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CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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CHAPTER II PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating provider is a school division which has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. Providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment and Certification Unit of the FIRST HEALTH Services Corporation; an original signature of the provider is required. Provider enrollment forms may be found on the DMAS website at www.dmas.virginia.gov.

School divisions may be reimbursed by DMAS for two types of health services provided in the schools under the Virginia Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) program; (1) health screenings and (2) medically necessary health care services approved for Medicaid enrolled children in special education. School divisions must be enrolled with DMAS as providers to receive reimbursement for services. For the health screenings and medical evaluations, services must be conducted in a school based clinic setting or setting led by a physician licensed by the Board of Medicine. A physician assistant licensed by the Board of Medicine or a certified nurse practitioner licensed by the Board of Nursing may conduct EPSDT health screenings and medical evaluations as long as they are under physician supervision.

To bill for the DMAS recognized health services under special education, school divisions must forward copies of the appropriate provider qualifications (copy of license or documentation of credentials) to the Medicaid Specialist at the Department of Education (DOE) with exception of providers of personal care assistant services and special education transportation services (which must meet the requirements set forth by Special Education policy).

If the school division is contracting out services with:

- A DMAS enrolled provider/agency, the school division needs to inform the DOE Medicaid Specialist of the name and address of the Medicaid enrolled provider/agency.
- A provider who is not enrolled with DMAS as a provider, the school division needs to forward copies of the appropriate provider qualifications (copy of license or documentation of credentials) to the DOE Medicaid Specialist.

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The DOE Medicaid Specialist will coordinate with DMAS to ensure that the school division has the appropriate special education services added under their assigned National Provider Identifier (NPI).

The school should notify the Medicaid Specialist at DOE when any of the following occur:

1. When a provider is new to the school division;
2. When a provider has new qualifications or changes to existing qualifications; or
3. When a provider has left the school division.

Virginia Department of Education, Medicaid Specialist
P.O. Box 2120
Richmond, VA 23219
Phone: (804) 692-0150
Fax: (804) 371-8796

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. Providers of medical and health services for Medicaid recipients must obtain a NPI and submit the NPI to DMAS. The NPI replaces all previously assigned Medicaid provider numbers and must be included on all claims and correspondence submitted to Medicaid.

This manual contains information about provider qualifications and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

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

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
Phone (804) 270-5105 or 1-888-829-5373 (in state toll-free)
Fax (804) 270-7027

The provider may download a copy of the appropriate provider agreement through the DMAS website at www.dmas.virginia.gov.

Note: Certification by the Virginia Department of Health or the Virginia Department of Education does not constitute automatic enrollment as a Medicaid provider.

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PARTICIPATION REQUIREMENTS

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

- Immediately notify First Health Services-Provider Enrollment Unit, in writing, of any change in the information which the provider previously submitted to First Health Services-Provider Enrollment Unit.
- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the 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 ground of race, color, or national origin.
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.
- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public.
- Accept Medicaid payment from the first day of eligibility if the provider was aware that application for Medicaid eligibility was pending at the time that services began.
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR §447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from a

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Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. The provider may not charge DMAS or the recipient for broken or missed appointments.

- Accept assignment of Medicare benefits for eligible Medicaid recipients.
- Use Program-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. 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 regarding documentation for medical records.)
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by the Program, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.
- Hold confidential and use for authorized Program purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

PARTICIPATION CONDITIONS

All providers enrolled in the Virginia Medical Assistance Program must adhere to the conditions of participation outlined in their individual provider agreements. The following paragraphs outline the special participation conditions for providers performing EPSDT screening services and providers serving students in special education. DMAS covers the following services in school divisions under the conditions listed below:

- EPSDT screenings,
- Physical therapy,

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- Occupational therapy,
- Speech-language pathology,
- Audiology,
- Skilled nursing,
- Psychiatric and psychological services,
- Personal care services,
- Medical evaluations,
- Transportation, and
- Assessments and reassessments for medical IEP services.

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

- Employ qualified professionals whose qualifications/licensures have been verified by the Medicaid Specialist at Virginia DOE;
- Only bill Medicaid for services provided by qualified staff who are employed or contracted with the schools; and
- Enter into and have in effect an agreement as a Medicaid provider of school services.

PROVIDER QUALIFICATIONS FOR SPECIFIC SERVICES

EPSDT Screening Services

EPSDT Screening services must be conducted by a:

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

Physical Therapy Services

Physical therapy services must be performed by one of the following:

- A physical therapist (LPT) licensed by the Virginia Board of Physical Therapy;
- A graduate of a physical therapy program approved by the American Medical Association and American Physical Therapy Association who is engaged in

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clinical experience under the direct supervision of a licensed physical therapist (LPT); or

- A physical therapy assistant (LPTA) licensed by the Virginia Board of Physical Therapy and directly supervised by a LPT. When services are provided by an LPTA, the PT must conduct a supervisory visit at least every 30 calendar days while therapy is being conducted and document accordingly as described in Chapter VI of this manual.

Occupational Therapy Services

Occupational therapy services must be performed by one of the following:

- An occupational therapist registered by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine;
- A graduate of an occupational therapy program approved by the American Medical Association and the American Occupational Therapy Association who is engaged in clinical experience under the direct supervision of a licensed occupational therapist; or
- A certified occupational therapy assistant (COTA) by the National Board for Certification in Occupational Therapy under the direct supervision of a licensed occupational therapist, as defined above. When services are provided by a COTA, the OT must conduct a supervisory visit at least every 30 calendar days while therapy is being conducted and document accordingly as described in Chapter VI of this manual.

