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PROVIDER PARTICIPATION REQUIREMENTS
CHAPTER II

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CHAPTER II

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Provider manuals and manual updates are posted on the Department of Medical Assistance Services (DMAS) website (www.virginiamedicaid.dmas.virginia.gov) for viewing and downloading. Providers are notified of manual updates through communications issued by Magellan to its network of behavioral health providers and by DMAS notices of Medicaid manual updates and Medicaid memos to providers.

The 2011 Acts of Assembly directed DMAS to implement a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization (Item 297, MMMM). DMAS released a Request for Proposals (RFP) for a Behavioral Health Services Administrator (BHSA) in December 2011. The contract was awarded to Magellan Health Services in May 2013. Implementation of Magellan of Virginia, BHSA, occurred December 1, 2013.

Magellan works with DMAS to improve access to quality behavioral health services and improve the value of behavioral health services purchased by the Commonwealth. Magellan administers a comprehensive care coordination model which is expected to reduce unnecessary expenditures. Other Magellan benefits include:

- Comprehensive care coordination including coordination with Medicaid/FAMIS managed care plans providing coverage of acute care services;
- Promotion of more efficient utilization of services;
- Development and monitoring of progress towards outcomes-based quality measures;
- Management of a centralized call center to provide eligibility, benefits, referral and appeal information;
- Provider recruitment, issue resolution, network management, and training;
- Service authorization;
- Member outreach, education and issue resolution; and
- Claims processing and reimbursement of behavioral health services that are currently carved out of Medicaid/FAMIS managed care.

The provider network is the Commonwealth's Medicaid network, managed and maintained by Magellan. Magellan is responsible for enrollment and credentialing of **fee-for-service** behavioral health providers into the network based upon DMAS regulatory requirements and geographical access needs.

The Magellan Call Center has a centralized contact number **(1-800-424-4046)** for Medicaid/FAMIS members and providers starting on December 1, 2013. The Call Center is located in Virginia and is available 24 hours a day, 365 days a year. Staff includes bilingual/multi-cultural representatives who speak English and Spanish. Interpreter services,

TDD/TTY and relay services are available for individuals with a hearing impairment. The TDD number is 1-800-424-4048.

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All calls related to the fee for service behavioral health services should go to the Magellan Call Center. Magellan staff is available to assist callers with:

- service authorizations,
- clinical reviews,
- member eligibility status,
- referrals for services,
- provider network status,
- claims resolution, and
- grievances and complaints.

Enrolled providers are encouraged to integrate Magellan's requirements and procedures into their day-to-day operations as a Medicaid provider.

Noted below are two (2) concepts that should be reflected in all providers' service delivery practices and that support the principles noted above.

Recovery and Resiliency

DMAS' Developmental Disabilities and Behavioral Health Services' Division mission is: to provide high quality, consumer-focused, recovery-based behavioral health services for individuals enrolled in Virginia Medicaid. To that end, DMAS encourages the provider network to integrate these principles into their practices and service delivery operations. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Cultural and Linguistic Competency

DMAS encourages providers to demonstrate an understanding and respect for each individual's health-related beliefs and cultural values through the establishment of policies, practices and allocation of resources that support culturally and linguistically appropriate services. Culture has a significant impact on how people of different backgrounds express themselves, seek help, cope with stress and develop social supports. It also affects every aspect of an individual's life, including how they experience, understand, and express, mental and emotional distress, illness and conditions.

Development of cultural and linguistic competency means that providers have the ability to value diversity, adapt to diverse populations, obtain any needed education and training in order to enhance cultural knowledge, work within values and beliefs that may be different from their own, and be capable of evolving over extended periods of time as cultures change.

Providers are responsible for adhering to this manual, available on the DMAS website portal, their Magellan provider contract and policies, and related state and federal regulations.

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PROVIDER QUALIFICATIONS

Provider Credentials for Mental Health Services Staff:

DMAS' administrative regulations for behavioral health services refer to the DBHDS administrative regulations. Staff qualification requirements for Medicaid funded behavioral health services are determined by the Department of Health Professions and DBHDS. DMAS does not license or certify providers. DBHDS is the entity with authority to define acceptable employee qualifications.

Residential treatment service providers are responsible to ensure that employed or contracted staff must meet the service-specific staff requirements of all services rendered by the service provider. All provider sites must be credentialed by Magellan, licensed and in compliance with all requirements as defined in the residential treatment service regulations.

"Clinical experience" (Children's Services) means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Licensed assistant behavior analyst" or **"LABA"** means a person who has met the licensing requirements of 18VAC85-150-10 et seq. and holds a valid license issued by the Department of Health Professions.

"Licensed behavior analyst" or **"LBA"** means a person who has met the licensing requirements of 18VAC85-150-10 et seq. and holds a valid license issued by the Department of Health Professions.

"Licensed mental health professional" or **"LMHP"** means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

"LMHP-resident" or **"LMHP-R"** means the same as "resident" as defined in (i) [18VAC115-20-10](#) for licensed professional counselors; (ii) [18VAC115-50-10](#) for licensed marriage and family therapists; or (iii) [18VAC115-60-10](#) for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not

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perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in [18VAC125-20-10](#), program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in [18VAC125-20-65](#) and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee" or "LMHP-S" means the same as "supervisee" as defined in [18VAC140-20-10](#) for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in [18VAC140-20-50](#) and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Qualified mental health professional-child" or "QMHP-C" means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP-C, the individual must have the designated clinical experience and must either (i) be a doctor of medicine or osteopathy licensed in Virginia; (ii) have a master's degree in psychology from an accredited college or university with at least one year of clinical experience with children and adolescents; (iii) have a social work bachelor's or master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents; (iv) be a registered nurse with at least one year of clinical experience with children and adolescents; (v) have at least a bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or (vi) be a licensed mental health professional.

"Qualified mental health professional-eligible" or "QMHP-E" means a person who has: (i) at least a bachelor's degree in a human service field or special education from an accredited college without one year of clinical experience or (ii) at least a bachelor's degree in a nonrelated field and is enrolled in a master's or doctoral clinical program, taking the equivalent of at least three credit hours per semester and is employed by a provider that has a triennial license issued by the department and has a DBHDS-approved supervision training program.

