<table>
<thead>
<tr>
<th>Manual Title</th>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Manual</td>
<td>II</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Subject</th>
<th>Page Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Participation Requirements</td>
<td>2/8/2012</td>
</tr>
</tbody>
</table>

CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS
CHAPTER II

TABLE OF CONTENTS

<p>| Participating Provider | 1 |
| Freedom of Choice       | 1 |
| Provider Enrollment     | 1 |
| Requests for Participation | 2 |
| Participation Requirements | 2 |
| Provider Responsibilities to Identify Excluded Individuals and Entities | 4 |
| Hospital Participation Conditions | 5 |
| General Acute Care Hospitals | 5 |
| Rehabilitation Facilities | 5 |
| Requirements of Section 504 of the Rehabilitation Act | 6 |
| Utilization of Insurance Benefits | 6 |
| Assignment of Benefits  | 7 |
| Use of Rubber Stamps for Physician Documentation | 7 |
| Documentation of Records | 7 |
| Review and Evaluation   | 8 |
| Fraud                   | 8 |
| Termination of Provider Participation | 9 |
| Termination of a Provider Contract upon Conviction of a Felony | 9 |
| Medicaid Program Information | 10 |</p>
<table>
<thead>
<tr>
<th>Manual Title</th>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Manual</td>
<td>II</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Subject</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Participation Requirements</td>
<td></td>
<td>2/8/2012</td>
</tr>
</tbody>
</table>

Reconsideration and Appeals of Adverse Actions

Provider Appeals
- Non-State Operated Provider: 10
- State-Operated Provider: 12
- Client Appeals: 13
PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating provider is an institution, facility, agency, partnership, corporation, or association that is certified by the Virginia Department of Health and that has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

FREEDOM OF CHOICE

The patient shall have freedom of choice in the selection of a provider of services. Generally, however, payments are limited under the Medical Assistance Program to providers who are qualified to participate in the Program under Title XVIII and who have signed a written agreement with DMAS.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the 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.

All providers must complete the participation agreement and return it to:

Virginia Medicaid -PES  
PO Box 26803  
Richmond, Virginia 23261-6803

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

All providers must sign a Medicaid Provider Agreement (see “Exhibits” at the end of the chapter for a sample Provider Agreement.) The signature must be an original signature. An agreement for a hospital must be signed by the authorized agent of the provider. The Virginia Medical Assistance Program must receive prior written ratification of the identity of any designated authorized agent and the fact that a principal agent relationship exists.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, the provider can download a participation agreement from the DMAS website (www.dmas.state.va.us) or can request a participation agreement by writing, calling, or faxing the request to the address listed below:

Virginia Medicaid -PES  
PO Box 26803  
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Note: Certification by the Division of Licensure and Certification of the Virginia Department of Health does not constitute automatic enrollment as a Medicaid provider.

PARTICIPATION REQUIREMENTS

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

- Immediately notify Xerox - Provider Enrollment Services Unit, in writing, whenever there is a change in any of the information that the provider previously submitted.
- Obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients.
- Ensure 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 § 504 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.

• Accept as payment in full the amount established by DMAS. 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. 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. The provider may not bill DMAS or recipients for broken or missed appointments.

Example: If a third party payer reimburses $5 out of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference from Medicaid, the recipient, a spouse, or a responsible relative;

• 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 DMAS-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.

• 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 in this manual on documentation of records.)

• Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

• 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.

• 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 DMAS. DMAS shall not disclose medical information to the public.

Provider Responsibilities to Identify Excluded Individuals and Entities

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.

2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly
by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.
3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS
Attn: Program Integrity/Exclusions
600 E. Broad St, Ste 1300
Richmond, VA 23219
-or-
E-mailed to: providerexclusions@dmas.virginia.gov

HOSPITAL PARTICIPATION CONDITIONS

General Acute Care Hospitals

A hospital is eligible for participation in the Virginia Medical Assistance Program if it meets one of the following criteria:

- Is certified by the Virginia Department of Health (VDH) as meeting the conditions for participation under Title XVIII of Public Law 89-97
- Is limited to an age group not eligible for Title XVIII benefits, but is accredited by the Joint Commission on Accreditation for Hospitals and has a Utilization Review Plan that meets the Title XVIII and Title XIX standards for utilization review

Rehabilitation Facilities

DMAS covers intensive rehabilitation services in rehabilitation hospitals and in rehabilitation units of acute care hospitals. To become a provider in this category, the facility must:

- Be certified by the VDH as a rehabilitation hospital, or be certified by VDH as a rehabilitation unit in an acute care hospital.
- Have met the requirements to be excluded from the Medicare Prospective Payment System.
- Enter into and have in effect a separate agreement as a Medicaid provider of rehabilitation services.
REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act, 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. As a condition of participation, each Medicaid provider is responsible for making provision for disabled individuals in his or her program activities.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding 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, or 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 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 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/TRICARE, 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 its lien established 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 Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the hospital is requested to forward the DMAS-1000 to:

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

(See “Exhibits” at the end of this chapter for a sample of this form.)

