CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PROVIDER ENROLLMENT

A participating provider is a person or organization who has a current, signed participation agreement with DMAS.

Effective April 4, 2022 all newly enrolling providers seeking to participate with Medicaid managed care or fee-for-service (FFS) must be screened and enrolled with DMAS.

DMAS's online provider enrollment process may be accessed through the Provider Enrollment link located on the DMAS Medicaid Enterprise System (MES) Provider Resources site at https://vamedicaid.dmas.virginia.gov/provider.

1. As a part of the enrollment process, providers must complete a Participation Agreement applicable to their provider type. In the case of a group practice, hospital, or other agency or institution, the authorized agent of the provider institution must sign the agreement. For group practice, hospital, or other agency or institution, DMAS must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

2. A National Provider Identifier (NPI) number must be obtained from the National Plan and Provider Enumeration System (NPPES) and provided with the enrollment application. An enrolled provider's NPI is used by MES to manage provider information across functions. For example, this number must be used on all claims submitted to DMAS.

Provider NPIs may be disclosed to other Covered Healthcare Entities pursuant to Centers for Medicaid and Medicare Services (CMS) regulations requiring the disclosure of NPIs as a part of HIPAA-compliant standard transactions. (Please reference the Healthcare Information Portability and Accountability Act (HIPAA) of 1996.)

3. Providers must have an active license from the relevant state licensing authority and provide proof of licensure during the enrollment process.

4. The provider must be successfully screened according to the requirements detailed in the next section (titled "Provider Screening Requirements").

5. Providers may be denied enrollment for any of the following reasons:
   - failing to submit any of the requested information;
   - conviction of a felony;
   - conviction of health care fraud;
   - if there are past licensure actions or actions related to privileges, enrollments, educational tenure, board certifications, authorizations, participation in health care programs, malpractice actions, liability actions, or other actions or

information indicating that the individual may pose a risk to the health, safety or welfare of Medicaid members.

6. Providers who are located in another state but within 50 miles of the Virginia border may be permitted to enroll if all other qualifications are met, but are required to submit claim documentation to DMAS during the enrollment process.

7. Providers will be notified of the enrollment decision by email notice or letter mailed to the address entered into the provider enrollment portal. For denied applications, information about filing an appeal is included in the notice or letter.

8. The enrollment effective date will begin the 1st day of the month in which the application is received, unless a retroactive effective date is approved for documented extenuating circumstances.

If you have any questions regarding the enrollment process, please email Provider Enrollment Services at VAMedicaidProviderEnrollment@gainwelltechnologies.com or phone toll free 1-888-829-5373 or local 1-804-270-5105.

PARTICIPATION IN MANAGED CARE AND FEE FOR SERVICE (FFS)

Any provider of services must be enrolled with DMAS prior to billing for services rendered to eligible individuals, including individuals enrolled in either FFS or Medicaid managed care.

Most individuals who are eligible for Medicaid or Family Access to Medical Insurance Security (FAMIS) benefits are enrolled with one of the Department of Medical Assistance Services' (DMAS') contracted Managed Care Organizations (MCOs) and receive services from the MCO's network of providers. All participating providers must confirm the individual's MCO enrollment status prior to rendering services. The MCO may require a referral, service authorization or other action prior to the start of services. All providers are responsible for adhering to state and federal requirements, their MCO provider contract(s) (as applicable), and the applicable DMAS provider manual. For providers to participate with one of DMAS' contracted MCOs, they must also become a participating provider in the MCO's network.

Please visit the DMAS website at https://vamedicaid.dmas.virginia.gov/provider for more information on participation with the Medicaid FFS and managed care programs

Carved-Out Services

Regardless of an individual's MCO enrollment, some services are "carved-out" of the managed care program and are paid directly by DMAS using FFS methodology. Providers must follow the FFS rules in these instances.

Individuals who receive services under one of the three 1915(c) Developmental Disabilities Home and Community-Based Services (HCBS) Waivers, including the Building Independence, Community Living, and Family and Individual Supports Waivers, are enrolled in managed care for their non-waiver services (e.g., acute, behavioral health, pharmacy, and non-waiver transportation services). The individual's waiver services benefits are carved-out and managed directly by DMAS.

PROVIDER SCREENING REQUIREMENTS

The 21st Century Cures Act (Cures Act)114 P.P.255 requires all states to screen Medicaid providers, both those in Medicaid fee-for-service (FFS) and managed care organizations (MCOs) upon enrollment.. An abbreviated screening is also performed on a monthly basis for any provider who participates with the Virginia Medicaid Program. The full screening is conducted at the time of revalidation, and providers are required to revalidate at least every 5 years.

The requirement for screening is in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid Program agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers' categorical risk levels are defined as "limited", "moderate", or "high."

Limited Risk Screening Requirements

The following screening requirements apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations and State requirements for the provider or supplier type; (2) Verification that a provider or supplier meets applicable licensure requirements; and (3) Verification that a provider or supplier has not been excluded from providing services in federally funded programs. The verification process includes a review of applicable federal and state databases checks and is completed on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

Moderate Risk Screening Requirements

In addition to the screening requirements applicable to the limited risk provider category listed above, unannounced pre-and/or post-enrollment site visits apply to moderate risk

providers. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submit fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening.

Application Fees

Institutional providers may be required to pay a federally-required fee at the time of application for enrollment, re-enrollment or reactivation, and when adding new locations. If a provider is required to pay an application fee, it will be outlined in the provider enrollment application and/or revalidation notice.

CMS determines the application fee each year. This fee is not required to be paid to DMAS if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request for CMS approval with their enrollment application. If CMS does not approve the hardship request, then providers have 30 calendar days from the date of the CMS notification to pay the application fee or the application for enrollment will be rejected.

An appeal of a hardship exception determination must may be made to CMS pursuant to 42 CFR 424.514.