QMHP Eligible Staff:

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In order to allow providers to develop QMHP staff, a new QMHP eligible category was created, effective September 1, 2010. This category was created to allow staff with a bachelor's degree the ability to provide services and gain clinical experience under supervision. Staff must have the following credentials:

Only one QMHP eligible staff will be allowed for each full time licensed staff. The number of QMHP eligible staff will not exceed 5% of total clinical adult staff in agency. The QMHP eligible staff must have at least one hour of licensed mental health provider (LMHP) supervision per week which must be documented in the employee file. The QMHP eligible staff must also participate in monthly training which must also be documented in the staff file. The monthly training cannot be duplication of supervision time. Evidence of compliance with the QMHP eligible criteria must be in the staff file.

The employing agency must have a triennial license from the DBHDS and have a DBHDS approved supervision training program. To apply for approval of the supervision training program please submit your agency's training curriculum to the DBHDS Office of Licensing

"Qualified paraprofessional in mental health" or "QPPMH" means a person who must, at a minimum, meet one of the following criteria: (i) registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate's degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iii) has a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP-Adult providing services to individuals with mental illness and at least one year of experience (including the 12 weeks of supervised experience).

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Residential treatment facility services shall be covered for the purpose of diagnosis and treatment of mental health and behavioral disorders when such services are rendered by:

- A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission; or a psychiatric facility that is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children or the Council on Quality and Leadership. Providers of residential treatment facility services shall be licensed by DBHDS.
- Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12VAC30-130-850 et seq.) of Amount, Duration and Scope of Selected Services.
- Residential treatment facility services are reimbursable only when the treatment program is fully in compliance with (i) the Code of Federal Regulations at 42 CFR Part 441 Subpart D, specifically 42 CFR 441.151 (a) and (b) and 441.152 through 441.156, and (ii) the Conditions of Participation in 42 CFR Part 483 Subpart G regarding the use

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of restraint and seclusion. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

- Psychiatric Residential Treatment Facility providers shall also be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

Inpatient Psychiatric Facilities (IPF) -“Services Provided Under Arrangement”

The U.S. Court of Appeals issued a decision on May 8, 2012 in a lawsuit brought by the DMAS challenging a federal audit finding related to DMAS reimbursements for services provided to members under the age of 21 in psychiatric residential treatment facilities and freestanding psychiatric hospitals (both state and private). This also applies to EPSDT specialized contracts for residential treatment facilities. **In this section**, these facilities will be referred to as *Inpatient Psychiatric Facilities (IPF)*.

In order to comply with the court decision and federal law, DMAS modified the reimbursement process for certain services furnished to Medicaid members who are under the age of 21 and who are residing in an IPF.

The services that are affected are “services provided under arrangement” with the IPF, including physician and other health care services that are furnished to children in an IPF and billed separately from the IPF per diem. Services that can be provided under arrangement with an IPF are listed below for each provider type.

In order for DMAS to continue to reimburse these services separately from the per-diem rate paid to IPFs, the Centers for Medicare and Medicaid Services (CMS) requires that the IPF:

1. arrange for and oversee the provision of all services;
2. maintain all medical records of services provided under arrangement furnished to the member residing in the IPF;
3. ensure that each member residing in an IPF has a comprehensive plan of care that includes services provided under arrangement; and
4. ensure that all services, including services provided under arrangement, are furnished under the direction of a physician.

If these requirements are not met, DMAS will not reimburse for these services and providers may not charge members directly. These requirements will apply to both in-state providers and out-of-state providers. These requirements also apply across all contractors who administer claims on behalf of DMAS and reimburse for services furnished members residing in IPFs.

IPF Requirements for Direct Reimbursement to Providers of Services Provided Under Arrangement

DMAS will reimburse services provided under arrangement separately from the per-diem rate paid to IPFs only if the IPF meets all of the following requirements:

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1. As required by regulations (42 CFR 441.155; 42 CFR 456.180; and 12 VAC 30-50-130), each initial and comprehensive plan of care must be specific to meet each child's medical, psychological, social, behavioral and developmental needs.
 - a. Each initial and comprehensive plan of care must include, within one (1) calendar day of the initiation of the service provided under arrangement, any service that the individual needs while residing in an IPF, and that is furnished to the member by a provider of services under arrangement. Physicians may implement the change to the plan of care by telephone, provided that the documented change is signed by the physician as soon as possible, and not later than the next 30-day plan review. Services provided under arrangement must be included in the plan of care -- documentation in the assessment, progress notes, or elsewhere in the medical record will not meet this requirement.
2. Each initial and comprehensive plan of care must document the prescribed frequency and circumstances under which the services provided under arrangement shall be sought.
3. Each IPF must document a written referral for each service provided under arrangement, and must maintain a copy of the referral in the member's medical record at the facility. The provider of the service under arrangement must also maintain a copy of the referral in the member's medical record. The referral must be consistent with the plan of care. A physician order will meet the requirement for a referral. For pharmacy services, the referral is the prescription. The prescribing provider must be employed or have a contract with the facility. Referrals must be documented when the provider has accepted the referral. A referral should not be documented when the provider does not accept the referral.
4. Providers of services under arrangement must either be employees of the IPF or, if they are not employees of the IPF, they must have a fully executed contract with the IPF prior to the provision of the service, with the exception of emergency services. For emergency services, the contract must be executed before the provider of emergency services bills DMAS for the emergency services. IPFs should begin preparations now to contract with usual providers of services under arrangement who are not employees of the IPF.
 - a. The contract must include the following: 1) if the provider of services under arrangement accepts a referral, it agrees to include the NPI of the referring IPF on its claim for payment; and 2) the provider of services under arrangement agrees to provide medical records related to the member residing in the IPF upon request by the IPF. A fully executed contract requires that a representative of the IPF and a representative of the provider of services under arrangement signs the contract and includes their name, title, and date. A letter of understanding or letter of agreement will meet the requirement for a contract, provided that both the IPF and provider of services under arrangement sign and date the letter.

