

Provider Enrollment Services Procedure Manual

Commonwealth of Virginia
Department of Medical
Assistance Services

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1. Introduction

1.1 Purpose

██████ is the Fiscal Agent for the Commonwealth of Virginia Department of Medical Assistance Services (DMAS) and serves as a liaison between DMAS and the provider community. Provider Enrollment Services (PES) is a key component of ██████ Fiscal Agent responsibilities.

This manual specifies the policies and procedures of Provider Enrollment Services in its role to support the Commonwealth of Virginia's Medicaid program, the Virginia Medicaid Management System (VA MMIS). Each task is detailed to efficiently enroll and maintain a provider's status in the VA MMIS. Responsibilities of Provider Enrollment Services include:

- Enrolling and Renewing Providers
- Provider Maintenance in VA MMIS
- Provider Rate Changes
- Terminating Providers
- Processing Return Provider Mail
- Researching 1099 Duplicate Requests
- Tracking Provider Complaints
- Processing DMAS Request for Research and Resolution

1.2 Provider Enrollment Services Department Overview

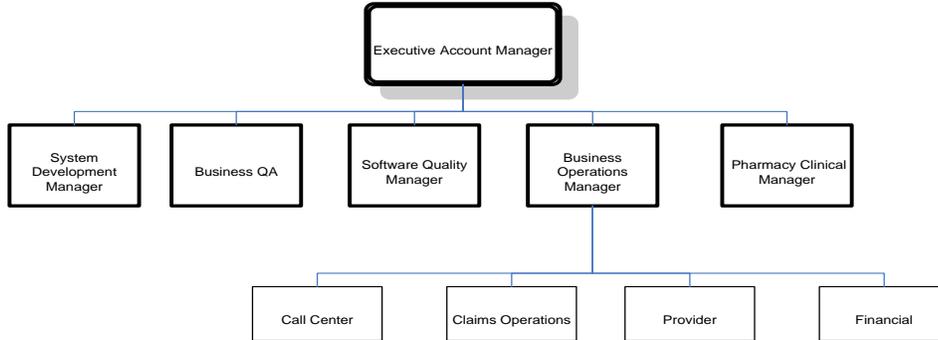
Provider Enrollment Services (PES) is one of the most critical ingredients of success for a state Medicaid program. Provider Enrollment Services is responsible for the accurate and timely enrollment of providers into the Medicaid program and maintenance in accordance with Federal and Commonwealth regulations for all participating providers.

1.3 Staffing Overview

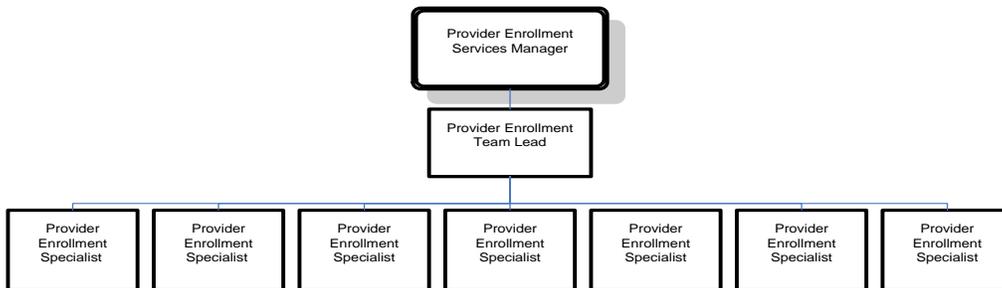
The Provider Enrollment Unit consists of a Provider Enrollment Services Manager, PES Team Lead, and Provider Enrollment Specialists.

The following illustrates (1) the relationship of Provider Enrollment Services to the Fiscal Agent Services (FAS) management team and (2) the organizational structure of Provider Enrollment Services.

FAS Management Organizational Structure



Provider Enrollment Services Organizational Structure



1.3.1 Provider Enrollment Services Manager

The Provider Enrollment Services Manager is responsible for overseeing the daily operation of the Provider Enrollment Services department. The Provider Enrollment Services Manager’s primary goal is to ensure the responsibilities of the department are successfully completed in an accurate, efficient and secure manner.

Responsibilities include:

1. Supervising and monitoring all activities of the Provider Enrollment Services department.
2. Ensuring the accurate and timely enrollment and maintenance of all Virginia Medicaid Provider Enrollment functions.
3. Ensuring HIPAA compliance.
4. Establishing processes relating to provider enrollment, maintenance, and termination of providers in the Medicaid program.

5. Initiating process improvements to more effectively maintain the provider network.
6. Interfacing with DMAS, the provider community and other Fiscal Agent Departments where necessary to meet DMAS objectives.
7. Reviewing and approving weekly time sheets.
8. Evaluating staff for optimal performance.
9. Overseeing continuing cross training of staff members.
10. Monitoring daily workflow.
11. Ensuring that training is available to PES staff as needed.
12. Researching escalated provider complaints when identified by FAS or DMAS.
13. Other duties as assigned.

1.3.2 Provider Enrollment Services Team Lead

The Provider Enrollment Services Team Lead supports the PES Manager and serves as liaison between Provider Enrollment Specialists, the PES Manager, and DMAS.

Other responsibilities include:

1. Ensuring the accurate and timely enrollment and maintenance of all Virginia Medicaid Provider Enrollment functions.
2. Ensuring HIPAA compliance.
3. Reviewing and approving all processes relating to provider enrollment, maintenance, and termination of providers in the Medicaid program.
4. Interfacing with DMAS, the provider community and other Fiscal Agent Departments as needed.
5. Escalating issues to the PES Manager when deemed necessary.
6. Working with the PES Manager to identify performance improvement opportunities.
7. Overseeing continuing cross training of staff members.
8. Monitoring daily workflow.
9. Reviewing accuracy of daily tasks.
10. Training as needed.
11. Research as assigned.
12. Other duties as assigned.

1.3.3 Provider Enrollment Specialist

The primary role for the Provider Enrollment Specialist is to process Provider Enrollment Applications and other documents relating to provider maintenance such as changes of address, terminations, or other activities that would change a provider's status within the Medicaid program.

Responsibilities include:

1. Reviewing Provider Enrollment Applications and other documents for completeness.
2. Verifying information provided within the Provider Enrollment Applications and other supporting documents.
3. Data entry of provider demographics into the VA MMIS.
4. Interfacing with providers to answer inquiries or gather further information regarding a provider's enrollment.

5. Ensuring the accurate and timely enrollment and maintenance of all Virginia Medicaid Provider Enrollment functions.
6. Other duties as assigned.

1.4 Service Level Agreements

PES Operational Service Level Requirements:

Service Level Agreements – Provider Enrollment Services	
Description	Performance Target
Process Provider Enrollment Applications	≤ 10 business days from receipt
Renewal and Termination of Providers	≤ 10 business days from receipt
Maintenance of Provider Records	≤ 5 business days from receipt
Provider Rates	≤ 2 business days from receipt
Respond and Resolve Complaints	≤ 5 business days from receipt
Process Provider Requests for duplicate 1099	≤10 business days from receipt
Return Provider Mail	≤ 5 business days from receipt

2. Document Types

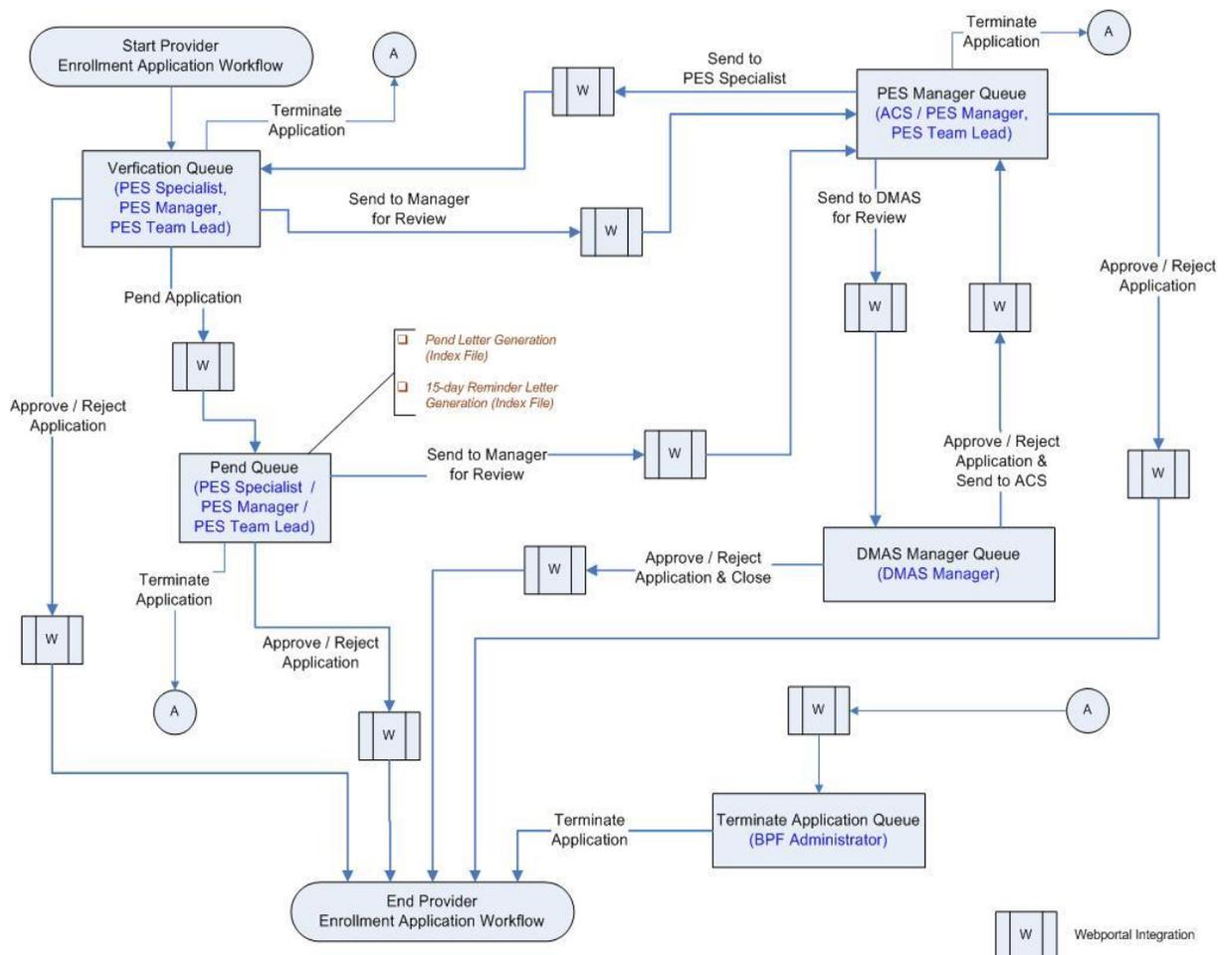
Provider Enrollment Services (PES) receives provider enrollment, revalidation, and updates to disclosure applications, correspondence, and missing information daily via provider entry to the Web Portal or through a FileNet Applications workflow from the Document Control Unit. Following are the types of documents received for processing in PES:

1. **Provider Enrollment Applications** – Provider Enrollment Applications received via provider entry into the Web Portal are loaded into a FileNet Workflow for processing. Provider Enrollment Applications received through the mail or fax are distributed via FileNet from Document Control to Provider Enrollment Services.
2. **Provider Revalidation Applications** – Provider Revalidation Applications received via provider entry into the Web Portal are loaded into a FileNet Workflow for processing. Provider Revalidation Applications received through the mail or fax are distributed via FileNet from Document Control to Provider Enrollment Services.
3. **Provider Updates to Disclosure Applications** -- Provider Updates to Disclosure Applications received via provider entry into the Web Portal are loaded into a FileNet Workflow for processing.
4. **Correspondence** – License Renewals, Provider Complaints, Provider Rate Change, Return Mail, Terminate Provider, Maintenance, Duplicate 1099 Requests, and other supporting documentation is received through FileNet or hard copy from Document Control.
5. **Missing Information** – This represents those items missing from an original Provider Enrollment or Revalidation Application and requested by PES.

3. Processing Automated Provider Enrollment Applications

Provider Enrollment Services will follow established Commonwealth of Virginia general enrollment guidelines to ensure accurate and timely enrollment and re-enrollment of providers into the Medicaid Program.

 **SLA (Service Level Agreement): Process provider enrollment applications within ten (10) business days of receipt.**



3.1 Workflow

- Provider Enrollment Applications
- Revalidations
- Updates to Disclosure

3.2 Overview

The Fiscal Agent has implemented a web based application through Web Portal for providers to manage their new enrollments, revalidations and updates to disclosure information. These online processes will include the transfer of data from Web Portal to the FileNet Workflow (Workflow). The frequency of the data transfer (batch runs) is twice daily. The data transfer process includes a system generated pdf of the online document submitted by the provider. These pdf's will be assigned a DCN through Datacap, indexed, assigned a risk category and score and attached to the data populated within the Workflow for processing.

New enrollments, and revalidations are also available to providers via paper forms including detailed directions via Web Portal. Providers may print documentation or contact PES to request paper forms and submit for processing. Upon receipt, all provider paper communication, whether new enrollments, revalidations, disclosure updates, missing information etc. is scanned and indexed within Datacap. From the scan, a pdf is generated, assigned a DCN, assigned a risk category and score and submitted to Workflow for processing.

Data within Workflow is categorized by predefined business rules, some associated to risk category and score and managed through various process steps with an Application Tracking Number (ATN). Data managed within Workflow includes the processing of enrollment applications, the processing of revalidation applications, the data entry of paper enrollments, revalidations and the processing of disclosure updates. Each record within Workflow contains the system generated pdf for reference for either Web Portal or Datacap.

The submission of data through Web Portal, whether enrollment, revalidations or disclosure updates and whether submitted by the provider online or by fiscal agent data entry from paper, allows for the provider to view the real time status of the process. Included to aid providers and minimize phone calls with the document status are also various options for submission of missing information and viewing mailed correspondence.

The Workflow system is used to track, process and retain an audit record of the complete processing of enrollment applications, revalidation applications and updates to disclosure. The Workflow output is an approved enrollment, an approved revalidation, a rejected application or a rejected revalidation. The resulting output, including supporting documentation and administrative data, of approvals is passed to MMIS to populate as a new provider, a new group, or an approved revalidation. Note that some revalidations and updates to disclosure information submitted via Web Portal (whether by provider or PES data entry) may bypass Workflow, thus directly populating into MMIS based on pre-defined controls of Federal Database Checks (FDBC).

A Service Level Agreement for the fiscal agent and DMAS is input into Workflow as a baseline and the management of data through defined structured steps is managed and reported to the baseline.

3.3 Log On Procedures

1. Log on into Virginia Medicaid Web Portal:
 - a. <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal>
 - b. Select Internal Users under Login
 - c. Enter User ID and Password
 - d. Under Quick Links select ECM Workflow

Tracking #	Application Received Date	Provider Type	Provider Name	Provider ID	Assigned Staff	Lead Manager Name	Application Status
2011179170	4/29/2011 3:00:00 PM	Health Department Clinic	GUNGANTY,NALINE	1912962085			Pend Application
2011179173	4/29/2011 3:00:00 PM		NALGANTY,GUNGANTY	1194091136			Send for verification
2011180183	4/29/2011 3:00:00 PM		J	1861891190		Kim Smed	Send for verification
2011180184	4/29/2011 3:00:00 PM		HEMARELLI,SREOVAS	171965777			Send for verification
2011180186	4/29/2011 3:00:00 PM		KRISHALA,SRI MAHESH	1203819828			Send for verification
2011180188	4/29/2011 3:00:00 PM	Hospital	DEVILA,BALACHANDR D	1395212121			Send for verification
2011180193	4/29/2011 3:00:00 PM		GUNGANTY,NALINE	1952418055			Send for verification
2011182211	7/5/2011 3:00:00 PM	Health Department Clinic	KHOKOU,SJAIL	103193354			Send for verification
2011182212	7/5/2011 3:00:00 PM		SABAJA,SHANTI	1679549823			Send for verification
2011182215	7/5/2011 3:00:00 PM	Physician/Medical	GUNGANTY,NALINE	1218910419			Send for verification
2011182216	7/5/2011 3:00:00 PM		BOSS,SHEILA	1336144807			Send for verification
2011193427	7/12/2011 3:00:00 PM		DOE,JOHN	1718994947			Send for verification
2011193432	7/12/2011 3:00:00 PM		DAVIDSON				Send for verification
2011193434	7/12/2011 3:00:00 PM	Physician	HOUSE,MINWIE	1528091063		Kim Smed	Send for verification
2011193435	7/12/2011 3:00:00 PM	Nurse Practitioner	HOUSE,MINWIE	1528091063	Test ID: 2	Kim Smed	Send for verification
2011193436	7/12/2011 3:00:00 PM	Clinical Psychologist	CLINICAL,CHARLES	4546104245		Kim Smed	Send for verification
2011193438	7/12/2011 3:00:00 PM	Hospital	ST. MARKETS HOSPITAL	9456104264		Kim Smed	Send for verification
2011193439	7/12/2011 3:00:00 PM	Hearing Aid	HARRIS,HEARSH	9556105156		Kim Smed	Send for verification
2011194487	7/14/2011 3:00:00 PM		JACOTHS ENTERPRISES, INC	1796151184			Send for verification
2011194488	7/14/2011 3:00:00 PM		BESICZI,PIRWOOD MD	1746218118			Send for verification
2011194489	7/14/2011 3:00:00 PM		HELMOTH, JAVOICE	1598453645			Send for verification
2011194490	7/14/2011 3:00:00 PM		KUTTY,ATTAMBEETH N MD	1608891563			Send for verification
2011194901	7/14/2011 3:00:00 PM		D'ALRISA,BELLAERIA	2121212121			Send for verification
2011194902	7/14/2011 3:00:00 PM	Audiologist	DASARD	5232112121			Send for verification
2011196544	7/15/2011 3:00:00 PM		D'ALRISA,BELLAERIA	4564564564			Send for verification

3.4 Definitions

1. In-baskets
 - a. Enrollments – The submission and processing of applications received from providers with the intent to enroll in the Medicaid program in order to submit claims for services rendered to Medicaid recipients.
 - b. Revalidations – Every 5 years all Medicaid providers must revalidate their current information on file which includes; payment of applicable fees, social security number, birthdate, ownership/disclosure information and screening process if required.
 - c. Updates to Disclosure – Providers must disclose ownership information. Providers must disclose if any adverse action is taken on their license and/or criminal conviction.
 - d. Pend for Missing Info – applications or revalidations that have been pended for missing information
 - e. Pend 15 Days – applications or revalidations that have been previously pended and have not submitted the requested information within 15 days are sent a 15 day reminder letter

- f. Pend for Site Visit – applications that have been pended awaiting outcome of the site visit
 - g. Pend for Other – applications that have been pended for a reason other than missing information or for awaiting the outcome of the site visit
- Note: The following in-baskets may only be visible to certain roles:
- h. Sent to DMAS – applications sent to DMAS for review
 - i. Review/Suspicious Application – Suspicious applications or revalidations that have been sent to the PES Manager for review.
 - j. Application Verification – All enrollments, revalidations, and updates to disclosure information applications that need to be processed.
 - k. Finance Manager – Applications or revalidations that have been submitted via WebPortal or PES data entry indicating a payment method other than online credit card submission and awaiting payment via check or manual credit card.
2. Column Headings – Applications will be displayed by date received from web portal, but can be sorted according to each Column Heading.
- a. Tracking #
 - b. Application Received Date
 - c. Provider Type
 - d. Provider Name
 - e. Provider ID
 - f. Assigned Staff
 - g. Lead Manager Name
3. Roles
- a. PES Specialist – can perform all actions except sending an application to DMAS
 - b. PES Manager – can perform all actions
 - c. Finance Manager – can perform actions available in the Finance in basket
 - d. DMAS Manager – can perform all actions

3. 5 Procedures for Data Entry of Paper Provider Enrollment Applications

The web portal data entry form was created to key paper enrollment applications for entry into the electronic provider enrollment workflow. The web portal data entry screen is located on the Virginia MMIS Web Portal and is accessed through the employee's XA code.

General Rules:

- The Section of the application and the online form are not the same. However, there are some fields on the paper application that do not exist on the on-line form and some fields on on-line form that do not be on the paper application. If this is the case, continue to the next field.
- Applications can be keyed in all lower case. No capitalization is needed.
- A * on the online form denotes a required field. The field will also be shaded in light yellow.
- The online form has a hover capability that will provide data entry requirements for certain fields.
- If you have any questions, put the application aside and ask your Manager for assistance. All questions will be forwarded to the PSR manager.
- If you need to stop in the middle of keying an application, please make sure you save the application by selecting the “SAVE” button located at the bottom of each page. Saving the application, will ensure you are able to go back in at a later date to complete the keying process.
- If an application appears to be a duplicate it should still be data entered.

Procedure:

1. Key a new application
 - a. Log-in to the MMIS Web Portal as an Internal User with your XA code and password
 - b. Under the Quick Links section, select PES Application Entry
 - c. The **PES Application Tracking Screen** will come up.
 - i. This screen will provide you with a list of the applications you have entered and the status.
 - d. Select the **Add New Application** button
 - e. On the **Become A Provider Screen**:
 - i. Select a Form Type from the drop down list. The form corresponds to the provider type. The provider type can be found on top of the front page which will be at the end of the application or on the Participation Agreement.
 - ii. Key the Paper Application DCN. The DCN is located on the back of the first page at the top of the application. The DCN is 14 characters and is alpha/numeric.
 - f. Select **Continue** to move to the next screen.
 - i. If you select **Cancel**, the request for a new application will be cancelled and all data will be lost.

Click Add New Application button to begin the Enrollment Process or to add a New Application

[Add New Application](#)

Application Type	NPI	User ID	Application Ref#	Application Submit Date	Status	% Complete	Action
Qualified Medicare Beneficiary (QMB)				May 29, 2015	Submitted	5%	
Qualified Medicare Beneficiary (QMB)				May 29, 2015	Submitted	5%	
Physician				May 29, 2015	Submitted	5%	
Physician				May 29, 2015	Submitted	5%	
Physician				May 29, 2015	Submitted	5%	
Physician				May 29, 2015	Submitted	5%	
Physician				May 29, 2015	Submitted	5%	
Physician				May 29, 2015	Submitted	5%	
Physician				May 29, 2015	Submitted	5%	
Physician				May 29, 2015	Submitted	0%	
Physician				May 29, 2015	Submitted	0%	
Physician				May 29, 2015	Submitted	5%	
Rehab Outpatient				May 29, 2015	Submitted	0%	
Nurse Practitioner				May 29, 2015	Submitted	5%	
Group Enrollment Packet				May 29, 2015	Pended	35%	Upload Letter
Independent Laboratory				May 29, 2015	Submitted	0%	

Become a Provider

If you would like to apply to become a Provider, you can do so by completing an application online. If you have any questions, please contact the Virginia Provider Enrollment Services Department toll-free at 888-829-9373 during business office hours from Monday to Friday, 9am - 5pm EST. To complete and mail a paper version of the enrollment application, please click [here](#).

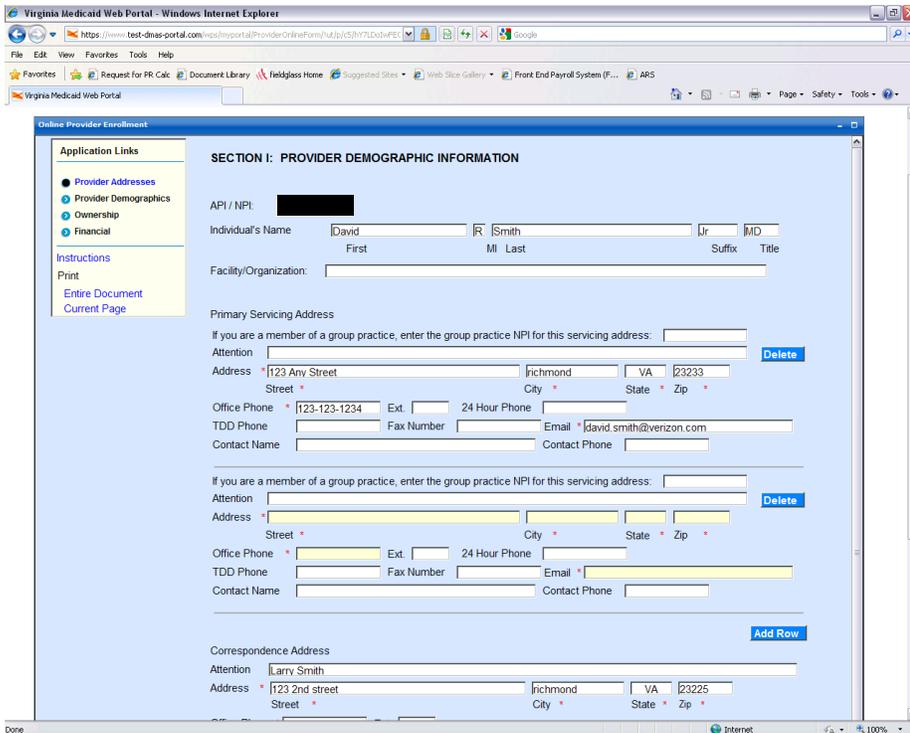
[FAQ](#)
[General Instructions](#)

Please select a form to continue.

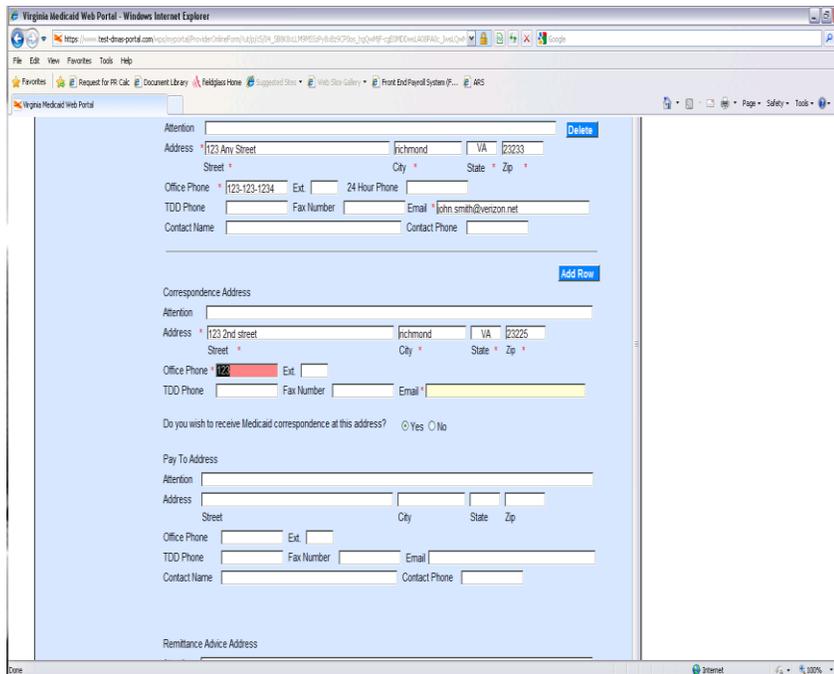
Physician Paper Application DCH

[Continue to](#) [Cancel](#)

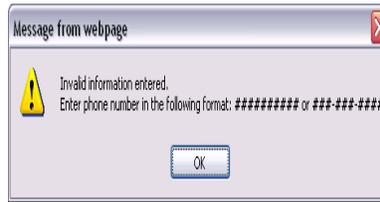
- g. Section I – Provider Demographics Screen
 - i. Enter all fields that are on paper application into the corresponding online fields.
 - ii. Notes:
 - 1. Servicing Address
 - a. If there is an Addendum A - Additional Servicing Address, select the **ADD ROW** button for each address. A new set of address fields will come up to allow you to add the information for each servicing address.
 - b. You can add unlimited number of servicing address.
 - c. The Addendum is normally located at the end of the enrollment package.
 - d. If you need to delete an address, select the **DELETE** button and the address will be removed.
 - e. When keying multiple servicing Addresses, please “**SAVE**” as you are keying to prevent the loss of data.



2. If a field is not entered in a required format, the system will let you know of the error and will not let you continue until the field is corrected. The field will highlight in Pink and an error message will appear.



Error Message:



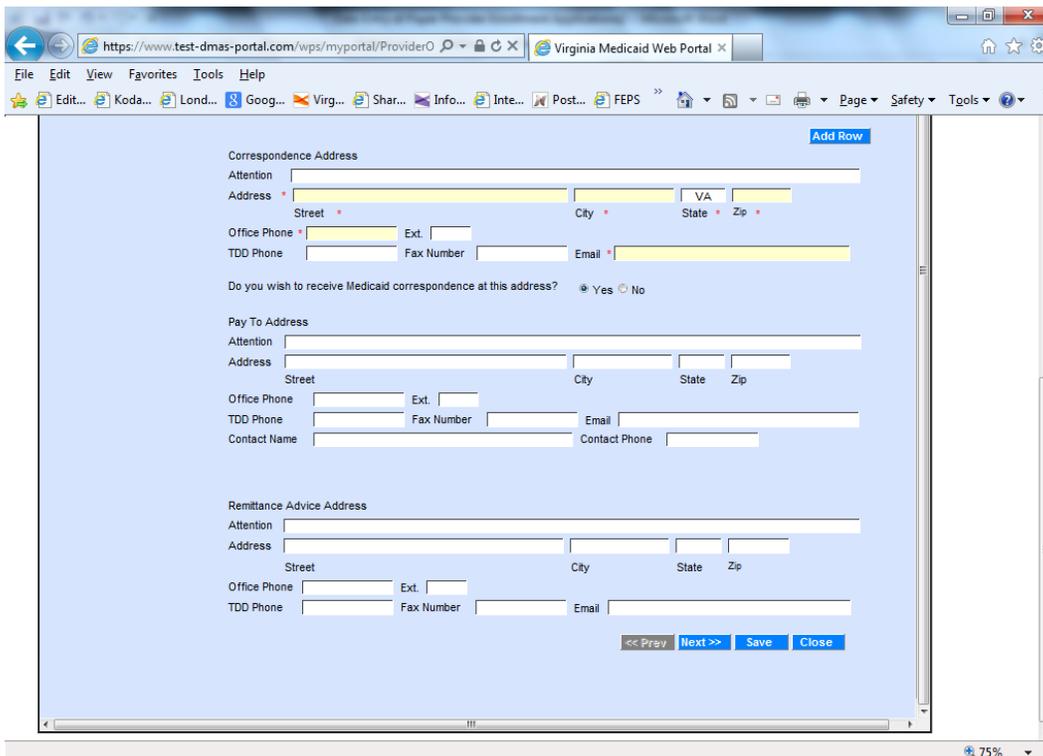
- iii. When you have completed this page of the Provider Demographics, select the **Next** button to move to the next page of Provider Demographic information.

iv. Note:

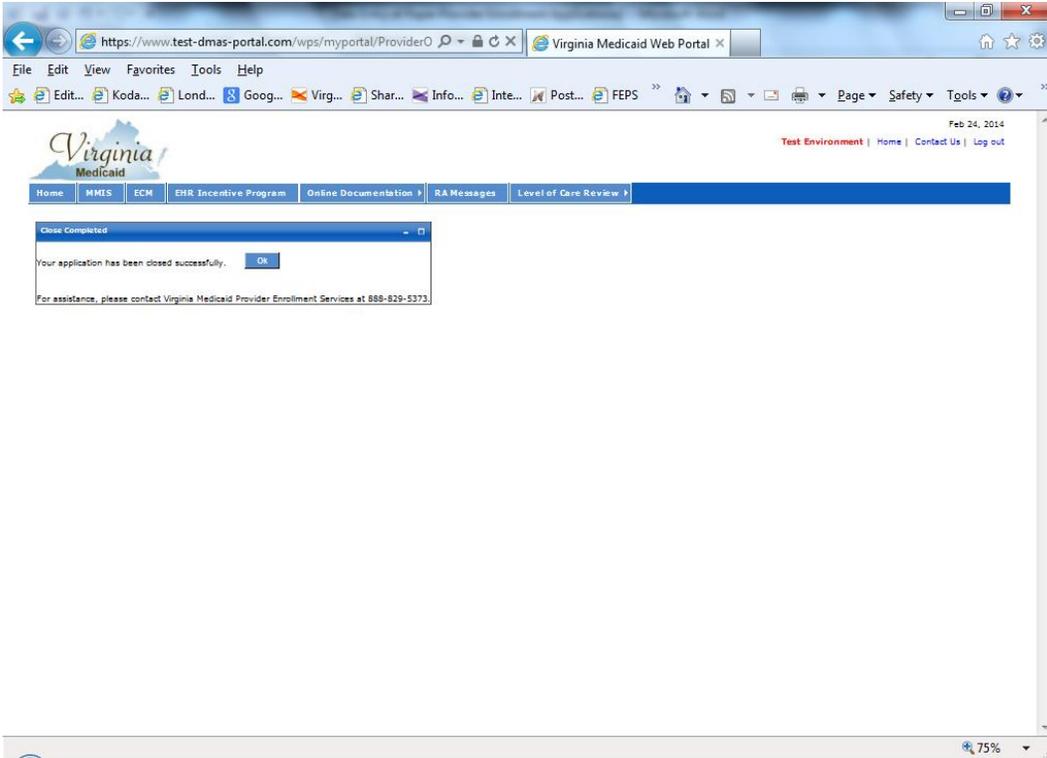
- 1. If a required field was missed, you will get the following error message.



- 2. If the information for an online required field is not provided on the paper application, the application will be rejected and not saved by selecting the **"CLOSE"** button at the bottom right corner of the screen.



- 3. The message "Your application has been closed successfully" is displayed.



4. Select OK and you will be positioned back to the PES Application Status Tracking screen where you will select **Delete** to remove the application from the queue.
 - a. Highlight the missing information field on the application and write your XA code on the top right hand corner.
 - b. Place the application in the Incomplete Application basket staged in your area.
 - c. Move on to the next application.

- v. Provider Screening Question
 1. This question will appear on Moderate and High Risk provider applications.
 2. Key the option selected on the paper application and complete the fields required for each option.
 3. If multiple options are checked on the application, key the first option selected.

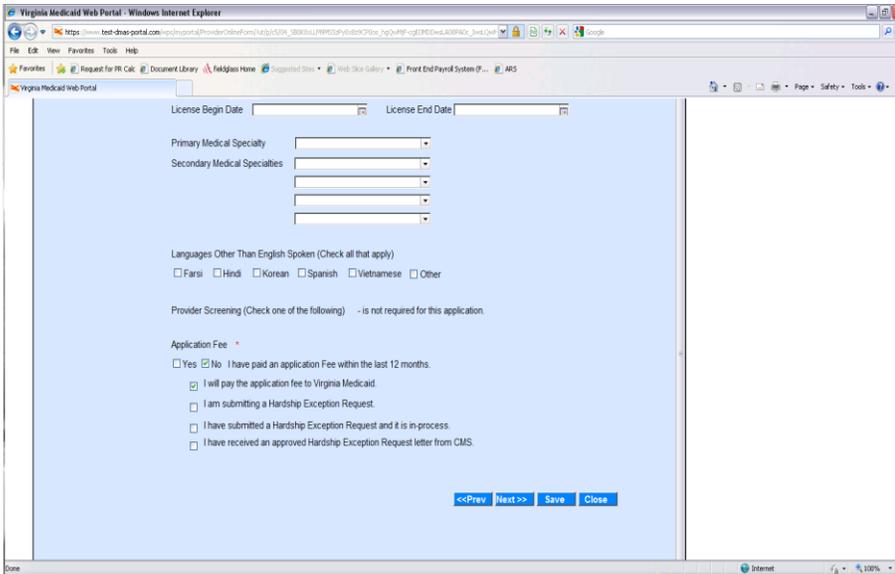
The screenshot shows the Virginia Medicaid Web Portal interface. The 'Requested Effective Date of Enrollment' is set to 09/11/2013. The 'Application Fee' section is expanded, showing the question: 'Application Fee *'. Below the question are two radio buttons: 'Yes' and 'No'. The 'No' option is selected. A note below the radio buttons reads: 'I have paid an application Fee within the last 12 months.'

vi. Application Fee Question

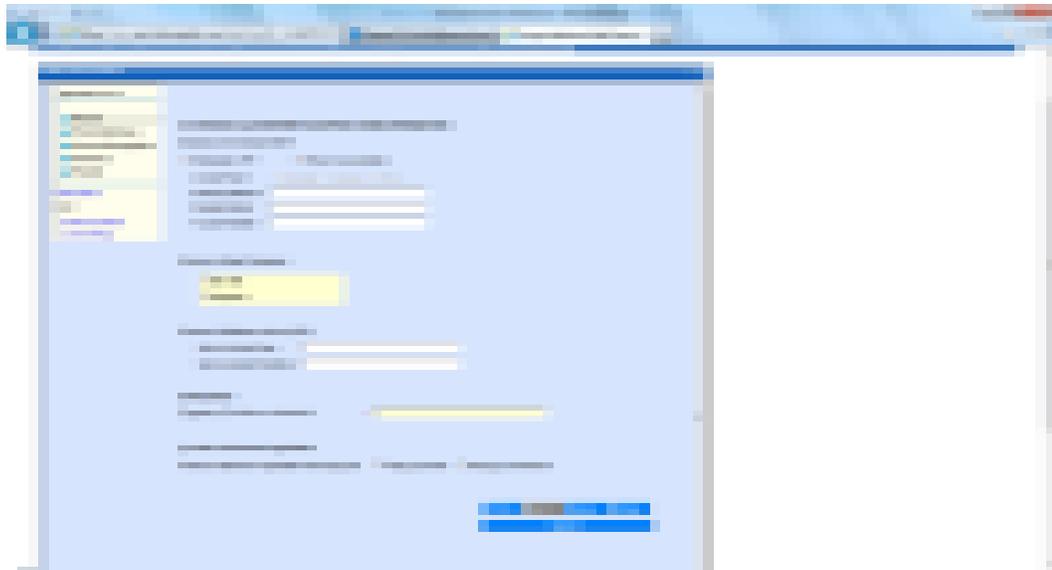
1. These fields will only appear on applications where a fee is required.
2. A YES or NO selection is required.
3. If YES is selected – key the Agency paid and the Date paid in the required fields.

This screenshot shows the same application form as the previous one, but with the 'Application Fee' section expanded further. The 'Yes' radio button is now selected. Below the radio buttons, there are two additional fields: 'I have previously paid an application fee to' (with a dropdown menu) and 'Date Paid' (with a date picker). At the bottom of the form, there are navigation buttons: '<<Prev', 'Next>>', 'Save', and 'Close'.

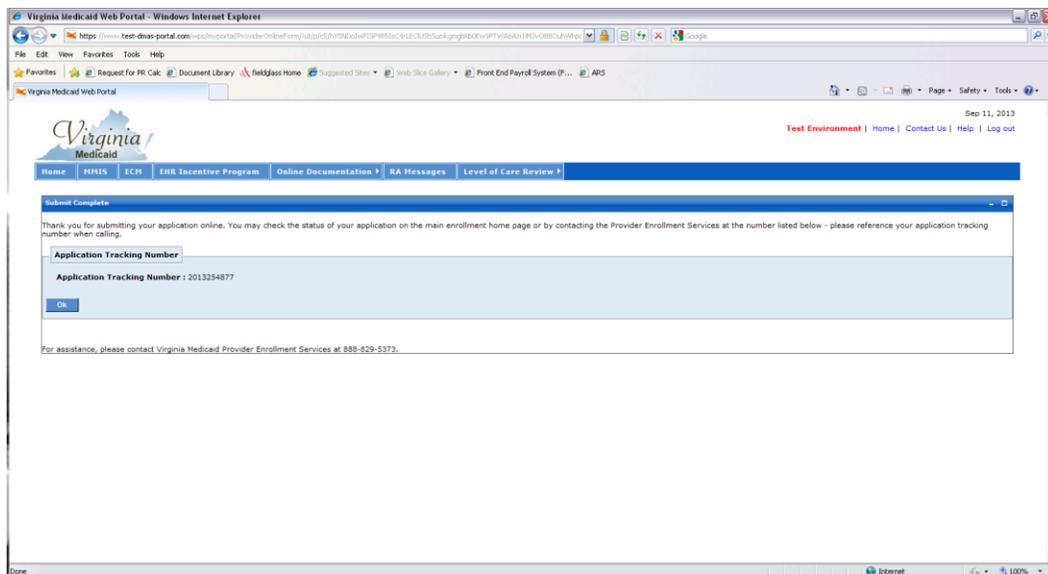
4. If NO is selected – Select the option that corresponds to the option selected on the paper application.



- h. Section II – Disclosure of Ownership and Control information for Disclosing Entity
 - i. A YES or NO selection is required for each question in this section
 - ii. If **YES** is selected, the additional information fields will appear.
 1. The required fields are marked with the * and are highlighted in yellow.
 2. Select **ADD ROW** if there are multiple entries for each question.
 3. You can add as many rows as needed to complete the question.
 4. There may be additional entries attached to the enrollment package.
 5. Select the **DELETE** button to remove an entry.
 - iii. If **NO** is selected, you can move on to the next question.
 - i. Section III – Claim Payment and Processing information
 - i. Complete this section by keying the information provided on the paper application.
 - ii. If the provider signature cannot be read, key “signature on file”.
 - iii. If a Provider Enrollment Application Fee Document appears behind the Participation Agreement, select the “Paying by Check” box.
- j. When the Submit button appears at the end of the screen you have completed the online data entry.
- k. Select the SUBMIT or Make Payment & Submit button



I. You will see the following screen on a successful submission.



m. Select OK. This will return you to the PES Application Tracking Status Screen.

2. PES Application Tracking Screen

- a. This is the starting point for all new applications and where you end up once an application is submitted
- b. It provides information that includes;
 - i. Application Type – shows the type of Application entered
 - ii. NPI – shows the NPI/API entered on each application
 - iii. User ID – your XA code

- iv. Application Reference #/Tracking# - Number assigned to individual applications for tracking
 - v. Application Submit Date – The date application was submitted. This will be blank if the application has not been submitted
 - vi. Status – the current status of each application entered
 - 1. Submitted – Application has been submitted into the workflow.
 - 2. Not Submitted - You have saved the application but have pended it for missing information or to finish keying the data at a later date.
 - vii. Action – Allows a saved application to be recalled for completion
 - 1. Recall Application – Allows a saved application to be recalled for completion
 - 2. Delete – Allows a saved application to be deleted
 - 3. All other Status do not pertain Data Entry
3. Once all applications in the batch have been keyed, complete the Data Entry section of the Batch Cover sheet. Set batch aside for pick-up and storage into the New Application retention box for 30 days.

3.6 Procedures for Enrollment Application Work Queue

1. Click Enrollments In-basket
2. Enrollments will be displayed
3. Make sure the enrollment applications are sorted by date received to access the next provider enrollment application to process. Note: any application that is currently being worked will display a locked icon to the left.
4. Note: Always use the “Close” button to close an application. This unlocks the application.
5. Note regarding Date fields: Dates may be entered using the calendar button, or may be typed into the field.
 - a. If typing a date into a field:
 - A. Type the date in one of the following formats:
 mmdyyy
 mm/dd/yyyy
 mm-dd-yyyy
 yyyy-mm-dd
 - B. Use the TAB key to move to the next field. Do not use the mouse or ENTER key to move to the next field.
6. If the DCN number displays: (ex. XXXXXXXXXX)

- a. W-application entered through provider web portal.
 - b. S-application entered through PES Application Entry (data entry).
7. Click the enrollment application to open. The “FDBC Prov” tab is the first page to open. (Note: if the application is older, click the Audits tab to determine what work has already been performed on the application.)
 8. Click on and open the Application attachment at bottom of page. Open the scanned image if the DCN contains “S”. Open the pdf if the DCN contains “W”.
 9. On the FDBC Prov tab:

The screenshot displays the 'FDBCProv' tab in the 'VIRGINIA MEDICAID PROVIDER FDBC INFORMATION' system. The interface includes a left-hand navigation menu with options like 'Review / Suspicious Applications (8)', 'Enrollments (107)', 'Revalidations (114)', and 'Application Verification (226)'. The main content area contains various data entry fields and dropdown menus. The 'Paid Agency' field is highlighted in red, indicating it is a required field. The 'Paid Amt' field shows a value of 0.00. The 'Payment Ind' field is currently empty. The 'Paid Date' and 'Paid Validation Date' fields are also empty. The 'Hardship Date' field is also empty. The 'Risk Category' is set to 'Limited' and the 'Risk Score' is '020'. The 'Screening Agency' is 'VA'. The 'Screening Date' and 'Screening Result' fields are empty. The 'Screening Validation Date' field is also empty. The 'Risk Comments' field is empty. The 'Adverse Legal Action Indicator' is set to 'No'. The 'Paid Agency' field is set to 'VA'. The 'Paid Amt' field is set to '0.00'. The 'Payment Ind' field is empty. The 'Paid Date' field is empty. The 'Hardship Date' field is empty. The 'Paid Validation Date' field is empty. The 'Original DCN' is '201312060904545'. The 'Search' button is visible at the bottom right.

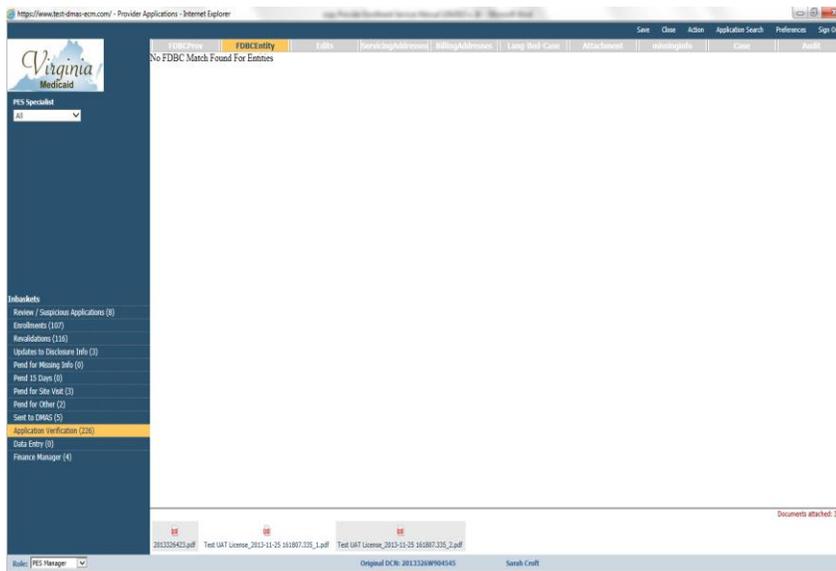
- a. Is an application fee required? (Is the Paid Agency field populated?) Reference the Risk Category Matrix in Appendix I.
 - A. No – proceed to step 8c.
 - B. Yes:
 - (1) If “Paid Agency” = VA, “Payment Indicator” should be populated with Credit Card Online, Credit Card Mail, or Check Mail and the “Paid Date” and “Paid Amount” fields should be populated. Click within the “Paid Validation Date Field”, select the calendar to populate with today’s date.
 - (2) If “Paid Agency” = Hardship Approved, verify a Hardship Exception Approval letter from CMS is attached. (If not the “action” to take is “pend for missing info”.) The Pend for Missing Information letter must state that PES must receive the CMS hardship approval letter before the application can be processed. If the Hardship Exception Approval Letter is attached, click within the “Paid Validation Date Field”, select the calendar to populate with today’s date.
 - (3) If “Paid Agency” = Hardship Requested, verify a Hardship Exception Request letter and a recent Financial Statement is attached. (If not, the “action” to take is “pend for missing info”.) The Pend for Missing Information letter must state that PES must receive the CMS hardship approval letter before the application can be processed. If the Hardship Exception Request Letter and Financial Statement is attached, send the application to the PES Manager. The PES Manager reviews the request

and sends to DMAS. DMAS selects the action pend-other, awaiting hardship exception response. DMAS sends the request to CMS and awaits a reponse.

- (4) If "Paid Agency" = Hardship In Process, the "action" to take is "pend other, awaiting hardship exception response from the provider.
 - (5) If "Paid Agency" = "CMS" or another State Medicaid Agency, verify the prior payment with that agency as follows (Note, if provider also indicates prior screening, validate that as well – see section 8b.):
 - (a) CMS – [PECOS instructions, Appendix J]
 - (b) State Medicaid Agency – [See 9.11 detailed instructions for each State Medicaid Agency]
 - (c) Once payment is verified and payment has been within the last 12 calendar months of the current date select the calendar to populate with today's date in the "Paid Validation Date" field.
 - (d) If payment is not verified, send the application to the PES Manager who will then select the action "Pend-Finance". Send an [REDACTED] letter to the provider indicating payment could not be verified and payment is due in order to further process the application.
- b. Does the "Screening Agency" field = "VA" or "(blank)"?
- A. Yes – proceed to step 8c
 - B. No – Is the Screening Date field populated?
 - (1) Yes - verify the screening within the last 12 calendar months with that agency as follows:
 - (a) CMS – PECOS instructions Appendix J
 - (b) State Medicaid Agency – [See 9.11for detailed instructions for each State Medicaid Agency]
 - (c) Once screening is verified, select the calendar to populate with today's date in the "Screening Validation Date" field.
 - (d) If screening is not verified select "VA" in the "Screening Agency" field and proceed to step 8c.proceed to step
 - (2) No – the screening is in process with CMS or another State Medicaid Agency. The action to take is "Pend-Other – Screening in Progress CMS/Other SMA".
- c. If the provider has an unfavorable match on any Federal Database Check (FDBC) the button will be blue. Click the button(s) to determine the level of match. Investigate the match per the detailed instructions in Appendix J.
Note: If the PECOS button is blue, see if "Paid Agency" field = CMS.
If Yes – See PECOS instructions, Appendix .
If No – You do not need to click the PECOS button or perform any override.
- A. Did the investigation reveal the match is invalid?