Out-of-State Provider Screening

Prior to enrollment in DMAS, providers with a primary servicing address located outside of the Virginia border must have a site visit conducted by either their state’s Medicaid program or by CMS due to their provider risk-level. Pursuant to 42 CFR 455 Subpart E, an application will be pended for proof of this information if it is received by DMAS prior to the completion of the site visit.

Revalidation Requirements

All participating providers are required to revalidate at least every 5 years. Providers are notified in writing of their revalidation due date and of any new or revised provider screening requirements. (Providers will indicate their preferred mode of notification, i.e.,

email or USPS, at the time of enrollment.) DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements if a provider is enrolled as a Medicare provider at the time of revalidation.

ORDERING, REFERRING, AND PRESCRIBING (ORP) PROVIDERS

42 CFR 455.410(b) states that state Medicaid agencies must require all ordering, or referring, and prescribing physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ORP providers to enroll to meet new program integrity requirements designed to ensure that all orders, prescriptions or referrals for items or services for Medicaid members originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. There is one exception: the provider enrollment requirements do not apply to physicians who order or refer services for a Medicaid member in a risk-based managed care plan.

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

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

PARTICIPATION REQUIRMENTS

Providers approved for participation in the Virginia Medicaid Program must perform the following activities, as well as any other activities specified by DMAS:

- Immediately notify Provider Enrollment Services in writing of any change in the information that the provider previously submitted to DMAS.
- Ensure freedom of choice to individuals who are eligible for medical assistance under the Virginia Medicaid Program (eligible individuals) in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required service(s) and participating in the Virginia Medicaid Program at the time the service was performed.
- Ensure the eligible individual's freedom to reject medical care and treatment.
- Provide services and supplies to eligible individuals in the same mode of delivery and of the same quality and as provided to the general public.

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

- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 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." A provider may not bill an eligible individual for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from an eligible individual, or any financially responsible relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered. A provider may not charge DMAS or an eligible individual for missed or broken appointments.

- Accept assignment of Medicare benefits for eligible individuals.

- Use DMAS-designated billing forms to submit claims.

- Maintain and retain business and professional records sufficient to fully and accurately document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than six 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.

- As requested by DMAS, 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 eligible individuals.

- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding eligible individuals. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

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

Payments cannot be made for items or services furnished, ordered, or prescribed by an excluded provider 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 payment itself is made to another provider, practitioner, or supplier that is not excluded, but is 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 the Virginia Medicaid Program may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to meet Federal and Virginia Medicaid program integrity requirements:

- Screen all new and existing employees and contractors to determine whether any of them have been excluded from participation in Medicaid or Medicare. (Go to https://oig.hhs.gov/exclusions/)

- Search the Health and Human Services Office of the Inspector General (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.

- 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, Suite 1300
Richmond, VA 23219
-or-
E-mailed to: providerexclusions@dmas.virginia.gov

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C. §794), provides that no disabled individual 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, all Medicaid providers are responsible for making provisions for disabled individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

All providers of care and suppliers of services under contract with DMAS must comply with the requirements of 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 basis of race, color, religion, sex, or national origin.

UTILIZATION OF INSURANCE BENEFITS

Virginia Medicaid is a "payer of last resort" program. Benefits available under Medicaid shall be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or State law; other insurance; or, third-party liability.

Health, hospital, workers' compensation, 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) – The Virginia Medicaid Program will pay the amount of any deductible or coinsurance up to the Medicaid limit 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 payments shall be made for a patient covered by Workers' Compensation.

- Other Health Insurance - When an eligible individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), the Virginia Medicaid Program requires that these benefits be used first. Supplementation shall be made by the Virginia 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 eligible individuals who receive medical care as the result of the negligence of another. DMAS should be notified promptly if an eligible individual is treated as the result of an accident, DMAS should be notified promptly so action can be initiated to establish a lien as set forth in the Code of Virginia §8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing DMAS.

In the case of an accident in which there is a possibility of third-party liability or if the eligible individual reports a third-party responsibility (other than those cited on his Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Casualty Unit, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219. The form can also be sent electronically to TPLcasualty@dmas.virginia.gov

DOCUMENTATION REQUIREMENTS

The Virginia Medicaid Program provider participation agreement requires that medical records fully disclose the extent of services provided to all Medicaid members. Medical records must clearly document the medical necessity for covered services. This documentation must be written at the time the service is rendered and the description of the services rendered must be clear. All documentation must be signed (name and title) and dated (month, day, year) on the date of service delivery.

ELECTRONIC SIGNATURES

An electronic signature that meets the following criteria is acceptable for clinical documentation:

- Identifies the individual signing the document by name and title;
- Assures that the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and
- Provides for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

Use of the electronic signatures for clinical documentation purposes shall be deemed to constitute a signature and will have the same effect as a written signature on a document. Providers shall have written policies and procedures in effect regarding use of electronic

signatures. In addition to complying with security policies and procedures, providers who use electronic signatures shall sign a statement assuring that they alone will have access to and use the key or computer password. The policies and procedures and statements of exclusive use shall be maintained and available at the provider's location.

Additionally, the use of electronic signatures shall be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies. These requirements for clinical documentation apply only to Medicaid claims, and do not preclude other state or federal requirements.

An original written signature is still required on provider enrollment forms and for medical consents. This clarification does not apply to electronic claims submission or the electronic sharing or transmission of clinical records.