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5. Each IPF must maintain medical records from the provider of services under arrangement in the individual's medical record at the facility. These may include admission and discharge documents, treatment plans, progress notes, treatment summaries and documentation of medical results and findings. These records must be requested in writing by the IPF within seven (7) calendar days of discharge from or completion of the service provided under arrangement. If the records are not received from the provider of services under arrangement within 30 days of the initial request, they must be re-requested or DMAS may retract the per diem reimbursement made to the IPF on behalf of a member during the period of non-compliance.

- a. If there is the potential for retroactive Medicaid eligibility, the IPF should comply with these requirements so that the provider of services under arrangement can bill Medicaid after eligibility is confirmed.

Providers of Services under Arrangement: Requirements for Direct Reimbursement

DMAS or its contractors will not reimburse providers for services furnished to Medicaid members residing in an IPF unless:

- 1) The provider is employed by the IPF or contracted with the IPF and
- 2) The provider has a referral from the IPF for the services furnished.

The referral should be documented in the records of the provider of services under arrangement. The provider must follow special billing instructions described below.

The requirements above are in addition to all other existing requirements for services. For example, providers of services under arrangement must still obtain service authorization for services that otherwise require service authorization.

Providers should always verify Medicaid eligibility prior to furnishing services. If the member is eligible but has an "IM" indicator in the level of care, providers should not furnish non-emergency services until they complete the requirement for contracting with and have a referral from the IPF. The IM indicator in the level of care is available through multiple methods: the Automated Response System (ARS), the Virginia Medicaid Web Portal, Medicall or a 271/272 electronic transaction.

Special Instructions for Dental, Pharmacy, Emergency Services, Non-Emergency Transportation and Inpatient Acute Care Services

Dental services for Medicaid members are provided through Smiles for Children (SFC) and are reimbursed by the Department's Dental Benefits Administrator (DBA), DentaQuest. IPFs that currently arrange for dental services should continue to do so based on the member's Plan of Care. IPFs must have a contract with a SFC participating dentist and must provide a referral to that dentist's office when the appointment is made for one of their residents/patients. The IPF shall provide the name of its contracted dentist to the Department or DentaQuest upon request.

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Pharmacies must have a contract with the IPF. DMAS will use the prescribing NPI as the referral NPI. The prescription can serve as the referral document. The prescribing provider must be an employee or contractor of the IPF.

IPFs should include emergency services in the plan of care and contract in advance with the usual providers of emergency services. If the IPF uses a non-contracted provider for emergency services, the IPF may contract with the emergency services provider after the fact. The emergency services provider must have a contract in place with the IPF provider prior to billing DMAS. A referral is required for emergency services, and the emergency services provider must include the NPI of the IPF in the referring provider locator on the claim for payment.

Some providers are affiliated with hospitals but provide outpatient services as a separate billable item from the hospital charge (such as radiologists, pathologists, anesthesiologists, etc.). The acute-care hospital shall be responsible for providing the referral NPI of the IPF to these “hidden” providers. These “hidden” providers must be addressed in the contract between the IPF and the hospital that provides the emergency services.

IPFs that use the Fee for Service (FFS) Non-Emergency Medical Transportation (NEMT) broker for medical transportation must have a contract with the FFS NEMT broker which allows non-emergency transportation to be provided as a service provided under arrangement. When the member residing in the IPF needs transportation, the IPF should contact the FFS NEMT broker reservation number (866-386-8331) or use the FFS NEMT broker online request system <https://transportation.dmas.virginia.gov> in order to arrange transportation services prior to the date transportation is required. Please make the members FFS NEMT reservations five business days in advance. This request for transportation will be considered the “referral”. PRTF providers enrolled with the FFS NEMT broker must 1) inform the FFS NEMT broker that they are a PRTF provider and that the member is exclusively ride with their facility; and 2) provide the transportation contractor with the PRTF provider name and if needed the NPI number to use as an assigned provider. The PRTF NPI will be used by the broker on the transportation encounter that is submitted to DMAS.

Inpatient admissions to acute care hospitals for treatment of acute care conditions do not require a referral or arrangement from the IPF. However, the IPF must report all patient discharges from their facility to Magellan within one business day. Failure to notify Magellan will result in any claims associated with the inpatient acute care stay being denied. Upon readmission to the IPF, the member will not require a new Certificate of Need unless the existing Certificate of Need authorizing the previous stay at the facility had expired during the member’s inpatient placement.

Detailed Coverage Criteria for Services Provided Under Arrangement by Provider Type

See chart below for services provided under arrangement that may be billed separately for each provider type, provided that the requirements discussed above are met. (Certain services are included in the per-diem rates for each provider type, which results in the differences shown in the list below.) No other services may be billed for members under age 21 residing in IPFs.

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Services Provided Under Arrangement	Psychiatric Residential Treatment Facilities	Private Freestanding Psychiatric Hospitals	State Freestanding Psychiatric Hospitals
Physician Services	Yes	Yes	No
Other medical and psychological services including those furnished by licensed mental health professionals and other licensed or certified health professionals (i.e. oral surgeons, nutritionists, podiatrists, respiratory therapists, substance abuse treatment practitioners)	Yes	Yes	No
Outpatient Hospital Services	Yes	Yes	No
Pharmacy services	Yes	No	Yes
Physical therapy, occupational therapy and therapy for individuals with speech, hearing or language disorders	Yes	Yes	No
Laboratory and radiology services	Yes	Yes	No
Durable medical equipment (including prostheses/orthopedic services and supplies and supplemental nutritional supplies)	Yes	No	No
Vision services	Yes	Yes	No
Dental and orthodontic services	Yes	Yes	No
Non-Emergency Transportation services	Yes	Yes	No
Emergency services (including outpatient hospital, physician and transportation services)	Yes	Yes	Yes

Utilization Review/Audit

If the IPF fails to comply with any one of the requirements listed above, DMAS may retract the per diem reimbursement made to the IPF on behalf of a member during the period of non-compliance.

