CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

CHAPTER II

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PARTICIPATING PROVIDER

A participating provider is an agency, program, or person that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and that has a current, signed Participation Agreement with DMAS.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information. Providers enrolled at multiple locations or who are a member of a group using one central office may receive multiple copies of manuals, updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing a written request to the Virginia Medicaid - PES address given under "Provider Enrollment" below.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in each specific Medicaid/FAMIS program providing services to Medicaid / FAMIS members in that program or billing for that program. A copy of the provider agreement with instructions on how to complete the forms can be found at the DMAS website, www.virginiamedicaid.dmas.virginia.gov or by calling Provider Enrollment Services at 1-888-829-5373 (in state, toll-free), 1-804-270-5105 (Richmond area and out-of-state long distance), or via fax at 1-804-270-7027. All providers must sign and complete the entire application and submit it to the Provider Enrollment/Certification Unit at:

Virginia Medicaid - PES
P.O. Box 26803
Richmond, Virginia 23261-6803

An original signature of every individual provider is required. The Medicaid Participation Agreement may be time-limited depending on the licensing required. All participating Medicaid providers are required to complete a new application and 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 to NPI number must be used on all claims and correspondence submitted to Medicaid.

This manual contains instructions for billing and specific details concerning the Medicaid

Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements. Providers approved for participation in the Medicaid Program must perform the following activities as well as any others specified by DMAS:

- Immediately notify Virginia Medicaid-PES in writing whenever there is a change in the information that the provider previously submitted. For a change of address, notify Virginia Medicaid-PES prior to the change and include the effective date of the change;

- Assure freedom of choice to members' 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 members' 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 members 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 members of the same quality and in the same mode of delivery as provided to the general public;

- Charge DMAS for the provision of services and supplies to members in amounts not to exceed the provider's usual and customary charges to the general public;

- 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 member or the member'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 member, a spouse, or a responsible relative. The provider may not charge DMAS or a member for broken or missed appointments;

- Accept assignment of Medicare benefits for eligible Medicaid members;
- Use Medicaid Program-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 members 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.
- Providers of all community mental health and substance abuse services are required to adhere to DMAS marketing requirements. Please see Appendix D of this manual for details on this requirement.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

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

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

excluded individual or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

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

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

2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.

3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

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

PROVIDER QUALIFICATIONS

To qualify as a DMAS provider of mental health, case management, and substance abuse services, the provider of the services must meet the following criteria:

- The provider must have the administrative and financial management capacity to meet state and federal requirements; and

- The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements.

In addition to the criteria stated above, a provider must meet the following requirements:

Mental Health

The following licenses are consistent with the Department of Behavioral Health and Developmental Services (DBHDS) licensing regulations. All CMHRS providers must be in

compliance with DBHDS licensing requirements.

- Intensive In-Home Services providers for children and adolescents must be licensed as a provider of Intensive In-Home Services by DBHDS. Please note that a Licensing Intensive In-Home Services Guidance Document is located at: http://www.dbhds.virginia.gov/documents/ol-guide-intensivein-homesvc.pdf

- Therapeutic Day Treatment providers for children and adolescents must be licensed as a provider of Day Treatment Services by DBHDS. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the Individualized Service Plan (ISP);

- Day Treatment/Partial Hospitalization providers must be licensed as a provider of Day Treatment Services by DBHDS;

- Psychosocial Rehabilitation providers must be licensed as a provider of Psychosocial Rehabilitation or Clubhouse Services by DBHDS;

- Crisis Intervention providers must be licensed as a provider of Outpatient Services by DBHDS;

- Intensive Community Treatment providers must be licensed by DBHDS as a provider of Intensive Community Treatment or a Program of Assertive Community Treatment;

- Crisis Stabilization providers must be licensed by DBHDS as a provider of Outpatient Services licensed by DBHDS as a provider of Outpatient Services with a Crisis Stabilization track or Residential Crisis Stabilization; and

- Mental Health Support Services providers must be licensed by DBHDS as a provider of Supportive In-Home Services, Intensive Community Treatment, or as a program of Assertive Community Treatment.

