COMMONWEALTH of VIRGINIA

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TO: **EMILY MCCLELLAN**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **USHA KODURU** UK
Assistant Attorney General

DATE: **July 13, 2018**

SUBJECT: **Emergency Regulation Regarding Community Mental Health Services Documentation of Qualifications 12 VAC 30-60-5 (4990/8151)**

I am in receipt of the attached regulation requiring providers to maintain documentation to establish Community Mental Health Services (CMHS) are rendered by individuals with appropriate qualifications and credentials. You have asked the Office of the Attorney General to review and determine if DMAS has the legal authority to promulgate the regulation and if the regulation comports with state and federal law.

Based on that review, it is my view that the Director, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code §§ 32.1-324 and 325, has the authority to promulgate this regulation, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

The authority for this emergency action is found in Va. Code § 2.2-4011. Chapter 2, Item 303.X(1) of the 2018 Acts of Assembly authorizes DMAS to promulgate emergency regulations. Accordingly, this regulation qualifies for the "emergency" exemption from Article 2 requirements. A Notice of Intended Regulatory Action relating to the proposed replacement regulation must be filed with the Registrar within sixty days of the effective date of the

emergency regulation, and appears to already have been so filed at the same time as the emergency regulation. The proposed replacement regulation must be filed with the Registrar within 180 days after the effective date of the emergency regulation. This regulation will amend the State Plan; therefore, approval by the Centers for Medicare and Medicaid Services also will be required.

If you have any questions or need additional information about this regulation, please contact me at 786-4074.

cc: Kim F. Piner, Esquire

Attachment

Emergency Text

Action:
CMHRS Documentation of Qualifications
Stage: Emergency/NOIRA
6/14/18 2:31 PM [latest]

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~~)~~ license shall be either a full, annual, triennial, or conditional license. Providers must be enrolled with DMAS or the BHSA 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. QMHP-Es shall maintain documentation of supervision and of progress toward the requirements for DHP registration as a QMHP-C or progress toward the requirements for DHP registration as a QMHP-A.