TERMINATION OF PROVIDER PARTICIPATION

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

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to DMAS 30 days prior to the effective date. The written notification should be sent to the following address:

DMAS Provider Enrollment Services
PO Box 26803
Richmond, Virginia 23261-6803

DMAS may terminate a provider's participation agreement. DMAS must provide written notification 30 days prior to the termination's effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

Pursuant to §32.1-325 (D) of the Code of Virginia, the DMAS Director of Medical Assistance Services is authorized to:

Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

Appeals of Provider Termination or Enrollment Denial: A provider has the right to appeal in any case in which a Virginia Medicaid Program provider agreement or contract is terminated or denied pursuant to Virginia Code §32.1-325(D). The provider may appeal

the decision in accordance with the Administrative Process Act (Code of Virginia §2.2-4000 et seq.) and the Provider Appeals regulations (12 VAC 30-20-500 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division within 15 calendar days of the receipt of the notice of termination or denial.

APPEALS OF ADVERSE ACTIONS

An appeal is a request for a review of an adverse decision taken by DMAS, a DMAS contractor, or another agency on behalf of DMAS. There are two types of appeals – a provider appeal, which may be filed by a provider or their authorized representative, and a client appeal, which may be filed by an individual or an authorized representative on the individual's behalf. The provider appeals process is described below. The client appeals process is described in Chapter III.

PROVIDER APPEALS

Definitions

Administrative Dismissal –the dismissal of a provider appeal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings.

Adverse Action – means, for services that have already been rendered, the termination, suspension, or reduction in covered benefits or the denial or retraction, in whole or in part, of payment for a service. An adverse action may also include the denial or termination of enrollment as a DMAS participating provider.

Appeal – means:

1. A request made by an MCO provider (in-network or out-of-network) to review the MCO's reconsideration decision of an adverse action in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a DMAS-enrolled provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

2. For fee-for-service ("FFS") services, a request made by a provider to review DMAS' adverse action or a DMAS Contractor's reconsideration decision of an adverse action in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the reconsideration process, after which Virginia Medicaid

affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Reconsideration – means a provider's reconsideration request of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers. Many adverse actions require a provider to request reconsideration with DMAS or the DMAS Contractor before appealing to the DMAS Appeals Division. Read the denial notice carefully to determine if reconsideration is required, as the reconsideration process is a pre-requisite to filing an appeal with the DMAS Appeals Division. Failure to exhaust a required reconsideration process will result in the appeal to the DMAS Appeals Division being deemed premature.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. For EAPG and ClaimCheck actions, the request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division
Department of Medical Assistance Services
600 East Broad Street,
Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal reconsideration rights with an MCO must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO. A reconsideration may also be required by other DMAS contractors before appealing to DMAS.

For services that have been rendered and any applicable reconsideration rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et seq.*

Provider appeals to DMAS must be submitted in writing and within 30 calendar days of the provider's receipt of the DMAS adverse action or final reconsideration decision. There are two case types that have other timeframes to file appeals: (1) provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed within 15 calendar days of the provider's receipt of the DMAS adverse action; and (2) providers appealing adjustments to a cost report are required to file the informal appeal within 90 calendar days of the provider's receipt of the notice of program reimbursement.

The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the adverse action being appealed. To ensure that the appeal is efficiently processed, include: the provider name, national provider identification number (NPI), recipient name(s) and Medicaid ID# *[if applicable]*, date(s) of service *[if applicable]*, claim or service authorization number *[if applicable]*, and the reason for the appeal. Also include a copy of the adverse action and a contact name, phone number, and address for appeal correspondence.

Failure to file a written notice of informal appeal within the prescribed timeframe or that does not identify the action being appealed will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

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

PROVIDER PARTICIPATION REQUIREMENTS (ARTS)

The Addiction and Recovery Treatment Services (ARTS) covered in this manual include: (i) medically managed intensive inpatient services (ASAM Level 4); (ii) substance use disorder (SUD) residential or inpatient services (ASAM Levels 3.1, 3.3, 3.5, and 3.7); (iii) SUD intensive outpatient and partial hospitalization programs (ASAM Levels 2.1 and 2.5); (iv) opioid treatment services (opioid treatment programs and preferred office-based addiction treatment); (v) SUD outpatient services (ASAM Level 1.0); (vi) early intervention services (ASAM Level 0.5); (vii) SUD care coordination; (viii) SUD case management services; and (ix) withdrawal management services. This chapter provides general provider participation requirements and provider specific requirements for ARTS.

Provider requirements for additional Behavioral Health services covered by the

Department of Medical Assistance Services (DMAS) are located in the Mental Health Services Manual, Psychiatric Services Manual, and Residential Treatment Services Manual located on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

Providers are responsible for adhering to all DMAS policies, this manual, available on the DMAS website portal, their provider contracts with the Medicaid Managed Care Organization (MCOs) and the fee for service (FFS) Contractor, and related state and federal regulations.

FEE FOR SERVICE (FFS) CONTRACTOR

Magellan of Virginia serves as the FFS contractor and is responsible for the management and direction of the FFS behavioral health benefits program under contract with DMAS.

Magellan of Virginia is authorized to train a FFS provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid covered behavioral health services.

The Magellan of Virginia Call Center has a centralized contact number (1-800-424-4046) for members and providers. The Call Center is located in Virginia and is available 24 hours a day, 365 days a year. Staff members include bilingual and multi-cultural representatives who speak English and Spanish. Interpreter services, TDD/TTY and relay services are available for individuals with a hearing impairment. The TDD number is 1-800-424-4048.

All calls related to fee-for-service behavioral health services should go to the Magellan of Virginia Call Center. Magellan of Virginia staff members are available to assist callers with:

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

Providers can also visit the Magellan of Virginia provider website at: https://www.magellanofvirginia.com/for-providers/ for service authorization and claims

information or email Magellan of Virginia at VAProviderQuestions@magellanhealth.com.

ADVERSE OUTCOMES

ARTS providers must notify the FFS contractor or the appropriate MCO of member adverse outcomes or critical incidents within one business day following the knowledge of the incident. Providers must follow notification or reporting processes required by applicable Local, State and Federal regulatory bodies or contracts with the MCOs and FFS contractor.