Community-Based Residential Services for Children and Adolescents under 21 (Level A) providers must be licensed by the Department of Social Services (DSS), Department of Juvenile Justice (DJJ), or Department of Education (DOE) under the Standards for Interdepartmental Regulation of Children's Residential Facilities;

- At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria; and

- Services provided by qualified paraprofessionals require supervision of a Qualified Mental Heath Professional (QMHP). Supervision is demonstrated by the QMHP 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 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.

- The program director supervising the program/group home must be, at a minimum, a qualified mental health professional (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.

- Therapeutic Behavioral Services (Level B) providers must be licensed by DBHDS under the Standards for Interdepartmental Regulation of Children's Residential Facilities;

  - 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

  - At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria.

  - Services provided by qualified paraprofessionals require supervision of a QMHP. Supervision is demonstrated by the QMHP 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 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.

  - The program director must be full time and be a QMHP with a bachelor's degree and at least one year's clinical experience.

  - If any services are subcontracted, the subcontracted provider must meet the same qualifications as listed in this chapter for program operation and provider qualifications.

Provider Credentials for Adult services:

CMHRS Adult Services include Mental Health Support Services, Day Treatment/Partial Hospitalization, Psychosocial Rehabilitation, and Intensive Community Treatment, Crisis Stabilization, and Crisis Intervention.

"Licensed mental health professional" (LMHP) refers to a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed marriage and family therapist, a psychiatric clinical nurse specialist or a psychiatric nurse practitioner . If psychotherapy is to be billed by the LMHP, the therapist must comply with the outpatient psychotherapy criteria outlined in Chapters II, VI, V, and VI of the *Psychiatric Services* Provider Manual.

A person who has completed their graduate degree and is under the direct personal supervision of a person licensed under Virginia law, who is working towards licensure, and who is in compliance with the appropriate Virginia licensing board may perform the functions of the LMHP for purposes of Medicaid reimbursement. The Board of Health Professions refers to masters prepared individuals in Counseling and Psychology as "Resident". The Board of Health Professions refers to masters prepared individuals in social work as "Supervisee". For purposes of Medicaid reimbursement, these persons shall use LMHP-E after their signatures to indicate this status.

"Qualified mental health professional (QMHP)" refers to a clinician in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a primary or secondary psychiatric diagnosis.

In the Commonwealth of Virginia, authorized professionals and minimal qualifications for a QMHP are as follows:

1. A doctor of medicine licensed in Virginia;

2. A doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia;

3. An individual with at least a masters or doctoral degree in psychology from an accredited college or university with at least one year of clinical experience;

4. An individual with a bachelor's degree or master's degree in social work from a college or university with at least one year of clinical experience;

5. A registered nurse licensed in Virginia with at least one year of clinical experience;

6. Mental Health Worker: The effective date for the following qualifications was Sept. 1, 2010. Providers were given until March 1, 2011 (six months) to ensure staff were in compliance. Any staff hired or rehired on or after September 1, 2010 must be in compliance with these new requirements:

    - An individual with a bachelor's degree in human services, a related field, or other

degree deemed equivalent (a listing of other degrees that are deemed equivalent is located on the DMAS website) from an accredited college and with at least one year of clinical experience; OR

- A Registered Psychiatric Rehabilitation Provider (RPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA) as of January 1, 2001; OR
- An individual with at least a bachelor's degree from an accredited college in an unrelated field with an associate's degree in a human services field and who has at least three years clinical experience; OR
- An individual with at a least bachelor's degree from an accredited college and certification from the United States Psychiatric Rehabilitation Association (USPRA) as a Certified Psychiatric Rehabilitation Practitioner (CPRP); OR
- An individual with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent credits based on a trimester system) in a human services field and who has at least three years clinical experience.

Clinical experience means providing direct behavioral health services to individuals with mental illness, intellectual disability or receiving gerontology or special education services. The clinician must have documented experience in the specific field that they are working. They must have experience with implementing individual service plans. The clinical experience may include supervised internships, practicums, and field experience.

