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CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

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CHAPTER II PROVIDER PARTICIPATION REQUIREMENTS

Provider Manuals and manual updates are posted on the DMAS website (www.dmas.virginia.gov) for viewing and downloading. Providers are notified of manual updates through messages posted on Medicaid remittance advices.

PROVIDER QUALIFICATIONS

Inpatient Hospital

All Medicaid recipients may receive inpatient hospital psychiatric care in a general acute care hospital. Residents over the age of 65 may receive services in a freestanding psychiatric hospital. Individuals under the age of 21 enrolled in EPSDT may receive psychiatric services in a freestanding hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The facility must also meet state licensure requirements.

Residential Treatment

Individuals under the age of 21 in the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) may receive residential psychiatric care in:

1. A residential treatment program for children and adolescents licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) that is located in a psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
2. A residential treatment program for children and adolescents licensed by DMHMRSAS that is located in a psychiatric unit of an acute general hospital accredited by the JCAHO; or
3. A psychiatric facility that is (i) accredited by JCAHO, the Commission on Accreditation of Rehabilitation Facilities, the Council on Quality and Leadership in Support for People with Disabilities, or the Council on Accreditation Services for Families and Children and (ii) licensed by DMHMRSAS as a residential treatment program for children and adolescents.

Treatment Foster Care Case Management

Treatment Foster Care Case Management shall be provided by child placing agencies with treatment foster care programs that are licensed or certified by the Virginia Department of Social Services (DSS) to be in compliance with DMAS and meet the provider qualifications for treatment foster care set forth in these regulations.

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Providers may bill Medicaid for case management for children in treatment foster care only when the services are provided by qualified foster care case managers. The case manager must meet, at a minimum, the qualifications specified by DMAS.

Minimum Standards for Case Managers

- a. A Ph.D. or master's degree in social work from a college or university accredited by the Council on Social Work Education or in a field related to social work such as sociology, psychology, education, or counseling, with a student placement in providing casework services to children and families. One year of experience in providing casework services to children and families may be substituted for a student placement; or
- b. A baccalaureate degree in social work or a field related to social work including sociology, psychology, education, or counseling and one year of experience in providing casework services to children and families; or
- c. A baccalaureate degree in any field plus two years' experience in providing casework services to children and families.

Enrolled Providers

Only facilities and licensed individuals enrolled as Medicaid providers may bill Medicaid for psychiatric services.

Provider Qualifications for Psychiatric and Substance Abuse Services

Psychiatric Services may be provided by:

- A psychiatrist who is a licensed physician who has completed at least three years of postgraduate residency training in psychiatry;
- A licensed clinical psychologist licensed by the Department of Health Professions, Board of Psychology;
- A licensed clinical social worker (LCSW) licensed by the Department of Health Professions, Board of Social Work;
- A licensed professional counselor (LPC) licensed by the Board of Counseling;
or
- A psychiatric clinical nurse specialist - Psychiatric (CNS) licensed by the Board of Nursing and certified by the American Nurses Credentialing Center;
- A psychiatric nurse practitioner, licensed by the Board of Nursing;
- A marriage and family therapist/counselor licensed by the Virginia Board of Counseling;

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- An individual who has completed his or her graduate degree and is under the direct personal supervision of an individual licensed under Virginia state law. The individual must be working towards licensure and supervised by the appropriate licensed professional in accordance with the requirements of the individual profession.

Substance Abuse Services

In addition to the following licensure requirements, substance abuse treatment providers must also be qualified by training and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities.

Licensure Requirements:

- A psychiatrist who is a licensed physician who has completed at least three years of postgraduate residency training in psychiatry and who has ;
- A licensed clinical psychologist licensed by the Department of Health Professions, Board of Psychology;
- A licensed clinical social worker (LCSW) licensed by the Department of Health Professions, Board of Social Work;
- A licensed professional counselor (LPC) licensed by the Board of Counseling; or
- A psychiatric clinical nurse specialist - Psychiatric (CNS) licensed by the Board of Nursing and certified by the American Nurses Credentialing Center;
- A Psychiatric Nurse Practitioner licensed by the Board of Nursing.
- A marriage and family therapist/counselor licensed by the Virginia Board of Counseling;
- An individual who is licensed as a substance abuse treatment practitioner by the Virginia Board of Counseling; or
- An individual who has completed his or her graduate degree and is under the direct personal supervision of an individual licensed under Virginia state law. The individual must be working towards licensure and supervised by the appropriate licensed professional in accordance with the requirements of the individual profession.

