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CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

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MANAGED CARE PROGRAMS

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:

- Medallion 3.0:
http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC):
http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Commonwealth Coordinated Care Plus (CCC Plus):
http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- 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,

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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.viriniamedicaid.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

PROVIDER MANUALS

Provider Manuals and manual updates are posted on the Virginia Department of Medical Assistance Services' (DMAS) website (www.viriniamedicaid.dmas.virginia.gov) for viewing and downloading. Providers are notified of manual updates through messages posted on Medicaid Remittance Advices.

PARTICIPATING PROVIDER

A participating provider is a nursing facility that is certified by the Center for Quality Health Care Services and Consumer Protection and the Virginia Department of Health (VDH) and that has a current, signed Participation Agreement with DMAS.

PROVIDER ENROLLMENT

A nursing facility must be enrolled in the Virginia Medicaid Program prior to billing for any services provided to Medicaid recipients. Billing forms will not be issued to providers who do not sign a Participation Agreement with DMAS.

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

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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.

Instructions for billing and specific details concerning the Virginia Medicaid Program are contained in this manual. Read all sections of this manual before signing the Participation Agreement. The provider must comply with all sections of this manual to maintain continuous participation in the Virginia 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 Xerox Provider Enrollment Services at toll free 1-888-829-5373 or local 1-804-270-5105.

PROVIDER SCREENING REQUIREMENTS

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved by DMAS. Screening is also performed on a monthly

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basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid 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”. Please refer to the table at the end of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will 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 prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

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. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications,

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online enrollment tool, and revalidation process. **The application fee requirements are also outlined in Appendix section of this provider manual.**

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid 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 to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied.

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

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

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

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

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

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

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

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

PARTICIPATION REQUIREMENTS

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

- Immediately notify DMAS, in writing, whenever there is a change in any of the information that the provider previously submitted;
- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner, which participates in the Virginia Medicaid Program at the time the service is performed and is qualified to perform the required service(s);
- Ensure the recipient'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 grounds of race, color, or national origin;
- Provide services, goods, and supplies to recipients in full compliance with the

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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/his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;

- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the resident or any other party;
- Accept Medicaid payment from the first day of eligibility, if Medicaid eligibility was pending at the time of admission. The nursing facility must accept payment back to the date of eligibility if the resident was in a certified bed, whether or not the facility knew that Medicaid application had been made;
- Provide services and supplies to recipients of the same quality and in the same mode of delivery that is provided to the general public;
- Charge DMAS for the provision of services and supplies to recipients 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 cost. 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 amounts paid by the agency plus any deductible, co-insurance, or co-payment required by the Plan to be paid by the individual."

A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. For example, if a third party payer reimburses \$5.00 out of an \$8.00 charge and Medicaid's allowance is \$5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the \$3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative. The provider may not bill DMAS or the recipient for broken or missed appointments;

- Accept assignment of Medicare benefits for eligible Medicaid recipients;
- Use program-designated billing forms for submission of charges;
- Maintain and retain the 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 five 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

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“Documentation of Records” section).

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by the Virginia Medicaid Program, 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 recipients of medical assistance; and
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his/her possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of the state agency.

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

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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@dmass.virginia.gov

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FREEDOM OF CHOICE

The patient shall have the right to receive services from any Medicaid-enrolled provider of services. However, payments under the Virginia Medical Assistance Programs are limited to providers who meet the provider participation standards and have signed a written agreement with DMAS.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 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.

Each Medicaid provider, as a condition of participation, is responsible for making provisions for such disabled individuals in the program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with the Rehabilitation Act of 1973, as amended (29 USC § 794). In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

All providers of care and suppliers of services under contract with DMAS must comply with the requirements of Title VI of the Civil Rights Act of 1964, which requires that services be provided to Medicaid recipients without regard to race, color, or national origin.

PROVIDER PARTICIPATION CONDITIONS

Responsible Party Requirements

Any nursing facility certified by Medicaid or Medicare shall not require a third-party guarantee of payment to the facility as a condition of admission or of expedited admission to, or continued stay in, the facility. This does not prevent a facility from requiring an individual, with legal access to a resident's income or resources available to pay for care in the facility, to sign a contract without incurring personal financial liability, except for breach of the duty to provide payment from the resident's income or resources for such care. The resident's income or resources shall include any amount deemed to be income or resources of the resident for purposes of Medicaid eligibility and any resources transferred by the resident to a third party if the transfer disqualifies the resident from Medicaid coverage for Nursing Facility Services.

