



CHAPTER 300 PROVIDER PARTICIPATION REQUIREMENTS

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DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.



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BACKGROUND

This chapter presents an overview of the minimum requirements that health care providers must meet to enroll in and be reimbursed by the West Virginia Medicaid Program and the West Virginia Children's Health Insurance Program (WVCHIP). West Virginia Medicaid/WVCHIP healthcare providers include individual practitioners, institutional providers, and providers of medical equipment or goods related to care. Unless otherwise specified, requirements in this chapter apply to all providers. Historically this has been referred to as a common chapter. Requirements discussed in other chapters only apply to those specific provider types. Additional requirements such as those for prior authorization, timely claims filing, maintenance of records, recovery of overpayments, audits and appeals, etc., can be found in [Chapter 100, General Information](#).

POLICY

300.1 PROVIDER ENROLLMENT

The Affordable Care Act (ACA) and related regulations at [42 CFR 455](#), imposed new requirements on state Medicaid agencies (SMAs), and Children's Health Insurance Programs (CHIP) to enhance their provider enrollment and screening practices. State Medicaid/CHIP agencies and providers must comply with these federal regulations and the Centers for Medicare and Medicaid Services (CMS) Medicaid Provider Enrollment Compendium (MPEC). In addition, Medicaid/WVCHIP enrolled providers must comply with all additional requirements established by the State and the West Virginia Department of Human Services (DoHS), Bureau for Medical Services (BMS). Providers may enroll as inpatient or outpatient facilities, agencies, pharmacies, suppliers, individual practitioners, or groups. All group practices must comply with West Virginia Law applicable to group and corporate practice. All rendering practitioners (i.e. providers who are providing services and directly bill West Virginia Medicaid/WVCHIP) and ordering or referring physicians or other professionals (ORP) practitioners (i.e. providers who are providing services, writing prescriptions and/or referring members, but are not permitted to directly bill West Virginia Medicaid/WVCHIP), must be enrolled as participating providers to be eligible for reimbursement of services. Not all applicable requirements are specified in [42 CFR 455](#).

The BMS fiscal agent's Provider Enrollment Unit is responsible for screening and enrolling providers into West Virginia Medicaid/WVCHIP. Some provider types also require the Bureau's approval for enrollment.

Enrolled providers, in accordance with their license and scope of practice, may be eligible to participate and receive reimbursement for services provided to Medicaid/WVCHIP members when they:

- Meet all applicable licensing as required by the State in which services will be performed and maintain a valid copy on file with the BMS fiscal agent.
- Have a valid signed provider enrollment application/agreement on file with the BMS fiscal agent.
- Meet and remain in compliance with the Bureau's provider enrollment requirements
- Meet all federal requirements pertaining to provider screening and enrollment

The required screening measures vary according to the provider's categorical risk level of "limited," "moderate" or "high" in accordance with [42 CFR 455](#) and [42 CFR 424.518](#). All screening includes

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mandatory disclosures related to ownership and controlling interests and information about disclosing entities, fiscal agents, or managed care entities. Screening for providers in the “moderate” and “high-risk” categories includes site visits. Screening for high risk also includes fingerprint-based background checks. Providers will not be assigned a risk category lower than that which Medicare has assigned to that same provider type. If a provider potentially fits within more than one risk level, the highest screening level is applicable. All providers are screened against state and federal databases to assure no provider is enrolled who is not deemed eligible based on federal and state criteria. A provider will not be enrolled, re-enrolled, reactivated, revalidated or practice locations added to an existing enrollment until all screening activities applicable to that provider are completed.

Providers designated “**Limited**” Risk - Section 424.518(a)(1) lists the following provider types under the “limited” risk category:

- Physician or non-physician practitioners (including physician assistant, nurse practitioners, certified registered nurse anesthetists, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics
- Ambulatory surgical centers (ASCs)
- Competitive Acquisition Program/Part B Vendors
- End-stage renal disease (ESRD) facilities
- Federally qualified health centers (FQHCs)
- Histocompatibility laboratories
- Home infusion therapy suppliers
- Hospitals, including critical access hospitals, Department of Veterans Affairs hospitals, and other federally-owned hospital facilities
- Institutional Health Providers Operated by an Indian Health Program
- Mammography screening centers
- Mass immunization roster billers
- Opioid treatment programs (if § 424.67(b)(3)(ii) apply)
- Organ procurement organizations
- Outpatient physical therapy (OPT)/outpatient speech pathology (OSP)
- Pharmacies newly enrolling or revalidating via the CMS-855B application
- Radiation therapy centers
- Religious non-medical health care institutions
- Rural health clinics (RHCs)

Providers designated “**Moderate**” Risk - Section 424.518(b)(1) lists the following provider types under the “moderate” risk category:

- Ambulance service suppliers
- Community mental health centers (CMHCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Independent clinical laboratories
- Independent diagnostic testing facilities
- Physical therapists enrolling as individuals or as group practices
- Portable x-ray suppliers

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- Prospective (newly enrolling) and revalidating opioid treatment programs that have been fully and continuously certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) since October 23, 2018
- Revalidating durable medical equipment prosthetics orthotics and supplies (DMEPOS) providers
- Revalidating home health agencies
- Revalidating Medicare Diabetes Prevention Program suppliers
- Revalidating skilled nursing facilities (effective January 1, 2023)
- Revalidating hospices (effective January 1, 2024)

Providers designated **“High” Risk** - “High” risk can apply to individual or organizational providers. Two federal regulations, §§ 424.518(c) and 455.450(e), are used to indicate the providers and provider types the SMA must categorize as “high” risk. Section 424.518(c)(1) lists the following provider types under the “high” risk category:

- Prospective (newly enrolling) DMEPOS suppliers
- Prospective (newly enrolling) home health agencies
- Prospective (newly enrolling) Medicare diabetes prevention program suppliers
- Prospective (newly enrolling) opioid treatment programs that have not been fully and continuously certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) since October 23, 2018
- Prospective (newly enrolling) skilled nursing facilities – Effective January 1, 2023
- Prospective (newly enrolling) hospices – Effective January 1, 2024

[Section 1902\(a\)\(27\) of the Social Security Act](#) provides general authority for the Department of Health and Human Services (DHHS) Secretary to require provider agreements with every person or institution providing services under the State Medicaid/CHIP Plans. Under these agreements, the Secretary may require information regarding any payments claimed by such a person or institution for providing services under the State Plan. In addition, [Section 2107\(e\) of the Act](#), provides that certain Title XIX and Title XI provisions apply to States under Title XXI, including 1902(a)(4)(C) of the Act, related to conflict of interest standards, and 1902(a)(77) and (kk) related to screening, oversight, and reporting requirements.

Renewals of license and/or certification must be current, and the documentation must be submitted to the BMS fiscal agent’s Provider Enrollment Unit for inclusion in the provider record. A provider’s participation in West Virginia Medicaid/WVCHIP may be terminated if the BMS fiscal agent does not receive a copy of the provider’s license/certification.

As a part of the federally required revalidation process, providers must verify their enrollment information and update the required disclosures at predetermined intervals. If a provider has been screened by Medicare or another State’s Medicaid or CHIP program within the previous five years, information pertaining to federal requirements from that screening may be accepted by West Virginia Medicaid/WVCHIP. Additional state requirements may apply. Off cycle revalidations may be carried out by West Virginia Medicaid/WVCHIP, when warranted by situations such as random checks, information indicating local health care fraud, complaints, national initiatives, evidence indicating noncompliance with statute or regulations by specific provider types, or other reasons that cause West Virginia Medicaid/WVCHIP to question compliance of the provider or supplier with Medicaid enrollment requirements.

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The state will comply with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse actions.

300.1.1 Enrollment Categories

Enrollment is the process the BMS uses to establish a provider's eligibility to submit claims for Medicaid/WVCHIP covered services and supplies. The process includes identification of a provider or supplier; validation of the provider's or supplier's eligibility to provide items or services to Medicaid/WVCHIP members; identification and confirmation of the provider's or supplier's service locations and owners; and granting the provider or supplier Medicaid billing/WVCHIP privileges.

- **Initial Enrollment:** The enrollment process when a provider has not previously been enrolled with West Virginia Medicaid/WVCHIP.
- **Reenrollment:** The enrollment process when a provider has been enrolled with West Virginia Medicaid/WVCHIP and was voluntarily disenrolled (terminated, deactivated or otherwise removed). These providers must submit a new enrollment application to West Virginia Medicaid/WVCHIP's fiscal agent.
- **Reactivation:** The enrollment process when a provider was enrolled and was involuntarily disenrolled by West Virginia Medicaid/WVCHIP. For example, a provider is inadvertently disenrolled by the fiscal agent or the BMS.
- **Revalidation:** The enrollment process when a provider is required to update enrollment information. Providers are required to revalidate with West Virginia Medicaid/WVCHIP at least every five years. Providers will be notified when they are scheduled to revalidate. Failure to provide appropriate documentation to complete revalidation will result in termination of the provider's participation.

300.2 ENROLLMENT OF PRACTICE LOCATION

New enrollment of a practice location includes a site visit when the provider falls in the "moderate" or "high-risk" category. When a new practice location is added to an existing "moderate" or "high-risk" provider enrollment, a site visit is also required.

