TO: All Substance Use Disorder Providers, Prescribers, Managed Care Organizations (MCOs) and Magellan of Virginia Participating in the Virginia Medical Assistance Program

FROM: Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services (DMAS)

MEMO: Special
DATE: 6/8/18

SUBJECT: Updates to the ARTS Service Authorization for ASAM Levels 2.1 to 4.0 – Effective July 1, 2018; and Information for Providers on Virginia Medicaid’s Implementation of the Centers for Medicare and Medicaid Services (CMS) Requirement for Medicated Assisted Treatment (MAT) in Addiction and Recovery Treatment Services (ARTS) Intensive Outpatient Programs, Partial Hospitalization Programs, and Residential Treatment Settings (RTS) – Effective December 1, 2018

The purpose of this memorandum is to inform Substance Use Disorder (SUD) providers of the update to the Addiction and Recovery Treatment Services (ARTS) Service Authorization Form effective July 1, 2018.

This memo also serves to notify the SUD providers for: Intensive Outpatient Programs (IOPs)/American Society of Addiction Medicine (ASAM) Level 2.1; Partial Hospitalization Programs (PHPs) (ASAM Level 2.5); and Residential Treatment Service (RTS) programs (ASAM Levels 3.3, 3.5 and 3.7) about a new requirement implemented by the Centers for Medicare and Medicaid Services (CMS) for States that have obtained a 1115 SUD Demonstration Waiver. This CMS requirement was detailed in a letter to State Medicaid Directors. CMS published requirements that “residential treatment facilities offer Medication Assisted Treatment (MAT) on site or facilitate access off-site” (Table 1, Milestone 3, specification 3). The letter also stated that there be “sufficient provider capacity at critical levels of care, including for MAT for Opioid Use Disorder (OUD)” (Table 1, Milestone 4). (https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf) This memo describes the changes needed to meet the CMS requirements.

**Update to the ARTS Service Authorization for ASAM Levels 2.1 to 4.0**
DMAS, DMAS contracted Managed Care Organizations (MCOs), and the DMAS contracted Behavioral Health Services Administrator (BHSA), along with providers, recognize MAT as the standard of care for OUD. Thus, effective July 1, 2018, DMAS and its contractors will require documentation on the ARTS Service Authorization for ASAM Levels 2.1 to 4.0 Form that the
provider has assessed for MAT and performed all service coordination necessary to ensure the member receives MAT, if that is the member’s choice of treatment and determined medically necessary. MAT shall include access to Buprenorphine containing products or Vivitrol (naltrexone extended-release injectable suspension), or to Methadone dispensed by Opioid Treatment Programs licensed by the Department of Behavioral Health and Developmental Services (DBHDS).

**Requirement that Intensive Outpatient Programs (IOPs), Partial Hospitalization Programs (PHPs), and Residential Treatment Services (RTS) ensure access to MAT**

Effective December 1, 2018, IOPs, PHPs and RTS Medicaid providers shall ensure that Medicaid and FAMIS enrolled members with OUD admitted to any of these programs have access to evidence-based MAT, including buprenorphine. This requirement is grounded in substantial evidence that has shown that MAT, when used for those recently discharged from institutional settings, is effective by sustaining recovery and reducing the likelihood of death by overdose, due to the loss of tolerance to opioids during treatment. The use of MAT has shown reductions in the overdose death rate of 75% compared to no MAT. MAT provides life-saving medication options, which DMAS requires providers to make available to these individuals while in treatment in these levels of care, not after they have been stepped down to outpatient (ASAM Level 1.0) treatment and/or discharged back to the community. To discharge individuals from these programs who are considered to have an elevated risk of overdose, without having access to MAT as medically necessary, is not evidenced based practice since MAT is the recognized and accepted standard of care for individuals with OUD. Thus, DMAS requires that discharge planning for these individuals shall document realistic plans for the continuity of MAT services with an in-network Medicaid provider.

DMAS will issue a new survey via Survey Monkey for IOP, PHP and RTS providers to attest to meeting these requirements which shall be completed by October 1, 2018. IOP, PHP and RTS providers will also need to document how they met this requirement on the ARTS ASAM Level 2.1 to 4.0 Service Authorization Form as indicated in this memo. The new ARTS ASAM Level 2.1 to 4.0 Service Authorization Form will be posted online at [http://www.dmas.virginia.gov/Content_pgs/bh-sa.aspx](http://www.dmas.virginia.gov/Content_pgs/bh-sa.aspx) and shall be used beginning July 1, 2018. Providers who are initiating becoming an ARTS provider for ASAM Level 2.1 to 3.7 will need to submit the updated ARTS Attestation Form for ASAM Level 2.1 to 3.7 located online at [http://www.dmas.virginia.gov/Content_pgs/bh-cred.aspx](http://www.dmas.virginia.gov/Content_pgs/bh-cred.aspx) as of July 1, 2018.

Please note that the ARTS rates for IOP and PHP providers are designed to build an infrastructure for quality care. This includes the assurance of member access to MAT, the evidence-based treatment for opioid use disorder. DMAS will work with the MCOs to develop accountability using financial incentives. In the future, payment of the full ARTS rates will require providers to meet structural requirements, report quality and outcome metrics, and have a significant portion of payments at risk. By 2020, providers must meet thresholds for process and outcome measures. Two of the key measures that will determine payment rates will be the percent of members with opioid use disorder who receive MAT in an IOP, PHP, or RTS program and the percent of members who are discharged from an IOP, PHP, or RTS program with sufficient discharge planning. Sufficient discharge planning will include, at minimum, scheduling appointments with outpatient MAT providers and “warm hand-offs” to these providers to ensure
continuity of care beyond the IOP, PHP, and RTS settings. The MCOs will also be encouraged to develop risk-based alternative payment models such as bundled payments and medical homes. These value-based payments will support the goal of the ARTS program.

The goal of the ARTS program is to improve access to high quality, clinically appropriate treatment for OUD and other SUDs. A significant improvement in access to OUD and SUD treatment was approval of the 1115 Waiver by CMS, which allows DMAS to cover SUD treatment in RTS settings with greater than 16 beds (Institutions of Mental Disease or IMDs). With approval of the 1115 Waiver, CMS requires Virginia to demonstrate how the inpatient and residential levels of care will supplement and coordinate with community based care to ensure a robust continuum of care. Over the course of the 1115 Waiver, CMS is requiring DMAS to report on specific milestones and measures demonstrating progress toward meeting the goals for this demonstration. Federal Medicaid funds for services in IMDs may be withheld if Virginia is not making adequate progress meeting milestones such as ensuring that all Medicaid members in ASAM Levels of Care have access to MAT.

Specific Requirements for Residential Treatment Services

All ARTS residential treatment providers (ASAM Levels 3.3, 3.5, and 3.7) are strongly encouraged to employ or contract with buprenorphine waivered practitioners, and/or to ensure their prescribers already on staff obtain their buprenorphine waiver, so they can provide access to MAT on-site at their facility. If these programs can demonstrate that they are unable to hire a buprenorphine-waivered practitioner and if their current practitioners are unwilling to obtain their buprenorphine waiver despite recognition that MAT is the standard of care for OUD, residential treatment providers may fulfill this CMS requirement by coordinating care with outpatient MAT providers. These outpatient MAT providers include Preferred Office-Based Opioid Treatment (OBOT) Providers, Community Services Boards (CSB), Opioid Treatment Programs (OTP), or in-network Medicaid buprenorphine waiver practitioners. The residential treatment setting will be required to facilitate access to the off-site MAT provider; this includes, but is not limiting to, scheduling appointments and arranging transportation to all MAT related appointments and needs.