An IPF may arrange for services for members with providers who are not enrolled with DMAS. As long as these services are included in the plan of care, the IPF is in compliance. The IPF should not arrange for services with a DMAS enrolled provider without either an employee relationship or an executed contract as this could result in a retraction to the per diem during an audit.

Special Rules for Services Funded Solely through the Comprehensive Services Act (CSA) or Other Payers for Medicaid Members in a PRTF

The PRTF facility has the responsibility to arrange and oversee all services provided under arrangement for Medicaid members residing in the facility, even if the facility's service is reimbursed entirely by CSA or another payer. In order for Medicaid to pay for services provided under arrangement, the facility and the provider of services under arrangement must meet all the requirements outlined in this manual and other guidance from DMAS to arrange and oversee such services. Providers of services under arrangement will need to submit the

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referring NPI of the facility on all claims. Magellan service authorization is not required for PRTF services reimbursed by non-Medicaid payers, but PRTF providers are required to notify Magellan when a Medicaid member is residing in the PRTF and there is a non-Medicaid payer so that the Medicaid member is assigned the correct benefit plan including the “IM” indicator which defines the member’s level of care. PRTF providers may call 1-800-424-4536 and ask to speak to the Magellan residential team supervisor or one of the residential care coordinators who will record admissions and discharges in the member’s record.

Billing Requirements

When a provider of services under arrangement submits a claim for their services to DMAS or one of its contractors (Magellan, DentaQuest, Logisticare), the NPI of the referring IPF must be submitted on the claim. The claim will deny or be retracted if no referring NPI is submitted. This referral number will be required as indicated below:

Please refer to Magellan’s billing instructions for managing services provided under arrangement.

CMS-1500: Locator 17 - Name of Referring PRTF Locator 17b - Enter the National Provider Identifier (NPI) of the PRTF

UB 04:Locator 78 Other Provider Name and Identifiers - Enter the NPI for the PRTF.

EDI 837 Professional:

Loop	Segment	Data Element	Comment
2310A-Referring Provider Name	NM1	NM109-Referring Provider Identifier	Submit the Referring IPF Provider's NPI in this field.
2310A – Referring Provider Name	NM1	NM108 – Referring Provider Identification Code	Use ‘XX’ for NPI

EDI 837 Institutional:

Loop	Segment	Data Element	Comment
2310F- Referring Provider Name	NM1	NM101 – Entity Identifier Code	Should always be ‘DN’ for the NPI of referring provider
2310 F – Referring Provider Name	NM1	NM108 – Identification Code Qualifier	Use ‘XX’ for NPI
2310F- Referring Provider Name	NM1	NM109 – Identification Code	Submit the Referring IPF Provider's NPI in this field.

A fact sheet has been posted on the behavioral health page of the DMAS website and FAQs will soon follow. The link for this information is at

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http://www.dmas.virginia.gov/Content_pgs/obh-home.aspx. Additional questions can be directed to the DMAS Behavioral Health Unit at 804-786-1002 or email to CMHRS@dmas.virginia.gov. Behavioral health providers with billing questions can also call Magellan at 800-424-4046 or email VAProviderQuestions@MagellanHealth.com. Non-behavioral health providers with billing questions can call the HELPLINE at 800-552-8327 (804-786-6273 Richmond area or out-of-state).

THERAPEUTIC GROUP HOME

Therapeutic group home services providers shall be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46). Service Providers must be credentialed and enrolled with Magellan.

- Room and board costs shall not be reimbursed. Facilities that only provide independent living services or non-clinical services that do not meet the requirements of this subsection are not reimbursed eligible for reimbursement.
- DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds regardless of the funding source. DMAS shall not reimburse for Therapeutic Group Home services provided in any facility that meets the definition of an Institution for Mental Disease (IMD).
- Therapeutic group home services may only be rendered by an licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, LMHP-RP, a qualified mental health professional-children (QMHP-C), a qualified mental health professional-eligible (QMHP-E), or a qualified paraprofessional-mental health (QPPMH).
- Treatment Team/Team Responsible for the Plan of Care must contain an LMHP, LMHP-R, LMHP-RP, or LMHP-S and a family member or legally authorized representative.
- The clinical director must be a (LMHP). The caseload of the clinical director must not exceed 16 total clients including all sites for which the clinical director is responsible; and
- The program director must be full time and be at least a QMHP-C with a bachelor's degree and at least one year's clinical experience. The program must be under the clinical direction of a LMHP employed or contracted as the clinical director.
- At least 50% of the direct care staff onsite at the group home must at least meet DBHDS paraprofessional staff criteria.
- Services provided by qualified paraprofessionals require supervision by a QMHP-C. Supervision is demonstrated by the QMHP-C by a review of progress notes, the member's progress towards achieving CIPOC goals and objectives, and recommendations for change based on the member's status. Supervision must occur and be documented monthly in the clinical record.
- Direct staff who do not meet the minimum QPPMH requirements may provide services for Medicaid reimbursement if they are working directly with at least a QPPMH on-site and being supervised by a QMHP-C. Supervision must include on-site observation of services, face-to-face consultation with the direct staff member, a review of the progress notes, the consumer's progress towards achieving CIPOC goals and objectives, and recommendations for change based on the member's status. Supervision must occur and be documented monthly in the clinical record.

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- If any services are subcontracted, the subcontracted provider must meet the same qualifications as listed in this chapter for program operation and provider qualifications. The provider who subcontracts services is responsible for ensuring that the subcontracted employees meet all psychiatric service requirements and psychiatric services staffing requirements.