ASSIGNMENT OF BENEFITS

If a Virginia Medical Assistance Program beneficiary is the holder of an insurance policy which assigns benefits directly to the patient, **the hospital must require that benefits be assigned to the 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:  1-23-92]

All physician or other health care professionals’ documentation, including certifications, must be signed with the initials, last name, and title. DMAS will allow the use of rubber stamps for physician signatures when the use is consistent with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation requirements and physician documentation. When a rubber stamp is used, the individual whose signature the stamp represents must provide DMAS with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. All rubber-stamped signatures are also required to be accompanied by the initials of the physician.

The signature waiver form must be received 30 days prior to the date of the anticipated use of the rubber stamp. (See “Exhibits” at the end of this chapter for a sample of this form.) All documentation must be completely dated with the month, day, and year.

DOCUMENTATION OF RECORDS

The 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 patient on each page.
- Entries must be signed and dated by the responsible licensed participating provider. Care rendered by personnel under the direct personal 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, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.

The record must indicate the progress at each visit, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written for every office, clinic, or hospital visit billed to Medicaid.

**REVIEW AND EVALUATION**

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services of providers and by recipients. This function is handled by the Virginia Medical Assistance Program’s Prepayment and Postpayment Review Sections.

Provider and recipient utilization patterns to be reviewed are identified either from computerized exception reports or by referrals from agencies or individuals. To ensure a thorough and fair review, trained professionals review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Providers will be required to refund Medicaid if they are found to have billed Medicaid contrary to policy, failed to maintain records to support their claims, or billed for medically unnecessary services. Due to the provision of poor quality services or of any of the above problems, Medicaid may limit, suspend, or terminate the provider's participation agreement.

Providers selected for review will be contacted directly by personnel with detailed instructions. This will also apply when information is requested about a recipient or when a recipient is restricted to the physician or pharmacy, or both, of his or her choice because of misutilization of Medicaid services.

Additional information on hospital utilization review activities and on physician certification of the need for care may be found in Chapter VI, Utilization Review and Control.

**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 item of value for services rendered or supposedly rendered to recipients under Medicaid. A provider participation agreement will be terminated or denied in cases where a provider is found guilty of fraud.
Investigation of allegations of provider fraud is the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General of Virginia. Provider records are to be made available to personnel in this unit for investigative purposes.

Further information on submission of fraudulent claims may be found in Chapter V of this manual.

**TERMINATION OF PROVIDER PARTICIPATION**

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and Xerox - PES 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

- **Virginia Medicaid - PES**
  - PO Box 26803
  - Richmond, Virginia 23261-6803

*DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.*

**TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY**

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." 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.
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 a member of a group using one central office may receive multiple copies of 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 Xerox - Provider Enrollment Services Unit at the address given under "Requests for Participation" earlier in this chapter.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse actions that afford appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the overpayment and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division  
Department of Medical Assistance Services  
600 East Broad Street,  
Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider’s request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

A provider may appeal an adverse decision where a service has already been provided, by filing a written notice for a first-level Informal Appeal with the DMAS Appeals Division within 30 calendar days of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division  
Department of Medical Assistance Services  
600 East Broad Street, 11th Floor  
Richmond, VA 23219
If the provider is dissatisfied with the first-level Informal Appeal decision, the provider may file a written notice for a second-level appeal Formal Appeal, which includes a full administrative evidentiary hearing under the Virginia Administrative Process Act (APA), Code of Virginia, § 2.2-4000 et seq. The notice for a second-level Formal Appeal must be filed within 30 calendar days of receipt of the first-level Informal Appeal decision. The notice for second-level Formal Appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

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

Administrative appeals of adverse actions concerning provider reimbursement are heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) (the APA), the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia and the DMAS appeal regulations at 12 VAC 30-20-500 et. seq. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

If the provider is dissatisfied with the second-level Formal Appeal decision, the provider may file an appeal with the appropriate county circuit court, in accordance with the APA and the Rules of Court.

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

The provider may not bill the recipient (client) for covered services that have been provided and subsequently denied by DMAS.

Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325.1D and E. The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code §2.2-4000 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division within 15 calendar days of the receipt of the notice of termination or denial.

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 lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the Code of Virginia, § 32.1-313.1. Repayment and interest will not apply pending the administrative 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.

**State-Operated Provider**

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director 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 a Notice of Program Reimbursement (NPR), 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 reason(s) for seeking the adjustment. The Division Director or his/her designee 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 laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director’s decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director’s Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.
CLIENT APPEALS

The Code of Federal Regulations at 42 CFR §431 et seq., and the Virginia Administrative Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual’s receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the client. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the client will be expected to repay DMAS for all services received during the appeal period. For this reason, the client may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals must be requested in writing and postmarked within 30 days of receipt of the notice of adverse action. The client or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at the local department of social services, or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

The appeal request must be signed and mailed to the:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street, 11th floor
Richmond, Virginia 23219
Appeal requests may also be faxed to: (804) 371-8491