All ARTS residential treatment providers will also be required to ensure that members with OUD receive discharge planning that includes scheduling appointments with outpatient MAT providers and steps completed to ensure “warm hand-offs” to these providers. These outpatient MAT providers can include Preferred OBOTs, CSBs, OTPs, or in-network Medicaid buprenorphine waiver practitioners. Please visit http://www.dmas.virginia.gov/Content_pgs/bh-meet.aspx for a map to locate nearby outpatient MAT providers who you can contact. The ARTS website also has a list of the ARTS providers, including Preferred OBOTs and OTPs, in each region.

If the member refuses or does not follow through with the coordinated appointments, the provider shall document in the medical record the strategies attempted to address the barriers to treatment. This will support the provider meeting the DMAS requirements for care coordination to access MAT, as well as the documentation of the potential barriers for the member’s treatment compliance.
Specific Requirements for IOP and PHP Services
IOPs and PHPs are considered critical levels of care. Thus, DMAS will require IOP and PHP providers to meet the CMS requirements for offering or coordinating access for members to receive evidenced based MAT. IOP and PHP providers may utilize outpatient MAT providers as indicated in the section above to meet this requirement.

Similar to residential treatment providers, all ARTS IOP and PHP providers will also be required to ensure that members with OUD receive discharge planning including scheduling appointments with outpatient MAT providers and steps completed to ensure “warm hand-offs” to these providers. These outpatient MAT providers can include Preferred OBOTs, CSBs, OTPs, or innetwork Medicaid buprenorphine waiver practitioners. Please visit http://www.dmas.virginia.gov/Content_pgs/bh-meet.aspx for a map to locate nearby outpatient MAT providers who you can contact. The ARTS website also has a list of the ARTS providers, including Preferred OBOTs and OTPs, in each region.

Buprenorphine Waiver Management Trainings and Other Supports for ARTS Providers
DMAS recognizes that ARTS providers may experience challenges in hiring buprenorphine waivered practitioners, especially in regions of the Commonwealth with provider shortages. DMAS and the contracted MCOs and BHSA will work with ARTS providers who are experiencing difficulty securing these practitioners, to help identify and link existing buprenorphine waivered prescribers who are already participating with MCOs and the BHSA.

DMAS, the Virginia Department of Health, and the American Society of Addiction Medicine are collaborating for a virtual "live" Medication Assisted Treatment waiver training, available for physicians, nurse practitioners, and physician assistants interested in seeking their waiver to prescribe buprenorphine in the treatment of opioid use disorders. This session will deliver the required live portion of the total training hours. Following the training, participants who have successfully completed their course may apply to the Substance Abuse and Mental Health Services Administration (SAMHSA) to obtain their waiver. These trainings can assist prescribers already on staff at your facility with obtaining their buprenorphine waiver in order to meet the December 1, 2018 deadline. Please save the date for one of these trainings starting this summer: July 6, 2018, August 3, 2018, September 7, 2018, October 19, 2018, and November 2, 2018. More information will be provided soon, which will include links to the required online portion of the total training hours. Additionally, links to connect to the virtual training will be posted online at: http://www.dmas.virginia.gov/Content_pgs/bh-meet.aspx.

Prescribers can also obtain the required training for their buprenorphine waiver (8 hours for physicians and 24 hours for nurse practitioners and physician assistants) online. For more information on online training opportunities, please visit: https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver

Preferred Medication Assisted Treatment (MAT) Providers - An Opportunity to Waive Prior Authorizations for Buprenorphine-Containing Products
ARTS IOP (ASAM Level 2.1), PHP (ASAM Level 2.5) and RTS providers (ASAM Levels 3.3, 3.5 and 3.7) who are providing MAT and who are currently credentialed with the MCO or the BHSA to provide ARTS services, can apply to be recognized by DMAS as a “Preferred Medication
Assisted Treatment Provider.” The Preferred MAT status will allow the buprenorphine waivered practitioners at the facility to prescribe buprenorphine-containing products without completing service authorizations for preferred buprenorphine products prescribed at daily doses of 16 mg or less. The prescriptions can be filled by a local pharmacy. The Preferred MAT provider must meet the service requirements documented in the Opioid Treatment Services Supplement located online at: http://www.dmas.virginia.gov/Content_pgs/bh-pm.aspx. The Preferred Medication Assisted Treatment Provider application is located online at: http://www.dmas.virginia.gov/Content_pgs/bh-cred.aspx.

If a provider is interested in Preferred MAT status, please complete the application and fax to DMAS: 804-452-5450 for the panel of addiction credentialed physicians to review.

If DMAS approves the application, DMAS will notify the MCOs and the BHSA that the provider now has Preferred MAT status. The residential treatment providers will also need to submit applications for the individual buprenorphine waivered practitioners to be credentialed by the MCOs and the BHSA if they are not already credentialed. The MCO Network staff are located online at: http://www.dmas.virginia.gov/Content_pgs/bh-cred.aspx.

The 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. For fee-for-service members, the practitioner will need to be enrolled with DMAS at a minimum as an “Ordering, Referring or Prescribing (ORP)” provider. More information may be located online at: www.virginiamedicaid.dmas.virginia.gov under Provider Services / Provider Enrollment. The provider may also meet this requirement by credentialing with the BHSA. For serving members enrolled in managed care, the provider must credential with the individual MCO. The BHSA and MCO Network contacts may be located online at: ARTS Network Relations Contacts.

**Licensing and Reimbursement Information**

Providers of MAT services are not required to obtain a DBHDS OTP license in order to prescribe buprenorphine products. Please review the DBHDS Guidance Document “Opioid/Medication Assisted Treatment License & Oversight” here, for more information. DMAS offers separate reimbursement for MAT services (e.g., physician visits, labs, urine drug screens, etc.) provided in residential treatment settings. Please see the attached Table 1 for the MAT Billing Codes and Authorization Chart for MAT services provided by IOP/ASAM Level 2.1, PHP/ASAM Level 2.5, and Residential Treatment Services/ASAM Levels 3.1, 3.3, 3.5, and 3.7.

Please see the attached Table 2 describing which MAT services can be billed by each ASAM level of care in community-based vs. facility settings.

If you have any questions concerning the relevant DMAS policy cited in this memorandum, please contact the SUD email address at SUD@dmas.virginia.gov.

**Attachment 1:** Table 1: MAT Billing and Authorization Chart

**Attachment 2:** Table 2: MAT Provided Simultaneously and Approved to be Reimbursed Separately from other ASAM Levels of Care
MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Most Medicaid individuals are enrolled in one of the Department’s managed care programs: Medallion 3.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual’s managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0:
- Medallion 4.0:
  http://www.dmas.virginia.gov/Content_pgs/medallion_4-home.aspx
- Commonwealth Coordinated Care Plus (CCC Plus):
- Program of All-Inclusive Care for the Elderly (PACE):

COMMONWEALTH COORDINATED CARE PLUS

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long-term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.
KEPRO PROVIDER PORTAL
Providers may access service authorization information including status via KEPRO’s Provider Portal at http://dmas.kepro.com.”