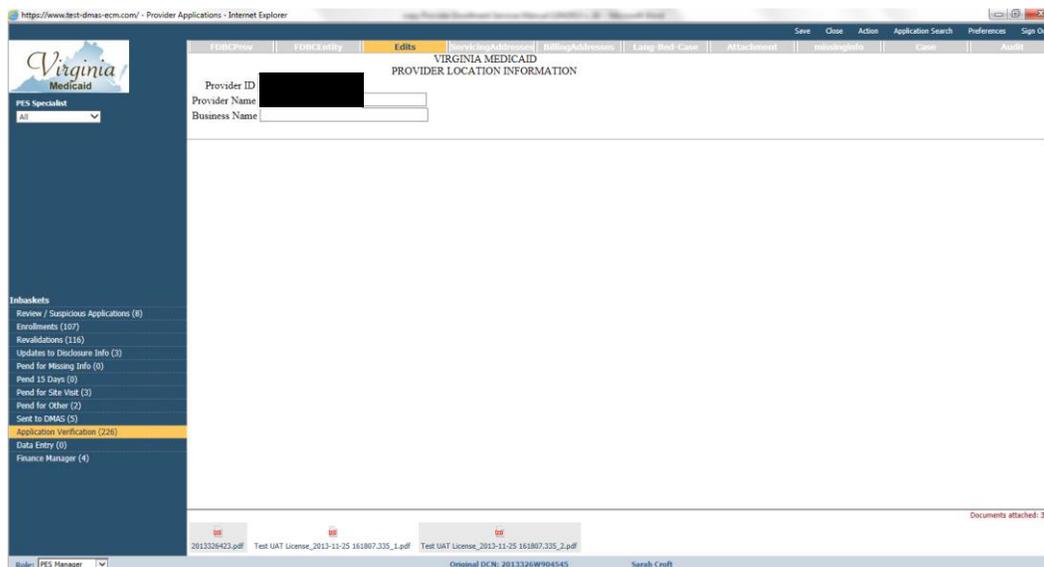
- (1) Yes – Select “Y” in the “Override Indicator” field and enter comments in the “Override Comments” field. (Perform this action for each match.)
Proceed to step 8d.
 - (2) No – Follow the instructions in Appendix J.
- d. Does the “Adverse Legal Action Indicator field” = “Yes”
 - A. No – proceed to step 9.
 - B. Yes – verify the relevant disposition is attached. If not, the “action” to take is “pend for missing info”. It will need to be ‘sent to the PES Manager’ for review if the information is attached.
 - e. Click the “Update” button.

10. On the FDBC Entity tab:



- a. Does the text “No FDBC Match Found for Entities” display?
 - A. Yes – proceed to step 10
 - B. No – Investigate the match per the detailed instructions in Appendix J.
 - A. Did the investigation reveal the match is invalid?
 - (1) Yes – Select “Y” in the “Override Indicator” field and enter comments in the “Override Comments” field. (Perform this action for each match) Click the “Update” button. Proceed to step 10.
 - (2) No -- Follow the instructions in Appendix J.

11. On the Edits tab:



- a. Existing NPI or FEIN edits – investigate provider status using the MMIS to determine whether the provider is adding a provider type, adding a location, is a physician enrolling in a group, or is a physician enrolled with an MCO (if MCO,

deactivate MCO location in the MMIS, then process the application in workflow).
Note: If the edit “Group NPI not on file” displays, the “NPI Indicator” field on the Servicing Address tab will identify which group NPI is in question.

- b. Zip code edits – investigate or contact the provider to determine the correct zip code. Enter the information on the corresponding address tab (see 11 and 12). If Servicing Address Zip code is changed, click the “FIPS” button to assign the correct FIPS code.

12. On the Servicing Addresses tab:

- a. Enter/verify the Program(s) and assign a begin date(s)
- b. Enter/verify the Provider Type and assign a begin date. Some applications will have default provider types that PES will need to change. Examples:
 - A. Group provider type defaults to 20; provider type is assigned based on the main specialties of the providers.
 - B. Physicians default to 20 but will need to be changed to 95 for out of state.
 - C. ORPs default to 78 but will need to be changed if provider type selected is not “ORP other”. Specialty for ORP other is based on the selection in the application (ORP Physician Assistant (123), ORP Intern (124), or ORP Other (125).
- c. Enter/verify the Provider Specialty(s) and assign a begin date(s)
 - A. Specialty should be pre-populated-verify on Appendix Physician Specialty Codes 9.8
- d. Verify the provider’s license information.
 - A. Determine license requirements based on Provider Class Type-See Appendix 9.12, Detailed Procedures by Provider Class Type
 - (1) Licensed verified, continue to next step, 11e.
 - (2) If licensed not verified, pend for missing information.
 - (3) If the license begin date is later than the requested effective date:
 - (a) Enter the license begin date in the Effective Date field.
 - (b) Click the Verify button. The Program, Provider Type, and Provider Specialty begin dates will automatically change to the new effective date. (Note: If the provider has multiple service locations each service location will be updated.)
- e. Agreement Indicator
 - A. Individual provider select “I” in the “Agreement Indicator” dropdown.
 - B. Group, select the “G” in the “Agreement Indicator”.
- f. Rates & Restrictions
 - A. If the provider type requires rates, select “This Provider Needs Rate Info” from the drop-down box.
 - B. If the provider type requires restrictions, select “This Provider Needs Restrictions Info” from the drop-down box.

- C. Once the provider is approved, the provider will be listed on report PS-O-726 and an email will be generated to the PES specialist who approved the application. The PES specialist will then enter the rates, restrictions, or CLIA information in the MMIS screens.
- g. Site Visit Fields are on this tab. See 3.8 Site Visit Procedures for using these fields.
- h. Click the “Update” button.
- i. Multiple Servicing Locations
 - A. If a provider is enrolling more than one location, “Next” and “Previous” buttons will display. Click the “Next” button to move to the next location. Repeat steps 11 a. – h. for each location.
 - B. A provider may not enroll a second (or third, etc.) location in a state different than the first location. The provider would need to complete a separate application for each state’s location(s). If a provider has indicated an additional location(s) in a different state, perform the following:
 - (1) Use the “Next” button to move to the location with a different state.
 - (2) Select “Do NOT Enroll This Location” from the “Enrollment Indicator” field.
 - (3) Click the “Update” button.
 - (4) If necessary, repeat steps 1-3 for additional locations.
 - (5) Send an [REDACTED] letter to the provider notifying them which locations have been enrolled and which have not. Ask them to complete a separate application for each state’s location(s).

13. On the Billing Addresses Tab:

- a. Verify:
 - A. Provider IRS Information
 - B. Fiscal Year Information
 - C. EFT Information
- b. If changes are made, click the “Update” button.
- c. Electronic Claims Exemption and Electronic Funds Exemption fields:
 - A. If a provider is requesting EFT and/or Claims Exemptions, the Electronic Claims Exemption field and/or the Electronic Funds Exemption fields will be populated with “Asked for Exemption”. Select “Action” then “Send to PES Manager for Review”. In the Comments field in the pop-up box, enter “EFT and/or Claims Exemption requested”. The PES Manager sends to DMAS for review. Comments field in the pop-up box should be completed and will be used for audit trail. Comments can be viewed on the “Audit” Tab.
- d. Provider Electronic Remittance Information:
 - A. If a provider is requesting an electronic remittance, the RA Ind field will be populated with a “Y”. Also, the Service Center field will be populated with a Service Center number. If the provider is requesting an electronic remittance, continue to step B.
 - B. Click the Edits tab. Does the edit “Service Center Found” display?

- (1) Yes – proceed to step 12.d.C
 - (2) No – If the application was keyed from a paper enrollment, verify the number was entered correctly. Outreach to the provider to determine the correct number. If the number supplied is correct according to the Provider, open an [REDACTED] ticket for EDI to resolve and continue to process the application.
- C. Does the edit “Service Center Not Set Up To Receive Electronic RA” display?
- (1) Yes - open an [REDACTED] ticket for EDI to resolve and continue to process the application.
 - (2) No – continue to process the application.

14. On the Lang-Bed-Case Tab:

- a. Verify Signature Waiver and Enter Practice Type
 - A. Practice Type with signature waiver=no
 - (1) 01-individual
 - (2) 03-facility
 - (3) 06-group
 - B. Practice Type of signature waiver=yes
 - (1) 11-individual
 - (2) 13-facility
 - (3) 16-group
- b. Beds-enter for Nursing Homes-See 9.12 Detailed Procedures by Provider Class Type.
- c. POS-enter for Pharmacy- use the requested Effective Date on the application regardless of what the Provider indicated on the application.

15. Utilizing the Application attachment, begin review of the application.

PES reviews each enrollment application for general requirements as well as individual provider types prior to approval or rejection. Through on-line enrollment there are specific required fields the provider must complete prior to submission. PES is responsible for performing a thorough review of each enrollment application.

Checklist to meet minimum requirements:

- A. Is the provider located in Virginia or within 50 miles of Virginia Border? (Go to www.mapquest.com to determine whether the provider is within fifty miles of VA border if necessary.)
 - (1) Yes — Proceed to step C.
 - (2) No –Proceed to step B.
- B. If outside of fifty miles of Virginia border was claim or supporting documentation attached?
 - (1) Yes — Proceed to step C.

- (2) No – the “action” to take “pend application” for claim or supporting documentation must be submitted in order to enroll into VA Medicaid and proceed through steps C through E to determine additional pend reasons. (See 3.10 Pend / Missing Information section for appropriate pend per document type).

Note: Exceptions: Durable Medical Equipment (DME) and Pharmacies that hold a Virginia Department of Health (VA DHP) non-resident permit will not be rejected for a claim(s).

- C. Is provider a Provider Class Type (PCT) 077 Residential Treatment Facility or PCT 108 Early Intervention did they submit Letter of Attestation on their company letter head?
 - (1) Yes — Proceed to step D.
 - (2) No — the “action” to take “pend application” for Letter of Attestation form must be submitted on your company letter head for enrollment into VA Medicaid and proceed to step D to determine additional pend reasons. (See 3.10 Pend / Missing Information section for appropriate pend per document type).
- D. If provider is required to submit a Community Based Care (CBC) application in addition to the enrollment application did they complete all required fields on that portion of application and submit supporting documentation if applicable?
 - (1) Yes — Proceed to step E for further pend determination.
 - (2) No — the “action” to take “pend application” for missing information on CBC and any required supporting documentation, and proceed to step E to determine additional pend reasons. (Refer to 9.12 Detailed Enrollment Procedures by Provider type to determine required fields for their individual CBC application)
- E. Did the provider complete all applicable Sections of the Disclosure of Ownership and Control Interest Statement?
 - (1) Yes — (Refer to 9.12 Detailed Enrollment Procedures by Provider type to determine additional requirements per Provider Type for Approval, Pend, or Reject determination.)
 - (2) No — the “action” to take is “pend” or “reject” for Section I Part (a) or Section II of the Disclosure of Ownership and Control Interest Statement not complete and proceed to step F for additional pend determination. (See 9.12 Detailed Enrollment Procedures by Provider Type to determine additional requirements for Pend or Rejection determination).
- F. Is the application for an Individual joining a Group?
 - (1) Yes – Verify if the Group NPI is enrolled with Virginia Medicaid or if a Group application has been submitted.
 - (2) No – Application Determination (G, H or I.)
- G. Is this a Group Application?
 - (1) Yes-Review Group Enrollment-3.7
 - (2) No-Proceed to step H, I or J.
- H. Pend for missing information- See 3.10 Pend / Missing Information section
- I. Reject Application – Follow steps in section 3.12
- J. If not pend or reject proceed to step 15.

16. Click the FDBC Prov tab.
 - a. Is the provider a Limited risk category provider?
 - A. Yes – verify/select “VA” in the “Screening Agency” field. Select the calendar to populate with today’s date in the “Screening Date” field and “Screening Validation Date” field. Enter “Passed” in the “Screening Result” field.
 - B. No – proceed to step 15.b.
 - b. Is the provider is a Moderate or High risk category provider who was previously screened by CMS or another State Medicaid Agency?
 - A. Yes – Verify today’s date (or the date screening was validated per step 3.5.8.b.3) is entered in the “Screening Validation Date” field and that “Passed” is entered in the “Screening Result” field.
 - B. No – the action to take is “pend – site visit”.



SLA (Service Level Agreement): Enroll provider must be processed within ten (10) business days of receipt.

Procedures:

1. Provider Correspondence Address will be verified (entered) on the billing addresses tab.
2. In the Application the following must be completed prior to approval and indicated by checking the following:
 - A. Check either New Provider or New Location on the Case Tab. Note: An edit “NPI on file” will post on the Edits tab if the provider’s NPI is on file and is adding a new location.
3. Select Approve Application from Action tab

4. Proceed to 9.12 to validate and enter MMIS fields appropriate to Provider Type that were not entered into MMIS from WebPortal On-Line Enrollment and any Manual Letter processing procedures.

3.7 Enrolling by Specific Provider Class Type Guidelines

PES follows guidelines specific for Provider Type when enrolling or re-enrolling a provider into MMIS. The guidelines can be found in Appendix 8 Section L Detailed Enrollment Procedures by Provider Class Type. Group Enrollment specific procedures can be found in Section 4.1.14 Group Enrollment and 4.1.6 License Verification steps. These steps will be followed after Review of Enrollment Application

3.8 Group Enrollment

In concurrence with the transition to the NPI, DMAS mandated the enrollment of Group Practices. Group Practice enrollment is mandatory for any practice with one or more participating provider practicing under the same Tax Identification Number (TIN). A detailed list of all Group Eligible provider types can be found in 9.6 Alpha Provider Type Listing or 3.7.1 Group Eligible Provider Class Types. The Group Practice will obtain an Organization NPI (Type II), and enroll under Group Practice NPI. Individuals practicing within the Group Practice will obtain an individual NPI (Type I) which will be enrolled and subsequently affiliated with the Group Practice NPI in order to bill and be paid under Group Practice NPI and Tax ID.

3.8.1 Group Eligible Provider Class Types

1. Audiologist (PCT 044)
2. Baby Care (PCT 036)
3. Case Management Waiver – Individual Only (PCT 073)
4. Chiropractor (PCT 026)
5. Clinical Nurse Specialist (PCT 034)
6. Clinical Psychologist (PCT 025)
7. Family Caregiver Training (PCT 061)
8. Licensed Clinical Social Worker (PCT 076)
9. Licensed Professional Counselor (PCT 021)
10. Licensed School Psychologist (PCT 101)
11. Licensed Substance Abuse Treatment Practitioner (PCT 103)
12. Marriage and Family Therapist (PCT 102)
13. Nurse Practitioner (PCT 023)
14. Optician (PCT 032)
15. Optometrist (PCT 031)

16. Physician (PCT 020 and 095)
17. Podiatrist (PCT 030)
18. Prosthetic/Orthotic (PCT 064)
19. Qualified Medicare Beneficiary (PCT 099)

3.8.2 General Rules

The following are general rules that have been established for Group Enrollment. If the Group Enrollment application doesn't meet all requirements it will be pended or rejected if necessary.

1. All individual providers in the group must be actively enrolled in the Virginia Medicaid program.
2. If individuals are not actively enrolled in Medicaid they must complete an Individual Enrollment application for their provider type, and submit and Reassignment of Benefits (ROB) form to be affiliated to Group in order to bill for services.
3. All individual providers requesting to be in a Group must submit a new enrollment application and sign an ROB form to acknowledge he or she will become part of that provider group.
4. If an individual submits an enrollment application for a TIN that has not yet enrolled into Medicaid or no Group application for TIN has been received, the individual enrollment application will be rejected for reason code 146 Shared TIN requires the formation of a Billing Group. If the Group has submitted an application at the same time as the individual, but the Group application is rejected, we cannot enroll the individual. Do NOT enroll the individual without an approved group enrollment.
5. If a Group Practice has multiple NPIs each Group NPI can be enrolled for Group Billing by completing an enrollment application for each NPI. Each TIN can have several "subparts"
6. Group name must be a business name. If it is an individual name it will be pending for provider to correct name or if it is determined to be an individual trying to enroll as a Group they will be rejected stating Provider type not eligible for Group enrollment.
7. For PCT 073 and 099 Group enrollment is available only for individuals. If an organization Type II PCT 073 or 099 completed an enrollment application to enroll with a Group it will be rejected based on an Organization Provider type is not eligible for enrollment as a Group.
8. Managed Care only providers (PGM 010) cannot be enrolled as Groups.
9. Atypical providers are not eligible for Group Practice Enrollment. An Atypical provider is defined as a provider that does not meet the HIPAA definition of a healthcare provider. These providers supply atypical or non-healthcare services. Examples of these providers are: Adult Day Care, Assisted Living, Family Caregiver Training, Non-Emergency Transportation, Non-Medical Mental Retardation Services, Personal Care, Respite Care, and Treatment Foster Care. Atypical providers will be rejected stating Provider type not eligible for Group enrollment.
10. A Group must also submit IRS Documentation supporting Ownership of Group and TIN. There are three forms acceptable as IRS documentation for Group Enrollment. They are as follows:

- a. W-9 – This form is used to provide the correct TIN to the person or organization that requests it.
- b. LTR 147C- The TIN owner may request verification from the IRS as to what their TIN is and this is the letter that the IRS sends in reply.
- c. SS4 Form – This form is sent in reply to a request for a TIN from the IRS. It contains the new TIN and the date it was assigned to the requester.

3.9 Site Visit Procedures

The Federal regulations at 42 CFR 455.432 require that all participating providers be screened according to their risk level, upon initial enrollment, re-enrollment or revalidation (every 5 years) of enrollment. A State Medicaid agency must screen all initial applications, including applications for a new practice location, any applications received in response to a re-enrollment or revalidations request based on a categorical risk level of limited, moderate or high. The provisions are being implemented for the purpose of prevention of provider fraud and abuse.

Screening includes:

- On-site visit of servicing location.
- Federal and State database checks.
- Criminal background checks. (not required at this time)
- Fingerprinting. (not required at this time)

Each provider is assigned to a Risk Category based on the Provider Class Type. (See Appendix I)

Providers with a Moderate or High Risk Category require an on-site visit; below are listed the Provider Class types that require an on-site visit.

<i>Prov Class Type</i>	<i>Provider Type</i>
019	CORF
080	Transportation-Emergency Ambulance
083	Out-of-State Transportation-Emergency Ambulance
062	Durable Medical Equipment/Supplies
082	Emergency Air Ambulance
084	Out-of-State Emergency Air Ambulance
058	Home Health Agency-State
059	Home Health Agency-Private
046	Hospice
070	Independent Laboratory
098	Out-of-State Laboratory
064	Prosthetic/Orthotic
062	Personal Emergency Response System
021	Mental Health/Mental Retardation and Substance Abuse Services

Service Level Agreement for site visits:

- Must be completed within 5 business days from the receipt of the enrollment application.

On-site Visit Procedures:

1. On-site visit is *not* announced.

2. All on-site visits must be approved by manager prior to visit.
 - a. Pend application on Workflow for Site Visit
 - b. One day prior to site visit email manager with Provider name, servicing address and estimated time of arrival.
 - c. Perform the Pre-work section of the Site Visit Form (Z: drive>PES>Site Visit)
 - d. Prepare the letter of authorization and obtain manager's signature (Z: drive>PES>Site Visit)
3. Dress must be business professional.
4. Professional courtesy must be given to provider at all times.
5. Discretion must be provided around any patients/members.
6. If for any reason safety is a concern at the servicing location do not approach; note reason, contact manager and terminate on-site visit.
7. At time of arrival advise provider the purpose of your visit is to conduct an On-site Visit according to the CMS Provider Enrollment Screening Regulations, produce a photo ID and provide a copy of letter of authorization.
 - a. If provider denies the request then politely thank them for their time, document information and pend application to Manager.
8. Complete the on-site visit form below:

	NPI: _____ Provider Name: _____ OFFICE USE ONLY: PASS ___ FAIL ___
COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES PROVIDER ENROLLMENT SERVICES PRE-ENROLLMENT/REVALIDATION SITE VISIT CHECKLIST	
<small>Per Federal Regulation 42 CFR 455.422, the State Medicaid agency— (a) Must conduct pre-enrollment and post-enrollment site visits of providers who are designated as "providers" or "high" category for the Medicaid program. The purpose of the site visit will be to verify that all information submitted to the State Medicaid agency is accurate and to determine compliance with Federal and State enrollment requirements. (b) Must require any enrolled provider to permit CMS, its agents, its designated contractors, or the State Medicaid agency to conduct unannounced on-site inspections of any and all provider locations.</small>	
Date: _____ Time: _____ Attempt: _____ Site Visit Performed by: _____	
PROVIDER INFORMATION <small>Instructions: From the provider application and most recent provider maintenance (if any), complete the information below. The type of services provided by the enrolling provider will determine necessary observations during the tour of the facility.</small>	
Provider name: _____ NPI: _____ Business Name: _____	
1	

Business Telephone: _____

Servicing Address: _____

Provider Type: _____

Specialty: _____

Revalidation or New Enrollment: _____

Contact Name: _____

Title: _____

Phone: _____

Email: _____

ON SITE

Instructions: The site visit to the servicing location of the enrolling/revalidating provider will be unannounced. Upon arrival at the location, verify physical address. Upon entering the business, introduce yourself, provide business card, letter of authorization and OMAS photo ID, ask to speak with provider. Explain the purpose of your visit. Complete the following information.

1. Presented photo ID? YES NO
2. Provided letter of Authorization? YES NO
3. Obtain initials of copy of Authorization letter? Yes NO
4. Is the servicing location address correct? YES NO
5. Picture taken of the exterior of the business? YES NO
6. Business signage present? YES NO
7. Hours of operation posted? YES NO
8. Is the site/office open? YES NO
9. Type of facility?
 - a. Store Front
 - b. Office Suite
 - c. Warehouse
 - d. Private Residence
 - e. Multi-Office Building
 - f. Other: _____

2

- a. Do you have additional servicing location? YES NO If yes, please list below:

2. Is the site operational?
 - a. Working on site? YES NO Verify phone#: _____
 - b. Working Computers? YES NO Verify email: _____
 - c. Customers at site? YES NO
3. Tour:
 - a. Picture of Interior? YES NO
 - b. Reception area? YES NO
 - c. License Displayed? YES NO

Licenses held: _____

4. Are you accepting patients/clients at this time? YES NO
 - i. If not, when do you expect to be open for business? _____

OWNER BACKGROUND

Instructions: If the contact person is not the owner, ask who the owner is and match names to those documented in the provider application. If no answers are provided, please document that the information is not available.

5. Name of Owner(s)? _____
6. Does the owner have interested in any other medical related business? YES NO
 - a. If yes, what percentage? _____

PROVIDER EDUCATION

7. Web portal registration (ask if registered)
8. EPT (discuss this only if the provider is not setup)
9. EDI (discuss this only if the provider is not setup)
10. Process for adding additional locations to the provider file.

3

1. Process for updating license (write down the current license end date)
2. Accessing online manuals that's applicable to PCTs and memos
3. Process for revalidations
4. PPSIT functions
5. Was provider education provided? YES NO

NOTES _____

CONCLUSION/RECOMMEND

By signing below, I verify that the information given on this site visit is accurate and that it was performed at the address given for this enrollment and/or revalidation.

Signature of the Provider _____

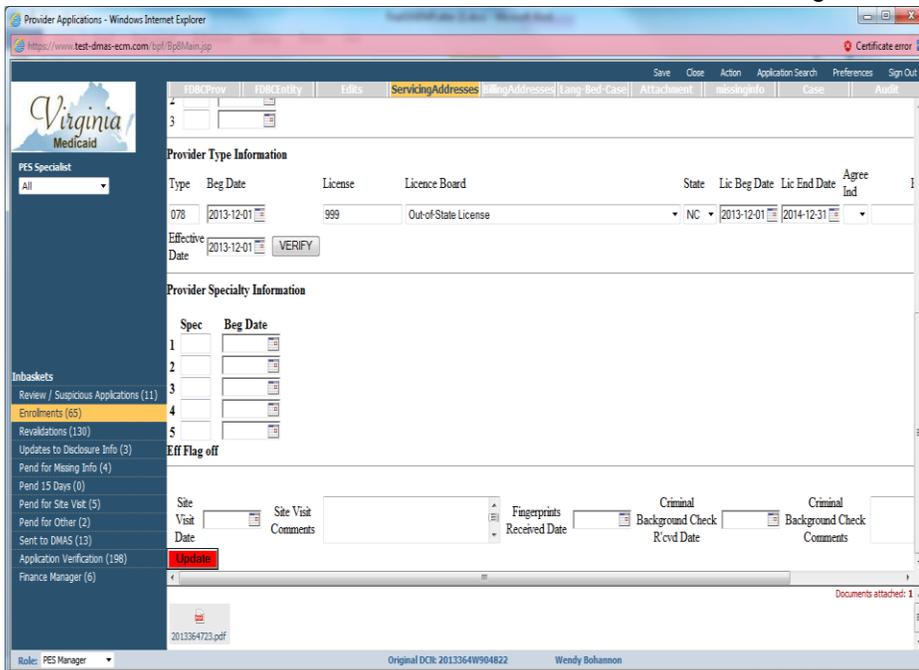
By signing below, I verify that I have personally performed this site visit at the location and on the date and time listed above and that the observations I have recorded are correct.

Signature of Individual Performing Site Visit _____

PASS _____ FAIL _____

Reason for Failure (if applicable): _____

9. Photographs must be taken of the exterior of the location.
10. Thank provider for time and information.
11. Notify manager at time on-site visit is complete.
12. Within 1 business days of Site Visit complete Site Visit information on Servicing Address tab.
 - a. Site Visit Date
 - b. Site Visit Comments: Enter "Pass" or "Refer to Management"



13. If provider passes Site Visit proceed with processing of enrollment application or revalidation. (Note: On-Site Visit form should be uploaded to ECM and attached to application within 3 business days.)
14. If the Site Visit Recommendation is "Refer to Management", pend to Manager.
 - a. Manager will forward results to DMAS for pass or fail determination.

- b. Send On-Site Visit form to be imaged (back-end scan).

Site Visit Script – Call Center

Should a provider call to verify that a site visitor is from [REDACTED], please refer to the call script below to answer questions:

Call Center Site Visit Confirmation Script

Specialist: Thanks for calling Virginia Medicaid; may I have your name and NPI number?

Caller: My name is Regina Barnes and I am the Office Manager at Lacy Manor Home Health Agency and my NPI number is 1649515777.

Specialist: How may I assist you?

Caller: Well, I am calling because I have someone here who says they are supposed to do a site visit.

Specialist: May I ask who the name of the person is?

Caller: Yes, their name is Rudy Bailey.

Specialist: Well, Ma'am, Mr. Bailey is on our staff and he is authorized by the Department of Medical Assistance Services to conduct site visits as part of our Provider Enrollment Services Department.

Caller: Ok, why did they come unannounced?

Specialist: Ma'am Federal regulation 42CFR 455.432 specifies that site visits are to be unannounced. Mr. Bailey can show you the chapter of the regulation if you wish.

Caller: No, that's ok. I was just making sure that this was official.

Specialist: Yes Ma'am it is. Is there anything else I can help you with?

Caller: No, that's it.

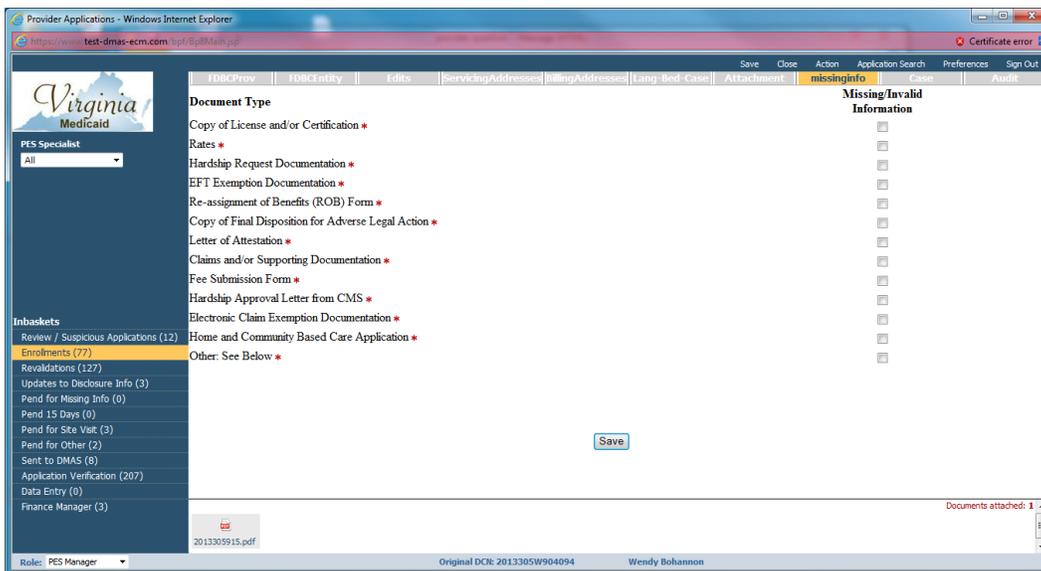
Specialist: Ok, well your call reference number is 3257821. Thank you and have a nice day.

3.10 Pend/Missing Information

If an enrollment, revalidation or update to disclosure application has missing information or is incomplete the PES Specialist will pend the enrollment application. If an application is pended, the provider will be sent a missing information letter detailing the missing or incomplete information necessary to process their application. If 15 days have passed since the application pend date, the provider will be sent a second reminder notice again outlining the information necessary to complete the processing. If the missing or incomplete information is received within 30 business days, it will be processed. If the required information is not received by 30 days the enrollment application will be rejected due to missing or incomplete information and a rejection letter will be sent to the provider. (3.1.13 Rejection Application Process) Note: If the provider has submitted the application online via Web Portal, the provider also has access to validate the status of the enrollment, revalidation or update to disclosure application via Web Portal. The provider also has the capability to view their generated letters as well as attach documented missing information and resubmit.

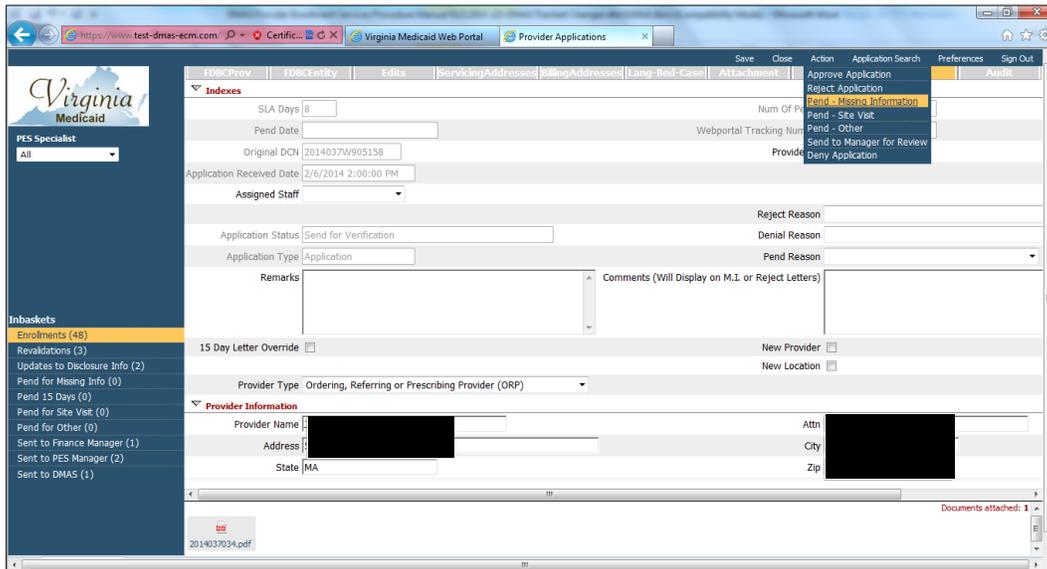
Procedures:

1. PES determines the provider has submitted an incomplete application.
2. Verify Provider Correspondence Address on the Billing Addresses Tab
3. Click Missing Information Tab.



4. Click under Missing Invalid Information all documents that are missing from Enrollment Application that has been submitted. (Note: If "Other: See Below" is selected, comments should be entered on the Case Tab. See step 7.)
5. Click Save button.
6. Click Case Tab

7. If “Other: See Below” was selected on the Missing Information Tab, enter details about what is missing in the Comments field. These comments will be printed on the missing information letter that is sent to the provider. If a selection(s) other than “Other See Below” was made on the Missing Information Tab, the comments field is not required, but could be used for any text that needs to be printed on the missing information letter.
8. Click Action Tab, scroll down to Pend-Missing information and select.



9. Application will be placed in the Pend for Missing Info inbasket, and Missing Information letter will be sent to provider. Refresh the workflow page by clicking the “Pend for Missing Info” inbasket to ensure the application has successfully moved to that inbasket.
10. PES will receive missing or incomplete information returned by the provider through the FileNet work queue.
11. If missing documents have not been returned within 15 business days of initial pend the enrollment application will be moved automatically into the 15 day in basket and another letter will be generated reminding the provider that PES is still waiting for additional documents or information to be returned to process their enrollment.
12. If missing documents have not been returned within 30 business days of initial pend the enrollment application will be Rejected. (3.12 Reject Enrollment)
13. Missing information that is supplied by the provider via the web portal or scanned and indexed using the ATN will automatically attach to the application and cause the application to move automatically to the enrollments in-basket for further processing. (Note: the copy of the missing info letter and the documentation the provider sends along with it will be indexed with the ATN and with a Doc Type of Prov_Other.) If missing information is received from the provider without the missing information letter, it will be indexed as Maintenance. PES must monitor Maintenance documents periodically every business day for incoming missing documents for every provider application that is in the following FileNet work queue in baskets.
 - a. Pend for Missing Info
 - b. Pend 15 Days
 - c. Pend 30 Days

14. All missing documents received as originally requested?
 - a. Yes, continue processing the application per 3.5 Procedures for Enrollment Application
 - b. No, Application will continue to pend up to 30 days at which time will be Rejected (3.12 Reject Enrollment Process) if all missing or incomplete information is not received the PES Specialist will continue to pend that application.

3.11 Pend – Other

The table below lists the Pend-Other reasons and their uses:

Pend Reason	Use When...	Duration	Remove From Pend When...
Screening In-process CMS / Other SMA	PES verifies screening is not complete	60 days	PES determines screening is complete After 60 days Automatically Reject / letter
Awaiting Hardship Exception Response	Hardship Exception Request and Financial Statement sent to CMS	Indefinite	Response received
Hardship Exception Denied	Hardship Exception denied	30 days	Payment or Proof of Appeal received After 30days Automatically Reject / letter
Hardship Exception Appeal	Proof of Appeal received	Indefinite	Proof of Appeal Approval received
Awaiting Criminal Background Check Results	Site Visit Approved	30 days	(Note: Awaiting CMS Guidance. Do not use this pend reason until otherwise notified.) Results received After 30 days Automatically Reject / letter
Nursing Facility – Awaiting Documentation	PES Manager	Indefinite	PES Manager receives requested info
Other	For use with unforeseen circumstances (Must have “comments” field)	TBD	TBD

3.12 Reject Enrollment

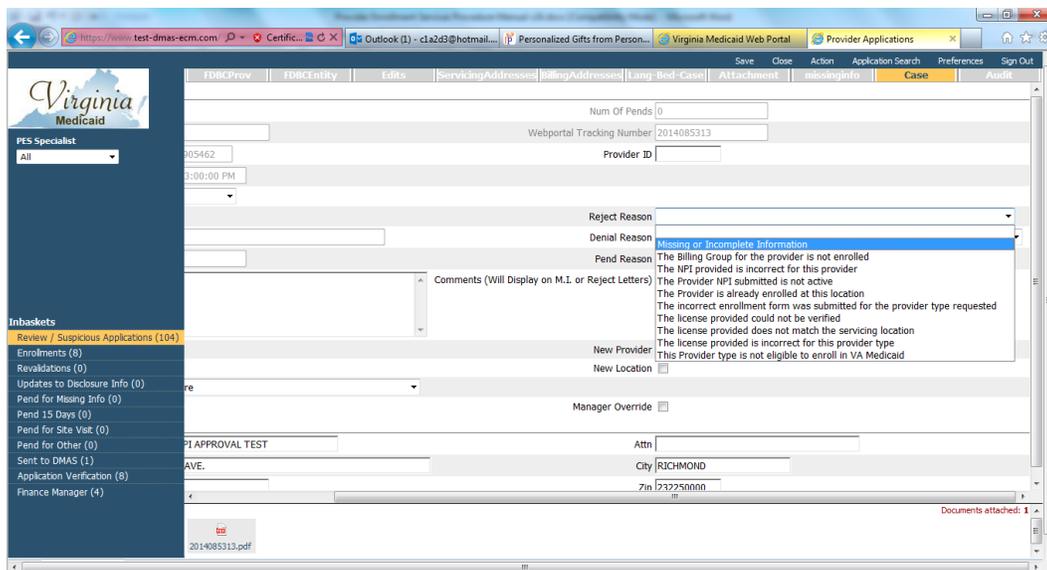
Automatic Rejections:

An application will automatically reject if it has been pended for missing information and the information is not received within the designated timeframe. An application will also automatically reject for certain other pend reasons (see 3.10 – Pend-Other for a list of these pend reasons and timeframes for automatic rejection). In both of these instances, no further action is required on the part of the PES Specialist.

Manual Rejections:

An application can be manually rejected at any time if it meets one of the following criteria:

- The provider's application should be returned to the provider to correct information provided (Missing or Incomplete Information)
- The Billing Group for the provider is not enrolled
- The NPI provided is incorrect for the provider
- The NPI provided is not active
- The Provider is already enrolled at this location
- The incorrect enrollment form was submitted for the provider type requested
- The license provided could not be verified
- The license provided does not match the servicing location
- The license provided is incorrect for this provider type
- This Provider type is not eligible to enroll in VA Medicaid



To manually reject an application:

1. On the Case tab, select the appropriate reason from the Reject Reason drop down list. (Note: in the case that the provider's application should be returned to the provider to correct information provided, select "Missing or Incomplete Information".)
2. Enter comments in the Comments field if needed. (Note: in the case that the provider's application should be returned to the provider to correct information provided, list what information should be corrected in the comments field.)
3. Click "Action" then select "Reject Application".
4. A rejection letter is automatically sent to the provider.

Rejections or Denials due to Federal Database Checks:

Refer to Appendix J for information

Rejections of Paper Applications due to incomplete information:

If during data entry it is discovered that a paper application has incomplete or missing information for a required field(s), the paper application will be sent to PES. PES will generate a rejection letter from [REDACTED] advising the provider to resubmit the application with the required fields and to utilize the web portal for this new submission if possible.

3.13 Revalidations

1. Open the PDF and validate all attached documents as outlined below:

Ownership and Controlling Interest

Does provider have managing employees with ownership or controlling interest of 5% or more?

- a. Yes—Validate that individuals listed provided SSN and DOB.. If organization is listed, validate TIN is listed. (If same SSN/TIN is listed for more than one individual, there is a high probability that the TIN was submitted instead of the SSN. In these cases, reject revalidation and request the SSN for all individuals listed.
- b. No—Search attachments for Board of Directors, Shareholders, etc. If appropriate documentation is not attached, reject for missing documentation of Board of Directors.

Criminal Offenses

Did the provider indicate "Yes" to criminal offenses?

- a. Yes—Search attachments for relevant information and final disposition. PES Specialist will refer to PES Manager.
- b. No—Proceed .

Adverse Actions

Does the provider indicate "Yes" to adverse actions?

- a. Yes—Search attachments for relevant documentation. PES Specialist will refer to PES Manager.
- b. No—Proceed to Workflow

2. On the FDBC Prov tab:

3. Is an application fee required? (Is the Paid Agency field populated?) Reference the Risk Category Matrix in Appendix I. Note: Reference the MMIS if there is a question as to whether the fee is required based on PCT.
 - a. No – proceed to step 4.
 - b. Yes:
 - (1) If “Paid Agency” = VA, “Payment Indicator” should be populated with Credit Card Online, Credit Card Mail, or Check Mail and the “Paid Date” and “Paid Amount” fields should be populated. Click within the “Paid Validation Date Field”, select the calendar to populate with today’s date.
 - (2) If “Paid Agency” = Hardship Approved, verify a Hardship Exception Approval letter from CMS is attached. (If not the “action” to take is “reject for missing Hardship Exemption Approval letter ”.) Click within the “Paid Validation Date Field”, select the calendar to populate with today’s date.
 - (3) If “Paid Agency” = Hardship Requested, verify a Hardship Exception Request letter and a recent Financial Statement is attached. (If not, the “action” to take is “reject for Missing Hardship Exemption Request letter and recent Financial statement. ”.) Send the application to the PES Manager. The PES Manager reviews the request and sends to DMAS. DMAS selects the action pend-other, awaiting hardship exception response. DMAS sends the request to CMS and sends a letter to the provider.
 - (4) If “Paid Agency” = Hardship In Process, verify a Hardship Exception Request letter and Financial Statement is attached. (If not, the “action” to take is “reject, awaiting hardship exception response.
 - (5) If “Paid Agency” = “CMS” or another State Medicaid Agency, verify the prior payment with that agency as follows (Note, if provider also indicates prior screening, validate that as well – see section 3b.):
 - (a) CMS – PECOS instructions, Appendix J
 - (b) State Medicaid Agency – [See 9.11 for detailed instructions for each State Medicaid Agency]
 - (c) Once payment is verified and payment has been within the last 12 calendar months of the current date select the calendar to populate with today’s date in the “Paid Validation Date” field.
 - (d) If payment is not verified the select “action”, “reject for missing payment, which generates a letter to the provider.
4. Does the “Screening Agency” field = “VA” or “(blank)”?
 - a. Yes – proceed to step 5.
 - b. No – verify the screening within the last 12 calendar months with that agency as follows:
 - (1) CMS – [PECOS instructions – Appendix J]
 - (2) State Medicaid Agency – [See 9.11 for detailed instructions for each State Medicaid Agency]

- (3) Once screening is verified, select the calendar to populate with today's date in the "Screening Validation Date" field.
 - (4) If screening is not verified select "VA" in the "Screening Agency" field and proceed to step 5.
5. If the provider has an unfavorable match on any Federal Database Check (FDBC) the button will be blue. Click the button(s) to determine the level of match. Investigate the match per the detailed instructions in Appendix J.

Note: If the PECOS button is blue, see if "Paid Agency" field = CMS.
 If Yes – See PECOS instructions, Appendix .
 If No – You do not need to click the PECOS button or perform any override.

 - a. Did the investigation reveal the match is invalid?
 - (1) Yes – Select "Y" in the "Override Indicator" field and enter comments in the "Override Comments" field. (Perform this action for each match.) Proceed to step 5.
 - (2) No -- Follow the instructions in Appendix J.
6. Does the "Adverse Legal Action Indicator field" = "Yes"
 - a. No – proceed to step 7.
 - b. Yes – verify the relevant disposition is attached. (If not, the "action" to take is "reject for missing info".) It will need to be 'sent to the PES manager' if information is attached.
 - c. Click the "Update" button.
7. On the FDBC Entity tab:
 - a. Does the text "No FDBC Match Found For Entities" display?
 - i. Yes – proceed to step 8
 - b. No – Investigate the match per the detailed instructions in Appendix J.
 - i. Did the investigation reveal the match is invalid?
 - (1) Yes – Select "Y" in the "Override Indicator" field and enter comments in the "Override Comments" field. (Perform this action for each match) Click the "Update" button. Proceed to step 8.
 - (2) No -- Follow the instructions in Appendix J.
8. Click the FDBC Prov tab.
 - a. Is the provider a Limited risk category provider?
 - i. Yes – verify/select "VA" in the "Screening Agency" field. Select the calendar to populate with today's date in the "Screening Date" field and "Screening Validation Date" field. Enter "Passed" in the "Screening Result" field.
 - ii. No – proceed to step 9.

- b. Is the provider is a Moderate or High risk category provider who was previously screened by CMS or another State Medicaid Agency?
 - i. Yes – Verify today’s date (or the date screening was validated per step 3.5.8.b.3) is entered in the “Screening Validation Date” field and that “Passed” is entered in the “Screening Result” field.
 - ii. No – the action to take is “pend – site visit”.
9. Approve Revalidation – select Action – Approve Application
10. Note: Always use the “Close” button to close an application. This unlocks the application.

Reject Revalidation Reasons

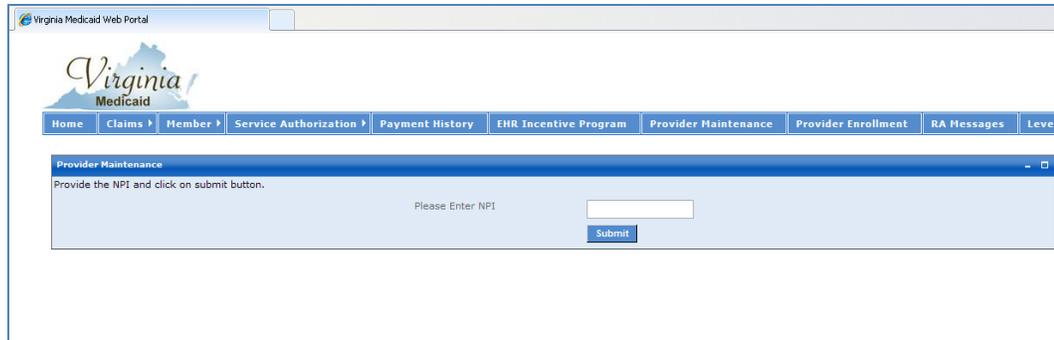
A revalidation can be manually rejected at any time if it meets one of the following criteria:

- The Provider did not submit the screening fee
- The Provider failed a site visit
- Other-- Free form text reasons are listed below:
 - Out of State providers must be screened by CMS or another Medicaid Agency (for moderate an high risk providers only).
 - Please submit a copy of transaction receipt showing that you have paid CMS or another state Medicaid within the last 12 months.
 - Ownership and Control Information for Disclosing Entity requires the owners SSN. Please resubmit your revalidation listing the owners SSN.

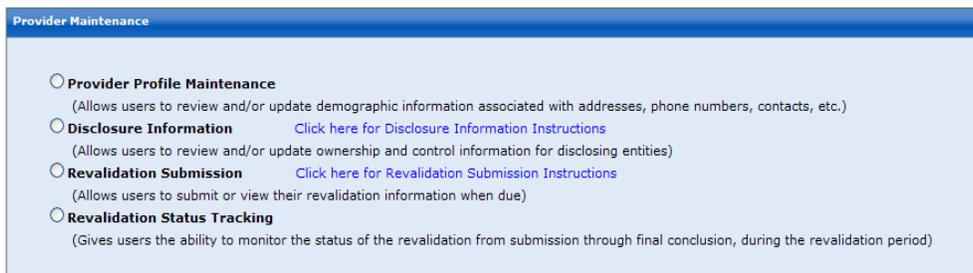
Processing Paper Revalidation Procedures

A provider who cannot access the internet may request a paper revalidation from PES. In this case, PES must perform the following procedures.

1. Log into the Web Portal using the “superuser” ID and current password.
2. Click “Provider Maintenance”.



3. Enter the provider's NPI and click "Submit".



4. Click "Revalidation Submission".
5. Print the subsequent screen(s). Click "Cancel" to close the screen. Fax or mail to the provider for their review/corrections.
 - Fax cover sheet or cover letter when mailed should instruct the provider is to fax to 1-888-335-8476 or mail to VA Medicaid Provider Enrollment Services, PO Box 26803, Richmond, VA 23261-6803.
 1. When received it should be scanned and indexed as maintenance.
 2. Worked in maintenance batch work:
 - a. Log into the Web Portal using the 'superuser' ID and current password.
 - b. Click Provider Maintenance.
 - c. Enter the provider's NPI and click 'submit'.
 - d. Enter any changes per the provider's corrections and click the submit button. Note: if the provider has no corrections must still click 'submit' button to submit the revalidation.

3.14 Updates to Disclosure

1. Click Updates to Disclosure In-basket
2. Updates to Disclosure will be displayed

3. Make sure it is sorted by date received to access the next Update to Disclosure to process. Note: an Update to Disclosure that is currently being worked will display a Locked icon to the left.
4. On the FDBC Entity tab:
 - a. Does the text “No FDBC Match Found For Entities” display?
 - i. Yes – proceed to step 6
 - b. No – Investigate the match per the detailed instructions in Appendix J.
 - i. Did the investigation reveal the match is invalid?
 - (1) Yes – Select “Y” in the “Override Indicator” field and enter comments in the “Override Comments” field. (Perform this action for each match) Click the “Update” button. Proceed to Step 6.
 - (2) No -- Follow the instructions in Appendix J.
5. Approve Update to disclosure – select Action – Approve Application
6. Note: Always use the “Close” button to close an update to disclosure. This unlocks the update to disclosure.

3.15 Daily Reports

The following reports will run one or more times daily, with the exception of PS-O-726 which will run on an as-needed basis. Reports are available in ECM. Some reports require PES action, as noted in the details below.

PS-O-732 Provider Screening 15 Day Cancellation Notice (Daily)

This report lists providers whose revalidation due date is within 15 days. A provider who does not submit a revalidation by the due date will be terminated. Review this report daily and perform outreach to each provider listed. It may be determined that a provider(s) should have their revalidation due date extended (communicate with DMAS as necessary to make this determination.)

To extend/change a provider’s revalidation due date, perform the following:

From the VA MMIS Main System Menu:

1. Choose the **Provider** icon.
2. The **Provider Main Menu** screen (PS-S-000) will be displayed.
3. Select **Screening Information** from the drop-down menu in the **Selection** field.
4. Select the **Change** radio button in the **Function** field.
5. Enter the provider’s NPI in the **ID Value** field and press **Enter**.
6. The **Provider Screening Information** screen (PS-S-290) will be displayed.
7. Enter the new revalidation due date in the **Revalidation Date** field.
8. Press **Enter** to ensure no edits are invoked, then press **Update**.

PS-O-725 Provider Screening Sweep (Every 15 minutes)

This report lists the enrollments, revalidations, and updates to disclosure that were processed to the MMIS in the most recent sweep. This report also lists any applications that were not processed to the MMIS (bypassed) due to edits that were not resolved in workflow. An email is also sent to the PES Specialist who processed the bypassed application(s) and the PES Manager. The provider must be manually added to the MMIS (see Appendix K, Business Continuity Procedures).

PS-O-726 Provider Screening – Rates/Restrictions/Licenses Needed (Runs when a provider application which needs Rates, Restrictions, or Provider CLIA is approved to the MMIS.)

This report lists providers who have been approved to the MMIS and need Rates, Restrictions, or Provider CLIA information added to the MMIS. PES should update this information in the MMIS.

Rates Instructions – see Section 5.2 Rate Change

Restrictions Instructions:

An approved Mental Health, Mental Retardation, and Developed Disabled Provider will be allowed to perform and bill for certain procedure codes. These procedures are entered onto the provider file using Screen (PS-S-010) Provider Active Restriction Update. Detailed license requirements and procedure codes allowable per provider can be found in Section 9.10 Behavioral Health and Developmental Disabled Services Matrix, Developed Disabled Waiver, Mental Health, Mental Retardation and Substance Abuse Services.

The following will provide the procedures to enter Restrictions on the provider file.

From the VA MMIS Main System Menu:

1. From Provider Main Menu, enter the following selections:
2. From the selection drop-down box select **Provider Restrictions**
3. Select **Add** from the **Select Function** field
4. Enter API or NPI
5. Press **Enter**
6. **Program Code:** Enter 01 or 08
7. **Restriction Type:** Enter 01
8. **Begin Date:** Enter Begin Date of Procedure (licensed begin date for National Code designated for Mental Health Mental Retardation or Development Disability Procedure)
9. **End Date:** Enter 12/31/9999
10. **Procedure Type:** Enter 1

11. **From Procedures:** Enter National Code/Service Code from Appendix 7.9 Behavioral Health and Development Services Matrix.
12. **Thru Procedures:** Enter same code entered into From Procedure
13. **Inclusive Exclusive:** Enter I
14. **Action Type:** No data entered
15. **Apply to NPI:** N
16. Repeat steps 1-15 for each Program Code and for each Procedure Code

Provider CLIA Instructions – see Section 5.5.4 CLIA Maintenance

3.16 Management Reports

Management reports on workflow activities are available in ECM. PES management can access the following reports:

PS-O-790 Provider Enrollment Inventory Report
PS-O-791 Provider Enrollment Aging Inventory Report
PS-O-792 Provider Enrollment Agent Productivity Report
PS-O-793 Provider Enrollment Screening Fees Collected

4. Monthly Monitoring

4.1 MMIS Monthly Monitoring

Monthly monitoring of enrolled providers will be performed. The following database reports will be available on the 2nd day of the month:

PS-O-750 NPPES
PS-O-755 MCSIS
PS-O-765 LEIE (Disclosed Individuals and Entities)
PS-O-770 SSA-DMF
PS-O-780 EPLS

PES will pull the reports from ECM and review the monthly monitoring reports to determine if any enrolled providers or their disclosed individuals or entities are listed on the report. PES will investigate to determine if the listing is accurate.

