12VAC30-50-141. Outpatient substance abuse treatment services.

1. Outpatient substance abuse treatment services shall be limited to an initial availability of 26 therapy sessions, without prior authorization during the first treatment year. An additional extension of up to 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 therapy sessions each succeeding year when prior authorized by DMAS or its designee. Outpatient substance abuse treatment services are further restricted to no more than three sessions in any given seven-day period. Consistent with §6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary substance abuse services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening.

2. Outpatient substance abuse services shall be provided by medical doctors or by doctors of osteopathy who have completed three years of post-graduate residency training in psychiatry; or by a physician or doctor of osteopathy who is certified in addiction medicine. The provider must also be qualified by training and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities.

3. Psychological and psychiatric services shall be prescribed treatment that is directly and specifically related to an active written plan designed and signature-dated by one of the professionals listed in (2) above.

4. Psychological or psychiatric services shall be considered appropriate when an individual meets the criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence shall not be covered. The Axis I substance-related disorder shall meet American Society of Addiction Medicine (ASAM) Level of Care Criteria .

5. Psychological or psychiatric services may be provided in an office or a clinic.

12VAC30-50-151. Substance abuse treatment services provided by other licensed practitioners within the scope of their practice as defined by state law.

A. Outpatient substance abuse services are limited to an initial availability of 26 sessions, without prior authorization during the first treatment year. An additional extension of up to 26 sessions is available during the first treatment year and must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding year when prior authorized by DMAS or its designee. Outpatient substance abuse services are further restricted to no more than three sessions in any given seven-day period. Consistent with §6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary substance abuse services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening.

B. Outpatient substance abuse services shall be provided by a licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a psychiatric nurse practitioner, a licensed marriage and family therapist, or a licensed substance abuse treatment practitioner. The provider must also be qualified by training

and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities.

C. Psychological and psychiatric services shall be prescribed treatment that is directly and specifically related to an active written plan designed and signature-dated by one of the professionals listed in (3)(b).

D. Psychological or psychiatric services shall be considered appropriate when an individual meets criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence shall not be covered. The Axis I substance-related disorder shall meet American Society of Addiction Medicine (ASAM) Level of Care Criteria.

E. Psychological or psychiatric services may be provided in an office or a clinic.

12VAC30-50-181. Clinic services: substance abuse treatment services.

A. Coverage of community mental health clinics for substance abuse treatment services is provided only when performed by a qualified therapist. For purposes of providing this service a qualified therapist shall be:

i. Outpatient substance abuse services can be provided by medical doctors and doctors of osteopathy who have completed three years of post-graduate residency training in psychiatry or by a physician or doctor of osteopathy who is certified in addiction medicine;

ii. A licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a psychiatric nurse practitioner, a licensed marriage and family therapist, or a licensed substance abuse treatment practitioner. The provider must also be qualified by training and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities.

iii. An individual who holds a master's or doctorate degree, who has completed all coursework necessary for licensure by the respective board, and who has applied for a license but has not yet received such license, and who is currently supervised in furtherance of the application for such license, in accordance with requirements or regulations promulgated by DMAS, by one of the licensed practitioners listed in subdivisions 1 and 2 of this subsection.

B. Substance abuse treatment services provided in clinics shall be prescribed treatment that is directly and specifically related to an active written plan designed and signature-dated by one of the professionals listed in (D)(1) or (2).

12 VAC 30-50-228. Community substance abuse treatment services

A. Services to be covered shall include crisis intervention, day treatment services in non-residential settings, intensive outpatient services, and opioid treatment services. These services

shall be rendered to Medicaid recipients consistent with the criteria specified in 12VAC30-60-250. Individuals shall not receive any combination of day treatment, opioid treatment, and intensive outpatient services concurrently. To be reimbursed by Medicaid, covered services shall meet the following definitions:

1. Crisis intervention. This service shall provide immediate substance abuse care, available 24 hours a day, seven days per week, to assist recipients who are experiencing acute dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the recipient or others, and to provide treatment in the context of the least restrictive setting.