The “HELPLINE” is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The “HELPLINE” numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the “HELPLINE” is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE
There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx and the form can be accessed from there by clicking on, “Click here to download a Provider Appeal Request Form.” The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

PROVIDERS: NEW MEDICARE CARDS ARE COMING
CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1st.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

MEMBERS: NEW MEDICARE CARDS ARE COMING
Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that’s unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link: https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html
<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Service Name</th>
<th>Prior Authorization Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99205</td>
<td>Evaluation and management services new patient</td>
<td>No</td>
</tr>
<tr>
<td>99211-99215</td>
<td>Evaluation and management services established patient</td>
<td>No</td>
</tr>
<tr>
<td>82075</td>
<td>Alcohol Breathalyzer</td>
<td>No</td>
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<tr>
<td>80305-80307</td>
<td>Presumptive drug class screening, any drug class</td>
<td>No</td>
</tr>
<tr>
<td>G0480-G0483</td>
<td>Definitive drug classes</td>
<td>No</td>
</tr>
<tr>
<td>86592</td>
<td>RPR Test</td>
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</tr>
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<td>86593</td>
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</tr>
<tr>
<td>86780</td>
<td></td>
<td></td>
</tr>
<tr>
<td>86704</td>
<td>Hepatitis B and C / HIV Tests</td>
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<td>86803</td>
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<td>86701</td>
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<tr>
<td>81025</td>
<td>Pregnancy Test</td>
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<td>86580</td>
<td>TB Test</td>
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<td>93000</td>
<td>EKG</td>
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<tr>
<td>93005</td>
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</tr>
<tr>
<td>93010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90832 – alone or GT (w/o E&amp;M)</td>
<td>Psychotherapy, 30 minutes with patient and/or family member</td>
<td>No</td>
</tr>
<tr>
<td>90833 – alone or GT (w/ E&amp;M)</td>
<td>Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service</td>
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</tr>
<tr>
<td>Billing Code</td>
<td>Service Name</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>90834 – alone or GT</td>
<td>Psychotherapy, 45 minutes with patient and/or family member</td>
<td>No</td>
</tr>
<tr>
<td>(w/o E&amp;M)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90836 – alone or GT</td>
<td>Psychotherapy, 45 minutes with patient and/or family member when performed</td>
<td>No</td>
</tr>
<tr>
<td>(w/ E&amp;M)</td>
<td>with an evaluation and management service</td>
<td></td>
</tr>
<tr>
<td>90837 – alone or GT</td>
<td>Psychotherapy, 60 minutes with patient and/or family member</td>
<td>No</td>
</tr>
<tr>
<td>(w/o E&amp;M)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90838 – alone or GT</td>
<td>Psychotherapy, 60 minutes with patient and/or family member when performed</td>
<td>No</td>
</tr>
<tr>
<td>(w/ E&amp;M)</td>
<td>with an evaluation and management service</td>
<td></td>
</tr>
<tr>
<td>90846 alone or GT</td>
<td>Family psychotherapy (without patient present)</td>
<td>No</td>
</tr>
<tr>
<td>or GT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90847 – alone, GT or</td>
<td>Family psychotherapy (with patient present)</td>
<td>No</td>
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<tr>
<td>HF if SA</td>
<td></td>
<td></td>
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<tr>
<td>90853 – alone, GT or</td>
<td>Group psychotherapy (other than multi-family)</td>
<td>No</td>
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<tr>
<td>HF if SA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90863 – alone, GT or</td>
<td>Pharmacologic management, including prescription and review of medication,</td>
<td>No</td>
</tr>
<tr>
<td>HF if SA</td>
<td>when performed with psychotherapy services</td>
<td></td>
</tr>
<tr>
<td>Q3014 – GT</td>
<td>Telehealth originating site facility fee</td>
<td>No</td>
</tr>
</tbody>
</table>
### Table 2
Medication Assisted Treatment
Provided Simultaneously and Approved to be Reimbursed Separately from other ASAM Levels of Care

<table>
<thead>
<tr>
<th>MAT Services</th>
<th>Procedure Code</th>
<th>ASAM Level 2.1 and 2.5</th>
<th>ASAM Level 3.1 Group Home</th>
<th>ASAM Level 3.3 RTS</th>
<th>ASAM Level 3.5 Inpt Psych Unit (sub-acute)</th>
<th>ASAM Level 3.7 Inpt Psych Unit (sub-acute)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner Induction Day 1</td>
<td>OBOT/OTP -H0014 Non OBOT/OTP = E&amp;M Codes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Practitioner Visits after Day 1 (OBOT/OTP and non-OBOT/OTP)</td>
<td>E&amp;M Codes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychotherapy* for MAT</td>
<td>CPT Psychotherapy Codes</td>
<td>No, included in IOP/PHP rate</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Medications</td>
<td>Prescription filled at Pharmacy or Dispensed on site = HCPCS Codes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Urine drug screens</td>
<td>80305 - 80307</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Labs</td>
<td>CPT Codes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>G9012</td>
<td>No, included in IOP/PHP rate</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*MAT psychotherapy must be provided by the providers of ASAM Level of Care 2.1 – 4.0 and requires a credentialed addiction treatment professional practicing within the scope of their license. This does not replace the minimum requirements for psychotherapy as required in RTS. Professionally qualified practitioners affiliated with RTS providers may bill additional psychotherapy as an ancillary service.
TO: All Substance Use Disorder Providers, Prescribers, Managed Care Organizations (MCOs) and Magellan of Virginia Participating in the Virginia Medical Assistance Program

FROM: Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services (DMAS)

MEMO: Special
DATE: 9/20/18

SUBJECT: Addiction and Recovery Treatment Services (ARTS) Updates

The purpose of this memorandum is to provide ARTS providers with several updates including:

- The link to the required Medication Assisted Treatment (MAT) survey for ARTS Intensive Outpatient Programs (IOPs), Partial Hospitalization Programs (PHPs) and Residential Treatment Service (RTS) providers – due by October 1, 2018.
- The removal of the prior authorization for preferred/formulary buprenorphine/naloxone drugs written by buprenorphine waivered providers (BWP) affiliated with a Preferred Office-Based Opioid Treatment (OBOT) and in-network (credentialed) BWPs when prescribed in dosages of 16 mg or less per day;
- The recognition of the update to the Code of Virginia allowing certain Nurse Practitioners to practice independently from a Physician; and
- Free Monthly Buprenorphine Waiver trainings for physicians, nurse practitioners, and physician assistants.