To determine if the listing is accurate, PES will perform the following steps:

- Retrieve and review provider application to determine if keying error occurred
- Search NPPES using NPI and/or name to identify provider as a false positive result or to obtain additional NPI
- Verify the provider is active in MMIS

- If needed, PES will outreach to the provider

If the listing is found to be accurate, a provider will be referred to DMAS for possible termination. If the listing is found to be inaccurate, PES will override the listing using the MMIS screen PS-S-335 Federal Database Check.

Procedures for downloading the Sanction Provider report from ECM:

Sanction Provider Report (PS-O-141) will be downloaded from ECM on monthly basis by PES. This report is received from CMS monthly to VAMMIS.

1. PES Team Lead or Manager will retrieve the Sanction Provider Report (PS-O-141) from ECM.
2. From Reports Search in ECM type in Report name PS-O-141 and press search button
3. All providers on list will be cross referenced to active MMIS providers by Facility or Group name, individual name, NPI, or Social Security Number.
 - A. 3) If a match is found DMAS Provider Enrollment Contract Monitor will be notified of match found on Sanction report and directed to copy of report in ECM.
4. DMAS will respond to PES Manager or Team Lead of Termination decision.
5. PES Manager or Team Lead will ensure that all documentation regarding decision is uploaded to Electronic Content Management system (ECM) – see Section 5.8)

4.2 Risk Score

A Risk Score (numerical value) is assigned to each provider. The following risk scores are assigned by default:

Risk Category	Default Risk Score	Risk Score Range
High	80	80 - 100
Moderate	50	50 - 70
Limited	20	20 - 40

The following situations will cause the system to automatically increase the risk score to the highest possible value within the range for that risk category:

- Provider or a disclosed entity has a previous LEIE sanction but has been reinstated
- Provider indicates an adverse legal action

4.3 License Verification

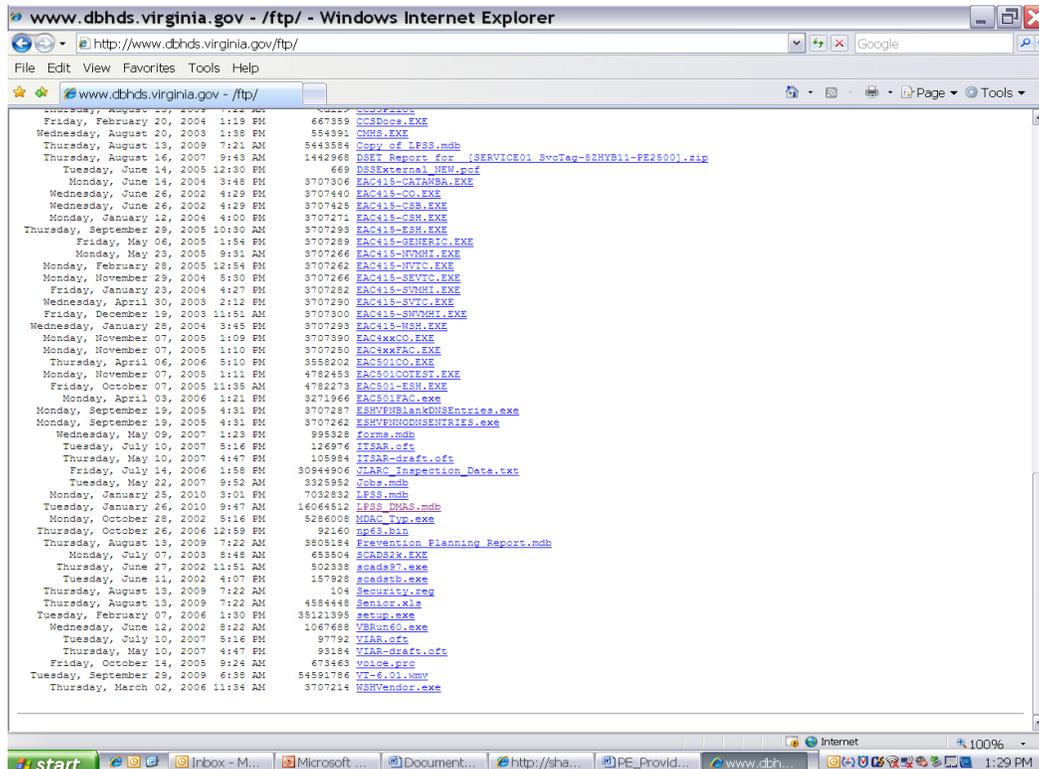
Each license or certification submitted for renewal will be verified via an internet search along with hard copy if necessary per license requirements per provider class type (see 9.12 for individual Provider Class Type detailed enrollment procedures), or, Commonwealth of Virginia database search, and also a recertification of previous license submitted by provider that is saved in ECM.

Procedures for Internet Search:

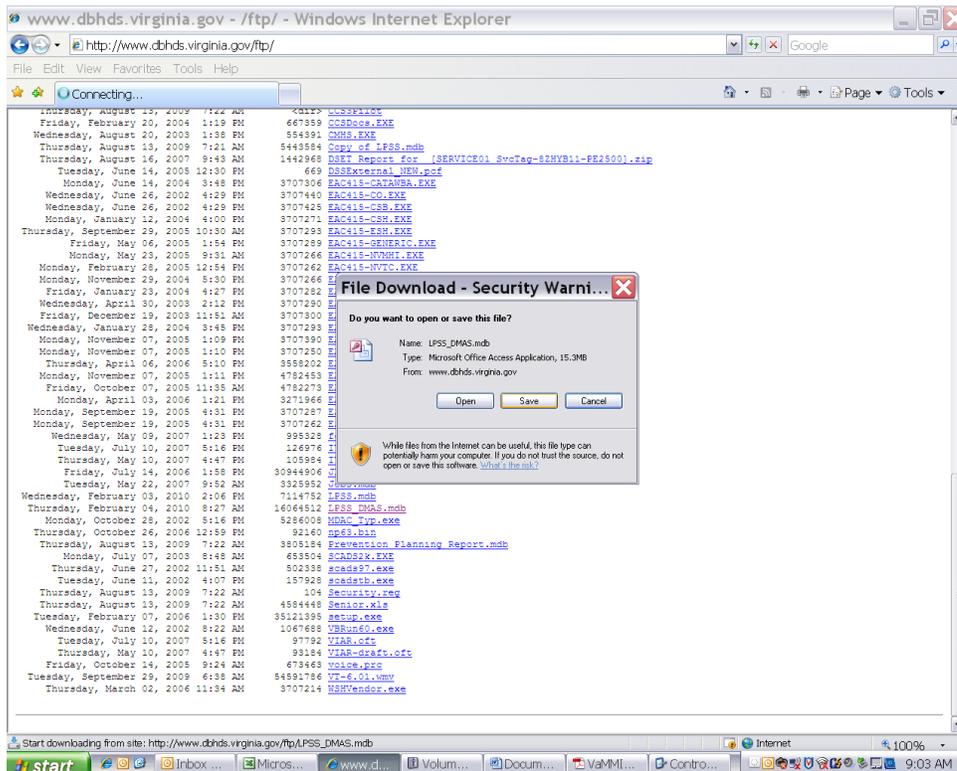
1. Click on Internet site appropriate to verify license or certification for Provider Class Type.
2. Choose the License/Certification Number field or Name field.
3. Type in the License/Certification number or name you want searched.
4. If on the database, a record will be returned. See Section 5.8 for uploading an image of the verification to ECM.
5. Verify this is the same provider and license number in MMIS on screen PS-S-001-03.
6. If valid update provider file, save screen print of license verification in ECM.
7. If invalid pend enrollment in workflow for missing information; or update in MMIS if renewal.

Procedures for Database Search:

1. Enter web address www.dbhds.virginia.gov/ftp.



2. Scroll down to LPSS_DMAS_mdb. Double click and the searchable Microsoft Access database will be displayed.



3. Click Open (you might have to click on this twice before it opens).
4. Begin search of Department of Behavioral Health and Developmental Services database by license and provider name.
5. Once search is complete:
 - a. If valid update provider file, save screen print of license verification in ECM.
6. If a 'provider's license is invalid no update will be made to MMIS, the provider file will terminate, and a termination letter will be sent.

4.4 License Renewal

Provider eligibility is dependent on timely renewal of licensure. MMIS automatically generates a 90 day grace period after the license end date. Providers will receive an automatic license/certification renewal notice 90 days prior to the license end date. The notices request providers to submit an updated license/certification to continue their eligibility. If provider does not submit an updated license prior to the 90 grace period, the provider will be terminated retroactively to their original license end date. If the provider has been terminated, they must complete a new Enrollment Application and be screened according to the patient protection and affordable care act.

If a Provider submits their updated license, PE Specialist will process as follows:

1. If the provider license has lapsed, they must submit a new Enrollment Application.

The PESpecialist will process as follows:

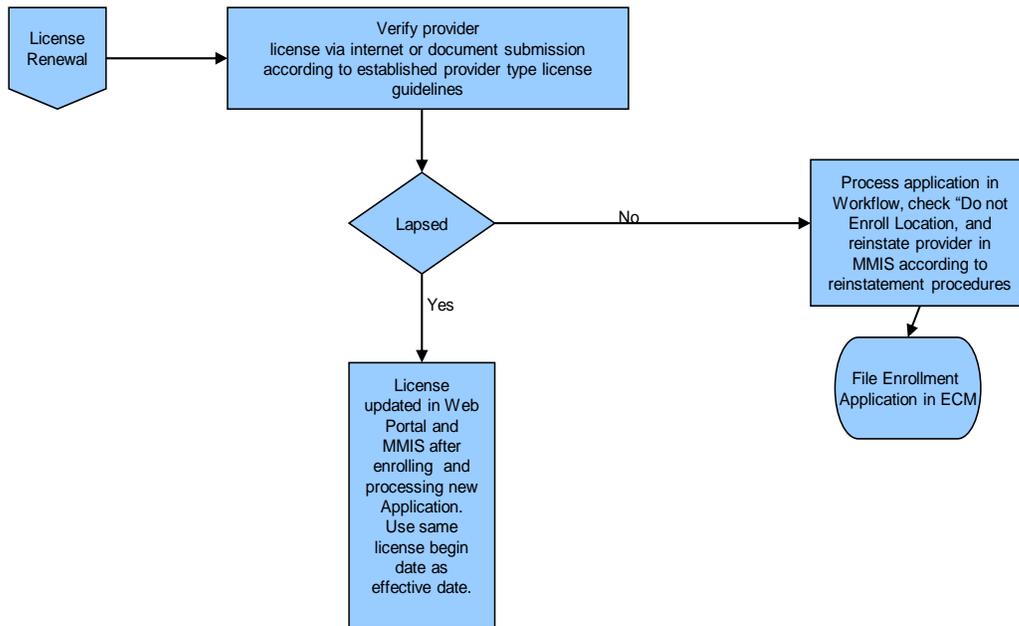
- A. Perform an Application Search in Workflow to see if an Enrollment Application was received.

- B. If Application received, assign your name to the application to prevent someone else from processing it. If no application found, follow reject procedures listed in Section 3 below.

- C. Reinstate the provider in MMIS following the procedures listed below:

1. From the VA MMIS Main System Menu Choose the **Provider** icon.
2. The **Provider Main Menu** screen (PS-S-000) will be displayed.
3. Select **Cancel** from the drop-down menu in the Selection field.
4. Select the **Change** radio button in the **Function** field.
5. Change the 009 code to 099, click Enter and Update at the bottom of the screen.
6. Return to the **Provider Main Menu** screen (PS-S-000).
7. Select **Reinstate** from the drop-down menu in the **Selection** field.
8. Select the **Change** radio button in the **Function** field
9. Key API/NPI ID Value field blank.
10. Select **Enter**.
11. The Provider **Information** Location Reinstate screen (PS-S-001-03) will be displayed.
12. The license field reason code should be changed from 000 to 099.
13. Select **Enter** and **Update**.
14. Enter the license number, the begin date, and the end date.
15. Select **Enter**.
16. If no errors occur, select **Update** to post the record.
17. If an error messages appears on the bottom of the screen, make necessary correction(s) and select **Enter**.
18. When no error messages appear, select **Update** post the data. Make sure to update all locations on file according to the application.
19. Update Program 01 and 08 with the begin date of the new license.

20. Process application in Workflow, and select “Do Not Enroll this location” on the Servicing Addresses tab and click Save.
 21. Approve application in Workflow.
2. If the provider’s license never lapsed, a new Enrollment Application is still required.
 - A. Perform an Application Search in Workflow to see if an Enrollment Application was received.
 - B. If Application received, assign your name to the application to prevent someone else from processing it. If no application found, follow reject procedures listed in Section 3 below.
 - C. Update the license, using the following procedures: (See Behavioral Health and Development Services, and Nursing Facility Provider Class Type detailed enrollment for special license renewal procedures and termination).
 1. From the VA MMIS Main System Menu Choose the **Provider** icon.
 2. The **Provider Main Menu** screen (PS-S-000) will be displayed.
 3. Select **Cancel** from the drop-down menu in the Selection field.
 4. Select the **Change** radio button in the **Function** field.
 5. Change the 009 code to 099, click Enter and Update at the bottom of the screen.
 6. Return to the **Provider Main Menu** screen (PS-S-000).
 7. Select **Reinstate** from the drop-down menu in the **Selection** field.
 8. Select the **Change** radio button in the **Function** field
 9. Key API/NPI **ID Value** field blank.
 10. Select **Enter**.
 11. The Provider **Information** Location Reinstate screen (PS-S-001-03) will be displayed.
 12. **Enter** updated license data in the “End Date” license field for the location being reinstated.
 13. Select **Enter**.
 14. If no errors occur, select **Update** to post the record.
 15. If an error messages appears on the bottom of the screen, make necessary correction(s) and select **Enter**.
 16. When no error messages appear, select **Update** post the data. Make sure to update all locations on file according to the application.
 17. Update Program 01 and 08 with the original effective date.
 18. Process application in Workflow, and select “Do Not Enroll this location” on the Servicing Addresses tab and click Save.
 19. Approve Application in Workflow.



3. If a provider submits a license without an application, create a License Renewal Reject letter listed under the “PES Rejection Letters” Category and “PES Rejection Other” Subject in [REDACTED].

A. Use the verbiage listed on the sample letter below when applicable:

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PROVIDER ENROLLMENT SERVICES

John Doe
600 East Broad Street
Richmond, VA 23219

July 21, 2015

RE NPI:

Dear Provider:

Your request to update your license with Virginia Medicaid could not be approved for the following reason(s).

- All providers terminated due to failure to submit a renewed license must submit a new enrollment agreement along with the updated license to comply with the Patient Protection And Affordable Care Act, reference CFR 455.420

If you still wish to participate in the Virginia Medicaid program, you will need to complete the application process from the beginning. We encourage you to submit your application through the secure Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov. All providers are required to register in the Virginia Medicaid Web Portal in order to complete the online enrollment process and to track the status of their application.

If you have any questions, please call Provider Enrollment Services at 888-829-5373 or 804-270-5105 (local) or visit www.virginiamedicaid.dmas.virginia.gov.

Thank you,

Provider Enrollment Services

4.4 Procedures: PES QA Rejection

1. The following Quality Checks are completed by designated PES Staff member for all Manual PES Enrollment Application rejections:
 - a. Name and API/NPI on manual letter match MMIS
 - b. Name and API/NPI of all documentation attached with rejection belong to provider.
 - c. Grammar

4.5 Provider End of Month Report (PS-0-130)

PES proactively ensures the timely renewal of special processing providers (**Provider Class Types** 056,061,077,106 or 108 –Behavioral Health and Developmental Services, 001-005,007-009,012-014 –Hospital, 006,010-011,015-018,027-029 –Nursing Facilities,)

by downloading the Provider End of Month Report (PS-O-130) on a monthly basis. This report is generated to show all provider are due to expire in the next 90-60-30 days if their provider file is not updated with new licensure/certification end dates.

Procedures:

- 1) PES Team Lead or Manager will download the end of month report (PS-O-130)
- 2) PES will extract all special processing providers and will take necessary steps according to processing guidelines for license renewal of each of these provider types to ensure that their provider numbers do not terminate or terminate if license/certification has not been renewed.

5. Processing Correspondence Procedures

5.1 Provider Complaints

PES will ensure professional and timely research and resolution to all providers' written expression of dissatisfaction with the contractor's performance, customer service, or the Medicaid Program.



SLA (Service Level Agreement): Provider complaints will be resolved within five (5) business days of receipt.

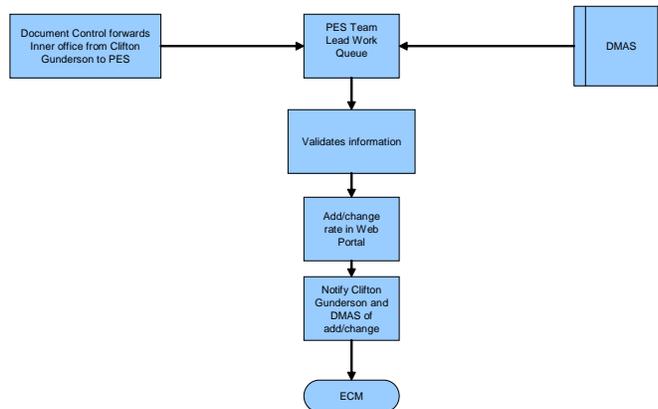
Procedures:

1. From the dashboard click on complaint inquiry work queue to access the oldest record to process.
2. PES receives complaint inquiry.
3. Inquiry forwarded to PES Team Lead Queue.
4. PES Team Lead will call provider to acknowledge complaint and document in [REDACTED] (refer to 6.2 [REDACTED] Correspondence Tracking).
5. Begin Research of Complaint.
6. If Complaint is resolved within five (5) business days:
 - a. Contact provider and DMAS of resolution.
 - b. Update [REDACTED].
7. Ensure all documentation uploaded into ECM.

8. If complaint is not resolved in five (5) business days:
 - a. Contact Provider to give status – record outreach into [REDACTED].
 - b. Once resolved follow procedures indicated in step six above.

5.2 Rate Change

The PES Manager or Team Lead is responsible for entering initial rates and the update/change of rates to provider file. Rate Changes are received from Clifton Gunderson via USPS mail or DMAS via PES e-mail box.



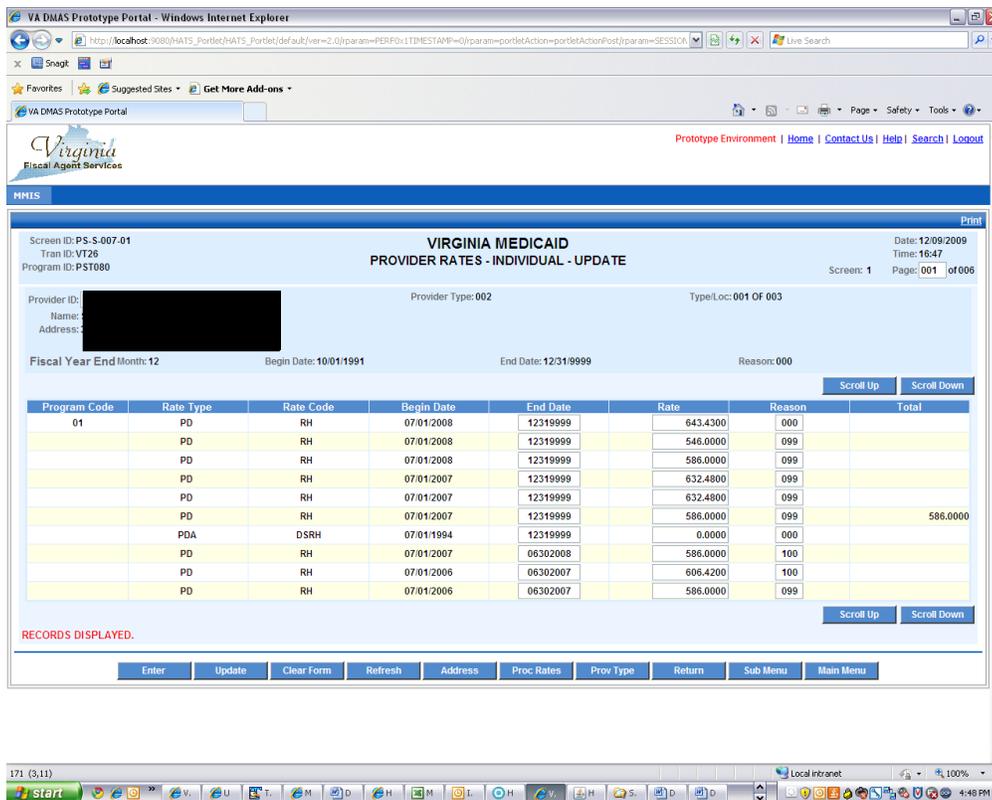
 **SLA (Service Level Agreement): Provider Rate Change will be processed within two (2) business days of receipt.**

Procedures:

From the VA MMIS Main System Menu:

1. Select the **Provider** icon.
2. The **Provider Main Menu** screen (PS-S-000) will be displayed.
3. Select **Provider Rates** from the drop-down menu in the Selection field.
4. Select the **Add** or **Update** radio button in the **Function** field.
5. **Enter** the API/NPI in the **ID Value** field blank.
6. Select **Enter**.

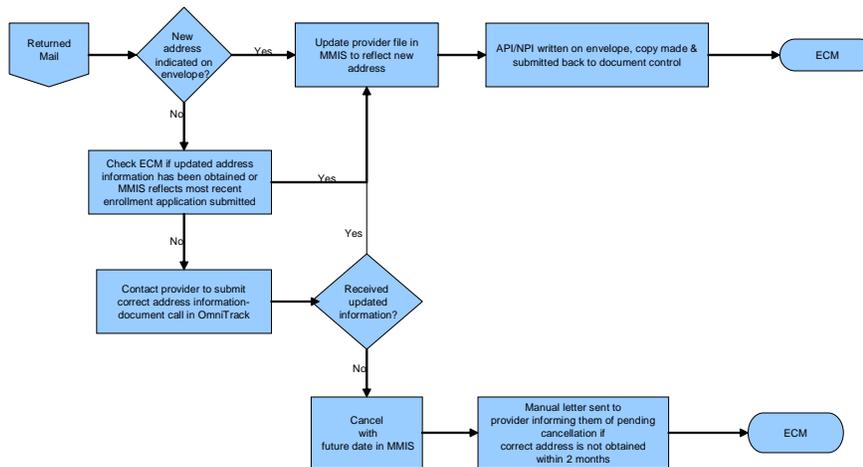
- The **Provider Individual Rate** screen will be displayed.



- Enter** rate data. Reference Rate Types and Rate Codes by Provider Type in Appendix 99.0.D Rate Types and Rate Codes by Provider.
- Select **Enter**.
- If no errors occur, select **Update** to post the record.
- If an error messages appear on the bottom of the screen, make correction(s) and select **Enter**.
- If no error messages appear, select **Update** to post the data.
- PES Team Lead notifies PES Manager of rate update.
- PES Manager verifies rates entered correctly.
- PES Manager or Team Lead will notify Clifton Gunderson by initialing rate form, make copy, send back to Clifton Gunderson through USPS, and place copy to be scanned/indexed and signed rate form gets into ECM.
- PES Manager or Team Lead will notify DMAS of update via DMAS e-mail box.

5.3 Return Mail

PES receives returned mail from [REDACTED] mass mailing, MMIS letter mailings, and 1099s. It must be sorted and resolved according to the procedures outlined as follows.



 **SLA (Service Level Agreement): Return Mail will be processed within five (5) business days from receipt.**

Procedures:

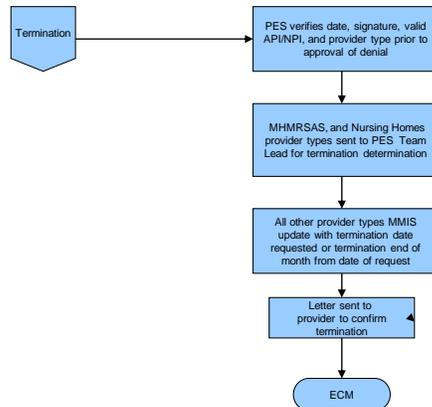
1. PES Specialist will sort Return mail by the following:
 - a. [REDACTED] mass mailing and no API/NPI indicated on envelope.
 - A. [REDACTED] API/NPI indicated on envelope, MMIS letter mailings, and 1099 and new address indicated by the post office (yellow sticker).
 - B. [REDACTED] API/NPI indicated on envelope, MMIS letter mailings, and 1099 and no New address indicated.
2. [REDACTED] Mass Mailings and no API/NPI indicated on envelope will be placed in secure recycle bin and no further processing will occur.
3. [REDACTED] API/NPI indicated on envelope, MMIS letter mailings, and 1099 and new address indicated by the post office (yellow sticker).
 - a. Write NPI on returned envelope.
 - b. Review MMIS address information on provider file (PS-S-001-02) and (PS-S-022-01).
 - c. If address in MMIS is different than the new address indicated on the envelope,
 - A. Update MMIS with new address information.

- B. Make copy of envelope.
 - C. Place the copy of envelope in the scan bin for scanning and indexing into ECM.
 - D. Mail contents of envelope back to provider at new address.
- d. If address in MMIS is same as the new address indicated on the envelope,
- A. Make copy of envelope.
 - B. Place the copy of the envelope in the scan bin for scanning and indexing into ECM.
 - C. Return contents of envelope to provider at new address.
4. [REDACTED] API/NPI indicated on envelope, MMIS letter mailings, and 1099 and no New address indicated.
- a. On the envelope to the left of the address, indicate with the initial below from where the envelope was mailed.
 - A. S= servicing
 - B. C= correspondence
 - C. P= pay to
 - D. R =remittance advice
 - b. On the envelope above FIRST CLASS MAIL, write the API/NPI.
 - c. Review MMIS for current address information on provider file (PS-S-001-02) and (PS-S-022-01) for all returned mail and follow specific procedure for processing of new address indicated and new address not indicated.
 - A. If there is another address in MMIS, write it on the envelope above the words RETURN SERVICE REQUESTED with the appropriate initial to the left.
 - B. Call the provider's contact number given in MMIS and ask for the information to be faxed or in writing via USPS, create correspondence record in [REDACTED], place return mail envelope in designated Return Mail pend file to await response from provider. If no response within 2 business days go to step f. If response back complete step 2 to update MMIS.
 - C. No answer:
 - d. If another address on file other than previous mail to address:
 - A. Create manual Return Mail Termination Letter (example will be attached in appendices when created) and return to the other address on provider file in MMIS.
 - B. Save letter in ECM showing alternate mailing address used.
 - C. Terminate the API/NPI of provider with an end date two months in the future with the cancel Reason Code of 007- unable to locate updated address not on file. Refer to step 3 Section 5.6 Terminate Provider for procedure to terminate.
 - e. Another address is not on file in MMIS:
 - A. Check ECM for updated address information.

- B. If not updated information, place "Y" in Bypass Label indicator on Provider Information Location Screen (PS-S-001-5) for provider API/NPI to indicate no more mail will be sent to provider.
 - C. Save research documentation into ECM.
- 5. Recipient Mail needs to be forwarded to the correct DMAS Department.
 - a. Most Recipient letters begin with EPO or R followed by a number. Letter CPO44701 is also Recipient mail. Place these letters in an inner-office envelope addressed to DMAS Customer Service and place in the cubby hole to be sent to DMAS.
 - b. Recipient ID cards
 - c. Post Cards – place Recipient Post Cards in an inner-office envelope addressed to DMAS Patricia Thomas
- 6. Letters CPO44801 do not require processing. Place them in a secured recycling bin.
- 7. Provider Post Cards without NPI numbers can be recycled.
- 8. Letters FN0049 need to be sent to Toni Bell at DMAS.

5.4 Terminate Provider

A provider participation in one or more Virginia Medicaid program may end at any time.



 **SLA (Service Level Agreement): Provider terminations will be processed within ten (10) business days from receipt.**

Procedures:

1. Request must be submitted in writing and be on the company's letterhead that is requesting update. The request must include the following:
 - a. Identify Provider servicing name
 - b. Servicing address and Group NPI if applicable
 - c. API/NPI
 - d. Program cancellation request
 - e. Effective cancellation date
 - f. Must be signed and dated
2. If Provider Type requesting termination is one of the following please refer to PES Manager or PES Team Lead for special processing.
 - a. Any Group Provider must be referred to PES Manager prior to termination. For example [redacted] Physicians Group NPI [redacted], [redacted] Medical Group [redacted] or [redacted]
 - b. 056,061,077,106 or 108 –Behavioral Health and Developmental Services
 - c. 001-005,007-009,012-014 –Hospital
 - d. 006,010-011,015-018,027-029 –Nursing Facilities

3. If Provider Type requesting termination does not require referral to Manager or Team Lead, process as follows;
 - a. From the VA MMIS Main System Menu:
 - A. Select the Provider icon.
 - B. The Provider Main Menu screen (PS-S-000) will be displayed.
 - C. Select Cancel from the drop-down menu in the Selection field.
 - D. Choose the Change radio button in the Function field.
 - E. Enter the Provider Identification Number in the ID Value field.
 - F. If no entry is made in the ID field, enter the Provider ID number on the Cancel screen.
 - G. Select Enter.
 - H. The Provider Cancel/Un-Cancel screen (PS-S-004) will be displayed.
 - I. To cancel the program(s) of a provider, type over the End Date of the record(s) with requested termination date, and enter appropriate Cancel Reason Code (see appendix 99.0.B for appropriate Reason Code).
 - J. For reinstatement purposes use code 099
 - K. Select Enter.
 - L. If no errors occur, choose Update to save the record.
 - M. If error messages appear on the bottom of the screen, make correction(s), and choose Enter. When no error messages appear, choose Update to save the data.
 - N. If provider belongs to a Group their Group affiliation must be terminated:
 - O. From the Selection drop-down box Select Provider/Group maintenance
 - P. Select Change and enter NPI in ID Field, Click enter. Update Screen (PS-S-005) will display.
 - Q. Select appropriate location and group affiliation
 - R. Enter termination date in end date field
 - S. Enter appropriate termination reason code
 - T. Click Enter, then Update

5.5 Maintenance

The provider may request certain information to be updated on the provider database.
General Process

 **SLA (Service Level Agreement): Provider updates will be processed within five (5) business days from receipt.**

Note regarding missing information for Enrollments or Revalidations that are in-process: If missing information is received from the provider without the missing information letter, it will be indexed as Maintenance. PES must monitor Maintenance documents periodically every business day for incoming missing documents for every provider application that is in the following FileNet work queue in baskets.

- c. Pend for Missing Info
- d. Pend 15 Days
- e. Pend 30 Days

Procedures:

1. From the dashboard click on maintenance queue to access the oldest record to process.
2. Request must be submitted in writing and be on the company's letterhead that is requesting update. The request must include the following: (If not see rejection Step 5)
 - a. Provider servicing name
 - b. Servicing address and Group NPI if applicable
 - c. API/NPI
 - d. Specific details of the update/change.
 - e. Effective date of update
 - f. Must be signed and dated
3. If Provider Type requesting update is one of the following, refer to PES Manager or Team Lead for special processing.
 - a. 056,061,077,106 or 108 –Behavioral Health and Developmental Services
 - b. 001-005,007-009,012-014 –Hospital
 - c. 006,010-011,015-018,027-029 –Nursing Facilities
4. If the Provider Type requesting an updates is not a referral to the PES Manager or Team Lead, process the update as follows:
 - a. From the VA MMIS Main System Menu
 - b. Choose the Provider icon.
 - c. The Provider Main Menu screen (PS-S-000) will be displayed.
 - d. Choose the appropriate screen for the update. For address updates Screen (PS-S-001-02 Provider Billing Information and (PS-S-022-01) Provider Services Address Screen will be utilized. For TIN, or EFT updates (PS-S-001-01) Provider

Billing Information Screen will be utilized. For CLIA (PS-S-030). CLIA Update screen will be utilized.

- e. Select the Change radio button in the Function field.
 - f. Enter the Provider NPI or API Number in the ID Value field.
 - g. Select Enter to display the record.
5. If a request is received and is not on the requesting companies letterhead, then it must be rejected with the following:
- a. This request must come from the requesting company/provider and be received on their letterhead, and must include signature.

5.5.1 Provider Name Maintenance

Guidelines:

1. Request must be submitted in writing and be on the company's letterhead that is requesting update. The request must include the following: (If not see rejection Step 8).
2. Request must contain API/NPI
3. If organization must submit a copy of new W-9 and updated certification or license showing updated name. If TIN update is noted follow steps 6.8.4 TIN Maintenance.
4. If individual due to marriage provider must submit a copy of marriage certification and if applicable copy of updated license.

5.5.2 Address Maintenance

Guidelines:

5. Request must be submitted in writing and be on the company's letterhead that is requesting update. The request must include the following: (If not see rejection Step 8).
6. Do not change the provider's physical location or payment location for any Behavioral Health and Development Disability Service, or Nursing Home. Refer these to PES Manager or Team Lead Queue.
7. Do not change physical/servicing location for providers when their license is based on physical/servicing location, unless license is verified with updated service location. Upload license verification into ECM. – If servicing address cannot be verified to match most current provider license the address maintenance will be rejected.
8. IRS address changes must be submitted with a copy of W-9, SS-4, and provider cancel letter with address change completed, or other approved IRS documentation. If supporting documentation is not submitted for an IRS address change the address maintenance request will be rejected.
9. Providers that are adding an additional location to their already existing provider file, please amend correspondence, pay to, and remit address to most current enrollment application.

10. If an API/NPI has been canceled with RSN 007 (Return mail, unable to locate, and PEU receives corrected address information), provider file MUST be re-instated along with any address information amended.
11. All address changes verify that FIPS code will remain the same.
12. If a request is received and is not on the requesting companies letterhead, then it must be rejected with the following:
 - a. This request must come from the requesting company/provider and be received on their letterhead, and must include signature.

Procedures:

1. Billing address maintenance – Provider Screen (PS-S-001-02) Provider Billing Information will be used. Update all correspondence, pay to, or remittance addresses indicated on provider maintenance request in MMIS For specific fields refer to section 9.12.
2. Servicing address maintenance – Provider Screen (PS-S-022-01) Provider Servicing Address Screen will be used. Update all servicing address information indicated on provider maintenance request in MMIS. For specific fields refer to section 9.12.
3. IRS Address- Provider Screen (PS-S-001-01) Provider Billing Information Screen will be used. Update all IRS address information indicated on provider maintenance request. For specific fields refer to section 9.12.

5.5.3 TIN Maintenance

When an IRS change is requested by a provider, the IRS change will fall into two categories:

Guidelines:

1. New API/NPI Established and Old API/NPI Number(s) Terminated:
 - a. A provider who has requested an IRS change and has received a new NPI number must complete a new Enrollment Application, and terminate old NPI number.
 - b. A provider who has requested an IRS change and is receiving a new API number must complete a new Enrollment Application, and terminate old API number.
2. IRS information to be Changed on Existing Provider File(s):
3. A provider who has requested an IRS change and will not receive a new API/NPI can have the IRS and effective date changed on already existing file if they supply PEU the following documentation:
 - a. W-9 with new IRS information
 - b. Brief narrative of IRS change transaction
 - c. Documentation that there will be no need in a new API/NPI
 - d. Complete Enrollment Application for provider type
4. All IRS changes must be approved by PEU Team Lead or Supervisor. If all information is not received to process IRS change request TIN Maintenance request will be rejected.

Procedures:

1. IRS maintenance will be processed on screen (PS-S-001-01) Provider Billing Information Screen.

The screenshot shows the 'VIRGINIA MEDICAID PROVIDER BILLING INFORMATION - INQUIRY' screen. Key information includes:

- Screen ID: PS-S-001-01, Trans ID: VT01, Program ID: PST010
- Provider ID: [Redacted], Legacy ID: [Redacted], API Ind: [Redacted], NPI Type: 2, Tracking ID: 2007297042
- Provider IRS Information: SSN: [Redacted], FEIN: [Redacted], IRS Name: [Redacted], IRS Address: CHESAPEAKE VA 23320-2800. Begin Date: 01/01/2000, End Date: 12/31/9999, Reason: 000.
- Provider Fiscal Year Information: Fiscal Month: 12, Begin Date: 01/01/2007, End Date: 12/31/9999, Reason: 000.
- Provider EFT Information: Institution: [Redacted], Status: [Redacted], Account Type: [Redacted], ABA: [Redacted], Account Class: [Redacted], Account Number: [Redacted], Begin Date: [Redacted], End Date: [Redacted], Reason: [Redacted].
- Provider Electronic Remit Information: RA Ind: P, Service Center: [Redacted], Begin Date: 10/24/2007, End Date: 12/31/9999, Reason: 000.

 The bottom of the screen features a navigation bar with buttons for Enter, Update, Clear Form, Refresh, SSM Hist, FEIN Hist, FYE Hist, EFT Hist, Return, Sub Menu, Main Menu, ERA Hist, Address, MC Enroll, Affiliation, Service Center, Financial, Restrictions, Group, Ind Rate, and Next.

2. Terminate previous IRS Number:
3. Begin date- Enter the new IRS number in the IRS Number field and begin date of new IRS number.
 - a. Reason – Enter 070 termination of IRS number.
 - b. Click Enter then Update.
4. If the new IRS Number is new to MMIS:
 - a. Enter in the IRS Name according to the W-9 or IRS letter
 - b. Enter the IRS address information according to the W-9 or IRS letter
 - c. Reason -000.
 - d. Click Enter then Update.

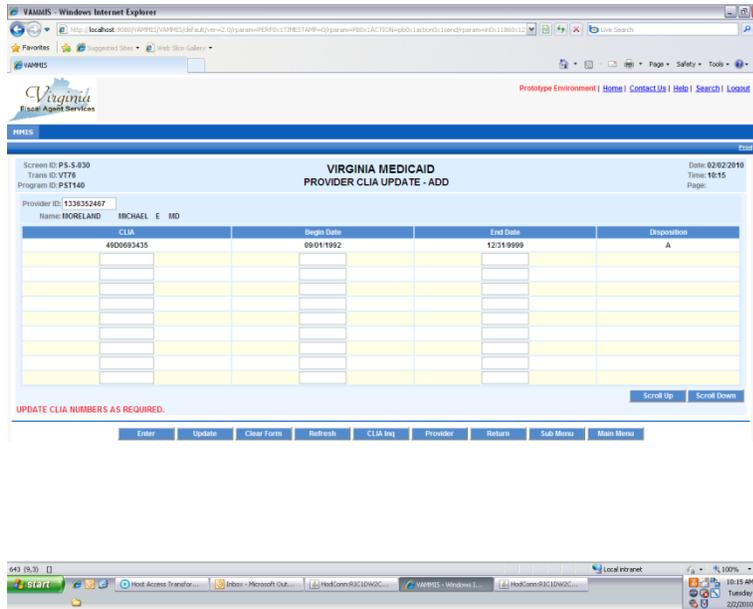
5.5.4 CLIA Maintenance

The CLIA (Clinical Laboratory Improvement Amendments) number is required for certain Laboratories (Provider Class Types 070 and 098 only).

Procedures:

1. From the VA MMIS Main System Menu:
2. Choose the Provider icon.
3. You see the Provider Main Menu screen (PS-S-000).
4. Select Provider CLIA from the drop-down menu in the Selection field.
5. Choose the Add or Update radio button in the Function field.
6. Enter the Provider Identification Number in the ID Value field.
7. Choose Enter.

8. You see the Provider CLIA Update screen (PS-S-030).



9. Enter CLIA Number
10. Enter begin date on CLIA certification
11. Enter end date on CLIA certification
12. Choose Enter.
13. If no errors occur, choose Update.

5.5.5 Electronic Funds Transfer Update

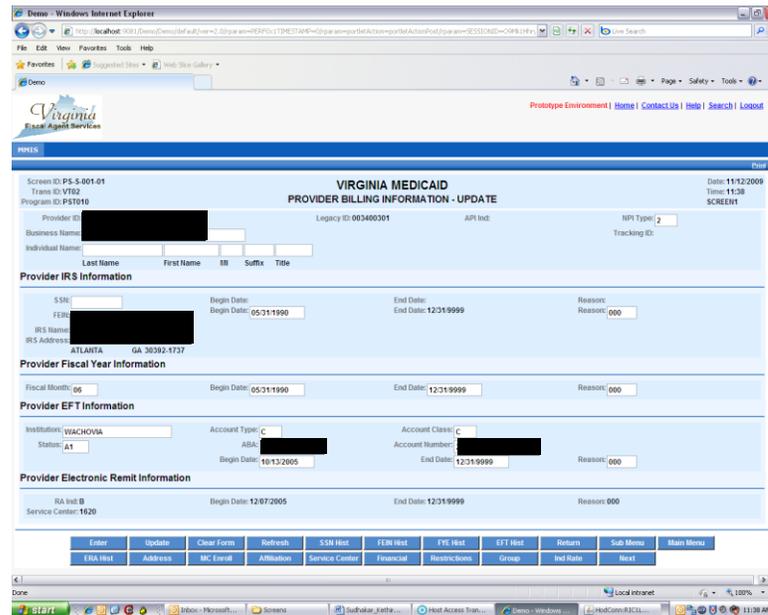
As of 7/1/2012 all Billing Providers are required to receive their payments by Electronic Funds Transfer (EFT) to be a participating provider. When a provider signs up to receive payments electronically, they provide an ABA or routing number which designates which financial institution their account is with, along with their account number. For two weeks or so, a transaction for \$0 is sent to their account to ensure that the information is correct. This is called a pre-note. Pre-notes can be rejected for the same reasons that transactions with money can be rejected. The Pre-note period gives us a chance to update the Provider's file before transactions with money are sent. While the provider or payee is in the Pre-note period, their payments are sent using a paper check.

Procedures:

1. General Requirements for EFT Application:
 - a. Mandatory Provider Information — If any of the following is missing, follow procedures 4.1.9 Reject Enrollment Process.
 - A. API or NPI – One EFT bank account can be designated per API/NPI
 - B. Provider Name

- C. TIN — TIN in MMIS for API/NPI indicated must match TIN indicated on EFT Form.
 - D. Signature
 - E. Payment and Processing Information
- b. Did provider indicate EFT?
- A. Yes and the following was provided proceed to Procedure in 2 to Enroll EFT. If information incomplete follow 4.1.9 Reject Enrollment Process.
 - (1) Account Type
 - (2) Name of Banking Institution
 - (3) Routing Number also called ABA/ACH number
 - (4) Bank Account Number
 - (5) Voided Check attached or official letter from Banking Institution (not required with new EFT Application as of 10/1/2011)
 - (6) Signature and Date
 - B. No – Proceed to Step 2
 - (1) Did provider indicate an EFT Exemption by checking unable to transact business through a banking institution capable of EFT?
 - (a) Yes – Proceed to Step 4 EFT Exemption Process
 - (b) No – Proceed to Step 3 EFT Exemption Other 4.1.99 Reject Enrollment Process.
 - (2) Did provider indicate an Other EFT Exemption and supporting documentation submitted?
 - (a) Yes – Proceed to 7.2.1 Create Communication Record and Refer to DMAS PES Contract Monitor for approval or denial of exemption using the following in XXXXXXXXXX
 - (i) Category – PES
 - (ii) Subject – EFT Exemption Referral
 - (iii) No -- Proceed to 4.1.9 Reject Enrollment to request Missing Information
2. Enroll EFT:
- a. From VA MMIS Main Menu choose Provider Information Screen (PS-S-001) from the drop down menu.
 - b. Choose Change.
 - c. Enter API/NPI into Id Field.
 - d. Click Enter.
 - e. Provider Information Update Screen (PS-S-001) will appear.
 - f. Institution — Enter Banking Institution Name.
 - g. Account Type- C.

- h. Account Class- C.
 - i. ABA – Routing Number of Banking Institution on Voided Check on Financial Statement. Use the ACH number if they supply both the ABA and ACH routing numbers.
 - j. Account Number – Account Number on Voided Check or on Financial Statement.
 - k. Begin Date — Current Date.
 - l. End Date- 12/31/9999 Indefinite.
 - m. Reason- 000.
3. Change EFT used if the Provider submits a new EFT Application:
- a. Cancel the current EFT with current date Reason 099.
 - b. Press Enter and Update
 - c. Follow steps for enrolling EFT 66.8.4 Electronic Funds Transfer Update



4. EFT Exemption Process :
- a. From Provider Main Menu Select Provider Information



- b. Select Change in Function field
 - c. Enter API/NPI in ID Value field
 - d. Press Enter
 - e. Proceed to Screen PS-S-001-05 Provider Location Information Update
 - f. Enter EEFT (Exempt EFT) in Comment Field
 - g. Enter
 - h. Update
 - i. Enter EB (Exempt Both) if you have also followed procedures in 6.8.5 Electronic Submission of Claims Update
5. EFT Maintenance Requests from Finance
- a. The Finance Department will receive a Return Item Report from the bank that result in changes or cancelations of account information. An [REDACTED] Ticket will be routed to the PES Unit to be worked. The record will state if it is a change in information, which will allow the account to remain in the current status or if the account needs to be canceled and reentered to return to an initial (P1) status.
 - b. Change in Routing/Account number remaining in current Status- For example: A change in a routing number can occur if a bank has been bought out by another financial institution. An account number might change if a bank has changed accounting systems and requires all account numbers to be updated. The Omnitrack record should indicate to leave the provider in their current status.
 - A. From VAMMIS Main Menu
 - B. Choose Provider Information Screen (PS-S-001) from the drop down menu.
 - C. Choose Change
 - D. Enter the NPI/API in the ID Value field, Select Enter.
 - E. Make corrections to the routing or account number as stated in the Omnitrack record, change the Begin Date to the current date.
 - F. Select Enter and Update
 - c. Change in Account information and Status — For example: If the EFT information was keyed incorrectly by PES. The Omnitrack record would not indicate to leave in current status.
 - A. Check ECM to see if the information was keyed incorrectly or if the provider did not give PES the correct information. See section 5.8 for directions on finding documents in ECM.
 - B. From VAMMIS Main Menu
 - C. Choose Provider Information Screen (PS-S-001) from the drop down menu.
 - D. Choose Change
 - E. Enter the NPI/API in the ID Value field. Select Enter.
 - F. Delete the incorrect or 'old' account information from the provider profile using the current date as the end date and reason code 099.

- G. Type in the correct or current account information provided in the [REDACTED] record. (You may have to make note of the bank name, routing and/or account number depending on what corrections need to be made.)
- H. Enter and Update.

5.5.6 Electronic Submission of Claims Update

Providers are required to submit their claims electronically via Claims Direct Data Entry through Virginia Medicaid Webportal (DDE) or via Electronic Data Interchange (EDI) to be a participating provider.

Procedures:

1. General Requirements for Electronic Claims Submission Application:
 - a. Mandatory Provider Information — If any of the following is missing, follow procedures 4.1.9 Reject Enrollment Process.
 - A. API or NPI
 - B. Provider Name
 - C. TIN — TIN must match API/NPI indicated on
 - D. Signature
 - b. Claims Submission Information
 - A. Did provider indicate EDI?
 - (1) Yes- Proceed to 7.2.1 Create Communication Record and refer to EDI Coordinator as Request for Provider Outreach:
 - (a) Category – PES
 - (b) Subject- EDI Enrollment Request
 - (2) No- Proceed to step 2
 - B. Did provider indicate Claims DDE?
 - (1) Yes- No action taken by PES
 - (2) No- Proceed to Step 3
 - C. Did provider indicate by checking Electronic Claims Submission Exemption and submit supporting documentation?
 - (1) Yes –Proceed to Step 5 Electronic Claims Submission Exemption Process
 - (2) No – Proceed to Step 4.
 - D. Did provider indicate Other Electronic Claims Submission Exemption and supporting documentation submitted?

- (1) Yes – Proceed to 7.2.1 Create Communication Record and Refer to DMAS PES Contract Monitor for approval or denial of exemption using the following in [REDACTED]
 - (a) Category – PES
 - (b) Subject – EFT Exemption Referral
 - (2) No-Proceed to 4.1.9 Reject Enrollment to request Missing Information
- c. Electronic Claims Submission Exemption Process.
- A. From Provider Main Menu Select Provider Information
 - B. Select Change in Function [REDACTED]
 - C. Enter API/NPI in ID Value field
 - D. Press Enter
 - E. Proceed to Screen PS-S-001-05 Provider Location Information Update
 - (a) Enter EEC (Exempt Electronic Claims) in Comment Field
 - (b) Enter
 - (c) Update
 - (d) Enter EB (Exempt Both) if you have also followed procedures in 6.8.4 Electronic Funds Transfer Update

5.5.7 Provider Service Center Maintenance

PES will receive phone calls from providers requesting to “opt out” of receiving electronic correspondence in their secure mailbox and opt for receiving paper correspondence via regular mail delivery.

Note: These requests should be treated as a Maintenance Request and the provider should be instructed to provide the following:

- 1 Fax or mail the request on their company letterhead
2. Include the NPI, date, and signature

The provider should be advised that the change could take up to 5 days to complete after receiving the request and the change will be effective on the date updated in the system, not the date of the request.

Once a written request is received, perform the following steps to change the indicator from “E” electronic to “P” paper:

1. From the Provider Main Menu, access the Provider Service Center (PS-S-033) in “Add” mode.

2. On the first blank row, enter "J" or "M" for Type (J = RAs, M = all other letters)
Enter "P" for Ind (Indicator), today's date for begin date, 12/31/9999 for end date, and reason code "006" (Provider Requested).
Note: You must insert the date with slashes (or the system will not take the begin date entry as a valid entry.)
3. Click "Enter" then "Update".
4. Repeat for either J or M if desired.

Change from “P” to “E”.

1. Please Note: it is not necessary to change the indicator from a P to an E, as once an email address is entered for a provider the nightly jobs will change the P to an E. However, if desired to have the indicator changed immediately, please proceed to step 2.
2. At least one email address must be on file for the provider. If none exists, add a valid email obtained from the provider in writing.
3. Access PS-S-033 in “Add” mode.
5. On the blank row, enter “J” or “M” for type (J = RAs, M = all other letters)
4. Enter “E” for Ind, today’s date for begin date, 12/31/9999 for end date, and reason code “000”.
5. Click “Enter” then “Update”.
6. Repeat for either J or M if desired.