Early Periodic Screening, Diagnosis and Treatment (EPSDT) Psychiatric Residential Treatment Facilities

EPSDT Residential treatment facility services shall be covered for the purpose of diagnosis and treatment of mental health and behavioral disorders when such services are rendered by:

- A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission; or a psychiatric facility that is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children or the Council on Quality and Leadership. Providers of residential treatment facility services shall be licensed by DBHDS.
- Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12VAC30-130-850 et seq.) of Amount, Duration and Scope of Selected Services.
- EPSDT Residential treatment facility services are reimbursable only when the treatment program is fully in compliance with this manual and (i) the Code of Federal Regulations at 42 CFR Part 441 Subpart D, specifically 42 CFR 441.151 (a) and (b) and 441.152 through 441.156, and (ii) the Conditions of Participation in 42 CFR Part 483 Subpart G. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.
- EPSDT Psychiatric Residential Treatment Facility providers shall also be licensed by the DBHDS under the Regulations for Children's Residential Facilities (12VAC35-46).
- EPSDT Residential treatment facilities must abide by the “services provided under arrangement” or “IMD” contracting and reimbursement requirements.

EPSDT Therapeutic Group Home

EPSDT Therapeutic Group Home services providers shall be licensed by the DBHDS under the Regulations for Children's Residential Facilities (12VAC35-46).

EPSDT Therapeutic Group Home services may only be rendered by an LBA, LABA, LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

- Treatment Team/Team Responsible for the Plan of Care must contain an LMHP, LMHP-R, LMHP-RP, or LMHP-S and a family member or legally authorized representative. The treatment team should also have a clinician such as a licensed

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behavior analyst or licensed assistant behavior analyst or LMHP who is able to provide applied behavior analysis services.

- Applied Behavior Analysis Services must be provided by either:
 1. An LMHP practicing within the scope of their practice as defined by the applicable Virginia Health Professions Regulatory Board or an agency that employs a LMHP, or
 2. An LBA meeting all requirements established by the Virginia Board of Medicine in 18VAC85-150-10 et seq. or an agency that employs a LBA.
- Direct ABA interventions must be provided by either:
 1. An LMHP acting within the scope of their practice
 2. An LBA
 3. An LABA under the supervision of a LBA or
 4. Personnel under the supervision of a LBA in accordance with 18VAC85-150-10 et seq. of the Virginia Board of Medicine regulations.
- EPSDT Residential Treatment Services providers practicing ABA must meet all established by the Virginia Board of Medicine in 18VAC85-150-10 et seq.
- The clinical director must be a licensed mental health professional (LMHP). The caseload of the clinical director must not exceed 16 clients including all sites for which the clinical director is responsible; and
- The program director must be full time and be at least a QMHP-C with a bachelor's degree and at least one year's clinical experience. The program must be under the direction of a LMHP.
- At least 50% of the direct care staff onsite at the group home must meet DBHDS QPPMH criteria.
- Services provided by a QPPMH requires supervision by a QMHP-C. Supervision is demonstrated by the QMHP-C by a review of progress notes, the member's progress towards achieving ISP goals and objectives, and recommendations for change based on the member's status. Supervision must occur and be documented monthly in the clinical record.
- Paraprofessionals who do not meet the experience requirements listed in this chapter may provide services for Medicaid reimbursement if they are working directly with a QPPMH on-site and being supervised by a QMHP-C. Supervision must include on-site observation of services, face-to-face consultation with the paraprofessional, a review of the progress notes, the consumer's progress towards achieving ISP goals and objectives, and recommendations for change based on the member's status. Supervision must occur and be documented monthly in the clinical record.
- If any services are subcontracted, the subcontracted provider must meet the same qualifications as listed in this chapter for program operation and provider qualifications. The provider who subcontracts services is responsible for ensuring that the subcontracted employees meet all psychiatric service requirements and psychiatric services staffing requirements.

Independent Assessment, Certification and Coordination Teams (IACCT)

- a. The independent certification team shall certify the need for residential treatment or therapeutic group home services and issue a certificate of need document within the

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process and timeliness standards as approved by DMAS under contractual agreement with Magellan.

- b. The independent certification team shall be approved by DMAS through a Memorandum of Understanding with a locality or be approved under contractual agreement with Magellan. The team shall initiate and coordinate referral to the FAPT (as defined in Va. Code 2.2-5207 and 2.2-5208) to facilitate care coordination and for consideration of educational coverage and other supports not covered by DMAS.
- c. The independent certification team shall assess the individual's and family's strengths and needs in addition to diagnoses, behaviors, and symptoms that indicate the need for behavioral health treatment and also consider whether local resources and community-based care are sufficient to meet the individual's treatment needs, as presented within the previous 30 calendar days, within the least restrictive environment.

Each IACCT team¹ will include at a minimum:

- A Licensed Mental Health Professional (LMHP) or an approved LMHP Resident or Supervisee (LMHP-resident; LMHP-resident in psychology; or LMHP-supervisee in social work) who performs the required diagnostic assessment, i.e., psychosocial history. The LMHP OR LMHP Resident/Supervisee will collect, review, and/or complete the Child and Adolescent Needs and Strengths Tool (CANS) and Adverse Childhood Experiences (ACEs) screening tool (note, only the Whole Child Assessment- ACEs only or the Center for Youth Wellness ACEs Questionnaire are allowed to be utilized for this required screening).
- A physician, who either: 1) actively sees this member for medical care 2) can be accessed through the youth's MCO; or 3) is identified by the locality as physician willing to engage in this process with identified youth. Physicians engaged in this process need to have knowledge of the service delivery system and are able to assess the youth's medical history and current status through either a face to face contact scheduled during the IACCT process or via their current health related knowledge of this youth including having seen the youth face to face in the last 13 months.
- The youth and family/legally authorized representative who are active participants in the assessment and decision-making process.
- It is expected that the team will also include representatives of local agencies and other supports involved in the child's plan of care who will provide information to the team regarding the youth's service history and current level of functioning.

Level A Group Home Level of Care (Service will end in 2018)

Current regulations establish three levels of residential care, i.e., Level A Group Home, Level B Group Home, and Level C Psychiatric Residential Treatment Facility. Research of the licensing requirements of DBHDS, DSS and Medicaid regulations indicates that DSS licensed Level A Group Homes will not be eligible for continued Medicaid reimbursement. Medicaid regulations require therapeutic group home programs to provide counseling services and

¹ Team members may participate in person or by teleconference

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therapeutic interventions. The therapeutic interventions are not an allowable service under the DSS licensure for Level A Group Homes.