Direct Supervision

When services are provided by an unlicensed individual, the provider must ensure that:

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- The plan of care is approved and signed by the licensed professional. It must state the need for psychiatric or substance abuse treatment; the objectives or goals of the psychotherapy, which fall within the parameters of Medicaid-covered services, and be congruent with the diagnosis and initial evaluation of the client; and it must include a treatment regimen, projected schedule, and schedule for reevaluation. Documentation in the client's record should include written records of client contacts, services rendered, the role of the service to the care plan, and updates of the client's progress. The medical record must contain the notes that are countersigned or signed by the licensed individual to show that he or she personally reviewed the patient's medical history and confirmed the plan of care.
- Each psychotherapy or substance abuse treatment session must be written at the time the service is rendered and must be signed and dated by the therapist rendering the service. If the therapy session is rendered by an unlicensed therapist, and under the direct, personal supervision of a qualified, Medicaid enrolled provider, the therapy session must contain not only the dated signature of the therapist rendering the service but also the dated signature of the supervising provider. Each therapy session must contain the dated co-signature of the supervising provider on the date the service was rendered indicating that he or she has reviewed the note.
- The licensed supervisor does not have to be present in the room during the session, but must be in the facility during the session and meet regularly with the professional to discuss the client's plan of care and review the record. The record should indicate that the patient's progress and plan of care are reviewed at least after every six sessions by the supervising licensed professional.

FREEDOM OF CHOICE

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

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, the provider must request a participation agreement by contacting:

First Health
 VMAP-PEU
 PO Box 26803
 Richmond, Virginia 23261-6803

Telephone Numbers:

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804-270-5105 (Local)
1-888-829-5373 (In state toll-free)
804-270-7027 (Fax)

PROVIDER ENROLLMENT

Each provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. All providers must sign a Medicaid Provider Agreement. The signature must be an original signature. An agreement for specific psychiatric services must be signed by the authorized agent of the provider. All providers must complete the participation agreement and return it to the Provider Enrollment and Certification unit of FIRST HEALTH (FH/PEU).

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

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

As part of the supporting documentation for a psychiatric residential treatment provider, DMAS must receive a signed letter of attestation from the Chief Executive Officer (CEO) of the facility stating that the facility is in compliance with the federal condition of participation of restraint and seclusion in psychiatric residential facilities (42 CFR §§ 483.350 – 483.376). If there is a change in CEOs, a new letter of attestation must be submitted. Letters are required at enrollment and annually thereafter. A sample letter of attestation can be found in the Exhibits section at the end of this chapter. Letters are due by 5 PM on July 1 or the first business day thereafter each year and are to be sent to:

Provider Enrollment Contract Manager
Department of Medical Assistance Services (DMAS)
Suite 1300
600 East Broad Street
Richmond, VA 23219

Adherence to the regulations regarding restraint & seclusion, including the reporting of any serious incident involving any resident, is a condition of continued participation as a Medicaid provider. If the letter of attestation is not received by DMAS by the due date, approval of new authorizations will not occur. Also, DMAS Utilization Review Audits will monitor for compliance with the Condition of Participation.

Instructions for billing and specific details concerning the Medicaid Program are contained in this manual. Providers must comply with all sections of this manual to maintain

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continuous participation in the Medicaid Program.

Enrollment of providers for Level C Residential Psychiatric Treatment for Children and Adolescents are generally limited to those located in Virginia or within 50 miles of the state line. If a child requires this level of service that is not available in Virginia, an out-of-state provider may enroll for a specific child only for the duration of the admission. Out-of-state providers or Comprehensive Services Act Coordinators who are interested in obtaining Virginia Medicaid reimbursement for a specific child may contact the Behavioral Health Consultant at DMAS to discuss enrollment. This must be done prior to out-of-state placement. Information on a proposed out-of-state placement may be faxed to (804) 612-0059.