5.6 POS Update

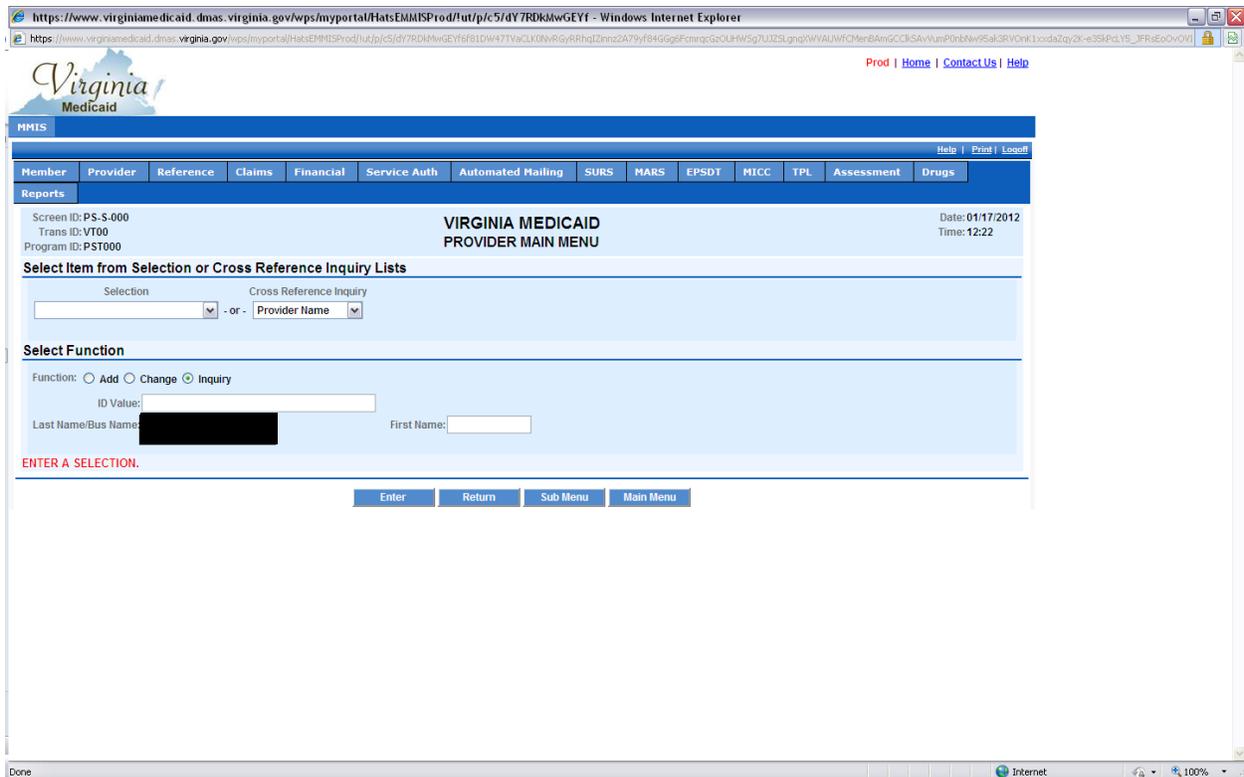
Point of Sale (POS) refers to the capturing of Data and customer payment information at a physical location when goods or services are bought and sold. VA Medicaid Pharmacies (PCT 060 only) have the option to enroll for POS for services rendered to Medicaid Members.

Procedures:

1. POS Begin date will be current date.
2. Enter 12/31/9999 as end date.
3. Click Enter then Update.

5.6.1 Nursing Facility Certificate & Transmittal (C&T)

1. Virginia Department of Health will send Nursing Facility C & Ts to be processed by PES.
2. Identify the Provider by performing a name search in MMIS



- a. From the Provider Main Menu, select Provider Name from Cross Reference Inquiry drop box
 - b. In the Last Name/Bus Name field type in the name of the facility using a percentage sign (%) in place of a space and an asterisk (*) at the end of the name.
3. Verify the name and address of the facility
 4. Update the bed information on screen PS-S-001-05 to reflect the number and types of beds on the C&T.
 - a. Total: must equal the total number of beds.
 - b. NF: refers to the number of beds listed under 19SNF or L39.
 - c. SNF-NF: refers to the number of beds listed under 18/19SNF or L38.
 - d. SNF: refers to the number of beds listed under 18SNF or L37.
 - e. Non-Cert: do not key any beds in this field
 - f. ICF-MR: refers to the total number of beds listed under both ICF/L42 and IMR/L43.
 5. From the Provider Main Menu, select Reinstate from the Selection drop down box
 6. Select Function Change
 7. Enter NPI number in ID Value field and Enter

8. Screen PS-S-001-03 will appear. Select Next tab at the bottom right corner of the screen.
9. Update bed numbers accordingly.
10. The C & T type of action can be found in the upper right hand corner. Refer any action 3, 4, or 6 to PES Team Lead or PES Manager for further action.

5.6.2 API/NPI Maintenance

Providers may change their API to an NPI in their provider file if they have received approval for an NPI because they also provide healthcare services.

1. Provider requesting to change their API to their NPI must provide a signed copy of Atypical Provider NPI Attestation Form which can be found on the website at www.virginiamedicaid.dmas.virginia.gov. The Atypical Provider NPI Attestation Form confirms that the provider is using an NPI in place of a Virginia Medicaid issued Atypical Provider Number.
2. From Provider Main Menu Selection Select Provider API/NPI Maintenance
3. Function Add
4. Enter API number
5. From Screen (PS-S-017), enter NPI requested in NPI field located under API.
6. Press Enter then Update

VA DMAS Prototype Portal - Windows Internet Explorer

http://localhost:9080/Yamms/News/default/ver=2.0/?param=PERFDx1TPESTAPP=0j?param=PBDx1ACTION=pb0x1action0:1sendj?param=mbx12660x140=0j

VA DMAS Prototype Portal

Test Environment | Home | Contact Us | Help | Search |

HMIS

Screen ID: PS-S-017
Trans ID: VTR7
Program ID: PST017

**VIRGINIA MEDICAID
PROVIDER API/NPI MAINTENANCE**

Date: 02/09/2010
Time: 16:58
Page: 01 of 01

API: [REDACTED]
NPI: [REDACTED]
NPI Type: 2
Name: NATIONAL MENTOR HEALTHCARE INC
Prov Type: 022

API/NPI	API	Base ID	Begin Date	End Date	Date Added	Site Ind	Reason Code
0002006036	Y	160939	12/17/2002	12/31/9999	03/24/2007	01	000

NPI REQUIRED

Enter Update Clear Form Base ID Maint Return Sub Menu Main Menu

Local intranet 100%

275 (4,35) Start Inbox - Micros... Host Access T... My Documents DSD Full V - 4... VA DMAS Prot... ModConn.RIC... Screen Custo... data.doc - Mic... 5:05 PM

5.6.3 Client Medical Management Update

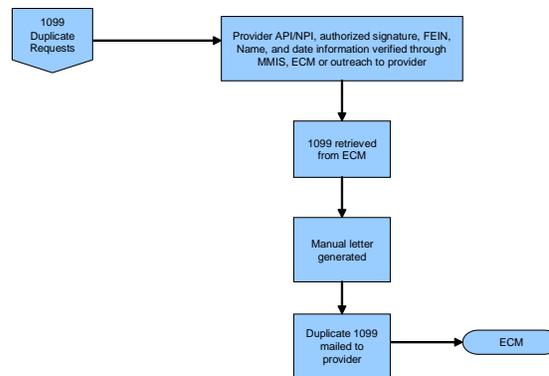
The Recipient Monitoring Unit administers the Client Medical Management (CMM) Program. Medicaid or FAMIS recipients who abuse medical services are identified and enrolled in CMM for 36 months to control over-utilization. PES receives DMAS requests to affiliate providers to an existing CMM provider.

Procedures:

1. DMAS will approve and indicate that program "05" (CMM) has been placed on provider file, by faxing in to the PES CMM forms which will be placed in Correspondence FileNet Work flow queue and then placed in PES Team Lead queue for processing.
2. From VA MMIS Main Menu click on Provider Icon.
3. From Selection Click on Affiliation Update Screen (PS-S-023)
4. Click on Change.
5. Enter NPI into input field click Enter.
6. Place 03 in Group Type field click Enter.
7. Enter NPI for first provider designated on CMM form as provider affiliation for CMM provider.
8. Begin date- Effective date provided on CMM form.
9. End date- 12/31/9999.
10. Affiliation Type- Enter "2" for CMM.
11. Group Type- Enter "1" for Managed Care and enter "2" for CMM.
12. Click Enter then Update.

5.6.4 1099 Duplicate Request

Form 1099 is a tax document that is sent to all providers annually to report earnings for income tax purposes. These forms are mailed to providers annually between January 5th and January 31st. The Provider Enrollment Services unit will receive 1099 forms that are returned to the Financial Services Unit and all requests from providers for duplicate copies of 1099 forms.



 **SLA (Service Level Agreement): 1099 Duplicate Requests must be processed within ten (10) business days from receipt.**

Procedures:

1. The provider must request a duplicate 1099 in writing on company letterhead, signed and dated. They must provide the name, API/NPI, TIN, signature, address and year requested.
2. PES Specialist will verify information received with request for name, API/NPI, TIN, signature, and address for accuracy.
3. PES Specialist will access ECM to print a duplicate of 1099 form.
4. From Financial Search enter API/NPI in Account Number
5. Document Type 1099 press search button
6. 1099 will displayed

7. CR Record will be opened and manual letter created and PES Specialist will mail 1099 form to provider.

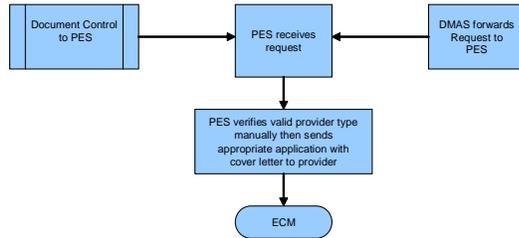
5.6.5 DMAS Request for Research/Resolution

DMAS Research/Resolution request will be sent to PES e-mail box which will be distributed according to workflow process or special processing through PES Manager and Team Lead.

Procedures:

1. Create [REDACTED] Correspondence Record (CR) (refer to 88.2 Creating Communication Record (CRs)).
2. Research the request.
3. Update the research results and Close the CR in [REDACTED].
4. Notify DMAS.
5. Upload all documentation into ECM.

5.6.6 Mailing Request for Enrollment Application



Procedures:

1. PES receives request from the Correspondence FileNet workflow.
2. Verify valid provider type.
3. Select appropriate enrollment application from Web.
4. Follow steps for creating manual letter through [REDACTED]
5. Mail to provider.

5.7 PES Escalation Procedures

PES shall notify DMAS of a breach of unsecured PHI on the first day on which such breach is known by Contractor.

Procedures:

1. Notify PES Manager of breach
2. PES Manager will obtain the following information regarding breach:
 - a. Brief description of what happened, including date of the breach
 - b. Description of the types of unsecured PHI that were involved in breach

- c. Contact party involved in breach to gather any additional information and to acknowledge
3. PES Manager will contact the following with details and description of breach:
 - a. VAMMIS Executive Account Manager
 - b. VAMMIS Business Operations Manager
 - c. Provider Enrollment Contract Monitor
 - d. DMAS Director of Operations
 - e. Business QA Manager
4. Corrective Action
 - a. Resolve or correct any data or provider information that may have caused breach
 - b. Contact party involved of resolution
 - c. Develop Corrective Action Plan (CAP) along with QA
 - d. Update PES Procedure Manual of new process developed in CAP

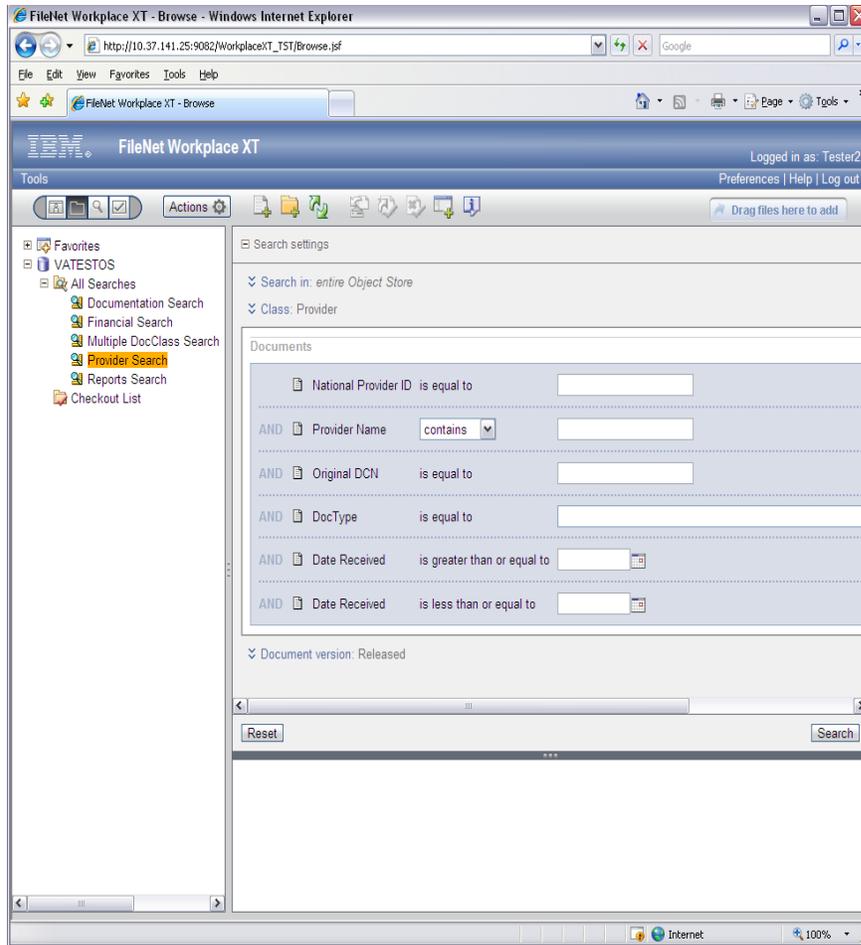
5.8 Electronic Content Management System (ECM)

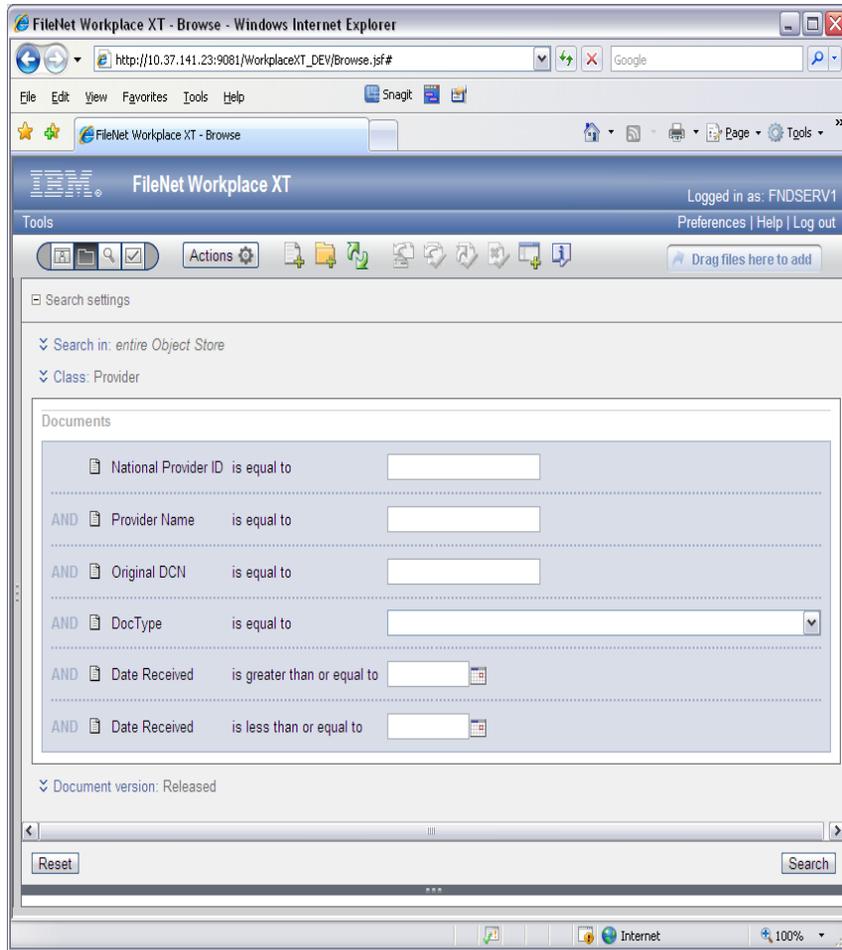
FileNet suite is a modular, integrated suite of applications [REDACTED] utilizes for storing and managing information from multitude of sources. It allows for the storage, distribution and retrieval of documents in electronic format, rather than physical paper format.

5.8.1 Searching for Provider Documents

Procedures:

1. From Virginia MMIS Web portal click on ECM tab
2. FileNet Workplace XT Screen will be displayed
3. Click on the Provider Search under VATESTOS→All Searches





4. This screen shows the available property fields used to search for Provider Enrollment type of document.
 - a. National Provider ID- Search by exact 10 digit NPI or API
 - A. Provider Name- Search by contains in name, begins with, or ends with
 - B. Original DCN- Search by exact DCN – This search will result in all individual documents associated with enrollment application to be displayed.
 - C. Doc Type- Search by the following:
 - (1) Enrollment Request Letter
 - (2) Enrollment Instructions
 - (3) Enrollment Application
 - (4) Disclosure of Ownership and Control Interest
 - (5) Mailing Suspension Request/Signature Waiver/Pharmacy POS Form
 - (6) Electronic Funds Transfer Information Letter
 - (7) Electronic Funds Transfer Application
 - (8) Electronic Service Center Authorization
 - (9) Reassignment of Benefits Form

- (10) Participation Agreement
- (11) Letter
- (12) Acknowledgement Letter
- (13) EDI
- (14) Termination
- (15) Complaints
- (16) License
- (17) Rate Change
- (18) Maintenance
- (19) Provider Correspondence
- (20) B Notice
- (21) IRS Documentation
- (22) Finance
- (23) Prov. Other

D. Date Received – Document scanned/index date

5.8.2 Re-Indexing Provider Documents

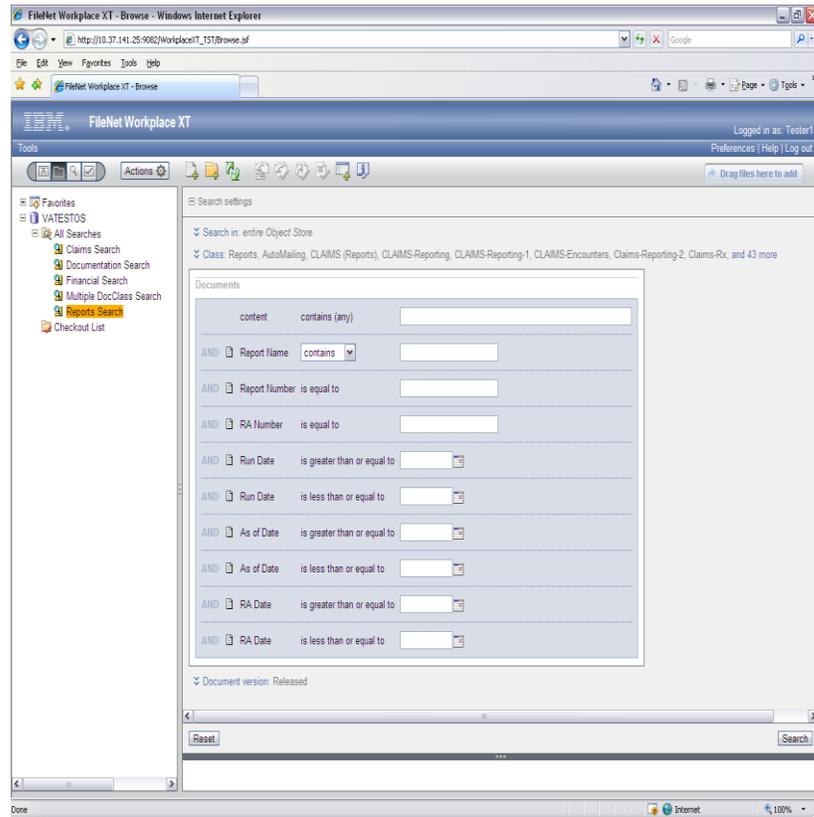
PES performs a quality check on all incoming documents for accurate index properties. If documents are indexed incorrectly PES can perform a re-index of documents to correctly represent provider file.

1. PES will perform search function following procedures in 5.8.1,
2. PES will retrieve incorrectly indexed document and right click on the mouse a drop down menu will be displayed.
3. Click on properties.
4. Properties available to be re-indexed will be displayed.
5. Re-type over incorrect information or correct document type.
6. Click OK button located in bottom right hand corner of page.
7. Update complete.

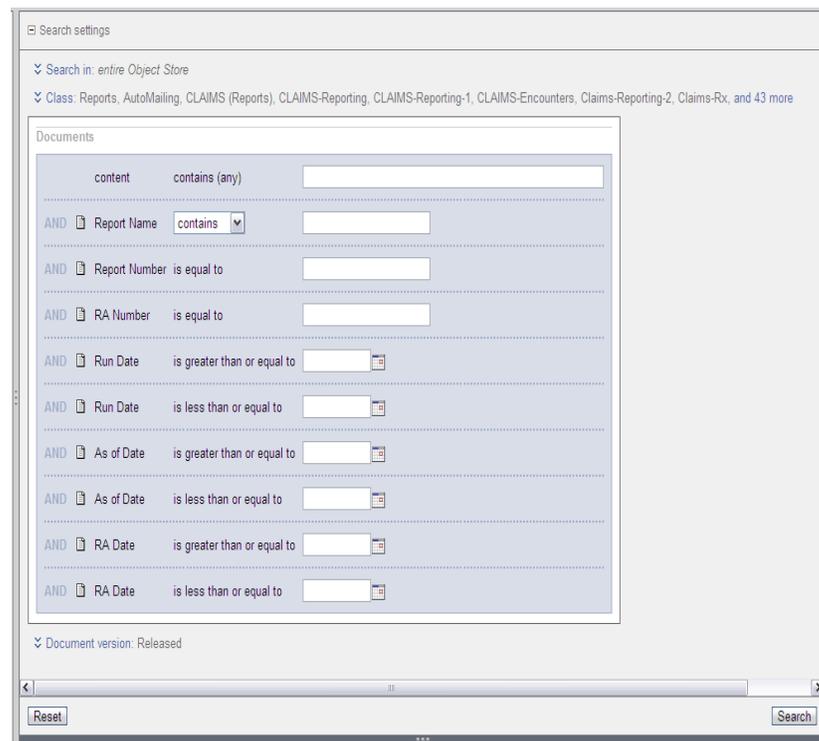
5.8.3 Searching for PES Reports

PES performs research and update functions for provider files from MMIS generated reports that are uploaded into ECM on a monthly basis. Those reports include PS-O-141 Sanction Provider Report and PS-O-130 Provider End of Month Report.

1. Click on the Report Search listed under VATESTOS→All Searches



2. This screen shows the available fields that can be used to search for MMIS reports.



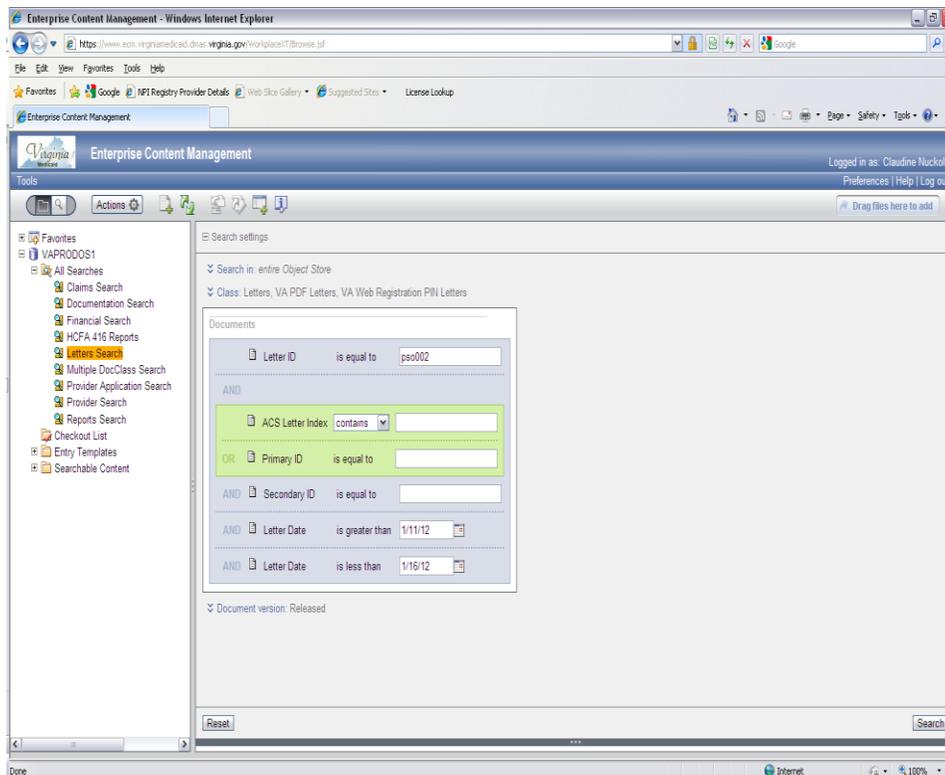
3. Enter the search parameters and click on Search button

4. This screen shows the results of searching for reports with “Daily” in the Report Name.

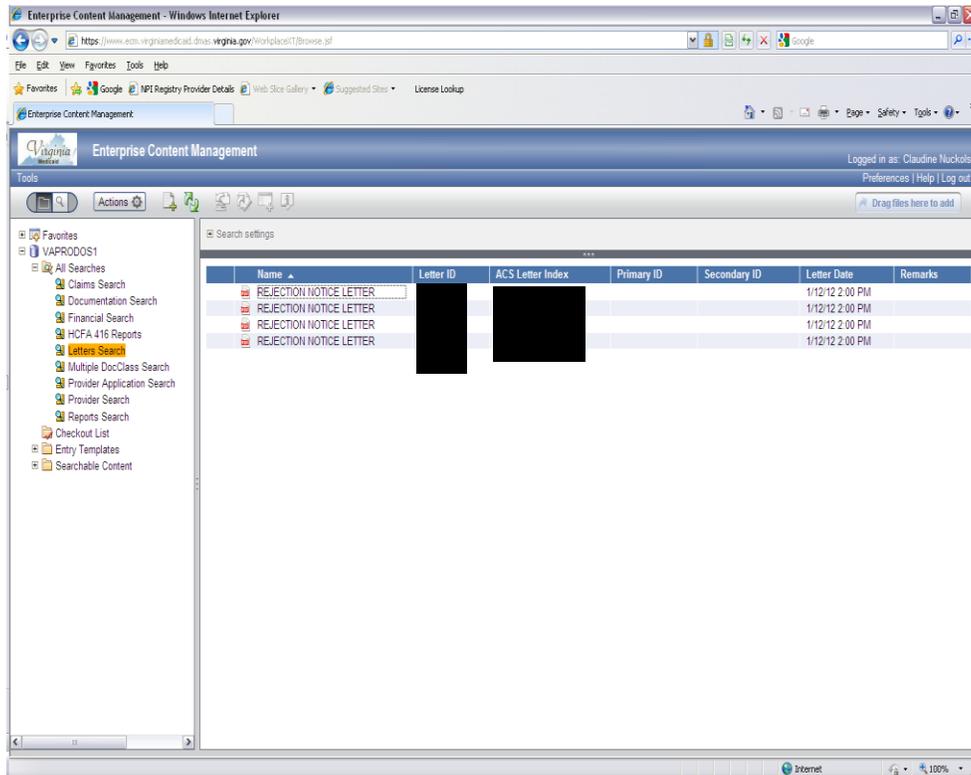
5.8.4 Searching for MMIS Rejection Letters in ECM

MMIS generates Rejection letters for applications that were rejected through Application Tracking.

1. From the ECM homepage click on VAPRODOS1
2. Select All Searches
3. Select Letters Search
4. Type in Letter ID PSO002 and select desired date range.



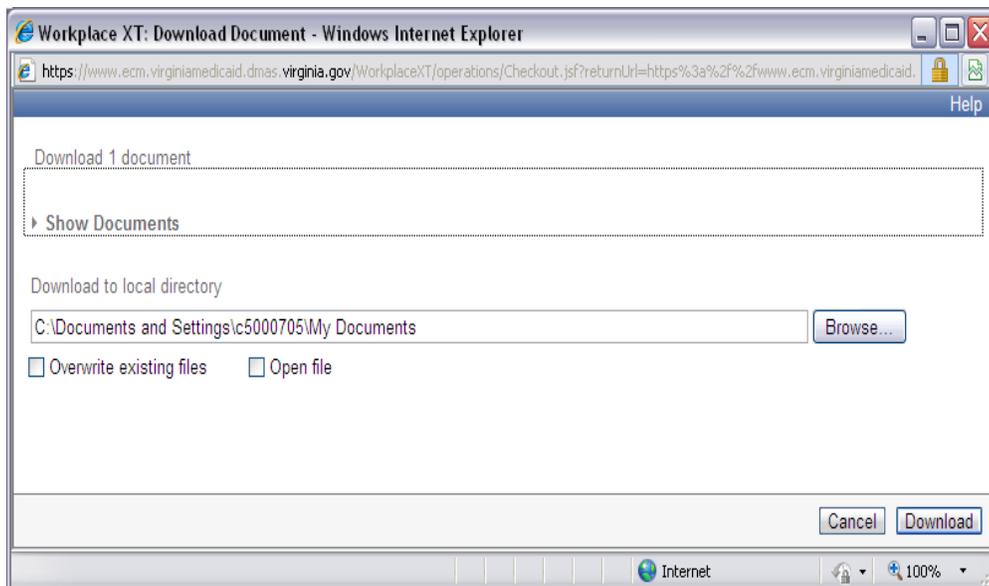
5. All MMIS generated Rejection letters from the dates selected will appear:



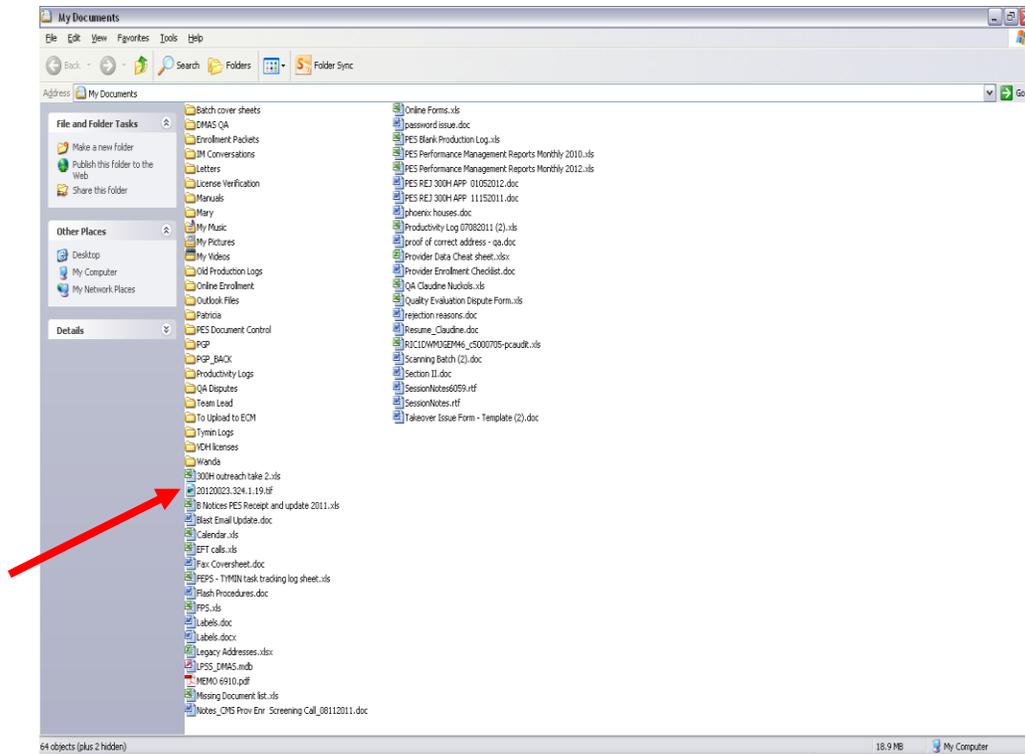
5.8.5 Manually Uploading Documents to ECM

1. PES will perform this procedure following License, LEIE and NPI verification in 4.1.3 – 4.1.7 and following Maintenance requests for multiple providers submitted on one document.
2. The document for upload must first be saved to the PES Specialists computer. For License, LEIE and NPI verifications:
 - a. Open Microsoft Word
 - b. Take a print screen of the License verification, etc. by pressing the 'Alt' key and the 'Print Screen/Sys Sq.' key at the same time.
 - c. Paste the image into the Word document by right-clicking on the mouse and selecting Paste.
 - d. Save the file to your documents.
3. For Documents that must be imaged under multiple Provider Numbers you can scan a copy of the document on the Cannon Printers
 - A. Sign in to the Printer by pressing the Right arrow at the top of the LCD screen
 - B. enter your WINID and 'email' password (the Shift key provides capital letters and characters). The domain should always be 'Americas'

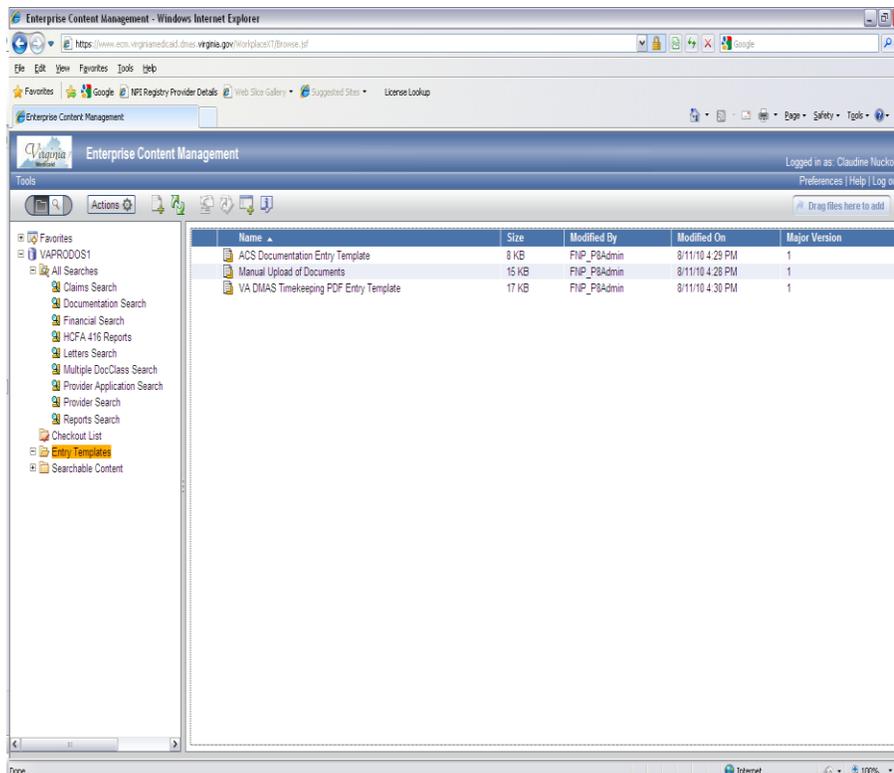
- C. press Login.
 - D. Place your documents of the scanning tray. Verify your email address. You may change the subject/body of the email if you choose.
 - E. Press the green button 'Send' to send the documents to your email. A filename will automatically be generated.
 - F. Make sure to Log Off before you walk away from the printer.
 - G. Save a copy of the emailed document to your computer.
4. For Documents that have already been indexed in ECM once but must be indexed under multiple provider numbers:
- a. Right click on the document
 - b. Select Download



- c. The document gets saved under the DCN number:

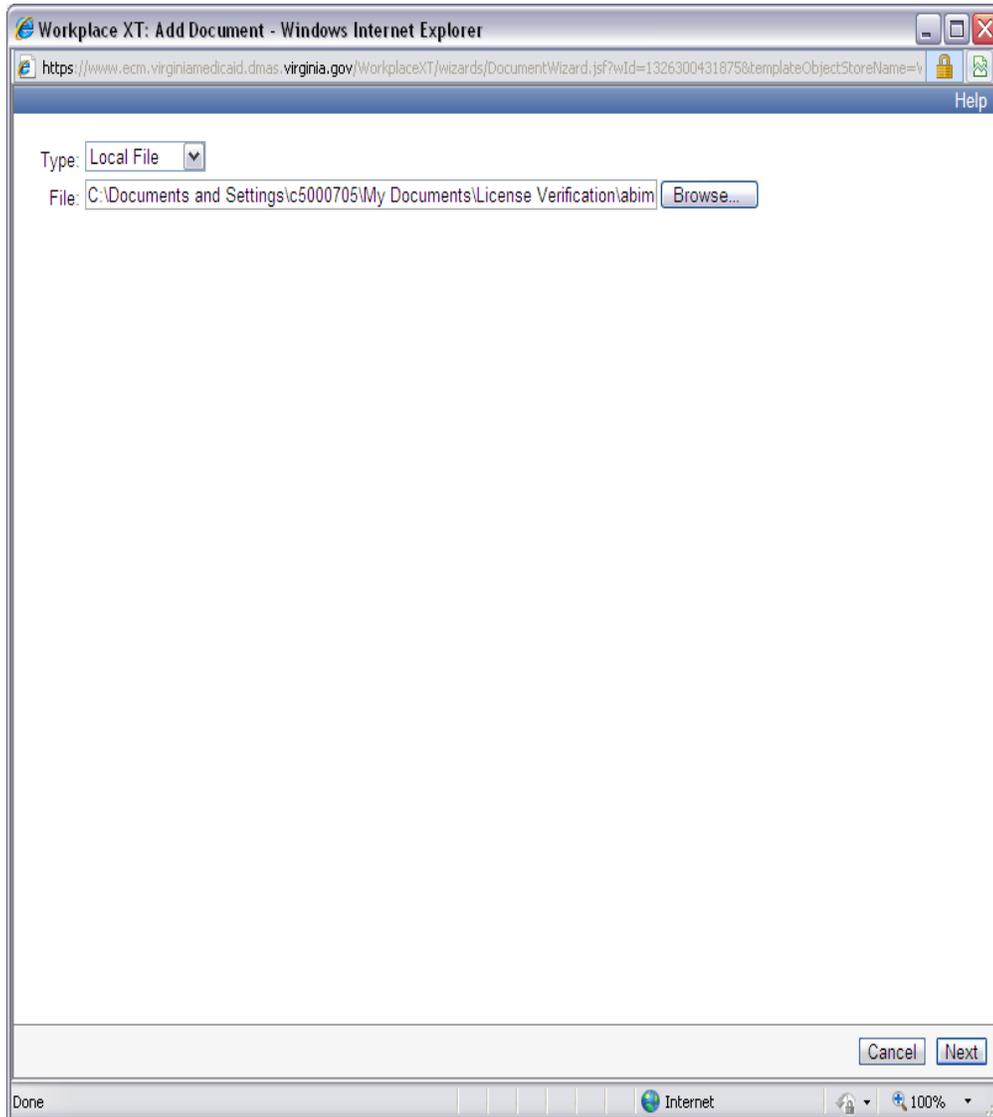


5. Uploading the documents to ECM by selecting Entry Templates from the ECM Main Menu. This screen will appear:



6. Double click on Manual Upload of Documents
7. Locate the desired file from your documents by selecting the Browse button.

8. Select Next.



9. Complete all of the fields. You can change Document Title to reflect what the document is, for example: Maintenance, License Verification, Enrollment Application, etc.

10. Select Add and OK.

5.8.6 ECM SHORTCUTS

Advanced Search vs. Search Templates: The majority of searches can be completed using Search Templates; however, in some cases it is much more effective to use the Advanced Search capability. (Detailed course material is available on this topic)

Search Priority: The order of performing searches should be from the most effective to least effective.

For example:

1. Most effective is “is equal to” or an exact match.
2. Next most effective is a “date range” or “greater than/less than” fields.
3. Least effective is the “wildcard” search such as “contains” or “starts with and ends with”.

Specifics:

1. “██████ Letter Index”*, “Primary ID”** and “Secondary ID” Letter Fields: The value of these two fields is different depending on which “Letter ID” is being queried.
 - a. = ██████ Letter Index field is used for letters entered after 06/27/2010
 - b. ** = “Primary ID” field is used for letters entered before 06/27/2010
2. The Power of a DCN or ICN Based Search: These two fields are unique because they utilize an “Input Type” and “Media Code”.
 - a. When using a DCN to search the input type equates to:

A. “U”; Origin is Manual Upload	“X”; Origin is Print Facility/██████
B. “H”; Origin is Hummingbird	“S”; Origin is Scan/Paper
C. “F”; Origin is Fax	“C”; Origin is CMOD
D. “W”; Origin is Web Portal	“R”; Origin is Reports
██████ “O”; Origin is ██████	
 - b. When using an ICN to search the Media Code equates to:

A. “A”; Origin is Scanner A (to search, “A” should be replaced with a “3”)
B. “B”; Origin is Scanner B (to search, “B” should be replaced with a “4”)
3. **Leading Zeros:** When any Integer search field is being used to retrieve content, leading zeros are not allowed. (A comprehensive table of these Integer fields is available)
4. **Letters Search:** When searching for letters do not include dashes in the Letter ID.
5. **Reports Search:** When searching for reports, do include dashes in the Report Number.
6. **“Class” Distinction:** When performing an advanced search, all documents are sorted by “Class” such as “Claims”, “Financial”, or “Letters”.
 - a. “VA PDF Checks” houses all First Health and ██████ checks
 - b. “VA PDF Letters” houses all First Health letters prior to 06/28/10
 - c. “Letters” houses all ██████ letters since 06/28/10 forward

5.9 Miscellaneous Correspondence

Periodically PES will receive correspondence that does not fit within one of the categories listed above. Specialist will follow the following procedures when responding to any correspondence.

Procedures:

1. PES Specialist receives Miscellaneous Correspondence through the FileNet workflow which will consist of Medicaid Member Inquiries or updates, DentaQuest (Dental Provider's) Inquiries, and Provider Claim Inquiries are considered miscellaneous correspondence.
2. PES Specialist will route Medicaid Member inquiries and updates to DMAS work queue.
3. PES Specialist will print and mail DentaQuest Inquiries to DentaQuest and document action taken in FileNet.
4. PES Specialist will route Provider Claim Inquiries to DMAS queue.

6. Primary Physician Care Incentive Program Attestation Form Procedures

PPC

This document outlines the procedures for a provider who submits Certification and Attestation for Primary Care Rate Increase Forms.

6.1 Attestation Form Screening

1. In order for PES to process Attestation forms there must be a Provider Name, NPI Number, options checked and Provider Signature.
2. Provider Name, Provider NPI Number, Attestation checked and Signature on Form?
3. Yes and form submitted is FFS Attestation form, Proceed to Step 7.1.2 Approved Attestation Information on provider file.
4. Yes and form submitted is MCO attestation form, Proceed to Step 7.1.6 Referral Process to DMAS
5. No, if any or all information is incomplete proceed to Step 7.1.6 Provider Submits Incomplete Attestation Form?

6.2 Approved Attestation Forms

Procedures:

From the VA MMIS Main System Menu:

1. Choose the Provider icon.
2. The Provider Main Menu screen (PS-S-000) will be displayed.
3. Select Provider Information from the drop-down menu in the Selection field.
4. Select the Change radio button in the Function field.
5. Key NPI ID Value field.
6. Select Enter.

7. The Provider Billing Information Update Screen is displayed PS-S-001-01 –No information is updated on this screen
Article I.

- Article II.
8. Hit Next Button
9. The Provider Billing Information Update PS-S-001-02 Screen is displayed- No information is updated on this screen

10. Hit Next Button
11. The Provider Location Information Update Screen is displayed PS-S-001-03

12. Review Provider Program Information

13. If provider enrolled in Program 10 only, put aside until end of day then follow Referral to DMAS process section 6.7

14. If provider enrolled as a Group, place in Incomplete bin and at end of day follow Section 6.3 Provider submits Incomplete or Group Attestation.

a) How to determine if provider is a Group:

(1) Name would be an organization name not individual name

(2) NPI would be indicated as a Group in Agreement Indicator field with a "G"

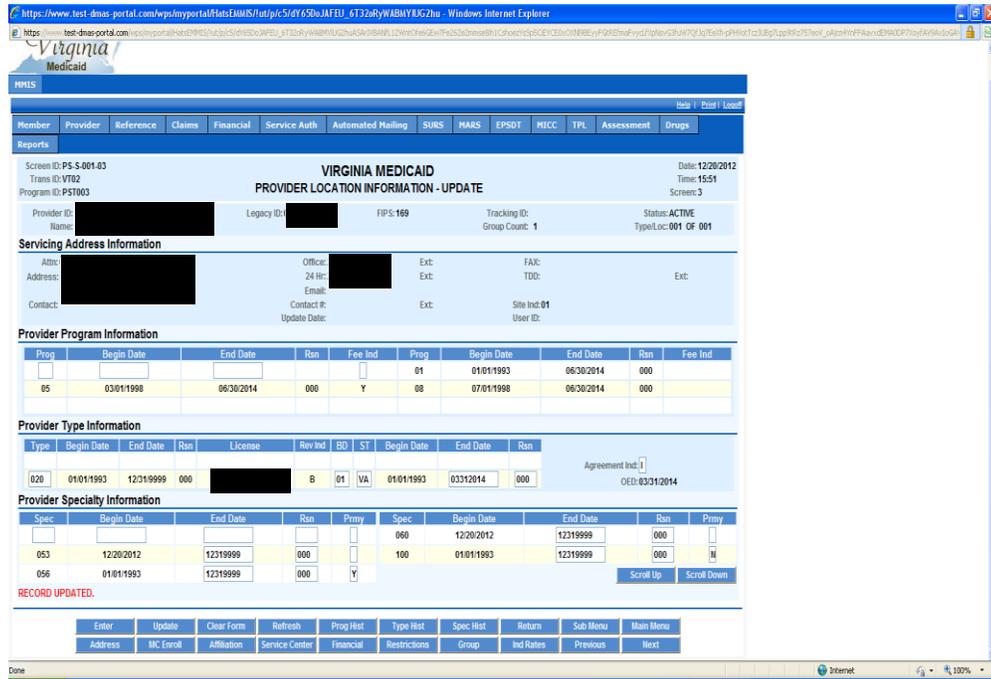
The screenshot shows the 'VIRGINIA MEDICAID PROVIDER LOCATION INFORMATION - INQUIRY' screen. Key fields include: Provider ID, Legacy ID (FIPS 065), Tracking ID, Status (ACTIVE), and Type Loc (01 OF 001). The 'Servicing Address Information' section includes fields for Name, Address, Contact, Office, 24 Hr, Email, Contact #, Update Date, Ext, Fax, TDD, and Site Ind (01). The 'Provider Program Information' table has columns for Prog, Begin Date, End Date, Ran, Fee Ind, and Prog. The 'Provider Type Information' table has columns for Type, Begin Date, End Date, Ran, License, Res Ind, SD, ST, Begin Date, End Date, Ran, and Agreement Ind (G). The 'Provider Specialty Information' table has columns for Spec, Begin Date, End Date, Ran, Primary, Spec, Begin Date, End Date, Ran, and Primary. A red arrow points to the 'Agreement Ind G' field in the 'Provider Type Information' table.

15. All others please Enter Specialty appropriate for option checked:

- First Check Box - Board Certified Physicians – Specialty Code 121
- Second Check Box- Non-Board Certified Physicians – Specialty Code 122
- If both boxes are checked – Add both specialties 121 and 122
- If duplicate attestation received and additional box is checked -Add specialty not previously checked.

16. Effective date – Enter the date document received

- a) For Mail there will be a stamped date on form
 - b) For Fax received date will be located on the bottom or top of the fax
17. End Date Field- Do not enter anything this will be defaulted to 12319999.
 18. Reason code field – Do not enter anything this will be defaulted to “000”.
 19. PRMY Code Field – Do not enter anything. This will be defaulted to “N”



20. Select **Enter**. By selecting enter the system will run through any possible edits/errors that may occur.
21. If no edits/errors occur the bottom of your screen will say “Data passes all edits”.
22. Select **Update**. Record has been inserted. You will not need to update anything else on the provider file.
23. Once all attestation forms in your batch are complete please set aside until the end of the day. They will be placed in an “Approved” Bin located in PES printer area.
24. If an error message “Provider Type/specialty code does not match” appears on the bottom of the screen, put attestation form aside for referral to DMAS. Please see Referral Process to DMAS section 6.7

6.3 Provider Submits Incomplete or Group Attestation

PES will not be sending back incomplete applications. PES will call provider to request complete attestation form be submitted. This phone call will be documented in [REDACTED] for future reference if needed.

6.4 Outgoing Call and [REDACTED] Procedures

Script to be followed:

Article III. This script is intended as a guide for your phone call, not to be read verbatim. Please familiarize yourself with the script prior to placing the first call. This way the information is delivered with confidence and, of course, professionalism. 😊

Article IV.

Article V. “LIVE CONVERSATION” SCRIPT

Article VI.

1. Good morning/afternoon. May I speak with <Mr./Ms./Dr. _____>? (Ask for contact person listed on the attestation form.)

1.1.1.1 This is <CSR Name> calling from Virginia Medicaid. We have received and incomplete Primary Care Rate Increase Form submitted.

The following information was incomplete, inaccurate or completed for the Group.
(Please choose correct option)

1.1.1.2 Provider Name and/or NPI Missing?

In order for us to approve your Attestation we must have Provider Name and NPI.

Option not checked?

In order for us to approve your Attestation you must check one of the selections that meet the requirements in the final federal rule to receive the increased payment for the designated primary care services. Please complete another form and resubmit to PES at the following toll free fax or address below.

Group information completed on attestation?

In order for us to approve your Attestation you must complete an Attestation for each qualifying Physician that meet the requirements in the final federal rule to receive the increased payment for the designated primary care services.

Please complete another form and resubmit to PES at the following toll free fax or address below

2. If you still have a copy of the form submitted, please insert the missing information on the form and you can fax or mail the forms to:

FAX: Toll free 888-335-8476 (Fax)

OR

MAIL: Provider Enrollment Services
PO Box 23803
Richmond, VA 23261-6803

3. If you do not have a copy you may get a form online at <https://www.viriniamedicaid.dmas.virginia.gov>. Do you have access to the web? I can show you where the form is. Once you are on the web site, click on Provider Services on the blue bar across the top of the page. Click on Provider Forms Search. If you type the word Physician Primary Care Attestation form

Article VII. "VOICEMAIL" SCRIPT
Article VIII.

