CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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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, CCC, CCC Plus, and 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, the Community Living (CL) Waiver, and the Family and Individual Supports (FIS) Waiver) will be enrolled in CCC Plus for their non-waiver services only; the individual's DD waiver services will continue to be covered through the Medicaid fee-for-service program.

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, MCO enrollment, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating provider is a local education agency which has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS). A local education agency refers to a school district, an entity which operates local public primary and secondary schools. The provider enrollment agreement and manual is located on the web at: www.virginiamedicaid.dmas.virginia.gov.

Local education agencies must also complete the Business Associate Agreement with DMAS. The local education agency and DMAS, as defined in 45 CFR **§** 160.103 of the Final HIPAA Privacy Rule, must enter into this agreement which states parties will comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Final Privacy regulation requirements for such an Agreement, as well as protect the confidentiality and integrity of Protected Health Information (PHI) required by law, Department policy, professional ethics, and accreditation requirements. More information about the Business Associate Agreement may be located on the web at: http://dmasva.dmas.virginia.gov/Content_pgs/pr-sbs.aspx.

PROVIDER ENROLLMENT

Providers must be currently enrolled in the DMAS Program prior to billing for any services for Medicaid, Family Access to Medical Insurance Security Plan (FAMIS) - Virginia's Child Health Insurance Program, FAMIS Plus or FAMIS MOMS recipients. Providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment and Certification Unit of the fiscal agent. An original signature of the provider is required on the Participation Agreement. Provider enrollment forms may be found on the Virginia Medicaid Web Portal www.virginiamedicaid.dmas.virginia.gov.

Local education agencies may be reimbursed by DMAS for two types of health services provided by local education agency employees or local education agency-contracted providers under the Virginia Medicaid program; (1) well child visits/ EPSDT screenings and (2) medically necessary health care services approved for Medicaid and FAMIS- enrolled children receiving special education and related services. Local education agencies must be enrolled with DMAS as providers to receive reimbursement for services.

To bill for the DMAS recognized health services under special education, local education agencies must keep copies of the appropriate service provider qualifications (copy of license or documentation of credentials) on file. The service provider qualifications must be made available upon request in the event of a quality management review by DMAS.

The local education agency will coordinate with DMAS to ensure that the local education agency has the appropriate special education services added under their assigned National Provider Identifier (NPI), and must notify DMAS of any new service or discontinuation of service so that the local education agency's NPI can be updated. The local education agency may contact DMAS at:

Department of Medical Assistance Services
Maternal and Child Health Unit
600 E. Broad Street
Richmond, VA 23219
Phone: (804) 371-7824
Fax: (804) 452-5451

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. Providers of medical and health services for Medicaid and FAMIS recipients must obtain a National Provider Identifier (NPI) and submit the NPI to DMAS.

For school health services, the local education agency must submit claims to DMAS using the local education agency NPI.

Upon receipt of the above information, the ten-digit NPI number that was provided with the enrollment application is assigned to the local education agency. This number must be used on all claims and correspondence submitted to DMAS.

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.

This manual contains information about provider qualifications and specific details concerning the DMAS reimbursable services for local education agencies. Providers must comply with all sections of this manual and must be practicing in accordance with the requirements of the individual licensing board within the Department of Health Professions to maintain continuous participation in the DMAS 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**.**

REQUESTS FOR PARTICIPATION

To become a provider of services for DMAS, the provider must request a participation agreement by writing, calling, or faxing the request to:

Virginia Medicaid Provider Enrollment Services
PO Box 26803
Richmond, VA 23261-6803
Phone (804) 270-5105 or 1-888-829-5373 (In-state Toll Free)
Fax (804) 270-7027 or 1-888-335-8476

The provider may download a copy of the appropriate provider agreement through the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov.

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

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

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

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

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

PARTICIPATION REQUIREMENTS

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

- Immediately notify the fiscal agent with the Provider Enrollment Unit, in writing, of any change in the information which the provider previously submitted to the Provider Enrollment Unit.

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

- 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 ground of race, color, or national origin.

- Provide services, goods, and supplies to recipients 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 Act requires reasonable accommodations for certain persons with disabilities.

- Provide recipients the same quality of service and in the same mode of delivery as provided to the general public.