Requirement that IOPs, PHPs, and RTS Providers Ensure Access to MAT

DMAS issued a Provider Memo on June 8, 2018 informing Medicaid providers of the below requirements:

Effective December 1, 2018, IOP, PHP and RTS Medicaid providers shall ensure that Medicaid and FAMIS enrolled members with an Opioid Use Disorder (OUD) admitted to any of these programs have access to evidence-based MAT, including buprenorphine. This requirement is grounded in substantial evidence that has shown that MAT, when used for those recently discharged from institutional settings, is effective by sustaining recovery and reducing the likelihood of death by overdose, due to the loss of tolerance to opioids during treatment. DMAS requires that discharge planning for these individuals shall document realistic plans for the continuity of MAT services with an in-network Medicaid provider.
DMAS is requiring ARTS IOP, PHP and RTS providers to complete a survey via Survey Monkey to attest to meeting these requirements established in the June 8, 2018 Provider Memo. **This survey shall be completed by October 1, 2018.** The link to the survey is: [https://www.surveymonkey.com/r/G2VXTBP](https://www.surveymonkey.com/r/G2VXTBP)

**Removal of Prior Authorization and Preferred Products for Buprenorphine**

Beginning October 1, 2018, DMAS will require all Managed Care Organizations (MCOs) to remove the prior authorization for preferred/formulary buprenorphine/naloxone drugs written by in-network (credentialed) buprenorphine waivered providers (BWP) affiliated with a Preferred Office-Based Opioid Treatment (OBOT) and in-network (credentialed) BWPs when prescribed in dosages of 16 mg or less per day. In-network BWPs and Preferred OBOTs will be required to submit a prior authorization for daily dosages greater than 16 mg/day and non-preferred buprenorphine containing drugs.

A prior authorization is **required** for the buprenorphine mono-product when prescribed by in-network BWPs. The prior authorization for the buprenorphine mono-product is **waived from in-network BWPs affiliated with a Preferred OBOT** when prescribed in dosages of 16 mg or less per day. DMAS expects all providers to comply with the [Board of Medicine Regulations Governing Prescribing of Opioids and Buprenorphine](https://www.boardofmedicine.virginia.gov/Regulations/PrescribingofOpioidsandBuprenorphine) (click [here](https://www.boardofmedicine.virginia.gov/Regulations/PrescribingofOpioidsandBuprenorphine) for the Board of Medicine website). The Common Core Formulary (CCF) will be effective on December 1, 2018, for all members in the Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus Managed Care health plans as well as the Medicaid Fee-for-Service program. The CCF will include the following preferred/formulary opioid dependency drugs: Suboxone®, buprenorphine SL tablets, naltrexone tablets, and Vivitrol®.

The Medicaid Managed Care health plans will continue to assign members receiving treatment for OUD to in-network BWPs and preferentially to in-network Preferred OBOTs because of the comprehensive services including medication, counseling, and “high touch” care coordination that the Preferred OBOTs provide.

**Nurse Practitioners**

DMAS recognizes the recently updated Virginia Code §54.1-2957(I), that nurse practitioners who provide attestation to the Boards of Medicine and Nursing that they have completed the equivalent of at least five years of full time clinical experience, may practice without a practice agreement with a patient care team physician. Nurse Practitioners must contact the Medicaid Managed Care health plans directly regarding any updates to their contract as necessary.

**Buprenorphine Waiver Trainings**

DMAS, the Virginia Department of Health, and the American Society of Addiction Medicine (ASAM) are collaborating to offer a virtual "live" course that will cover all medications and treatments for OUD. This course provides the required education needed to obtain the waiver to prescribe buprenorphine.

This course is available for physicians, nurse practitioners, and physician assistants interested in seeking their waiver to prescribe buprenorphine in the treatment of OUD. This online session will deliver the required live portion of the total training hours. Participants will receive a link to complete an additional 4 hours of training online after the live training. Following the training, participants who have successfully completed their required training hours (8-hour course for physicians and 24 hours for nurse practitioners and physician assistants) may apply to the Substance Abuse and Mental Health Services Administration (SAMHSA) to obtain their buprenorphine waiver.
The registration links are available here: [http://www.dmas.virginia.gov/#/artstraining](http://www.dmas.virginia.gov/#/artstraining). You will receive an email confirmation once you have registered. Following this confirmation email from ASAM, you will receive an email from DMAS with the link for the live training.

Please see the dates for the remainder scheduled trainings below:

- **October 19, 2018** 11 a.m.-3:00 p.m.
- **November 2, 2018** 11 a.m.-3:00 p.m.

If you have any questions concerning the relevant DMAS policy cited in this memorandum, please contact the SUD email address at [SUD@dmas.virginia.gov](mailto:SUD@dmas.virginia.gov).

**MAGELLEN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)**

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting [www.MagellanHealth.com/Provider](http://www.MagellanHealth.com/Provider). If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting [www.magellanofvirginia.com](http://www.magellanofvirginia.com) or submitting questions to [VAPrviderQuestions@MagellanHealth.com](mailto:VAPrviderQuestions@MagellanHealth.com).

**MANAGED CARE PROGRAMS**

Most Medicaid individuals are enrolled in one of the Department’s managed care programs: Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual’s managed care plan/PACE provider directly.

Contact information for managed care plans can be found on the DMAS website for each program as follows:

- Medallion 4.0: [http://www.dmas.virginia.gov/#/med4](http://www.dmas.virginia.gov/#/med4)
- Program of All-Inclusive Care for the Elderly (PACE) [http://www.dmas.virginia.gov/#/longtermprograms](http://www.dmas.virginia.gov/#/longtermprograms)

**COMMONWEALTH COORDINATED CARE PLUS**

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: [http://www.dmas.virginia.gov/#/ccplus](http://www.dmas.virginia.gov/#/ccplus)

**VIRGINIA MEDICAID WEB PORTAL**

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: [www.virginiamedicaid.dmas.virginia.gov](http://www.virginiamedicaid.dmas.virginia.gov). If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except
holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

**KEPRO PROVIDER PORTAL**
Providers may access service authorization information including status via KEPRO’s Provider Portal at https://providerportal.kepro.com/Account/Login.aspx?ReturnUrl=%2f

**HEPLINE**
The “HEPLINE” is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The “HEPLINE” numbers are:

- 1-804-786-6273 Richmond area and out-of-state long distance
- 1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the “HEPLINE” is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

**TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE**
There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is [http://www.dmas.virginia.gov/#/appealsresources](http://www.dmas.virginia.gov/#/appealsresources) and the form can be accessed from there by clicking on, “Provider Appeal Request Form.” The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

**PROVIDERS: NEW MEDICARE CARDS ARE COMING**
CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1st.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

**MEMBERS: NEW MEDICARE CARDS ARE COMING**
Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that is unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link: [https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html](https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html)
TO: All Substance Use Disorder Providers, Managed Care Organizations (MCOs) and Magellan of Virginia Participating in the Virginia Medical Assistance Program

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 10/12/17

SUBJECT: Clarification on Residential Levels of Care in the Addiction and Recovery Treatment Service (ARTS) Benefit

On April 1, 2017, the Department of Medical Assistance Services (DMAS) launched an enhanced substance use disorder treatment benefit - Addiction and Recovery Treatment Services (ARTS). The ARTS benefit provides treatment for those with substance use disorders across the state. The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, FAMIS, FAMIS MOMS and the Governor’s Access Plan (GAP) including expanded community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment.

Prior to the implementation of ARTS, DMAS applied for and was approved by the Centers for Medicare and Medicaid Services (CMS) for a 1115 Demonstration Waiver. The waiver allowed DMAS to avoid the federal limitation of not funding residential facilities that meet the federal definition of an Institution for Mental Disease (IMD) under the ARTS benefit for members between the ages of 21 and 64. The State Medicaid Manual, published by CMS, defines an IMD as “…a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.” Thus, with the ARTS Waiver, CMS is allowing DMAS to cover short term residential services in facilities that meet the definition of an IMD for the treatment of substance use disorders and withdrawal management. However, with the approval of the waiver, CMS has several requirements for DMAS to meet in order to continue to receive federal funding for the payment of substance use disorder treatment services in these IMD settings.