300.3 MEDICAID/WVCHIP MANAGED-CARE ENROLLMENT

Managed care organizations (MCOs) that participate in West Virginia Medicaid/WVCHIP must enroll as a provider and are responsible for contracting and credentialing their participating providers. MCOs establish standards for providers that participate in their networks. MCO standards must meet or exceed those for traditional Medicaid/WVCHIP fee-for-service providers. If a provider wants to become a participating provider with a participating West Virginia Medicaid MCO, they must contact the MCO directly. Please refer to [Chapter 527 Mountain Health Trust \(Managed Care\)](#) of the BMS Policy Manual for additional information.

Under Section 5005(b)(2) of the 21st Century Cures Act, by July 1, 2018, the BMS must require that a provider in a managed care network is enrolled with West Virginia Medicaid/WVCHIP consistent with section 1902(kk)- Enrollment of the managed care provider must include provision of the provider's identifying information, including the name, specialty, date of birth, Social Security Number, National Provider Identifier (NPI) Number, Federal Tax ID Number, and the state license or certification number

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of them. Each provider must execute a provider agreement with BMS, and all applicable screening must be performed.

300.4 PRACTITIONERS ELIGIBLE ENROLLMENT

Practitioners eligible for enrollment in West Virginia Medicaid/WVCHIP to provide covered services within their scope of practice include, but are not limited to, the following:

- A Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Optometry (OD), Doctor of Dental Surgery (DDS), Doctor of Medicine in Dentistry (DMD), and Doctor of Oral Maxillofacial Surgery (OMS) within the scope of a professional license issued under State law.
- A non-physician practitioner (NPP) e.g. an advanced practice registered nurse (APRN), physician assistant (PA).
- An occupational therapist, physical therapist, speech therapist, peer recovery support specialist, direct-care workers.
- A licensed independent clinical social worker and licensed professional counselor
- A licensed psychologist
- A licensed certified social worker and licensed graduate social worker, when affiliated with an enrolled West Virginia Medicaid/WVCHIP provider.

In accordance with [42 CFR 455.410](#), all ORPs must be enrolled with West Virginia Medicaid/WVCHIP. Ordering/referring/prescribing practitioners (i.e. providers who may write prescriptions or refer members but are not directly billing Medicaid/WVCHIP) must be enrolled as participating providers. Any services ordered, referred, or prescribed by a practitioner not enrolled in West Virginia Medicaid/WVCHIP will be denied. In a situation where an ORP is eligible to enroll, it is not permissible to submit claims with an organizational NPI in place of that individual's NPI. West Virginia Medicaid/WVCHIP requires all claims for payment for items and services that are ordered or referred contain the NPI of the physician or other professional who ordered or referred items or services. For example, if a hospital submits a claim with the hospital's NPI in the "ordering/referring" claim field and the services were ordered, referred, or prescribed by a provider type that is eligible to enroll in West Virginia Medicaid/WVCHIP, the claim is not compliant with [42 CFR 455.440](#) and must be denied.

Enrolled MDs, DOs, APRNs, and PAs are encouraged to provide a medical home which uses a team approach to providing health care and care management for Medicaid members. The primary care practitioner is the primary contact for provision and coordination of a member's health care services or needs.

Non-emergency medical transportation (NEMT) providers who provide only non-emergency transportation services must enroll through the Bureau for Medical Service's NEMT enrollment broker. For additional information please see [Chapter 524 Transportation](#).

300.4.1 Specialty Practitioner Enrollment and Participation Requirements

Podiatric, chiropractic, and other specialty physicians (Board-certified or Board-eligible) and NPPs that have hospital privileges must provide a copy of their certification(s) and a copy of their current hospital

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delineation of privileges, authorized by a hospital senior manager, to the BMS fiscal agent's Provider Enrollment Unit.

To be paid for services related to skills attained after initial enrollment, an individual must submit documentation of the new capabilities and request an addition of the specialty with applicable service codes to their provider profile.

300.4.2 In-Network/Out-of-Network Versus In-State/Out-of-State

While West Virginia Medicaid/WVCHIP does not have a formal provider network, providers are considered to have an in-network or out-of-network status as defined below:

- **In-Network Provider:** West Virginia Medicaid/WVCHIP enrolled provider that is physically located within the state, within the 30-aeronautical mile radius of its border and select specialty hospitals located out of the state and their affiliated practitioners
- **Out-of-Network Provider:** Any provider located outside of the state of West Virginia, beyond the 30-aeronautical mile radius of the West Virginia border that has been approved for enrollment with West Virginia Medicaid/WVCHIP. These providers can provide covered services West Virginia Medicaid/WVCHIP services. However, prior to rendering any service they must obtain prior authorization, except in medically necessary emergent situations as defined in [WV State Code §33-1-21](#), or in cases where a foster child has been placed out-of-state and/or resides in an out-of-state psychiatric residential treatment facility (PRTF). Out-of-Network provider contracts require that all non-emergent services, per the BMS policy, are only approved when an In-Network provider is not available or appropriate to treat the member.

Refer to [Chapter 100, General Information](#) for additional information.

300.5 ENROLLMENT FEE

[42 CFR 424.514](#) requires a non-refundable enrollment (application) fee be collected from each "institutional provider of medical or other items or services or supplier" when enrolling, reenrolling, reactivating, revalidating, and establishing a new service location. The fee increases each calendar year based on the consumer price index for all urban consumers.

Federal regulations define "institutional provider[s] of medical or other items or services or supplier" to include, but not be limited to:

- The range of ambulance service suppliers;
- ASCs;
- CMHCs;
- Comprehensive outpatient rehabilitation facilities (CORFs);
- DMEPOS;
- End-stage renal disease (ESRD) facilities;
- FQHCs;
- Histocompatibility laboratories;
- Home health agencies ;
- Hospices;

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- Hospitals, including but not limited to acute inpatient facilities, inpatient psychiatric facilities, inpatient rehabilitation facilities, and physician-owned specialty hospitals;
- Critical access hospitals;
- Independent clinical laboratories;
- Independent diagnostic testing facilities;
- Mammography centers;
- Immunizers (roster billers);
- Organ procurement organizations;
- Outpatient physical therapy/occupational therapy/speech pathology services;
- Pharmacies;
- Portable x-ray suppliers;
- Skilled nursing facilities;
- Radiation therapy centers;
- Religious non-medical health care institutions;
- RHCs; and
- Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian health service pursuant to title V of the Indian Health Care Improvement Act.

If a provider is enrolling as two separate institutional provider types, two fees will apply. In addition, Federal regulations allow Medicaid/CHIP to impose the application fee on any institutional entity that bills on a fee-for-service basis, such as personal care agencies, non-emergency transportation providers, and residential treatment centers, in accordance with the approved Medicaid or CHIP State plan.

Providers are only required to pay a fee to one entity, for example. If a provider is applying for enrollment in Medicare, and/or a state Medicaid Agency and/or a state CHIP program, it should pay a fee to only one of those authorities. The application fee or documentation verifying payment to another entity must accompany the application. Additionally, simple changes to the provider enrollment information, that is, new phone numbers, new bank account information, new billing address, change in the name of the provider or other such updates are not subject to the fee. The fee applies to newly enrolled providers, revalidating providers, the addition of new practice locations, and the addition of a new owner(s).

A provider or supplier requesting a hardship exception from the application fee must include, with its enrollment application, a letter that describes the hardship and why the hardship justifies an exception to the application fee requirement, plus supporting documentation such as historical cost reports, recent financial reports such as balance sheets and income statements, bank statements, cash flow statements, tax returns or an official documentation of bankruptcy filing. The BMS may deny a provider's hardship exception request, however, only the CMS may approve a request. The hardship exception request and supporting documentation will be evaluated by the BMS. The BMS may request approval by the CMS and will forward the provider's request by email. If the provider has already paid an application fee to Medicare, the CMS will notify the BMS that the provider is not subject to a fee, and the CMS will not review the request for a decision. The enrollment application will not be processed until a decision is made by the CMS on the hardship exception and communicated by the CMS to the BMS. In the case of a



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denial, the BMS may ask for reconsideration and supply additional documentation to support their position that the exception should be granted.

Providers may contact the BMS fiscal agent's Provider Enrollment Unit for additional information regarding the application fee.

300.6 PROVIDER ENROLLMENT APPLICATION PROCESS

Healthcare providers who are currently licensed, certified, accredited, or registered under West Virginia law, or under another state's law where their practice is located, may apply for enrollment in West Virginia Medicaid/WVCHIP. Providers may enroll using the internet-based Provider Enrollment Application Portal, or by submitting a paper application. Submission of an enrollment application does not guarantee enrollment, and not all provider types are eligible for enrollment in Medicaid/WVCHIP. Providers with questions regarding enrollment eligibility should contact the BMS fiscal agent's Provider Enrollment Unit at (888) 483-0793, option 3, Monday through Friday, between the hours of 7:00am and 7:00pm or at WVProviderFieldRepresentative@gainwelltechnologies.com

The applicant must complete all required fields, sign, and submit all applicable forms. Proof of current licensure, certification, accreditation, or registration per the BMS provider enrollment criteria also must be submitted, including but not limited to a West Virginia Business License. Medicaid claims will not be paid prior to the date of the application of the West Virginia Business license. This also applies with a Change of Ownership. The applicant must also indicate whether their license or other accreditation has been revoked or suspended in any state.