QMHP Eligible Staff:
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:

a. At least a Bachelor's in a clinical field without one year of clinical experience; or
b. A Bachelor's in a non-clinical field and is enrolled in a Master's or Doctoral clinical program and actively taking at least 3 credits per semester.

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 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 can not 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 DMAS and DBHDS approved supervision training program. To apply for approval of the supervision training program please submit your agency's training curriculum to DMAS and send via email to cmhrs@dmas.virginia.gov.

Variance Requests For Staff working with Adults:

Until February 11, 2011, providers had the opportunity to submit a variance for staff that do not have a bachelor's degree but who have at least four year's experience in providing behavioral health services. The variance approval process was established jointly with DBHDS. The adult services are Mental Health Support Services, Day Treatment/Partial Hospitalization, Psychosocial Rehabilitation, Intensive Community Treatment, Crisis Stabilization, and Crisis Intervention. Variance requests submitted to DMAS were evaluated with consultation from DBHDS. Variances were granted based on the type and years of experience, agency licensure status, continuing education, and the ability of the provider to provide clinical and administrative supervision.

Documentation that the individual meets the variance criteria must be maintained in the personnel file. The variance remains in effect as long as the staff person remains employed by the same employer.

Paraprofessionals in mental health must, at a minimum, meet one of the following criteria:

1. Be registered with the International Association of Psychosocial Rehabilitation Services (IAPSRS) as an Associate Psychiatric Rehabilitation Provider (APRP) as of January 1, 2001.

2. An associate's degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services, Community Mental Health Rehabilitative Services counseling) and at least one year of experience providing direct services to persons with a diagnosis of mental illness or gerontology and special education.

3. An associate's degree, or higher degree, in an unrelated field and at least three years' experience providing direct services to persons with a diagnosis of mental illness or gerontology clients or special education clients.

4. A minimum of 90 hours of classroom training and 12 weeks of experience under the direct personal supervision of a QMHP providing services to persons with mental illness and at least one year of experience (including the 12 weeks of supervised experience). Direct personal supervision means that the QMHP is on-site at all times and countersigns all documentation. Please refer to the "Exhibits" section at the end of Chapter IV for the 90-hour training program for paraprofessionals.

5. College credits (from an accredited college) earned toward a bachelor's degree in a human service or related field (social work, gerontology, psychology, psychiatric rehabilitation, special education, sociology, counseling, vocational rehabilitation, and human services counseling) that are equivalent to an associate's degree will be accepted to meet the educational requirements. One year of clinical experience is also required. The experience may include supervised internships, practicums, and field experience.

6. Licensed Practical Nurse (LPN): licensed by the Commonwealth of Virginia and with at least one year of clinical experience. The clinical experience may include supervised internships, practicums, and field experience.

7. Certification from the International Association of Psychosocial Rehabilitation Services (IAPSRS) as a Certified Psychiatric Rehabilitation Practitioner (CPRP).

Provider Credentials For Children's Services:

CMHRS children's services include Intensive In-Home, Day Treatment for Children and Adolescents, Community-Based Residential Services for Children and Adolescents Under 21 (Level A) and Therapeutic Behavioral Services (Level B):

Licensed mental health professional (LMHP) refers to a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed marriage and family therapist, a psychiatric clinical nurse specialist or a psychiatric nurse practitioner. If psychotherapy is to be billed by the LMHP, the therapist must comply with the outpatient psychotherapy criteria outlined in Chapters II, VI, V, and VI of the *Psychiatric Services* Provider Manual.

A person who has completed their graduate degree and is under the direct personal supervision of a person licensed under Virginia law, who is working towards licensure, and who is in compliance with the appropriate Virginia licensing board may perform the functions of the LMHP for purposes of Medicaid reimbursement. The Board of Health Professions refers to masters prepared individuals in Counseling and Psychology as "Resident". The Board of Health Professions refers to masters prepared individuals in social work as "Supervisee". For purposes of Medicaid reimbursement, these persons shall use LMHP-E after their signatures to indicate this status.

