board of Pharmacy and having a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

Provider Enrollment (Pharm)

All providers of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid members.

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.

Requests for Participation (Pharm)

An original signature of the individual provider is required. An agreement must be signed by the provider or by the authorized agent of the provider. Participating providers are required to complete new agreement forms when a name change or change of ownership occurs. For a sample Pharmacy Participation Agreement, see the exhibits at the end of this chapter.

Upon receipt of the above information, the ten-digit National Provider Identifier (NPI) number that was provided with the enrollment application is **assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.**

DMAS is informing the provider community that NPIs may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share your NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs.

Participation Requirements

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

- Immediately notify Provider Enrollment Services in writing of any change in the information that the provider previously submitted to DMAS.
- Ensure freedom of choice to individuals who are eligible for medical assistance under the Virginia Medicaid Program (eligible individuals) in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required service(s) and participating in the Virginia Medicaid Program at the time the service was performed.
- Ensure the eligible individual's freedom to reject medical care and treatment.
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.
- Provide services, goods, and supplies to eligible individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Rehabilitation Act requires reasonable accommodations for certain persons with disabilities.

- Provide services and supplies to eligible individuals in the same mode of delivery and of the same quality and as provided to the general public.
- Charge DMAS for the provision of services and supplies to eligible individuals in amounts not to exceed the provider's usual and customary charges to the general public.
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill an eligible individual for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from an eligible individual, or any financially responsible relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered. A provider may not charge DMAS or an eligible individual for missed or broken appointments.
- Accept assignment of Medicare benefits for eligible individuals.
- Use DMAS-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than six years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section titled "Documentation of Records," page 4.)
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to eligible individuals.
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding eligible individuals. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

Participation Conditions (Pharm)

All pharmacies enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their provider agreements. A copy of a provider agreement form may be found at the end of this chapter. The paragraphs which follow outline special participation conditions which must be agreed to by pharmacies.

Requirements for pharmacy providers for participation include, but are not limited to:

- A license from the Virginia State Board of Pharmacy to operate in accordance with State statutes; drugs are to be dispensed by a pharmacist authorized to practice pharmacy under the laws of the state in which the applicant is licensed and practicing;
- Provision of services to Medicaid members without regard to race, color, religion, or national origin;
- Keeping of records necessary to fully disclose the extent of services provided to individuals receiving assistance under the State Plan;
- Provision of information to DMAS as requested and access to records and facilities by personnel of DMAS, the Office of the Attorney General, and federal personnel;
- Submission of claims for drugs dispensed to Medicaid members for reimbursement by Medicaid based on the pharmacy's usual and customary charge to the public not to exceed the upper limits established by DMAS;
- Medicaid participation is limited to providers who accept, as payment in full, the amounts paid by DMAS plus any deductible, copayment, or coinsurance required by the State Plan to be paid by the individual;
- Agreement to abide by Medicaid policies and procedures; and
- Allowance of freedom of choice in the selection of a provider service.

Certification of Unit-Dose Dispensing (Pharm)

To be certified as a unit-dose provider to nursing facilities, the pharmacy should contact the Pharmacy Supervisor and request that certification information and forms be sent to the pharmacy. The address is:

Pharmacy Supervisor

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

To be considered for certification, the pharmacy must submit the form, Unit-Dose Distribution Services (Form DMAS-32), that describes the unit-dose system to be utilized, identifies the facilities and location of each, and identifies the unit-dose dosage forms. A certification statement must be signed by the pharmacy owner or official indicating agreement to meet the requirements and to provide a **prompt** (within 30 days) written notification to the Pharmacy Supervisor if there are any changes in the method of dispensing to the facilities.

Requirements for Certification

The requirements for certification are as follows:

- Each dose must be packaged individually;

- Each dose must be labeled identifying the drug and strength;
- Packaging/labeling must meet the requirements established by the State Board of Pharmacy for unit-dose dispensing;
- Up to a seven day supply can be dispensed to the facility;
- A multiple-day dose (e.g., greater than seven days and up to 30-day supply) **system** does **not** qualify for unit-dose certification;
- The facility must be identified as a nursing facility;
- Unit-dose dispensing to a home for the aged, adult day care residence, or assisted living facilities does **not** qualify for unit-dose certification.

Requirements of Section 504 of the Rehabilitation Act (ARTS)

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for individuals with disabilities in the provider's programs or activities.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

Utilization of Insurance Benefits (Pharm)

Insurance Information

On paper claims, pharmacy providers are to disregard the information on billing primary insurance carriers for reimbursement in the drug program. The Insurance Company Codes and the Type of Coverage in Chapter III do not apply to pharmacy providers when preparing claims for the dispensing of drugs. Bill primary insurance carriers only for durable medical equipment. For Instructions for Point-of-Service (POS) submission, see Chapter IV.