Speech-Language Pathology Services

Speech-Language Pathology services must be performed by one of the following:

1. A speech-language pathologist (SLP) licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology who meets one of the following categories:
 - A SLP with a master's degree from an accredited audiology and speech-language program licensed by examination;
 - A SLP with a master's degree from an accredited audiology and speech-language program and endorsement by DOE licensed without examination from the Virginia Board of Audiology and Speech-Language Pathology; or

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- A SLP with a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA) and licensed by the Virginia Board of Audiology and Speech-Language Pathology.

Individuals who have completed the master's level academic program and are acquiring supervised work experience to qualify for the ASHA certification must be under the direct supervision of a licensed CCC/SLP or SLP. These individuals are in their Clinical Fellowship Year (CFY), typically a nine month supervision. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity.

2. Individuals identified by DMAS as a speech-language assistant, e.g., a bachelor's level licensed by DOE (excluding provisional license), a master's level without licensure by the Virginia Board of Audiology and Speech-Language Pathology, or a master's level with licensure only by DOE (effective January 1, 2001).

Speech-language assistants must be under the direct supervision of a licensed CCC/SLP or SLP that meets DMAS' licensure requirements. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity.

Audiology Services

Audiology services must be provided by an audiologist licensed by the Virginia Board of Audiology and Speech-Language Pathology.

Skilled Nursing Services

Skilled nursing services must be provided by a:

- A Licensed Registered Nurse (RN); or
- A Licensed Practical Nurse (LPN) under the supervision of a RN.

When LPN services are provided, the licensed RN must conduct a supervisory visit at least every 30 calendar days while LPN services are being conducted and document accordingly as described in Chapter VI of this manual.

Psychiatric and Psychological Services

Psychiatric and Psychological 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;

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- A licensed clinical psychologist licensed by the Department of Health Professions, Board of Psychology;
- A school psychologist licensed by the Department of Health Professions, Board of Psychology as a school psychologist or school psychologist-limited;
- 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 Department of Health Professions, Board of Counseling;
- A psychiatric clinical nurse specialist (CNS) licensed by the Board of Nursing and certified by the American Nurses Credentialing Center;
- A marriage and family therapist licensed by the Department of Health Professions, Board of Counseling; or
- A school social worker with a minimum of a master's level degree and endorsed by Department of Education.

Psychiatric and Psychological service providers must provide services within their scope of licensure, within the guidelines of Special Education regulations (8 VAC 20-80-10) and within the Medicaid covered services detailed in Chapter IV of this manual.

Personal Care Services

Personal care aides must be supervised by a licensed RN, PT, OT, SLP, Psychiatrist or Psychologist who is acting within the scope of licensure and employed by or contracted with the school division. Basic qualifications for personal care aides include:

- Physical ability to do the work;
- Perform services consistent with the training received through DOE:
 - Guidelines for Specialized Health Care Procedures;
 - Medication Manual for Unlicensed Personnel; and
 - Insulin and Glucagon Manual.

A link to the DOE training manuals may be found on the DMAS website at www.dmas.virginia.gov/ch-home.htm under School Services.

Documentation must be present indicating the training has been received prior to assigning an aide to a recipient. Based on continuing evaluations of the aide's performance and the recipient's individual needs, the supervising RN, PT, OT, SLP, Psychiatrist or Psychologist shall identify any significant gaps in the aide's ability to

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function competently and shall provide the necessary training. When personal care services are provided, the appropriate licensed RN, PT, OT, SLP, Psychiatrist or Psychologist must conduct a supervisory visit at least every 30 calendar days while personal care services are being conducted and document accordingly as described in Chapter VI of this manual.

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

Medical Evaluation Services

Qualified providers of Medical Evaluation Services include:

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

Transportation

Drivers and vehicles must be employed through the school or have a contract with the school and must meet applicable federal and state statutes and regulations for transporting students.

Assessments and Reassessments for Medical IEP Services

Assessments necessary to assess or reassess the need for medical services in a child's IEP may be completed by any of the above mentioned licensed practitioners acting within the scope of his or her practice.

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.

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

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

TERMINATION OF PROVIDER PARTICIPATION

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

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

DMAS may terminate a provider from participation upon thirty (30) calendar days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to recipients subsequent to the date specified in the termination notice. Termination by DMAS shall be treated as an adverse action, and in certain instances the provider shall be entitled to a reconsideration and/or hearing as identified in the following section.

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

RECONSIDERATION OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action:

The provider is afforded a reconsideration process. The provider will have thirty (30) calendar days to submit information for written reconsideration. 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 Virginia Code §2.2-4019. A provider may appeal an adverse decision by filing a written notice of appeal with the DMAS

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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, 11th 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 Virginia 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, 11th Floor
Richmond, VA 23219

Repayment of Identified Overpayments

Pursuant to §32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to §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.

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.

A provider may not wish to receive a provider manual and Medicaid memoranda because he or she has access to the publications as part of a group practice. To suppress the receipt of this information, the First Health Provider Enrollment Unit requires the provider to complete the Mail Suppression Form and return it to:

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First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
Phone (804) 270-5105 or 1-888-829-5373 (in state toll-free)
Fax (804) 270-7027

Upon receipt of the completed form, FH-PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.