Recipient-specific information required for out-of-state placement consideration:

- Referral source and contact person
- Name and contact information, such as website, of the proposed placement
- Basic demographics of recipient (age, sex, current location, family involvement, Medicaid number)
- Current description of the recipient's need for intensive psychiatric residential treatment, such as planned focus of treatment, problem behaviors, DSM-IV diagnosis, medications, court involvement, previous treatments-successful or not, discharge summaries (within the past 6 months)
- Virginia Medicaid providers approached and the outcomes (provide specific reasons for denial of admission)
- Discharge plan

PARTICIPATION REQUIREMENTS

Requirements for providers approved for participation include, but are not limited to, the following:

- Immediately notify FH/PEU, in writing, whenever there is a change in any of the information that the provider previously submitted.
- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required service(s) and participating in the Medicaid Program at the time the service was performed;
- Ensure the recipient's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended, (42 U.S.C. §§ 2000d through 2000d-4a) which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the basis of race, color, or national origin;
- Provide services, goods, and supplies to recipients in full compliance with the

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requirements of the Rehabilitation Act of 1973, as amended, (29 U.S.C. § 794) which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;

- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public;
- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;
- Not require, as a precondition for admission, any period of private pay or a deposit from the patient or any other party;
- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;
- Serious incidents involving any resident must be reported to DMAS and DMHMRSAS Licensing and the Virginia Office of Protection and Advocacy. Serious incidents include a resident's death, suicide attempt, or a serious injury that requires medical attention. The incident reports should be faxed to DMAS at (804) 612-0059. The fax must include the following information:
 - Recipient's name and Medicaid number, if applicable;
 - Facility name and address of incident;
 - Names of staff involved;
 - Description of the incident, including the date;
 - Outcome, including the persons notified; and
 - Current location of the recipient.
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable cost. 42 CFR § 447.15 states: "A State Plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. If a third-party payer reimburses \$5.00 out of an \$8.00 charge, and Medicaid's allowance is \$5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the \$3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative. The provider may not charge DMAS or the recipient for broken or missed appointments;

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- Reimburse the patient or any other party for any monies contributed toward the patient's care from the date of eligibility. The only exception is when a patient is spending down excess resources to meet eligibility requirements;
- Accept assignment of Medicare benefits for eligible Medicaid recipients;
- Use program-designated billing forms for submission of charges;
- Maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved (refer to the section on documentation of records);
- Furnish to authorized state and federal personnel access to records and facilities in the form and manner requested;
- Disclose, as requested by DMAS, all financial, beneficial ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance; and
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of the state agency. The state agency shall not disclose medical information to the public.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. § 794) provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. Each Medicaid participating provider is responsible for making provisions for such disabled individuals in the provider's programs and activities.

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

In the event a discrimination complaint is lodged, DMAS is required to provide to the

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Office of Civil Rights (OCR) any evidence regarding non-compliance with these requirements.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under medical assistance shall be reduced to the extent that they are available through: other federal, state, or local programs; coverage provided under federal or state law; other insurance; or third party liability.

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

- Title XVIII (Medicare) - Virginia Medicaid will pay the amount of any deductible or coinsurance up to the Medicaid limits for covered health care benefits under Title XVIII of the Social Security Act (42 U.S.C. §§ 1395 through 1395ggg) for all eligible persons covered by Medicare and Medicaid.
- Workers' Compensation - No Medicaid program payments shall be made for a patient covered by workers' compensation.
- Other Health Insurance - When a recipient has other health insurance (such as CHAMPUS, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.
- Liability Insurance for Accidental Injuries - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to enforce any lien that may exist under § 8.01-66.9:1 of the Code of Virginia. In liability cases, providers may choose to bill the third party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and regardless of whether or not Medicaid is billed by the provider for rendered services related to the accident, the psychiatric hospital is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Unit, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

ASSIGNMENT OF BENEFITS

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If a Virginia Medical Assistance Program beneficiary is the holder of an insurance policy which assigns benefits directly to the patient, the psychiatric hospital must require that benefits be assigned to the psychiatric hospital or refuse the request for the itemized bill that is necessary for the collection of the benefits.

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION

[Effective Date: January 23, 1992]

A required physician signature for Medicaid purposes may include signatures, written initials, computer entries, or rubber stamps initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the *Physician Manual* issued by DMAS.

FRAUD

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

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

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

TERMINATION OF PROVIDER PARTICIPATION

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

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and FH-PEU 30 days prior to the effective date. The addresses are:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

First Health –VMAP-PEU

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P.O. Box 26803
Richmond, VA 23261-6803

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. The participation agreement may be terminated immediately if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

Any provider losing JCAHO accreditation will be notified of DMAS termination. DMAS can rescind the termination of the provider agreement if accreditation is restored; however, Medicaid reimbursement will not be available for any period during which the provider does not meet DMAS provider participation standards.