Workers' Compensation

No Medicaid Program payments shall be made for a patient covered by Workers' Compensation.

Liability Insurance for Accidental Injuries

The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid members who receive medical care as the result of the negligence of another. If a member is treated as the result of an accident and DMAS is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in § 8.01-66.9 of the Code of Virginia.

When the provider bills and accepts payment by Virginia Medicaid in liability cases, the provider,

under federal regulations, must accept Virginia Medicaid payment as payment in full; however, providers can initially choose to bill the third-party carrier or file a lien in lieu of billing Virginia Medicaid.

Documentation of Records (Pharm)

The provider agreement requires the provider to maintain records that fully disclose the services provided to Medicaid members. Pursuant to federal law [42 CFR § 440.120(a)(2)], Medicaid can only provide payment for drugs dispensed by a licensed pharmacist in accordance with the State Medical Practice Act. In Virginia, this means that Medicaid can provide payment only for prescribed drugs dispensed and documented in accordance with the Drug Control Act and the Board of Pharmacy Regulations. Documentation supporting Medicaid claims must be maintained for a minimum of **five (5) years**. The following elements constitute Medicaid policy regarding documentation.

Original Prescriptions

Original prescriptions must include the following information:

- Name and address of the member receiving the service;
- Name and address of the prescriber;
- Prescription number, name, strength, and quantity of the drug dispensed;
- Directions for use;
- Date dispensed and initials of the dispensing licensed pharmacist; and
- "Brand Medically Necessary" in the prescriber's handwriting on the face of the prescription, when required.

  NOTE: The "Brand Medically Necessary" documentation requirement also applies to telephoned prescriptions. Pharmacists must document in indelible ink on the face of the oral prescription the prescriber's instructions in regards to the substitution.

Prescription Refills

Refills of prescriptions must include the following information on the back of the prescription:

- The refill date and initials of the dispensing licensed pharmacist;
- The quantity dispensed, if different from the face amount; and
- A notation of the refill authorization by the prescriber, if different from that on the face of the prescription.

Automated Records

In lieu of maintaining refill documentation on the back of the prescription, pharmacies with an automated data processing system must have online retrieval (via CRT display or hard-copy print-outs) documenting the following:

- The prescription number, name, strength, and quantity of the drug dispensed;
- The refill date and code or initials of the dispensing licensed pharmacist;
- The total number of refills authorized by the prescriber and the balance number of refills remaining;
- The name of both the member and the prescriber; and
- The address of both the member and the prescriber, if not on file elsewhere in the pharmacy.

Records of Dispensing to Nursing Facilities

Physician orders must be on file for each drug dispensed for a member residing in a nursing facility.

Non-Unit-Dose

Non-unit-dose packaged drugs provided to the facilities by either unit-dose certified pharmacies or non-unit-dose pharmacy providers are to be documented in the prescription records as described above or in a patient profile as described below for unit-dose.

Unit-Dose

In lieu of the foregoing described documentation, certified unit-dose pharmacies must maintain records (patient profiles) which include the following information:

- The name and address of the member receiving the service;
- The name of the prescriber and his or her address, if not available elsewhere in the pharmacy;
- The prescription number, name, strength, and quantity of the drug dispensed;
- The directions for use; and
- Documentation on a daily basis of the delivery of a 24-hour supply of each drug.

Non-Legend Drugs

Documentation requirements described above apply to both legend and covered non-legend (over-the-counter) drugs.

Discontinued Drugs

Pursuant to the Board of Pharmacy regulations, records must show dispensed medications, which have been discontinued and not administered to the patient, as having been returned to the pharmacy. Billing records must reflect an adjustment in payments where appropriate.

Signature Log

Pharmacy providers must maintain a log containing the following information:

- Member's name;
- The signature of the member or that of his representative; and
- The date of receipt of the prescription.

The log must effectively differentiate between prescriptions received by a member for which counseling was accepted and provided, and those for which counseling was offered and was declined. This log must be retained for review by DMAS or DMAS' agent for five (5) years and is subject to audit. The signature log serves as verification of the member receiving the prescription billed. The absence of the appropriate signature indicates the member did not receive the prescription, and funds may be subject to recoupment.

Prescription signature records for shipped prescriptions must be retained for a period of five (5) years and must include the delivery confirmation for audit purposes.