The purpose of this memorandum is to share with providers the CMS requirements that DMAS must meet for the ARTS residential benefit, specifically the American Society of Addiction Medicine (ASAM) Levels 3.1, 3.3, 3.5 and 3.7.

Residential Services Length of Stay
CMS requires that any member receiving residential substance use disorder services pursuant to the ARTS demonstration, regardless of the length of stay or the bed size of the facility, be a “short-term resident” of the residential or inpatient facility in which they are receiving the services. Short-term residential treatment is defined as a statewide average length of stay of 30 days. CMS further stated residential treatment services should be provided as medically necessary as determined by an independent party consistent with the ASAM...
assessment, detailed in the “Service Authorization for Residential Services” section in this memorandum. CMS requires DMAS to track and report members who are receiving residential levels of care. DMAS will utilize weighted averages to take into consideration those members with higher levels of need, such as members who are pregnant and receiving residential levels of care. As of September 22, 2017, CMS removed the maximum limit of days in residential or inpatient facilities including any individual admitted into a facility who is certified as meeting ASAM Level 3.1, 3.3, 3.5 or 3.7, as long as DMAS meets the statewide 30-day average lengths of stay. Thus is it imperative that providers begin planning and preparing with the member for the transition from the current level of care to other appropriate levels of care when the member no longer requires the current level of care based on ASAM Criteria 3rd Edition.

Discharge Planning
Since CMS requires “short term” residential stays, providers shall begin planning for the member’s discharge at time of their admission. Thus, all comprehensive individual service plans (ISPs) for residential levels of care shall include an individualized discharge plan to the most appropriate ASAM Level of Care based on the multidimensional assessment. Anticipated discharge plans are documented at the start of treatment. The discharge plan describes the discharge planning activities, summarizes an estimated timetable to achieving the goals and objectives in the service plan, and includes discharge plans that are kept current and specific to the needs of the member. The discharge plan shall address the plan for transitioning from an appropriate residential ASAM Levels of Care to a lower ASAM Levels of Care.

Service Authorization for Residential Services
CMS requires an independent third party to review all requests for residential levels of care to determine if members meet medical necessity based on ASAM Criteria 3rd Edition. CMS requires DMAS to contract with each of the managed care organizations (MCOs) and Magellan of Virginia for ARTS Care Coordinators, physician reviewers and medical directors to perform these independent reviews. Practitioners reviewing these service authorization requests must determine the appropriate level of care and length of stay recommendations based upon the ASAM Criteria 3rd Edition and the multidimensional assessment to match severity and level of function with type and intensity of service for adults and adolescents. DMAS requires the ARTS Care Coordinators, physician reviewers or medical directors to document the use of the ASAM multidimensional assessment and matrices for matching severity with type and intensity of services based on the ARTS Uniform Service Authorization form.

ASAM specifies that once admission for a given level of care has met the Criteria, there are specific requirements for continued service, discharge or transfer from that particular level of care. Providers, MCOs and Magellan of Virginia shall apply the ASAM Criteria as specified below:

Continued Service Criteria: It is appropriate to retain the member at the present level of care if:

1. The member is making progress, but has not yet achieved the goals articulated in the individualized service plan. Continued treatment at the present level of care is assessed as necessary to permit the member to continue to work towards treatment goals; or

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1 ARTS Care Coordinators are as follows: licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, nurse practitioners, or registered nurses with substance use disorder experience and the necessary competencies to use the ASAM multidimensional assessment criteria and matrices, to match severity and level of function with type and intensity of service for adults and adolescents.
2. The member is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized service plan. Continued treatment at the present level of care is assessed as medically necessary to permit the member to continue to work toward his or her treatment goals; and/or

3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the member’s new problems can be addressed effectively.

The provider shall document and communicate the member’s readiness for discharge or need for transfer to another level of care based on each of the six dimensions of the ASAM Multidimensional Assessment. If the assessment reflects that the member’s problems continue to exist or new problem(s) are identified in the residential level of care, the member should continue in treatment at the present level of care. If not, the member shall be discharged/ transferred to another ASAM Level of Care as indicated below.

Discharge/Transfer Criteria: It is appropriate to transfer or discharge the member from the present level of care if he or she meets the following criteria:

1. The member has achieved the goals articulated in the individualized service plan, thus resolving the problem(s) that justified admission to the current level of care; or

2. The member has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the individual service plan. Treatment at another level of care or type of service therefore is indicated; or

3. The member has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated; or

4. The member has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

Managed Care and ASAM
The ASAM Criteria 3rd Edition provide principles on how to work effectively in a managed care environment (beginning on page 119 of the ASAM Criteria). ASAM states that all practitioners as well as managed care organizations are responsible for “managing care” and utilizing resources appropriately. ASAM Criteria provides the following guidance for working with managed care:

- Clinical assessments by the treatment team shall encompass factual, biopsychosocial data;
- A case presentation format can be used to document the biopsychosocial data following the multidimensional assessment (same format in ASAM Criteria page 125);
- Use the decisional flow process to match the assessment and treatment/placement assignment to guide the clinical discussion (ASAM Criteria page 124);
- If the provider and the ARTS Coordinator/Physician disagree with the treatment/placement discussion, identify the specific area of disagreement; and
- If no agreement is reached, providers may utilize the managed care/Magellan of Virginia appeal process that will be documented in the authorization denial.
Patient Utilization and Safety Management Program (PUMS)
All contracted Medicaid MCOs including Medallion 3.0 and Commonwealth Coordinated Care Plus (CCC Plus) are required to have a Patient Utilization & Safety Management Program (PUMS). Note: Neither the CCC plans (Medicare/Medicaid Plans) nor Magellan of Virginia have the PUMS requirements. The PUMS program is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and case management program designed to promote proper medical management of essential health care. Upon the member’s placement in the PUMS, the MCO must refer members to appropriate services based upon the member’s unique situation and service needs. Medical providers or social service agencies such as Department of Social Services or Community Service Boards may provide direct referrals to the Department or the Medicaid managed care health plan (MCO).

Placement into a PUMS Program
Members may be placed into a PUMS program for a period of twelve (12) months when either of the following trigger events occurs:

- **(PUMS1) Buprenorphine Containing Product**: Therapy in the past thirty (30) days – AUTOMATIC LOCK-IN
  *If on monoprodct (indicating pregnancy), refer to case management.
  **Exclude members using Butrans and Belbuca only when used for the treatment of pain.

- **(PUMS2) High Average Daily Dose**: > one hundred and twenty (120) cumulative morphine milligram equivalents (MME) per day over the past ninety (90) days.

- **(PUMS3) Opioids and Benzodiazepines concurrent use** – at least one (1) Opioid claim and fourteen (14) day supply of Benzo (in any order).

- **(PUMS4) Doctor and/or Pharmacy Shopping**: > three (3) prescribers OR > three (3) pharmacies writing/filling claims for any controlled substance in the past sixty (60) days.

- **(PUMS5) Use of a Controlled Substance with a History of Dependence, Abuse, or Poisoning/Overdose**: Any use of a controlled substance in the past sixty (60) days with at least two (2) occurrences of a medical claim for controlled Substance Abuse or Dependence in the past three hundred and sixty-five (365) days.