Article IX. Direct Line or General Office Voicemail

Article X.

Article XI. This is <CSR Name> calling from Virginia Medicaid. We have recently received a Certification and Attestation form from you attesting that you meet the requirements in the final federal rule to receive the increased payment for the designated primary care services. Our records indicate that this form was incomplete. Please resend that information to Provider Enrollment Services at toll free fax 1-888-335-8476.

6.5 Creating Record for Outgoing Calls

1. From Dashboard click Tasks
2. From Tasks Log Correspondence
3. Log Correspondence "New"
 - a. There are several fields that you must complete for this  Record and they are as follows:
 - b. Entity Type ID- Provider
 - c. Entity ID Type- Medicaid

- d. Source- Phone-Outbound
 - e. Category – PES
 - f. Subject- PPC-Incomplete Attestation or PPC Group Attestation submitted
 - g. Priority – Low
 - h. Status – Closed
 - i. Open date –Current date and time
4. In order to log a correspondence for an already existing provider API/NPI you must enter search criteria to begin by clicking on the “*” icon.
- a. The Entity Selection screen will be displayed.
 - 
 - b. You will be able to search by Entity Type, Entity Id (API/NPI), SSN, EIN, Last Name, and First Name.
 - A. Example: Entity Type- Un-enrolled Provider
 - B. Last Name- Norton
 - c. Select entity to start your correspondence.
 - d. Click search
5. Maintain Correspondence screen will be displayed and you may begin logging your new correspondence.
- a. Entity Type ID- Provider
 - b. Entity ID Type- Medicaid
 - c. Source- Outbound Phone
 - d. Category – PES
 - e. Subject- PCP-Incomplete Attestation or PPC Group Attestation Completed
 - f. Priority – Low
 - g. Status – Closed
 - h. Open date –Defaulted to current date and time
 - i. Contact Name – Name of person you spoke with
 - j. Contact Number – Telephone number called

6. Text field- The following are options to place in the text field by using the cut and paste option. This will ensure that [REDACTED] documentation is consistent
- A. Incomplete attestation form contact made with Designated Contact or other member of Provider office.
 - I spoke with:
 - I let them know that they were missing the following on their attestation form:
 - Gave them toll free fax number and asked them to resubmit:
 - Any further comments:
- B. Incomplete attestation form Voice Mail left
 - Name on Voicemail:
 - Let them know the following was missing from their original attestation submission:
 - Gave them toll free fax number and asked them to resubmit:
 - Any further comments:
7. When information regarding correspondence is entered click

8. Click "Yes" to save changes
9. When outbound call and Omnitrack complete set aside until end of day when you will follow end of day procedures section 4.0.

6.6 [REDACTED] Documentation – Source- Phone-Outbound

- Category- PES
- Subject-
 - PPC - Incomplete Attestation or PPC Group Attestation Completed
- Status-Open (leave status open do not close until documentation comes in or rejected)
- [REDACTED] Text- Reason for Pend i.e. Provider Name, NPI, appropriate attestation missing, or signature missing.
- Contact- Person Spoke with or left message

Article XII.

Article XIII.

Article XIV.

Article XV.

Article XVI.

Article XVII.

Article XVIII.

Article XIX.

6.7 Referral Process to DMAS

PES will inter-office DMAS daily all attestation forms that are Program 10 MCO Only providers or providers who do not qualify. There will be Inner Office envelopes available near the PES printer and they can be placed in outgoing PES bin in the copier room located at the main entrance.

- MCO Attestation forms ONLY- Please place in Inner Office envelope at end of day to
Healthcare Services Attn: Jill Gambosh
- Providers whose Provider Type/specialty do not match and MCO Program 10 only providers that submitted a FFS Attestation form – Please place in Inner Office Envelope to
DMAS – 12th Fl. Attn: Darryl Hellams

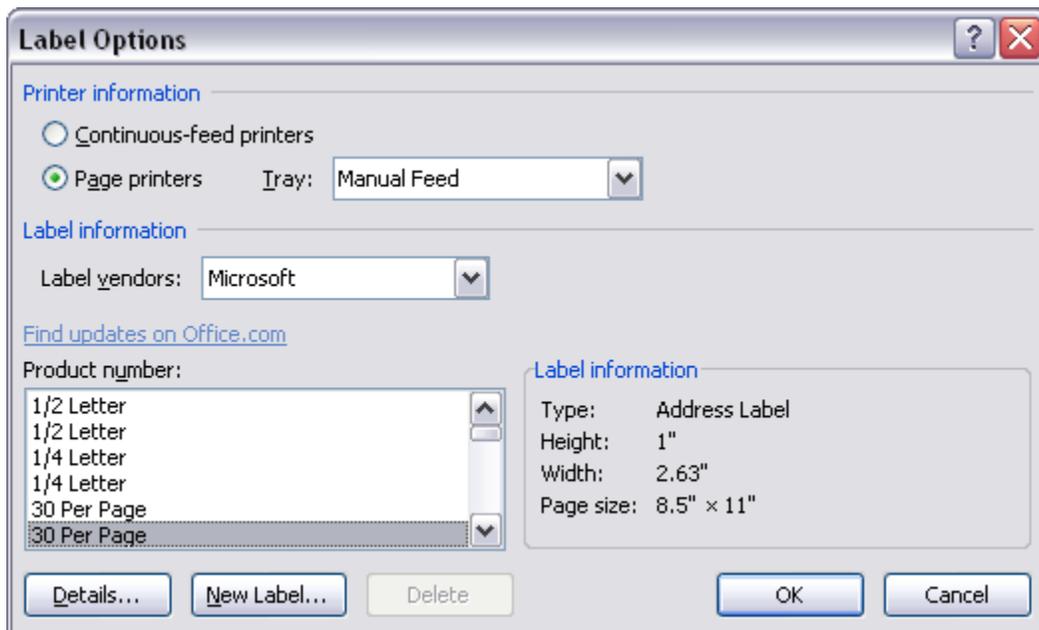
7. Quality Assurance (QA) of Outgoing Mail

PES Specialists will review all outgoing documents, including Approval Letters and Rejections letters for proper spelling and grammar. This is not verification that the work was processed correctly but rather a verification that we are not sending out any improper documentation.

1. Rejection letters:
 - a. Verify the Provider Name and Address are spelled correctly.
 - b. Check the body of the letter for any grammatical or formatting errors.
 - c. Verify that all paperwork within the packet belongs to that provider and no additional documentation has been mixed together during processing. (If there

are no names or NPI numbers to confirm, you can verify by checking the handwriting, DCN numbers, fax markings, etc.) If there is a question about whether or not the paperwork belongs together, refer it to the PES Team Lead or Manager.

- d. Using Microsoft Word create a mailing label
 - A. Open Microsoft Word.
 - B. Select the Mailings tab and Create Labels
 - C. Select Options in the Labels window
 - D. Select Product Number: 30 per page Type: Address Label Height: 1" Width: 2.63" Page Size: 8.5" x 11". Word will save this as the default setting for Labels until you manually change it again.



- E. Select New Document
- e. If there is an error on the letter, give it back to the PES Specialist who created it to be corrected.
2. Approval Letters
 - a. Verify the Provider's Name and Address are correct.
 - b. Verify the NPI numbers are correct
 - c. Verify the Affiliation and/or Begin date are correct.
 - d. Fold and Place in windowed envelope for mailing unless there is an error, in which case, give it back to the PES Specialist who created it to be corrected.
 3. Metering Mail
 - a. All mail needs to be batched with a Metered Mail Department Cover Sheet which can be found in the PES Document Control area. See the Account List for Postage Meter for the appropriate Meter code.
 - A. Commonly used codes are as follows:

Code	Abbreviation	Type of Mail
6	PES/APPR LTRS	PES Approval Letters
7	PES/REJ LTRS	PES Rejection Letters
8	PES/ENROLL APP REQUEST	PES Enrollment Application
9	PES/DUPLICATE 1099	PES Duplicate 1099 Request
10	PES/APPR PART AGREEMENT	PES Copy of Approved Part Agreement
11	PES/RTRN MAIL LTRS	PES Return Mail Letters

- b. Place the packet in the designated cubby hole in the Supply room to be metered and mailed by the Mail Room Staff.

8.

Procedures

Requests for information from DMAS or from the Call Center will come in using the communication tracking system called [REDACTED]. Also EFT Rejects will be recorded using the [REDACTED] system, so that communications with providers or other payees regarding their EFTs can be recorded and accesses by PES or another unit.

8.1 Accessing [REDACTED]

Procedures:

1. Enter your [REDACTED] login ID and password in the [REDACTED] login screen and click <OK>

Figure 1: [REDACTED] Login Screen

2. The user's dashboard will be displayed.
3. When the user first logs into [REDACTED], a blank frame will appear or a list of Communication Records (CR) that were not closed by the user or Work Unit.
4. The dashboard window has several buttons on the toolbar. For each button, there is an option on the pull down menus. From the toolbars and pull down menus on this screen, the user can create new Communication Records, search for Communication Records, retrieve on-line help, create reports and print screens.

Figure 2:  Dashboard

8.2 Creating Communication Records (CRs)

A Communication Record (CR) is comprised of all information pertaining to a single Communication.

This includes not only information about the Communication itself, but any research that was performed for the communication, as well as all responses to the communication.

1. Upon exiting the CR, the associate will be prompted to save the communication record.
2. If the associate fails to save the record, the documentation will not be stored and must be re-created.
3. Each new CR is assigned a unique Communication Record Number (CRN) and is tracked from receipt through resolution.
4. Responses, whether formal or informal, are tracked along with the original communication record.

8.3 Create a Communication Record

Procedures:

10. From Dashboard click Tasks
11. From Tasks Log Correspondence
12. Log Correspondence "New"
13. There are several fields that are defaulted but can be updated there are as follows
 - a. Entity Type ID- Provider
 - b. Entity ID Type- Medicaid
 - c. Source- Phone
 - d. Priority – Medium
 - e. Status – Open
 - f. Open date –Current date and time

14. In order to log a correspondence for an already existing provider API/NPI you must enter search criteria to begin by clicking on the  icon.

a. The Entity Selection screen will be displayed.



b. You will be able to search by Entity Type, Entity Id (API/NPI), SSN, EIN, Last Name, and First Name.

A. Example: Entity Type- Un-enrolled Provider

B. Last Name- Norton

c. Select entity to start your correspondence.

d. Click search

15. Maintain Correspondence screen will be displayed and you may begin logging your new correspondence.

16. Category, Subject Fields, Priority, Contact and Status are mandatory fields.

17. Text Field is free form.

18. When information regarding correspondence is entered click



19. Click "Yes" to save changes

8.3.1 Create Manual Letter and Referral Sheet through



PES will generate Manual letters and Referral sheets for Approval, Inquiries, Rejection, and SID letters for providers related enrollment issues.

Procedures:

1. Follow steps in 8.2.1 to Log Correspondence Record.
2. In Text field indicate Approval Letter, Referral Reason Detailed Explanation, or Rejection Letter with reasons indicated.
3. Category drop down choose PES Letters.
4. Subject drop down choose approval or rejection as appropriate.
5. Click on the Response Tab
6. Click plus in left corner, response to provider options will be displayed

(1)

7. Click on Source

8. From drop down menu choose written
9. From template field choose appropriate response for PES Manual Letter generation or Referral.
10. Click Create Document Icon on menu bar
11. Manual letter or PES Referral Sheet will be displayed
12. Complete letter or referral
13. Print and Save Manual Letter to be attached to rejected Enrollment Application or Documentation or route/transfer Referral Sheet to PES Specialist, PES Team Lead, PES Manager, or other Virginia Operations area for review. (see section 8.2.3 Routing and Transfer [REDACTED] for Referral)
14. Close CR Record and save changes

8.4 Routing and Transfer through [REDACTED] for Referral.

1. Follow steps to Log correspondence.
2. Category field: Choose description that best describes type of transfer
3. Subject field: Choose subject that best describes type of transfer
4. Status: Transferred
5. Text Field: Enter any additional transfer information
6. Click Routing tab button
7. Assigned to drop down: choose person you wish to transfer or referral to.
8. Close the CR
9. Click yes to save record
10. Record will display on assigned transfer party dashboard

9. Appendices and Supporting Documentation

9.1 Abbreviations and FIPS

FIPS	State	Abbreviation
901	Alabama	AL
902	Alaska	AK
903	Arizona	AZ
904	Arkansas	AR
905	California	CA
906	Colorado	CO
907	Connecticut	CT
908	Delaware	DE
909	District of Columbia	DC
910	Florida	FL
911	Georgia	GA
912	Hawaii	HI
913	Idaho	ID
914	Illinois	IL
915	Indiana	IN
916	Iowa	IA
917	Kansas	KS
918	Kentucky	KY
919	Louisiana	LA
920	Maine	ME
921	Maryland	MD
922	Massachusetts	MA
923	Michigan	MI
924	Minnesota	MN
925	Mississippi	MS
926	Missouri	MO
927	Montana	MT
928	Nebraska	NE

929	Nevada	NV
930	New Hampshire	NH
931	New Jersey	NJ
932	New Mexico	NM
933	New York	NY
934	North Carolina	NC
935	North Dakota	ND
936	Ohio	OH
937	Oklahoma	OK
938	Oregon	OR
939	Pennsylvania	PA
940	Puerto Rico	PR
941	Rhode Island	RI
942	South Carolina	SC
943	South Dakota	SD
944	Tennessee	TN
945	Texas	TX
946	Utah	UT
947	Vermont	VT
950	Washington	WA
951	West Virginia	WV
952	Wisconsin	WI
953	Wyoming	WY

9.2 Reason Code List / Missing Information

Code	Reason
001	CMS SANCTION
002	OUT OF BUSINESS OR RETIRED
003	NEW PROVIDER NUMBER
004	CHANGED SPECIALTY
005	DEATH
006	PROVIDER REQUESTED
007	RETURNED MAIL UNABLE TO LOCATE
008	TERMINATED DUE TO INACTIVITY (MMIS)
009	PROVIDER DID NOT REENROLL (MMIS)
010	DMAS TERMINATION
011	POLICY CHANGE

012	INDEFINITE AGREEMENT NOT RECEIVED
013	LICENSE CERTIFICATION NOT RENEWED
014	INDEFINITE AGREEMENT NOT RECEIVED AND LICENSE CERTIFICATION NOT RENEWED
021	ADDITIONAL INFORMATION REQUIRED
022	NO SIGNATURE
023	NOT AN ORIGINAL CONTRACT
024	INCORRECT IRS NUMBER
028	NOT A VMAP AGREEMENT
029	NOT AN ENROLLABLE PROVIDER
037	NEW PROVIDER NUMBER DUE TO IRS NUMBER
038	SSN/TIN NUMBER MISSING
039	ORIGINAL SIGNATURE REQUIRED
040	NEED PROVIDER NUMBER FOR NEW LOCATION
041	DBHDS LICENSE EXPIRED
101	THREE YEAR RESIDENCY IN PSYCHIATRY IS REQUIRED IN ORDER TO ENROLL
102	SERVICING ADDRESS CAN NOT BE A PO BOX
103	INCORRECT AGREEMENT FORM FOR PROVIDER TYPE
104	A TELEPHONE NUMBER FOR SERVICING ADDRESS IS REQUIRED
105	CMS CERTIFICATION IS REQUIRED FOR SERVICING ADDRESS
106	CMS OR JCAHO ACCREDITATION MISSING
107	SPECIALTY MISSING ON PROVIDER APPLICATION
108	CLAIM(S) OR SUPPORTING DOCUMENTATION MUST BE SUPPLIED IN ORDER TO ENROLL
109	PROVIDER AGREEMENT/APPLICATION INCOMPLETE WHEN RECEIVED
110	HIPAA COMPLIANT PROVIDER AGREEMENT/APPLICATION NOT SUBMITTED
111	ALL CHANGES MUST HAVE DATE, PROVIDER NUMBER(S) AND SIGNATURE(S)
112	PROVIDER CAN ENROLL AS A QUALIFIED BENEFICIARY PROVIDER ONLY
114	CHIROPRACTOS MUST SUBMIT CLAIM(S) OR SUPPORTING DOCUMENTATION TO ENROLL
115	INTERN/RESIDENTS ARE NOT ABLE TO ENROLL
116	HIGHLIGHTED AREAS ON PARTICIPATION AGREEMENTS/APPLICATION TO BE COMPLETED
117	HIGHLIGHTED AREAS ON PARTICIPATION AGREEMENT/APPLICATION NEED TO BE CORRECTED
118	AN OPTICIANS LICENSE IS REQUIRED TO ENROLL AS AN OPTICAL CLINIC
119	A COPY OF THE DEPARTMENT OF SOCIAL SERVICES LICENSE IS REQUIRED

121	PLEASE CORRECT INDIVIDUAL NAME ON AGREEMENT FORM
122	BUSINESS LICENSE
123	VA BOARD OF PHARMACY OR NON-RESIDENT PERMIT
124	VA BOARD OF PHARMACY MEDICAL EQUIPMENT SUPPLY OR NON-RESIDENT PERMIT
126	A VDH(DOH) CENTER FOR QUALITY HEALTH ACCREDITATION PROGRAM PERMIT
128	A CHAP-COMMUNITY HEALTH ACCREDITATION OF REHAB FACILITIES LICENSE
129	A CARF-COMMISSION ON ACCREDITATION OF REHAB FACILITIES LICENSE
130	COUNCIL ON ACCREDITATION OF SERVICES FOR FAMILIES AND CHILDREN LICENSE
132	SERVICES NEED TO BE MARKED OFF CORRECTLY ON PARTICIPATION AGREEMENT
133	SERVICES MARKED OFF ON PARTICIPATION DO NOT MATCH LICENSE
134	UNABLE TO VERIFY LICENSE
135	NURSE PRACTITIONER SPECIALTY ONLY ABLE TO ENROLL AS A QMB PROVIDER
136	CARE COORDINATION- COPY OF RN LICENSE, M.S.W., OR B.S.W. LICENSE
137	NUTRITIONAL SERVICES-REGISTERED DIETICIANS REGISTRATION
138	PATIENT EDUCATION SERVICES-INTERNATIONAL CHILDBIRTH EDUCATORS ASSOCIATION
139	PATIENT EDUCATION SERVICES-RICHMOND CHILDBIRTH EDUCATORS ASSOCIATION
141	PATIENT EDUCATION SERVICES-AMERICAN RED CROSS
142	HOMEMAKES SERVICES-RN, LPN
143	HIGHLIGHTED AREAS ON CBC APPLICATION NEED TO BE CORRECTED OR COMPLETED
144	EMS CERTIFICATION REQUIRED
145	NPI ID Missing
146	FEIN REQUIRES FORMATION OF BILLING GROUP
147	Reassignment of Benefits Form is missing
148	Electronic Funds Transfer application is required to be completed.
149	Submission of Claims application is required to be completed.
C00	LETTER INFORMATION INCLUDED

9.3 Provider Rate Types and Rate Codes by Provider

Provider Type Number	Provider Type	Rate Type	Rate Code	Rate Description	Rate Setting Entity
001	Hospital, In-State, General Acute Care	DRG	DRGF	DRG Factor	DMAS
		DRG	HCAS	Hospital Specific Operating Case Rate	
		DRG	OADJ	Outlier Adjustment Factor	
		DRG	OCCR	Operating Cost to Charge Ratio	
		DRG	OLAB	Outlier Non-Labor Component	
		DRG	ONLB	Outlier Non-Labor Component	
		DRG	OPVH	Outlier Private Hospital	
		DRG	OTHS	Outlier Threshold	
		DRG	PCPX	Acute/Psychiatric Capital Percentage	
		DRG	POPD	Psychiatric Operating Per Diem	
		DRG	WAGI	Wage Index	
		PD	NICU	Neonatal Hospital Per Diem	
		PD	RH	Regular Hospital Per Diem	
		PDA	DSNI	Disproportionate Share-Neonatal Intensive Care Unit (NICU)	
		PDA	DSRH	Disproportionate Share-Regular Hospital (RH)	
		EAPG	OUTP	Enhanced Ambulatory Patient Groups Base Rate	
002	State Mental Hospital (Aged)	PD	RH	Regular Hospital Per Diem	Myers and Stauffer
		PDA	DSRH	Disproportionate Share-Regular Hospital (RH)	
003	Private Mental Hospital (Inpatient Psych)	PD	EPSY	EPSDT Psychiatric	DMAS
		PD	RH	Regular Hospital Per Diem	
004	Long Stay Hospital	PD	RH	Regular Hospital Per Diem	DMAS
		PDA	DSRH	Disproportionate Share-Regular Hospital (RH)	

Provider Type Number	Provider Type	Rate Type	Rate Code	Rate Description	Rate Setting Entity
005	TB Hospital	PD	RH	Regular Hospital Per Diem	Myers and Stauffer
006	Skilled Nursing Home Mental Health	PD	NF	Nursing Facility Per Diem	Myers and Stauffer
007	State Mental Hospital (Less Than Age 21)	PD	EPSY	EPSDT Psychiatric	Myers and Stauffer
		PD	RH	Regular Hospital Per Diem	
008	State Mental Hospital (Med-Surg)	PD	RH	Regular Hospital Per Diem	Myers and Stauffer
		PDA	DSRH	Disproportionate Share-Regular Hospital (RH)	
009	Medical Surgery-Mentally Retarded	PD	RH	Regular Hospital Per Diem	Myers and Stauffer
		PDA	DSRH	Disproportionate Share-Regular Hospital (RH)	
010	Skilled Nursing Home Non Mental Health	PD	AIDS	AIDS Specialized Care – <i>Requires DMAS LTC approval</i>	DMAS – <i>Prior to 11/01/2014 Myers and Stauffer</i>
		PD	COMP	Complex Specialized Care– <i>Requires DMAS LTC approval</i>	
		PD	PIRS	PIRS Per Diem-Nursing Facility (NF)	
		PD	RHAB	Rehabilitation Specialized Care– <i>Requires DMAS LTC approval</i>	
		PD	RUGS	RUGS Per Diem-Nursing Home (NH)	
		PD	VENT	Ventilator Specialized Care– <i>Requires DMAS LTC approval</i>	
		PDA	PRRM	Private Room Differential – <i>Requires DMAS LTC approval</i>	
		PDI	NTCP	NATCEP	
		RUG	DRCT	Direct Rate	
		RUG	CMRC	Criminal Medical Record Check	
		RUG	PLNT	Plant Rate	
		RUG	NTCP	Nurse Aid Training and Competency Evaluation Program	
		RUG	INDT	Indirect Rate	

Provider Type Number	Provider Type	Rate Type	Rate Code	Rate Description	Rate Setting Entity
011	Skilled Nursing Facility-Mentally Retarded	PD	NF	Nursing Facility Per Diem	Myers and Stauffer
012	Long Stay Inpatient Hospital-Mental Health	PD	RH	Regular Hospital Per Diem	Myers and Stauffer
		PDA	DSRH	Disproportionate Share-Regular Hospital (RH)	
013	Med-Surg Mental Health Retardation	PD	RH	Regular Hospital Per Diem	DMAS
014	Rehab Hospital	DRG	RCPX	Rehabilitation Capital Percentage	DMAS
		DRG	ROPD	Rehabilitation Operating Per Diem	
		PD	RH	Regular Hospital Per Diem	
		PDA	DSRH	Disproportionate Share-Regular Hospital (RH)	
		EAPG	OUTP	Enhanced Ambulatory Patient Groups Base Rate	
015	Intermediate Care Facility	PD	AIDS	AIDS Specialized Care – <i>Requires DMAS LTC approval</i>	DMAS – Prior to 11/01/2014 Myers and Stauffer
		PD	COMP	Complex Specialized Care– <i>Requires DMAS LTC approval</i>	
		PD	PIRS	PIRS Per Diem-Nursing Facility (NF)	
		PD	RHAB	Rehabilitation Specialized Care– <i>Requires DMAS LTC approval</i>	
		PD	RUGS	RUGS Per Diem-Nursing Home (NH)	
		PD	VENT	Ventilator Specialized Care– <i>Requires DMAS LTC approval</i>	
		PDA	PRRM	Private Room Differential – <i>Requires DMAS LTC approval</i>	Differential
		PDI	NTCP	NATCEP	
		RUG	DRCT	Direct Rate	
		RUG	CMRC	Criminal Medical Record Check	
		RUG	PLNT	Plant Rate	
		RUG	NTCP	Nurse Aid Training and Competency Evaluation Program	

Provider Type Number	Provider Type	Rate Type	Rate Code	Rate Description	Rate Setting Entity
		RUG	INDT	Indirect Rate	
016	Intermediate Care Facility-Mental Health	PD	NF	Nursing Facility Per Diem	Myers and Stauffer
017	ICF-Mentally Retarded-State Owned	PD	NF	Nursing Facility Per Diem	Myers and Stauffer
018	ICF-Mentally Retarded-Community Owned	PD	NF	Nursing Facility Per Diem	Myers and Stauffer
019	CORF-(Outpatient Rehab Facility)	XO	OUTP	In-State Outpatient Percentage	DMAS
027	Christian Science SNF	PD	NF	Nursing Facility Per Diem	Myers and Stauffer
028	Skilled Nursing Facility-State	PD	NF	Nursing Facility Per Diem	Myers and Stauffer
029	Intermediate Care Facility	PD	NF	Nursing Facility Per Diem	Myers and Stauffer
051	Health Department Clinic	BA	MGTF	Managed Care Management Fee	DMAS
052	Federally Qualified Health Center (FQHC)	BA	CLVS	Cost Based Clinic	Myers and Stauffer
		BA	MGTF	Managed Care Management Fee	
053	Rural Health Clinic (RHC)	BA	CLVS	Cost Based Clinic	Myers and Stauffer
		BA	MGTF	Managed Care Management Fee	
077	Residential Treatment Facility	PD	RESN	Residential Per Diem	DMAS
086	Out-of-State Intermediate Care Facility	PD	NF	Nursing Facility Per Diem	DMAS
092	Out-of-State Skilled Care	PD	NF	Nursing Facility Per Diem	DMAS
104	PACE	PD	PC1	Dual Eligible FY rate based on location	DMAS
		PD	PC2	Non-Dual Eligible rate based on location	

9.4 Provider Program Code List

Code	Program
01	Medicaid
02	MEDALLION
04	Options
05	Client Medical Management (CMM)
06	TDO
07	SLH
08	FAMIS
10	Managed Care Only (DMAS enrolled) providers

9.5 Alpha Provider Type Listing

Provider Class Type	Provider Type	API/NPI	Group Enrollment
073	Adult Care Residence (ACR) Assessment and Case Management (no longer enrolled as of 06/30/2010)	NPI	No
079	Adult Care Residence (ACR) Assisted Living (no longer enrolled as of 06/30/2010)	API/NPI	No
048	Adult Day Health Care	API/NPI	No
073	AIDS Case Management (no longer enrolled as of 06/30/2012)	API/NPI	No
080, 083	Ambulance	NPI	No
049	Ambulatory Surgical Care	NPI	No
044	Audiologist	NPI	Yes
036	Baby Care	NPI	Yes
026	Chiropractor	NPI	Yes
034	Clinical Nurse Specialist	NPI	Yes
025	Clinical Psychologist- As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.	NPI	Yes
105	Certified Professional	NPI	Yes

Provider Class Type	Provider Type	API/NPI	Group Enrollment
	Midwife		
019	Comprehensive Outpatient Rehab Facility (CORF)	NPI	No
073	Consumer Directed Service Coordination	API/NPI	No-Type II entity, Yes-Type I individual
056	Developmental Disabled Waiver	See Appendix 7.9	No
062	Durable Medical Equipment	NPI	No
108	Early Intervention	API/NPI	No
073	Elderly Case Management	API/NPI	No
082, 084	Emergency Air Ambulance	NPI	No
061	Family and Caregiver Training	API/NPI	No
052	Federally Qualified Health Center (FQHC)	NPI	No
051	Health Department Clinic	NPI	No
059	Home Health Agency – Private	NPI	No
058	Home Health Agency – State	NPI	No
046	Hospice	NPI	No
003	Hospital – EPSDT Psychiatric Hospital	NPI	No
001	Hospital – In-state	NPI	No
014	Hospital – In-state Rehab	NPI	No
012	Hospital – Long Stay Inpatient Mental Health	NPI	No
004	Hospital – Long Stay Health	NPI	No
001, 091	Hospital (SLH)	NPI	No
002	Hospital – State Mental (Aged)	NPI	No
013	Hospital – Medical Surgery – Mental health Retardation	NPI	No
009	Hospital – Medical Surgery – Mental Retarded	NPI	No
091	Hospital – Out of State	NPI	No
085	Hospital – Out of State Rehab	NPI	No
007	Hospital (State Mental)	NPI	No
091	Hospital (Out of State)	NPI	No
001	Hospital (SLH)	NPI	No
005	Hospital – TB	NPI	No

Provider Class Type	Provider Type	API/NPI	Group Enrollment
070, 098	Laboratory	NPI	No
076	Licensed Clinical Social Worker (LCSW)- As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.	NPI	Yes
102	Licensed Marriage and Family Therapist (LMFT) - As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.	NPI	Yes
021	Licensed Professional Counselor (LPC) - As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.	NPI	Yes
101	Licensed School Psychologist- As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.	NPI	Yes
103	Licensed Substance Abuse Treatment Practitioner- As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.	NPI	Yes
056	Mental Health Mental Retardation and Substance Abuse Services	See Appendix 7.9	No
056	Mental Retardation Waiver- As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.(041, 042, 043, 045, 000)	See Appendix 7.9	No
107	MMIS Contractors and Vendors		No
023	Nurse Practitioner (NP)	NPI	Yes
015	Nursing Home Part 1	NPI	No
018, 006, 010, 011, 015, 016,	Nursing Home Part 2	NPI	No

Provider Class Type	Provider Type	API/NPI	Group Enrollment
017			
032	Optician	NPI	Yes
031	Optometrist	NPI	Yes
020,095	Outpatient Clinic	NPI	No
057	Outpatient Rehabilitation	NPI	No
055	Personal Care	API/NPI	No
104	PACE – Program for the All-inclusive Care of the Elderly	NPI	No
060	Pharmacy	NPI	No
020, 095	Physician	NPI	Yes
030	Podiatrist	NPI	Yes
063	Private Duty Nursing	NPI	No
064	Prosthetic / Orthotic	NPI	No
020, 095	Psychiatrist	NPI	Yes
099	Qualified Medicare Beneficiary (QMB) – Medicare Crossover	NPI	No-Type II entity, Yes-Type I individual
050	Renal Clinic	NPI	No
077	Residential Psychiatric Treatment	NPI	No
047	Respite Care	API/NPI	No
053	Rural Health Clinic (RHC)	NPI	No
072	Schools	NPI	No
007	State Mental (Less than Age 21)	NPI	No
008	State Mental (Medical Surgery)	NPI	No
071	Substance Abuse Clinic- As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.	NPI	No
073	Case Management for DD Waiver	API/NPI	No
106 & 073	106- Transition Coordinator 073 Spec. 117 – Transition Coordinator for the Children’s Mental Health Program	API/NPI	No
022	Treatment Foster Care Program- As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH	NPI	No

Provider Class Type	Provider Type	API/NPI	Group Enrollment
	SERVICES.		

9.6 Names of Health Departments

County/City	County/City	County/City	County/City
Amherst	Fauquier	Middlesex	Rockingham/Harrisonburg
Augusta/Staunton	Floyd	Montgomery	Russell
Appomattox	Fluvanna	Mount Rogers	Scott
Arlington	Franklin	Nelson	Shenandoah
Bath	Fredericksburg	New Kent	Smyth
Bedford	Giles	Newport News	Southampton
Bland	Galax	New River	Southside
Botetourt	Gloucester	Norfolk	Spotsylvania
Brunswick	Goochland	Northampton	Stafford
Bristol	Grayson	Northumberland	Suffolk
Buchanan	Greene	Nottoway	Surry
Buckingham	Greensville/Emporia	Orange	Sussex
Buena Vista	Hampton	Page	Tazewell
Campbell	Hanover	Patrick	Thomas Jefferson
Caroline	Henry/Martinsville	Peninsula	Three Rivers
Carroll	Henrico	Petersburg	Virginia Beach
Central Shenandoah	Highland	Piedmont	Warren
Central Virginia	Hopewell	Pittsylvania/Danville	Washington
Charles City	Isle of Wight	Portsmouth	Waynesboro
Chesapeake	James	Powhatan	West Piedmont
Chesterfield	King George	Prince Edward	Westmoreland
Children's Specialty	King and Queen	Prince George	Western Tidewater
Clark	King William	Prince William	Williamsburg
Clifton Forge	Lancaster	Pulaski	Winchester Child Development
Colonial Heights	Lee	Radford	Wise/Norton
Craig	Lenowisco	RAHD	Wythe
Crater Child Development	Lord Fairfax	Rappahannock	York/Poquoson
Culpeper	Loudoun	Rappahannock/Rapidan	
Cumberland	Louisa	Richmond City	

9.7 Physician Specialty Codes

Physician Specialty Matrix	Specialty Code
Anesthesiology	057
Cardiac Surgery	073
Cardiology	060
Colon & Rectal Surgery	058
Critical Care	060
Dermatology	059
DO (Doctor of Osteopathy)	060
Emergency	060
Endocrinology	060
Ear, Nose, and Throat (ENT)	060
Family Practice	053 and 056
Gastroenterology	060
General Practice	056
General Surgery	073
Hematology/Oncology	060
Infectious Disease	060
Internal Medicine	060
Neonatology	067
Nephrology	060
Neurological Surgery	061
Neurology	071
Nuclear Medicine	060
Obstetrics & Gynecology	062
Ophthalmology	063
Orthopedic Surgery	064
Osteopathy	060
Other	076
Otolaryngology	065
Pathologist	066
Pediatrics	067
Perinatology	062
Physical Medicine & Rehabilitation	068
Plastic Surgery	069
Preventive Medicine	070
Psychiatry	071
Pulmonary	060
Radiation Oncology	060

Physician Specialty Matrix	Specialty Code
Radiology	072
Rheumatoid	060
Substance Abuse – Restricted	047
Surgery Cardiothoracic	074
Thoracic Surgery	074
Transplant Surgery	073
Urology	075
Vascular	073

9.8 All Provider Specialty List

Specialty Code	Specialty Name
001	Ambulance
009	Neonatal Ambulance
016	Developmental Disabled (DD) Waiver
017	Case Management for DD Waiver
018	Audiology
019	Personal Care
020	Transportation
021	Emergency Air Ambulance
022	Women's Health (OBGyn) Nurse Practitioner
023	Family Nurse Practitioner
024	Pediatric Nurse Practitioner
025	Skilled Nursing Services
026	Special Education Psych Services
027	Physical Therapy
028	Occupational Therapy
029	Speech/Language Therapy
030	Area Agency on Aging (AAA)
031	Community Services Board (CSB)
033	Center for Independent Living Skills (CILS)
034	Department of Social Services (DSS)
035	EDSDT
036	Care Coordination
037	Nutritional Services
038	Patient Education Services
039	Homemaker Services
040	Consumer Directed Service Coordination
041	CSB- Mental Health Clinic

Specialty Code	Specialty Name
042	CSB- State Plan Options
043	CSB- MR State Plan Options
044	MR Private Provider
045	MH Private Provider
046	MR Waiver
047	Substance Abuse
048	Regular Assisted Living
049	Intensive Assisted Living
051	School Based Clinic
053	Family Practice
054	Hospital Based (HHA)
055	Non-Hospital Based (HHA)
056	Family Practice
057	Anesthesiology
058	Colon & Rectal Surgery
059	Dermatology
060	Cardiology (Physician)
060	Critical Care (Physician)
060	Doctor of Osteopathy (DO)
060	Emergency (Physician)
060	Ear, Nose, and Throat (Physician)
060	Gastroenterology (Physician)
060	Hematology/Oncology (Physician)
060	Infectious Disease (Physician)
060	Internal Medicine (Physician)
060	Nephrology (Physician)
060	Nuclear Medicine (Physician)
060	Osteopathy (Physician)
060	Pulmonary (Physician)
060	Radiation Oncology (Physician)
060	Rheumatoid (Physician)
061	Neurological Surgery(Physician)
062	Obstetrics and Gynecology (Physician)
063	Ophthalmology (Physician)
064	Orthopedic Surgery (Physician)
065	Otolaryngology (Physician)
066	Pathologist (Physician)
067	Pediatrics (Physician)
068	Physical Medicine & Rehabilitation (Physician)
069	Plastic Surgery (Physician)

Specialty Code	Specialty Name
070	Preventative Medicine (Physician)
067	Neonatology (Physician)
071	Neurology (Physician)
071	Psychiatry (Physician)
072	Radiology (Physician)
073	Cardiac Surgery (Physician)
073	General Surgery(Physician)
073	Transplant Surgery (Physician)
073	Vascular (Physician)
074	Surgery Cardiothoracic (Physician)
074	Thoracic Surgery (Physician)
075	Urology (Physician)
076	Other (Physician)
086	Vent (Nursing Facility)
087	AIDS (Case Management)
089	Complex (Nursing Facility)
090	Elderly (Case Management)
092	Rehab (Nursing Facility)
105	Alzheimer Waiver
107	Adult (Nurse Practitioner)
108	Geriatric (Nurse Practitioner)
109	Neonatal (Nurse Practitioner)
110	Acute Care (Nurse Practitioner)
111	Psychiatric (Nurse Practitioner)
112	Certified Nurse Midwife
113	Full PACE
114	Level A Community Residential Services
115	Level B Community Residential Services
116	Early Intervention
117	Transition Coordinator – Children’s Mental Health Program
118	Residential Respite Care
119	Early Intervention Targeted Case Management
120	EPSDT Behavioral Therapy

9.9 Behavioral Health and

Developmental Services Matrix-

As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES; SEE DETAILED ENROLLMENT PROCEDURES BY PCT FOR FURTHER INSTRUCTIN FOR PCT.

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
DD	Assistive Technology	T1999	DBHDS - Community Services Boards (CSBs) only will enroll under PCT 056, all other providers wanting to enroll with have to enroll as a Durable Medical Equipment Supplier (PCT 062) and follow all license requirements for a DME PCT 062	CSB enrolling no license required, all others must enroll as PCT 062 and follow license requirements			056 or 062	NPI
DD	Companion Services (Agency Directed)	S5135	DBHDS or if not licensed by DBHDS they would enroll as a Personal Care (PC) PCT 055	DBHDS-licensed as Residential, Supportive Residential, Day Support, or Respite Service, all others must enroll as PCT 055 or 047	01,02,03,08,14		056 spec. 016 or PCT 047 or 055	API/NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
			or Respite Care (RC) PCT 047 provider and follow all license requirements for PC PCT 055 and RC PCT 047 enrollment	and follow license requirements				
DD	Crisis Stabilization	H2011	DBHDS	Residential, Supportive Residential, outpatient Services or Day Support	01,02,03,07	019-021 or 042-044	056 spec. 016	NPI
DD	Crisis Supervision	H0040	DBHDS	Residential or Supportive Residential	01,02,03,07	019-021 or 042-044	056 spec. 016	NPI
DD	Day Support	97537	DBHDS	Day Support Services	02	006-011	056 spec. 016	NPI
DD	Environmental Modifications	n/a	DBHDS - Community Services Boards (CSBs) only, Department of Rehab Services (DRS) as an approved vendor will enroll under PCT 056, all other providers wanting to enroll with have to enroll as a Durable Medical	CSB enrolling no license required, DRS Vendor Agreement, all others must enroll as PCT 062 and follow license requirements			056 spec. 16 or 062	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
			Equipment Supplier (PCT 062) and follow all license requirements for a DME PCT 062					
DD	Family and Caregiver Training	S5111	Enrolled as a PCT 061 and would complete the enrollment application attestation	Entities eligible to participate are: <ul style="list-style-type: none"> • Home Health Agencies • Community Developmental Disabilities Providers • Developmental Disabilities Residential Providers • Community Mental Health Centers • Public Health Agencies (Hospitals, Clinics, In-Home Rehabilitation Agencies, or other agencies/organizations) • Psychologists • Licensed Clinical Social Workers • Licensed Professional Counselors 			061	

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
DD	In-Home Residential Support	H2014 and 97535	DBHDS	Residential Support	01 or 03		056 spec. 016	
DD	Personal Assistance (Agency Directed)	T1019	DBHDS or if not licensed by DBHDS they would enroll as a Personal Care (PC) PCT 055 or Respite Care (RC) PCT 047 provider and follow all license requirements for PC PCT 055 and RC PCT 047 enrollment	DBHDS-licensed as Residential, Supportive Residential, all others must enroll as PCT 055 or 047 and follow license requirements	01 or 03		056 spec. 16, PCT 055 or 047	NPI
DD	Personal Emergency Response Systems (PERS)		Enrolled as a Durable Medical Equipment Supplier (PCT 062) - Business license or state license is normally the license entity for this provider	Enrolled as a Durable Medical Equipment Supplier (PCT 062) - Business license or state license is normally the license entity for this provider			062	

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
DD	Prevocational Services	H2025	DBHDS	DBHDS-Day Support services or DRS-Approved Vendor of Extended Employment Services, Long-Term Employment Services or Supported Employment	02	006-011	056 spec. 16	NPI
DD	Respite Care (Agency Directed)	T1005	DBHDS or if not licensed by DBHDS they would enroll as a Personal Care (PC) PCT 055 or Respite Care (RC) PCT 047 provider and follow all license requirements for PC PCT 055 and RC PCT 047 enrollment	DBHDS-licensed as Supportive Residential, Center-Based Respite, In-Home Respite, Out-Of-Home respite or Residential Services, DSS-Foster Care Home, all others must enroll as PCT 055 or 047 and follow license requirements	01,03		056 spec. 044 or 046, PCT 055 or 047	NPI
DD	Skilled Nursing Services	T1002 and T1003	DBHDS or if not licensed by DBHDS they would enroll as a Home Health Agency (HHA) PCT 058-059 or	DBHDS-Respite Care, Day Support, Residential and Supportive Residential provider, all others must enroll as PCT 058-059 or 063 and follow license	01,09,10	036-041	056 spec. 044 or 046, PCT 058,059 or 063	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
			Private Duty Nursing (PDN) PCT 063 provider and follow all license requirements for HHA PCT 058,059 and PDN PCT 063 enrollment	requirements				
DD	Supported Employment	H2023 and H2024	Department of Rehabilitation Services (DRS)	DRS-Approved Vendor of Extended Employment Services, Long-Term Employment Services or Supported Employment			056 spec. 044 or 046	API/NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
DD	Therapeutic Consultation	97139	<p>Psychology Consultation – Psychiatrist, Psychologist, Licensed Professional Counselor, Licensed Clinical social Worker, or Psychiatric Clinical Nurse Specialist, all must be licensed by the Virginia Department of Health Professions.</p> <p>Behavioral Consultation – Psychiatrist, Psychologist, Licensed Professional Counselor, Licensed clinical social Worker, or Psychiatric Clinical Nurse Specialist, all must</p>	<p>Psychology Consultation – Psychiatrist, Psychologist, Licensed Professional Counselor, Licensed Clinical social Worker, or Psychiatric Clinical Nurse Specialist, all must be licensed by the Virginia Department of Health Professions.</p> <p>Behavioral Consultation – Psychiatrist, Psychologist, Licensed Professional Counselor, Licensed clinical social Worker, or Psychiatric Clinical Nurse Specialist, all must be licensed by the Virginia Department of Health Professions or, a Certification as a Board Certified Behavioral Analyst (BCBA) or Board Certified</p>			056 spec. 044 or 046	API/NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
			be licensed by the Virginia Department of Health Professions or, a Certification as a Board Certified Behavioral Analyst (BCBA) or Board Certified Associate Behavior Analyst (BCABA) or, an endorsement in Positive Behavioral Supports issued by the Partnership for People with Disabilities at Virginia Commonwealth University.	Associate Behavior Analyst (BCABA) or, an endorsement in Positive Behavioral Supports issued by the Partnership for People with Disabilities at Virginia Commonwealth University. Speech Consultation - Speech/Language Pathologist licensed by the Virginia Department of Health Professions. Occupational Therapy Consultation - Occupational Therapist licensed by the Virginia Department of Health Professions. Physical Therapy Consultation - Physical Therapist licensed by the Virginia Department of Health Professions. Therapeutic Recreation				

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
			Health Professions. Occupational Therapy Consultation - Occupational Therapist licensed by the Virginia Department of Health Professions. Physical Therapy Consultation - Physical Therapist licensed by the Virginia Department of Health Professions. Therapeutic Recreation Consultation - Therapeutic Recreational Specialist certified by the National Council for Therapeutic	Consultation - Therapeutic Recreational Specialist certified by the National Council for Therapeutic Recreation Certification. Rehabilitation Consultation - Rehabilitation Engineer certified by the Virginia Department of Rehabilitative Services OR Certified Rehabilitation Specialist.				

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
			Recreation Certification. Rehabilitation Consultation - Rehabilitation Engineer certified by the Virginia Department of Rehabilitative Services OR Certified Rehabilitation Specialist.					
MR	Assistive Technology	T1999	DBHDS - Community Services Boards (CSBs) only will enroll under PCT 056, all other providers wanting to enroll with have to enroll as a Durable Medical Equipmen	CSB enrolling no license required, all others must enroll as PCT 062 and follow license requirements			056 or 062	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
			t Supplier (PCT 062) and follow all license requirements for a DME PCT 062					
MR	Companion Services (Agency Directed)	S5135	DBHDS or if not licensed by DBHDS they would enroll as a Personal Care (PC) PCT 055 or Respite Care (RC) PCT 047 provider and follow all license requirements for PC PCT 055 and RC PCT 047 enrollment	DBHDS-licensed as Residential, Supportive Residential, Day Support, or Respite Service, all others must enroll as PCT 055 or 047 and follow license requirements	01,02,03,08,14		056 spec. 044 or 046, PCT 055 or 047	API/NPI
MR	Crisis Stabilization	H2011	DBHDS	Residential, Supportive Residential, outpatient Services or Day Support	0107	019-021006,007	056 spec. 044 or 046	NPI
MR	Crisis Supervision	H0040	DBHDS	Residential or Supportive Residential	01,02,03,07	019-021 or 042-044	056 spec. 044 or 046	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
MR	Day Support	97537	DBHDS	Day Support Services	02	006-009	056 spec. 044 or 046	NPI
MR	Environmental Modifications	n/a	DBHDS - Community Services Boards (CSBs) only, Department of Rehab Services (DRS) as an approved vendor will enroll under PCT 056, all other providers wanting to enroll with have to enroll as a Durable Medical Equipment Supplier (PCT 062) and follow all license requirements for a DME PCT 062	CSB enrolling no license required, DRS Vendor Agreement, all others must enroll as PCT 062 and follow license requirements			056 spec. 044 or 046 or 062	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
MR	Personal Assistance (Agency Directed)	T1019	DBHDS or if not licensed by DBHDS they would enroll as a Personal Care (PC) PCT 055 or Respite Care (RC) PCT 047 provider and follow all license requirements for PC PCT 055 and RC PCT 047 enrollment	DBHDS-licensed as Residential, Supportive Residential, all others must enroll as PCT 055 or 047 and follow license requirements	01 or 03		056 spec. 044 or 046, PCT 055 or 047	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
MR	Prevocational Services	H2025	DBHDS	DBHDS-Day Support services or DRS-Approved Vendor of Extended Employment Services, Long-Term Employment Services or Supported Employment	02	006-011	056 spec. 044 or 046	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
MR	Residential Support	97535 and H2014	DBHDS	DBHDS-Residential, Supportive Residential, Sponsored Placement, Interdepartmental license (CORE) License. DSS-Approved Adult Foster Care/Adult Family Care	01 03 08 014	001,002, 011011,012, 013035-047	056 spec. 044 or 046	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
MR	Respite Care (Agency Directed)	T1005	DBHDS or if not licensed by DBHDS they would enroll as a Personal Care (PC) PCT 055 or Respite Care (RC) PCT 047 provider and follow all license requirements for PC PCT 055 and RC PCT 047 enrollment	DBHDS-licensed as Supportive Residential, Center-Based Respite, In-Home Respite, Out-Of-Home respite or Residential Services, DSS-Foster Care Home, all others must enroll as PCT 055 or 047 and follow license requirements	01 09 10	036,037 001,002,003 001,002,003	056 spec. 044 or 046, PCT 055 or 047	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
MR	Skilled Nursing Services	T1002 and T1003	DBHDS or if not licensed by DBHDS they would enroll as a Home Health Agency (HHA) PCT 058-059 or Private Duty Nursing (PDN) PCT 063 provider and follow all license requirements for HHA PCT 058,059 and PDN PCT 063 enrollment	DBHDS-Respite Care, Day Support, Residential and Supportive Residential provider, all others must enroll as PCT 058-059 or 063 and follow license requirements . Required to provide a valid RN license if contracted by DBHDS approved agency to perform respite, day support, or residential and supportive residential care with approved service and program codes.	Residential 01 Day Support 02 Respite 01 Respite 10	001, 002, 011 006-009 036-037 001-003	056 spec. 044 or 046, PCT 058,059 or 063	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
MR	Supported Employment	H2023 and H2024	Department of Rehabilitation Services (DRS)	DRS-Approved Vendor of Extended Employment Services, Long-Term Employment Services or Supported Employment			056 spec. 044 or 046	API/NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
MR	Therapeutic Consultation	97139	<p>Psychology Consultation – Psychiatrist, Psychologist, Licensed Professional Counselor, Licensed Clinical social Worker, or Psychiatric Clinical Nurse Specialist, all must be licensed by the Virginia Department of Health Professions.</p> <p>Behavioral Consultation – Psychiatrist, Psychologist, Licensed Professional Counselor, Licensed clinical social Worker, or Psychiatric Clinical Nurse Specialist, all must be licensed by the Virginia Department of Health Professions or, a Certification as a Board Certified Behavioral Analyst (BCBA) or Board Certified</p>	<p>Psychology Consultation – Psychiatrist, Psychologist, Licensed Professional Counselor, Licensed Clinical social Worker, or Psychiatric Clinical Nurse Specialist, all must be licensed by the Virginia Department of Health Professions.</p> <p>Behavioral Consultation – Psychiatrist, Psychologist, Licensed Professional Counselor, Licensed clinical social Worker, or Psychiatric Clinical Nurse Specialist, all must be licensed by the Virginia Department of Health Professions or, a Certification as a Board Certified Behavioral Analyst (BCBA) or Board Certified</p>			056 spec. 044 or 046	API/NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
			be licensed by the Virginia Department of Health Professions or, a Certification as a Board Certified Behavioral Analyst (BCBA) or Board Certified Associate Behavior Analyst (BCABA) or, an endorsement in Positive Behavioral Supports issued by the Partnership for People with Disabilities at Virginia Commonwealth University.	Associate Behavior Analyst (BCABA) or, an endorsement in Positive Behavioral Supports issued by the Partnership for People with Disabilities at Virginia Commonwealth University. Speech Consultation - Speech/Language Pathologist licensed by the Virginia Department of Health Professions. Occupational Therapy Consultation - Occupational Therapist licensed by the Virginia Department of Health Professions. Physical Therapy Consultation - Physical Therapist licensed by the Virginia Department of Health Professions. Therapeutic Recreation				

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
			Health Professions. Occupational Therapy Consultation - Occupational Therapist licensed by the Virginia Department of Health Professions. Physical Therapy Consultation - Physical Therapist licensed by the Virginia Department of Health Professions. Therapeutic Recreation Consultation - Therapeutic Recreational Specialist certified by the National Council for Therapeutic	Consultation - Therapeutic Recreational Specialist certified by the National Council for Therapeutic Recreation Certification. Rehabilitation Consultation - Rehabilitation Engineer certified by the Virginia Department of Rehabilitative Services OR Certified Rehabilitation Specialist.				