By signing the enrollment form, the applicant agrees to comply with all applicable laws, regulations, and policies of the WV Medicaid/WVCHIP. This includes Title XIX of the Social Security Act, the Code of Federal Regulations, the West Virginia Medicaid/WVCHIP State Plans, and all applicable state and federal laws, standards, guidelines, and program instructions. An electronic signature is acceptable on all documents with the required verification information. A Provider Agreement is required for every person or institution providing services.

Provision of false information or failure to disclose information required by the federal requirements during the application process may result in denial of participation, and the case may be referred to the appropriate legal authority.

300.6.1 Provider Enrollment Application Portal (PEAP)

Health care providers may complete the BMS enrollment application or update existing provider information online by using the internet-based provider portal. Providers must contact the BMS fiscal agent's Provider Enrollment Unit to obtain a case number which allows access to the Provider Enrollment Application Portal for a new enrollment. The PEAP may be accessed via the Provider Enrollment page on the [BMS fiscal agent's website](#).

For additional information visit the Reference Material tab on the [BMS Fiscal agent's website Provider page](#).

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300.6.2 Provider Enrollment Paper Application

Healthcare providers that cannot enroll using the on-line portal may submit a paper application. These providers must obtain a paper application by contacting the BMS fiscal agent's Provider Enrollment Unit. The completed paper application and supporting documentation must be submitted to the BMS fiscal agent's Provider Enrollment Unit at:

Provider Enrollment Department
P.O. Box 625
Charleston, WV 25322-0625

300.7 PROVIDER IDENTIFICATION NUMBERS

A healthcare provider must have an NPI to enroll and bill for services rendered to Medicaid/WVCHIP members. If the provider is not eligible for an NPI under National Provider and Plan Enumeration System (NPPES) rules, the BMS fiscal agent may assign an atypical provider identifier (API). In addition, the enrollment process may require additional identification numbers such as, but not limited to, Social Security Number, Federal Employer ID, Medicare Identification Number, Drug Enforcement Agency (DEA) number, and Clinical Laboratory Improvement Amendments (CLIA) number.

300.7.1 National Provider Identifier (NPI)

All eligible providers **must** obtain an NPI based on the National Provider and Plan Enumeration System (NPPES) criteria. Providers can apply for an NPI online at the [NPPES website](#).

Entities with subparts must have an NPI for each subpart as defined by NPPES. It may be necessary for providers with multiple service locations to obtain additional NPI numbers for each location providing differing services. Sole proprietors must have only one NPI regardless of the number of locations.

The NPI of the provider who ordered or referred items and/or services must be present on all claims.

300.7.2 Atypical Provider Identifier (API)

An atypical provider is an individual or organization that provides non-traditional services that are indirectly healthcare related and do not meet the definition of a healthcare provider. Examples include non-emergency transportation, housekeeping services, vehicle modifications, and physical alterations to living quarters for purposes of accommodating disabilities, billing services, value-added networks, repricers, health plans, and healthcare clearinghouses. An Atypical Provider Identifier, formerly the West Virginia Medicaid Identification Number, will be assigned by the BMS fiscal agent to providers that do not meet NPPES criteria to obtain an NPI number.

300.7.3 Medicare Identification Number

A Medicare provider must have their Medicare identification number(s) on file with the West Virginia Medicaid Program. This will help expedite prompt and accurate payment for services rendered to Medicaid members who are also eligible for Medicare benefits. For these "dual eligible" members,

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Medicare is the primary payer, and Medicaid is the secondary payer, as explained in [Chapter 600, Reimbursement Methodologies](#).

Additionally, to ensure accurate claims processing, providers must notify the Provider Enrollment Unit in writing of any change to their Medicare identification number, or any Medicare identification number received after Medicaid enrollment. Erroneous or missing Medicare numbers may result in denials and inaccurate or delayed Medicaid payments.

300.8 DISCLOSURES

Federal regulations require all Medicaid/WVCHIP providers to disclose full and complete information regarding individuals or entities that own, control, represent or manage them. This requirement applies to all provider types that are either enrolling or revalidating as a Medicaid/WVCHIP provider regardless of business structure (large corporation, partnership, non-profit or other type of business organization).

Disclosures are due at any of the following times:

- Upon the provider or disclosing entity submitting a Medicaid provider application.
- Upon the provider or disclosing entity executing the provider enrollment agreement.
- Within 35 days of being requested by the BMS or during the revalidation of the enrollment process.
- Within 35 days after any change in ownership of the disclosing entity.

When disclosures are required, the enrollment application must capture both direct and indirect owners.

300.8.1 Information on Ownership and Control

In accordance with [42 CFR 455.104](#) providers must submit the following information:

- The name and address of each person (individual or corporation) with an ownership or control interest in the disclosing entity or in any subcontractor which the disclosing entity has direct or indirect ownership of five percent or more. The percentage of ownership interest will be based on [42 CFR 455.102](#). The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box addresses, if any.
- Date of birth and Social Security Number of all individuals subject to disclosure.
- Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
- The name, address, date of birth, and Social Security Number of any managing employee – Board of Directors of the disclosing entity.

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At the request of the CMS, the BMS reports any ownership discrepancies noted between the provider application and the information on file in the CMS Provider Enrollment, Chain, and Ownership System (PECOS) to the CMS. An email is sent to the CMS at MedicaidProviderEnrollment@cms.hhs.gov that includes specific provider demographic information including name, tax identification number (TIN), NPI, ownership information (5% or more owners) and the date the ownership information was reported to the BMS.

300.8.2 Information Related to Business

In accordance with [42 CFR 455.105](#), providers must submit full and complete information about:

- The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the application request; and
- Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.

300.8.3 Information on Persons Convicted of Crimes

In accordance with [42 CFR 455.106](#), providers must disclose the identity of any person who:

- Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
- Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

This information must be disclosed before any enrollment activity or at any time of written request by BMS. These disclosures and any related provider enrollment action(s) will be provided to the Department of Health and Human Services (DHHS) Office of Inspector General (OIG).

300.9 STATE LICENSURE

A healthcare provider must maintain a valid state license/certification number in the state(s) where the provider practices. In addition, the health care provider may have to satisfy other credentialing requirements to continue participating in the West Virginia Medicaid/WVCHIP.

The provider's current license/certification must always be on file with the BMS fiscal agent's Provider Enrollment Unit. **It is the responsibility of the provider to ensure that licensing or certification information is kept current.**

The provider must scan and upload via the web portal, mail or fax to the BMS fiscal agent's Provider Enrollment Unit a copy of any renewed license or other credential before the current credential expires.

If a license limitation is imposed by another state based upon conduct or a violation and the BMS believes this makes the provider unable or unqualified to provide care to Medicaid beneficiaries, the application

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could be denied, or enrollment terminated. Examples of license limitations may include, but are not limited to probation, limited prescribing authority and monitoring.

A provider's participation in the West Virginia Medicaid/WVCHIP may be suspended or terminated if the BMS fiscal agent's Provider Enrollment Unit cannot verify the status of the provider's credentials.

300.10 DENIAL OF ENROLLMENT

In accordance with [42 CFR 455.416](#), the BMS must deny or terminate a provider's enrollment if any of the following conditions exist:

- The provider, or a person with an ownership or control interest or who is an agent or managing employee of the provider did not submit timely and accurate information, unless the BMS determines that denial is not in the best interests of the Medicaid/WVCHIP program and the BMS documents that determination in writing.
- The provider, or any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with Medicare or Medicaid in the last 10 years. The BMS determines that denial or termination of enrollment is not in the best interests of the Medicaid/WVCHIP program and BMS documents that determination in writing.
- Any provider that is terminated on or after January 1, 2011, under Title XVIII of the Act or under the Medicaid program or CHIP of any other state and is included in the termination database.
- If the provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, unless the BMS determines that termination or denial of enrollment is not in the best interests of Medicaid/WVCHIP program and the BMS documents that determination in writing.
- If the provider, or any person with a five percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the BMS within 30 days of the CMS or the BMS request, unless the BMS determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.
- If the provider fails to permit access to provider locations for any site visits under [42 CFR 455.432](#), unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid/WVCHIP and the BMS documents that determination in writing. If fingerprints have been submitted as an owner on a separate newly enrolling provider and the BMS has retained those fingerprints, the BMS is not required to request a new set of fingerprints. The BMS will conduct a new fingerprint criminal background check using the previously submitted fingerprints. The BMS may rely on the results from previous fingerprint submission for up to three years before conducting a new fingerprint criminal background check.
- If the provider fails to permit access to provider locations for any site visits under [42 CFR 455.432](#), unless the BMS determines that termination or denial of enrollment is not in the best interests of the Medicaid/WVCHIP and BMS documents that determination in writing.

In accordance with [42 CFR 455.416](#), the BMS may deny or terminate a provider's enrollment in the West Virginia Medicaid/WVCHIP:

- If it is determined that the provider has falsified any information provided on the application; or

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- The identity of any provider applicant cannot be verified.

A provider may also be denied enrollment in the West Virginia Medicaid Program if the following circumstances exist:

- The applicant previously failed to correct deficiencies in the operation of a business or enterprise after receiving written notice of the deficiencies from a state or federal licensing or auditing agency. For example, failure to correct a deficiency in a state licensed facility that would pose a threat of harm to its patients;
- One or more factors exist that directly impair the applicant's ability to render quality health care to Medicaid/WVCHIP members, including actions by persons employed by or affiliated with the provider.

A provider may reapply for participation at any time after the cause for the denial is remedied satisfactorily.