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A nursing facility may require financial guarantees from a third party as a condition of admission or continued stay of a Medicaid recipient **only** if:

- The agreement is limited to non-covered services; and
- The agreement does not apply to covered services or prior time periods when the recipient is determined to be retroactively Medicaid-eligible.

Preconditions for Admission or Continued Stay in Medical Facilities

The right of Medicaid recipients to receive Medical Facility Services is based upon medical necessity and a determination of eligibility by the local DSS offices in Virginia. Additional requirements, such as prior status as a private-paying resident, a pre-admission deposit, gifts, donations, or other considerations, may not be established by a participating provider as a precondition for admission or as a requirement for continued stay in a facility.

Federal regulations (42 CFR § 447.15) provide that participation will be limited to providers of service who accept as payment in full the amounts paid in accordance with the fee structure. Section 4 of Public Law 95-142 (The Medicare-Medicaid Antifraud and Abuse Amendments of 1977, subsection (d) of 42 USC § 1320a-7b), quoted below, provides that certain actions by facilities constitute a criminal act:

Whoever knowingly and willfully (1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a Medicaid managed care organization under subchapter XIX of this chapter under a contract under section 1396b(m) of this title or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or (2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or (B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and, upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

Medicaid policies regarding preconditions for admission or continued stay address three specific situations:

- **The patient is Medicaid-eligible at the time of admission.** – If a patient is admitted to a Medicaid-enrolled facility, there can be no precondition for admission requiring any period of private pay or a deposit from the resident or any other party.
- **Medicaid eligibility is pending at the time of admission.** – Medicaid long-term care providers cannot collect more than the Medicaid rate from a Medicaid

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recipient. When Medicaid eligibility is determined, it is most often made retroactive to a time prior to the date that the eligibility decision is made. Federal statutory and regulatory requirements mandate that the nursing facility accept Medicaid payment as payment in full when a person's Medicaid eligibility begins. Thus, nursing facilities are required to refund any excess payment received from a resident or family member for the period of time that the Medicaid eligibility was pending and the resident is determined eligible for Medicaid.

- **A private pay resident applies for Medicaid and becomes eligible after admission.** – An enrolled provider may not require discharge of the resident or continue to require a period of private pay subsequent to the initial eligibility date for residents in Medicaid-certified units. The Virginia Medicaid Program must be billed for all covered services delivered by a provider beginning with the date of eligibility in such cases (42 CFR §§ 442.311 and 405.121 and § 32.1-138 of the *Code of Virginia*, 1950 as amended).

NOTE: Nothing in this section is to be construed as altering DMAS policy concerning nursing facility pre-admission screening (see Chapter VI of this manual).

Pre-Admission Screening of Individuals with Mental Illness and/or Mental Retardation

As a condition of Medicaid participation, all individuals who apply for nursing facility admission must be screened for conditions of mental illness, mental retardation, or a related condition, to determine if Medicaid-eligible applicants meet the criteria for nursing facility placement. It is the responsibility of the nursing facility to ensure that the applicable requirements are met. Refer to Appendix C for specific policies and procedures regarding these requirements.

Certain Contract Provisions Prohibited

Section 32.1-138.2 of the *Code of Virginia* requires:

No contract or agreement for nursing facility care shall contain any provisions which restrict or limit the ability of a resident to apply for and receive Medicaid or which require a specified period of residency prior to applying for Medicaid. The resident may be required to notify the facility when an application for Medicaid has been made. No contract or agreement may require a deposit or other prepayment from Medicaid recipients. No contract or agreement shall contain provisions authorizing the facility to refuse to accept retroactive Medicaid benefits.

Nursing Facility

For the purpose of Medicaid, a nursing facility is a licensed institution, public or private, or a part thereof, which provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

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To become a DMAS provider, a nursing facility must:

- Be licensed and certified by VDH as meeting standards required by federal regulations to provide Nursing Facility Services or be identified as a distinct part of another medical institution which is either operated by the state or licensed by the appropriate state authority (e.g., a state institution for the mentally retarded);
- Enter into a Participation Agreement with DMAS;
- Comply with the participation requirements of DMAS; and
- Submit acceptable financial data to establish a Medicaid reimbursement rate with DMAS.

