TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Emergency Regulation

Title of Regulation: **12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-5).**

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

Effective Dates: October 23, 2018, through April 22, 2020.

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Preamble:

Section 2.2-4011 of the Code of Virginia states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of § 2.2-4006 A 4 of the Code of Virginia. Item 303 X of Chapter 2 of the 2018 Acts of the Assembly, Special Session I, directs the agency to make changes to the utilization review and provider qualifications for community mental health services in order to ensure appropriate utilization and cost efficiency. The amendments provide clarification to providers of the documentation required to establish that services are rendered by individuals with appropriate qualifications and credentials and update the regulations to include Department of Health Professions requirements for registration of qualified mental health professionals.

12VAC30-60-5. Applicability of utilization review requirements.

A. These utilization requirements shall apply to all Medicaid covered services unless otherwise specified.

B. Some Medicaid covered services require an approved service authorization prior to service delivery in order for reimbursement to occur. ~~1.~~ To obtain service authorization, all providers' information supplied to the Department of Medical Assistance Services (DMAS), service authorization contractor, or the behavioral health service authorization contractor shall be fully substantiated throughout individuals' medical records.

~~2.~~ C. Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in providers' care. Such documentation shall fully disclose the extent of services provided in order to support providers' claims for reimbursement for services rendered. This documentation shall be written, signed, and dated at the time the services are rendered unless specified otherwise.

D. Providers shall maintain documentation that demonstrates that individuals providing services have the required qualifications established by DMAS, the Department of Health Professions (DHP), or the Department of Behavioral Health and Developmental Services (DBHDS).

~~C.~~ E. DMAS, or its designee, shall perform reviews of the utilization of all Medicaid covered services pursuant to 42 CFR 440.260 and 42 CFR Part 456.

~~D.~~ F. DMAS shall recover expenditures made for covered services when providers' documentation does not comport with standards specified in all applicable regulations.

~~E.~~ G. Providers who are determined not to be in compliance with DMAS requirements shall be subject to 12VAC30-80-130 for the repayment of those overpayments to DMAS.

~~F.~~ H. Utilization review requirements specific to community mental health services, as set out in 12VAC30-50-130 and 12VAC30-50-226, shall be as follows:

1. To apply to be reimbursed as a Medicaid provider, the required ~~Department of Behavioral Health and Developmental Services (DBHDS)~~ DHBDS license shall be either a full, annual, triennial, or conditional license. Providers must be enrolled with DMAS or the ~~BHSA~~ behavioral health services administrator to be reimbursed. Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS requires, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.

2. Health care entities with provisional licenses issued by DBHDS shall not be reimbursed as Medicaid providers ~~of community mental health services~~.

3. Payments shall not be permitted to health care entities that either hold provisional licenses or fail to enter into a Medicaid Provider Enrollment Agreement for a service prior to rendering that service.

4. The behavioral health service authorization contractor shall apply a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual Criteria, or an equivalent standard authorized in advance by DMAS. Services that fail to meet medical necessity criteria shall be denied service authorization.

5. Service providers shall maintain documentation to establish that services are rendered by individuals with appropriate qualifications and credentials, including proof of licensure or registration through DHP if applicable. Qualified mental health professional-eligibles shall maintain documentation of supervision and of progress toward the requirements for DHP registration as a qualified mental health professional-child or progress toward the requirements for DHP registration as a qualified mental health professional-adult.

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