RECOVERY AND RESILIENCY

DMAS encourages the provider network to integrate principles into their practices and service delivery operations including providing high quality, consumer-focused, recovery-based behavioral health services for individuals enrolled in Virginia Medicaid. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations (https://www.samhsa.gov/recovery).

A person's recovery is built on his or her strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members. Because recovery is a highly individualized process, recovery services and supports must be flexible to ensure cultural relevancy.

Resilience refers to an individual's ability to cope with adversity and adapt to challenges or change. Resilience develops over time and gives an individual the capacity not only to cope with life's challenges but also to be better prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resilience and the process of recovery.

A recovery focus is also a preventive approach that simultaneously supports building resiliency, wellness, measurable recovery and quality of life.

CULTURAL AND LINGUISTIC COMPETENCY

DMAS encourages providers to demonstrate an understanding and respect for each individual's health-related beliefs and cultural values through the establishment of policies, practices and allocation of resources that support culturally and linguistically appropriate services. Culture has a significant impact on how people of different

backgrounds express themselves, seek help, cope with stress and develop social supports. It also affects every aspect of an individual's life, including how they experience, understand, and express, mental and emotional distress, illness and conditions.

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

Providers licensed by the Department of Behavioral Health and Developmental Services (DBHDS) should refer to DBHDS for guidance in this area.

PROVIDER QUALIFICATIONS (ARTS)

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

Provider Credentials for ARTS

ARTS providers are responsible for ensuring that employed or contracted staff meet the service-specific staff requirements of all services rendered by the service provider including licensure or registration, as appropriate, by a health regulatory board at the Department of Health Professions (DHP). Staff shall only work within the scope of practice as defined by the applicable DHP health regulatory board. All provider sites must be credentialed by the DMAS contractor, licensed by DBHDS or Virginia Department of Health (VDH) as applicable and in compliance with all requirements as defined in DMAS, DHP, VDH and DBHDS regulations.

Providers, please note that obtaining a license through DBHDS, VDH and/or DHP does not guarantee credentialing and contracting with DMAS or its contractors.

Payments shall not be permitted to health care entities that either hold provisional DBHDS licenses or are not credentialed for each service site with the FFS contractor or Medicaid-contracted MCO prior to rendering that service.

All providers of the ARTS services listed below shall submit the appropriate ARTS Attestation Credentialing Packet to the MCOs and the FFS contractor to initiate the credentialing process. The ARTS Attestation Forms and Staff Roster are posted online at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/credentialing/ .

ARTS Attestation Form for ASAM Level 2.1 to 4.0, ARTS Staff Roster and copy of relevant licenses are required for the following:

- ASAM Level 4.0: Medically Managed Intensive Inpatient Services (Note: Applies to DBHDS licensed settings only. VDH Licensed Acute Care Hospitals are not required to submit an ARTS Attestation to be credentialed for this level of care.);

- SUD Residential/Inpatient Services (ASAM Levels 3.1, 3.3, 3.5, and 3.7) (DBHDS licensed); and

- SUD Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5) (DBHDS licensed).

Providers are required to verify that they have the appropriate license for the service they are requesting based on the ASAM level.

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

SPECIFIC PROVIDER REQUIREMENTS (ARTS)

In addition to the following licensure requirements, SUD treatment providers including outpatient physician and clinic services, intensive outpatient, partial hospitalization, residential treatment services and inpatient withdrawal management services (as defined in 12VAC30-130-5040 through 12VAC30-130-5150), must also be qualified by training and experience as defined in the American Society of Addiction Medicine (ASAM) Criteria: Treatment Criteria for Addictive, Substance-Related and Co- occurring Conditions, Third Edition, as published by ASAM. Any ASAM trainings completed by staff may be kept in their personnel file or records to support this requirement. The ASAM Criteria establishes standards for substance use/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities. Trainings provided in-person or virtually are considered sufficient to fulfill this ASAM training requirement.

In addition to following all general provider requirements outlined in this chapter, providers must also meet the applicable requirements listed below in addition to practicing within the scope of their license/certification/registration with DHP (i.e. Board of Medicine, Nursing, Counseling, Social Work, Psychology, etc.) Providers must have the knowledge, skills and abilities (KSAs) for SUDs and treatment with applicable experience. Providers may obtain certification for SUD treatment to support having the KSAs, however

certification is not required. Attendance in trainings, conferences, classes, etc. that staff participate in to increase their KSAs for SUD treatment and recovery may be kept in their personnel file or records to support this requirement. Trainings provided in-person or virtually are considered sufficient to fulfill this ASAM training requirement.

SPECIFIC ASAM LEVEL OF CARE STAFFING REQUIREMENTS

These ARTS services, as defined by ASAM and DMAS policy, include the following:

- ASAM Level 4.0: Medically Managed Intensive Inpatient for adults, children and adolescents;
- ASAM Level 3.7: Medically Monitored Intensive Inpatient for adults, children and adolescents;
- ASAM Level 3.5: Clinically managed high-intensity residential care for adults, children and adolescents;
- ASAM Level 3.3: Specific high-intensity residential service for adults;
- ASAM Level 3.1: Clinically managed low-intensity residential care for adults, children and adolescents;
- ASAM Level 2.5: Partial Hospitalization service for adults, children and adolescents;
- ASAM Level 2.1: Intensive Outpatient for adults, children and adolescents
- Opioid Treatment Programs (OTP) and Office Based Addiction Treatment (OBAT)*; SUD Outpatient Services (ASAM Level 1);
- ASAM Level 0.5: Early Intervention Services / Screening Brief Intervention and Referral to Treatment (SBIRT);
- SUD Care Coordination;
- SUD Case Management Services, and
- Withdrawal Management services shall be provided when medically necessary, as a component of the following:
    - ASAM Level 4.0: Medically Managed Intensive Inpatient for adults, children and adolescents;
    - ASAM Level 3.7: Medically Monitored Intensive Inpatient for adults, children and adolescents;
    - ASAM Level 3.5: Clinically managed high-intensity residential care for adults, children and adolescents;
    - ASAM Level 3.3: Specific high-intensity residential service for adults;
    - ASAM Level 2.5: Partial Hospitalization service for adults, children and adolescents;
    - ASAM Level 2.1: Intensive Outpatient for adults, children and adolescents
    - OTP and Preferred OBAT*; and
    - ASAM Level 1: SUD Outpatient Services.