- **(PUMS6) History of Substance Use, Abuse or Dependence or Poisoning/Overdose**: Any member with a diagnosis of substance use, substance abuse, or substance dependence on any new* claim in any setting (e.g., ED, pharmacy, inpatient, outpatient, etc.) within the past sixty (60) days.

PUMS Program Details
Once a member meets the placement requirements, the MCO may limit a member to a single pharmacy, primary care provider, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the MCO and the circumstances of the member. The MCO shall limit a member to providers and pharmacies that are credentialed in their network.
**PUMS1 Lock-In Process Requirements**

Members identified for placement in PUMS1 shall be automatically locked-in to an in-network Buprenorphine waivered prescriber. The MCO shall review automatic lock-ins and transition members to a Preferred Office Based Opioid Treatment (OBOT) practice when available. The MCO shall lock-in the member to all MCO credentialed Buprenorphine waivered prescribers associated with the OBOT practice.

If members are referred to an ARTS Residential Treatment Facility, and need to continue medication management, the Residential provider shall contact the MCO to request the prescriber/pharmacy be updated to one that the Residential provider utilizes, so that the member may continue the current medical regimen. Provider may contact the health plans and Magellan of Virginia to update the preferred prescriber/pharmacy while member is in the residential treatment program. The health plan contacts are attached to the memorandum. Upon discharge from the Residential Treatment Facility, the provider shall notify the member’s MCO of the discharge so that the member’s prescriber/pharmacy provider can be updated based on the member’s choice and proximity to their place of discharge. This task shall be included on the discharge planning process.

**Buprenorphine Prescriptions**

Medicaid health plans have the contractual authority to deny coverage of buprenorphine prescribed by out-of-network providers and will not pay for buprenorphine prescribed by out-of-network providers beginning November 1, 2017. In-network providers will be exempt from the service authorization requirement for the first 7 days during induction however will require service authorizations after the initial 7 days. Providers who are approved and credentialed with the MCOs and Magellan of Virginia as a Preferred OBOT provider and/or a Preferred Residential Treatment Provider as detailed below are exempt from service authorization requirements for buprenorphine products. If the Residential provider is not approved as a “Preferred Residential Treatment Provider” they may collaborate with an approved OBOT provider or an in-network buprenorphine waivered provider. A list of DMAS approved and credentialed Preferred OBOT providers are located: [http://www.dmas.virginia.gov/Content_pgs/bh-home.aspx](http://www.dmas.virginia.gov/Content_pgs/bh-home.aspx).

**New Preferred Medication Assisted Treatment Providers**

Residential treatment providers, along with Intensive Outpatient and Partial Hospitalization providers, who are providing Medication Assisted Treatment (MAT) and who are currently credentialed with a Medicaid Managed Care Organization or Magellan of Virginia as an ARTS provider can apply to be a “Preferred Medication Assisted Treatment Provider”. The Preferred MAT status will allow the buprenorphine waivered practitioner of the facility to prescribe buprenorphine related products to be filled at local pharmacy and be exempt from the service authorization process. The Preferred Medication Assisted Treatment attestation packet is located online at: [http://www.dmas.virginia.gov/Content_pgs/bh-cred.aspx](http://www.dmas.virginia.gov/Content_pgs/bh-cred.aspx).

Providers should complete these forms and send to DMAS at fax: 804-452-5450 for the physician team to review for decision. If DMAS approves the application, DMAS will notify the MCOs and Magellan of Virginia. Providers will still need to complete the credentialing process with each MCO and Magellan of Virginia to ensure that the buprenorphine waivered practitioners are credentialed to be reimbursed for the professional services and waive the buprenorphine service authorization.
**Initial Rate Setting Process for New Residential Treatment Facilities ASAM Level 3.3/3.5/3.7**

All new Residential Treatment Facilities or providers adding on a new ASAM Level of Care for Residential Services (ASAM Level 3.3, 3.5 or 3.7) are required to file a pro-forma cost report for the determination of the initial rate. Allowable costs for reimbursement purposes are determined in accordance with Medicare Principles of Reimbursement, including the rules set forth in the Provider Reimbursement Manual, (CMS Pub 15-1). Allowable costs for determining the Residential Treatment Facility Rate do not include costs for drugs and professional (physician) services or primary/secondary/post-secondary education costs. The Residential Treatment Facility Rate cannot exceed $393.50 per day. Drugs and professional services must be billed directly to the MCO or Magellan of Virginia (professional services) / Magellan Health Services (pharmacy), depending on the member’s benefit.

A copy of the pro-forma cost reporting form RTF-608 can be found on the Medicaid Web Provider Portal at [https://www.virginiamedicaid.dmas.virginia.gov](https://www.virginiamedicaid.dmas.virginia.gov) under “Provider Services” and "Provider Forms Search" section. Complete the RTF – 608 Cost Reporting Form in accordance with the following instructions and submit with additional documentation per Attachment A – Submission Instructions. The completed cost report with additional information as described in the instructions should be submitted to the DMAS cost settlement and auditing contractor.

Additional information about the ARTS program can be found at [http://www.dmas.virginia.gov/Content_pgs/bh-home.aspx](http://www.dmas.virginia.gov/Content_pgs/bh-home.aspx).

**ASAM Level and Licensing Crosswalk for Residential Settings**

DBHDS Office of Licensing developed a crosswalk for residential provides that aligned the various DBHDS licenses by ASAM Level of Care. DMAS is notifying providers that they must meet the ASAM Criteria for the appropriate level of care, and providers must also be licensed appropriately based on the ASAM Level of Care and Licensing Crosswalk below:

<table>
<thead>
<tr>
<th>ASAM Level of Care</th>
<th>ASAM Description</th>
<th>DBHDS Licenses</th>
<th>DBHDS License Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.7</td>
<td>Medically Monitored Intensive Inpatient Services (Adult)</td>
<td>Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License;</td>
<td>04-001 thru 004 (adults); 04-005 (children); 04-011 thru 012 (medical detox); or 01-025 thru 026 (managed withdrawal)</td>
</tr>
<tr>
<td></td>
<td>Medically Monitored High-Intensity Inpatient Services (Adolescent)</td>
<td>Substance Abuse Residential Treatment Services (RTS) for adults/children with a DBHDS Managed Withdrawal License;</td>
<td>01-006 (adults); 14-007 (children); or 01-025 thru 026 (managed withdrawal)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Residential Crisis Stabilization Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License;</td>
<td>01-019 (adults); 01-020 (children); 04-011 thru 012 (medical detox); or 01-025 thru 026 (managed withdrawal)</td>
</tr>
<tr>
<td>3.5</td>
<td>Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)</td>
<td></td>
<td></td>
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<td>---------------------------------</td>
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<tr>
<td>Substance Abuse Residential Treatment Services (RTS) for Women with Children with a DBHDS Managed Withdrawal License;</td>
<td>01-033 thru 034 (Women); or 01-025 thru 026 (managed withdrawal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level C or Mental Health Residential Children with a substance abuse residential license and a DBHDS Managed Withdrawal License;</td>
<td>14-001 thru 003 w/ SA in licensed as description; 14-004 thru 006; 14-054 thru 058 w/SA in licensed as description; or 01-025 thru 026 (managed withdrawal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managed Withdrawal-Medical Detox Adult Residential Treatment Service (RTS) License; or Medical Detox/Chemical Dependency Unit for Adults.</td>
<td>01-025 thru 026</td>
<td>04-011 thru 012 (medical detox)</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Residential Treatment Services (RTS) for Adults or Children; Psychiatric Unit that have substance abuse on their license or within the “licensed as statements”;</td>
<td>01-006 (Adults); or 14-007 (Child)</td>
<td>04-001 thru 004 (adults); or 04-005 (children)</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse RTS for Women with Children;</td>
<td>01-033 thru 034 (Women)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the “licensed as statements.”; or Level C or Mental Health Residential Children that have substance abuse on their license or within the “licensed as statements”.</td>
<td>01-006 (Adults)</td>
<td>14-001 thru 006 (only with SA in license description); or 014-007 (only with SA in license description)</td>
<td></td>
</tr>
<tr>
<td>If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.</td>
<td></td>
<td>04-011 thru 012 (medical detox); or 01-025 thru 026 (managed withdrawal)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.3</th>
<th>Clinically Managed Population-Specific High-Intensity Residential Services (Adults)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Residential Treatment Services (RTS) for Adults;</td>
<td>01-006</td>
</tr>
<tr>
<td>Substance Abuse Residential Treatment Services (RTS) for Women with Children;</td>
<td>01-033 thru 034 (Women)</td>
</tr>
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<td>3.1</td>
<td>Clinically Managed Low-Intensity Residential Services</td>
</tr>
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<td></td>
<td>Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the “licensed as statements.” or</td>
</tr>
<tr>
<td></td>
<td>01-006</td>
</tr>
<tr>
<td></td>
<td>Level C or Mental Health Residential Children that have substance abuse on their license or within the “licensed as statements.”</td>
</tr>
<tr>
<td></td>
<td>14-001 thru 006 (only with SA in license description); or</td>
</tr>
<tr>
<td></td>
<td>14-007 (only with SA in license description)</td>
</tr>
<tr>
<td></td>
<td>If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.</td>
</tr>
<tr>
<td></td>
<td>04-011 (medical detox – adults)</td>
</tr>
<tr>
<td></td>
<td>Mental Health &amp; Substance Abuse Group Home Service for Adults or Children; or</td>
</tr>
<tr>
<td></td>
<td>01-006 (Adults) (only with SA in license description); 14-033 (Children); or 14-034 (Children</td>
</tr>
<tr>
<td></td>
<td>Supervised Living Services for Adults.</td>
</tr>
<tr>
<td></td>
<td>01-013</td>
</tr>
<tr>
<td></td>
<td>Note: DBHDS is no longer issuing the Substance Abuse Halfway House for Adults licenses. Providers who need to update their licenses should contact their licensing specialist with DBHDS for further guidance.</td>
</tr>
</tbody>
</table>

DMAS has contracted with a third party vendor to perform site visits of residential treatment providers to perform an assessment and certify whether the provider meets the particular ASAM Criteria for that level of care. The ASAM certification is required for the provider to be credentialed with the Medicaid MCOs and Magellan of Virginia in addition to meeting the licensing requirements.

**Attachment 1: PUMS Lock-In Point-of-Contact**

**MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)**
Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting [www.MagellanHealth.com/Provider](http://www.MagellanHealth.com/Provider). If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting [www.magellanofvirginia.com](http://www.magellanofvirginia.com) or submitting questions to [VAPrviderQuestions@MagellanHealth.com](mailto:VAPrviderQuestions@MagellanHealth.com).

**MANAGED CARE PROGRAMS**
Most Medicaid individuals are enrolled in one of the Department’s managed care programs: Medallion 3.0, Commonwealth Coordinated Care (CCC), Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may
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Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:


**COMMONWEALTH COORDINATED CARE PLUS**
Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: [http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx](http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx).

**VIRGINIA MEDICAID WEB PORTAL**
DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: [www.virginia Medicaid.dmas.virginia.gov](http://www.virginia Medicaid.dmas.virginia.gov). If you have any questions regarding the Virginia Medicaid Web Portal, please contact Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

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1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the “HELPLINE” is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

**TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE**
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to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

**PROVIDERS: NEW MEDICARE CARDS ARE COMING**

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the [New Medicare Card](https://www.medicare.gov) homepage and [Provider webpage](https://www.medicare.gov), and visit often, so you have the information you need to be ready by April 1.

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Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that’s unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link: [https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html](https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html)
### PUMS Lock-In Point of Contact

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Contact</th>
</tr>
</thead>
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<tr>
<td><strong>Aetna Better Health &amp; Aetna Better Health of Virginia</strong></td>
<td>Robert Coalson, Pharm. D, MBA&lt;br&gt;Aetna Better Health of Virginia&lt;br&gt;(717) 673-2113 (w)&lt;br&gt;<a href="mailto:rlcoalson@aetna.com">rlcoalson@aetna.com</a></td>
</tr>
<tr>
<td><strong>Anthem HealthKeepers Plus</strong></td>
<td>Linda Worley&lt;br&gt;1-844-533-1994 Ext. 48360&lt;br&gt;<a href="mailto:linda.worley@anthem.com">linda.worley@anthem.com</a></td>
</tr>
<tr>
<td><strong>INTotal Health</strong></td>
<td>Kristi Fowler, R. Ph.&lt;br&gt;Director&lt;br&gt;Managed Pharmacy Services&lt;br&gt;INTotal Health&lt;br&gt;(202) 681-8046&lt;br&gt;<a href="mailto:Kristi.Fowler@inova.org">Kristi.Fowler@inova.org</a></td>
</tr>
<tr>
<td><strong>Kaiser Permanente</strong></td>
<td>Pharmacy Benefit Team&lt;br&gt;(703) 466-4800, Option 1&lt;br&gt;<a href="mailto:MAS-PHARM-BENEFITS@kp.org">MAS-PHARM-BENEFITS@kp.org</a>&lt;br&gt;</td>
</tr>
<tr>
<td><strong>Magellan Complete Care of Virginia</strong></td>
<td>Gabrielle Williams, PharmD, MBA&lt;br&gt;Pharmacy Services Manager&lt;br&gt;(804) 461-9475&lt;br&gt;<a href="mailto:GWilliams5@magellanhealth.com">GWilliams5@magellanhealth.com</a></td>
</tr>
<tr>
<td><strong>Optima Family Care</strong></td>
<td>(800) 648-8420&lt;br&gt;(757) 552-7174</td>
</tr>
<tr>
<td><strong>Optima Health Community Care</strong></td>
<td>(888) 946-1168</td>
</tr>
<tr>
<td><strong>Virginia Premier Health Plan &amp; Virginia Premier Complete Care</strong></td>
<td>Javier Menendez, R.Ph.&lt;br&gt;Pharmacy Director&lt;br&gt;800-727-7536 Ext. 55269&lt;br&gt;<a href="mailto:Javier.Menendez@vapremier.com">Javier.Menendez@vapremier.com</a>&lt;br&gt;</td>
</tr>
<tr>
<td></td>
<td>Emily Allen, 800-727-7536 Ext. 55367&lt;br&gt;<a href="mailto:Emily.Allen@vapremier.com">Emily.Allen@vapremier.com</a></td>
</tr>
<tr>
<td></td>
<td>Pharmacy Hunt Group (anyone can assist) 800-727-7536 Ext.77121</td>
</tr>
</tbody>
</table>
TO: All Providers, Magellan and Managed Care Organizations

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services

MEMO: Update

DATE: 12/29/17

SUBJECT: New Opioid Treatment Services Supplement and Updates to the Addiction and Recovery Treatment Services Manual and the Peer Services Supplement.