300.11 TERMINATION "FOR CAUSE"

Generally, "for cause terminations" or "termination for cause" are terminations of provider participation related to fraud, integrity, or quality issues which are not in line with the overall success of Medicaid/WVCHIP. For example, the BMS may "terminate for cause" any provider where the provider or a person with a five percent or greater direct or indirect ownership interest in the provider does not submit timely and accurate information and cooperate with any screening methods required under [42 CFR 455 Subpart D](#). Provider appeal rights must be exhausted or the time for appeal must be expired upon "termination for cause".

For "cause mandatory terminations", it is mandatory for all SMAs to terminate a provider in all the following "for cause" circumstances:

- Criminal Conviction.** Where the provider or any person with a five percent or more direct or indirect ownership interest in the provider was within the preceding 10 years convicted (as defined in 42 CFR 1001.2) of a federal or state criminal offense related to that person's involvement with Medicare, Medicaid or CHIP. This requirement applies unless the SMA determines that termination is not in the Medicaid Program's best interests and documents that determination in writing. 42 CFR 455.416(b)
- Failure to Comply with Screening Requirements.** Where the provider, or any person with a five percent or more direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455 Subpart E. 42 CFR 455.416(a).
- Failure to Submit Fingerprints.** Where the provider, or any person with a five percent or more direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the SMA within 30 days of the CMS or SMA request, unless the SMA determines that the termination or denial of enrollment is not in the best interests of the Medicaid program and the SMA documents that determination in writing. 42 CFR 455.416(e)
- Failure to Submit Timely and Accurate Information.** Where the provider or a person with an ownership control interest, an agent, or managing employee of the provider failed to submit timely and accurate information, unless the SMA determines that termination is not in the Medicaid Program's best interests and documents that determination in writing. 42 CFR 455.416(d)

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- e. **Onsite Review.** Where the provider fails to permit access to provider locations for any site visit, unless the SMA determines the termination is not in the best interests of the Medicaid program. 42 CFR 455.416(f)
- f. **Terminated or Revoked for Cause under Separate Medicaid or Medicare Enrollment.** Where the provider's enrollment has been terminated or revoked "for cause" by Medicare or another state's Medicaid program and such termination has been published in the Data Exchange System, the SMA shall terminate the provider's enrollment in its program. 42 CFR 455.416(c), 455.101

For cause discretionary terminations, the SMA may terminate the provider's enrollment for the following discretionary "for cause" termination reasons:

- a. **Abuse of Billing Privileges** - The provider submits a claim or claims for services that could not have been furnished to a specific individual on the date of service for various reasons. Examples include when the beneficiary is deceased, where the directive physician or the beneficiary is not in the state when the services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.
- b. **Billing with Suspended License** - Billing for services furnished while the provider's license is in a state of suspension.
- c. **False or Misleading Information** - The provider certified false or misleading information on their enrollment application as "true" to be enrolled or maintain enrollment in the State Medicaid program. Please note that CMS considers this authority mandatory under the Medicare program. 42 CFR 455.416(g)(1).
- d. **Improper Prescribing Practices** - The SMA determines that a provider has a pattern of practice of prescribing drugs that is abusive or represents a threat to the health and safety of Medicaid beneficiaries or the pattern or practice of prescribing fails to meet Medicaid requirements.
- e. **Inability to Verify** - The SMA cannot verify the identity of any provider applicant. 42 CFR 455.416(g)(2).
- f. **Misuse of Billing Number** - The provider knowingly sells to or allows another individual or entity to use its billing number, other than a valid reassignment of benefits.
- g. **Noncompliance** - The provider is determined not to be in compliance with enrollment requirements established by the SMA. This does not include license expiration.
- h. **Noncompliance with Licensure Standards** - When the provider has been subject to an adverse licensure action resulting in the loss of license. This does not include license expiration.
- i. **Onsite Review** - The provider failed onsite review due to one of the following circumstances:
 - I. No longer operational to furnish Medicaid covered items or services
 - II. Otherwise fails to satisfy any Medicaid enrollment requirement
- j. **Other** - Any other reason that poses a threat of fraud, waste, or abuse to the Medicaid program that does not fall under any of the classifications listed above.
- k. **Prescribing Authority** - The provider's DEA Certificate of Registration is suspended or revoked or the applicable licensing or administrative body for any state in which the provider practices suspend or revokes the provider's ability to prescribe drugs.
- l. **Provider Conduct** - The provider or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other healthcare personnel of the provider are:
 - I. Excluded from the Medicare, Medicaid, and/or any other state or federal healthcare program as defined in 42 CFR 1001.2.

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- II. Debarred, suspended, or otherwise excluded from participating in any other federal procurement, or nonprocurement program, or activity in accordance with the Federal Acquisition Streamlining Act (FASA) implementing regulations and the DHHS Nonprocurement Common Rule at 45 CFR part 76.
- III. Any other state or federal exclusion. Please note that an individual or entity, found on the List of Excluded Individuals and Entities, is ineligible to receive payments from Medicaid, Medicare, or any other federal healthcare program (see the [State Medicaid Director Letter #19-001, March 22, 2019](#)). Accordingly, payments made for items or services furnished by an excluded provider are not eligible for federal financial participation.
- m. **Patient Harm.** The physician or other professional has been subject to prior action from a state oversight board, federal or state healthcare program, Independent Review Organization determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm.
- n. **Failure to Repay an Overpayment.** To be considered “for cause”, this termination must meet both of the following conditions:
 - I. The overpayment must be delinquent, meaning the provider has failed to address the overpayment within the deadline communicated to them.
 - II. The overpayment exceeds \$1,500.
- o. **Falsification of Medical Records** - The State Medicaid agency has determined that the provider knowingly falsified medical records to support services billed to Medicaid. This determination is up to the review of the State Medicaid agency based on any supporting documentation available such as witness statements, emails, etc.

300.12 MANDATORY EXCLUSIONS

All providers are screened against state and federal databases to assure no provider is enrolled who meets federal or state criteria for exclusion. Section 1128(a) of the Social Security Act and 42 U.S.C. 1320a-7 mandates the following individuals and entities must be excluded from participation in federal healthcare programs:

1. **Conviction of Program-Related Crimes** - Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under subchapter XVIII of this chapter or under any state health care program.
2. **Conviction Relating to Patient Abuse** - Any individual or entity that has been convicted, under federal or state law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a healthcare item or service.
3. **Felony Conviction Relating to Healthcare Fraud** - Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under federal or state law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any federal, state, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
4. **Felony Conviction Relating to Controlled Substance** - Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under federal or state law, of a

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criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

300.13 PERMISSIVE EXCLUSIONS

Section 1128(a) of the Social Security Act and 42 U.S.C. § 1320a–7 allows the following individuals and entities to be excluded from participation in federal healthcare programs:

- (1) Conviction relating to fraud. Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, under federal or state law:
 - (A) Of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct:
 - (i) In connection with the delivery of a healthcare item or service, or
 - (ii) With respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any federal, state, or local government agency; or
 - (B) Of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any federal, state, or local government agency.
- (2) Conviction relating to obstruction of an investigation or audit. Any individual or entity that has been convicted, under federal or state law, in connection with the interference with or obstruction of any investigation or audit related to:
 - (i) Any offense described in paragraph (1) or in subsection (a);
 - (ii) The use of funds received, directly or indirectly, from any federal healthcare program (as defined in section 1128B(f)).
- (3) Misdemeanor conviction relating to controlled substance. Any individual or entity that has been convicted, under federal or state law, of a criminal offense consisting of a misdemeanor relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
- (4) License revocation or suspension. Any individual or entity:
 - (A) Whose license to provide health care has been revoked or suspended by any state licensing authority, or who otherwise lost such a license or the right to apply for or renew such a license, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity, or
 - (B) Who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional performance, or financial integrity.
- (5) Exclusion or suspension under federal or state health care program. Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under:
 - (A) Any federal program, including programs of the Department of Defense or the Department of Veterans Affairs, involving the provision of health care, or
 - (B) A state healthcare program, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.
- (6) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services. Any individual or entity that the Secretary determines:

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- (A) Has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under Title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;
 - (B) Has furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under Title XVIII or under a state healthcare program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care is;
 - (i) A health maintenance organization (as defined in section 1903(m)) providing items and services under a State plan approved under Title XIX, or
 - (ii) An entity furnishing services under a waiver approved under section 1915(b)(1), and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under Title XIX) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or
 - (D) Is an entity providing items and services as an eligible organization under a risk-sharing contract under section 1876 and has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.
- (7) Fraud, kickbacks, and other prohibited activities. Any individual or entity that the Secretary determines has committed an act which is described in section 1128A, 1128B, or 1129.
- (8) Entities controlled by a sanctioned individual. Any entity with respect to which the Secretary determines:
- (A) A person:
 - (i) Who has a direct or indirect ownership or control interest of five percent or more in the entity or with an ownership or control interest (as defined in section 1124(a)(3)) in that entity;
 - (ii) Who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of that entity; or
 - (iii) Who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause.
 - (B) Is a person:
 - (i) Who has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;
 - (ii) Against whom a civil monetary penalty has been assessed under section 1128A or 1129; or
 - (iii) Who has been excluded from participation under a program under Title XVIII or under a state healthcare program.