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

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action. Adverse action for purposes of this section includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration of the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 30 days' notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (APA) (Section 2.2-4000, et seq.) and the *State Plan for Medical Assistance* provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

Repayment of Identified Overpayments

Pursuant to Section 32.1-325.1 of the Code of Virginia, DMAS is required to collect

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identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to Section 32.1-313.1 of the Code of Virginia. Repayment and interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

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**Sample Restraint & Seclusion
Letter of Attestation**

(Date)

Provider Enrollment Contract Manager
Department of Medical Assistance Services
Suite 1300
600 East Broad Street
Richmond, Virginia 23219

Dear Mr. Lubinskas,

By this letter, I am attesting that I have read the interim final rule and federal regulations for Seclusion and Restraint for Psychiatric Residential Facilities for Recipients under 21 and that my facility is in compliance with the Centers for Medicare and Medicaid Services (CMS) rule. The regulations begin at 42 CFR 483.350 (Subpart G).

Facility Director

Facility Name

Medicaid Provider Number

Address

Sincerely,

Facility Director



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Hospital Participation Agreement

This is to certify:

Provider Name _____ NPI _____

On this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. The provider is currently licensed and certified under applicable laws of this state. (Check the item which applies to your hospital.)
 - ____ A.) As of _____ (Date) has been fully certified for participation with Title XVIII (Medicare) of Public Law 89-97.
 - ____ B.) Is limited to an age group not eligible for Title XVIII benefits, but is as of _____ (Date), accredited by the Joint Commission on Accreditation for Hospitals and has a utilization review plan which meets Title XVIII AND Title XIX standards for utilization review.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his medical or physical handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) in VMAP.
3. The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP, on request, information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General, or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.
4. The applicant agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered under Medicaid. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid recipient for any service provided under Medicaid is expressly prohibited and may subject the provider to federal or state prosecution.
6. The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment to the provider. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
9. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party. This agreement may be terminated by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.
10. Except as otherwise provided by applicable state or federal law, all disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
12. This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For First Health's use only	
Director, Division of Program Operations	Date

Original Signature of Provider Date



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Hospital Early Periodic Screening, Diagnosis, and Treatment Program Participation Agreement

This is to certify:

Provider Name _____ NPI _____

On this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. The provider participating in the EPSDT program is one who is not identified in the State Plan.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited and may subject the provider to federal or state prosecution.
6. The provider agrees to pursue all other health care resources of payment prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
9. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party. This agreement may be terminated by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.
10. Except as otherwise provided by applicable state or federal law, all disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.
12. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
13. This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For First Health's use only	
Director, Division of Program Operations	Date

Original Signature of Provider

Date



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Residential Psychiatric Treatment for Children and Adolescents Participation Agreement

This is to certify:

Provider Name _____ NPI _____

On this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

- 13. The provider is a psychiatric entity licensed by DMHMRSAS as a Residential Treatment Program and accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) OR Council on Accreditation of Services for Families and Children OR the Commission on Accreditation of Rehabilitation Facilities and meets all the requirements in 42 CFR 441, Subpart D.
- 14. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his medical or physical handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) in DMAS.
- 15. The applicant agrees to keep such records as DMAS determines necessary. The applicant will furnish DMAS, on request, information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized DMAS representatives, the Attorney General, or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.
- 16. The provider agrees to care for patients at the lessor of the rate established by the Community Planning and Management Team or the current maximum rate established for the facility by VMAP at the date of service.
- 17. Payment made by DMAS at its established rates constitutes full payment except for patient pay amounts determined by DMAS, and the applicant agrees not to submit additional charges to the recipient for services covered under Medicaid. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid recipient for any service provided under Medicaid is expressly prohibited and may subject the provider to federal or state prosecution. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider will reimburse DMAS upon demand.
- 18. The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to DMAS.
- 19. The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
- 20. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party. This agreement may be terminated by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.
- 21. Except as otherwise provided by applicable state or federal law, all disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
- 22. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
- 23. This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For First Health's use only	
Director, Division of Program Operations	Date

Original Signature of Provider Date



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Participation Agreement

This is to certify:

Provider Name _____ NPI _____

On this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. The provider is authorized to practice under the laws of the state in which he is licensed and practicing and is not as a matter of state or federal law disqualified from participating in the Program.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
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11. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
12. This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

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Date