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CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

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CHAPTER II PROVIDER PARTICIPATION REQUIREMENTS

PROVIDER MANUALS

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

PARTICIPATING PROVIDER

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

PROVIDER ENROLLMENT

A nursing facility must be enrolled in the Virginia Medicaid Program prior to billing for any services provided to Medicaid recipients. Billing forms will not be issued to providers who do not sign a Participation Agreement with DMAS. (See the "Exhibits" section at the end of this chapter for a copy of the Nursing Facility Participation Agreement.)

The authorized agent of the nursing facility should complete and sign (only original signatures are accepted) two nursing facility Participation Agreements and return them to First Health Services Provider Enrollment and Certification Unit.

Upon completion of the enrollment process, a nine-digit provider number will be assigned to each provider. This number must be used on all claims and correspondence submitted to Medicaid.

Instructions for billing and specific details concerning the Virginia Medicaid Program are contained in this manual. Read all sections of this manual before signing the Participation Agreement. The provider must comply with all sections of this manual to maintain continuous participation in the Virginia Medicaid Program.

REQUEST FOR PARTICIPATION

To become a Medicaid-certified provider of services, the nursing facility must request a Participation Agreement in writing from:

First Health
VMAP-PEU
P.O. Box 26803
Richmond, Virginia 23261-6803

Phone: 1-804-270-5105 or 1-888-829-5373 (in-state, toll-free)/Fax: 1-804-270-7027

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NOTE: Certification by VDH does not constitute automatic enrollment as a Medicaid provider.

PARTICIPATION REQUIREMENTS

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

- Immediately notify DMAS, in writing, whenever there is a change in any of the information that the provider previously submitted;
- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner, which participates in the Virginia Medicaid Program at the time the service is performed and is qualified to perform the required service(s);
- Ensure the recipient's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her/his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;
- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the resident or any other party;
- Accept Medicaid payment from the first day of eligibility, if Medicaid eligibility was pending at the time of admission. The nursing facility must accept payment back to the date of eligibility if the resident was in a certified bed, whether or not the facility knew that Medicaid application had been made;
- Provide services and supplies to recipients of the same quality and in the same mode of delivery that is provided to the general public;
- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;

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- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable cost. 42 CFR § 447.15, provides that “A State Plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, co-insurance, or co-payment required by the Plan to be paid by the individual.”

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

- Accept assignment of Medicare benefits for eligible Medicaid recipients;
- Use program-designated billing forms for submission of charges;
- Maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided;

In general, such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved (refer to the “Documentation of Records” section).

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by the Virginia Medicaid Program, all financial, beneficial ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance; and
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his/her possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of the state agency.

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FREEDOM OF CHOICE

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

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance.

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

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

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

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

PROVIDER PARTICIPATION CONDITIONS

Responsible Party Requirements

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

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

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

Preconditions for Admission or Continued Stay in Medical Facilities

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

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

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

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

- **The patient is Medicaid-eligible at the time of admission.** – If a patient is admitted to a Medicaid-enrolled facility, there can be no precondition for admission requiring any period of private pay or a deposit from the resident or any other party.
- **Medicaid eligibility is pending at the time of admission.** – Medicaid long-term care providers cannot collect more than the Medicaid rate from a Medicaid recipient. When Medicaid eligibility is determined, it is most often made retroactive to a time prior to the date that the eligibility decision is made. Federal statutory and regulatory requirements mandate that the nursing facility accept Medicaid payment as payment in full when a person’s Medicaid eligibility begins. Thus, nursing facilities are required to refund any excess payment received from a resident or family member for the period of time that the Medicaid eligibility was pending and the resident is determined eligible for Medicaid.
- **A private pay resident applies for Medicaid and becomes eligible after admission.** – An enrolled provider may not require discharge of the resident or continue to require a period of private pay subsequent to the initial eligibility date for residents in Medicaid-certified units. The Virginia Medicaid Program must be billed for all covered services delivered by a provider beginning with the date of eligibility in such cases (42 CFR §§ 442.311 and 405.121 and § 32.1-138 of the *Code of Virginia*, 1950 as amended).

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

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

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

Certain Contract Provisions Prohibited

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

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

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Nursing Facility

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

To become a DMAS provider, a nursing facility must:

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

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

Specialized Care Provider

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

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

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

It is intended that the per diem received by the facility for providing Specialized Care Services be all-inclusive for the resident's care with the exception of certain allowable items (e.g., medications) that would be billed by the pharmacy. For example, nursing facilities may not bill Medicare Part B for the tube-feeding portion of the resident's care for enterally fed residents who

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are in specialized care beds. In addition, the facility may not bill the co-insurance portion of the tube-feeding claim to Medicaid, as this would constitute a double billing to the Virginia Medicaid Program.