- Accept DMAS payment from the first day of eligibility if the provider was aware that application for Medicaid/FAMIS eligibility was pending at the time that services began.

- 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 a recipient for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from a Medicaid/FAMIS recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established DMAS allowance for the service rendered. The provider may not charge 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 business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Refer to Chapter VI of this manual for specific record retention policy.

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by the 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.

- Hold confidential and use for authorized Program purposes only all medical assistance information regarding recipients. 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 is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

The provider, as defined in 45 CFR **§** 160.103 of the Final HIPAA Privacy Rule, have entered into this Business Associate Agreement to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Final Privacy regulation requirements for such an Agreement, as well as our duty to protect the confidentiality and integrity of Protected Health Information (PHI) required by law, Department policy, professional ethics, and accreditation requirements. Parties signing this Agreement shall fully comply with the provisions of the Regulations implementing HIPAA.

Provider Responsibilities to Identify Excluded Individuals and Entities

In order to comply with Federal Regulations and Virginia DMAS policy, providers are required to ensure that DMAS is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. DMAS 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 DMAS 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 DMAS may be subject to overpayment liability as well as civil monetary penalties. All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.

2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.

3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

Department of Medical Assistance Services
Attn: Program Integrity/Exclusions
600 E. Broad St, Ste 1300
Richmond, VA 23219

-or-

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

PARTICIPATION CONDITIONS

All providers enrolled in the Virginia DMAS Program must adhere to the conditions of participation outlined in their individual provider agreements. The following paragraphs outline the special participation conditions for providers performing well child visits/EPSDT screening services and providers serving students receiving special education and related services. These providers are referred to in this manual as a DMAS qualified providers. DMAS qualified provider means the practitioner is licensed in Virginia to diagnose and/or treat individuals with the physical or mental disability or functional limitations at issue, and operates within the scope of practice defined in State law.

DMAS covers the following services in local education agencies (Note: Service conditions are in Chapter IV of this manual):

- Well child visits/EPSDT screenings,
- Physical therapy,
- Occupational therapy,
- Speech-language therapy,
- Audiology,
- Nursing,
- Psychiatry, psychology and mental health,
- Personal care,
- Medical evaluations,
- Specialized Transportation, and
- Assessments/reassessments for DMAS billable special education and related services in the Individualized Education Program (IEP).

To become a DMAS provider in this category, the provider must:

- Employ qualified professionals whose qualifications/licensures have been verified by the Medicaid Specialist at Virginia DOE;
- Only bill DMAS for services provided by qualified staff who are employed or contracted with the local education agency; and

- Enter into and have in effect an agreement as a DMAS provider of local education agency services.

DMAS does not reimburse a DMAS qualified provider when providing therapy or other service if they are a parent, stepparent or legal guardian of the student. Payment may be made for services rendered by other family members only when there is written objective documentation as to why there are no other providers available to provide therapy or other service for the student. The family member providing therapy or other service to the student must be employed by the local education agency and must meet all provider qualifications.

PROVIDER QUALIFICATIONS FOR SPECIFIC SERVICES

Supervision Requirements

DMAS qualified providers must follow their individual licensing regulations regarding supervision requirements. If the individual licensing regulations do not include specific time periods regarding supervisory visits (i.e., every 30 days) or type of supervisory visits (direct/face-to-face or general/indirect), then the qualified provider must meet the minimum requirements as defined by DMAS. The minimum supervision requirements for DMAS/Local Education Agency providers are the supervisor shall make supervisory visits at a minimum of every 30 to 90 days, to ensure both quality and appropriateness of services. The supervision is required to review the student's progress and make any adjustment to goals or treatment modalities. Supervision may be provided indirectly (i.e., telephonically), if allowed under the individual licensing regulations. The supervisor must document accordingly as described in Chapter VI of this manual.

Well Child Visits/EPSDT Screening Services

Well Child Visits/EPSDT Screening services must be conducted by a:

- A physician licensed by the Board of Medicine;
- A physician assistant licensed by the Board of Medicine under supervision as required by their license; or
- A nurse practitioner licensed by the Board of Nursing under supervision as required by their license.

Physical Therapy Services

Physical therapy services must be performed by the following:

- A physical therapist (PT) licensed by the Virginia Board of Physical Therapy (18VAC112-20-30); or
- A physical therapy assistant (PTA) licensed by the Virginia Board of Physical Therapy (18VAC112-20-30) under the supervision of a PT (18VAC112-20-90).