*Preferred OBAT and OTP services are defined in a Supplement to this manual.

Medically Managed Intensive Inpatient Services (ASAM Level 4.0) (H0011/rev.1002)

ASAM Level 4.0: Providers shall be licensed by VDH as an acute care general hospital which meet the conditions for participation under Title XVIII of Public Law 89-97 and are limited to an age group not eligible for Title XVIII benefits or by DBHDS as one of the following:

- "Medically Managed Intensive Inpatient for adults";
- "Medically Managed Intensive Inpatient for children and adolescents".

DBHDS licensed agencies must follow requirements set forth in 12VAC35-105-1430 through 12VAC35-105-1470. Acute care facilities are accredited by the Joint Commission on Accreditation for Hospitals and have a Utilization Review Plan that meets the Title XVIII and Title XIX standards for utilization review. ASAM Level 4.0 providers shall be the designated setting for medically managed intensive inpatient treatment and shall be contracted by the MCOs and the FFS contractor.

ASAM Level 4.0 providers shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and/or other drugs.

ASAM Level 4.0 shall meet these staff requirements:

> An interdisciplinary staff of appropriately credentialed clinical staff including, for example, addiction-credentialed physicians or physicians with experience in addiction medicine, licensed nurse practitioners, licensed physician assistants, registered nurses, licensed professional counselors, licensed clinical psychologists, or licensed clinical social workers shall assess and treat individuals with severe substance use disorders or addicted individuals with concomitant acute biomedical, emotional, or mental health disorders.
>
> Medical management by physicians and primary nursing care shall be available 24 hours per day and counseling services shall be available 16 hours per day.

Co-Occurring Enhanced Programs
ASAM Level 4.0 co-occurring enhanced programs shall meet these staff requirements:

- Credentialed Addiction Treatment Professionals who assess and treat the individual's co-occurring mental illness shall be knowledgeable about the biological and psychosocial dimensions of psychiatric disorders and their treatment.
- Co-occurring programs shall be led by an Addiction-Credentialed Physician.

Medically Monitored Intensive Inpatient Services (Adult) and Medically Monitored High Intensity Inpatient Services (Adolescent) (ASAM Level 3.7) (H2036/rev 1002)

ASAM Level 3.7 programs provide a planned and structured regimen of 24 hours per day physician directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient/residential treatment center setting. They function under a defined set of policies, procedures, and clinical protocols.

Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) services may be offered in freestanding, appropriately licensed facility located in a community setting, or a specialty unit in a licensed health care facility such as general or psychiatric hospital. ASAM Level 3.7 providers are contracted by the MCOs and the FFS contractor. Providers shall be licensed by DBHDS as one of the following license types:

- ASAM Level 3.7: “Medically Monitored Intensive Inpatient for adults”;

- ASAM Level 3.7: “Medically Monitored High-Intensity Inpatient Services for children and adolescents”.

Providers must meet the requirements set forth in 12VAC35-105-1480 through 12VAC35-105-1520.

ASAM Level 3.7 providers shall meet these staff requirements:

- The interdisciplinary team shall include credentialed addiction treatment professionals acting within the scope of their practice and addiction-credentialed physicians or physicians with experience in addiction medicine to assess and diagnose, treat, and obtain and interpret information regarding the individual's psychiatric and substance use disorders.

- Credentialed addiction treatment professionals shall be knowledgeable about the biological and psychosocial dimensions of substance use disorders and mental illnesses and their treatment. Credentialed addiction treatment professionals shall be able to identify and diagnose acute psychiatric conditions, symptom increase or escalation, and decompensation. Credentialed addiction treatment professionals shall have specialized training in behavior management techniques and evidenced based best practices in working with individuals experiencing addiction.

- Behavior management is used here as a generic phrase that includes a variety of behavioral intervention techniques that are intended to bring about positive behavioral changes. Behavioral management is a proactive approach to reducing disruptive and/or harmful behaviors. This includes but is not limited to: cognitive-

behavioral therapy, contingency contracting, contingency management, token economy, motivational enhancement therapy, crisis prevention, and other techniques. Credentialed addiction treatment professionals personnel records should reflect having received training in behavior management techniques.

- Credentialed addiction treatment professionals shall be able to provide a planned regimen of 24 hours per day professionally directed evaluation, care and treatment including the administration of prescribed medications.

- An addiction-credentialed physician or physician with experience in addiction medicine shall oversee the treatment process and assure the quality of care. Licensed physicians or physician extenders under supervision of a physician shall perform physical examinations for all individuals who are admitted within 24 hours of admission, except for instances when ASAM Level 3.7 is a step-down from ASAM Level 4.0 within the same facility, in which case records from the physical exam within the preceding 7 days should be evaluated by a physician within 24 hours of admission. The physician or psychiatrist, or physician extender as defined in 12VAC30-130-5020, if knowledgeable about addiction treatment, shall have the ability to supervise addiction pharmacotherapy, integrated with psychosocial therapies in addiction treatment.

Co-Occurring Enhanced Programs

Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) co-occurring enhanced programs as required by ASAM shall meet staff requirements as follows:

- Psychiatrists and credentialed addiction treatment professionals who have specialized training in behavior management techniques as defined earlier in this chapter, and evidenced-based practices related to addiction and co-occurring conditions shall be available to assess and treat co-occurring psychiatric disorders.