Tamper-Resistant Prescription Pads (Pharm)

In 2007, Congress enacted Section 7002 (b) of the U.S. Troop Readiness, Veterans' Health Care, Katrina Recovery and Iraq Accountability Appropriations Act (P.L. 110-28), which mandates that federal reimbursement be denied to states for Medicaid patients' outpatient prescriptions that are not written on tamper-resistant prescription pads/paper. **To comply with this federal mandate, the Virginia Medicaid and FAMIS Fee-For-Service Program requires the use of tamper-resistant pads/paper on all non-electronic, outpatient prescriptions (excluding e-prescribing, fax, or telephone), effective April 1, 2008.**

Affected Medicaid/FAMIS Clients

For prescriptions written on or after April 1, 2008, the use of tamper-resistant prescription pads is mandated for the Medicaid, FAMIS fee-for-service, and FAMIS Plus fee-for-service populations. Based on CMS guidance, the tamper-resistant pad requirement applies to all outpatient drugs, **including over-the-counter drugs**, whether Medicaid is the primary or secondary payor of the prescription. This includes prescriptions for "dual eligibles" where a Medicare Part D plan is the primary payor and Virginia Medicaid is the secondary payor. While the law specifies the term "prescription pad", the Centers for Medicare and Medicaid Services (CMS) have stated that these requirements also apply to computer-generated prescriptions that are printed using paper inserted into the printer.

Exemptions to Requirement:

According to CMS, the following are exemptions to the tamper-resistant prescription pad requirements:

- Prescriptions paid by a Medicaid/FAMIS managed care entity (this means prescriptions written for patients enrolled in any of Virginia's contracted managed care organizations are not subject to this requirement). Dentists contracted through Doral Dental are NOT exempt from this requirement.

- Prescriptions transmitted to the pharmacy via e-prescribing, fax, or telephone (faxing is the preferred method). (Please note, however, that Drug Enforcement Administration regulations require Schedule II controlled substances to be written prescriptions); In addition, Guidance Document 110-35 from the Virginia Board of Pharmacy,

http://www.dhp.virginia.gov/Pharmacy/guidelines/110-35%20Requirements%20for%20prescriptions.doc, provides further guidance on faxed and electronically transmitted prescriptions; and

- Drugs provided in nursing facilities, intermediate care facilities for the mentally retarded, and other specified institutional and clinical settings, as long as the patient never has the opportunity to handle the written prescription.

What Qualifies As A Tamper-Resistant Prescription Pad?

Although this is a federal law, there is not a single national regulation. Each State Medicaid Agency must determine which tamper-resistant features will be required. Virginia Medicaid has reviewed the recommendations of the industry and of states that currently use tamper-resistant prescription pads/paper. Effective April 1, 2008, Virginia Medicaid will require that all prescription pads/paper used for Medicaid and FAMIS fee-for-service members contain at least one of the following three characteristics:

1) One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form,

2) One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the

prescriber, or

3) One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Prescription pads/paper are required to contain at least one feature in all of the three categories above. Providers who write prescriptions for Medicaid and FAMIS fee-for-service members should contact their vendor to secure an appropriate supply of prescription pads/paper that will meet the above requirements. Table 1 is a summary of features that could be used on a tamper-resistant pad/paper in compliance with the CMS guidelines within the timeframe required. They are categorized according to the three types of tamper-proof features as described by CMS. Features in bold tend to be less costly and easier for physicians to implement than other features._

Table 1

Note: Features in bold tend to be less costly and easier for physicians to implement than other features.

Category 1 - One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.

Feature	Description

Uniform non-white background color	**Background is one color. This will inhibit a forger from physically erasing written or printed information on a prescription form. If someone tries to erase or copy, the consistent background color will look altered.**
"Void" or "Illegal" pantograph	The word "Void" appears when the prescription is photocopied. Due to the word "Void" on faxed prescriptions, this feature requires the pharmacy to document if the prescription was faxed.
Reverse "RX" or White Area on prescription	"Rx" symbol or white area disappears when photocopied at light setting. This feature is normally paired with the "Void" pantograph to prohibit copying on a light setting.
Coin-reactive ink	Ink that changes color when rubbed by a coin. This is an expensive option.
Security Back print	Printed on the back of prescription form. The most popular wording for the security back print is "Security Prescription" or the security back print can include the states name.
Watermarking (fourdrinier)	Special paper containing "watermarking".
Diagonal lines (patented "Void")	Diagonal lines with the word "void" or "copy". Can be distracting or expensive.
Micro printing	Very small font writing, perhaps acting as a signature line. This is difficult to photocopy and difficult to implement if using computer printer. It is also difficult for a pharmacist to see.

Category 2 - One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.