A physical therapist shall be fully responsible for any action of persons performing physical therapy functions under the physical therapist's supervision or direction.

Occupational Therapy Services

Occupational therapy services must be performed by the following:

- An occupational therapist (OT) licensed by the Virginia Board of Medicine; or
- An occupational therapy assistant licensed by the Virginia Board of Medicine under the supervision of a licensed occupational therapist (18 VAC 85-80-10 et seq.).

An occupational therapist shall be fully responsible for any action of persons performing occupational therapy functions under the occupational therapist's supervision or direction.

Speech-Language Therapy Services

Speech-Language Therapy services must be performed by:~~:~~

- A speech-language pathologist (SLP) licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology ~~(18VAC30-20-170)~~(18VAC30-21-60) with a Master's Degree or
- A SLP licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology, licensure as school speech-language pathologist without a Master's degree, under the supervision of a licensed SLP with a Master's Degree.

A speech-language pathologist shall be fully responsible for any action of persons performing speech-language therapy functions under the speech-language pathologist's supervision or direction.

NOTE: As of July 1, 2015, all SLPs must be licensed through the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology. The Virginia Department of Education endorsements are no longer valid as of June 30, 2015.

Audiology Services

Audiology services must be provided by an audiologist licensed by the Virginia Board of Audiology and Speech-Language Pathology ~~(18VAC30-20-45)~~(18VAC30-21-60).

Nursing Services

Nursing services must be provided by a:

- A Licensed Registered Nurse (RN); or
- A Licensed Practical Nurse (LPN) under the supervision of a RN as required by the Virginia Board of Nursing (18VAC90-20-37).

A registered nurse shall be fully responsible for any action of persons performing nursing functions under the registered nurse's supervision or direction

Psychiatry, Psychology, and Mental Health Services

Psychiatry, Psychology and Mental Health Services may be provided by:

- A psychiatrist licensed by the Board of Medicine;
- A licensed clinical psychologist, licensed school psychologist, or licensed school psychologist-limited licensed by the Board of Psychology;
- A licensed clinical social worker (LCSW) licensed by the Board of Social Work;
- A licensed professional counselor (LPC) licensed by the Board of Counseling;
- A psychiatric clinical nurse specialist (CNS) licensed by the Board of Nursing and certified by the American Nurses Credentialing Center;
- A licensed marriage and family therapist (LMFP) licensed by the Board of Counseling; or
- A school social worker endorsed by Department of Education.

Psychiatry, psychology and mental health service providers must provide services within their license scope (18 VAC 125-20-10 et seq. and 18 VAC 140-20-10 et seq.) and in accordance with Special Education regulations (8 VAC 20-80-10) as well within the DMAS covered services detailed in Chapter IV of this manual.

Personal Care Assistant Services

Basic qualifications for personal care assistants include:

- Physical ability to do the work;
- Ability to be trained by appropriate licensed professional to perform tasks.
- Perform services consistent with the training received by the appropriate DMAS qualified provider;

Personal Care Assistant – Nursing-like services require training as outlined in the following:

- Virginia School Health Guidelines Manual;
- Specialized Health Care Procedures Manual;
- Manual for the Training of Public School Employees in the Administration of Medication; and
- Manual for Training of Public School Employees in the Administration of Insulin and Glucagon.

The Department of Education training publications may be found on the DOE website at www.doe.virginia.gov under "Student and School Support", "Health and Medical".

Supervision of Personal Care Assistants

Any licensed practitioner who meets DMAS provider requirements stated in this chapter may supervise the personal care assistant providing services within the scope of their individual discipline. **DMAS requires that a supervisory visit must be conducted at least every 90 calendar days.** It may be necessary for a PCA to have multiple supervisors depending on the scope of services the student is receiving. The licensed supervisor shall make supervisory visits as often as needed as per their licensing requirements to ensure both quality and appropriateness of services. The supervisor should consider the following:

- The stability and condition of the student;
- The experience and competency of the personal care assistant;
- The nature of the tasks, procedures or services being performed; and

- The proximity and availability of the supervising staff to the personal care assistant when the tasks will be performed.