- Access to an addiction-credentialed physician shall be available 24 hours per day along with access to either a psychiatrist, a certified addiction psychiatrist, or a psychiatrist with experience in addiction medicine.

- Credentialed addiction treatment professionals shall have experience and training in addiction and mental health to understand the signs and symptoms of mental illness and be able to provide education to the individual on the interaction of substance use and psychotropic medications.

- Registered nurses and licensed practical nurses shall be available to provide care to and observation of individuals as defined in the individual service plan.

Clinically Managed High-Intensity Residential Services (Adult) and Clinically Managed Medium-Intensity Residential Services (Adolescent) (ASAM Level 3.5) (H0010/rev 1002)

Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) are residential treatment service providers who are contracted by the MCOs and the FFS contractor. Providers shall be licensed by DBHDS as a provider of one of the following:

- ASAM Level 3.5: “Clinically managed high-intensity residential care for adults”;
- ASAM Level 3.5: “Clinically managed high-intensity residential care for children and adolescents”.

Providers must meet the requirements set forth in 12VAC35-105-1530 through 12VAC35-105-1570.

Residential treatment providers (ASAM Level 3.5) shall meet these staff requirements:

- The interdisciplinary team shall include credentialed addiction treatment professionals acting within the scope of their practice, physicians, or physician extenders and allied health professionals.
- Staff shall provide 24 hours per day awake supervision on site.
- Credentialed addiction treatment professionals shall be experienced in and knowledgeable about the biopsychosocial dimensions and treatment of substance use disorders and be able to identify and diagnose acute psychiatric conditions and decompensation. Credentialed addiction treatment professionals shall have specialized training in relevant behavior management techniques and evidence-based best practices in working with individuals experiencing addiction.
- SUD case management shall be provided in this level of care to coordinate all services offered to each member. Note: SUD case management services (H0006) are not reimbursable for individuals while they are residing in institutions, including institutions for mental disease, except that SUD case management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period.
- Behavior management is used here as a generic phrase that includes a variety of behavioral intervention techniques that are intended to bring about positive behavioral changes. Behavioral management is a proactive approach to reducing disruptive and/or harmful behaviors. This includes but is not limited to: cognitive-

behavior therapy, contingency contracting, contingency management, token economy, motivational enhancement therapy, crisis prevention, and other techniques. The clinical staff personnel records should reflect having received training in behavior management techniques.

- Staff who are credentialed as addiction treatment professionals, physicians, or physician extenders shall be available on-site or by telephone 24 hours per day, seven days per week to respond to member treatment needs, assess and treat co-occurring biological and physiological disorders and to monitor the individual's administration of medications in accordance with a physician's prescription.

Co-Occurring Enhanced Programs
Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) co-occurring enhanced programs as required by ASAM shall have staff requirements as follows:

- Staff shall be credentialed addiction treatment professionals who are able to assess and treat co-occurring substance use and psychiatric disorders.

- Credentialed addiction treatment professionals shall be cross-trained in addiction and mental health to understand the signs and symptoms of mental illness, and be able to provide education to the individual on the interactions with substance use and psychotropic medications. Credentialed addiction treatment professional staff shall be available on site or by telephone 24 hours per day and 7 days per week.

- Staff shall provide 24 hours per day awake supervision on site. The provider's staffing plan must be in compliance with DBHDS staffing plan regulations set forth in 12VAC35-105-1530 and 12VAC35-46-1570.

- Registered nurses and licensed practical nurses shall be available to provide care and observation to individuals as defined in the individual service plan.

<u>Clinically Managed Population-Specific High Intensity Residential Service (ASAM Level 3.3) (H0010/rev 1002)</u>

Clinically managed population-specific high intensity residential services (ASAM Level 3.3) are facility-based providers and who are contracted with the MCOs and the FFS contractor. Providers shall be licensed by DBHDS as ASAM Level 3.3: "Specific high-intensity residential service for adults".

Providers must meet the requirements set forth in 12VAC35-105-1580 through 12VAC35-105-1620.

Residential treatment service providers for clinically managed population-specific high intensity residential services (ASAM Level 3.3) shall meet these staff requirements:

- The interdisciplinary team shall include credentialed addiction treatment professionals acting within the scope of their practice, physicians, or physician extenders and allied health professionals in an interdisciplinary team.

- Staff shall provide 24 hours per day awake supervision on site. The provider's staffing plan must be in compliance with DBHDS staffing plan regulations set forth in 12VAC35-105-1580.

- Credentialed addiction treatment professionals shall be experienced and knowledgeable about the biopsychosocial dimensions and treatment of substance use disorders and be available on-site or by telephone 24 hours per day. Clinical staff shall be able to identify and diagnose acute psychiatric conditions and decompensation.

- SUD case management is included in this level of care to coordinate all services offered to each member. Note: SUD case management services (H0006) are not reimbursable for individuals while they are residing in institutions, including institutions for mental disease, except that SUD case management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period.

- Appropriately credentialed medical staff shall be available to assess and treat co-occurring biomedical disorders and to monitor the individual's administration of prescribed medications.

Co-Occurring Enhanced Programs

- Clinically managed population-specific high intensity residential service co-occurring enhanced programs, as required by ASAM, shall have staff requirements as follows:

- Staff shall be credentialed addiction treatment professionals who are able to assess and treat co-occurring substance use and psychiatric disorders.

- Credentialed addiction treatment professionals shall be available to assess and treat co-occurring substance use and mental health disorders using specialized training in behavior management.

- Credentialed addiction treatment professionals shall be knowledgeable about the biological and psychosocial dimensions of substance use disorders and mental illnesses and their treatment. Clinical staff shall be able to identify and diagnose

acute psychiatric conditions, symptom increase or escalation, and decompensation. Clinical staff shall have specialized training in relevant behavior management techniques and evidenced based best practices in working with individuals experiencing addiction.