Nursing facility care is defined as the provision primarily of resident services such as: help in walking, transferring, bathing, dressing, feeding, preparation of diet, supervision of medications which cannot be safely self-administered, and other types of personal assistance which are usually provided by trained nurses' aides and licensed nurses under the supervision of a professional registered nurse (RN). Nursing facility criteria are defined in Appendix B.

Specialized Care Provider

To participate in Medicaid, a specialized care facility must meet all of the requirements outlined for nursing facility participation and enter into an additional Provider Agreement with DMAS specifically for Specialized Care Services.

Note: Nursing facilities must have a separate contract with DMAS to receive reimbursement for Specialized Care Services.

Specialized Care targets residents who require a higher intensity of nursing care than that which is normally provided in a nursing facility but who do not require the degree of care and treatment that a hospital is designed to provide. Care must be provided by a nursing facility. The resident must have long-term health conditions requiring close medical supervision, 24 hours of licensed nursing care, and specialized services or equipment. Admission requirements are outlined in Chapter VI.

It is intended that the per diem received by the facility for providing Specialized Care Services be all-inclusive for the resident's care with the exception of certain allowable items (e.g., medications) that would be billed by the pharmacy. For example, nursing facilities may not bill Medicare Part B for the tube-feeding portion of the resident's care for enterally fed residents who are in specialized care beds. In addition, the facility may not bill the co-insurance portion of the tube-feeding claim to Medicaid, as this would constitute a double billing to the Virginia Medicaid Program.

Intermediate Care Facilities for the Mentally Retarded (ICF/MRs)

For Medicaid purposes, a facility for the mentally retarded is a licensed facility, public or private, which provides health and (re)habilitative services for persons who have mental retardation or have "related conditions."

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To participate in Medicaid, an ICF/MR must be certified by VDH as meeting standards required by federal regulations to provide intermediate care for the mentally retarded and must comply with the participation requirements of DMAS. The facility may be identified as a distinct part of another medical institution that is operated by the state or licensed by the appropriate state authority.

In addition to meeting the certification and participation requirements, the facility must provide “active treatment” as defined in the 42 CFR §§ 435.1009 and 483.440. “Active treatment” includes each of the following:

- Each resident must receive a continuous active treatment program, which includes the aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services directed toward: 1) the acquisition of behaviors necessary for the resident to function with as much self-determination and independence as possible, and 2) the prevention or deceleration of regression or loss of current optimal functional status.

NOTE: Active treatment does not include services to maintain generally independent residents who are able to function with little supervision or in the absence of a continuous active treatment program;

- Each resident must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines, or service areas that are relevant to identifying the resident’s needs and designing programs to meet those needs; and
- Appropriate facility staff must participate in interdisciplinary team meetings. Participation by the resident and his/her parent or guardian is required unless unobtainable or inappropriate.

Assessments required include the following:

- Admission decisions must be based on a preliminary evaluation of the resident conducted or updated by the facility or outside sources. This evaluation must include background information as well as currently valid assessments of functional, developmental, behavioral, social, health, and nutritional status;
- Within 30 days after admission, the interdisciplinary team must perform accurate assessments or re-assessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the resident’s age and implications for active treatment at each stage, as applicable;
- Within 30 days after admission, the interdisciplinary team must prepare for each resident an individual program plan stating the specific measurable objectives in behavioral terms which are necessary to meet the resident’s needs and the planned sequence for dealing with those objectives;
- As soon as the interdisciplinary team has formulated a resident’s individual

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program plan, the resident must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary;

- At least annually, the comprehensive functional assessment of each resident must be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan must be revised, as appropriate; and
- At the time of discharge, the facility must develop a final summary of the resident's development, behavioral, social, health, and nutritional status and, with the consent of the resident, parents (if the resident is a minor), or legal guardian, provide a copy to authorized persons and agencies and provide a post-discharge Plan of Care (POC) that will assist the resident with adjusting to the new living arrangement.

Services for persons with mental retardation are defined as a combination of habilitative, rehabilitative, and health services directed toward increasing the functional capacity of the person. The overall objective of programming shall be the attainment of the optimal physical, intellectual, social, and task-learning levels that the person can presently or potentially achieve. Criteria for ICF/MRs are included in Appendix B.