The purpose of this memorandum is to notify providers of the clarifications to the Addiction and Recovery Treatment Services (ARTS) Provider Manual which was effective April 1, 2017. ARTS covers the full spectrum of the American Society of Addiction Medicine (ASAM) levels of care for substance use disorders including alcoholism and other drug addictions. This memorandum also serves as notice that the Opioid Treatment Services, including Opioid Treatment Programs, Preferred Office Based Opioid Treatment Programs and Preferred Medication Assisted Treatment have been pulled out of the ARTS Provider Manual and a new Opioid Treatment Services Supplement has been created. In addition to the new Opioid Treatment Services Supplement, there have been additional clarifications made to the Peer Services Supplement. The clarifications to the ARTS Provider Manual and the Peer Services Supplement are summarized below.

The changes in the ARTS Provider Manual are listed below:

Chapter II:
- Added Commonwealth Coordinated Care (CCC) Plus language.
- Moved Opioid Treatment Services (OTS) Provider Requirements to OTS Supplement.
- Added rate setting process for newly enrolled Residential Treatment Service providers.
- Updated licensing requirements to match ASAM Level Licensing Crosswalk.
- Added the new Preferred Medication Assisted Treatment provider qualifications.
- Clarified Screening Brief Intervention and Referral to Treatment (SBIRT) provider requirements.
- Added reference to Peer Support Services Supplement.

Chapter IV:
- Added Commonwealth Coordinated Care (CCC) Plus language.
- Added definitions.
- Added new Governor’s Access Program (GAP) ARTS treatment services.
• Moved Opioid Treatment Services (OTS) service requirements to OTS Supplement.
• Clarified staff qualification for the Individual Service Plan (ISP) by American Society of Addiction Medicine (ASAM) Level of Care.
• Added the reference to the new Preferred Medication Assisted Treatment.
• Clarified the distinct activities required for Substance Use Case Management.
• Clarified that group substance use counseling shall have recommended maximum limit of 10 members but can exceed based on determination of the credentialed addiction treatment provider.
• Clarified residential services lengths of stay based on CMS and ASAM requirements.
• Added Reporting of Adverse Outcomes for Institutions for Mental Diseases (IMD) requirements.
• Added Patient Utilization Management (PUMS) language.

Chapter VI:
• Added Commonwealth Coordinated Care (CCC) Plus language.
• Clarified ISP documentation requirements.
• Clarified the Substance Use Case Management documentation requirements.

DMAS has created a new supplement titled Opioid Treatment Services. This incorporates all Medication Assisted Treatment requirements. This supplement clarifies the service requirements for the Preferred Office Based Opioid Treatment Services as well as the requirements for the ISP and the new Interdisciplinary Plan of Care.

DMAS has also clarified in the Peer Supports Supplement and Intensive Community Treatment (ICT).

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Additional information is available at the following link:
## SUMMARY OF REVISIONS

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<tr>
<td>ARTS Manual Chapters II, IV, &amp; VI</td>
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<td>Entire Chapters</td>
<td>12/29/2017</td>
</tr>
<tr>
<td>Opioid Treatment Services</td>
<td></td>
<td></td>
<td>New Supplement</td>
<td>12/29/2017</td>
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<td>Peer Services Supplement</td>
<td></td>
<td></td>
<td>Entire Supplement</td>
<td>12/29/2017</td>
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## FILING INSTRUCTIONS

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</tbody>
</table>
TO: All Substance Use Disorder Providers, Prescribers, Managed Care Organizations (MCOs) and Magellan of Virginia Participating in the Virginia Medical Assistance Program

FROM: Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services (DMAS)

DATE: 8/20/19

SUBJECT: Prohibition to Charge Medicaid Members Out-of-Pocket for Covered Substance Use Disorder Services

The purpose of this Department of Medical Assistance Services (DMAS) provider bulletin is to restate Virginia Medicaid requirements on the prohibition of Medicaid providers requiring or accepting cash or other items of monetary value in exchange for Medicaid-covered substance use disorder (SUD) treatment services. Accepting payment for Medicaid-covered services from an enrolled member is federally prohibited in accordance with 42 CFR § 447.15, and 12 VAC 30-10-580, as well as the Medicaid Provider Agreements. The requirements are stated in the April 10, 2018 Medicaid memo located online at: www.virginiamedicaid.dmas.virginia.gov.

This bulletin also serves to remind Medicaid providers that the Virginia Board of Medicine has amended the Code of Virginia, effective July 1, 2019. The amendment as enacted by the General Assembly is located: https://lis.virginia.gov/cgi-bin/legp604.exe?191+ful+CHAP0223. Pursuant to §54.1-2910.3:1 any licensed provider is prohibited by the Board of Medicine to request or require a patient who is enrolled with Medicaid to pay out-of-pocket for the provision of the following services:

- Prescribing of an opioid for the management of pain; or
- Prescribing of buprenorphine-containing products, methadone, or other opioid replacements approved for the treatment of opioid addiction by the U.S. Food and Drug Administration for medication-assisted treatment of opioid addiction.

The Code further requires that if the provider chooses to provide these services to a Medicaid member, not only can they not request or require the member to pay out-of-pocket, the provider shall also provide written notice to the member and document in the member’s record that:

- DMAS will pay for such health care services meeting medical necessity criteria as defined in the Addiction and Recovery Treatment Services (ARTS) provider manual; and
- The provider does not participate with DMAS or its contractors and will not accept payment from DMAS nor its contractors for such health care services.
More information about the ARTS benefit is located online at:  

Inquiries about the ARTS benefit may be sent to:  SUD@dmas.virginia.gov.

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**Medicaid Expansion**

New adult coverage begins January 1, 2019. Providers will use the same web portal and enrollment verification processes in place today to verify Medicaid expansion coverage. In ARS, individuals eligible in the Medicaid expansion covered group will be shown as “MEDICAID EXP.” If the individual is enrolled in managed care, the “MEDICAID EXP” segment will be shown as well as the managed care segment, “MED4” (Medallion 4.0), or “CCCP” (CCC Plus). Additional Medicaid expansion resources for providers can be found on the DMAS Medicaid Expansion webpage at:  http://www.dmas.virginia.gov/#/medex.

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### PROVIDER CONTACT INFORMATION & RESOURCES

| Medallion (Audio Response System) | 1-800-884-9730 or 1-800-772-9996 |
| KEPRO | https://dmas.kepro.com/ |

### Managed Care Programs

Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.

| Medallion 4.0 | http://www.dmas.virginia.gov/#/med4 |
| CCC Plus | http://www.dmas.virginia.gov/#/cccplus |
| PACE | http://www.dmas.virginia.gov/#/longtermprograms |

### Magellan Behavioral Health

Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.

| Magellan Behavioral Health | www.MagellanHealth.com/Provider |
| Magellan Behavioral Health | www.MagellanHealth.com/Provider |
| www.magellanofvirginia.com | email: VAProviderQuestions@MagellanHealth.com |
| or | call: 1-800-424-4046 |

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| Provider HELPLINE | 1-800-552-8627 |