- Behavior management is used here as a generic phrase that includes a variety of behavioral intervention techniques that are intending to bring about positive behavioral changes. Behavioral management is a proactive approach to reducing disruptive and/or harmful behaviors. This includes but is not limited to: cognitive-behavior therapy, contingency contracting, contingency management, token economy, motivational enhancement therapy, crisis prevention, and other techniques. The clinical staff personnel records should reflect having received training in behavior management techniques.

- Registered nurses and licensed practical nurses shall be available to provide care and observation to individuals as defined in the individual service plan.

Clinically Managed Low Intensity Residential Services (ASAM Level 3.1) (H2034)

Clinically Managed Low Intensity Residential Services (ASAM Level 3.1) shall be contracted with the MCOs and FFS contractor. The provider shall be licensed by DBHDS as a provider of one of the following:

- ASAM Level 3.1: “Clinically managed low-intensity residential care for adults”;

- ASAM Level 3.1: “Clinically managed low-intensity residential care for children and adolescents”.

Providers must meet the requirements set forth in 12VAC35-105-1630 through 12VAC35-105-1670.

Clinically directed program activities constituting at least 5 hours per week of professionally directed treatment shall be designed to stabilize and maintain SUD symptoms and to develop and apply recovery skills. ASAM Level 3.1 clinically managed low intensity residential service providers shall meet these staff requirements:

- Staff shall provide 24 hours per day awake supervision on site. In addition to this requirement, the provider’s staffing plan must be in compliance with DBHDS staffing plan regulations set forth in 12VAC35-105-1630.

- Allied health professional means a professional who is involved with the delivery of health or related services pertaining to the identification, evaluation, and

prevention of diseases and disorders, such as a certified substance abuse counselor, certified substance abuse counseling assistant, peer recovery support specialist, certified nurse aide, occupational therapist or qualified mental health professionals (QMHPs).

- Credentialed addiction treatment professionals shall be experienced and knowledgeable about the biopsychosocial and psychosocial dimensions and treatment of substance use disorders and able to identify the signs and symptoms of acute psychiatric conditions and decompensation.

- An addiction-credentialed physician, physician with experience in addiction medicine, or physician extenders under supervision of a physician shall review the residential group home admission to confirm medical necessity for services, and a team of credentialed addiction treatment professionals shall develop and shall ensure delivery of the individual service plan.

- SUD case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving ASAM Level 3.1 services in a group home setting.

- Coordination with the member's primary care physician and other specialists shall occur as needed to review treatment and help align treatment plans among all treating practitioners.

- Appropriately credentialed medical staff shall be available to assess and treat co-occurring biomedical disorders and appropriately trained staff to monitor the individual's administration of prescribed medications.

Co-Occurring Enhanced Programs

Clinically managed low intensity residential services (ASAM Level 3.1) co-occurring enhanced programs as required by ASAM shall have staff requirements as follows:

- Credentialed addiction treatment professionals shall be cross-trained in addiction and mental health to understand the signs and symptoms of mental illness and to understand and be able to explain to the individual the purpose of psychotropic medications and interactions with substance use.

- Access to an addiction credentialed physician shall be available for consultation as necessary.

- Registered nurses and licensed practical nurses shall be available to provide care and observation to individuals as defined in the individual service plan.

Partial Hospitalization Services (ASAM Level 2.5) (S0201/rev 0913)

Partial Hospitalization Services (ASAM Level 2.5) shall be a structured program of skilled treatment services for adults, children and adolescents delivering a minimum of 20 hours per week and at least five service hours per service day of skilled treatment services with a planned format including individual and group counseling, medication management, family therapy, education groups, occupational and recreational therapy and other therapies. Withdrawal management services may be provided as necessary. Time not spent in skilled, clinically intensive treatment is not billable.

Partial hospitalization services (ASAM Level 2.5) providers shall be licensed by DBHDS as one of the following and contracted with the MCOs and the FFS contractor:

- ASAM Level 2.5: “Partial Hospitalization service for adults”;
- ASAM Level 2.5: “Partial Hospitalization service for children and adolescents”.

Providers must meet the requirements set forth in 12VAC35-105-1680 through 12VAC35-105-1720.

Partial hospitalization service providers shall meet the ASAM Level 2.5 support systems and staff requirements as follows:

- An interdisciplinary team comprised of credentialed addiction treatment professionals acting within the scope of their practice and an addiction-credentialed physician, or physician with experience in addiction medicine, or physician extenders as defined in 12VAC30-130-5020, shall be required.
- Physicians shall have specialty training or experience, or both, in addiction medicine or addiction psychiatry. Physicians who treat adolescents shall have experience with adolescent medicine.
- Program staff shall be cross-trained to understand signs and symptoms of mental illness and be able to understand and explain the uses of psychotropic medications and understand interactions with substance use and other addictive disorders.
- SUD case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving partial hospitalization services.

Partial hospitalization services (ASAM Level 2.5) co-occurring enhanced programs shall have staff requirements as follows:

- Credentialed addiction treatment professionals shall have experience assessing and treating co-occurring mental illness.

- Clinical leadership and oversight shall be provided by an addiction credentialed physician or physician with experience in addiction medicine, or physician extender as defined in 12VAC30-130-5020.

- Co-occurring programs shall provide case management for individuals with co-occurring mental illness who have unstable living environments or lack positive support systems conducive to recovery. Staff providing case management shall have training and experience working with individuals with a dual diagnosis in substance use and mental health disorders. SUD case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving partial hospitalization services.

Intensive Outpatient Services (ASAM Level 2.1) (H0015/rev 0906)

Intensive outpatient services (ASAM Level 2.1) shall be a structured program of skilled treatment services for adults, children and adolescents delivering a minimum of 3 service hours per service day for adults to achieve an average or 9 to 19 hours of services per week and a minimum of two service hours per service day for children and adolescents to achieve an average of 6 to 19 hours of services per week.