Any staff person hired or rehired on or after September 1, 2010, must be in compliance with the the following requirements in order to provide Intensive In-Home, Day Treatment for Children and Adolescents, Community-Based Residential Services for Children and Adolescents Under 21 (Level A) and Therapeutic Behavioral Services (Level B):

To qualify as a QMHP to provide Intensive In-Home, Day Treatment for Children and Adolescents, Community-Based Residential Services for Children and Adolescents Under 21 (Level A) and Therapeutic Behavioral Services (Level B), the individual must have the designated clinical experience and must:

i. be a physician; or
ii. have master's degree in psychology from an accredited college or university with at least one year of clinical experience; or
iii. have a social work bachelor's or master's degree from an accredited college or university with at least one year of clinical experience with children or adolescents; or
iv. be a registered nurse with at least one year of clinical experience with children and adolescents; or
v. have at least a bachelor's degree in a human services field or in special education from an accredited college and with at least one year of clinical experience with children and adolescents.

Clinical Experience means providing direct behavioral health services to children and adolescents with mental illness. It includes supervised internships, practicums, and field

experience. A human services field is defined as social work, psychology, sociology, or counseling. A listing of other degrees that are deemed equivalent is located on the DMAS website.

Variance Process for staff working with children:
Until February 11, 2011, providers had the opportunity to request a variance for staff. The process was established jointly with DBHDS to approve qualified persons with a bachelor's degree in an unrelated field. Considerations included history of coursework in the human services fields, experience with children with mental health or substance abuse issues, and the ability of the employing organization to provide supervision.

For children's services, persons with the following qualifications were allowed to continue to provide services as a QMHP with the variance as long as the person stays in the same position with their same employer of record:

Documentation that the individual meets the variance criteria must be maintained in the personnel file. The variance remains in effect as long as the staff person remains employed by the same employer.

QMHP Eligible Staff:
In order to allow providers to develop QMHP staff, a new QMHP eligible category was created, effective September 1, 2010. This category is 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:

i At least a bachelor's degree in a human services field or in special education from an accredited college without one year of clinical experience; or
ii A bachelor's degree from an accredited college in an unrelated field and is enrolled in a Master's or Doctoral clinical program and is actively taking at least 3 credits per semester.

Only one QMHP eligible staff will be allowed for each full time licensed staff. The number of QMHP eligible staff will not exceed five (5) percent of total clinical child staff in the agency. The QMHP eligible staff must have at least one hour of LMHP supervision per week which must which must be documented in the supervisor's file. The QMHP eligible staff must also participate in monthly training which must also be documented in the staff file. The monthly training can not be duplicative of supervision time. Evidence of compliance with the QMHP eligible criteria must be in the staff's personnel file.

The employing agency must have a triennial license from the DBHDS and have a DMAS and DBHDS approved supervision training program. To apply for approval of the supervision training program please submit your agency's training curriculum to DMAS and send via email to cmhrs@dmas.virginia.gov.

<u>Certified Pre-screener</u>
A Certified Pre-screener is an employee of the local Community Services Board or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by DBHDS.

Substance Abuse Services

- Residential Treatment programs for pregnant and postpartum women shall be licensed by DBHDS to provide Residential Substance Abuse Services.

- Day Treatment programs for pregnant and postpartum women must be licensed by DBHDS to provide Outpatient Services or Substance Abuse Day Treatment Services.

- Opioid Treatment Programs must be accredited by the Board of Pharmacy and the Center for Substance Abuse Treatment approved accreditation body, and licensed by the U.S. Drug Enforcement Administration and DBHDS

For Residential and Day Treatment for Pregnant and Post Partum Women a Qualified Substance Abuse Professional must be one of the following:

- A counselor who has completed master's level training in psychology, social work, counseling, or rehabilitation; who is also either certified as a substance abuse counselor by the Board of Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Treatment Professionals, or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

- A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, RN, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

- A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master education counselor by the National Association of Alcoholism and Drug Abuse Counselors.