Revised regulations establish two levels of residential care, i.e., Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH). Both levels of care require licensure by DBHDS.

In order to better align service delivery with federal mandates and licensing requirements Level A group homes who wish to provide Medicaid covered services must obtain a DBHDS license to provide Medicaid reimbursed therapeutic group home services.

During December, 2016 Level A Providers were instructed to contact DBHDS to indicate their interest in applying for licensure by February 1, 2017, DBHDS conducted an information session in January, 2017 to outline the transition process for Level A provider to become licensed as a Therapeutic Group Home. Providers should note that the DBHDS licensing process may take up to 12 months. Licensing Applications are due to DBHDS by June 30, 2017.

As of February 1, 2017 Magellan stopped enrolling new Level A providers with a DSS license. Current Level A providers who are contracted with Magellan have until April 30, 2018 to obtain a conditional license as defined by DBHDS in [12VAC35-46-90](#).

As of May 1, 2018 DMAS will cease reimbursement for therapeutic group home services provided by a DSS licensed facility.

Level A Group Home Requirements (Service will end in 2018)

- Community-Based Residential Services for Children and Adolescents under 21 (Level A) providers must be licensed by the DSS, Department of Juvenile Justice, or DBHDS under the Standards for Licensed Children's Residential Facilities (22VAC40-151), or Regulations for Children's Residential Facilities (12VAC35-46).
- These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.
- At least 50% of the direct care staff onsite at the group home must meet DBHDS paraprofessional staff criteria; and
- Services provided by qualified paraprofessionals require supervision of a Qualified Mental Health Professional (QMHP). Supervision is demonstrated by the QMHP by a review of progress notes, the member's progress towards achieving ISP goals, objectives, and recommendations for change based on the member's status. Supervision must occur and be documented monthly in the clinical record.
- Paraprofessionals who do not meet the experience requirements listed in this chapter may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and being supervised by a QMHP. Supervision must include on-site observation of services, face-to-face consultation with the paraprofessional, a review of the progress notes, the consumer's progress towards achieving ISP goals and objectives, and recommendations for change based on the member's status. Supervision must occur and be documented monthly in the clinical record.

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- The program director supervising the program/group home must be, at a minimum, a QMHP with a bachelor's degree and have at least one year of direct work with mental health clients. The program director must be employed full time.

FREEDOM OF CHOICE

The individual has the right to choose to receive services from any Medicaid-enrolled provider of services. However, payments under the Medical Assistance Program are limited to providers who meet the provider participation standards and who have signed a written agreement with the Department of Medical Assistance Services. Fee for service providers must have a signed provider contract with Magellan, meet the appropriate credentialing requirements, and adhere to Magellan policies and procedures.

PROVIDER ENROLLMENT

Each provider of services must be enrolled in the Medicaid Program or with the BHSA prior to billing for any services provided to Medicaid enrolled individuals. All providers must sign a Medicaid Provider Agreement or a BHSA contract. The signature must be an original signature. An agreement for specific psychiatric services must be signed by the authorized agent of the provider.

DMAS is informing the provider community that National Provider Identifier numbers (NPIs) may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share a provider's NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs.

As part of the supporting documentation for a psychiatric residential treatment provider, the BHSA must receive a signed letter of attestation from the Chief Executive Officer (CEO) of the facility stating that the facility is in compliance with the federal condition of participation of restraint and seclusion in psychiatric residential facilities (42 CFR §§ 483.350 – 483.376). If there is a change in CEOs, a new letter of attestation must be submitted. Letters are required at enrollment and annually thereafter. A sample letter of attestation can be found in the Exhibits section at the end of this chapter. Letters are due by 5 PM on July 1 or the first business day thereafter each year and are to be sent to:

Adherence to the regulations regarding restraint & seclusion, including the reporting of any serious incident involving any individual, is a condition of continued participation as a Medicaid provider. If the letter of attestation is not received by the BHSA by the due date, approval of new authorizations will not occur. Also, DMAS Utilization Review Audits will monitor for compliance with the provider contract with the BHSA.

For further information on requirements related to restraint and seclusion, refer to Chapter IV of this manual.

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Instructions for billing and specific details concerning the Medicaid Program are contained in this manual. Providers must comply with all sections of this manual, their provider agreement or BHSA contract and policies, and related state and federal regulations to maintain continuous participation in the Medicaid Program.

Out-of-State Facilities

Enrollment of providers for Psychiatric Residential Treatment Facilities and Therapeutic Group Homes are generally limited to those located in Virginia or within 50 miles of the state line. If an individual requires this level of service that is not available in Virginia, an out-of-state provider may enroll for a specific individual only for the duration of the admission. Out-of-state providers or Comprehensive Services Act Coordinators who are interested in obtaining Virginia Medicaid reimbursement for a specific individual may contact Magellan and provide information.

Specific information required for out-of-state placement consideration:

- Referral source and contact person
- Name and contact information, such as website, of the proposed placement
- Basic demographics of the individual (age, sex, current location, family involvement, Medicaid number)
- Description of the individual's current need for intensive psychiatric residential treatment, such as planned focus of treatment, problem behaviors, DSM diagnosis, medications, court involvement, previous treatments-successful or not, discharge summaries (within the past 6 months)
- Virginia Medicaid providers approached to access services for the individual and the outcomes (provide specific reasons for denial of admission)
- Discharge plan

Specific Information for Out-of-State Providers

Out of state providers are held to the same service authorization processing rules as in-state providers and must be enrolled with Magellan prior to submitting a request for out of state services for a specific individual only for the duration of the admission to the BHSA. If the provider is not enrolled as a participating provider, the provider is encouraged to submit the request to Magellan as timeliness of the request will be considered in the review process. Magellan will complete the service authorization review and will request the completion of enrollment documentation.