Intensive outpatient services (ASAM Level 2.1) shall be provided by providers/programs licensed by DBHDS as one of the following and contracted with the MCOs and the FFS contractor to provide this service:

- ASAM Level 2.1: “Intensive Outpatient service for adults”;

- ASAM Level 2.1: “Intensive Outpatient for children and adolescents”.

Providers must meet the requirements set forth in 12VAC35-105-1730 through 12VAC35-105-1770.

Intensive outpatient service providers shall meet the ASAM Level 2.1 staff requirements as follows:

- An interdisciplinary team of credentialed addiction treatment professionals acting within the scope of their practice is required.

- Generalist physicians or physicians with experience in addiction medicine are permitted to provide general medical evaluations and concurrent/integrated general medical care.

- Staff shall be cross-trained to understand signs and symptoms of psychiatric disorders and be able to understand and explain the uses of psychotropic

medications and understand interactions with substance use and other addictive disorders.

- Emergency services, which shall be available, when necessary, by telephone 24 hours per day and seven days per week when the treatment program is not in session.

- Direct affiliation with (or close coordination through referrals to) higher and lower levels of care and supportive housing services such as Clinically Managed Low Intensity Residential Services.

Co-Occurring Enhanced Programs
Intensive outpatient services (ASAM Level 2.1) co-occurring enhanced programs shall have staff requirements as follows:

- Credentialed addiction treatment professionals shall have experience assessing and treating co-occurring mental illness.

- Clinical leadership and oversight, at a minimum, have capacity to consult with an addiction credentialed physician, or a physician with experience in addiction medicine, or a physician extender as defined in 12VAC30-130-5020.

SUD case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving intensive outpatient services.

Outpatient SUD Treatment Services (ASAM Level 1.0)

Outpatient SUD treatment services shall be provided by a Credentialed Addiction Treatment Professional as defined in 12VAC30-130-5020 under the scope of their practice and contracted by the MCOs or the FFS contractor to perform these services. Services can be provided in the following community based settings: primary care clinics, outpatient health system clinics, psychiatry clinics, Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), Community Service Boards (CSBs)/Behavioral Health Authorities (BHAs), local health departments, and provider offices - private or group practices.

The ARTS specific procedure codes and reimbursement structure for outpatient services are posted online at:
https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/ .

Outpatient services (ASAM Level 1) staff requirements include:
- A Credentialed addiction treatment professional;

- Providers who are licensed through DBHDS for ASAM Level 1.0 must meet the requirements set forth in 12VAC35-105-1780 through 12VAC35-105-1820.

Outpatient services (ASAM Level 1) co-occurring enhanced programs shall include:

- Ongoing SUD case management for highly crisis prone individuals with co-occurring disorders. SUD case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving outpatient services.

- Credentialed addiction treatment professionals who are trained in severe and chronic mental health and psychiatric disorders and are able to assess, monitor and manage individuals who have a co-occurring mental health disorder.

Screening Brief Intervention and Referral to Treatment (ASAM Level 0.5) (99408 and 99409)

Early intervention (ASAM Level 0.5) settings for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services shall include health care settings such as: local health departments, FQHCs, RHCs, CSBs/ BHAs, health systems, emergency departments of hospitals, pharmacies, physician offices and private and group outpatient practices. Individual practitioners shall be licensed by DHP and either directly contracted by the MCOs and the FFS contractor to perform this level of care, or employed by organizations that are contracted by the MCOs and the FFS contractor.

Provider qualifications of SBIRT (ASAM Level 0.5) include: Physicians, pharmacists, and other credentialed addiction treatment professionals, within the scope of their practice, shall administer the evidence-based screening tool with the individual and provide the counseling and intervention. Licensed providers may delegate administration of the evidence-based screening tool, counseling and intervention to other clinical staff as allowed by their scope of practice, such as physicians delegating to a licensed registered nurse or licensed practical nurse. Billing of SBIRT must be through the licensed agency or provider who is credentialed with the MCO or FFS contractor.

SUD Case Management (H0006)

SUD Case Management services are for individuals who have a primary diagnosis of SUD. Provider qualifications for a SUD case management shall meet the following criteria:

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

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

- The enrolled provider must be licensed by DBHDS as a provider of SUD case management services.

SUD case management services shall be provided by a professional or professionals who meet at least one of the following criteria:

- 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 either 1) one year of substance use related direct experience providing services to individuals with a diagnosis of SUD or 2) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of SUD and mental illness; or

- Licensure by the Commonwealth as a registered nurse with at least either: 1) one year of substance use related direct experience providing services to individuals with a diagnosis of SUD; or 2) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of SUD and mental illness; or

- Board of Counseling Certified Substance Abuse Counselor (CSAC), CSAC-Supervisee or CSAC-Assistant under supervision as defined in 18VAC115-30-10 et seq. Community Service Boards that have CSACs, CSAC-Supervisees or CSAC–Assistants performing Substance Use Case Management Services shall be under supervision according to the supervision requirements of the Board of Counseling which allows for supervision by another person with substantially equivalent education, training, and experience, or such counselor shall be in compliance with the supervision requirements of a licensed facility, as long as the they are in compliance with the supervision requirements of the licensed facility (§54.1-3507.1 and §54.1-3507.2).

Peer Recovery Support Services

Effective July 1, 2017, DMAS expanded the Medicaid benefit to allow for reimbursement of Peer Recovery Support Services to include Peer Support Services and Family Support Partners. For more information about the Medicaid Peer Recovery Support Service benefit, please view the Peer Recovery Support Services Provider Supplement to this manual online: https://vamedicaid.dmas.virginia.gov/pdf_chapter/addiction-and-recovery-treatment-services.