1. For Medicaid reimbursed Substance Abuse Day Treatment, Substance Abuse Intensive Outpatient Services, Opioid Treatment Services a Qualified Substance Abuse Professional (QSAP) is defined as:

a. An individual who has completed Master's level training in psychology, social work, counseling, or rehabilitation; who also is either

(i) certified as a substance abuse counselor by the Virginia Board of Counseling, or

(ii) is a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or

(iii) who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors, or the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc (IC & RC);

b. An individual licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, psychiatric clinical nurse specialist, a psychiatric nurse practitioner, marriage and family therapist, clinical psychologist, or physician who be qualified by training and experience in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities;

c. An individual who is licensed as a substance abuse treatment practitioner by the Virginia Board of Counseling;

d. An individual who is certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a Master Addiction Counselor by the National Association of Alcoholism and Drug Abuse Counselors or from the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc (IC & RC).

e. An individual who has completed Master's level training in psychology, social work, counseling, or rehabilitation and is certified as a Master Addiction Counselor by the National Association of Alcoholism and Drug Abuse Counselors or from the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc (IC & RC).

f. An individual who has completed a bachelor's degree and is certified as a Substance Abuse Counselor by the Board of Counseling;

g. An individual who has completed a bachelor's degree and is certified as an Addictions Counselor by the Substance Abuse Certification Alliance of Virginia;

h. An individual who has completed a bachelor's degree and is certified as a Level II Addiction Counselor by the National Association of Alcoholism and Drug Abuse Counselors or from the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc (IC & RC).

i. If staff providing services meet only the criteria specified in (A)(1)(f) through **(**A)(1)(h), they must be supervised every two weeks by a professional who meets one of the criteria specified in (A)(1)(a) through **(**A)(1)(e). Supervision shall include documented face-to-face meetings between the supervisor and the professional providing the services. Documentation shall include

review and approval of the plan of care for each member to whom services were provided but shall not require that the supervisor be onsite at the time the treatment service is provided.

2. In order to provide substance abuse treatment services a paraprofessional (peer support specialist) must meet one of the following qualifications:

a. Has an associate's degree in one of the following related fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least one year of experience providing direct services to persons with a diagnosis of mental illness or substance abuse;

b. An associate's or higher degree, in an unrelated field and at least three years experience providing direct services to persons with a diagnosis of mental illness, substance abuse, gerontology clients, or special education clients. The experience may include supervised internships, practicums and field experience.

c. A minimum of 90 hours classroom training in behavioral health and 12 weeks of experience under the direct personal supervision of a QSAP providing services to persons with mental illness or substance abuse and at least one year of clinical experience (including the 12 weeks of supervised experience).

d. College credits (from an accredited college) earned toward a bachelor's degree in a human service field that is equivalent to an associate's degree and one year's clinical experience.

e. Licensure by the Commonwealth as a practical nurse with at least one year of clinical experience.

3. Paraprofessionals must participate in clinical supervision with a QSAP at least twice a month. Supervision shall include documented face-to-face meetings between the supervisor and the professional providing the services. Supervision may occur individually or in a group.

4. All providers of substance abuse treatment services must adhere to the requirements of 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.

5. Substance Abuse Day treatment providers must be licensed by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services as a provider of day treatment services.

6. Substance Abuse Intensive outpatient providers must be licensed by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services as a provider of outpatient substance abuse services.

7. Providers of Opioid Treatment Services must be licensed as a provider of Opioid Treatment services by the DBHDS and must also comply with all federal and state law and regulations.

8. The provider of substance abuse crisis intervention services shall be licensed as a provider of Substance Abuse Outpatient Services by DBHDS.

Substance Abuse Case Management

1. The provider of substance abuse case management services must meet the following criteria:

a. The enrolled provider must have the administrative and financial management capacity to meet state and federal requirements;

b. The enrolled provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

c. The enrolled provider must be licensed by DBHDS as a provider of substance abuse case management services.

2. Providers may bill Medicaid for substance abuse case management only when the services are provided by a professional or professionals who meet at least one of the following criteria:

a. Has at least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least one year of substance abuse related clinical experience providing direct services to persons with a diagnosis of mental illness or substance abuse;

b. Licensure by the Commonwealth as a registered nurse or as a practical nurse with at least one year of clinical experience.

