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State Name: Virginia

State Plan Amendment (SPA) #: 11-12

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT# 092020114038

DEC 15 2011

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

Dear Ms. Jones:

We have reviewed State Plan Amendment (SPA) 11-12, in which the Commonwealth is updating the State Plan to conform to a change to the Code of Virginia which requires providers who have received notices of termination of their provider enrollment and who wish to file an appeal of this action, to notify DMAS within 15 days of their intention to appeal.

This SPA is acceptable. Therefore, we are approving SPA 11-12 with an effective date of August 17, 2011. Enclosed is the approved SPA page and signed CMS-179 form.

If you have further questions about this SPA, please contact Melanie Benning at (215) 861-4267.

Sincerely,

/S/

Francis McCullough
Acting Associate Regional Administrator

Enclosures

Do you know someone who has been denied medical insurance because of a pre-existing condition? If so, they may be eligible for the new Pre-Existing Condition Insurance Plan. Call toll free 1-866-717-5826 (TTY 1-866-561-1604) or visit www.pcip.gov and click on "Find Your State" to learn more.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 11 — 12
2. STATE: Virginia
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: August 17, 2011

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 431

7. FEDERAL BUDGET IMPACT
a. FFY 2011 $ 00.00
b. FFY 2012 $ 00.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 7.5A, Page 3 of 6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same page

10. SUBJECT OF AMENDMENT: Informal Provider Appeals Update

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2011
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL: /S/

13. TYPED NAME: Cynthia B. Jones

14. TITLE: Director

15. DATE SUBMITTED: 9/16/11

16. RETURN TO:
Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 16, 2011

18. DATE APPROVED: DEC 15 2011

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: August 17, 2011

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Francis Mc Cullough

22. TITLE: Acting Associate Regional Administrator

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

Save

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

INFORMAL AND FORMAL PROVIDER APPEALS

PART II. INFORMAL APPEALS

12 VAC 30-20-540. Informal appeals.

A. Providers appealing a DMAS reimbursement decision shall file a written notice of informal appeal with the DMAS Appeals Division within 30 days of the provider's receipt of the decision. Providers appealing the termination or denial of their Medicaid agreement pursuant to § 32.1-325 D of the *Code of Virginia* shall file a written notice of appeal with the DMAS' Appeals Division within 15 days of the provider's receipt of the notice of termination or denial. Providers appealing adjustments to a cost report shall file a written notice of informal appeal with the DMAS Appeals Division within 90 days of the provider's receipt of the notice of program reimbursement. The notice of informal appeal shall identify the issues being appealed. Failure to file a written notice of informal appeal within 30 days of receipt of the decision or within 90 days of receipt of the notice of program reimbursement shall result in dismissal of the appeal. Failure to file a written notice of informal appeal for termination or denial of a Medicaid agreement pursuant to § 32.1-325 D of the *Code of Virginia* within 15 days of receipt of the notice of termination or denial shall result in dismissal of the appeal.

B. DMAS shall file a written case summary with the DMAS Appeals Division within 30 days of the filing of the provider's notice of informal appeal. DMAS shall mail a complete copy of the case summary to the provider on the same day that the case summary is filed with the DMAS Appeals Division. The case summary shall address each adjustment, patient, service date, or other matter disputed and shall state DMAS' position for each adjustment, patient, service date, or other disputed matter. The case summary shall contain the factual basis for each adjustment, patient, service date, or other disputed matter and any other information, authority, or documentation DMAS relied upon in taking its action or making its decision. Failure to file a written case summary with the Appeals Division in the detail specified within 30 days of the filing of the provider's notice of informal appeal shall result in dismissal in favor of the provider on those issues not addressed in the detail specified.