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CHAPTER VI  
UTILIZATION REVIEW AND CONTROL

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## **CHAPTER VI UTILIZATION REVIEW AND CONTROL**

### **INTRODUCTION**

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid by Medicaid, including review of utilization of the services by providers and by recipients. These reviews are mandated by Title 42 of the Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals. Review of records can go back five years from the date of review. DMAS reserves the right to do 100 percent review.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

### **COMPLIANCE REVIEWS**

The Department of Medical Assistance Services routinely conducts utilization compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455. Providers and recipients are identified for review by systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. An exception profile report is generated for each recipient and provider that exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

The use of statistical sampling and extrapolation may be used in a review. DMAS may use a scientific random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

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Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may restrict limit, suspend, or terminate the provider's participation in the program.

## **FRAUDULANT CLAIMS**

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

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

### Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit  
Program Integrity Section  
Division of Cost Settlement & Audit  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit  
Office of the Attorney General  
900 E. Main Street, 5th Floor  
Richmond, Virginia 23219

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## RECIPIENT FRAUD

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the *Virginia State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit  
Program Integrity Section  
Division of Cost Settlement & Audit  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

## REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See the "Exhibits" section at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. A voicemail receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit  
Program Integrity Section  
Division of Cost Settlement & Audit  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

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Telephone: 804-786-6548  
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

### **CHILDREN'S MENTAL HEALTH PROGRAM SERVICES QUALITY MANAGEMENT REVIEW GENERAL REQUIREMENTS**

DMAS conducts utilization review to assure that the services provided are appropriate and comply with the policies and procedures for the provision of Children's Mental Health Program (CMH Program) services. For the general requirements, DMAS uses the following procedures:

1. DMAS will conduct an on-site review of service delivery;
2. Quality Management Reviews (QMR) is comprised of desk audits, on-site record review and may include observation of service delivery, as well as face-to-face or telephone interviews with the client or family or significant other(s), or both. The sampling method includes both random selections and records reviewed to examine specific variables, such as numbers of clients served, types of services rendered, numbers of private providers, etc;
3. Billing records are matched to service delivery documentation. Any infractions will be cited in the QMR written report and may result in billing overpayments, voids to continued billing;
4. QM Reviews will be unannounced;
5. Providers may be asked to bring program and billing records to the provider's central location;
6. Upon completion of on-site activities for a routine QMR, DMAS staff will be available to meet with designated staff to conduct an exit conference. The purpose of the exit conference is for DMAS to provide a general overview of the QMR findings, preliminary actions required, and recommendations that may help the provider correct problems in documentation or billing practices;
7. Following the review, a written report of the findings is sent to the provider;
8. If a billing adjustment is needed, it will be outlined in the report to the provider, as will the timeline for submitting the adjustment; and

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9. Findings identified in the written report are subject to a request from the provider for reconsideration. The procedures for submitting a request are specified in the cover letter that accompanies the written QMR report and must be submitted within 30 days of receipt of the letter.

If there are findings that are related to licensing procedures, a letter stating these findings will be submitted to the appropriate licensing or approving agency.

## **REVIEW OF CASE MANAGEMENT AND CMH PROGRAM SERVICES**

In addition to the general QMR requirements, DMAS also reviews for specific requirements for the provision of Targeted Case Management and CMH Program Services. These requirements are: eligibility for services; that the services are based on comprehensive and ongoing assessment and planning; that services are delivered, reviewed, and modified; that the provider is qualified; and that the services are consistent with billing limitations. Specific requirements for each area follow.

### Eligibility for Services

- A. The client meets the following criteria:
  1. Is eligible for Medicaid;
  2. Is younger than 21 years of age;
  3. Has a psychiatric diagnosis;
  4. Has been a resident of a PRTF for at least 90 days prior to applying for the CMH program;
  5. Meets the PRTF criteria described in 12VAC30-50-130.
- B. The client meets functional criteria. The Child and Adolescent Functional Assessment Scale (CAFAS), completed no more than six months prior to the start of CMH Program services, must be in the case management record. The CAFAS must be updated at least annually or more often as needed to reflect the current status of the client.
- C. The client continues to meet eligibility for services.
  1. It should be clearly documented in the case management record that the client's eligibility and need for continuation of any CMH Program service is reviewed at least annually; and
  2. The case management record must contain a CAFAS that was administered on at least an annual basis by the case manager or CSA staff.
- D. There is basis for initiating Targeted Case Management services.