Mental Health Case Management

There shall be no restriction on an individual's free choice of case management providers or other mental health or medical services providers. The mental health case management provider must be a Community Services Board member and licensed by DBHDS.

To qualify as a provider of services through DMAS for Rehabilitative Mental Health Case Management for adults with serious mental illness and children and adolescents with serious emotional disturbance, the provider must meet the following criteria:

- The provider must have the administrative and financial management capacity to meet state and federal requirements;

- The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

- The services shall be in accordance with the *Virginia Comprehensive State Plan for Mental Health, Mental Retardation, and Substance Abuse Services*; and

- The provider must be licensed as a provider of Case Management Services by DBHDS.

Providers may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers. Persons providing case management services must have knowledge of:

- Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, mental retardation, and substance abuse treatment programs;

- The nature of serious mental illness, mental retardation, and substance abuse depending on the population served, including clinical and developmental issues;

- Different types of assessments, including functional assessments, and their uses in service planning;

- Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;

- The service planning process and major components of a service plan;

- The use of medications in the care or treatment of the population served; and

- All applicable federal and state laws, regulations, and local ordinances.

Persons providing case management services must have skills in:

- Identifying and documenting an individual's needs for resources, services, and other supports;

- Using information from assessments, evaluations, observation, and interviews to develop ISPs;

- Identifying services and resources within the community and establishing service systems to meet the individual's needs and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal habilitative, rehabilitative, and life goals; and

- Coordinating the provision of services by public and private providers.

Persons providing case management services must have abilities to:

- Work with team members, maintaining effective inter- and intra-agency working relationships;
- Work independently, performing position duties under general supervision; and
- Engage and sustain ongoing relationships with individuals receiving services.

The provider must be a DBHDS-licensed case management provider, and case management must be provided by a qualified mental health case manager as defined above.

The individual providing case management services is not required to be a member of an organizational unit that provides only case management. The case manager who is not a member of an organized case management unit must possess a job description that describes case management activities as job duties, must provide services as defined for case management, and must comply with service expectations and documentation requirements as required for organized case management units.

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. As a condition of participation, each Medicaid provider has the responsibility for making provisions for individuals with disabilities in the provider's programs or activities.

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

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical assistance shall be reduced to the extent that they are available through other federal, state, or local programs, other insurance, or third party liability. Health, hospital, Workers' Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Virginia Medicaid will pay the amount of any deductible or co-insurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- **Workers' Compensation** - No Medicaid Program payments shall be made for a patient covered by Workers' Compensation.
- **Other Health Insurance** - When a consumer has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires

that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

- **Liability Insurance for Accidental Injuries -** DMAS will seek repayment from any settlements or judgments in favor of Medicaid consumers who receive medical care as the result of the negligence of another. If a consumer is treated as the result of an accident and DMAS is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish any lien that may exist under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

- If there is an accident in which there is a possibility of third-party liability or if the consumer reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 form to the attention of the Third Party Liability Unit, DMAS, 600 East Broad Street, Richmond, Virginia 23219. (To obtain a copy of this form, see the "Replenishment of Billing Materials" section in Chapter V of this manual.)

TERMINATION OF PROVIDER PARTICIPATION

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

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

Virginia Medicaid-PES
P.O. Box 26803
Richmond, VA 23261-6803

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

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Section 32.1-325 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.

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

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

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

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

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

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

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

The provider may not bill the recipient (client) for covered services that have been provided and

subsequently denied by DMAS.

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

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

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

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

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

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

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

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

CLIENT APPEALS

The Code of Federal Regulations at 42 CFR $43 1 *et seq.*, and the Virginia Administrative Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the client. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

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

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

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

The appeal request must be signed and mailed to the:

Appeals Division
Department of Medical Assistance Services

600 E. Broad Street, 11th floor
Richmond, Virginia 23219
Appeal requests may also be faxed to: (804) 371-8491

EXHIBITS

The exhibit listed below can be accessed on the DMAS website at www.virginiamedicaid.dmas.virginia.gov

- Mailing Suspension Request Form