Institutions for Mental Diseases (IMDs)

An institution for mental diseases (IMD) is a public or private facility that is certified by VDH. Any facility may be considered an IMD when it is established or maintained primarily for the care and treatment of individuals with mental diseases. In Virginia, medical assistance is available only for those recipients in institutions for mental diseases when the recipient is over the age of 65. The following guidelines are used in determining whether or not a facility is an IMD:

- The facility is licensed as a psychiatric facility for the care and treatment of individuals with mental diseases;
- The facility advertises or holds itself out as a facility for the care and treatment of individuals with mental diseases;
- The Joint Commission accredits the facility as a psychiatric facility for Accreditation of Hospitals;
- The facility specializes in providing psychiatric care and treatment. This may be ascertained through review of residents' records and may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric training;
- The facility is under the jurisdiction of the Commonwealth of Virginia's mental health authority [the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)];
- More than 50 percent of the residents have a diagnosis of a mental disease, which

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requires inpatient treatment and is documented in their medical records;

- A large proportion of the residents in the facility have been transferred from a state mental institution for continuing treatment of their mental disorders;
- Independent professional review teams report a preponderance of mental illness in the diagnoses of the residents in the facility;
- The average age in the facility is significantly lower than that of a typical nursing facility; and
- Part or all of the facility consists of locked wards.

Out-of-State Nursing Facilities

Generally, non-enrolled, out-of-state nursing facilities are subject to the same policies and program limitations as participating nursing facilities, except that non-enrolled, out-of-state, and non-participating nursing facilities will be reimbursed based upon the average per diem reimbursement to enrolled nursing facilities.

If the specific nursing facility's services required by the resident are available in a Virginia nursing facility within a reasonable distance of the recipient's home, the recipient should not be referred to an out-of-state nursing facility. Out-of-state placements must be approved by DMAS prior to placement. Out-of-state nursing facility providers are subject to the same regulations as in-state nursing facility providers.

UTILIZATION OF INSURANCE BENEFITS

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

- **Title XVIII (Medicare)** - Medicaid will pay the amount of any deductible or co-insurance up to the Medicaid limits for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- **Workers' Compensation** - No Medicaid payments shall be made for a patient covered by workers' compensation.
- **Other Health Insurance** - When a recipient has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by Medicaid when necessary, but the combined total payment from all insurance shall not exceed the amount payable under DMAS had there been no other insurance.
- **Liability Insurance for Accidental Injuries** - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients, who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical

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Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish any lien that may exist under § 8.01-66.9 of the *Code of Virginia*. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his/her 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 a DMAS-1000 form to:

Third-Party Liability Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DOCUMENTATION OF RECORDS

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

- The record must identify the resident on each page;
- Entries must be signed (with first initial, last name, followed by professional title) and dated (month, day, year) by the author. Care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed, participating provider;
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based;
- All services provided, as well as the treatment plan, must be entered in the record. Any drugs prescribed and administered as part of a physician's treatment plan, including the quantities, route of administration, and the dosage, must be entered in the record; and
- The record must indicate the resident's progress, any change in diagnosis or treatment, and the response to treatment. For additional record documentation requirements, see Chapter VI.

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

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- 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 and 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

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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.

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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

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- 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

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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.

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. Providers enrolled at multiple locations or who are members of a group using one central office may receive multiple copies of Provider Manuals, updates, and other publications sent by DMAS.

FRAUD

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Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his/her agent to obtain or seek direct or indirect payment, gain, or items of value for services rendered or supposedly rendered to recipients under Medicaid. A provider's Participation Agreement will be terminated or denied when a provider is found guilty of fraud.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Further information about fraudulent claims is available in Chapter V ("Billing Instructions") and Chapter VI ("Utilization Review and Control") of this manual.

TERMINATION OF PROVIDER PARTICIPATION

The Participation Agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to the expiration of the agreement.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and Xerox - PES 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
PO Box 26803
Richmond, Virginia 23261-6803

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

Section 32.1-325(c) of the *Code of Virginia* mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

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VALUE-BASED PURCHASING (VBP) PROGRAMS

In a continued effort to support improved quality of care for Medicaid recipients in Virginia, DMAS has established Value-Based Purchasing programs to support providers in quality improvement efforts. Please refer to Appendix H: Value-Based Purchasing (VBP) Programs for specific program information.

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