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1. There must be documentation of eligibility for the CMH Program in the record of a client receiving case management services;
  2. There must be documentation that the client requires and receives active case management services; and
  3. Case management services must not duplicate any other Medicaid service provided under the Medicaid State Plan or under any program other than the CMH Program.
- E. There is basis for initiating CMH Program services.
1. The transition coordination and case management record must indicate that the client meets eligibility as described above; and
  2. Documentation must be evident that the client is receiving case management services during any month in which CMH Program services are provided. The case management ISP must be available in the record.

CMH Waiver Services are Based on Comprehensive and Ongoing Assessment and Planning

- A. A Consumer Service Plan is completed and reviewed.
1. The transition coordination and case management record must include a Consumer Service Plan (CSP) that organizes the services and supports that are provided to the client. The four essential components to a CSP include a) a Social Assessment, b) primary goals and outcomes desired by the client, c) an Individual Service Plan (ISP) for each CMH Program Service (including case management), and d) a signature page or documentation of agreement by those participating in the development and implementation of the CSP; and
  2. There must be evidence that the CSP is reviewed by the case manager and updated annually and whenever changes or service modifications occur.
- B. There is comprehensive and current assessment information.
1. There must be a Social Assessment in the transition coordination and case management record, completed no earlier than one year prior to the start date of services and updated at least annually. This assessment must include a review of the current situation and the client's strengths and desires within the following areas:
    - Physical/Mental Health, Personal Safety, and Behavior Issues;
    - Financial, Insurance, Transportation, other Resources;
    - Home and Daily Living;
    - Education and Vocation;
    - Leisure and Recreation;
    - Relationships and Social Supports;

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- Legal Issues and Guardianship; and
  - Client Empowerment, Advocacy, and Volunteerism.
2. There should be documentation in the case management record that demonstrates clients receiving CMH Program services are receiving any necessary medical care. Medical examinations of children should follow the schedule of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) administered by DMAS;
  3. The mental health assessment for clients must reflect the current psychological status, including diagnoses, and adaptive level of functioning. A new mental health assessment is required whenever the current mental health assessment is no longer reflective of the client's current condition.
  4. The functional assessment information used to develop the plan of care must be available in the client's service provider record and reflect an individualized approach to gathering additional information about the client's personal preferences, interests, strengths, and attributes.
- C. The client and others, as appropriate, are involved in the planning process.
1. Documentation must indicate that the client (or legal guardian, when appropriate) was informed of all feasible alternatives under the CMH Program and given the choice between institutional care or CMH Program services. The transition coordination and case management record must contain a copy of the Recipient Choice Form (DMAS 801). This is required at the initiation of CMH Program services;
  2. Documentation must be in the transition coordination and case management record that the client has been presented with all feasible alternatives of available agency and consumer-directed services for which he or she is eligible under the CMH Program (this can be done on the Recipient Choice Form);
  3. Documentation must indicate that the client (or legally responsible relative) was informed of all CMH Program providers in the community and had the option of choosing from among qualified providers. It must be clear that the choice of providers was offered no more than six months prior to the initiation of any CMH Program services, whenever new services were added, when changes occur in providers, or when requests are made by the client. The choice must be documented in writing, prior to the start of services, by having the client (or parent or guardian when appropriate) sign a list of available providers and designate the selected provider;
  4. Documentation must indicate that the client and family/caregiver was involved in the development of the supporting documentation. At a minimum, the client's and family/caregiver's input and satisfaction with the plan should be documented by signature(s) on the CSP in addition to the transition coordinator's or case manager's signature;

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5. Documentation must indicate that the client and family/caregiver was informed of any changes in services, provided the opportunity for input, and agreed to the changes before they were implemented. Documentation of this involvement (either in the service plan itself or in the case notes) should accompany any changes to the CSP; and
  6. For any termination or decrease of case management or CMH Program service, the transition coordination or case management record must contain written notification to the client of the pending action and the right to appeal. Reference Chapter IV, "Consumer's Right to Appeal and Fair Hearing" for specific requirements.
- D. The case manager receives and reviews each Individual Service Plan (ISP).
1. Each ISP must be completed prior to the initiation of services and must be based on current information and reflect the client's and family/caregiver's desires, input, and other assessment information and agreed to by the team;
  2. Each ISP must clearly describe the activities of the client and staff, reflecting training and supports, as appropriate for the client and congruent with the type and amount of service units on the ISAR. The ISP must justify service components;
  3. Each ISP must include activities and strategies that are meaningful and address the client's and family/caregiver's primary goals. Each ISP must satisfy the specific Medicaid criteria and service limitations for each client service as described in Chapter IV; and
  4. The schedule of services must be consistent with the service units on the ISAR.
- E. Documentation of all planned services. The CSP is completed annually by the case manager or as needed. It should list all current CMH Program and non-waiver services.