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
			Recreation Certification. Rehabilitation Consultation - Rehabilitation Engineer certified by the Virginia Department of Rehabilitative Services OR Certified Rehabilitation Specialist.					
MH	Crisis Intervention	H0036	DBHDS	Outpatient Mental Health Program	07	001-002	056, possible specialties 042,043,044 or 045	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
MH	Crisis Stabilization	H2019	DBHDS	Outpatient Mental Health Program with Crisis Stabilization or Residential Crisis Stabilization	0107	019-021006-007	056, possible specialties 042,043,044 or 045	NPI
MH	Day Treatment Children and Adolescents	H0035 and H0032	DBHDS	Mental Health Day Treatment Program	02	014-015029-031	056, possible specialties 042,043,044 or 045	NPI
MH	Day Treatment for Pregnant Women	H0015	DBHDS	Outpatient Substance Abuse Program or Day Treatment	01	033-034	056, possible specialties 042,043,044 or 045	NPI
MH	Day Treatment Partial Hospitalization	H0035 and H0032	DBHDS	Mental Health Day Treatment Program	02	019 - 021	056, possible specialties 042,043,044 or 045	NPI
MH	EPSDT Behavioral Therapy	H2033	DBHDS	Mental Health Outpatient Service with Applied Behavioral Analysis Track	05 and 07	010	056, possible specialties 042,043,044 or 045	NPI
MH	Intensive Community Treatment	H0039 and H0032	DBHDS	Outpatient Mental Health Program or Program of Assertive Community Treatment	1718	001001	056, possible specialties 042,043,044 or 045	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
MH	Intensive In-Home	H2012 and H0031	DBHDS	Intensive In-Home Services Program	05		056, possible specialties 042,043,044 or 045	NPI
MH	MH-Case Management - Community Services Boards (CSBs)	T1017, H0032 and H0023	DBHDS	Community Services Boards can only enroll			056, possible specialties 042,043,044 or 045	NPI
MH	MR-Case Management-Community Services Boards (CSBs)	T1017, H0032 and H0023	DBHDS	Community Services Boards can only enroll			056, possible specialties 042,043,044 or 045	NPI
MH	Psychosocial Rehabilitation	H2017 and H0032	DBHDS	Mental Health day Support Program, Psychosocial Rehabilitation or Clubhouse Services	02	011-012	056, possible specialties 042,043,044 or 045	NPI
MH	Residential Treatment for Pregnant Women	H0018	DBHDS	Residential Substance Abuse (SA) Program	01	033-034	056, possible specialties 042,043,044 or 045	NPI
MH	Support Services	H0032 and H0046	DBHDS	Supported Living, Mental Health Supports or Supportive Residential	03	001-003	056, possible specialties 042,043,044	NPI

Type	Type of Service	Restriction Code Entered	License Entity	License Type Required	DBHDS Service Code	DBHDS Program Code	MMIS PCT and Spec.	API/NPI
							or 045	
MH	Substance Abuse (SA) Crisis Intervention	H0050	DBHDS	Outpatient Services - Substance Abuse	07	001-002	056, possible specialties 042,043,044 or 045	NPI
MH	Substance Abuse (SA) Intensive Outpatient	H2016	DBHDS	Intensive Outpatient Services	02	001-003	056, possible specialties 042,043,044 or 045	NPI
MH	Substance Abuse (SA) Day Treatment	H0047	DBHDS	Day Treatment Services	02	021	056, possible specialties 042,043,044 or 045	NPI
MH	Opioid Treatment	H0020	DBHDS	Opioid Treatment, Board of Pharmacy, center for Substance Abuse Treatment or US Drug Enforcement Administration	06	001-002	056, possible specialties 042,043,044 or 045	NPI
MH	Substance Abuse (SA) Case Management	H0006	DBHDS	Case Management Services	16	003	056, possible specialties 042,043,044 or 045	NPI

9.10 Provider Enrollment Services Contact List

(List to be inserted when complete)

9.11 Detailed Enrollment Procedures by Provider Class Type

9.11.1 Adult Care Residence (ACR) Assessment – NO LONGER ENROLLED

**THIS PROVIDER TYPE NO LONGER ENROLLED AS
OF 06/30/2010**

Class Type

073 – Adult Care Residence (ACR) Assessment

Specialty

030 – AAA (Area Agency on Aging)

031 – CSB (Community Service Board)

032 – DOH (Department of Health)-NOT CURRENTLY USED

033 – CILS (Center for Independent Living Skills)

034 – DSS (Department of Social Services)

Type of Enrollment Application

Adult Care Residence (ACR) Assessment Participation Agreement

Required Documents/Notes

Must be one of the following AAA, CSB, CILS, or DSS to enroll no licensure required.

No licensure requirement so the name of the provider will designate which state department they are enrolling; i.e., Southside Community Services Board (CSB), Richmond Center for Independent Living Skills (CILS), or Richmond Department of Social

Services (DSS). If not able to identify, please get supervisor approval prior to enrolling any “new” Adult Care Residence (ACR) Assessment provider.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Program Eligibility End Date

Indefinite

Reimbursement Type

Fee for service

Manual Type

ACR Assessment Manual

Overview of Program

Case Management agencies provide services designed to prevent or reduce inappropriate institutional care by providing the continuous assessment, coordination, and monitoring of needs and services for Medicaid-eligible individuals.

9.11.2 Alzheimer’s Assisted Living Waiver

Class Type

079 – Alzheimer’s Assisted Living Waiver

Specialty – AS OF 06/30/2010 DMAS/PES WILL NO LONGER ENROLL OR RE-ENROLL REGULAR AND INTENSIVE ASSISTED LIVING FACILITIES

105 – Alzheimer’s Waiver (DMAS approved)

Type of Enrollment Application

Alzheimer’s Assisted Living Waiver

Required Documents/Notes

Prior to enrolling a provider for Alzheimer’s Waiver the provider must go through a 5 step process:

1. Provider must be enrolled with DSS to participate in the Auxiliary Grant Program.
2. Be designated as a Safe and Secure Unit by DSS.
 - a. Complete and Submit the DMAS-482 “Request to be Screened as a Provider for the Alzheimer’s Assisted Living Waiver” to DMAS Long Term Care (LTC) Department.
 - b. DMAS LTC Schedules an onsite review for the facility.
 - A. Review enrollment packet

- B. Review AAL Waiver Regulations
 - c. DMAS LTC Approves
 - d. Notifies PES of Approval by submitting completed Enrollment Applications, and Alzheimer Assisted Living Waiver approval letter.
3. If the provider submits their Enrollment Application prior to contacting DMAS LTC.
- a. PES will contact DMAS LTC with Provider Name and contact information.
 - b. PES will place note in remarks section of ECM on Enrollment Application and create [REDACTED] Communication Record.
 - c. Steps 1-2 will be followed.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License end date

Reimbursement Type

Fee for service

Manual Type

Alzheimer’s Assisted Living Waiver

9.11.3 Adult Day Health Care

Class Type

048 – Adult Day Health Care

API/NPI

Specialty

None

Type of Enrollment Application

Adult Day Health Care Participation Agreement and Community Based Care (CBC) Application

Required Data/Notes

Department of Social Services (DSS) Adult Day Care License

No out of state providers

Make certain that address on license corresponds with physical location on agreement.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date.

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for Service

Manual Type

Adult Day Health Care

3.9.3.1 Community Based Care Enrollment and Re-enrollment Instructions

New Enrollments:

CBC Application

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: The only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%.

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, RTP with appropriate letter designated to request offense information. Once received please route to Team Lead for approval from DMAS Provider Enrollment Contract Monitor.

Part C of the application

Adult Day Health Care

Must have information on at least one individual

Optional

9.11.4 AIDS Case Management – AS OF 06/30/2012 DMAS/PES WILL NO LONGER ENROLL OR RE-ENROLL AIDS Case Management

Class Type

073 – Case Management

API/NPI

Specialty

087 – AIDS Case Management –

Type of Enrollment Application

AIDS Case Management Participation Agreement and Community Based Care (CBC)
Application

Requirements/Notes

No out-of-state providers

This provider type is designated for Case Management Services only

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date

Program Eligibility End Date

5 years from begin date

Reimbursement Type

Fee for service

Manual Type

AIDS Case Management.

New Enrollments

CBC Application

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: Only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%.

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, RTP with appropriate letter designated to request offense information. Once received please route to Team Lead for approval from DMAS Provider Enrollment Contract Monitor

Part C of the application

AIDS CASE MANAGEMENT

Must have information on at least one individual.

Optional.

Re-Enrollment Requirements

Complete a new enrollment application every five years.

9.11.5 Emergency Ambulance

Class Type

080 – Ambulance – In-State

083 – Ambulance – Out-of-State

NPI

Specialty

001 – Ambulance

009 – Neonatal

Type of Enrollment Application

Transportation

Required Documents/Notes

EMS Certificate – For specialty Neonatal it must be designated on Certificate

LogistiCare Manages all non-emergency transportation services for the Virginia Medicaid program.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Transportation

9.11.6 Ambulatory Surgical Center

Class Type

049

NPI

Specialty

None

Type of Enrollment Application

Ambulatory Surgery Center Enrollment Application, which includes a Physician-Directed Participation Agreement

Required Documents/Notes

American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Ambulatory Surgery Centers (AAASC), Accreditation for Ambulatory Surgical Centers (AASC), American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP), Center for Medicare/Medicaid (CMS) certification, or Joint Commission (JC) as an Ambulatory Surgical Center.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Date Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Physician Manual

9.11.7 Audiologist

Class Type

044 – Audiologist

NPI**Specialty**

035 – EPSDT

Type of Enrollment Application

Participation Agreement

Required Documents/Notes

Medical License – Board of Audiology, Otolaryngologist, or as a “Hearing Aid Specialist”

If the provider were dispensing hearing aids, they would need to enroll as a Hearing Aid Provider, which is enrolled under Provider Class Type 062 (Durable Medical Equipment-DME). Their Medical License will be all they would need to enroll as a Hearing Aid Provider.

NOTE: For District of Columbia (DC) Audiologists must submit a copy of their Audiologist degree or proof of DC Medicaid enrollment in order to enroll into Virginia Medicaid.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date.

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Physician

9.11.8 Baby Care

Class Type

036 – Baby Care

NPI

Specialty

036 – Care Coordination

037 – Nutritional Services`

038 – Patient Education Services

039 – Homemaker Services

Type of Enrollment Application

Baby Care – Expanded Prenatal/Maternal Infant Care Agreement

Required Documents/Notes

Care Coordination – RN license, Social Worker’s MSW or BSW degree

Nutritional Services – Registered Dieticians Registration

Patient Education Services –Copy of DMAS approved license or certification. DMAS approved patient education providers include individuals employed by the Virginia Department of Health who are approved to provide education in the health department setting. Health Departments should maintain a copy of the employees approved certification/training in the personnel file at the agency.

All providers wanting to be approved for this service must first submit their certification from programs other than the Health Department and their course content, a copy of their certificate and the Baby Care provider enrollment application to DMAS at the following address to be reviewed for approval:

DMAS Attention: Baby Care, Request for Patient Education Certification Approval 600 East Broad Street, Suite 1300 Richmond, VA 23219 804-225-3961 (Fax)

Homemaker Services – RN, LPN, or Certified Nurse Aide

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date Never prior to license begin date

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Baby Care

9.11.9 Chiropractor

Class Type

026 – Chiropractor

NPI**Specialty**

035 – EPSDT

Type of Enrollment Application

EPSDT

Required Documents/Notes

Medical license and claim or supporting documentation necessitating enrollment

Claim or supporting documentation necessitating enrollment

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Physician

9.11.10 Clinical Nurse Specialist

Class Type

034 – Clinical Nurse Specialist

NPI**Specialty**

None

Type of Enrollment Application

Clinical Nurse Specialist

Required Documents/Notes

Medical license

Specialty of Psychiatry

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Physician

**9.11.11 Clinical Psychologist - AS OF 11/30/2013
DMAS/PES WILL NO LONGER ENROLL OR RE-
ENROLL Behavioral Health Services.**

Class Type 025 – Clinical Psychologist

NPI

Specialty

016 – DD Waiver

046 – MR Waiver

Type of Enrollment Application

Clinical Psychologist

Required Documents/Notes

Medical license

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Physician

9.11.12 Certified Professional Midwife

Class Type

105 – Certified Professional Midwife

NPI

Specialty

000

Type of Enrollment Application

Certified Professional Midwife

Required Documents/Notes

VA Department of Health Certified Professional Midwife license or individual state license

Effective date for participation in the Virginia Medicaid Program for this provider type began on 10/01/2007. In no event should a Certified Professional Midwife be enrolled with an effective date prior to 10/01/2007.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date Never prior to license begin date or program effective date 10/01/2007

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Physician/Practitioner

9.11.13 Comprehensive Outpatient Rehab Facility (CORF)

Class Type

019 – Comprehensive Outpatient Rehab Facility (CORF)

NPI

Specialty

N/A

Type of Enrollment Application

Comprehensive Outpatient Rehab Facility (CORF)

Required Documents/Notes

CMS Certification

Rates with Clifton Gunderson must be established prior to enrollment

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite

Reimbursement Type

Cost Settled-Clifton Gunderson

Manual Type

Outpatient Rehab

9.11.14 Consumer Directed Service Coordination

Class Type

073 – Case Management

API/NPI

Specialty

040 – Consumer Directed Service Coordination

Type of Enrollment Application

Consumer Directed Service Coordination

Required Documents/Notes

No out of state providers

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Five years from begin date

Reimbursement Type

Fee for Service

Manual Type

Elderly or Disabled with Consumer Directed Services

New Enrollments

CBC Application

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: Only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%.

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, RTP with appropriate letter designated to request offense information. Once received please route to Team Lead for approval from DMAS Provider Enrollment Contract Monitor

Part C of the application

Consumer Directed Service Coordination

Must have information on at least one individual.

Optional.

Re-Enrollment Requirements

Complete a new Community Based Care (CBC) application.

9.11.15 Dentist

Class Type

040- Dentist

NPI

Specialty

080 – Oral Surgeon

084 - Other

Type of Enrollment Application

Physician

Required Documentation/Notes

Medical License

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Dental

9.11.16 Developmental Disabled Waiver

Class Type

056 – Mental Health Mental Retardation and Substance Abuse Services

API/NPI

Specialty

016 – DD Waiver Community Service Board

116 – Early Intervention

119- Early Intervention Case Management

Type of Enrollment Application

Mental Health Mental Retardation and Substance Abuse Services, Durable Medical Equipment, Personal Care, Respite Care, Private Duty Nursing, or Home Health Agency

Required Documents/Notes

Providers are authorized to perform certain procedures only. Each procedure has its own licensure requirements and procedure/restriction code that will be placed on the individual provider file.

1. The following are all licensing entities:
 - a. DBHDS- Department of Behavioral Health and Developmental Services
 - b. DRS- Department of Rehabilitation Services
 - c. DSS-Department of Social Services
 - d. DHP-Department of Health Professions
 - e. BCBS-Board Certified Behavior Analyst
 - f. Endorsement in Positive Supports issued by Partners for People with Disabilities at Virginia Commonwealth University
 - g. NCTRC-National Council for Therapeutic Recreation Consultation
2. The Commissioner may issue the following types of licenses per 12VAC35-105-50:
 - A. A conditional license shall be issued to a new provider for services that demonstrates compliance with administrative and policy regulations but has not demonstrated compliance with all the regulations.
 1. A conditional license shall not exceed six months.
 2. A conditional license may be renewed if the provider is not able to demonstrate compliance with all the regulations at the end of the license period.
 3. A conditional license and any renewals shall not exceed 12 successive months for all conditional licenses and renewals combined.
 4. A provider holding a conditional license for a service shall demonstrate progress toward compliance.
 5. A provider holding a conditional license shall not add services or locations during the conditional period.
 6. A group home or community residential service provider shall be limited to providing services in a single location, serving no more than four individuals during the conditional period.
 - B. In accordance with the regulation, Provider Enrollment Services can accept a DBDHS conditional license for new enrollments of those providers who are licensed for services covered under the VA Medicaid Fee for Service program.
3. DBHDS authorization takes the form of a letter either submitted by mail, fax, or email; or verification can take place via download from the DBHDS website LPSS/mbd.
4. Providers complete "new" enrollment Application each time they are approved or

want to add new services.

5. The provider can choose to bill under one designated NPI #, although they should have each location where services are rendered enroll.
6. Optional – Early Intervention Attestation form
7. The DBHDS may be late in renewing licenses and DMAS and DBHDS have an agreement wherein for provider's whom are affected the PES will accept a letter of good standing either via email, fax, or USPS from DBHDS or provider stating that their facility is still in good standing 6 months from original license end date. PES will key 6 months in future from original license end date.
8. Appendix 7.10 Behavioral Health and Developmental Services Matrix has all Procedure Codes for Development Disabled provider types. This Matrix will be used to determine the procedures to be entered into the Provider Restriction Screen (PS-S-10) Provider Restriction. Detailed Instructions on how to enter Provider Restrictions can be found in Section 3.1.10.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Individual and Family Developmental Disabilities Waiver Services

9.11.17 Durable Medical Equipment

Class Type

062 – Durable Medical Equipment

NPI

Specialty

None

Type of Enrollment Application

Durable Medical Equipment

Required Documents/Notes

1. In VA
 - a. VA Board of Pharmacy License or,

- b. VA Board of Pharmacy Medical Equipment Supply Permit or,
 - c. Business License or,
 - d. Contractor's license, permit or certification (for environment modifications only), or
 - e. Documentation stating that a license is not required in their area or for services they are rendering.
2. Out of State- 50 miles of VA
- a. Individual State DME License if the Virginia Board of Pharmacy does not consider them eligible for a non-resident DME permit
 - b. VA Board of Pharmacy Non-Resident License or,
 - c. VA Board of Pharmacy Non-Resident Medical Equipment Supply Permit or,
 - d. Business License or,
 - e. Contractor's license, permit or certification (for environmental modifications only), or
 - f. Documentation stating that a license is not required in their area or for services they are rendering.
3. Out of State- Not within 50 miles of VA – Will be rejected unless they have the following licensure.
- a. Must have claim(s) or supporting documentation and one of the following,
 - b. Individual State DME License if the Virginia Board of Pharmacy does not consider them eligible for a non-resident DME permit
 - c. VA Board of Pharmacy Non-Resident License or,
 - d. VA Board of Pharmacy Non-Resident Medical Equipment Supply Permit or,
 - e. Business License or,
 - f. Contractor's license, permit or certification (for environmental modifications only), or
 - g. Documentation stating that a license is not required in their area or for services they are rendering.

The following Provider types are enrolled under PCT 062 although they are categorized for all intents and purposes with their own Provider Name and in some cases have their own required documents:

Assistive Technology - specialized equipment, supplies, devices, etc that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control or communicate with the environment in which they live.(ex - adaptive utensils, wall-mounted insulin delivery devices & automatic feeder systems.)

Environmental Modifications - physical adaptations to an individual's home or place of residence, which provide direct medical or remedial benefit to the individual. Ex – ramps, grab bars. Usually Contractors will enroll for this service.

Hearing Aid – a Hearing Aid Specialist is enrollable under PCT 038.

Personal Emergency Response Services (PERS) – no license is required to enroll but the provider must be a Home Health agency, Personal Care provider, Hospital or a PERS Manufacturer. See L.57 for more information

Prosthetics and Orthotics – some services for PCT 064 can fall under DME PCT 062.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Durable Medical Equipment

9.11.18 Early Intervention

Class Type

108 – Early Intervention

NPI

Specialty

000- Early Intervention Case Management

Type of Enrollment Application

Early Intervention

Required Documents

Early Intervention Professional – DBHDS license

Early Intervention Specialist – DBHDS license

Early Intervention Case Management – DBHDS license

Notes:

1. When enrolling PCT 108, (Early Intervention), enter the speciality “000”. Do not enter any other speciality type.
2. Terminate upon request, the speciality 116 or 119 for any enrolled providers and add the speciality “000” with the same effective date of the earliest program code effective date.

3. If a provider is enrolled as a PCT 057(Outpatient Rehabilitation), and they are not billing Outpatient Rehabilitation claims (by their own attestation), ask the providers to submit a letter to Provider Enrollment requesting to terminate the PCT 057 and provide the end date. The provider must also submit an Early Intervention application.

4. If the provider has requested to have their PCT 057 cancelled and be enrolled as a PCT 108 because they fit the criteria in #3 above, then the effective date for the PCT 108 is allowed to be retroactive up to 365 calendar days from the date of the application receipt upon request.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date.

Never prior to license begin date or 10/01/2009

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Early Intervention

9.11.19 Elderly Case Management - AS OF 11/30/2012 DMAS/PES WILL NO LONGER ENROLL OR RE-ENROLL Elderly Case Management providers

Class Type

073 – Case Management

API/NPI

Specialty

090 – Eldercare

Type of Enrollment Application

Elderly Case Management

Required Documents/Notes

No out-of-state providers

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Five years from begin date

Reimbursement Type

Fee for Service

Manual Type

Elderly Case Management

New Enrollments

CBC Application

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: Only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%.

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, RTP with appropriate letter designated to request offense information. Once received please route to Team Lead for approval from DMAS Provider Enrollment Contract Monitor

Part C of the application

ELDERLY CASE MANAGEMENT

Must have information on at least one individual.

Optional.

Re-Enrollment Requirements

Complete a new Community Based Care (CBC) application.

9.11.20 Emergency Air Ambulance

Class Type

082 – Emergency Air Ambulance – In-State

084 – Emergency Air Ambulance – Out-of-State

NPI

Specialty

021

Type of Enrollment Application

Transportation

Required Documents/Notes

EMS Certificate

LogistiCare Manages all non-emergency transportation services for the Virginia Medicaid program.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date.

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for service

Manual Type

Transportation

9.11.21 Family and Caregiver Training

Class Type

061 – Family and Caregiver Training

NPI**Specialty**

016 – DD Waiver

Type of Enrollment Application

Mental Health Mental Retardation and Substance Abuse Services and Developmental Disability and Family and Caregiver Training Community Based Care (CBC) application

Required Documents/Notes

Individual License or Certification required for entity enrolling

Entities or Individuals who are eligible to enroll and must be appropriately licensed or certified as such:

Home Health Agencies

Community Developmental Disabilities Providers

Development Disabilities Residential Providers

Community Mental Health Centers

Public Health Agencies (Hospitals, Clinics, In-Home Rehabilitation Agencies, or other agencies/organizations)

Psychologists

Licensed Clinical Social Workers

Licensed Professional Counselors

Licensed Practical Nurse

Nurse Aide

Occupational Therapist

Physical Therapist

Physician
Psychologist
Registered Nurse
Speech/Language Pathologist
Teacher

Eligible Program Codes

01- Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date.

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Developmental Disability

New Enrollments

CBC Application

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: Only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%.

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, RTP with appropriate letter designated to request offense information. Once received please route to Team Lead for approval from DMAS Provider Enrollment Contract Monitor

Part C of the application

Family and Caregiver Training

Must have information on at least one individual.

Optional.

Re-Enrollment Requirements

Complete a new Community Based Care (CBC) application.

9.11.22 Federally Qualified Health Center (FQHC)

Class Type

052 – Federally Qualified Health Center (FQHC)

NPI

Specialty

None

Type of Enrollment Application

Federally Qualified Health Center (FQHC)

Required Documents/Notes

CMS Certification

Rates from Clifton Gunderson.

Eligible Program Codes

01 – Medicaid

05 – Client Medical Management (CMM)

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite

Reimbursement Type

Cost Settled-Clifton Gunderson

Manual Type

Physician, Health Department, Baby Care

9.11.23 Health Department Clinic

Class Type

051 – Health Department Clinic

NPI**Specialty**

None

Type of Enrollment Application

Health Department Clinic

Required Documents/Notes

Provider should be listed on Health Department Table

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date

Program Eligibility End Date

Indefinite

Reimbursement Type

Fee for Service

Manual Type

9.11.24 Hearing Aid

Class Type

038 – Hearing Aid

NPI**Specialty**

n/a

Type of Enrollment Application

EPSDT Audiology and Hearing Aid Program

Required Documents/Notes

Hearing Aid Specialist License from the Department of Professional and Occupational Regulations through the Hearing Aid Specialist, Business License, or documentation stating a Business License is not required in their area for services being rendered.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date

Program Eligibility End Date

License end date

Reimbursement Type

Fee for Service

Manual Type

EPSDT Hearing Aid

9.11.25 Home Health Agency – Private

NOTE: The current Home Health Agency application does not ask the provider to indicate if they are Private or State HHA. Therefore, you must follow the steps listed below when processing a HHA application.

1. Outreach the provider to verify if they are Private or State HHA.
2. If the provider is a Private HHA, the Provider Class Type on the Servicing Address Tab in the workflow should already reflect class type 059. After validating the correct class type, continue to process the application following the instructions in sections 3.9.3 Home Health Agency-Private.
3. If the provider is a State HHA, you must update the Provider Class Type on the Servicing Address Tab in workflow to a 058. After updating the Class Type to 058, continue to process the application following the procedures outlined in section 3.9.4, Home Agency-State.

Class Type

059 – Home Health Agency

NPI

Specialty

054 – Hospital Based

055 – Non-Hospital Based

116 – Early Intervention

119-Early Intervention Case Management

Type of Enrollment Application

Home Health

Required Documents/Notes

Accreditation Commission for Health Care, Inc. (ACHC), Community Health Accreditation Program (CHAP), Centers for Medicare/Medicaid Services (CMS) certification as a Home Health Agency, Joint Commission for Accreditation of Health Care Organizations (JCAHO) “deemed states” certification as a Home Health Agency, Virginia Department of Health (VDH) Home Care Organization Certification, and Virginia Department of Health (VDH) Centers for Quality Healthcare Services and Consumer Protection as a Home Health Agency

All certification must be site specific

Each site must have own NPI

Optional- Early Intervention Attestation form

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date

Program Eligibility End Date

Indefinite if CMS certified, License expiration date for all others

Reimbursement Type

Fee for Service

Manual Type

Home Health

9.11.26 Home Health Agency – State

NOTE: The current Home Health Agency application does not ask the provider to indicate if they are Private or State HHA. Therefore, you must follow the steps listed below when processing a HHA application.

1. Outreach the provider to verify if they are Private or State HHA.
2. If the provider is a Private HHA, the Provider Class Type on the Servicing Address Tab in the workflow should already reflect class type 059. After validating the correct class type, continue to process the application following the instructions in sections 3.9.3 Home Health Agency-Private.
3. If the provider is a State HHA, you must update the Provider Class Type on the Servicing Address Tab in workflow to a 058. After updating the Class Type to 058, continue to process the application following the procedures outlined in section 3.9.4, Home Agency-State.

Class Type

058 – Home Health Agency

NPI**Specialty**

054 – Hospital Based

055 – Non-Hospital Based

116- Early Intervention

119-Early Intervention Case Management

Type of Enrollment Application

Home Health

Required Documents/Notes

Accreditation Commission for Health Care, Inc. (ACHC), Community Health Accreditation Program (CHAP), Centers for Medicare/Medicaid Services (CMS) certification as a Home Health Agency, Joint Commission for Accreditation of Health Care Organizations (JCAHO) “deemed states” certification as a Home Health Agency, Virginia Department of Health (VDH) Home Care Organization Certification, and Virginia Department of Health (VDH) Centers for Quality Healthcare Services and Consumer Protection as a Home Health Agency

All certification must be site specify

Each site must have own NPI

Optional- Early Attestation form

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date.

Program Eligibility End Date

Indefinite if CMS certified, License expiration date for all others

Reimbursement Type

Fee for Service

Manual Type

Home Health

9.11.27 Hospice

Class Type

046 – Hospice

NPI

Specialty

None

Type of Enrollment Application

Hospice

Required Documents/Notes

Accreditation Commission for Health Care (ACHC), CMS Certification, Community Health Accreditation Program (CHAP), or Joint Commission (JC) as a Hospice.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date.

Program Eligibility End Date

Indefinite

Reimbursement Type

Fee for Service

Manual Type

Hospice

9.11.28 Hospital – EPSDT Psychiatric Hospital

Class Type

003 – Hospital – EPSDT Psychiatric Hospital

NPI

Specialty

None

Type of Enrollment Application

EPSDT Psychiatric Hospital

Required Documents/Notes

CMS Certification or JCAHO Accreditation

Rates from DMAS

Supervisor must approve prior to enrolling

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite for CMS, or end of JCAHO Accreditation

Reimbursement Type

Cost Settled-DMAS

Manual Type

Hospital

9.11.29 Hospital – In-State

Class Type

001 – Hospital

NPI

Specialty

116- Early Intervention

119-Early Intervention Case Management

Type of Enrollment Application

Hospital

Required Documents/Notes

American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP), CMS Certification, Joint Commission, or Det Norske Veritas Healthcare (DNV) Inc. as a General Acute Care Hospital

Rates from DMAS:

Supervisor must approve prior to enrolling

If a hospital wants to enroll for Early Intervention they must do so under PCT

108

Eligible Program Codes

01 – Medicaid

07- SLH

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite for CMS, or end of JCAHO Accreditation

Reimbursement Type

Cost Settled-DMAS

Manual Type

Hospital

9.11.30 Hospital – In-State Rehab

Class Type

014 – Hospital In-State Rehab

NPI**Specialty**

None

Type of Enrollment Application

Hospital

Required Documents/Notes

American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP), CMS Certification, Joint Commission, or Det Norske Veritas Healthcare (DNV) Inc. as a General Acute Care Hospital

Rates from Clifton Gunderson:

Facility must also be enrolled as a PCT 001 prior to enrolling as a PCT 014

Supervisor must approve prior to enrolling

If a Rehab Hospital would like to enroll for Early Intervention they must do so under PCT 108

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date Never prior to license begin date

Program Eligibility End Date

Indefinite for CMS, or end of JCAHO Accreditation

Reimbursement Type

Cost Settled-DMAS

Manual Type

Hospital

9.11.31 Hospital – Long Stay Inpatient Mental Health

Class Type

012 – Hospital – Long Stay Inpatient Mental Health

NPI

Specialty

None

Type of Enrollment Application

Hospital

Required Documents/Notes

CMS Certification or JCAHO Accreditation

Rates from Clifton Gunderson

Supervisor must approve prior to enrolling

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite for CMS, or end of JCAHO Accreditation

Reimbursement Type

Cost Settled-Clifton Gunderson

Manual Type

Hospital

9.11.32 Hospital – Long Stay Health

Class Type

004 – Hospital – Long Stay

NPI

Specialty

None

Type of Enrollment Application

Hospital

Required Documents/Notes

CMS Certification or JCAHO Accreditation

Rates from DMAS

Supervisor must approve prior to enrolling

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite for CMS, or end of JCAHO Accreditation

Reimbursement Type

Cost Settled-DMAS

Manual Type

Hospital

9.11.33 Hospital – State Mental (Aged)

Class Type

002 – Hospital – State Mental (Aged)

NPI

Specialty

None

Type of Enrollment Application

Hospital

Required Documents/Notes

CMS Certification or JCAHO Accreditation

Rates from Clifton Gunderson

Supervisor must approve prior to enrolling

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite for CMS, or end of JCAHO Accreditation

Reimbursement Type

Cost Settled-Clifton Gunderson

Manual Type

Hospital

9.11.34 Hospital – Medical Surgery – Mental Health Retardation

Class Type

013 – Hospital – Medical Surgery – Mental Health Retardation

NPI**Specialty**

None

Type of Enrollment Application

Hospital

Required Documents/Notes

CMS Certification or JCAHO Accreditation

Rates from Clifton Gunderson

Supervisor must approve prior to enrolling

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date Never prior to license begin date

Program Eligibility End Date

Indefinite for CMS, or end of JCAHO Accreditation

Reimbursement Type

Cost Settled-Clifton Gunderson

Manual Type

Hospital

9.11.35 Hospital – Medical Surgery – Mental Retarded

Class Type

009 – Hospital – Medical Surgery – Mental Retarded

NPI**Specialty**

None

Type of Enrollment Application

Hospital

Required Documents/Notes

CMS Certification or JCAHO Accreditation

Rates from Clifton Gunderson

Supervisor must approve prior to enrolling

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite for CMS, or end of JCAHO Accreditation

Reimbursement Type

Cost Settled-Clifton Gunderson

Manual Type

Hospital

9.11.36 Hospital – Out-of-State

Class Type

091 – Hospital – Out-of-State

NPI**Specialty**

None

Type of Enrollment Application

Hospital

Required Documents/Notes

CMS Certification or JCAHO Accreditation, Claim

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite for CMS, or end of JCAHO Accreditation

Reimbursement Type

Rate Based

Manual Type

Hospital

9.11.37 Hospital – Out-of-State Rehab

Class Type

085 – Hospital Out-of-State Rehab

NPI

Specialty

None

Type of Enrollment Application

Hospital

Required Documents/Notes

American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP), CMS Certification, Joint Commission, or Det Norske Veritas Healthcare (DNV) Inc. as a General Acute Care Hospital

Supervisor must approve prior to enrolling

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date.

Program Eligibility End Date

Indefinite for CMS, or end of JCAHO Accreditation

Reimbursement Type

Rate-based

Manual Type

Hospital

9.11.38 Hospital (State Mental)

Class Type

007 – Hospital State Mental (less than age 21)

NPI**Type of Agreement**

Hospital

Required Documents/Notes

CMS Certification or JCAHO Accreditation

Rates from Clifton Gunderson

Supervisor must approve prior to enrolling

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date.

Program Eligibility End Date

Indefinite for CMS, or end of JCAHO Accreditation

Reimbursement Type

Cost Settled-Clifton Gunderson

Manual Type

Hospital

9.11.39 Hospital – TB

Class Type

005 – Hospital – TB

NPI**Specialty**

None

Type of Enrollment Application

Hospital

Required Documents/Notes

CMS Certification

Rates from Clifton Gunderson

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date.

Program Eligibility End Date

Indefinite

Reimbursement Type

Cost Settled-Clifton Gunderson

Manual Type

Hospital

9.11.40 Laboratory

Class Type

070 – Laboratory

098 – Laboratory (out-of-state)

NPI

Specialty

None

Type of Agreement

Independent Laboratory

Required Documents/Notes

CMS Certification, OR (A copy of a recent Medicare RA may be used if the certification is unavailable)

CLIA Certification (The name on the certificate must be a close match to the name on the Application.)

Mobile Imaging Labs do not have either of these certifications. A letter must accompany the Application with an explanation of why neither of these two certifications is required for the provider.

Eligible Program Codes

01- Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date Never prior to license begin date

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Physician

9.11.41 Licensed Clinical Social Worker (LCSW) - AS OF 11/30/2013 DMAS/PES WILL NO LONGER ENROLL OR RE-ENROLL Behavioral Health Services.

Class Type

076 – LCSW

NPI**Specialty**

016 – DD Waiver

047 – Substance Abuse (restricted, see Substance Abuse remarks)

Type of Agreement

Participation

Required Documents/Notes

Department of Health of VA License or license from state in which provider practices

Substance Abuse Specialty: Providers requesting to enroll as a Substance Abuse Provider must submit proof of one of the following licenses/certificates before receiving a specialty of 047:

Substance Abuse Counselor certified by the Board of Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals of DHP

Addictions Counselor certified by the Substance Abuse Certification Alliance of VA, OR physician credentials, by the American Society of Addictions Medicine

Clinical Psychologist certified in the treatment of alcohol and other psychoactive substance abuse use disorders by the American Psychological Association

Eligible Program Codes

01- Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date Never prior to license begin date

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Physician

**9.11.42 Licensed Marriage and Family Therapist - AS
OF 11/30/2013 DMAS/PES WILL NO LONGER
ENROLL OR RE-ENROLL Behavioral Health
Services.**

Class Type

102 – Licensed Marriage and Family Therapist

NPI

Specialty

None

Type of Enrollment Application

Licensed Marriage Family Therapist

Required Documents

Department of Health of VA License or license from state in which provider practices

Eligible Program Codes

01-Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date Never prior to license begin date

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Physician

9.11.43 Licensed Professional Counselor (LPC) - AS OF 11/30/2013 DMAS/PES WILL NO LONGER ENROLL OR RE-ENROLL Behavioral Health Services.

Class Type

021 – LPC

NPI

Specialty

016- DD Waiver

047 Substance Abuse (must send extra documentation)

Type of Agreement

Participation

Required Documents

Department of Health of VA License or license from state in which provider practices

Substance Abuse Specialty: Providers requesting to enroll as a Substance Abuse Provider must submit proof of one of the following licenses/certificates before receiving a specialty of 047:

Substance Abuse Counselor certified by the Board of Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals of DHP

Addictions Counselor certified by the Substance Abuse Certification Alliance of VA, OR physician credentials, by the American Society of Addictions Medicine

Clinical Psychologist certified in the treatment of alcohol and other psychoactive substance abuse use disorders by the American Psychological Association

Eligible Program Codes

01- Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date Never prior to license begin date

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Physician

9.11.44 Licensed School Psychologist - AS OF 11/30/2013 DMAS/PES WILL NO LONGER ENROLL OR RE-ENROLL Behavioral Health Services.

Class Type

101 – Licensed School Psychologist

NPI

Specialty

026 – Psychology Services

Type of Enrollment Application

Licensed School Psychologist

Required Documents

Department of Health of VA License or license from state in which provider practices

Eligible Program Codes

01-Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date Never prior to license begin date

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Physician

9.11.45 Medallion – PCT 020,051,052,053 – NO LONGER ENROLLED

AS OF 04/30/2012 DMAS/PES WILL NO LONGER ENROLL OR RE-ENROLL MEDALLION PROGRAM 02 FOR PHYSICIANS, HDCs, FQHCs, or RHCs.

Class Type

020- Physician

051 – Health Department Clinic

052 – Federally Qualified Health Center

053 – Rural Health Clinic

NPI

Specialty-

053,056- (Family/General Practice)

060- Internal Medicine

062- OB/GYN, Women's Health

067- Pediatrician

Type of Enrollment Application

Medallion Enrollment Application

Required Documents/Notes

Physician –State Medical License

Health Department Clinic- State approved

Federally Qualified Health Center and Rural Health Clinic– CMS Certification and rates from Clifton Gunderson

All providers enrolling for Medallion must submit a signed Medallion Participation Agreement along with Medallion Panel/Enrollment form in order to enroll.

**Qualifications for MEDALLION FFS Provider AS OF 04/30/2012
DMAS/PES WILL NO LONGER ENROLL OR RE-
ENROLL MEDALLION PROGRAM FOR PHYSICIANS,
HDCs,FQHCs, or RHCs.**

Provider must have servicing location in MEDALLION designated area. Out of state providers may participate if they are in a contiguous area to a designated area. Bristol TN is contiguous to Bristol VA. Please review with Manager prior to approval of contiguous area.

- 051 – Health Department Clinic
- 052 – Federally Qualified Health Center
- 053 – Rural Health Clinic
- 053,056- (Family/General Practice)
- 060- Internal Medicine
- 062- OB/GYN, Women’s Health
- 067- Pediatrician

Provider must complete Provider Enrollment Application for Provider Type

Complete the MEDALLION Participation Agreement and application which includes the following

- Enrollment Type – Open, History Only, or Existing Members only
 - Open – Open (History & Random) Practice will accept all MEDALLION members not to exceed panel enrollment size of 2000.
 - History – only Medicaid members billed to Medicaid within the last 12 months will be assigned to provider panel. No other patients can be added unless your office contacts the MEDALLION Unit directly by phone (800-643-2273) or by FAX (800-613-5955) with the Client Assignment Fax form.
 - Existing Members only- only the patients that provider has listed will be assigned to panel. Note: You must provide the MEDALLION Unit with a list of patients with Medicaid numbers. No other patients can be added unless your office contacts the MEDALLION Unit directly by phone (800-643-2273) or by FAX (800-613-5955) with the Client Assignment Fax form.
 - Panel Enrollment Size- Selected Panel Size
 - Enrollment Age Type – Adults only, Children Only, or Adults and Children
 - Special Services – Handicapped Access or EPSDT
 - Languages – English, Spanish, Korean, Hindi, Farsi, or other

Eligible Program Codes

- 01 – Medicaid
- 02- Medallion
- 08 – FAMIS

Program Eligibility Begin Date

AS OF 04/30/2012 DMAS/PES WILL NO LONGER ENROLL OR RE-ENROLL MEDALLION PHYSICIANS, HDCs, FQHCs, or RHCs.

Program Eligibility End Date

Physician – License Expiration Date

Health Department Clinic, Federally Qualified Health Center, and Rural Health Clinics-Indefinite

Reimbursement Type

Physician – Case Management Fee

Health Department Clinic, Federally Qualified Health Center, and Rural Health Clinics-Case Management Fee and cost settled

Manual Type

Physician

Medallion Detailed Enrollment Procedures – to be completed after enrollment into MMIS as a Program code 002 provider.

Procedures:

- 1) From the Provider Main Menu, enter the following selections:
- 2) From Selection drop-down box select, Reinstate change
- 3) Click Change for Function
- 4) Enter NPI in ID field
- 5) Click Enter to display PS-S-001-03 Provider Location Information-Reinstate
- 6) Scroll to Medallion approved Service Location/Group Affiliation
- 7) From Provider Program Information
- 8) Enter Program 02
- 9) Program Begin Date – Begin date should be date Medallion participation approved
- 10) Program End Date- 12/31/9999
- 11) RSN – 000
- 12) Fee Ind – Enter “Y”
- 13) Press Enter
- 14) Press Update
- 15) From the Provider Main Menu, enter the following selections:

From the **Selection** drop-down box, select Managed Care Enrollment Update

Enter NPI in ID field

Click Enter to display PS-S-026 Managed Care Enrollment update screen

Choose from the following according to Medallion Panel Form

Enrollment Type – Open, History Only, or Existing Members only

Panel Enrollment Size- Selected Panel Size

Enrollment Age Type – Adults only, Children Only, or Adults and Children

Special Services – Handicapped Access or EPSDT Ind

Languages – English, Spanish, Korean, Hindi, Farsi, or other

Enter

Update

If provider has completed Affiliation form Click Affiliation at bottom of screen

Medallion detailed affiliation procedures

- 1) From VA MMIS Main Menu.
- 2) Click on Provider Icon.
- 3) From Selection Click on Affiliation Update Screen (PS-S-023)
- 4) Click on Change.
- 5) Enter NPI into input field click Enter.
- 6) Place 02 in Group Type field click Enter.
- 7) Enter NPI for first provider designated on Medallion provider affiliation form.
- 8) Begin date- Effective date of Medallion enrollment.
- 9) End date- 12/31/9999.
- 10) Affiliation Type– Enter “1” for Managed Care.
- 11) Group Type- Enter “1” for Managed Care.
- 12) Click Enter then Update.

Medallion detailed termination procedures

- 16) Is the termination date requested by provider within current month and prior to Medallion Run for the month?
 - 2) Termination date would be end of current month
 - 3) Is the termination date requested by provider within current month, but after Medallion run for the month?
 - 4) Termination date would be last day of month for the following month.
 - 5) Is the termination date requested by provider a future date?
 - 6) Termination date would be last day of month of request.
 - 7) Once termination date is determined, please proceed to terminate provider accordingly using steps outlined in section 5.5 Terminate provider.

9.11.46 Mental Health – Mental Retardation and Substance Abuse Services

Class Type

056 – Mental Health Mental Retardation and Substance Abuse Services

NPI

Specialty

041– CSB Clinic – Mental Health Clinic –DBHDS as Outpatient Mental Health — As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.

042 – CSB Mental Health: State Plan Options- As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.

043 – CSB Mental Retardation: State Plan Options- As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.

045 – Private Provider AS OF 11/30/2013- As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.

116- Early Intervention

119-Early Intervention Targeted Case Management

120 – EPSDT- Behavioral Therapy

Type of Enrollment Application

Mental Health Mental Retardation and Substance Abuse Services

Required Documents/Notes

Department of Department Behavioral Health and Developmental Services (DBHDS)
License

Providers are authorized to perform certain procedures only. Their authorization comes from the (DBHDS), each procedure has its' own licensure requirements and procedure/restriction code that will be placed on the individual provider file.

This authorization takes the form of a letter submitted by mail, fax, or email, or verification can take place via download from the DBHDS website LPSS/mdb.

Providers complete “new” enrollment packer each time they are approved or want to add new services.

The provider has the choice of billing under one main NPI #; although they should have each location where services are rendered enroll.

Optional-Early Intervention Attestation form

The DBHDS may be late in renewing licenses and DMAS and DBHDS have an agreement wherein for provider's whom are affected the PES will accept a letter of good standing either via email, fax, or USPS from DBHDS or provider stating that their facility is still in good standing 6 months from original license end date. PES will key 6 months in future from original license end date.

Appendix 7.10 Behavioral Health and Developmental Services Matrix has all Procedure Codes for Development Disabled provider types. This Matrix will be used to determine the procedures to be entered into the Provider Restriction Screen (PS-S-10) Provider Restriction. Detailed Instructions on how to enter Provider Restrictions can be found in Section 3.1.10.

Mental Health Clinics must be licensed as Outpatient Mental Health Services through DBHDS

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Mental Health and Rehabilitative Services

9.11.47 Mental Retardation Waiver

Class Type

056 – Mental Health Mental Retardation and Substance Abuse Services

API/NPI

Specialty

044 – MR Waiver Community Service Board

046 – MR Waiver Private

116- Early Intervention

119-Early Intervention Case Management

Type of Enrollment Application

Mental Health Mental Retardation and Substance Abuse Services, Durable Medical Equipment, Personal Care, Respite Care, Private Duty Nursing, or Home Health Agency.

Required Documents/Notes

1. Specific license/certification for service type from one of the following entities:
 - a. DBHDS-Department of Behavioral Health and Developmental Services
 - b. DRS-Department of Rehabilitation Services
 - c. DSS-Department of Social Services
 - d. DHP-Department of Health Professions

- e. BCBA-Board Certified Behavior Analyst
 - f. BCABA-Board Certified Associate Behavior Analyst
 - g. Endorsement in Positive Supports issued by Partners for People with Disabilities at Virginia Commonwealth University
 - h. NCTRC-National Council for Therapeutic Recreation Consultation
2. The Commissioner may issue the following types of licenses per 12VAC35-105-50:
 - A. A conditional license shall be issued to a new provider for services that demonstrates compliance with administrative and policy regulations but has not demonstrated compliance with all the regulations.
 1. A conditional license shall not exceed six months.
 2. A conditional license may be renewed if the provider is not able to demonstrate compliance with all the regulations at the end of the license period.
 3. A conditional license and any renewals shall not exceed 12 successive months for all conditional licenses and renewals combined.
 4. A provider holding a conditional license for a service shall demonstrate progress toward compliance.
 5. A provider holding a conditional license shall not add services or locations during the conditional period.
 6. A group home or community residential service provider shall be limited to providing services in a single location, serving no more than four individuals during the conditional period.
 - B. In accordance with the regulation, Provider Enrollment Services can accept a DBDHS conditional license for new enrollments of those providers who are licensed for services covered under the VA Medicaid Fee for Service program.
 3. Providers are authorized to perform certain procedures only. Their authorization comes from the (DBHDS). Each procedure has its' own licensure requirements and procedure/ restriction code that will be placed on the individual provider file.
 4. This authorization takes the form of a license/certification submitted by mail, fax, or email, or verification can take place via download from the DBHDS website LPSS/mdb.
 5. Providers complete "new" enrollment packer each time they are approved or want to add new services.
 6. The provider has the choice of billing under one main NPI #; although they should have each location where services are rendered enroll.
 7. Optional-Early Intervention Attestation form
 8. The DBHDS may be late in renewing licenses and DMAS and DBHDS have an agreement wherein for provider's whom are affected the PES will accept a letter of good standing either via email, fax, or USPS from DBHDS or provider stating that their facility is still in good standing 6 months from original license end date. PES will key 6 months in future from original license end date.

9. Appendix 7.10 Behavioral Health and Developmental Services Matrix has all Procedure Codes for Development Disabled provider types. This Matrix will be used to determine the procedures to be entered into the Provider Restriction Screen (PS-S-10) Provider Restriction. Detailed Instructions on how to enter Provider Restrictions can be found in Section 3.1.10.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Mental Health and Rehabilitative Services

9.11.48 Nurse Practitioner (NP)

Class Type

023 – Nurse Practitioner

NPI

Specialty

022 – Women’s Health (formerly OB/GYN)

023 – Family

024 – Pediatric

107 – Adult

108 – Geriatric

109 – Neonatal

110 – Acute Care

111 – Psychiatric

112 – Certified Nurse Midwife (formerly PCT 035)

Type of Enrollment Application

Nurse Practitioner

Required Documents/Notes

Department of Health License for VA or state in which provider is practicing

Eligible Program Codes

01- Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date.

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for service

Manual Type

Manual

Physician

9.11.49 Nursing Home - Intensive Care/Nursing Facility (ICF/NF)

NURSING HOME – PCT = 015

Agreement requests are referred to LTC supervisor.

Class Type

015

NPI

Specialty – Written approval through DMAS LTC

086 – Vent

087 – AIDS

089 – Complex

092 – Rehab

Type of Agreement

Nursing Home

Required documents/Notes

CMS certification as ICF/NF

Certificate and Transmittal (C & T) - CMS 1539

VDH license Nursing Home License

LTC approval letter

Rates from Clifton Gunderson

Must already be enrolled as a PCT 10

Supervisor approval prior to enrolling

Change of ownership bed transfer procedures following Section 6.11.46
Nursing Home II detailed procedure manual

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite

Reimbursement Type

Cost Settled-Clifton Gunderson

Manual Type

Nursing Facilities

Nursing Facility Certificate and Transmittal (C&T) Process Instructions:

A participating nursing home provider is a nursing facility that is certified by the Centers for Medicare/Medicaid Services (CMS), Virginia Department of Health (VDH), and has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS). CMS maintains oversight of the survey and certification of nursing homes, and makes available to State surveyors information about these activities and nursing home quality. Periodically, CMS initiates a Medicare/Medicaid C&T form for one or more of the following reasons:

Initial: A facility has applied and been approved for certification by CMS.

Recertification: A nursing home's Medicare/Medicaid eligibility has been recertified by CMS.

Change of Ownership (CHOW): A nursing home has reported a change of ownership to CMS.

Validation: Confirmation or finding of fact regarding a specific issue in a nursing home.