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- (9) Failure to disclose required information. Any entity that did not fully and accurately make any disclosure required by section 1124, section 1124A, or section 1126.
- (10) Failure to supply requested information on subcontractors and suppliers. Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary or by the State agency administering or supervising the administration of a State healthcare program:
- (A) Full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount of more than \$25,000, or
 - (B) Full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor).
- (11) Failure to supply payment information. Any individual or entity furnishing, ordering, referring for furnishing or certifying the need for items or services for which payment may be under Title XVIII or a State healthcare program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary of that agency as may be necessary to verify such information.
- (12) Failure to grant immediate access. Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:
- (A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment).
 - (B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g).
 - (C) To the Inspector General of the DHHS, for the purpose of reviewing records, documents, and other data necessary to the performance of the Statutory functions of the Inspector General.
 - (D) To a state Fraud Control Unit (as defined in section 1903(q)), for the purpose of conducting activities described in that section.
- (13) Failure to take corrective action. Any hospital that fails to comply substantially with a corrective action required under section 1886(f)(2)(B). Default on health education loan or scholarship obligations. Any individual who the Secretary determines is in default on repayments of scholarship obligations or loans in connection with health professions education made or secured, in whole or in part, by the Secretary and with respect to whom the Secretary has taken all reasonable steps available to the Secretary to secure repayment of such obligations or loans, except:
- (A) The Secretary shall not exclude pursuant to this paragraph a physician who is the sole community physician or sole source of essential specialized services in a community if a State requests that the physician not be excluded, and
 - (B) The Secretary shall consider, in determining whether to exclude any other physician pursuant to this paragraph, the access of members to physician services for which payment may be made under Title XVIII or XIX.
- (14) Individuals controlling a sanctioned entity:
- (A) Any individual:

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- (i) Who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the basis for the conviction or exclusion described in subparagraph .
- (ii) Who is an officer or managing employee (as defined in section 1126(b)) of such an entity.
- (B) For purposes of subparagraph (A), the term “sanctioned entity” means an entity:
 - (i) That has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;
 - (ii) That has been excluded from participation under a program under Title XVIII or under a state healthcare program.
- (15) Making false statements or misrepresentation of material facts. Any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1128B(f)), including Medicare Advantage organizations under part C of Title XVIII, prescription drug plan sponsors under part D of Title XVIII, Medicaid/WVCHIP managed care organizations under Title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans.
- (16) Default on health education loan or scholarship obligations.
- (17) Failure to meet statutory obligations of practitioners and providers to provide medically necessary services meeting professionally recognized standards of health care.

300.14 APPEALS

Providers that are denied participation or have participation with West Virginia Medicaid/WVCHIP terminated have appeal rights. Requests for reconsideration of provider enrollment denials may be submitted to the BMS fiscal agent’s Provider Enrollment Unit. Requests for reconsideration must include a copy of the denial letter from the fiscal agent and supportive documentation. A formal appeal following denial of a reconsideration request for provider enrollment may be submitted in writing to the BMS Commissioner.

Should the provider disagree with this decision, they may request a document desk review to address actions taken by the agency which affect their participation in the West Virginia Medicaid Program or its reimbursement of services. This request must be made pursuant to the provisions of the West Virginia Medicaid Policy Manual, [Chapter 800, Program Integrity](#). All requests for a Document Desk Review must be in writing, dated, signed, and filed within 30 days of receipt of this decision. This request must contain a statement as to the specific findings in dispute and the position. The request must also identify the provider representatives who will be present at the hearing. A request for an administrative hearing must be addressed to:

West Virginia Bureau for Medical Services
Office of Program Integrity – Provider Appeals
350 Capitol Street, Room 251
Charleston, WV 25301-3706

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300.15 MORATORIA

Under federal regulations, the CMS and/or a State Medicaid Agency may impose moratoria on specific provider types. Access to care must be considered prior to imposing a State Medicaid Agency moratorium and the CMS will be notified of the details in writing.

300.16 MAINTENANCE OF PROVIDER INFORMATION

The information that a provider submits at enrollment may change as time passes. Participating providers must notify the BMS-fiscal agent's Provider Enrollment Unit-within 30 days of changes including but not limited to, the following items:

- Provider name
- Provider pay-to, physical and mailing address
- Change in banking information (electronic fund transfer (EFT))
- Provider office telephone number
- Provider legal status or practice name
- License or certification status
- Medicare provider identification number
- Practice ownership including mergers, acquisitions, or consolidations
- Tax identification number
- Provider affiliations
- Other pertinent information

Certain items may be updated on the provider portal described in [Section 300.6.1 Provider Enrollment Application Portal \(PEAP\)](#) of this Chapter. The notification must be sent in writing, as an attachment, on the provider's Letterhead to the BMS fiscal agent address below or by email at wvproviderenrollment@gainwelltechnologies.com and must contain the provider's NPI:

Provider Enrollment Department
P.O. Box 625
Charleston, WV 25322-0625

Failure to notify the BMS fiscal agent's Provider Enrollment Unit may result in denied or delayed Medicaid/WVCHIP payments, as well as important mailings and other correspondence being sent to incorrect addresses or business names.

300.17 CHANGE OF OWNERSHIP

In accordance with [42 CFR 489.18](#), the BMS defines a change in ownership as follows:

- **Partnership:** In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law, constitutes a change of ownership.
- **Unincorporated Sole Proprietorship:** Transfer of title and property to another party constitutes a change of ownership.

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- **Corporation:** The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes a change of ownership. **Note:** Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership.
- **Leasing:** The lease of all or part of a provider facility constitutes change of ownership of the leased portion.

A change in ownership automatically cancels the selling provider's enrollment in the West Virginia Medicaid/WVCHIP. The new provider must complete an enrollment to participate in the West Virginia Medicaid Program. In addition, the prior owner must reenroll if they start a new practice independently or form a group.

For income tax purposes, the BMS-fiscal agent's Provider Enrollment Unit must be notified at least 30 days in advance about ownership changes that affect the provider's tax identification number. Early notice will help avoid payment delays, denials, and Internal Revenue Service (IRS) Tax Form 1099 errors.

New disclosures are required within 35 days of a change of ownership.

300.17.1 UNREPORTED CHANGE OF OWNERSHIP INFORMATION

If the BMS learns via any means that an enrolled provider has: (1) been purchased by another entity or (2) purchased another West Virginia Medicaid/WVCHIP provider, the-BMS will immediately request a new enrollment application. If the new owner fails to submit a new enrollment application within the latter of: (1) the date of acquisition or (2) 30 days after the request, the BMS shall stop payments to the provider. Payments may be resumed upon receipt of the completed enrollment application.

300.18 VOLUNTARY AND INVOLUNTARY DISENROLLMENT

A provider's participation in the West Virginia Medicaid/WVCHIP may be discontinued voluntarily or involuntarily.

Voluntary Disenrollment: Healthcare providers may voluntarily disenroll with West Virginia Medicaid/WVCHIP by mailing a signed letter on the provider's letterhead to the BMS fiscal agent's Provider Enrollment Unit. A health care provider must give at least 30-days' notice before terminating his or her participation. In all cases, the letter of disenrollment must include the provider's NPI/API and specify a termination date. The letter must possess the provider's original signature in blue ink.

In the case of an emergency that renders the provider unable to continue as a Medicaid/WVCHIP participant, the BMS must be notified as soon as possible. The notice should include a brief explanation of the reason for disenrollment and must possess the provider or the provider's legal representative's original signature in blue ink.

Involuntary Disenrollment: The BMS may terminate a provider's enrollment in the West Virginia Medicaid Program for one or more of the following reasons:

- Breach of the provider agreement;
- Demonstrated inability to perform under the terms of the provider agreement;
- Failure to comply with applicable state and federal laws;

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- Loss of license or certification;
- Failure to comply with West Virginia Medicaid/WVCHIP regulations and policies, as well as those of the DHHS;
- Involuntary termination of participation in Medicare, another State Medicaid or CHIP program; or
- Medicaid/WVCHIP inactivity for three consecutive years.

The state conducts ongoing screening against federal and state databases to ensure continuing compliance with federal and state criteria for exclusion.

300.19 CONDITIONS OF PARTICIPATION

Providers who participate in the West Virginia Medicaid/WVCHIP must sign a “provider participation agreement” indicating that they will comply fully with the standards and rules established by the DHHS, as well as all applicable state and federal laws and regulations governing the services rendered to Medicaid members. All Medicaid providers are required to enter into an agreement with the SMA under 1902(a)(27) of the Social Security Act.

The BMS Provider Manual is the providers’ principle source of information about the West Virginia Medicaid/WVCHIP. Providers can access the Provider Manual via the BMS website. Providers that do not have access to the internet may request paper copies of individual chapters by contacting the BMS fiscal agent’s Provider Services Unit. Participating providers are responsible for thoroughly familiarizing themselves with those chapters specific to the services offered by the provider and all Common Chapters.

During enrollment and revalidation providers are required to attest to having reviewed the BMS Provider Manual, especially the Common Chapters and those applicable to the services they provide. If the provider is part of a large organization, several key members or directors need to have a working knowledge of the manual.

The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service, nor does it mean that the individual is eligible for West Virginia Medicaid/WVCHIP benefits. It is the provider’s responsibility to verify eligibility at each date of service and obtain appropriate authorizations before services are provided. The provider assumes full financial risk in serving an individual when West Virginia Medicaid/WVCHIP eligibility has not been confirmed.