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### Services are Delivered, Reviewed, and Modified

- A. Services occur as planned or are adjusted to accommodate the client's needs and requests.
1. There must be ongoing documentation in the record of each service provider regarding the services to the client and available for review by the case manager, DMAS, and the client or family or both. Documentation can include case notes, various modes of measurable data collection, attendance records, notes regarding significant incidents, monthly summaries, and progress notes;
  2. The record must document a minimum of one face-to-face contact with the case manager within each 90-day period. There must be evidence that the case manager assessed the client's satisfaction with services (through observation and interviews with the client and significant others), determined any unmet needs, evaluated the client's status, and assisted with adjustments in the services and supports as appropriate. Missed face-to-face contacts with no documented reason, particularly patterns of missed contacts, may result in the entire quarter being disallowed for Medicaid reimbursement; and
  3. Each service provider's record (including case management) must contain documentation that corresponds to the ISP objectives and indicates that services have been provided according to the plan. While this data may take many forms, it should be meaningful for the client and show that his or her goals being addressed.
- B. Services are reviewed at least quarterly or more often as needed.
1. There must be documentation that the case manager reviewed on a quarterly basis all services provided (including case management services). The first quarterly review will be due by the last day of the third month from the effective date of the ISP. However, a grace period of one month will be given to complete the review. The next quarterly review will be based on the month the previous quarterly review was due and not on the date when the review was actually completed in the grace period. This update should include a statement/comment on the current status of the client in relationship to all services and supports being provided. That is, **this is a review of the comprehensive ISP, not just of the progress made.**
  2. There must be evidence that quarterly reviews for CMH Program services are completed at the end of each quarter and as determined by the effective date of the start of the CSP. However, the original quarterly due dates should always resume if this grace period must be utilized; and
  3. The quarterly review for each service, including case management, will be reviewed to determine if it addresses a) the results of the services; b) any significant events; c) the client's and, when appropriate, the family's satisfaction

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with the services and other input; and d) changes in the goals or strategies when they are ineffective or upon the client's request.

C. A comprehensive review of each service occurs annually.

1. The record will be reviewed to determine if the annual review includes a combination of record review, observation of service delivery, and interviews with the client and family to determine if the services provided are effective and match the client's needs and desires for support; and
2. Every service must have an ISP developed at the time of the annual CSP review (no longer than 365 days/366 days in a leap year). There is no grace period. There must be documentation of client and family involvement in the review and development of the new CSP.

The Provider is Qualified

A. There is documentation of the needed license, certification, vendor agreement, or approval.

1. It is the responsibility of the service provider to maintain documentation, readily available for review, which verifies the provider's qualifications; and
2. Provider qualifications and expectations are outlined in Chapter II of this manual.

B. Certain additional requirements are met.

1. A case manager must not be a direct service provider for the same client;
2. DMAS-enrolled respite agencies providing agency-directed respite services must employ or subcontract with and directly supervise a QMHP or LMHP who will provide ongoing supervision of all respite assistants;
3. Agencies providing companion services must have a companion supervisor who, at a minimum, meets QMHP qualifications;
4. Documentation must be available that verifies a provider has special skills or training in working with individuals with SED; and
5. Staff providing respite (agency or consumer-directed), companion (agency or consumer-directed), or in-home residential services may not be the parent of a minor child receiving services, the client's spouse, a legally responsible relative or legal guardian for the client. In addition, staff providing services may not be other family members unless there is objective written documentation as to why there are no other providers available to provide the care. Relatives who provide services must meet the same standards as providers who are unrelated to the client.