Complaint: Investigation of a complaint regarding a specific nursing home from a recipient, recipient family member, State or Federal agency, etc.

On-site visit: Random or scheduled on-site visit by State or Federal surveyors for evaluation of compliance with program requirements.

Termination of ICF Beds: A nursing home's certification for Intermediate Care Facility beds has been terminated.

Other: Default for any reason other than the previously listed categories. When this reason is used, an explanation is usually given in the State Survey Remarks field of the C&T.

The CMS C&T form consists of 2 parts. Part 1 is completed by the State survey agency (VDH) and Part 2 is completed by the CMS Regional Office or State survey agency.

Once the C&T has been approved by VDH, it is forwarded to Virginia Medicaid Provider Enrollment Service for verification and possible maintenance to provider file. Once processing is complete, it is signed, dated, and forward to DMAS Long Term Care (LTC) Department for their records and further processing.

Procedures for Processing C&T

Identify the provider

1. Verify name and Address of Facility
2. Identify and Process the Type of Action indicated in Section 4 of the C&T- Section 4 off C&T contains the reason for the initiation of form.
 - a. Type 1 Initial- New Facility to enroll – Follow steps outlined in Nursing Home procedures 6.11.46 for documents received to enroll
 - b. Type 2 Recertification – Facility has been recertified. Make necessary changes to name or follow steps for update (section 5.7)
 - c. Type 3 Termination – PES will verify cancellation with DMAS LTC department prior to termination (Melissa Fritzman)
 - d. Type 4 Change of Ownership (CHOW) - Follow procedures for CHOW in section 6.11.46 Nursing Home detailed.
 - e. Type 5 Validation- No action taken by PES, sign and date in Section 30, forward to DMAS LTC Department.
 - f. Type 6 Complaint- No action taken by PES, sign and date in Section 30, forward to DMAS LTC Department.
 - g. Type 7 On-Site Visit- No action taken by PES, sign and date in Section 30, forward to DMAS LTC Department.
 - h. Type 8 Termination of ICF Beds- C&T with this action will be accompanied with an attachment that details the facilities new bed structure.
 - A. A Nursing Facility Response Letter must be created showing the bed breakdown information.
 - B. Save copy to ECM
 - C. Forward copy to Clifton Gunderson via inter-office.
 - D. PES will sign and date in Section 30 of C&T and forward to DMAS.
 - i. Type 9 Other- When this reason is used, an explanation is usually given in the State Survey Agency Remarks field Section 16) of the C&T. If the facility has had a change in certification of beds, follow the direction for Type 8.
 - A. Copy of C & T

9.11.50 Nursing Home – Skilled Nursing Facility (SNF)

NURSING HOME PCT = 006, 010, 011, 015, 016, 017, 018

Class Type

006 – SNF, Mental Health

010 – SNF, Non Mental Health

011 – SNF, Mentally Retarded

016 – ICF, Mental Health

017 – ICF, Mentally Retarded State Owned

018 – ICF, Mentally Retarded Community Owned

NPI**Specialty**

None

Type of Agreement

Nursing Home

Required Documents/Notes

Class Type 006, 011, 016,017, and 018

- 1) CMS Certification (C&T) as SNF Mental Health/Retarded or ICF Mental Health/Retardation State Owned or Community Owned.
- 2) C & T -CMS 1539
- 3) DBHDS License as ICF/SNF
- 4) Rates from Clifton Gunderson
- 5) Manager/Team Lead approval prior to enrolling

Class Type 010

- 6) CMS Certification as SNF
- 7) C& T - CMS 1539
- 8) VDH Nursing Home License
- 9) Rates from Clifton Gunderson
- 10) Manager/Team Lead approval prior to enrolling

Change of ownership bed transfer procedures following Section 6.11.46
Nursing Home II detailed procedure manual

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite

Reimbursement Type

Cost Settled-Clifton Gunderson

Manual Type

Nursing Facilities

Nursing Facility Certificate and Transmittal (C&T) Process Instructions:

A participating nursing home provider is a nursing facility that is certified by the Centers for Medicare/Medicaid Services (CMS), Virginia Department of Health (VDH), and has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS). CMS maintains oversight of the survey and certification of nursing homes, and makes available to State surveyors information about these activities and nursing home quality. Periodically, CMS initiates a Medicare/Medicaid C&T form for one or more of the following reasons:

- Initial:** A facility has applied and been approved for certification by CMS.
- Recertification:** A nursing home's Medicare/Medicaid eligibility has been recertified by CMS.
- Change of Ownership (CHOW):** A nursing home has reported a change of ownership to CMS.
- Validation:** Confirmation or finding of fact regarding a specific issue in a nursing home.
- Complaint:** Investigation of a complaint regarding a specific nursing home from a recipient, recipient family member, State or Federal agency, etc.
- On-site visit:** Random or scheduled on-site visit by State or Federal surveyors for evaluation of compliance with program requirements.
- Termination of ICF Beds:** A nursing home's certification for Intermediate Care Facility beds has been terminated.
- Other:** Default for any reason other than the previously listed categories. When this reason is used, an explanation is usually given in the State Survey Remarks field of the C&T.

The CMS C&T form consists of 2 parts. Part 1 is completed by the State survey agency (VDH) and Part 2 is completed by the CMS Regional Office or State survey agency. Once the C&T has been approved by VDH, it is forwarded to Virginia Medicaid Provider Enrollment Service for verification and possible maintenance to provider file. Once processing is complete, it is signed, dated, and forward to DMAS Long Term Care (LTC) Department for their records and further processing.

Procedures for Processing C&T

1. Identify the provider
2. Verify name and Address of Facility
3. Identify and Process the Type of Action indicated in Section 4 of the C&T- Section 4 off C&T contains the reason for the initiation of form.
 - a. Type 1 Initial- New Facility to enroll – Follow steps outlined in Nursing Home procedures 6.11.46 for documents received to enroll

- b. Type 2 Recertification – Facility has been recertified. Make necessary changes to name or follow steps for update (section 5.7)
- c. Type 3 Termination – PES will verify cancellation with DMAS LTC department prior to termination (Melissa Fritzman)
- d. Type 4 Change of Ownership (CHOW) - Follow procedures for CHOW in section 6.11.46 Nursing Home detailed.
- e. Type 5 Validation- No action taken by PES, sign and date in Section 30, forward to DMAS LTC Department.
- f. Type 6 Complaint- No action taken by PES, sign and date in Section 30, forward to DMAS LTC Department.
- g. Type 7 On-Site Visit- No action taken by PES, sign and date in Section 30, forward to DMAS LTC Department.
- h. Type 8 Termination of ICF Beds- C&T with this action will be accompanied with an attachment that details the facilities new bed structure.
 - A. A Nursing Facility Response Letter must be created showing the bed breakdown information.
 - B. Save copy to ECM
 - C. Forward copy to Clifton Gunderson via inter-office.
 - D. PES will sign and date in Section 30 of C&T and forward to DMAS.
- i. Type 9 Other- When this reason is used, an explanation is usually given in the State Survey Agency Remarks field Section 16) of the C&T. If the facility has had a change in certification of beds, follow the direction for Type 8.
 - A. Copy of C & T

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO. (L1)		3. NAME AND ADDRESS OF FACILITY (L3)		4. TYPE OF ACTION: <u>1</u> (L8)	
2. STATE VENDOR OR MEDICAID NO. (L2)		4. STATE VENDOR OR MEDICAID NO. (L2)		3. Initial 3. Termination 3. Voluntary 3. Out-of-State Visit 3. Termination of RCF Beds	
5. EFFECTIVE DATE CHANGE OF OWNER (L9)		7. PROVIDER/SUPPLIER CATEGORY (L7) (L7)		FISCAL YEAR ENDING DATE (L15) 12/31/10	
6. DATE OF SURVEY 09/21/2010 (L14)		8. ACCREDITATION STATUS: 1. Accredited 2. AOA		9. TYPE OF ACTION: 01 Hospital 02 SNF 03 Other 04 LAR 05 SNF 06 Other 07 RNF 08 RNF 09 RNF 10 RNF 11 RNF 12 RNF 13 RNF 14 ASC 15 RNF 16 RNF	
11. LTC PERIOD OF CERTIFICATION From (A): To (B):		10. THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: <input checked="" type="checkbox"/> 1 Acceptable POC B. Not In Compliance With Program Requirements under Applied Waiver: * Code: A1 (L17)		12. Total Facility Beds: 240 (L11) 13. Total Certified Beds: 240 (L12)	
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS		16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):	
18 SNF 18-19 SNF 19 SNF OCF DNR 0 240 0 0 0 (L13) (L14) (L15) (L16) (L17)		1801 (a) (1) or 1801 (d) (1) 1 (L18)		17. SURVEYOR SIGNATURE Date: 11/19/10 (L19)	
18. STATE SURVEY AGENCY APPROVAL Date: 11/19/10 (L20)					

PART II - TO BE COMPLETED BY CMS REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible To Participate 2. Facility is Not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT: N		21. Statement of Financial Solvency (CMS-2572) 1. Ownership/Control Interest Disclosure Sheet (CMS-1315) 2. Both of the Above	
22. ORIGINAL DATE OF PARTICIPATION (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		24. LTC AGREEMENT ENDING DATE (L25)	
25. LTC EXTENSION DATE (L17)		27. ALTERNATIVE SANCTIONS A. Suspension Of Admissions B. Revoked Suspension Date (L44) (L45)		26. TERMINATION ACTION: VOLUNTARY <u>01</u> (L30) 01-Merger, Closure 02-Discontinuation (w/ Reimbursement) 03-Risk Of Imminent Termination 04-Other Status For Withdrawal 05-Other 06-Other 07-Provides Name Change 08-VOLUNTARY 09-Fail To Meet Licensure/Safety 10-Fail To Meet Agreement	
28. TERMINATION DATE (L28)		29. INHERITITARY/CARRIER NO. (L31)		30. REMARKS Health Survey 9/21-9/23/10	
31. RO RECEIPT OF CMS-1339 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	

Additional Procedures

If a pink and white copy of the C&T is attached with original C&T (yellow), the pink and white copies are mailed to VDH once processing has been complete. The pink and white copies must also be signed by PES Enrollment Specialist. The mailing address for VDH is as follows:

Virginia Department of Health
PO Box 2448
Richmond, VA 23218-2448

9.11.51 Change in Nursing Home Ownership Bed Transfer Procedures—From Reference Menu, select System Support

1. On drop down menu, select System Parameters and Add.
2. System Parameter Screen: (Screen RF-S-016-01 System Parameter not available)
3. Enter data in the first blank line:
 - a. Subsystem = AS
 - b. Value ID = asr400
 - c. Description = provider number change
 - d. Begin = date after which you wish the change to be processed by the system
 - e. End = leave blank. System generated after the transaction is processed.
 - f. Value type = c
 - g. Length Val = 63 (value field length)
 - h. Length Dsc = 0 (number, not letter)
 - i. Date Type = leave blank
 - j. Value = new prov-9999999999,010,01,olprov-9999999999,010,01mm/dd/ccyy,
 - A. The string must be 63 characters long, including the commas and dashes, exactly as shown on the following screen (Screen RF S-016-01 System Parameter not available)
 - B. Enter the new provider NPI where the first sets of 9s show in above example.
 - C. Enter the old provider NPI where the second sets of 9s show in above example.
 - D. The 101 is the Provider Type. The 01 is the site locations. If the provider type and site location are not 010 and 01, enter the correct value for the new and old provider.
 - E. For the date, enter the effective date of the change. It should be the first day of the month following the system change.
4. Choose Update to save the transaction.
5. After completing the transaction, you must enter a request for the job to run and generate the AS-0-400 report.
6. Return to the main menu (RF-S-800 Batch On-Request Report will add when available)
7. Select Batch On-Request report.
8. Select Financial. The following screen will be displayed: (RF-S-801 Financial System will add when available)

9. Enter 01 in the Enter Report Selection Number field.
10. Click Add Request to submit.
11. The following day, report AS-0-400 should be available in ECM in the Assessment folder showing all recipients who were transferred.
12. Once reports are verified in ECM, notify DMAS LTC Melissa Fritzman via email that the reports are in ECM.

9.11.52 Optician

Class Type

032 – Optician, Optician Clinic

NPI**Specialty**

None

Type of Agreement

Participation

Required Documents/Notes

Department of Health License for VA or state in which provider is practicing

Optical Clinics are enrolled under this PCT as well. The name on Enrollment Application will reflect Optical Clinic.

Eligible Program Codes

01-Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date.

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for service

Manual Type

Physician

9.11.53 Optometrist

Class Type

031 – Optometrist

NPI

Specialty

None

Type of Agreement

Participation

Required Documents/Notes

Department of Health License for VA or state in which provider is practicing

Eligible Program Codes

01-Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date.

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for service

Manual Type

Physician

9.11.54 Ordering, Referring, Prescribing Provider (ORP)

Class Type

078 – ORP-Other

Corresponding Provider Type based on selection on application. The provider types, listed below, are the only eligible providers to be enrolled as an Ordering, Referring and Prescribing provider.

Audiologist	Licensed Substance Abuse Treatment Practitioners
Baby Care	Non-Medicaid TDO
Certified Professional Midwife	Nurse Anesthetist
Chiropractor	Nurse Practitioner
Clinical Nurse Specialist	Occupational Therapist
Clinical Psychologist	Optician
Dentist	Optometrist
Licensed Clinical Social Worker	ORP Other (See Below)
Licensed Marriage and Family Therapist	Out of State Physician
Licensed Professional Counselor	Out of State Psychiatrist
Licensed Psychologist	Physical Therapist
Licensed School Psychologist	Physician
	Podiatrist
	Psychiatrist
	Speech/Language Pathologist

NPI

Specialties

Specialties	Code
Physician Assistant	123
Intern	124
Other	125

Type of Agreement

Ordering, Referring, Prescribing Provider Participation

Required Documents/Notes

Required Documents: Copy of license

Notes: If an active Medicaid provider submits an ORP enrollment application:

1. The PES representative should not enroll the ORP provider type.
2. If there are any Federal Database matches, the PES Specialist should refer the work item to management for resolution before rejecting the application.
3. The PES representative must reject the application by doing the following:
 - a. Click on the Missing Information Tab in Workflow
 - b. Check the Other: See Below box
 - c. Click Save
 - d. Click on the Case Tab in Workflow
 - e. Click on reject reasons dropdown box
 - f. Select "This Provider type is not eligible to enroll in VA Medicaid"
 - g. In the Comments box, manually type "Provider is currently enrolled as an active provider. Therefore, it is not necessary to enroll as an Ordering, Referring, and Prescribing provider."
 - h. Click save
 - i. Click on the Action Tab and click Reject Application.

If an active ORP provider submits an enrollment application to be enrolled as a Medicaid provider:

1. The PES representative must process the enrollment application according to the normal procedures
2. Terminate the ORP type/loc with reason code 006 with a term date 1 day prior to the new enrollment effective date.
** Please note: The ORP enrollment is only canceled if the Medicaid provider application is approved.

Eligible Program Codes

11 – Ordering, Referring, Prescribing Provider

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License expiration date

Reimbursement Type

None

Manual Type

Ordering, Referring, Prescribing Provider

9.11.55 Outpatient Clinic – NO LONGER ENROLLED

Do not enroll any providers in this PCT as of 04/25/2001.

Class Type

020 – Outpatient Clinic

095 – Outpatient Clinic (out-of-state)

9.11.56 Outpatient Rehabilitation

Class Type

057

NPI

Specialty

116- Early Intervention

Type of Agreement

Outpatient Rehab

Required Documents/Notes

CMS certification as Outpatient Rehab Agency or Physical Therapy Clinic

Optional- Early Intervention Attestation form

Eligible Program Codes

01-Medicaid

08-FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date.

Program Eligibility End Date

Indefinite

Reimbursement Type

Fee for service

Manual Type

Rehabilitation and Physician Manual

9.11.57 Personal Care

Class Type

055

API/NPI

Specialty

046

016

Type of Agreement

CBC Personal Care application and Personal Care Participation Agreement

Required Documents/Notes

1. No out of state providers
2. Effective July 1, 2012, all Personal and Respite Care providers must hold license or certification that is site specific and must match the servicing address in MMIS for existing providers.
3. One of the following may be submitted as license or certification for these providers for new enrollment and for re-enrollment:
 - **VDH exemption letter stating that “provider” is exempt from VDH licensure because they hold a valid license through an entity such as CMS that would exempt them from having to obtain a VDH Home Care Organization license.**
 - **VDH Home Care Organization license**
 - **CMS certification**
 - **JC – Joint Commission Certification**
 - **CHAP – Community Health Accreditation Program Certification**
 - **ACHC – Accreditation Commission for Health Care, Inc. Certification**

Eligible Program Codes

01- Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date

Program Eligibility End Date

5 years from begin date

Reimbursement Type

Fee for service

Manual Type

N/A

New Enrollments

CBC Application

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: Only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, must have the type of offense, name, and title of individual. If those items are given, route the documents to the lead (CBC must review them). Must be signed and dated.

Part C of the application

Personal/Respite Care

Must have information on at least one individual.

Optional.

Must have at least one RN listed with a current license end date.

Re-Enrollment Requirements

Complete a new Community Based Care (CBC) application.

9.11.58 PACE – Program for the All-inclusive Care of the Elderly

Class Type

104 – PACE

API/NPI

Specialty

113 – Full Pace

Type of Enrollment Application

PACE

Required Documents/Notes

Specific Department of Social Services license, as an Adult Day Health Care, provider
Rates as provided by DMAS.

RATES are determined by Region and are provided by DMAS

Region	Dual Eligible FY 2012	Non-Dual Eligible FY 2012	Weighted Average FY 2011
Northern Virginia	\$4,295.12	\$5,824.73	\$4,454.80
Other MSA	\$3,166.46	\$4,526.80	\$3,244.70
Richmond/Charlottesville	\$3,473.84	\$5,287.17	\$3,620.00
Rural	\$3,044.96	\$4,716.64	\$3,145.15
Tidewater	\$3,418.67	\$4,912.76	\$3,562.09

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date.

Program Eligibility End Date

License expiration date

Reimbursement Type

Per Diem

Manual Type

Adult Day Health Care

9.11.59 Community Based Care Enrollment and Re-enrollment Instructions

New Enrollments:

CBC Application

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: The only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%.

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, RTP with appropriate letter designated to request offense information. Once received please route to Team Lead for approval from DMAS Provider Enrollment Contract Monitor.

Part C of the application

Adult Day Health Care

Must have information on at least one individual

Optional

Re-Enrollment Requirements

Complete a new Community Based Care (CBC) application and submit updated DSS license.

9.11.60 Personal Emergency Response System (PERS)

Class Type

062 – Durable Medical Equipment Supplier

NPI

Specialty

None

Type of Enrollment Application

Personal Emergency Response System Home and Community Based Care (CBC) application

Required Documents/Notes

Individual License or Certification for entity enrolling

Entities or Individuals who are eligible to enroll and must be appropriately licensed or certified as such and have the responsibility to furnish, install, maintain, test, monitor, and service the PERS equipment to keep it fully operational. The PERS provider must also employ an emergency response call center with fully trained operators that are capable of receiving signals for help from a members PERS equipment 24-hours a day, 365 days per year. The following entities are eligible to enroll as a PERS provider:

Home Health Agencies

Personal Care Agencies

Durable Medical Equipment Supplier

Hospital

PERS Manufacturer

Eligible Program Codes

01- Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date.

Program Eligibility End Date

5 Years

Reimbursement Type

Fee for service

Manual Type

Developmental Disability

New Enrollments

CBC Application

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: Only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%.

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, RTP with appropriate letter designated to request offense information. Once received please route to Team Lead for approval from DMAS Provider Enrollment Contract Monitor

Part C of the application

Personal Emergency Response System.

Must have information on at least one individual who is responsible for daily management of the PERS and who they report to.

Re-Enrollment Requirements

Complete a new Community Based Care (CBC) application.

9.11.61 Pharmacy

Class Type

060 – Pharmacy

NPI

Specialty

069 – used if approved by DMAS as a Unit Dose provider

Type of Enrollment Application

Pharmacy

Required Documents

1. In VA
 - a. RX Enrollment Application and,
 - b. VA Board of Pharmacy License
2. Out of State- 50 miles of VA
 - a. RX Enrollment Application and

- b. VA Board of Pharmacy Non-Resident License or,
- 3. Out of State- Not within 50 miles of VA – Will be rejected unless they have the following licensure.
 - a. Must have VA Board of Pharmacy Non-Resident License
- 4. If provider requests Point of Sale (POS) on enrollment application, follow detailed procedures for entering POS on provider file in Section 5.7.5. If they answer “No” or leave the field blank, follow the same detailed procedure found in Section 5.7.5.
- 5. We will enroll Mail Order Pharmacies only if provider holds a VA Board of Pharmacy permit
- 6. Unit Dose form must be completed by provider and submitted to Pharmacy Director at DMAS prior to approval

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Pharmacy

9.11.62 Physician

Class Type

020 – Physician

047-Substance Abuse

095 – Physician (out-of-state)

NPI

Specialties

Specialties	Code
Anesthesiology	057
Cardiac Surgery	073
Cardiology	060
Colon & Rectal Surgery	058
Critical Care	060
Dermatology	059

Specialties	Code
DO (Doctor of Osteopathy)	060
Emergency	060
Endocrinology	060
Ear, Nose, and Throat (ENT)	060
Family Practice	053 and 056
Gastroenterology	060
General Practice	056
General Surgery	073
Hematology/Oncology	060
Infectious Disease	060
Internal Medicine	060
Neonatology	067
Nephrology	060
Neurological Surgery	061
Neurology	071
Nuclear Medicine	060
Obstetrics & Gynecology	062
Ophthalmology	063
Orthopedic Surgery	064
Osteopathy	060
Other	076
Otolaryngology	065
Pathologist	066
Pediatrics	067
Perinatology	062
Physical Medicine & Rehabilitation	068
Plastic Surgery	069
Preventive Medicine	070
Psychiatry (Effective 12/1/14 this specialty is enrolled with Magellan)	071
Pulmonary	060
Radiation Oncology	060
Radiology	072
Rheumatoid	060
Substance Abuse – Restricted	047
Surgery Cardiothoracic	074
Telemedicine	127 (see required documents below)
Thoracic Surgery	074
Transplant Surgery	073

Specialties	Code
Urology	075
Vascular	073

Type of Agreement

Participation

Required Documents/Notes

Copy of license

Substance Abuse Specialty Agency – Providers requesting to enroll as a Substance Abuse Provider must submit proof of one of the following licenses/certificates before receiving a specialty of 47

Substance Abuse Counselor certified by the Board of Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals of DHP

Addictions Counselor certified by the Substance Abuse Certification Alliance of VA, OR physician credentials, by the American Society of Addictions Medicine

Clinical Psychologist certified in the treatment of alcohol and other psychoactive substance abuse use disorders by the American Psychological Association

Oral Surgeons – Please See Dentist Section

Telemedicine- Copy of the Virginia DHP licensed and copy of the out-of-state license where the provider is located. If the provider is in-state, only the DHP license is required.

SPECIAL NOTES for TELEMEDICINE

Adding Telemedicine Specialty 127 to existing provider:

1. In-State- A letter is required to add specialty.
2. Out-of-State (within 50 miles of the VA border) – A letter is required to add the specialty.
3. Out-of-State (not within 50 miles of the VA border) – must submit a letter and their VA DHP license to add the specialty.

Telemedicine information regarding effective for two licenses, see below examples:

1. If the requested effective date comes after both licenses begin dates then make that the effective date.
 - a. **Example:** Requested Effective Date: 05/01/2014; VA License Begin Date: 04/01/2014; OOS License Begin Date: 03/01/2014; In this case, program, provider type and specialty begin dates in workflow would be 05/01/2014
2. If the requested effective date comes before both license begin dates then set the effective date to the most recent license begin date.
 - a. **Example:** Requested Effective Date: 02/01/2014; VA License Begin Date: 04/01/2014; OOS License Begin Date: 03/01/2014; In this case, program, provider type and specialty begin dates in workflow would be 04/01/2014
3. If the requested effective date comes before one of the license begin dates then set the effective date to the most recent license begin date.

- a. **Example:** Requested Effective Date: 05/01/2014; VA License Begin Date: 07/01/2014; OOS License Begin Date: 03/01/2014; In this case, program, provider type and specialty begin dates in workflow would be 07/01/2014
- b. **Example:** Requested Effective Date: 05/01/2014; VA License Begin Date: 02/01/2014; OOS License Begin Date: 06/01/2014; In this case, program, provider type and specialty begin dates in workflow would be **06/01/2014**

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Physician

9.11.63 Podiatrist

Class Type

030 – Podiatrist

NPI

Type of Agreement

Participation

Required Documents/Notes

Department of Health of VA License or license from state in which provider practices

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Physician

9.11.64 Private Duty Nursing

Class Type

063 – Private Duty Nursing Services

NPI

Specialty

016 – DD Waiver

046 – MR Waiver

116- Early Intervention

Type of Enrollment Application

Community Based Care Private Duty Nursing Services application and Private Duty Nursing Services Enrollment Application

Required Documents

Accreditation Commission for Health Care, Inc. (ACHC)

Virginia Department of Health (VDH) Center for Quality Healthcare Services and Consumer Protection for the specific site as a Home Health Agency or Home Care Organization or,

JCAHO Accreditation or, CMS

Adult Day Care Center license from the Department of Social Services (DSS) or,

Community Health Accreditation Program (CHAP) certification

Optional-Early Intervention Attestation form

No out-of-state providers

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date.

Program Eligibility End Date

License or certification expiration date.

Reimbursement Type

Fee for Service

Manual Type

Technology Assisted Waiver and Private Duty Nursing Services

New Enrollments

CBC Application

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: Only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, must have the type of offense, name, and title of individual. If those items are given, route the documents to the lead (CBC must review them). Must be signed and dated.

Part C of the application

Private Duty Nursing Services

Must have information on at least one individual.

Optional.

Must have at least one RN listed with a current license end date.

Re-Enrollment Requirements

Complete a new Personal Care Enrollment application.

9.11.65 Prosthetic/Orthotic

Class Type

064 – Prosthetic/Orthotic

NPI

Specialty

None

Type of Agreement

Prosthetic and Orthotic

Required Documents/Notes

Certificate from the American Board for Certification on Orthotics and Prosthetics, or

Certificate from the Board for Orthotics/Prosthetics (BOC), or

Copy of Business License

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date**License expiration date****Reimbursement Type****Fee for service****Manual Type**

Prosthetic Devices

Some Prosthetics and Orthotics providers will dual enroll as a DME (PCT 062) provider, as well.

9.11.66 Psychiatrist

Class Type

020 – Physician

095 – Physician (out-of-state)

NPI**Type of Agreement**

Participation

Specialty

071 – Psychiatry

Required Documents/Notes

Department of Health of VA License or license from state in which provider practices

Certificate of completion of three years residency for new providers

Verify if the provider has or has been previously enrolled with VA Medicaid and there is a certificate of residency before sending a letter requesting a copy. Verify under name of provider.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Physician

9.11.67 Qualified Medicare Beneficiary (QMB) – Medicare Crossover

Class Type

099 – Qualified Medicare Beneficiary (QMB) – Medicare Crossover

API/NPI

Specialty

None

Type of Enrollment Application

Qualified Medicare Beneficiary (QMB) – Medicare Crossover

Providers who fall into this category are those Medicare-enrolled providers that DMAS cannot enroll for direct Medicaid reimbursement. This includes, but is not limited to:

- Certified Registered Nurse Anesthetics (CRNAs)

- Licensed Practical Nurses

- Occupational Therapists

- Physical Therapists

- Physician Assistant

- Registered Nurses

- Speech/language Pathologists

Additionally, some providers, who could and who are enrolled for direct Medicaid reimbursement, may wish to enroll for crossover as well.

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite

Reimbursement Type

Fee for Service

Manual Type

Physician

9.11.68 Renal Clinic

Class Type

050 – Renal Dialysis Clinics

NPI

Specialty

None

Type of Agreement

Clinic

Required Documents/Notes

CMS certification as a Renal Dialysis Clinic

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite

Reimbursement Type

Fee for Service

Manual Type

Renal Dialysis Clinic

9.11.69 Residential Psychiatric Treatment

Class Type

077 – Residential Psychiatric Treatment

NPI**Specialty**

114 – Level A

115 – Level B

000 – Level C

Type of Enrollment Application

Residential Psychiatric Treatment for Children and Adolescents

Required Documents/Notes

Level A – Department of Social Services (DSS), Department of Education (DOE), or Department of Juvenile Justice (DJJ), License

Level B – Department of Behavioral Health and Developmental Services (DBHDS) License

Level C – Department of Behavioral Health and Developmental Services (DBHDS/DBHDS) License as well as their current accreditation by one of the following; Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF); the Council on Quality and Leadership, or the Council on Accreditation Services for Families and Children. The Restraint and Seclusion Letter of Attestation must also be submitted for enrollment and no later than July first annually thereafter. Rates from DMAS.

Level C – The Restraint and Seclusion Letter of Attestation must also be submitted for initial enrollment and no later than July 1st annually thereafter

Residential Respite Care – Must complete the Respite Care Enrollment Application and enroll following procedures for Respite Care PCT 047 and be licensed through DBHDS as a provider of intellectual disability (mental retardation) services providing a children's residential services with a respite track for children/adolescents with intellectual disabilities.

Eligible Program Codes

Level C – 01 – Medicaid

Level A & B – 01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date.

Program Eligibility End Date

License expiration date

Reimbursement Type

Per Diem

Level C-Cost Settled-DMAS

Manual Type

Level A & B – Community Mental Health Rehabilitative Services Manual

Level C – Psychiatric Services Manual

9.11.70 Respite Care

Class Type

047

API/NPI**Specialty**

046

016

118 – Residential Respite Care

Type of Agreement

CBC Respite Care application and Respite Care Participation Agreement

Required Documents/Notes

- No out of state providers
- Effective July 1, 2012, all Personal and Respite Care providers must hold license or certification that is site specific and must match the servicing address in MMIS for existing providers.
- **VDH exemption letter stating that “provider” is exempt from VDH licensure because they hold a valid license through an entity such as CMS that would exempt them from having to obtain a VDH Home Care Organization license.**
- **VDH Home Care Organization license**
- **CMS certification**
- **JC – Joint Commission Certification**
- **CHAP – Community Health Accreditation Program Certification**
- **ACHC – Accreditation Commission for Health Care, Inc. Certification**
- Residential Respite Care –Complete a Respite Care Enrollment Application and be licensed through DBHDS as a provider of intellectual disability (mental retardation) services providing a children’s residential services with a respite track for children/adolescents with intellectual disabilities.

Eligible Program Codes**Eligible Program Codes**

01-Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date

Program Eligibility End Date

5 years from begin date

Reimbursement Type

Fee for service

Manual Type

N/A

New Enrollments**CBC Application**

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: Only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, must have the type of offense, name, and title of individual. If those items are given, route the documents to the lead (CBC must review them). Must be signed and dated.

Part C of the application**Personal/Respite Care**

1. Must have information on at least one individual
2. Optional
3. Must have at least one RN listed with a current license end date

Re-Enrollment Requirements

Complete a new Respite Care Enrollment application.

9.11.71 Rural Health Clinic (RHC)

Class Type

053 – Rural Health Clinic (RHC)

NPI

Specialty

None

Type of Enrollment Application

Rural Health Clinic (RHC)

Required Documents

CMS Certification

Rates from Clifton Gunderson

Eligible Program Codes

01 – Medicaid

05 – Client Medical Management (CMM)

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite

Reimbursement Type

Cost Settled-Clifton Gunderson

Manual Type

Physician, Health Department, Baby Care

9.11.72 Schools

Class Type

072 – Schools

NPI

Specialty

018 – Audiology

019 – Personal Care – Apply to all enrolled

020 – Transportation – Apply to all enrolled

025 – Skilled Nursing Services

026 – Special Education Psych Services

027 – Physical Therapy (PT)

028 – Occupational Therapy (OT)

029 – Speech/Language Therapy

051 – School Based Clinics

Type of Enrollment Application

School Division/Education Services

Required Documents/Notes

DMAS and DOE approve services

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite

Reimbursement Type

Fee for Service

Manual Type

School Division

DMAS and DOE approval for services

**9.11.73 Substance Abuse Clinic - As of 11/30/2013
DMAS/PES WILL NO LONGER ENROLL
BEHAVIORAL HEALTH SERVICES.**

Class Type

071

Specialty

N/A

Type of Agreement

Substance Abuse Clinic

Required Documents/Notes

Copy of substance abuse clinic license from DMHMRSAS

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite

Reimbursement Type

Fee for Service

Manual Type

Community Mental Health – Rehabilitation Services

9.11.74 Case Management for DD Waiver

Class Type

073

API/NPI**Specialty**

017

Type of Agreement

CBC Case Management for DD Waiver application and Case Management for DD Waiver Participation Agreement

Required Documents/Notes

No out of state providers

Eligible Program Codes

01-Medicaid

08-FAMIS

Program Eligibility Begin Date

Standard begin date

Program Eligibility End Date

Five years from begin date

Reimbursement Type

Fee for service

Manual Type

N/A

New Enrollments

CBC Application

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: Only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, must have the type of offense, name, and title of individual. If those items are given, route the documents to the lead (CBC must review them). Must be signed and dated.

Part C of the application

Case Management for DD Waiver

Must have information on at least one individual.

11) Optional.

Re-Enrollment Requirements

Complete a new Community Based Care (CBC) application.

9.11.75 State Mental Hospital Medical Surgery

Class Type

008 – State Mental Hospital Medical Surgical

NPI

Specialty

None

Type of Enrollment Application

Hospital

Required Documents/Notes

CMS or JCAHO Accreditation

Supervisor must approve prior to enrolling

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date

Program Eligibility End Date

Indefinite for CMS certification and expiration date on JCAHO

Reimbursement Type

Cost Settled-Clifton Gunderson

Manual Type

Hospital

9.11.76 Substance Abuse Treatment Practitioner - As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.

Class Type

103 – Substance Abuse Treatment Practitioner

NPI**Specialty**

None

Type of Enrollment Application

Licensed Substance Abuse Practitioner

Required Documents

Department of Health of VA License or license from state in which provider practices

Eligible Program Codes

01-Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date Never prior to license begin date

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Physician

9.12.77 Temporary Detention Ordering (TDO)

Class Type

100 –Temporary Detention Ordering (Non-Medical TDO)

NPI

Specialty

None

Type of Enrollment Application

Providers must complete an enrollment application that is associated with their (PCT) (Please see instruction for adding TDO to new and existing Medicaid Providers below)

Required Documents

Appropriate VA license from DHP, VDH, etc. or license from state in which provider practices. Claim form for Out of State Providers.

Eligible Program Codes

06-Medicaid

Program Eligibility Begin Date

Standard begin date Never prior to license begin date

Program Eligibility End Date

License expiration date

Reimbursement Type

Fee for service

Manual Type

Physician, Hospital, Nursing Homes

Special Instructions for enrolling Non-Enrolled and Currently Enrolled Medicaid Providers

Non-Enrolled Medicaid Providers Requesting Enrollment in the TDO Program

1. Providers must submit the following to PES via fax to the Specialist attention at (804) 267-1150 or (804) 267-1151:

- a. An enrollment application that is associated with their Provider Class Type (PCT). In the :Remarks" field indicate "TDO Enrollment Only"
- b. Current license
- c. If provider is Out of State, they must submit a claim

Procedures

PES will receive phone calls from Non-Enrolled Medicaid providers inquiring how to enroll as TDO providers. After informing the providers of the above enrollment requirements, perform the following steps:

1. Close [REDACTED] ticket stating "Provider was not currently enrolled, but wanted to become a TDO provider. Explained that they needed to fax an enrollment agreement."
2. Front end scan the application and have the mailroom return it to process the application. (A supervisor or manager can help with this process).
3. Process the application with Program 06 (TDO) and PCT 100 (non-medical TDO) **only.**

Rates

Rates are required for institutional providers submitting claims on an UB-04 (such as hospitals, nursing homes, etc.) If rates are required, submit an email with NPI and name of facility to Johnathan Walker and "Cc" Patricia Thomas at DMAS to request rates after approving the application in Workflow.

Currently Enrolled Providers Requesting Enrollment in the TDO Program

PES will receive phone calls from Currently Enrolled Medicaid providers inquiring how to enroll as a TDO provider. Perform the following procedures:

1. Inform them to fax their request in writing to Patricia Thomas at (804) 786-6229. The request should be on Company letterhead with the following information:
 - a) Service Address
 - b) Begin date of Enrollment
 - c) NPI
 - d) Provider's Name
 - e) Signature of the Administrator or Provider
2. Complete the [REDACTED] ticket stating "Caller was currently enrolled and wanted to enroll as a TDO provider. Provided them with the fax number to Patricia Thomas and instructions to submit request in writing on company letterhead."

9.12.78 Transition Coordinator

Class Type

106 – Transition Coordinator

API/NPI

Specialty

None

Type of Enrollment Application

Transition Coordinator and Transition Coordinator Community Based Care Application

Required Documents/Notes

In addition to meeting the general conditions and requirement for home-based and community-based care, participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, transition coordinators shall meet the following qualifications:

1. Transition coordinators shall be employed by one of the following:
 - a. A local government agency; a private, nonprofit organization qualified under 26 USC 501 (c) (3); or a fiscal management service with experience in providing this service.
2. A qualified transition coordinator shall possess, at a minimum, a bachelor's degree in human services or health care and relevant experience that indicates the individual possesses the following knowledge, skills, and abilities. These shall be documented on the transition coordinator's job application form or supporting documentation, or observable in the job or promotion interview. The transition coordinator shall be at least 21 years of age.
3. Knowledge Transition coordinators shall have knowledge of aging, independent living, the impact of disabilities and transition planning; individual assessments (including psychosocial, health, and functional factors); and their uses in service planning, interviewing techniques, individuals' rights, local human and health service delivery systems, including support services and public benefits eligibility requirements, principles of human behavior and interpersonal relationships, interpersonal communication principles and techniques, general principles of file documentation, the service planning process, and the major components of a service plan.
4. Skills Transition coordinators shall have skills in negotiating with individuals and service providers; observing and reporting behaviors; identifying and documenting an individual's needs for resources, services, and other assistance; identifying services within the established services system to meet the individual's needs; coordinating the provision of services by diverse public and private providers; analyzing and planning for the service needs of the individual; and assessing individuals using DMAS authorized assessment forms.
5. Abilities – Transition coordinators shall have the ability to demonstrate a positive regard for individuals and their families or designated guardian; be persistent and remain objective; work as a team member, maintaining effective interagency and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, both verbally and in writing;

develop a rapport; communicate with different types of persons from diverse cultural backgrounds; and interview.

No Enrollment prior to July 1, 2008. No individual can enroll, only Agencies.

Eligible Program Codes

01-Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date.

Never prior to July 1, 2008.

Program Eligibility End Date

Indefinite

Reimbursement Type

One Unit per Month

Manual Type

Elderly or Disabled with Consumer Directed Services

New Enrollments

CBC Application

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: Only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, must have the type of offense, name, and title of individual. If those items are given, route the documents to the lead (CBC must review them). Must be signed and dated.

Part C of the application

Transition Coordinator

1. Must have information on at least one individual.
2. Optional.
3. Must have at least one RN listed with a current license end date.

Re-Enrollment Requirements

Complete a new Community Based Care (CBC) application.

9.12.79 Transition Coordinator for the Children's Mental Health Program

Class Type

073 – Case Management

API/NPI

Specialty

117- Transition Coordinator for the Children's Mental Health Program.

Type of Enrollment Application

Transition Coordinator and Transition Coordinator Community Based Care Application

Required Documents/Notes

In addition to meeting the general conditions and requirement for home-based and community-based care, participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, transition coordinators shall meet the following qualifications:

1. Transition coordinators shall be employed by one of the following:
 - a. A local government agency; a private, nonprofit organization qualified under 26 USC 501 (c) (3); or a fiscal management service with experience in providing this service.
2. A qualified transition coordinator shall possess, at a minimum, a bachelor's degree in human services or health care and relevant experience that indicates the individual possesses the following knowledge, skills, and abilities. These shall be documented on the transition coordinator's job application form or supporting documentation, or observable in the job or promotion interview. The transition coordinator shall be at least 21 years of age.
3. Knowledge Transition coordinators shall have knowledge of aging, independent living, the impact of disabilities and transition planning; individual assessments (including psychosocial, health, and functional factors); and their uses in service planning, interviewing techniques, individuals' rights, local human and health service delivery systems, including support services and public benefits eligibility requirements, principles of human behavior and interpersonal relationships, interpersonal communication principles and techniques, general principles of file

documentation, the service planning process, and the major components of a service plan.

4. Skills Transition coordinators shall have skills in negotiating with individuals and service providers; observing and reporting behaviors; identifying and documenting an individual's needs for resources, services, and other assistance; identifying services within the established services system to meet the individual's needs; coordinating the provision of services by diverse public and private providers; analyzing and planning for the service needs of the individual; and assessing individuals using DMAS authorized assessment forms.
5. Abilities – Transition coordinators shall have the ability to demonstrate a positive regard for individuals and their families or designated guardian; be persistent and remain objective; work as a team member, maintaining effective interagency and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, both verbally and in writing; develop a rapport; communicate with different types of persons from diverse cultural backgrounds; and interview.

No Enrollment prior to July 1, 2008. No individual can enroll, only Agencies.

Eligible Program Codes

01-Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date.

Never prior to July 1, 2008.

Program Eligibility End Date

Indefinite

Reimbursement Type

One Unit per Month

Manual Type

New Enrollments

CBC Application

A provider requesting to participate is sent the appropriate CBC application and Medicaid participation agreement. Upon receipt of the application and agreement forms from the applicant, the CBC application is reviewed for completeness, prior to enrolling.

Review the agreement at this time also for required fields.

Part A of the application

If checked yes, must have provider type and number.

Must have the administrator's name.

Part B of the application

Contacts: Only contact required is the person responsible for signing contract, others are optional.

Areas: At least one county or city must be listed.

Ownership: The percentage must total 100%

Exceptions: If a provider states on application that ownership is in stock the total may not equal 100%, or if they state they are a non-profit organization, they must submit a complete list of the Board of Directors.

Other Federally Funded Programs: Required if N/A is not checked.

Agency Type: At least one item must be checked.

Agency Services: At least one item must be checked.

Requirements: If yes checked, must have the type of offense, name, and title of individual. If those items are given, route the documents to the lead (CBC must review them). Must be signed and dated.

Part C of the application

Transition Coordinator

1. Must have information on at least one individual.
2. Optional.
3. Must have at least one RN listed with a current license end date.

Re-Enrollment Requirements

Complete a new Community Based Care (CBC) application.

9.12.80 Treatment Foster Care Program- As of 11/30/2013 DMAS/PES WILL NO LONGER ENROLL BEHAVIORAL HEALTH SERVICES.

Class Type

022 – Treatment Foster Care

API/NPI

Specialty

None

Type of Enrollment Application

Treatment Foster Care

Required Documents/Notes

DSS License/certification as a “Treatment Foster Care Case Management Service”

License must state “Treatment Foster Care Case Management Services”

Eligible Program Codes

01 – Medicaid

08 – FAMIS

Program Eligibility Begin Date

Standard begin date. Never prior to license begin date or program begin date of 01/01/2000

Program Eligibility End Date

License Expiration Date

Reimbursement Type

Fee for Service

Manual Type

Treatment Foster Care

Requirements

Required Data

DSS license

Provider Application listed by Provider Type

9.12 Appendix H- United States Postal Service

Please view the following website for complete details on any mailing question:

<http://pe.usps.com/text/dmm300/pub268.htm>

9.13 Appendix I – Risk Category Matrix

VAMMIS Provider Type	Provider Class Type	Risk Category	Risk Score	Prev Screen	App Fee Req.	App Group	Application
Adult Day Health Care	048	Limited	20	N	N	4	Adult Day Health Care

VAMMIS Provider Type	Provider Class Type	Risk Category	Risk Score	Prev Screen	App Fee Req.	App Group	Application
Alzheimer's Assisted Living Waiver	079	Limited	20	N	N	7	Alzheimer's Assisted Living Waiver
Ambulatory Surgical Center	049	Limited	20	N	Y	25	Ambulatory Surgical Center
Audiologist	044	Limited	20	N	N	2	Audiologist
Baby Care	036	Limited	20	N	N	2	Baby Care
Case Management for DD Waiver	073	Limited	20	N	N	16	Case Management DD Waiver
Certified Professional Midwife	105	Limited	20	N	N	2	Certified Professional Midwife
Chiropractor	026	Limited	20	N	N	2	Chiropractor
Clinical Nurse Specialist - Psychiatric only	034	Limited	20	N	N	2	Clinical Nurse Specialist - Psychiatric Only
Clinical Psychologist	025	Limited	20	N	N	2	Clinical Psychologist
Consumer Directed Service Coordination	073	Limited	20	N	N	12	Consumer Directed Service Coordination
CORF (Outpatient Rehab Facility)	019	Moderate	50	Y	Y	1	Comprehensive Outpatient Rehab Facility (CORF)
Dentist	040	Limited	20	N	N	2	Physician
Developmental Disabled Waiver	056	Limited	20	N	N	6	Developmental Disability Waiver

VAMMIS Provider Type	Provider Class Type	Risk Category	Risk Score	Prev Screen	App Fee Req.	App Group	Application
Durable Medical Equipment/Supplies	062	Moderate – Revalidating High – Newly enrolling	5080	Y	Y	3	DME
Early Intervention	108	Limited	20	N	N	22	Early Intervention
Education Services (School Division)	072	Limited	20	N	N	3	Local Education Agency
Emergency Air Ambulance	082	Moderate	50	Y	Y	3	Emergency Air Ambulance
Family Caregiver Training	061	Limited	20	N	N	19	Family Caregiver Training
Federally Qualified Health Center	052	Limited	20	N	Y	5	Federally Qualified Health Center
Group Billing Enrollment	multiple	Limited	20	N	N	23	Group Enrollment
Health Department Clinic	051	Limited	20	N	N	5	Health Department Clinic
Hearing Aid	038	Limited	20	N	N	3	Hearing Aid
Home Health Agency - Private	059	Moderate – Revalidating High – Newly enrolling	5080	Y	Y	3	Home Health Agency

VAMMIS Provider Type	Provider Class Type	Risk Category	Risk Score	Prev Screen	App Fee Req.	App Group	Application
Home Health Agency - State	058	Moderate – Revalidating High – Newly enrolling	50 80	Y	Y	3	Home Health Agency
Hospice	046	Moderate	50	Y	Y	3	Hospice
Hospital – EPSDT Psychiatric Hospital	003	Limited	20	N	Y	1	Private Mental Hospital(inpatient psych)
Hospital – Medical Surgery – Mental Health Retardation	013	Limited	20	N	Y	1	Hospital Medical Surgery Mental Health and Mental Retarded
Hospital In-State Rehab	014	Limited	20	N	Y	1	Rehabilitation Hospital
Hospital, in-state, General	001	Limited	20	N	Y	1	Hospital
ICF - Mental Health	016	Limited	20	N	Y	9	ICF-Mental Health
ICF - Mentally Retarded - Community Owned	018	Limited	20	N	Y	9	ICF-MR Community Owned
ICF - Mentally Retarded - State Owned	017	Limited	20	N	Y	9	ICF-MR State Owned
Independent Laboratory	070	Moderate	50	Y	Y	3	Independent Laboratory
Intermediate Care Facility – State	029	Limited	20	N	Y	9	Intermediate Care Facility – State

VAMMIS Provider Type	Provider Class Type	Risk Category	Risk Score	Prev Screen	App Fee Req.	App Group	Application
Licensed Clinical Social Worker	076	Limited	20	N	N	2	Licensed Clinical Social Worker
Licensed Marriage and Family Therapist	102	Limited	20	N	N	2	Licensed Marriage and Family Therapist
Licensed Professional Counselor	021	Limited	20	N	N	2	Licensed Professional Counselor
Licensed School Psychologist	101	Limited	20	N	N	2	Licensed School Psychologist
Long Stay Hospital	004	Limited	20	N	Y	1	Long Stay Hospital
Long Stay Inpatient Hospital - Mental Health	012	Limited	20	N	Y	1	Long Stay Inpatient Hospital
Medical Surgery - Mentally Retarded	009	Limited	20	N	Y	1	Hospital Medical Surgery Mental Retarded
Medicare Crossover	099	Limited	20	N	N	8	Qualified Medicare Beneficiary (QMB)
Mental Health Mental Retardation and Substance Abuse Services	056	Limited - all others Moderate -- Community Mental Health Centers	20 50	Y	Y - only for specialty 041	2 1	Mental Health Services
Mental Retardation Waiver	056	Limited	20	N	N	2 0	Mental Retardation Waiver

VAMMIS Provider Type	Provider Class Type	Risk Category	Risk Score	Prev Screen	App Fee Req.	App Group	Application
MMIS Contractors or Vendors	107	Limited	20	N	N	N/A	N/A (DMAS or PES manager enrolls/maintains)
Non-Medicaid TDO	100	Limited	20	N	N	23	Group Enrollment
Nurse Anesthetist	033	Limited	20	N	N	2	Nurse Anesthetist
Nurse Practitioner	023	Limited	20	N	N	2	Nurse Practitioner
Nursing Home - Intensive Care/Nursing Facility (ICF/NF)	015	Limited	20	N	Y	9	Intensive Care Facility
Optician	032	Limited	20	N	N	2	Optician
Optometrist	031	Limited	20	N	N	2	Optometrist
ORP Other or Provider Type corresponding to Provider Type selected on application	If Provider Type selected = "Other", 078. Else assign based on selected provider type.	Limited	20	N	N	26	Ordering, Referring, or Prescribing Provider
Out of State ICF Provider	109	Limited	20	N	Y	N/A	N/A (DMAS-LTC enrolls)
Out-of-State Dental	097	Limited	20	N	N	2	Out-of-State Dental
Out-of-State Emergency Air Ambulance	084	Moderate	50	Y	Y	3	Emergency Air Ambulance
Out-of-State Hospital	091	Limited	20	N	Y	1	Hospital
Out-of-State Laboratory	098	Moderate	50	Y	Y	3	Independent Laboratory

VAMMIS Provider Type	Provider Class Type	Risk Category	Risk Score	Prev Screen	App Fee Req.	App Group	Application
Out-of-State Physician	095	Limited	20	N	N	2	Physician
Out-of-State Psychiatrist	095	Limited	20	N	N	2	Psychiatrist
Out-of-State Rehab Hospital	085	Limited	20	N	Y	1	Rehabilitation Hospital
Out-of-State Skilled Care Facility	092	Limited	20	N	Y	9	Out-of-State Skilled Care Facility
Out-of-State Transportation (Emergency Ambulance)	083	Moderate	50	Y	Y	3	Ambulance
Outpatient Rehabilitation	057	Limited	20	N	Y	1	Rehab Outpatient
PACE Provider	104	Limited	20	N	N	18	PACE
Personal Care	055	Limited	20	N	N	14	Personal Care
Personal Emergency Response System	062	Moderate – Revalidating High – Newly enrolling	5080	Y	Y	15	Personal Emergency Response System
Pharmacy	060	Limited	20	N	N	3	Pharmacy
Physician	020	Limited	20	N	N	2	Physician
Podiatrist	030	Limited	20	N	N	2	Podiatrist
Private Duty Nursing	063	Limited	20	N	N	4	Private Duty Nursing

VAMMIS Provider Type	Provider Class Type	Risk Category	Risk Score	Prev Screen	App Fee Req.	App Group	Application
Prosthetic/Orthotic	064	Moderate – Revalidating High – Newly enrolling	5080	Y	Y	3	Prosthetic Services
Psychiatrist	020	Limited	20	N	N	2	Psychiatrist
Registered Driver	081	Moderate	50	Y	Y	3	Registered Driver
Renal Unit (Renal Dialysis)	050	Limited	20	N	Y	3	Renal Unit
Residential Psychiatric Treatment	077	Limited	20	N	Y	10	Psych Residential Inpatient Facility
Respite Care	047	Limited	20	N	N	14	Respite Care
Rural Health Clinic	053	Limited	20	N	Y	5	Rural Health Clinic
Skilled Nursing Facility – State	028	Limited	20	N	Y	9	Skilled Nursing Facility – State
SNF - Mentally Retarded	011	Limited	20	N	Y	9	SNF-MR
SNF-Mental Health	006	Limited	20	N	Y	9	SNF-Mental Health
SNF-Non Mental Health	010	Limited	20	N	Y	9	Skilled Nursing Home
State Mental Hospital (Aged)	002	Limited	20	N	Y	1	State Mental Hospital(Aged)
State Mental Hospital (less than age 21)	007	Limited	20	N	Y	1	State Mental Hospital(less than age 21)
State Mental Hospital (Med-Surge)	008	Limited	20	N	Y	1	State Mental Hospital(Med-Surg)

VAMMIS Provider Type	Provider Class Type	Risk Category	Risk Score	Prev Screen	App Fee Req.	App Group	Application
Substance Abuse Practitioner	103	Limited	20	N	N	2	Substance Abuse Practitioner
TB Hospital	005	Limited	20	N	Y	1	Hospital TB
Transition Coordinator	106	Limited	20	N	N	17	Transition Coordinator
Transition Coordinator for the Children's Mental Health Program	073	Limited	20	N	N	17	CMHP Transition Coordinator
Transportation (Emergency Ambulance)	080	Moderate	50	Y	Y	3	Ambulance
Treatment Foster Care Program	022	Limited	20	N	N	7	Treatment Foster Care Program

9.14 Appendix J – FDBC Match Instructions

PES will enter the result of any research performed in the “Comments” field upon sending an application to the PES Manager for review.