The supervision is required so there is an opportunity to review the student's progress and make any adjustment to goals or treatment modalities.

The licensed practitioner needs to take into consideration the licensure requirements to determine the requirement for direct (face-to-face) supervision versus indirect (telephonic or off-site) and the frequency of supervisory visits. Documentation of supervision must not exceed 90 calendar days. The supervisor must document accordingly as described in Chapter VI of this manual.

Examples of personal care assistant services and suggestions for the appropriate supervising licensed practitioner of the healing arts include but are not limited to:

- Assistance to increase adaptive behavioral functioning supervised by the licensed provider of psychiatry, psychological or mental health services;
- Assistance with activities of daily living supervised by the PT, OT, SLP or RN;
- Assistance with hearing aides and assistive listening devices supervised by the audiologist or SLP;
- Assistance with adaptive equipment supervised by OT, PT, or SLP;
- Assistance with ambulation and exercise supervised by the PT or OT;
- Assistance with remedial services to reduce the impact of the disability supervised by a DMAS approved provider as documented in Chapter II of this manual; and
- Monitoring a health related service supervised by a RN.

A personal care assistant cannot be the parent, stepparent or legal guardian of the student. Payment may be made for services rendered by other family members only when there is written objective documentation as to why there are no other aides or providers available to provide care for the student. The family member providing care to the student must be employed by the local education agency and must meet the same requirements as other aides.

Medical Evaluation Services

Qualified providers of Medical Evaluation Services include:

- A physician licensed by the Board of Medicine;

- A physician assistant licensed by the Board of Medicine under supervision as required by their license; or
- A nurse practitioner licensed by the Board of Nursing under supervision as required by their license.

Specialized Transportation

Drivers must be employed through the local education agency or have a contract with the local education agency and must meet applicable federal and state statutes and regulations for transporting students. The specialized transportation must be a specially adapted school bus utilized to transport a Mediciaid or FAMIS enrolled student to the local education agency (or contracted provider) to receive a DMAS billable service that is documented in the student's IEP.

Note: Specialized transportation service is not covered by the VA Medicaid Non-Emergency Transportation (NET) Brokerage program. Specialized transportation arrangements and services are provided only by the local education agency.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

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. Each DMAS participating provider is responsible for making provisions for such disabled individuals in the provider's programs and activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. The provider's signature on the claim indicates compliance with the Rehabilitation Act.

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

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 its expiration.

A participating provider may terminate participation with DMAS at any time; however, written notification of voluntary termination must be made to the Provider Enrollment Unit thirty (30) calendar days prior to the effective date.

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

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

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325D 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

Provider Appeals

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse actions that afford appeal rights to providers.

A provider may appeal an adverse decision where a service has already been provided, by filing a written notice for a first-level Informal Appeal with the DMAS Appeals Division **within 30 calendar days** of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 6th Floor
Richmond, VA 23219

If the provider is dissatisfied with the first-level Informal Appeal decision, the provider may file a written notice for a second-level appeal Formal Appeal, which includes a full administrative evidentiary hearing under the Virginia Administrative Process Act (APA), *Code of Virginia*, § 2.2-4000 et seq. The notice for a second-level Formal Appeal must be filed **within 30 calendar days** of receipt of the first-level Informal Appeal decision. The notice for second-level Formal Appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 6th Floor
Richmond, VA 23219

Administrative appeals of adverse actions concerning provider reimbursement are heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) (the APA), the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia and the DMAS appeal regulations at 12 VAC 30-20-500 et. seq. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

If the provider is dissatisfied with the second-level Formal Appeal decision, the provider may file an appeal with the appropriate county circuit court, in accordance with the APA and the Rules of Court.

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

The provider may not bill the recipient (client) 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 reviews 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.

DMAS PROGRAM INFORMATION

Federal regulations governing program operations require Virginia DMAS 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 DMAS memoranda because he or she has access to the publications as part of a group practice. To suppress the receipt of this information, the Provider Enrollment Unit requires the provider to complete the Mail Suppression Form and return it to:

Virginia Medicaid Provider Enrollment Services
PO Box 26803
Richmond, VA 23261-6803
Phone (804) 270-5105 or 1-888-829-5373 (In-state Toll Free)
Fax (804) 270-7027 or 1-888-335-8476

Upon receipt of the completed form, PEU 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.