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The Services Delivered Are Consistent With Billing Limitations

A. Services are authorized or preauthorized as appropriate.

1. All CMH Program providers must have a current DMAS Participation Agreement that lists all services for which the provider is eligible to provide and bill; and
2. All CMH Program providers must have a copy of the current notification letter authorizing their services. It is not necessary for a provider of multiple services to a client to maintain the notification letter in each separate service record. CD Services Facilitation does not require preauthorization prior to service initiation; and
3. Terminations of single CMH Program services should be reflected on the CSP and indicated on Individual Service Authorization Requests (ISARs) submitted to DMAS or its contractor. Terminations of all CMH Waiver services should be reflected on documentation submitted to DMAS.

B. There is documentation that services were provided as billed.

1. Billing for case management services must be supported by a minimum of one direct or by client-related contact, activity, or communication and must be documented each month relevant to the CSP during any month for which a claim for case management is submitted. Written work is excluded;
2. In-home residential services are billed for actual service hours. Documentation must include dates, times, and services that were provided in accordance with the ISP;
3. Billing for respite care (agency and consumer-directed), therapeutic consultation, companion care (agency and consumer-directed) and family/caregiver training must be supported by documentation of the dates and times of actual service delivery. The format used for documentation of service hours should be reviewed by DMAS staff prior to use to ensure that all required components are present. Billing for CD services is supported by employee time sheets that are signed by the client and family/caregiver, as appropriate, and employee;
4. Billing for environmental modifications must be supported by bills from contractors, rehabilitation engineers (if required), and equipment purchase receipts;
5. It is not permissible to automatically bill each month at the maximum amount authorized on the notification letter. For all services, if the amount billed for a given service in the month audited does not correspond to documented hours/units of services delivered, the entire quarter is audited. If that quarter's billing does not correspond to service delivery records, subsequent quarters may be audited;

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6. All billing errors identified by DMAS staff are reported to the provider for correction. Billing errors identified during a formal Quality Management Review are also reported to the provider reviewed;
  7. All billing must be supported by the required documentation as outlined throughout this manual. As a result of reviews conducted by DMAS, infractions will be cited in the written report of findings and may entail a request for billing retractions or a void to continued billing. Plan of Correction may be requested when review issues cited are pervasive, repetitive, or of a serious nature. The following is a non-comprehensive list of circumstances most likely resulting in billing overpayments or voids when identified during utilization or more informal service reviews:
    - a) Absence of current ISP;
    - b) Services not delivered as described in the ISP;
    - c) Services rendered to an ineligible client;
    - d) Case management face-to-face contacts that are not completed in a timely manner (every 90 days);
    - e) Any periods of services billed for which there is an absence of or inadequate documentation to substantiate the service rendered (amounts, type, absence of data, assessment information, etc.);
    - f) Any periods of services billed during which the staff were not qualified, the provider had not fulfilled the terms of the Participation Agreement, and/or the required license/certification/approval had been revoked;
    - g) Any identified billing errors, such as inaccuracies in service amounts, incorrect dates of service, duplication of services, etc.;
    - h) There is no documentation reflecting the need for a service or for that level of service; and
    - i) Absence of a current CAFAS or a CAFAS that does not meet the requirements for eligibility.
- C. Designated CMH Waiver services are not used when available from the primary source. There should be documentation that it was determined that the equipment or supplies provided to a client under environmental modification services are not available under the Medicaid State Plan. This may be documented in the client's record by noting the results of reviewing the "Durable Medical Equipment and Supplies" list for a given item or the results of a phone inquiry to the DMAS Helpline about the item's availability through the State Plan, or both.

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## RECONSIDERATIONS AND APPEALS

Payment to providers may be denied when the provider has failed to comply with established federal and State regulations or policy guidelines.

If, upon reconsideration, the denial is upheld in whole or part, the provider has the right to a first-level informal appeal of the reconsideration decision, pursuant to Va. Code §2.2-4019. A provider may appeal an adverse decision by filing a written notice of appeal with the DMAS Appeals Division within 30 calendar days of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed and must be sent to:

Appeals Division  
Department of Medical Assistance Services  
600 East Broad Street, 11<sup>th</sup> Floor  
Richmond, VA 23219

If the denial is upheld, in whole or in part, as a result of the first-level informal appeal, the provider has the right to file for a second-level formal appeal, pursuant to Va. Code § 2.2-4020. The provider must file a request for a formal appeal within 30 calendar days of receipt of the first-level informal appeal decision. The notice of appeal and supporting documentation shall be sent to:

Appeals Division  
Department of Medical Assistance Services  
600 East Broad Street, 11<sup>th</sup> Floor  
Richmond, VA 23219