If Magellan receives the information in response to the provider's enrollment, the request will be completed and the provider will be informed of the status of their enrollment to serve the individual member.

If Magellan does not receive the information to complete the processing of enrollment within 12 business days, Magellan will reject the service authorization request and will

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not enroll the provider. It may take up to 10 business days to become a participating provider that is only serving a specific individual during the duration of admission.

REQUESTS FOR ENROLLMENT

All providers who wish to participate with Virginia Medicaid are being directed to complete their request via the online enrollment through our Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov.

Providers that wish to serve fee for service members for behavioral health services must contract with Magellan.

PROVIDER SCREENING REQUIREMENTS

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved by DMAS or Magellan for fee-for-service providers. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as “limited”, “moderate” or “high”. Please refer to the table at the end of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

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The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) Verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and revalidation process. Providers under contract with Magellan will receive notice from Magellan. **The application fee requirements are also outlined in Appendix section of this provider manual.**

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied. An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site

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visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

REVALIDATION REQUIREMENTS

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via DMAS' web portal or notice from Magellan for providers that are contracted with Magellan Registration into the Virginia Medicaid Web Portal will be required to access and use the online enrollment and revalidation system.

All enrolled providers in the Virginia Medicaid program will be notified in writing of a revalidation date and informed of the new provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, DMAS and Magellan may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

PARTICIPATION REQUIREMENTS

To be a network provider of behavioral health services with Magellan to serve members in the Virginia Medicaid/FAMIS programs, you or your agency must be credentialed and enrolled according to Magellan and DMAS standards, and must be contracted with Magellan. Providers are subject to applicable licensing requirements. Additionally, any licensed practitioner joining

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a contracted group practice or a contracted organization adding a newly licensed location must also become credentialed with Magellan prior to rendering services. To initiate the application process, providers can visit www.magellanofvirginia.com and click the “Join the Network” link under the *For Providers* tab on the homepage. Additional information regarding the credentialing criteria and contracting process can be reviewed in the Provider Handbook Supplement for Virginia Behavioral Health Service Administrator located at www.magellanofvirginia.com and click “Provider Handbook” link under the *For Providers* tab on the homepage.

All participating Medicaid providers are required to complete a new contract agreement as a result of any name change or change of ownership.

Upon completion of the enrollment process, a ten-digit Atypical Provider Identifier (API) will be assigned as the provider identification number for non-healthcare providers. Healthcare providers are required to submit their National Provider Identifier (NPI) number. The API or NPI number must be used on all claims and correspondence submitted to Magellan.

DMAS is informing the provider community that NPIs may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share your NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs.

This Medicaid provider manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual, their contract with Magellan, Magellan policies, and related state and federal regulations to maintain continuous participation in the Medicaid Program.

For any additional questions about credentialing and contracting, providers may contact a Magellan of Virginia Provider Network Coordinator at 1-800-424-4536, or send an email to VAProviderQuestions@MagellanHealth.com

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements/contracts, provider contracts, manuals, and related state and federal regulations. Behavioral Health providers approved for participation in the Magellan provider network must perform the following activities as well as any others specified by DMAS:

- Immediately notify Magellan in writing whenever there is a change in the information that the provider previously submitted, including adding new services, new service locations or changes in licensure. For a change of address, notify Magellan prior to the change and include the effective date of the change;
- Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as Magellan requires, a current Provider Enrollment Agreement for each

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Medicaid service that the provider offers.

- Send updated staff rosters no less that quarterly;
- Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;
- Assure the individual’s freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;
- Provide services, goods, and supplies to individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;
- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;
- Charge Magellan for the provision of services and supplies to individuals in amounts not to exceed the provider’s usual and customary charges to the general public;
- Not require, as a precondition for admission, any period of private pay or a deposit from the individual or any other party;
- Accept as payment in full the amount reimbursed by DMAS. 42 CFR § 447.15 provides that a “State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency” The provider should not attempt to collect from the individual or the individual’s responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses \$5.00 of an \$8.00 charge, and Medicaid’s allowance is \$5.00, the provider may not attempt to collect the \$3.00 difference from Medicaid, the individual, a spouse, or a responsible relative. The provider may not charge DMAS, Magellan or an individual for broken or missed appointments;
- Accept assignment of Medicare benefits for eligible Medicaid enrolled individuals;
- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;

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- Reimburse the individual or any other party for any monies contributed toward the individual's care from the date of eligibility. The only exception is when an individual is spending down excess resources to meet eligibility requirements;
- Use DMAS or Magellan-designated billing forms for submission of charges;
- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided;
- In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved;
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid members; and
- Hold information regarding Medicaid enrolled individuals confidential. A provider shall disclose information in his/her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. DMAS shall not disclose medical information to the public.

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

- Immediately notify in writing, whenever there is a change in any of the information that the provider previously submitted. Fee for Service providers must notify Magellan.
- Ensure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required service(s) and participating in the Medicaid Program at the time the service was performed;
- Ensure the individual's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended, (42 U.S.C. §§ 2000d through 2000d-4a) which requires that no individual be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the basis of race, color, or national origin;

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- Provide services, goods, and supplies to individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended, (29 U.S.C. § 794) which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;
- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;
- Charge DMAS or its contractors (MCOs and BHSA) for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public;
- Not require, as a precondition for admission, any period of private pay or a deposit from the individual or any other party;
- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;
- Serious incidents involving any individual must be reported to Magellan, DBHDS Licensing, and the Disability Law Center of Virginia (DLCV), the protection and advocacy system for persons with disabilities in the Commonwealth of Virginia. Serious incidents include an individual's death, suicide attempt, or a serious injury that requires medical attention. The incident does not need to be related to a restraint or seclusion. If an individual must go to the emergency room to address an injury while a resident of the facility, the report must be sent to Magellan. Providers contracted with Magellan should send incident reports by fax at 1-888-656-5396.