Feature	Description
Quantity check off boxes	**In addition to the written quantity on the prescription, Quantities are indicated in ranges. It is recommended that ranges be multiples of 25 with the highest being "151 and over". The range box corresponding to the quantity prescribed MUST be checked for the prescription to be valid.**
Refill Indicator (circle or check number of refills or "NR")	**Indicates the number of refills on the prescription. Refill number must be used to be a valid prescription.**

Pre-print “Rx is void if more than___ Rxs on paper” on prescription paper	**Reduces the ability to add medications to the prescription. - Line must be completed for this feature to be valid. Reduces the ability to add medications to the prescription. Computer printer paper can accommodate this feature by printing “This space intentionally left blank” in an empty space or quadrant.**
Quantity Border and Fill (for computer generated prescriptions on paper only)	**Quantities are surrounded by special characters such as an asterisk to prevent alteration, e.g. QTY **50** Value may also be expressed as text, e.g. (FIFTY), (optional)**
Refill Border and Fill (for computer generated prescriptions on paper only)	**Refill quantities are surrounded by special characters such as an asterisk to prevent alteration, e.g. QTY **5** Value may also be expressed as text, e.g. (FIVE), (optional)**
Chemically reactive paper	**If exposed to chemical solvents, oxidants, acids, or alkalis to alter, the prescription paper will react and leave a mark visible to the pharmacist.**
Paper toner fuser	Special printer toner that establishes strong bond to prescription paper and is difficult to tamper.
Safety or security paper with colored pattern	White (or some other color) mark appears when erased. This is expensive paper.

Category 3 - One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Feature	Description
Security features and descriptions listed on prescriptions	**Complete list of the security features on the prescription paper for compliance purposes. The pharmacy community, as represented by the American Pharmacist Association (APhA), National Association of Chain Drug Stores (NACDS), and National Community Pharmacist Association (NCPA) strongly believe this feature would be helpful to include to aid the pharmacist in identifying a tamper-resistant prescription.**
Form Batch Numbers	Each batch of prescriptions has a unique identifier. This feature is only effective in states with an approved vendor listing.
Serial number	Number issued by printer of prescription, may or may not be sequential. This feature is most effective where serial numbers are reported to the state.
Encoding techniques (bar codes)	Bar codes on prescription. Serial number or Batch number is encoded in a bar code.

Logos	Sometimes used as part of the background color or pantograph.
Metal stripe security	Metal stripe on paper, difficult to counterfeit.
Heat sensing imprint	By touching the imprint or design, the imprint will disappear.
Invisible fluorescent fibers/ink	Visible only under black light.
Thermo chromic ink	Ink changes color with temperature change. This is expensive paper and problematic for storage in areas not climate controlled.
Holograms that interfere with photocopying	May interfere with photocopying or scanning.

Termination of Provider Participation (Pharm)

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and to PES thirty (30) days prior to the effective date. Such action precludes further payment by DMAS for services subsequent to the date specified in the termination notice. Notice should be sent to these addresses:

Director

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia Medicaid -PES

P.O. Box 26803

Richmond, Virginia 23261-6803

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

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."

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.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

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

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

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

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

Appeal – means:

1) A member appeal is:

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

and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

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

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

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

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

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

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

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

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

MEMBER APPEALS

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

PROVIDER APPEALS

Non-State Operated Provider

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

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

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

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

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

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

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

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

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

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

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

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

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

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

  - Fax to (804) 452-5454.

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

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

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

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

Repayment of Identified Overpayments

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

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

State-Operated Provider

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

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

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

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

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

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

Client Appeals

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

Medicaid Program Information

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.

A provider may not wish to receive a provider manual and Medicaid memoranda because he or she has access to the publications as part of a group practice. To suppress the receipt of this information, the Xerox - Provider Enrollment Services Unit requires the provider to complete the Mail Suppression Form and return it to:

Virginia Medicaid - PES

PO Box 26803

Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Upon receipt of the completed form, Xerox – PES will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

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	Y
	High – Newly enrolling	
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate –Revalidating	Y
	High – Newly enrolling	
Home Health Agency - Private Owned	Moderate –Revalidating	Y
	High – Newly enrolling	
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate –Revalidating	Y
	High – Newly enrolling	
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	Y
	High – Newly enrolling	
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	Limited - all others	Y - only for Mental Health Clinics
	Moderate -- Community Mental Health Centers	
Early Intervention	Limited	N
Group Enrollment	Limited	N
Group Enrollment	Limited	N
Ambulatory Surgical Center	Limited	Y
Ordering, Referring, or Prescribing Provider	Limited	N