DHP

A match level of 1 indicates one of the following:

- LICENSE NOT FOUND / LICENSING STATE PROVIDED IS 'VA'
or
- LICENSE FOUND AND LICENSE END DATE IS PRIOR TO TODAY

If the match level = 1, perform the following:

1. If the application was sent in via paper, open the pdf of the paper application to confirm license information was keyed correctly. (License information is located on the Servicing Addresses tab.)
2. Send to PES Manager for review. Enter “DHP Issue” in the Comments.
3. PES Manager will forward back to PES Specialist to reject or approve.
4. If reject, PES specialist will reject as follows:
 - a. On the Case tab, select “The license provided could not be verified” from the Reject Reason drop down list.
 - b. Enter comments in the Comments field if needed.
 - c. Click “Action” then select “Reject Application”.

LEIE

A match level of 1 indicates one of the following:

- NPI FOUND AND NO REINSTATE DATE
or
- SSN/TIN FOUND AND NO REINSTATE DATE

If the match level = 1, perform the following:

5. If the application was sent in via paper, open the pdf of the paper application to confirm the NPI or SSN/TIN was keyed correctly.
6. Send to PES Manager for review. Enter “LEIE Issue” in the Comments.
7. PES Manager will forward back to PES Specialist to deny or approve.
8. If denial, PES Specialist will deny as follows:
 - a. On the Case tab, select “Provider or disclosed owner is excluded from participation in Federal programs” from the Denial Reason drop down list.
 - b. Click “Action” then select “Deny Application”.

EPLS

A match level of 1 indicates the following:

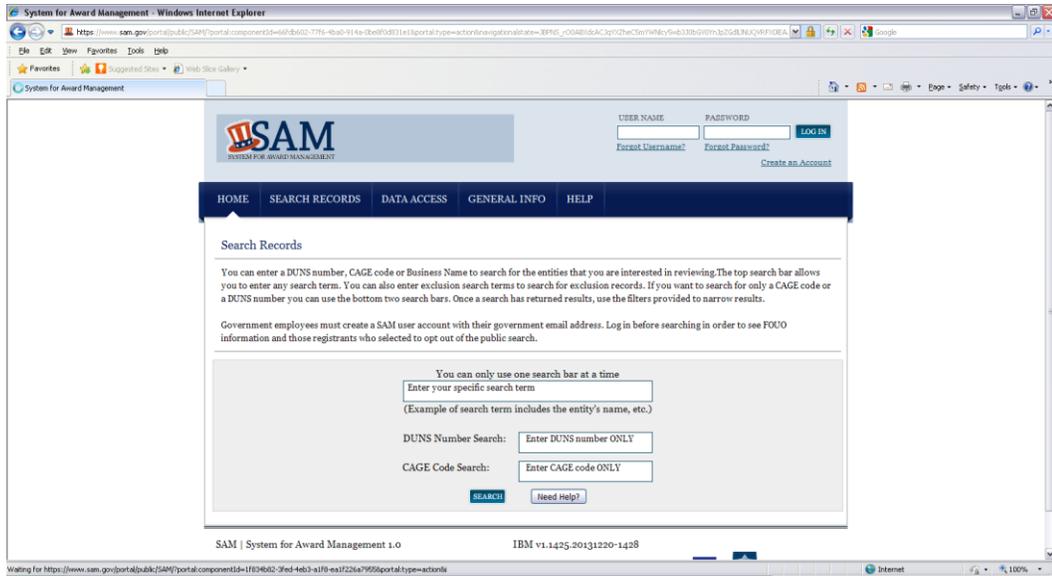
- **NAME FOUND:**
(LAST NAME / FIRST 6 OF FIRST NAME FOR INDIVIDUALS)
(FIRST 25 of ORG NAME)

If the match level = 1, perform the following:

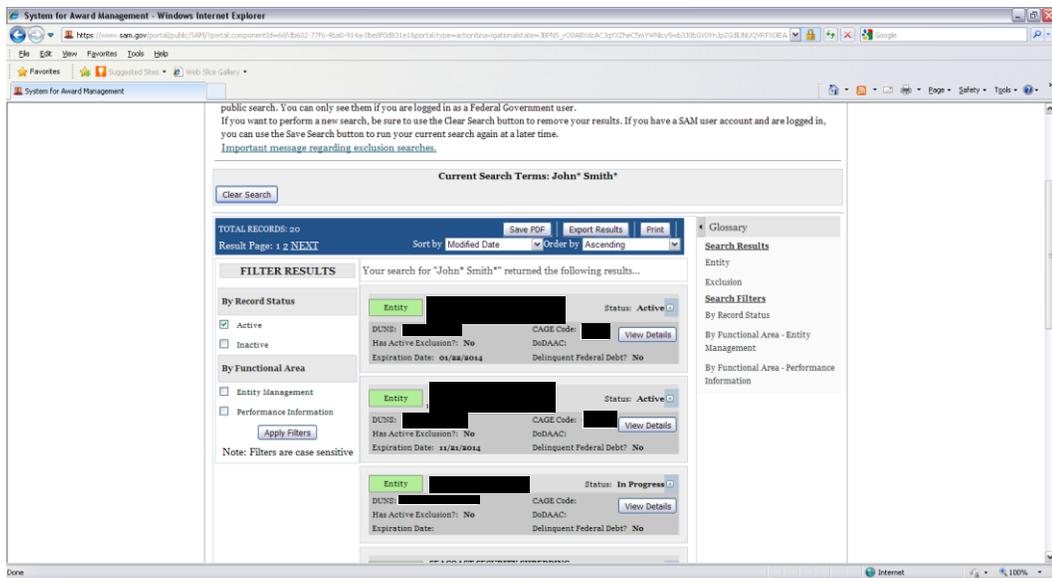
1. Go to the following website:
https://www.sam.gov/portal/public/SAM/?portal:componentId=66fdb602-77f6-4ba0-914a-0be8f0d831e1&portal:type=action&interactionstate=JBPNS_r00ABXc0ABBfanNmQnJpZGdlVmild0lkAAAAAQATL2pzZi9mdW5jdGlvbWFsLmpzcAAHX19FT0ZfXw**#1



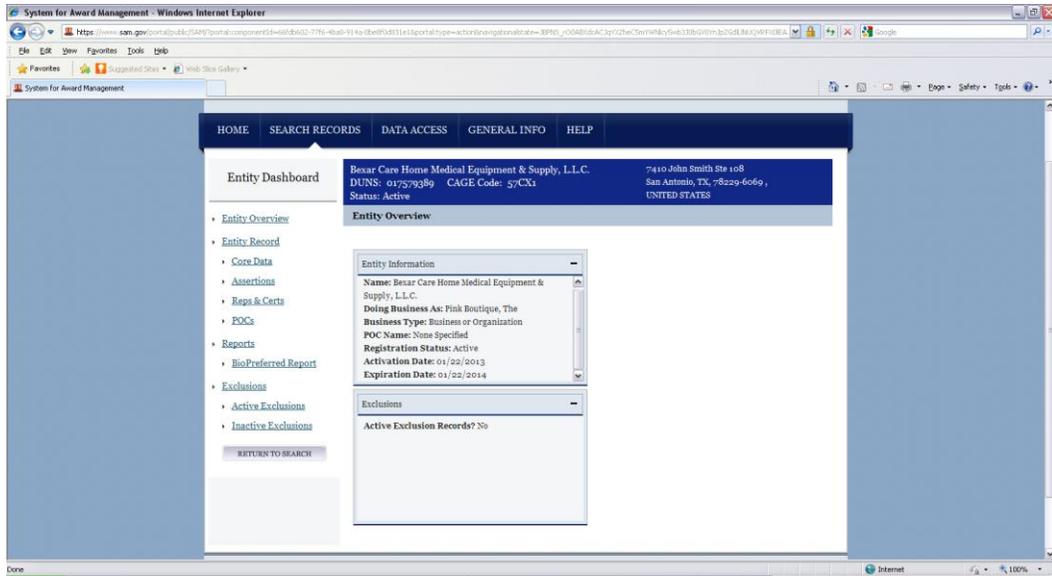
2. Click "Search Records".



3. Enter the individual or business name and click “Search”.



4. Click “View Details”.



5. Using the additional identifying information listed on this website, attempt to determine if the individual or business in question is in fact the provider or disclosed entity. Click other links on the left as desired.
6. If it is determined to be (or is most likely) the provider or disclosed entity, send to PES Manager for review. Enter "EPLS Issue" in the Comments.
7. PES Manager will forward back to PES Specialist to deny or approve.
8. If denial, PES Specialist will deny as follows:
 - a. On the Case tab, select "Provider or disclosed owner is excluded from participation in Federal programs" from the Denial Reason drop down list.
 - b. Click "Action" then select "Deny Application".

NPPES

A match level of 1 indicates the following:

- NPI NOT FOUND
or
MISMATCHED NPI TYPE

A match level of 2 indicates one of the following:

- NPI EXISTS / HAS DEACTIVATION DATE / NO REACTIVATED DATE
or
- NPI EXISTS / HAS DEACTIVATION DATE / HAS REACTIVATION DATE IN FUTURE

If the match level = 1 or 2, perform the following:

1. If the application was sent in via paper, open the pdf of the paper application to confirm the NPI was keyed correctly.
2. If MISMATCHED NPI TYPE, reject the application using the Reject Reason: "The NPI provided is incorrect for this provider." Enter in the comments field: "The application you are submitting requires a type(#) NPI. You submitted a type(#) NPI." See section 3.11 Reject Enrollment for specific instructions.

If other than MISMATCHED NPI TYPE, proceed to step #3.

3. Send to PES Manager for review. Enter "NPPES Issue" in the Comments.

4. PES Manager will forward back to PES Specialist to reject or approve.
5. If reject, PES specialist will reject as follows:
 - c. On the Case tab, select “The NPI provided is incorrect for this provider”, or “The Provider NPI submitted is not active” from the Reject Reason drop down list.
 - d. Enter comments in the Comments field if needed.
 - e. Click “Action” then select “Reject Application”.

PECOS

Note: PECOS validation is only needed if the provider class type requires a site visit and/or an application fee.

A match level of 0 indicates one of the following:

- NPI FOUND
- or
- SSN/TIN FOUND (ATYPICAL PROVIDERS ONLY)

A match level of 1 indicates one of the following:

- NPI NOT FOUND
- or
- SSN/TIN NOT FOUND (ATYPICAL PROVIDERS ONLY)

If the match level = 0, perform the following:

1. If the application was sent in via paper, open the pdf of the paper application to confirm the NPI or SSN/TIN was keyed correctly.
2. Verify the approved date is within the last 12 months.
3. If not within the last 12 months, send to PES Manager for review. Enter “PECOS Issue” in the Comments.
4. PES Manager will Pend-Finance for awaiting payment.
5. Finance Manager will outreach to the provider to request payment.

If the match level = 1, perform the following:

1. If the application was sent in via paper, open the pdf of the paper application to confirm the NPI or SSN/TIN was keyed correctly.
2. Send to PES Manager for review. Enter “PECOS Issue” in the Comments.
3. PES Manager will Pend-Finance for awaiting payment.
4. Finance Manager will outreach to the provider to request payment.

SSA-DMF

A match level of 1 indicates the following:

- SSN FOUND

A match level of 2 indicates the following:

- NO MATCH ON SSN BUT LAST NAME / FIRST 4 OF FIRST NAME / DOB (MM/YYYY only) MATCH

If the match level = 1 or 2, perform the following:

1. If the application was sent in via paper, open the pdf of the paper application to confirm the SSN was keyed correctly.
2. Send to PES Manager for review. Enter “SSADMf Issue” in the Comments.

3. PES Manager will forward back to PES Specialist to deny or approve.
4. If denial, PES Specialist will deny as follows:
 - a. On the Case tab, select "Submitted SSN found on the SSN-Death Master File" from the Denial Reason drop down list.
 - b. Click "Action" then select "Deny Application".

MCSIS

A match level of 1 indicates the following:

- NPI IS ON MCSIS

A match level of 2 indicates the following:

- NOT FOUND BY NPI BUT MATCH ON LAST NAME / FIRST 4 OF FIRST NAME / PRACTICING STATE = ANY STATE LISTED

If the match level = 1 or 2, perform the following:

1. If the application was sent in via paper, open the pdf of the paper application to confirm the NPI was keyed correctly.
2. Send to PES Manager for review. Enter "MCSIS Issue" in the Comments.
3. PES Manager will forward back to PES Specialist to deny or approve.
4. If denial, PES Specialist will deny as follows:
 - a. On the Case tab, select "Provider is excluded from another state Medicaid program" from the Denial Reason drop down list.
 - b. Click "Action" then select "Deny Application".

9.15 Appendix (K) – Business Continuity Procedures

In the event that the web portal and/or workflow cannot be accessed for an extended amount of time (greater than one business day), PES will use the MMIS to process newly received provider enrollment applications. Revalidations and updates to disclosure will be suspended until the system(s) is restored.

Procedures

1. Post a notification on the web portal instructing providers to submit enrollment applications via fax or mail, and that Revalidations and Updates to Disclosure are not accessible at this time. DMAS will approve all notifications.
2. Use the following procedures to process new provider enrollments:

Check MMIS for New Enrollment or Existing Status

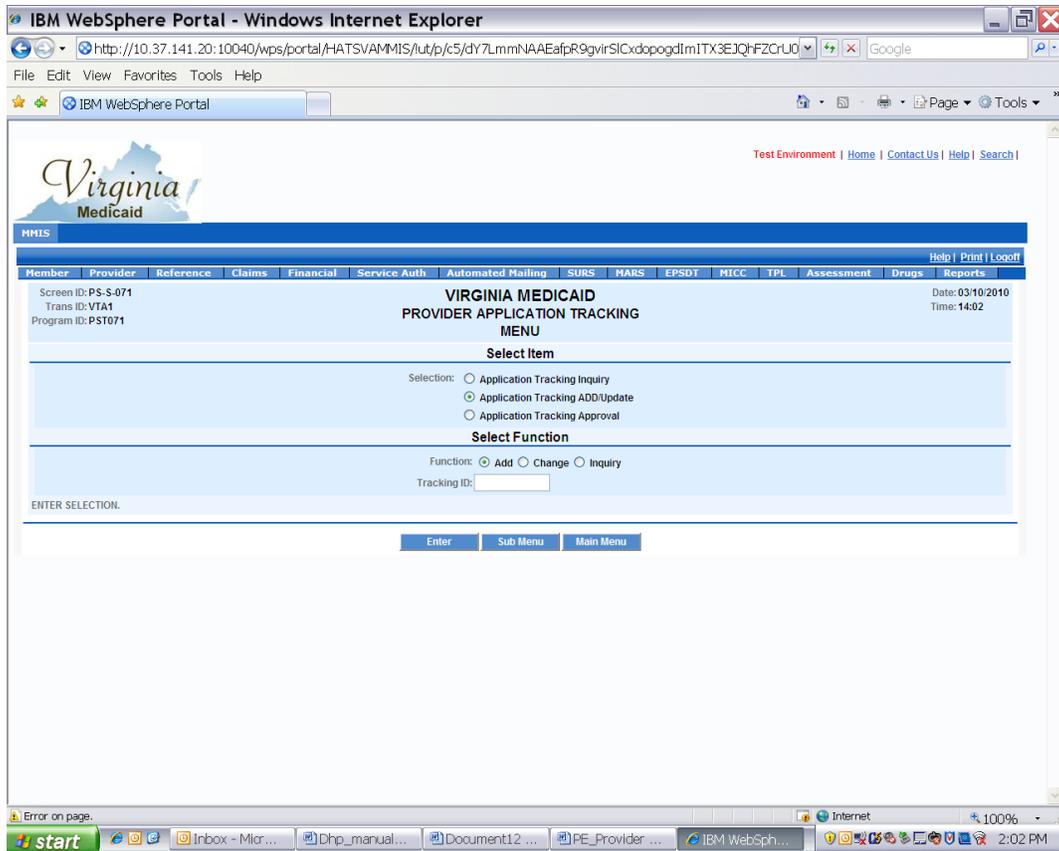
1. Check MMIS for provider status. Once in MMIS choose the Provider icon and the Provider Main Menu is displayed.
2. Select a value from the Provider Cross Reference Inquiry drop-down menu.
3. Select the Inquiry radio button.
4. Enter the value to search (NPI, API, EIN, Provider Name, etc.) in the ID Value field.

5. Select Enter.
6. The Provider Cross Reference screen (PS-S-012) is displayed.
7. Is provider enrolled in Medicaid?
 - a. Yes — Proceed to step 9.
 - b. No — Proceed to step 8.
8. Is provider Atypical (non-healthcare) provider not eligible for an NPI? (detailed definition of Atypical Provider is in section 4.1.12 Group Enrollment)
 - a. Yes — Continue on to Application Tracking using detailed procedures in 4.1.2 Application Tracking.
 - b. No — Proceed to step 9
9. Is provider enrolled and adding an additional Provider Class Type under already existing NPI?
 - a. Yes — Continue on to Application Tracking using detailed procedures in 4.1.2 Application Tracking.
 - b. No — Proceed to step 10.
10. Is provider enrolled for IRS Number or servicing location indicated on enrollment application?
 - a. Yes — Reject application indicate duplicate enrollment with a manual letter created through [REDACTED].
 - b. No — Proceed to step 11.
11. Is the provider enrolling for another location?
 - a. Yes — If individual provider you must verify if Group enrollment is applicable by following Group eligible guidelines in Section 4.1.12.2 and 4.1.12.3 are followed.
 - b. No – Proceed to step 12.
12. Is the provider enrolling using a new TIN?
 - a. Yes — If individual provider you must verify if Group enrollment is applicable by following Group eligible guidelines in Section 4.1.12.2 and 4.1.12.3 of Group Enrollment are followed.
 - b. No — Proceed to Section 3.1.3 LEIE Sanction Verification.

Enter New Provider and New Provider Class Type Data into VA MMIS Application Tracking.

Procedures: From the **Provider Main Menu**, enter the following selections:

1. From the Selection drop-down box, select Application Tracking (PS-S-071).
2. Select Add from the Function options.
3. Select Enter.
4. From the Provider Application Tracking Menu, enter the following selections:



5. From the Selection menu, select Application Tracking Add/Update.
6. Select Add from the Function options
7. Select Enter, and you see the following screen:

The screenshot shows a web browser window titled "IBM WebSphere Portal - Windows Internet Explorer". The address bar shows a URL starting with "http://10.37.141.20:10040/wps/portal/HATSVAMMIS/lut/p/c5/dY_JtqIwAES_yJMwkyLPnkwyCAIBTY46RIZBxTB8fdurXr". The page content includes the "Virginia Medicaid" logo and a navigation menu with tabs like "Member", "Provider", "Reference", "Claims", "Financial", "Service Auth", "Automated Mailing", "SURS", "MARS", "EPSDT", "MICC", "TPL", "Assessment", "Drugs", and "Reports". The main heading is "VIRGINIA MEDICAID PROVIDER APPLICATION TRACKING ADD/UPDATE". The form contains several sections: "Tracking Information" with fields for Tracking ID, Provider ID (055), FEIN, NPI Type, and Initial Date (03/10/2010); "Business Information" with fields for APIN indicator (N), Business Name, and Individual Name (Last, First, MI, Suffix, Title); "Service Information" with fields for Address, City, State, Zip, and Site Ind (00); "Correspondence Information" with fields for Address, City, State, and Zip; "Pay To Information" with fields for Address, City, State, and Zip; and "Remit To" with fields for Address, City, State, and Zip. A red text prompt at the bottom of the form reads "PLEASE ENTER EITHER BUSINESS OR INDIVIDUAL NAME". At the bottom of the form are buttons for "Enter", "Update", "Next Site", "App Tracking Inq", "Status", "Return", "Sub Menu", and "Main Menu".

8. Enter Provider Data:

- a. NPI or leave blank if provider is deemed to be Atypical (non-healthcare) provider. MMIS will generate a DMAS assigned ID Atypical Provider Identifier (API) for billing purposes.
- b. Provider Type
- c. APIN indicator- enter "N" in field and hit enter
- d. FEIN (if not part of group)
- e. NPI (type "1" for individual, "2" for group, facility, or hospital)
- f. Provider Name
- g. Servicing Address (Mandatory). A PO Box is not accepted as a Services Address and MMIS will edit when entered.
- h. Servicing Address Telephone Number (Mandatory)
- i. Servicing Address Contact Name if applicable
- j. Correspondence Address (Mandatory)
- k. Correspondence Address Telephone Number if applicable
- l. Payment Address if applicable
- m. Remit Address if applicable
- n. Double check information previously keyed in MMIS and make corrections as needed.

9. After Application Tracking data has been entered, click Enter to view edits.

- a. Correct any errors.
- b. Once errors are corrected, click Update.

License and FDBC Checks

1. Manual checks via websites are available for (checks must be performed on provider and disclosure information):
 - a. License (provider only)
 - i. www.dbhds.virginia.gov/ftp
 - b. LEIE
 - i. <http://exclusions.oig.hhs.gov>
 - c. EPLS
 - i. https://www.sam.gov/portal/public/SAM/?portal:componentId=66fdb602-77f6-4ba0-914a-0be8f0d831e1&portal:type=action&interactionstate=JBPNS_r00ABXc0ABBfanNmQnJpZGdVmlld0lkAAAAAQATL2pzZi9mdW5jdGlvbmlkLmpzcAAHX19FT0ZfXw**#1
 - d. NPPES (provider only)
 - i. <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>
 - e. PECOS (provider only)
 - i. <https://eftp2.cms.hhs.gov:11443/cfcc/login/login.jsp>
2. Manual checks via query of existing files are available for:
 - a. SSADMF (technical resource required)
 - b. MCSIS
3. If an unfavorable match is found during the manual FDBC checks:
 - a. Follow the procedures in this section titled “Reject Enrollment”.
 - i. Use Reason code: C00
 - b. Create a rejection or denial letter out of [REDACTED].

Review of Enrollment Application

PES reviews each enrollment application for general requirements as well as individual provider types prior to approval or rejection. The following will meet the general requirements:

Checklist to meet minimum requirements:

1. Is Provider Participation Agreement and Application signed and dated where required?
 - a. Yes — Proceed to step 2.
 - b. No — Reject application for signature missing on document and proceed through steps 2 through 9 to determine additional pend reasons. (See Appendix 7.2 Reason Code/missing information section for appropriate pend per document type).
2. Is a servicing address telephone number provided on provider application?
 - a. Yes — Proceed to step 3.
 - b. No — Reject application for servicing address telephone number missing and proceed through steps 3 through 9 to determine additional pend reasons. (See Appendix 7.2 Reason Code/missing information section for appropriate pend per document type).
3. Is the servicing address a PO Box?

- a. No — Proceed to step 4.
 - b. Yes – Reject application for servicing address cannot be a PO Box and proceed through steps 4 through 9 to determine additional pend reasons. (See Appendix 7.2 Reason Code/missing information section for appropriate pend per document type).
4. Is the provider located in Virginia and how to determine if provider is within fifty miles of Virginia Border?
 - a. Yes — Proceed to step 6.
 - b. No – Go to www.mapquest.com to determine whether the provider is within fifty miles of the VA border. If outside fifty miles proceed to step 5 if within proceed to step 6.
 5. If outside of fifty miles of Virginia border was claim or supporting documentation attached?
 - a. Yes — Proceed to step 6.
 - b. No – Reject application for claim or supporting documentation must be submitted in order to enroll into VA Medicaid and proceed through steps 6 through 9 to determine additional pend reasons. (See Appendix 7.2 Reason Code/missing information section for appropriate pend per document type).
 - A. Exceptions: Durable Medical Equipment (DME) and Pharmacies that hold a Virginia Department of Health (VA DHP) non-resident permit will not be rejected for a claim(s).
 6. Is provider a Provider Class Type (PCT) 077 Residential Treatment Facility or PCT 108 Early Intervention did they submit Letter of Attestation on their company letter head?
 - a. Yes — Proceed to step 7.
 - b. No — Reject application for Letter of Attestation form must be submitted on your company letter head for enrollment into VA Medicaid and proceed through steps 7 through 9 to determine additional pend reasons. (See Appendix 7.2 Reason Code/missing information section for appropriate pend per document type).
 7. If provider is required to submit a Community Based Care (CBC) application in addition to the enrollment application did they complete all required fields on that application?
 - a. Yes — Refer to Appendix 7.11 Detailed Enrollment Procedures by Provider type to determine required fields for their individual CBC application and Proceed to step 8. Proceed to step 8.
 - b. No — Pend for all incomplete fields on CBC application and proceed to step 8 and 9 for further pend determination. (See Appendix 7.2 Reason Code/missing information section for appropriate pend per document type).
 8. Did the provider complete the Section I Part (a) and Section II of the Disclosure of Ownership and Control Interest Statement?
 - a. Yes — Proceed to step 9.
 - b. No — Reject for Section I Part (a) or Section II of the Disclosure of Ownership and Control Interest Statement not complete and proceed to step 9 for additional

pend determination. (See Appendix 7.2 Reason Code/missing information section for appropriate pend per document type).

9. Did the provider sign and date the Disclosure of Ownership and Control Interest Statement?
 - a. Yes — Proceed to Step 10.
 - b. No — Reject for Disclosure of Ownership and Control Interest Statement not complete. (See Appendix 7.2 Reason Code/missing information section for appropriate pend per document type).

10. Is provider an individual joining a Group?
 - a. Yes – verify the Group NPI is enrolled or that a Group Enrollment Packet has been submitted.
 - b. No – proceed to step 11.
 - (1) 11) Is provider a new billing provider and the Electronic Funds Transfer (EFT) and Electronic Claims Submission section completed?

11. Payment and Processing Information
 - a. Did provider indicate EFT?
 - A. Yes and the following were provided proceed to 4.1.10 Approved Enrollment.
 - (1) Name of Banking Institution
 - (2) Routing Number also called ABA number
 - (3) Bank Account Number
 - (4) Voided Check attached or official letter from Banking Institution
 - B. No – If information incomplete proceed to 4.1.9 Reject Enrollment Process
 - b. Did provider indicate an EFT or Electronic Claims Exemption?
 - A. Yes –Proceed to 4.1.10 Approved Enrollment
 - B. No – Proceed to Step 3
 - c. Did provider indicate Other EFT or Electronic Claims Submission exemption and supporting documentation submitted?
 - A. Yes – Proceed to 7.2.1 Create Communication Record and Refer to DMAS PES Contract Monitor for approval or denial of exemption using the following in [REDACTED]
 - (1) Category – PES
 - (2) Subject – EFT Exemption Referral
 - B. No-Proceed to 4.1.9 Reject Enrollment to request Missing Information

Enrolling by Specific Provider Class Type

PES follows guidelines specific for Provider Type when enrolling or re-enrolling a provider into MMIS. The guidelines can be found in Appendix 9.12 Detailed Enrollment

Procedures by Provider Class Type. Group Enrollment specific procedures can be found in in the next section.

Group Enrollment

In concurrence with the transition to the NPI, DMAS mandated the enrollment of Group Practices. Group Practice enrollment is mandatory for any practice with one or more participating provider practicing under the same Tax Identification Number (TIN). A detailed list of all Group Eligible provider types can be found in Appendix 9.6 Alpha Provider Type Listing or below. The Group Practice will obtain an Organization NPI (Type II), and enroll under Group Practice NPI. Individuals practicing within the Group Practice will obtain an individual NPI (Type I) which will be enrolled and subsequently affiliated with the Group Practice NPI in order to bill and be paid under Group Practice NPI and Tax ID.

Group Eligible Provider Class Types

1. Audiologist (PCT 044)
2. Baby Care (PCT 036)
3. Case Management Waiver – Individual Only (PCT 073)
4. Chiropractor (PCT 026)
5. Clinical Nurse Specialist (PCT 034)
6. Clinical Psychologist (PCT 025)
7. Family Caregiver Training (PCT 061)
8. Licensed Clinical Social Worker (PCT 076)
9. Licensed Professional Counselor (PCT 021)
10. Licensed School Psychologist (PCT 101)
11. Licensed Substance Abuse Treatment Practitioner (PCT 103)
12. Marriage and Family Therapist (PCT 102)
13. Nurse Practitioner (PCT 023)
14. Optician (PCT 032)
15. Optometrist (PCT 031)
16. Physician (PCT 020 and 095)
17. Podiatrist (PCT 030)
18. Prosthetic/Orthotic (PCT 064)
19. Qualified Medicare Beneficiary (PCT 099)

General Rules

The following are general rules that have been established for Group Enrollment. If the Group Enrollment application doesn't meet all requirements it will be pended or rejected if necessary.

1. All individual providers in the group must be actively enrolled in the Virginia Medicaid program.

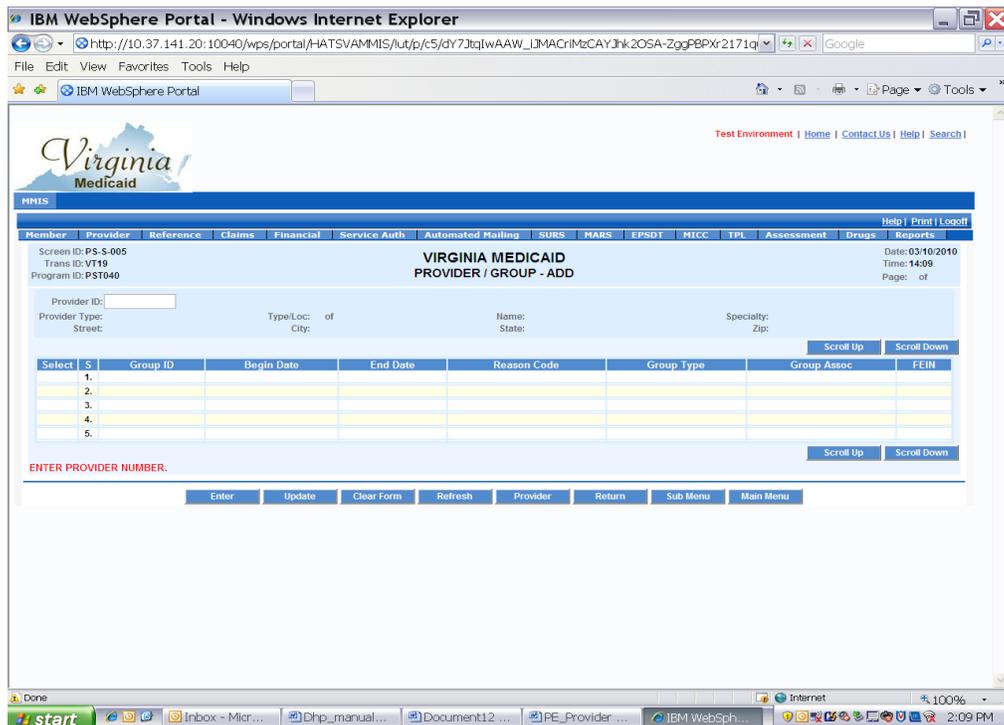
2. If individuals are not actively enrolled in Medicaid they must complete an Individual Enrollment application for their provider type, and submit and Reassignment of Benefits (ROB) form to be affiliated to Group in order to bill for services.
3. All individual providers requesting to be in a Group must submit a new enrollment application and sign an ROB form to acknowledge he or she will become part of that provider group.
4. If an individual submits an enrollment application for a TIN that has not yet enrolled into Medicaid or no Group application for TIN has been received, the individual enrollment application will be rejected for reason code 146 Shared TIN requires the formation of a Billing Group. If the Group has submitted an application at the same time as the individual, but the Group application is rejected, we cannot enroll the individual. Do NOT enroll the individual without an approved group enrollment.
5. If a Group Practice has multiple NPIs each Group NPI can be enrolled for Group Billing by completing an enrollment application for each NPI. Each TIN can have several "subparts"
6. Group name must be a business name. If it is an individual name it will be pending for provider to correct name or if it is determined to be an individual trying to enroll as a Group they will be rejected stating Provider type not eligible for Group enrollment.
7. For PCT 073 and 099 Group enrollment is available only for individuals. If an organization Type II PCT 073 or 099 completed an enrollment application to enroll with a Group it will be rejected based on an Organization Provider type is not eligible for enrollment as a Group.
8. Managed Care only providers (PGM 010) cannot be enrolled as Groups.
9. Atypical providers are not eligible for Group Practice Enrollment. An Atypical provider is defined as a provider that does not meet the HIPAA definition of a healthcare provider. These providers supply atypical or non-healthcare services. Examples of these providers are: Adult Day Care, Assisted Living, Family Caregiver Training, Non-Emergency Transportation, Non-Medical Mental Retardation Services, Personal Care, Respite Care, and Treatment Foster Care. Atypical providers will be rejected stating Provider type not eligible for Group enrollment.
10. A Group must also submit IRS Documentation supporting Ownership of Group and TIN. There are three forms acceptable as IRS documentation for Group Enrollment. They are as follows:
 - d. W-9 – This form is used to provide the correct TIN to the person or organization that requests it.
 - e. LTR 147C- The TIN owner may request verification from the IRS as to what their TIN is and this is the letter that the IRS sends in reply.
 - f. SS4 Form – This form is sent in reply to a request for a TIN from the IRS. It contains the new TIN and the date it was assigned to the requester.

Enroll Group

Procedures:

1. Follow Enroll Provider Procedures 3.1.1 – 3.1.10 with two exceptions
2. NPI indicator needs to be a "2"
3. Enter "G" in the Agreement Indicator field on Screen PS-S-001-03
4. Enter 06 on Screen PS-S-001-05 to indicate Group Practice.

5. Provider Add Group:
6. From the Provider Main Menu, enter the following selections:
 - a. From the Selection drop-down box select Provider/Group.
 - b. Select Add (PS-S-005) from the Function options.
 - c. Enter the Individual NPI.
 - d. Select **Enter**.
 - e. Provider/Group Update (PS-S-005) will appear ready to update with Group Affiliation information.



7. Enter Group NPI in Group ID field.
8. Begin Date will be the same begin date as program begin date for service location associated with the Group.
9. End date will be 12/31/9999.
10. Group Type — enter 01.
11. Select **Enter**.
12. Select **Update**.

Site Visits

1. Site Visits will be performed per steps 1-12 in section 3.8.
 - a. If provider passes Site Visit proceed with processing of enrollment application.

11. Click Enter then Update to submit Rejection.
12. Click letter information if additional comments are needed.
 - a. Note: If reason code 021 is used, put a "C" in the command field and click letter info. To specify corrections.

Procedures: Existing Provider

1. Provider already enrolled in MMIS and requires a rejection PES will create a Manual Rejection Letter through [REDACTED], Refer to Section 7.2.2 Manual letter creation in [REDACTED].
2. Place Manual Letter and all provider documents in designated PES QA Rejection Bin located in PES Document Control area.

Procedures: PES QA Rejection

1. The following Quality Checks are completed by designated PES Staff member for all Manual PES Enrollment Application rejections:
 - a. Name and API/NPI on manual letter match MMIS
 - b. Name and API/NPI of all documentation attached with rejection belong to provider.
 - c. Grammar

Approved Enrollment

Approved Application

Once the enrollment application is approved for processing in MMIS the PES specialist will enter data necessary to enroll provider into the Virginia Medicaid program.

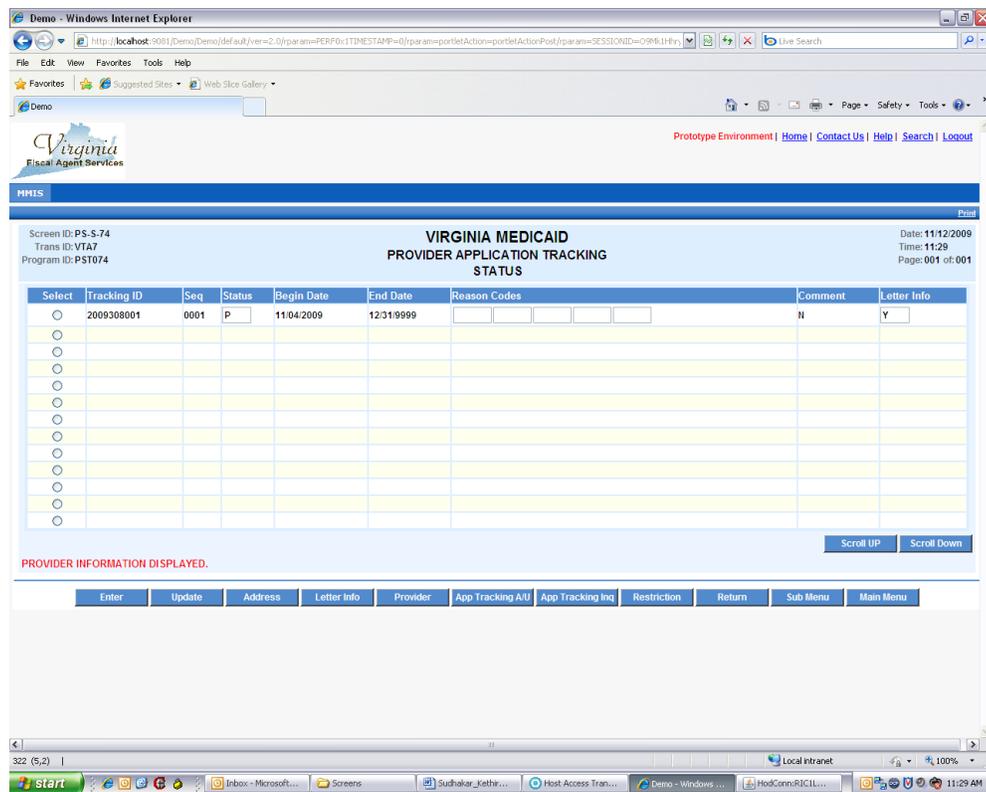


SLA (Service Level Agreement): Enroll provider must be processed within ten (10) business days of receipt.

Procedures:

1. From the VA MMIS Main Menu Screen:
2. Choose the Provider icon.
3. From the Selection drop-down box, select Application Tracking (PS-S-071).
4. Select Add from the function options.
5. Click Enter.
6. From Selection, select Application Tracking Application Tracking Approval radial button.
7. Select Change from the Function options.
8. Enter Tracking ID.
9. Select Enter.
10. Select Enter, Screen (PS-S-74) will appear:

- a. In command field enter A.
 - b. In Status field enter A.
 - c. In Letter Info. Field enters a “Y”. This will initiate an MMIS approval letter to be generated when approved.
11. Click Enter then Update...
 12. Place “A” in command field and select provider icon located at bottom. The Provider Billing Information – Update Screen (PS-S-001-01) will appear.
 13. From PS-S-001-01 screen make any corrections to NPI, Business Name, Individual Last Name, First Name, Middle Initial, Suffix, and Title by utilizing field designated for each.



14. From PS-S-001-01 under Provider IRS Information make any corrections to SSN or TIN on billing provider profiles, only.
15. Provider IRS Information:
 - a. SSN or TIN begin date- Enter begin date of IRS indicated on enrollment application or default to program begin date.
 - b. End date- 12/31/9999.
 - c. Reason – 000.
 - d. IRS Name- Enter name of IRS indicated on enrollment application.

- e. IRS Address- Enter address from either W-9 submitted or default to pay to address indicated on enrollment application. If no pay to address then correspondence address would be next to use as IRS address.
16. Provider Fiscal Year Information:
- a. Fiscal month- Enter fiscal month indicated on enrollment application or default to 12 (December).
 - b. Begin date- Default to 01/01/current year of the effective date year of the earliest active program.
 - c. End date- Enter 12/31/9999.
 - d. Reason- 000.
17. Provider EFT Information for billing providers only:
- a. Institution- Name of Banking Institution.
 - b. Account Type- C.
 - c. Account Class- C.
 - d. ABA – Routing Number of Banking Institution on Voided Check or Financial Statement. Use the ACH number if both an ABA and ACH number are given.
 - A. Routing Number must fall within the ranges of 01-12, 21-32 or 61-72. If a provider
 - e. Account Number – Account Number on Voided Check on Financial Statement.
 - f. Begin Date — Current Date.
 - g. End Date- 12/31/9999 Indefinite.
 - h. Reason- 000.
18. Provider Electronic Remit Information-PES does not enter
19. Click Enter, then next, then the Provider Billing Information – Update Screen (PS-S-001-02) will appear.
20. Update additional address information not previously entered into Application Tracking or make corrections at this time to information that was keyed incorrectly in Application Tracking.
- a. Correspondence Address – Add telephone numbers, attention name, and email address that were not available to key into application tracking.
 - b. Pay To Address — Add telephone numbers, attention name, and email address that were not available to key into application tracking.
 - c. Remittance Advice (RA) Address — Add telephone numbers, attention name, and email address that was not available to key into application tracking. Do not enter a Remittance Advice Address if it is the same as the Pay To Address.
21. Click Enter then Next Provider Location Information – Reinstate (PS-S-
- a. 001_03) will appear.

22. Update additional servicing address information not previously entered into Application Tracking or make corrections at this time to information that was keyed incorrectly in Application Tracking.
23. Provider Program Information:
 - a. Program – Enter Program Code applicable to provider as indicated on enrollment application (see appendix 7.4 Program Code List) Note: ALL providers should be enrolled in Program 01 Fee for Service Medicaid and Program 08 FAMIS)
 - b. Provider Program begin date-
 - A. Providers located in Virginia and within fifty miles of Virginia- Begin date would be date requested by provider on enrollment application or default begin date would be first day of the month prior to date of receipt. I.e. If enrollment application was received on 02/02/2010 then the begin date for provider would be 01/01/2010. Begin date should never be prior to effective date of license, or 12 months from current date. If a provider requests a begin date 12 months from the current date of their application, please referred to the PES Team Lead or Manager.
 - B. Providers outside the fifty mile radius of Virginia begin date will be begin date of service on claim submitting or of date of service designated on supporting documentation. Begin date should never be prior to effective date of license, or 12 months from current date. If a provider requests a begin date 12 months from the current date their application, please referred to the PES Team Lead or Manager.
 - c. Provider Program end date- 12/31/9999
 - d. Reason – 000
 - e. Provider Type Information
 - f. Enter provider type (see appendix 7.5 Alpha Provider Type Listing)
 - g. Provider Type Begin date – enter program begin date. Note: Provider Type begin date cannot be a future date, so if program begin date is a future date use current date as Provider type begin date.
 - h. End date- 12/31/9999
 - i. Reason – 000
 - j. License – Enter license or certification number *For out of state providers enter state abbreviation before license
 - k. Board – Enter:
 - A. 01 — Department of Health Professions license
 - B. 02 — Medicare Certification
 - C. 03 — Department of Behavioral Health and Developmental Services
 - D. 04 — JCAHO
 - E. 05 - DSS
 - F. 06 — Business License
 - G. 07 - Out-of-State License
 - H. 08 — CHAP
 - I. 09 — Other
 - l. State-State Abbreviation per servicing location
 - m. Begin date – Effective date of license

- n. End date- End date of license
 - o. Reason- 000
24. Agreement Indicator:
- a. I-Individual enrollment
 - b. G-Group enrollment
25. Provider Specialty Information
- a. Enter provider specialty or specialties (see appendix 7.8 All Provider Specialty List.)
 - b. Begin date- program begin date or current date if program begin date is in the future.
 - c. End date- 12/31/9999
 - d. Reason – 000
 - e. Primary – leave blank
26. Click **Enter** and Next Screen Provider Location Information – Update (PS-S-001-05) will appear.

27. Provider Information:
- a. Practice Type – For Individual enter 01, for facility enter 03, and group enter 06. If provider has marked off signature waiver mailing suppression form place a “1” in front of the 01 to indicate computer generated or stamped signature will be submitted on claims. See example above in Practice Type field. That indicates an Individual will be submitted computer generated or stamped signature on claims submissions.
 - b. Inactive Override – field not used at this time defaults to “N”
 - c. PPA Indicator- field not used at this time defaults to “N”
 - d. Assessment Indicator — field not used at this time defaults to “Y”
 - e. EPSDT Indicator- field not used at this time defaults to “N”
 - f. Facility Rating — field not used at this time
 - g. Facility Control- field not used at this time
 - h. Forms Indicator — field not used at this time defaults to “2”
 - i. Forms Count- field not used at this time defaults to “000”
 - j. Change Letter Indicator- field not used at this time
 - k. Point of Sale (POS) refer to section 5.7.5 POS Update
 - l. Administrator Name- Enter name of administrator indicated on enrollment application for all Hospitals and Nursing Facilities.
 - m. Comments – If Exemption to EFT or Electronic Claims Submission was indicated or exemption was approved by DMAS enter the following in the beginning of the comments field (this must be done for reporting purposes):
 - A. EEFT- Exempt Electronic Funds Transfer
 - B. EEC- Exempt Electronic Claims Submission

- C. EB- Exempt from both EFT and Electronic Claims Submission.
- n. DEA — field not used at this time
- o. Bypass Label- If provider marked off Mailing Suspension on Mail Suspension form place a “Y” in this field.
- p. Beds – Applicable for Nursing Facility enrollment see Section LL.49 and LL.50 for detailed Nursing Facility enrollment procedures.
- q. Case manager- field not used at this time
- r. Click Enter then update provider approval processed. See section 4.1.15.4 for Group Affiliations.
- s. If provider has additional locations to enroll place a “Y” in the Want to add more locations? Field and Screen PS-S-001-03 will appear, and follow steps 23 – 29 of Section 3.1.10 Approved Enrollment to begin the process of adding an additional location.
- t. MMIS will generate an Approval Letter for new provider.
- u. PES will create Manual letter for all new provider approved into MMIS to request provider register for a Security to register for the Virginia Medicaid Web portal. Refer to Section 88.2.2 Creating Manual Letters in [REDACTED].
- v. Stamp Participation Agreement with DMAS approved signature stamp of Program Operations Director
- w. Place Stamped Approved Participation Agreement in designated Back End Scanning bin.

Add Location

This process allows for an existing provider to enroll for additional servicing locations. Follow steps 23-29 of Approved Enrollment Applications and Section Provider Add Group if applicable.

Procedures:

1. From Provider Main Menu Select Provider Add Location Information
2. Function field click Add
3. ID Value – Enter NPI Press Enter
4. From Screen PS-S-001-03 Provider Location Information-ADD
5. Enter Servicing address information from provider application
6. Provider Program Information:
 - a. Program codes and program code begin dates displayed may not apply to additional servicing location.
 - b. Program codes that do not apply to additional servicing location may be removed by moving space bar over the program code, begin date, end date, and RSN code. Press Enter to update.
 - c. If the begin date of the program code displayed does not apply to additional servicing location type over existing begin date with begin date requested or default begin date, space bar over end date, Press Enter to update.

- d. Add additional Program codes if applicable
7. Provider Type Information:
- a. Provider Type remains the same
 - b. Provider Type begin date will correspond with original program begin dates.
 - c. Provider Type end date - 12/31/9999
 - d. Provider Type RSN — 000
 - e. License Field - Enter in license that applies to additional servicing location
 - f. Rev Ind – leave blank
 - g. BD - Enter licensing board associated with license
 - h. State - Enter state abbreviation which applies to license
 - i. Begin Date - Enter license begin date
 - j. End Date - Enter license end date
 - k. RSN -000
 - l. Agreement Indicator – “I”
8. Provider Specialty Information
- a. Specialty- Add any additional specialty through the Reinstatement function. See section 4.1.13
 - b. Specialty Begin Date- Begin date that corresponds with Program begin date
 - c. Specialty End Date- 12/31/9999
 - d. RSN- 000
 - e. Press Enter
 - f. Press Next
9. From Screen (PS-S-001-05) Provider Location – make any changes to Practice Type or Bypass Label as appropriate per the Enrollment Application
- a. Press Enter
 - b. Press Update
10. If additional locations need added enter “Y” into Want to add additional locations field, and repeat steps 5-1313 of this section.
11. If no additional locations or all locations added proceed to update Billing Address information with current Enrollment Application. If the provider has a tax id number on file, verify whether or not the tax id is unique to this provider by performing a FEIN search from the Provider Main Menu. If the tax id IS unique, do not update the billing address information. If the tax id is NOT unique, updated the Billing Addresses from Selection: Billing Addresses, Function: Change. 4949
12. 16) If individual provider is affiliated with a Group follow steps in Section Provider Add Group to affiliate individual to Group once additional servicing location are added.

Disclosure Information

Disclosure Information will be entered post-approval using screen PS-S-330.

Reporting

Reporting from MMIS application tracking will be used to monitor PES activities.

SLAs

In the event that there are in-process items in workflow that cannot be accessed, SLAs for those items will be calculated using the last set of workflow management reports.