It is illegal to provide referrals for any type of compensation. Federal law states that “It is unlawful to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by Medicaid”. See 42 U.S.C. §1320a - 7b(b). When remuneration is paid, received, offered, or solicited purposefully to induce or reward referrals of items or services payable by Medicaid, the Anti-Kickback Statute is violated.

300.19.1 Anti-Discrimination Policy

Healthcare providers must comply with all applicable sections of Title VI of the Civil Rights Act of 1964, as amended by the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, and the Rehabilitation Act of 1973. This means that a provider who participates in the West Virginia Medicaid/WVCHIP may not discriminate in the provision of Medicaid/WVCHIP benefits based on the

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member's race, color, national origin, creed, gender, religion, political ideas, marital status, age, or disability.

300.19.2 Restrictions on Billing Medicaid/WVCHIP Members

The provider may accept a new member as all-West Virginia Medicaid/WVCHIP, Medicaid/WVCHIP-secondary, or all-private pay. The provider may not accept the member as a Medicaid/WVCHIP patient for some covered services and as a private-pay patient for other covered services. In other words, selective participation is not permitted.

Additionally, a provider may not impose, bill, or collect any fees in advance of services from the Medicaid/WVCHIP member, and monies collected after Medicaid/WVCHIP payment is received, including co-payments due from other carriers must be returned to the member. Similarly, providers may not void claims and then subsequently bill members for services.

If a provider accepts the Medicaid/WVCHIP member as a patient, the provider must bill West Virginia Medicaid/WVCHIP for covered services and must accept the reimbursement amount as full payment. No charge may be billed to a West Virginia Medicaid/WVCHIP member for a covered service unless a co-payment is applicable by regulation.

To bill the member, the provider must inform or provide notice to the member prior to rendering services and obtain the member's signature when (1) West Virginia Medicaid/WVCHIP does not cover the service, (2) The member is not enrolled in West Virginia Medicaid/WVCHIP and (3) the member may be financially liable for the amount the provider charges for the service. The notice must be signed and dated by the provider and the member, and a copy given to the member. This procedure may help avoid problems that could arise concerning payment for medical bills. For more information on member liability and responsibility for certain charges, see [Chapter 400, Member Eligibility](#).

Medicaid members, if given prior notice, may be billed for:

- Services received after Medicaid benefits are exhausted
- Services not medically necessary that the member elected to receive
- Services not covered by Medicaid that the member elected to receive
- Non-emergent services not prior-approved, if applicable
- Convenience items not required for medical care
- Services rendered when the member is not eligible
- Services provided when the member refuses to use other available insurance. The exception to this is the non-methadone medication assisted treatment.

300.19.3 Protection of Member Privacy

Healthcare providers must safeguard the member's privacy and confidentiality, as required by all applicable state and federal laws. The use and disclosure of individually identifiable information must be consistent with [HIPAA](#).

As HIPAA permits, a participating provider does not have to obtain a member's consent or authorization for the BMS or its business associates to release sensitive information about the member for purposes of

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health care operations or the payment of claims. At the time the member applies for West Virginia Medicaid/WVCHIP eligibility, they sign an authorization to release medical records to the BMS or its designee.

300.19.4 Disclosure of Information

Healthcare providers must comply with all disclosure requirements in [42 CFR Part 455, Subpart B](#), such as those concerning practice ownership and control, business transactions, and persons convicted of fraud or other crimes. A provider also must fully disclose to the BMS information about the services furnished to individual West Virginia Medicaid/WVCHIP members, as circumstances may warrant.

300.20 PRACTITIONER PARTICIPATION

300.20.1 Physician Supervision in a Teaching Setting

The teaching physician must be present when a covered service is rendered by a resident unless the resident is licensed to practice medicine, and the service is within the scope of their license. Teaching physicians may bill for the services provided by residents under their supervision.

Residents in an approved graduate medical education program, who have received their license to practice, may be enrolled as West Virginia Medicaid/WVCHIP providers, but they may not bill West Virginia Medicaid/WVCHIP for physician services provided within the scope of the education program. Services related to that program are billed by the supervising physician if they meet the following criteria:

- The teaching physician must be present for a key portion of the time during the performance of the service.
- The teaching physician must be present during the critical portion of a surgical, complex, dangerous procedure, and be immediately available to provide care during the entire service or procedure.

EXCEPTION: Physicians do not need to be present for mid-level evaluation and management services provided through a family practice type of residency program that functions outside the inpatient hospital setting. This exception applies when medical services are provided within a specific residency program in an ambulatory care center.

For this exception to apply, all the following requirements must be met:

- Residents who provide services without a teaching physician present must have completed more than six months of an approved residency program.
- The teaching physician must not supervise more than four residents concurrently and must be immediately available to provide care or answer questions.
- The members must be an identifiable group of individuals who use the outpatient setting for their usual and continuing source of care.
- Residents may, within the scope of their training, provide acute, chronic, and comprehensive care not limited by organ system or diagnosis, or coordination of care rendered by multiple providers.
- The outpatient center must be in a setting that includes the resident's time in the full-time equivalency count used for direct graduate medical education costs.



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West Virginia Medicaid follows the CMS documentation guidelines for teaching physicians and residents.

Refer to [Chapter 510, Hospital Services](#) for additional information.

300.20.2 Residents

Physician services provided by residents within an approved Graduate Medical Education Program are hospital services and are not separately billable as physician services. The reimbursement is in the direct graduate medical contracted education program payments West Virginia Medicaid/WVCHIP makes to both teaching and non-teaching hospitals.

Licensed/enrolled residents may bill West Virginia Medicaid/WVCHIP directly for identifiable physician services, within their scope of practice, provided to members under the following circumstances:

- In non-approved teaching programs for covered services, they provide in hospital settings and within the scope of their license.
- In freestanding skilled nursing facilities, home health agencies, outpatient or emergency departments.
- In non-institutional settings such as freestanding clinics not part of the hospital if the non-institutional setting is not part of the teaching program.

Effective July 1, 2024, the BMS will require a valid educational permit before enrolling residents. Applicants seeking enrollment with West Virginia Medicaid/WVCHIP as a resident who fail to submit a valid educational permit with their application, will be pended until documentation is obtained from the provider. In addition, the BMS has implemented an edit to deny claims submitted by residents in the event their educational permit is noted on the [West Virginia Board of Medicine or the West Virginia Board of Osteopathic Medicine's website](#) as expired or terminated.

The BMS follows the CMS documentation guidelines for teaching physicians and residents.

Refer to [Chapter 510, Hospital Services](#) for additional information.

300.20.3 Non-Physician Practitioners (NPP)

The BMS considers non-physician practitioners to include but not be limited to physician assistants, APRNs (nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists), surgery, anesthesiology assistants, and certified diabetes educators. A physician must not bill for services provided by any employee who is enrolled, or eligible to be enrolled, as a West Virginia Medicaid/WVCHIP provider.

300.20.4 Physician Assistant (PA)

A PA has attained a baccalaureate or master's degree from an approved program of instruction in primary health care or surgery; has passed the national certification examination and is qualified to practice as a PA under West Virginia State Code or in the state in which services are being provided. These individuals perform only under the supervision-and control of a supervising physician within their scope of practice.

CHAPTER 300 PROVIDER PARTICIPATION REQUIREMENTS

A PA may be authorized by the Board of Medicine to write or sign prescriptions or transmit prescriptions by word of mouth, telephone, or other means of communication at the direction of their supervising physician. Limits on prescribing authority may be found in [WV State Code 30-3E-3](#). A PA may not prescribe a Schedule I controlled substance. A PA may prescribe up to a three-day supply of a Schedule II narcotic and non-narcotic Schedule II's may be prescribed within the same limits as a physician. There are no other limitations on the prescribing authority of a PA. To be eligible for prescription privileges, a PA must have performed patient care services for a minimum of two years immediately preceding the submission to the Board of Medicine of the job description containing prescription privileges and must have successfully completed an accredited course of instruction in clinical pharmacology approved by the Board.

PAs must be enrolled in West Virginia Medicaid/WVCHIP to render services. Services will be reimbursed to the supervising entity. The rules regarding supervision of physician assistants will fall under the Board of Medicine or Board of Osteopathy.

With the hospital's approval through the credentialing and delineation of privileges process, the PA may provide and bill for services in the emergency department and for specific inpatient hospital care under the direction of their supervising physician.

A PA may provide services in a federally qualified health center or rural health clinic to include the application of fluoride varnish to members six months to three years of age. Refer to [Chapter 522, Federally Qualified Health Center and Rural Health Clinic Services](#) and [Chapter 505, Oral Health Services](#) for additional information.

300.20.5 Advanced Practice Registered Nurse (APRN)

A APRN must meet requirements set forth by the West Virginia Board of Examiners for Professional Registered Nurses or in the state in which services are being provided and with the hospital's approval through the credentialing and delineation of privileges process, acting within their scope of practice, may provide and be reimbursed for hospital inpatient, observation and nursing home visits to West Virginia Medicaid/WVCHIP members. Additionally, APRNs may bill and be reimbursed when providing outpatient and home services to West Virginia Medicaid/WVCHIP members when enrolled independently in West Virginia Medicaid/WVCHIP.