(a) An assessment must be conducted to assess the crisis situation. The assessment must document the need for the service.

(b) Crisis intervention activities, limited annually to 180 hours, may include short-term counseling designed to stabilize the recipient, providing access to further immediate assessment and follow-up, and linking the recipient with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, telephone contacts, and face to face support or monitoring or other client-related activities for the prevention of institutionalization.

C) Assessment and counseling may be provided by a Qualified Substance Abuse Professional (QSAP) as defined in 12VAC30-50-250, or a certified prescreener described in 12VAC30-50-226.

(d) Monitoring and face to face support may be provided by a QSAP, a certified prescreener, or a paraprofessional. A paraprofessional, as described in 12VAC30-50-226, must be under the supervision of a QSAP and provide services in accordance with a plan of care.

2. Day treatment, intensive outpatient, and opioid treatment services. These services shall include the major psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. To be reimbursed by Medicaid, these covered services shall meet the following definitions:

a. Day treatment services shall be provided in a non-residential setting and shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week to provide a minimum of 20 hours up to a maximum of 30 hours of skilled treatment services per week. This service should be provided to those recipients who do not require the intensive level of care of inpatient or residential services but require more intensive services than outpatient services. The maximum annual limit is 1,300 hours. Day treatment services may not be provided concurrently with intensive outpatient services or opioid treatment services.

b. Intensive outpatient services for recipients are provided in a nonresidential setting and shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to provide a minimum of 4 hours and a maximum of 19 hours of skilled treatment services per week. This service should be provided to those recipients who do not require the intensive level of care of inpatient, residential, or day treatment services, but require

more intensive services than outpatient services. The maximum annual limit is 600 hours. Intensive outpatient services may not be provided concurrently with day treatment services or opioid treatment Services.

c. Opioid treatment shall be provided in daily sessions with a maximum of 600 hours per year. Day treatment and intensive outpatient services may not be provided concurrently with opioid treatment. Opioid treatment service covers psychological and psycho-educational services. Medication costs for opioid agonists shall be billed separately. An individual-specific, physician-ordered dose of medication may be administered or dispensed either for detoxification or maintenance treatment.

d. Staff qualifications for day treatment, intensive outpatient, and opioid treatment services shall be as follows:

i. Individual and group counseling, and family therapy, and occupational and recreational therapy must be provided by at least a QSAP.

ii. A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional and social functioning of the individual, relapse prevention, occupational and recreational activities. A QSAP must be onsite when a paraprofessional is providing services.

iii. Paraprofessionals must participate in supervision, as described in 12VAC30-60-250.

B. Evaluations required. Prior to initiation of day treatment, intensive outpatient, or opioid treatment services, an evaluation shall be conducted by at least a QSAP. The minimum

evaluation will consist of a structured objective assessment of the impact of substance use or dependence on the recipient's functioning in the following areas: drug use, alcohol use, legal system involvement, employment and/or school issues, and medical, family-social, and psychiatric issues. If indicated by history or structured assessment, a psychological examination and psychiatric examination shall be included as part of this evaluation. The assessment must be a written report as specified at 12VAC30-60-250 and must document the medical necessity for the service.

C. Consistent with §6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary substance abuse services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening and the above limits have been exceeded.

12VAC30-50-461 Case management services for individuals who have an Axis 1 substance-related disorder.

A. The Medicaid eligible recipient shall meet the current DSM diagnostic criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence shall not be covered.

1. An active client for case management shall mean a recipient for whom there is a plan of care in effect which requires regular direct or recipient-related contacts or communication or activity with the recipient, family, service providers, or significant others, including at least one face-to-face contact with the recipient every 90 days.

2. The maximum service limit for case management services is 52 hours per year. Case management services are not reimbursable for recipients residing in institutions for mental disease.