The fax must include the following information:

- Individual's name and Medicaid number;
 - Facility name, address, and NPI number;
 - Names of staff involved;
 - Detailed description of the incident, including the date and location of the incident;
 - Outcome, including the persons notified; and
 - Current location of the individual.
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable cost. 42 CFR § 447.15 states: "A State Plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill an individual for a covered service regardless of whether the provider received payment from the state. A provider may not seek to collect from a Medicaid

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enrolled individual, or any financially responsible relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered. If a third-party payer reimburses \$5.00 out of an \$8.00 charge, and Medicaid's allowance is \$5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the \$3.00 difference from Medicaid, the individual, a spouse, or a responsible relative. The provider may not charge DMAS, its contractors, or the individual for broken or missed appointments;

- Reimburse the individual or any other party for any monies contributed toward the individual's care from the date of eligibility. The only exception is when an individual is spending down excess resources to meet eligibility requirements;
- Accept assignment of Medicare benefits for eligible Medicaid enrolled individuals;
- Use program-designated billing forms for submission of charges;
- Maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved (refer to the section on documentation of records);
- Furnish to authorized state and federal personnel access to records and facilities in the form and manner requested;
- Disclose, as requested by DMAS or Magellan, all financial, beneficial ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to individuals receiving medical assistance; and
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding Medicaid enrolled individuals. A provider shall disclose information in his or her possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of the state agency, DMAS or its contractors DMAS shall not disclose medical information to the public.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

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

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

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

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

DMAS
Attn: Program Integrity/Exclusions 600 E. Broad St, Ste 1300
Richmond, VA 23219

-or-

E-mailed to: providerexclusions@dmas.virginia.gov

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. § 794) provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. Each Medicaid participating provider is responsible for making provisions for such disabled individuals in the provider's programs and activities.

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

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

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requirements.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under medical assistance shall be reduced to the extent that they are available through: other federal, state, or local programs; coverage provided under federal or state law; other insurance; or third party liability.

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

- Title XVIII (Medicare) - Virginia Medicaid will pay the amount of any deductible or coinsurance up to the Medicaid limits for covered health care benefits under Title XVIII of the Social Security Act (42 U.S.C. §§ 1395 through 1395ggg) for all eligible individuals covered by Medicare and Medicaid.
- Workers' Compensation - No Medicaid program payments shall be made for an individual covered by workers' compensation.
- Other Health Insurance - When an individual has other health insurance (such as CHAMPUS, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.
- Liability Insurance for Accidental Injuries - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid enrolled individuals who receive medical care as the result of the negligence of another. If an individual is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to enforce any lien that may exist under § 8.01-66.9:1 of the Code of Virginia. In liability cases, providers may choose to bill the third party carrier or file a lien in lieu of billing Medicaid.
- In the case of an accident in which there is a possibility of third-party liability or if the individual reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and regardless of whether or not Medicaid is billed by the provider for rendered services related to the accident, the facility is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Unit, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

ASSIGNMENT OF BENEFITS

If an individual enrolled in the Virginia Medical Assistance Program is the holder of an

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insurance policy which assigns benefits directly to the individual, the facility must require that benefits be assigned to the facility or refuse the request for the itemized bill that is necessary for the collection of the benefits.

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION

A required physician signature for Medicaid purposes may include signatures, written initials, computer entries, or rubber stamps initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the *Physician Manual* issued by DMAS and review Chapter VI in this manual for information on medical record documentation and retention for psychiatric services.

FRAUD

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain, or items of value for services rendered or supposedly rendered to individuals reenrolled in Medicaid. A provider participation agreement or contract will be terminated or denied when a provider is found guilty of fraud.

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

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

TERMINATION OF PROVIDER PARTICIPATION

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

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and FH-PEU 30 days prior to the effective date. The addresses are:

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

Virginia Medicaid –PES
PO Box 26803

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Richmond, Virginia 23261-6803

DMAS may terminate a provider's agreement to participate with Virginia Medicaid with thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

Any provider losing JCAHO accreditation will be notified of DMAS termination if their eligibility as an enrolled provider of a specific service required JCAHO accreditation. DMAS can rescind the termination of the provider agreement if accreditation is restored; however, Medicaid reimbursement will not be available for any period during which the provider does not meet DMAS provider participation standards.

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

Providers under contract with the BHSA should consult with the BHSA.

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325D and E. The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code §[2.2-4000](#) et seq.) the State Plan for Medical Assistance provided for in § 32.1-325 et. seq. of the Code of Virginia and the DMAS appeal regulations at 12 VAC 30-20-500 et. seq. Such a request must be in writing and must be filed with the DMAS Appeals Division **within 15 calendar days** of the receipt of the notice of termination or denial.

Providers under contract with the BHSA should also consult with the BHSA.

APPEALS OF ADVERSE ACTIONS

Provider Appeals

Non-State Operated Provider

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

A provider may appeal an adverse decision where a service has already been provided, by filing a written notice for a first-level Informal Appeal with the DMAS Appeals Division

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within 30 calendar days of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 6th Floor
Richmond, VA 23219

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

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 6th Floor
Richmond, VA 23219

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

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

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

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

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1.

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Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

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

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

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 days of receipt of the decision, or within 15 days of receipt of the notice of termination or denial of enrollment of their Medicaid agreement pursuant to §32.1-325D of the Code of Virginia, or within 90 days of receipt of the notice of program reimbursement of a cost report. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

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

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

Providers under contract with the BHSA should consult with the BHSA.

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CLIENT APPEALS

For client appeals information, see Chapter III of the Provider Manual.

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Facility Providers

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**SAMPLE ATTESTATION LETTER
(Submit on Facility Letterhead)**

(Date)

Provider Enrollment BHSA
Address Line 1
Address Line 2 City, State Zip Code

By this letter, I am attesting that I have read the interim final rule and federal regulations for Seclusion and Restraint for Psychiatric Residential Treatment Facilities for Recipients under 21 and that my facility is in compliance with the Centers for Medicare and Medicaid Services (CMS) rule. The regulations begin at 42 CFR 483.350 (Subpart G).

Facility Director

Facility Name

Medicaid Provider Number

Address

Sincerely,

Facility Director/Date