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

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

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

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

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

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

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

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Assessments required include the following:

- Admission decisions must be based on a preliminary evaluation of the resident conducted or updated by the facility or outside sources. This evaluation must include background information as well as currently valid assessments of functional, developmental, behavioral, social, health, and nutritional status;
- Within 30 days after admission, the interdisciplinary team must perform accurate assessments or re-assessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the resident's age and implications for active treatment at each stage, as applicable;
- Within 30 days after admission, the interdisciplinary team must prepare for each resident an individual program plan stating the specific measurable objectives in behavioral terms which are necessary to meet the resident's needs and the planned sequence for dealing with those objectives;
- As soon as the interdisciplinary team has formulated a resident's individual program plan, the resident must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary;
- At least annually, the comprehensive functional assessment of each resident must be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan must be revised, as appropriate; and
- At the time of discharge, the facility must develop a final summary of the resident's development, behavioral, social, health, and nutritional status and, with the consent of the resident, parents (if the resident is a minor), or legal guardian, provide a copy to authorized persons and agencies and provide a post-discharge Plan of Care (POC) that will assist the resident with adjusting to the new living arrangement.

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

Institutions for Mental Diseases (IMDs)

An institution for mental diseases (IMD) is a public or private facility that is certified by VDH. Any facility may be considered an IMD when it is established or maintained primarily for the care and treatment of individuals with mental diseases. In Virginia, medical assistance is available only for those recipients in institutions for mental diseases when the recipient is over

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the age of 65. The following guidelines are used in determining whether or not a facility is an IMD:

- The facility is licensed as a psychiatric facility for the care and treatment of individuals with mental diseases;
- The facility advertises or holds itself out as a facility for the care and treatment of individuals with mental diseases;
- The Joint Commission accredits the facility as a psychiatric facility for Accreditation of Hospitals;
- The facility specializes in providing psychiatric care and treatment. This may be ascertained through review of residents' records and may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric training;
- The facility is under the jurisdiction of the Commonwealth of Virginia's mental health authority [the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)];
- More than 50 percent of the residents have a diagnosis of a mental disease, which requires inpatient treatment and is documented in their medical records;
- A large proportion of the residents in the facility have been transferred from a state mental institution for continuing treatment of their mental disorders;
- Independent professional review teams report a preponderance of mental illness in the diagnoses of the residents in the facility;
- The average age in the facility is significantly lower than that of a typical nursing facility; and
- Part or all of the facility consists of locked wards.

Out-of-State Nursing Facilities

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

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

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UTILIZATION OF INSURANCE BENEFITS

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

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

In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his/her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward a DMAS-1000 form to:

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

See the "Exhibits" section at the end of this chapter for a sample of this form.

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DOCUMENTATION OF RECORDS

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

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

RECONSIDERATION OF ADVERSE ACTIONS

Non-State-Operated Providers

The following procedures are available to providers when DMAS takes adverse action, including termination or suspension of the Provider Agreement and denial of payment for services rendered based on compliance review decisions.

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

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Virginia Administrative Process Act (APA) (§§ 9-6.14:1 through 9-6.14:25 of the *Code of Virginia*) and the Virginia State Plan for Medical Assistance provided for in § 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.

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State-Operated Providers

The following procedures are available to state-operated providers when DMAS takes adverse action, which includes termination or suspension of the Provider Agreement and denial of payment for services rendered based on compliance review decisions. A state-operated provider is a provider of Medicaid services, which is enrolled in the Virginia Medicaid Program and operated by the Commonwealth of Virginia. A state-operated provider has the right to request reconsideration for any issue which would be otherwise administratively appealable under the Virginia *State Plan for Medical Assistance* by a non-state-operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process consists of three phases: an informal review by the Division Director, a DMAS Director review, and a Secretarial review. First, the state-operated provider will submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, Notice of Proposed Action, Findings Letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable law and regulations. The Division Director will consider any recommendation of his/her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his/her designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request that the DMAS Director refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information. Providers enrolled at multiple locations or who are members of a group using one central office may receive multiple copies of Provider Manuals, updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing a written request to the First Health/Provider Enrollment Unit (FH/PEU) at the address given under the "Request for Participation" section on page 1.

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FRAUD

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

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

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

TERMINATION OF PROVIDER PARTICIPATION

The Participation Agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to the expiration of the agreement. A participating provider may terminate his/her participation in Medicaid by giving written notification of voluntary termination to the DMAS Director 30 days prior to the effective date.

DMAS may terminate a provider from participation upon written notification to the provider 30 days prior to the effective date. Such action precludes further payment by DMAS for services provided to recipients subsequent to the date specified in the termination notice. Section 32.1-325(c) of the *Code of Virginia* mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

REPAYMENT OF IDENTIFIED OVERPAYMENTS

Pursuant to Section 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When 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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EXHIBITS

(NOTE: The following documents and forms related to this chapter can be downloaded from the DMAS website at www.dmas.virginia.gov.)

- Nursing Facility Participation Agreement – Sample (DMAS-129)
- Special Care Participation Agreement
- Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Provider Agreement
- Institutions for Mental Disease (IMDs) Provider Agreement
- Third-Party Liability Information Report (DMAS-1000, R 9/87)
- Mailing Suspension Request