Prescriptive authority is not required to be enrolled as a provider. APRNs with prescriptive authority must meet all eligibility requirements. Limits on prescriptive authority for APRNs are found in [WV Code §30-7-15a](#):

- a) An advanced practice registered nurse may not prescribe a Schedule I controlled substance as provided in [WV State Code 60A-2-204](#) *et seq.* of this code.
- b) An advanced practice registered nurse may prescribe up to a three-day supply of a Schedule II narcotic as provided in [WV State Code 60A-2-206](#) *et seq.* of this code. Non-narcotic Schedule II drugs may be prescribed within the same limits as a physician.
- c) There are no other limitations on the prescribing authority of an advanced practice registered nurse, except as provided in §16-54-1 *et seq.* of this code.



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Covered services are only reimbursed to APRNs within their scope of practice and with the required specialty certification. Covered services are only reimbursed to APRNs within their scope of practice and with the required specialty certification.

West Virginia Medicaid/WVCHIP may reimburse the APRN for their role as an assistant-at-surgery in a surgical procedure. The assistant-at-surgery's claim must include the surgical CPT code with modifier "AS." The operative report must reflect the assistant-at-surgery's services during the operative procedure. When documentation is not available, the APRN's services are not separately reimbursable.

Advanced practice registered nurses may also bill CPT codes when services are provided in an Emergency Department (ED) setting and within their scope of practice as directed by the West Virginia Board of Examiners for Registered Professional Nurses. APRNs are not eligible for reimbursement of West Virginia Medicaid/WVCHIP eligibility examinations.

Services provided by an APRN may include incidental services and supplies that are included as part of another service or procedure. The cost of incidental services is not separately reimbursable.

West Virginia Medicaid/WVCHIP may reimburse the advanced practice registered nurses for application of fluoride varnish to members six months to three years of age. Refer to [Chapter 505, Oral Health Services](#) for additional information.

West Virginia Medicaid recognizes the following as APRNs:

- The certified registered nurse anesthetist must have a diploma or certificate evidencing their successful completion of an educational program from a school of anesthesia accredited by the American Association of Nurse Anesthetists.
- The certified registered nurse anesthetist must submit a copy of the hospital's approval through the credentialing and delineation of privileges process to the BMS enrollment unit for inclusion in the certified registered nurse anesthetist's enrollment record.
- When general, regional, and monitored anesthesia is administered, the certified registered nurse anesthetist must be supervised by the operating practitioner performing the procedure or by an anesthesiologist who is immediately available, as required by licensure. The certified registered nurse anesthetist may bill directly to the BMS fiscal agent with their assigned NPI and must include the appropriate modifier "QS, QX, or QZ" on the claim form. When the appropriate modifier is not included on the claim form, the claim is denied.
- In addition to providing anesthesia services, a certified registered nurse anesthetist acting within the scope of their license may bill for Swan-Ganz placement or any other central venous pressure line, critical care visits, emergency intubations, spinal puncture, and blood patch. In addition, certified registered nurse anesthetists may bill for cardiopulmonary resuscitation performed in conjunction with the anesthesia procedure or outside the operating suite.

The clinical nurse specialist must have a current, active license in the State where they practice and have a Doctor of Nursing Practice (DNP) or Master's degree in defined clinical area of nursing from an accredited educational institution and be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for the clinical nurse specialist.

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The clinical nurse specialist must be enrolled to provide services to West Virginia Medicaid/WVCHIP members in collaboration with an enrolled physician(s) within their defined clinical area of nursing. The collaborating physician is not required to be present when services are provided, nor is the physician required to independently evaluate the member:

- The certified nurse midwife is a nurse who has been licensed by the West Virginia Board of Examiners for Registered Professional Nurses to practice nurse-midwifery as approved for in [WV State Code §30-15-1\(c\)](#). A collaborative agreement with an enrolled obstetrician or gynecologist or family practice is required as specified in West Virginia State Code §30-15-7. Refer to [Chapter 519, Practitioner Services, Policy 519.19 Women's Health Services](#) for more detail.

West Virginia Medicaid/WVCHIP may reimburse for vaginal deliveries performed in a hospital by enrolled certified nurse midwives when the hospital has approved these services through the credentialing and delineation of privileges process. In addition, the certified nurse midwives are approved for billing the appropriate CPT codes (99281, 99282, and 99283) in the ED. The certified nurse midwife's delineation of privileges must be on file with the BMS Provider Enrollment Unit. In addition, covered services within the certified nurse midwife's scope of practice may be provided in an office, outpatient, inpatient, free-standing birthing centers, and the member's home setting. Certified nurse midwives are eligible for reimbursement for newborn assessments, hospital observation care related to pregnancy and postpartum visits.

300.20.6 Assistant-at-Surgery

The BMS covers assistant-at-surgery services provided by an employed registered nurse (RN), an enrolled PA, or an enrolled APRN.

The employed RN must have a current, active RN license, be certified in perioperative nursing, and have successfully completed certification and hold a certificate from the Association of Perioperative Registered Nurses Care Curriculum and be certified in accordance with [WV State Code §9-4B-1](#). The surgeon must bill for services provided by the employed RN or PA.

Only one assistant-at-surgery per surgical encounter is reimbursable. Assistant-at-surgery is not reimbursable when co-surgeon(s) or team surgery is billed.

If the surgical procedure does not require prior authorization, the assistant-at-surgery must include the same CPT code as the surgeon with modifier "AS" on the CMS-1500 claim form and attach the operative report documenting their role during the procedure. The claim must be submitted with the operative report to the BMS fiscal agent for payment consideration. When documentation is not available, the assistant-at-surgery services are not separately reimbursable.

When the procedure requires prior authorization, the UMC must be informed that an assistant-at-surgery is planned to participate in the procedure by the treating surgeon. If the procedure and the assistant-at-surgery are approved by the UMC, the assistant-at-surgery must include the same CPT code as the surgeon with the "AS" modifier and prior authorization number. The claim form must be submitted to the BMS fiscal agent for payment consideration.

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300.20.7 Anesthesiologist Assistant

Anesthesiologist assistants are highly skilled, non-physician anesthetists who work under the direction of licensed anesthesiologists to implement anesthesia care plans. Refer to [Chapter 519, Practitioner Services, Policy 519.2 Anesthesia Services](#) for additional information.

300.20.8 Certified Diabetes Educator

A certified diabetes educator must have a current, unrestricted certification issued by the [Certification Board for Diabetes Care and Education](#). The certified diabetes educator seeking enrollment must:

- Meet the Certification Board for Diabetes Care and Education certification requirement noted above, and
- Demonstrate successful completion of six hours of continuing education units through the American Diabetic Association for a total of 12 hours every two years.

Practitioners managing certified diabetes educators must be a West Virginia Medicaid/WVCHIP enrolled physician (MD or DO), APRN, clinical nurse specialist, or PA. Certified diabetes educators are eligible for reimbursement for diabetes management extended visits and comprehensive educational services only.

300.21 MEDICAID/WVCHIP REQUIREMENT OF FREEDOM OF CHOICE

Under federal law Section 1902(a)(23) of Title XIX of the Social Security Act (the Act), Medicaid/WVCHIP members may obtain medical services “from any institution, agency, community pharmacy, or person, qualified to perform the service or services required...who undertakes to provide him such services.” This provision is often referred to as the “any willing provider” or “free choice of provider” provision.”

SUPPORT SERVICES

300.22 MEDICAID/WVCHIP PROVIDER FORMS

Some West Virginia Medicaid/WVCHIP forms are available as attachments to the applicable [Provider Manual Chapter](#). Providers also may request forms directly from the [Fiscal Agent's Provider Enrollment Unit](#). The BMS does not provide or supply copies of claim forms.

300.23 PROVIDER WORKSHOPS

The BMS conducts workshops that are designed specifically to address policy updates, program changes, and provider concerns. The workshops, which are a cooperative effort of the BMS and its fiscal agent, are presented virtually and/or in multiple geographical locations throughout the State. An open forum is conducted to answer questions raised by attendees. Workshops and their geographic locations are announced on the banner page of the remittance voucher. In addition, BMS and its fiscal agent participate in seminars conducted by other public agencies and provider groups.

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300.24 TECHNICAL ASSISTANCE

The BMS fiscal agent may be made available to visit the provider's office to help resolve issues that cannot be remedied via telephone. Providers requesting technical assistance should contact the [BMS Fiscal Agent's Provider Services Unit](#). While not routine, representatives from providers' offices may meet with BMS or Provider Services to resolve complex issues that may be too difficult to explain by telephone.

300.25 PROVIDER NEWSLETTERS

As circumstances warrant, newsletters are posted to the provider portal. The newsletters inform providers of recent developments, discuss billing and coding issues, and clarify medical coverage and payment policies.

Newsletters are also posted on the [Publications page](#) of the BMS website and the [BMS fiscal agent's website](#).

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid/WVCHIP services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Accreditation: A process of review that healthcare organizations participate in to demonstrate the ability to meet predetermined criteria and standards established by a professional accrediting organization. The CMS has established provider accreditation requirements for home health agencies, hospices, and DMEPOS agencies that participate in the Medicare program. While accreditation is a requirement for participation with Medicare for certain provider types, it does not guarantee approval of enrollment with Medicare. The BMS shall not accept accreditation in place of an approved enrollment with Medicare.

Agent: Any person who has been delegated the authority to obligate or act on behalf of a provider.

Application Fee: A fee imposed on certain provider types in accordance with the ACA to cover the cost of screening associated with provider enrollment processes and program integrity efforts. The application fee is adjusted annually.

Atypical Provider Identifier (API): The identification number assigned by the BMS fiscal agent for providers who do not qualify for an NPI under NPPES, for example, some county-government based providers. The API was formerly known as the BMS Provider ID.

Case Number: A number assigned and distributed to providers by the BMS fiscal agent which allows access to the web-based Provider Enrollment Application Portal.

Certification: A process, by which a State Agency contracted with the CMS, performs a survey of a provider or supplier to determine whether the provider is compliant with the standards required by Federal regulations. The authority for determining if the provider may participate with Medicare is delegated to the CMS Regional Office. The Regional Office relies upon the state agency certification as crucial evidence in determining the provider's eligibility to participate with Medicare. A successful certification does not

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guarantee that the Regional Office will approve the provider for enrollment with Medicare and as such, the BMS must not accept certification in place of an approved enrollment with Medicare.

Change of Ownership: Any mechanism which transfers actual or operational control from one or more persons or entities (owner) to another person, group of persons or entity (owner).

Conviction or Convicted: Means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.

Disclosing Entity: A West Virginia Medicaid/WVCHIP provider (other than an individual practitioner), or a fiscal agent. Any entity that does not participate in West Virginia Medicaid/WVCHIP, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XXI of the Act means:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
- Any Medicare intermediary or carrier; and
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XXI of the Act.

Electronic Funds Transfer (EFT): A type of financial transaction where money is transferred from one account to another without the use of paper checks. EFT allows enrolled providers to receive West Virginia Medicaid/WVCHIP payment directly to a designated bank account without the need to manually deposit a check. By-June 1, 2014, all providers were required to use EFT.

Enrollment Effective Date: The effective date of an applicant's enrollment as a West Virginia Medicaid/WVCHIP Provider is deemed to be the date the application has been fully reviewed and approved.

Exclusion from Participation in a Federal Health Care Program: A penalty imposed on a provider by the OIG under §1128 or 1128A of the Social Security Act. Individuals and entities may be excluded by the OIG for misconduct such as fraud convictions, patient abuse, and defaulting on health education loans. The BMS may also exclude providers from its program under state law or pursuant to 42 CFR §1002.2.

Federal Employer Identification Number (FEIN): A number issued by the-IRS to sole proprietors, partnerships, corporations, and other entities for tax purposes. It is also called an Employer Identification Number (EIN).

Fiscal Agent: A contractor that processes or pays vendor claims on behalf of the BMS.

Group of practitioners: Two or more health care practitioners who practice their profession at a common location (whether they share common facilities, common supporting staff, or common equipment)

Hardship Exception: A formal request by a provider who is unable to pay the required application fee. The provider must submit a letter defining the hardship as well as documented proof of financial hardship



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with the enrollment application. The BMS can deny the request, but only the CMS can approve the hardship request.

Indirect Ownership Interest: An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

In-Network Provider: A West Virginia Medicaid/WVCHIP enrolled provider located within the state, or within 30 aeronautical miles of its border. Select specialty hospitals located out of state beyond the 30-mile radius and their affiliated practitioners may also be considered for in-network status by West Virginia Medicaid/WVCHIP.

Managing Employee: A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

National Provider Identifier (NPI): The NPI is a HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Some entities may not qualify to receive NPIs. Specifically, any entity that does not meet the definition of a healthcare provider under [45 CFR 164.103](#). Definitions may not apply for an NPI. Such entities include billing services, value-added networks, repricers, health plans, health care clearinghouses, non-emergency transportation services, and others who do not furnish health care.

Network Provider: Any provider, group of providers or entity that has a network provider agreement with an MCO, Pre-Paid Inpatient Health Plan or Pre-Paid Ambulatory Health Plan, or a subcontractor, and receives West Virginia Medicaid/WVCHIP funding directly or indirectly to order, refer or render covered services because of the state's contract with an MCO, Pre-Paid Inpatient Health Plan or Pre-Paid Ambulatory Health Plan. A network provider is not a subcontractor by virtue of the network provider agreement.

Newly Enrolling Provider: A provider who has not previously been enrolled with West Virginia Medicaid/WVCHIP.

Ordering, Referring, or Prescribing (ORP) Provider: For provider enrollment, an ORP is an individual provider who orders, refers, or prescribes services but must be enrolled under a rendering provider and cannot receive direct payment from West Virginia Medicaid/WVCHIP.

Out-of-Network Provider: Any provider located outside of the state of West Virginia, beyond the 30-aeronautical mile radius of the West Virginia border that has been approved for enrollment with West Virginia Medicaid/WVCHIP. These providers can offer covered West Virginia Medicaid/WVCHIP services, however, prior to rendering any service they must obtain prior authorization, except in

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medically necessary emergent situations as defined in [WV State Code §33-1-21](#) or in cases where a foster child has been placed out-of-state and/or resides in an out-of-state PRTF. Out-of-Network provider contracts require that all non-emergent services, per BMS policy, are only approved when an In-Network provider is not available or appropriate to treat the member.

Ownership Interest: The possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an Ownership or Control Interest: A person or corporation that:

- Has an ownership interest totaling five percent or more in a disclosing entity;
- Has an indirect ownership interest equal to five percent or more in a disclosing entity;
- Has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity;
- Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity;
- Is an officer or director of a disclosing entity that is organized as a corporation; or
- Is a partner in a disclosing entity that is organized as a partnership.

Practitioner: A physician or other individual licensed under state law to practice his or her profession.

Provider: Any individual or entity furnishing reimbursable services under an agreement with the West Virginia Medicaid/WVCHIP agency.

Provider Enrollment Application Portal (PEAP): The web-based tool for provider enrollment located within the fiscal agent's provider portal.

Provider Type: A provider category approved by the BMS and identified by the provider and/or fiscal agent at the time of enrollment. The provider type establishes requirements for enrollment of the provider and determines the services approved for payment within the claims processing system.

Reactivation of Enrollment: The enrollment process for a provider who was previously enrolled with West Virginia Medicaid/WVCHIP and was involuntarily dis-enrolled by West Virginia Medicaid/WVCHIP. (for example, inadvertently dis-enrolled by the fiscal agent or the BMS).

Re-enrollment: The enrollment process for a provider who terminated participation with West Virginia Medicaid/WVCHIP and seeks to reestablish its enrollment. Reenrollment is basically the same as a new enrollment. A new enrollment application must be submitted, and the provider must meet all enrollment requirements.

Revalidation of Enrollment: The process whereby a provider is required to revalidate, i.e. review and update, enrollment information. In accordance with Patient Protection and Affordable Care Act (ACA), providers are required to revalidate with West Virginia Medicaid/WVCHIP at least every five years.

Rendering Provider: A provider who is eligible to be directly reimbursed for Medicaid/WVCHIP services. Through a group affiliation, the provider may opt for their reimbursement to be made to the group.



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Service or Practice Location: The physical address where health care services are rendered.

Significant Business Transaction: Any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and five percent of a provider's total operating expenses.

Site Visit: As mandated by the ACA, an unscheduled and unannounced site visit of certain provider types will be conducted to ensure program integrity. Site Visits prevent questionable providers and suppliers from enrolling in the West Virginia Medicaid/WVCHIP program. These visits are to verify and collect additional enrollment-related information as defined by a predefined checklist created by the BMS.

Specialty: A specialized field of practice for which the provider may be board certified or board eligible. A specialty requires completion of the appropriate residency program.

Subcontractor: An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the BMS agreement.

Supplier: An individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under West Virginia Medicaid/WVCHIP (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Tax ID: The Tax ID is the same as the FEIN (see above).

Taxonomy Code: Healthcare provider taxonomy codes are designed to categorize the type, classification, and/or specialization of health care providers. This national standard is a 10-character alpha-numeric code that ends with an "X." Taxonomy is a key identifier for processing and payment of claims. The National Uniform Claim Committee defines and maintains the code set.

West Virginia Medicaid Provider ID: A unique identification number assigned by the BMS fiscal agent. The West Virginia Medicaid/WVCHIP Provider ID has become a legacy number for most enrolled providers. The NPI or an API for atypical providers is now used for provider transactions. The legacy West Virginia Medicaid/WVCHIP Provider ID, when available, has been retained for historical purposes.

Wholly Owned Supplier: A supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

REFERENCES

The West Virginia State Plan covers [Section 2.7, Medicaid Furnished Out-of-State](#), [Section 3.2, Coordination with Medicare and Other Insurance](#), [Section 4.7, Maintenance of Records](#), [Section 4.13, Required Provider Agreement](#), [Section 4.22, Third-Party Liability](#), [Section 4.29, Conflict Of Interest Provisions](#), [Section 4.30, Exclusion of Providers and Suspension of Practitioners and Other Individuals](#), [Section 4.31, Disclosure of Information by Providers and Fiscal Agents](#), [Section 4.46, Provider Screening and Enrollment](#).

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CHANGE LOG

| SECTION NUMBER | TITLE | EFFECTIVE DATE |
|----------------|---|------------------|
| Entire Chapter | Chapter 300, Provider Participation Requirements | May 18, 2018 |
| Entire Chapter | Section 300.20.2 – Added requirement for residents to have a valid educational permit before enrollment. Added WVCHIP to policy. | July 1, 2024 |
| Entire Chapter | Medicaid Provider Enrollment Compendium (MPEC) Updates | January 10, 2025 |

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.