B. Services will be provided to the entire State.

C. Definition of services: Substance abuse case management services assist recipients in accessing needed medical, psychiatric, psychological, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided shall include:

1. Assessment and planning services, to include developing an Individual Service Plan (does not include performing assessments for severity of substance abuse or dependence, medical, psychological and psychiatric assessment but does include referral for such assessment);

2. Linking the recipient to services and supports specified in the Individual Service Plan. When available, assessment and evaluation information should be integrated into the Individual Service Plan within two weeks of completion. The Individual Service Plan shall utilize accepted patient placement criteria and shall be fully completed within 30 days of initiation of service;

3. Assisting the recipient directly for the purpose of locating, developing, or obtaining needed services and resources;

4. Coordinating services and service planning with other agencies and providers involved with the recipient;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;

6. Making collateral contacts with the recipients' significant others to promote implementation of the service plan and community adjustment;

7. Follow-up and monitoring to assess ongoing progress and to ensure services are delivered; and

8. Education regarding the need for services identified in the Individualized Service Plan (ISP).

D. Qualifications of Providers:

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 DMHMRSAS 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.

E. The State assures that the provision of case management services will not restrict a recipient's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients shall have free choice of the providers of case management services.

2. Eligible recipients shall have free choice of the providers of other services under the plan.

F. Payment for substance abuse treatment case management services under the Plan does not duplicate payments for other case management made to public agencies or private entities under other Title XIX program authorities for this same purpose.

12VAC30-60-250. Utilization review of community substance abuse treatment services.

A. To be eligible to receive these substance abuse treatment services, Medicaid recipients must meet the Diagnostic Statistical Manual diagnostic criteria for an Axis I Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria shall be used to determine the appropriate level of treatment. Referrals for medical examinations shall be made consistent with the Early Periodic Screening and Diagnosis Screening Schedule.

B. Provider qualifications.

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 either

(i) is 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) 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)(g) through **(**A)(1)(i), they must be supervised every two weeks by a professional who meets one of the criteria specified in (A)(1)(a) through **(**A)(1)(f). 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 recipient 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 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. 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. 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. The enrolled provider of opioid treatment services must be licensed as a provider of Opioid treatment services by the Department of Mental Health, Mental Retardation and Substance Abuse Treatment services.

C. Evaluations/assessments of the recipient shall be required for day treatment, intensive outpatient, and opioid treatment services. A structured interview shall be documented as a written report which provides recommendations substantiated by the findings of the evaluation and shall document the need for the specific service. Evaluations shall be reimbursed as part of day treatment, intensive outpatient, and opioid treatment services. The structured interview must be conducted by a qualified substance abuse professional as defined in (A)(1).

D. Individual Service Plan (ISP) for day treatment, intensive outpatient, and opioid treatment services.

1. An initial ISP must be developed. A comprehensive ISP must be fully developed within 30 calendar days of admission to the service.

2. A comprehensive Individual Service Plan shall be developed with the recipient, in consultation with the individual's family, as appropriate, and must address: (i) a summary or reference to the evaluation; (ii) short term and long term goals and measurable objectives for addressing each identified individually specific need; (iii) services and supports and frequency of service to accomplish the goals and objectives; (iv) target dates for accomplishment of goals and objectives; (v) estimated duration of service; (vi) the role of other agencies if the plan is a shared

responsibility and the staff responsible for the coordination and the integration of services, including designated persons of other agencies if the plan is a shared responsibility. The ISP must be reviewed at least every 90-calendar days and must be modified as appropriate.

E. Individuals shall not receive any combination of day treatment, opioid treatment and intensive outpatient services concurrently.

F. Crisis intervention. Admission to crisis intervention services is indicated following a marked reduction in the recipient's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress which is related to the use of alcohol or other drugs. Crisis intervention may be the initial contact with a recipient.

1. The provider of crisis intervention services shall be licensed as a provider of Substance Abuse Outpatient Services by DMHMRSAS. Providers may bill Medicaid for substance abuse crisis intervention only when the services are provided by either a professional or professionals who meet at least one of the criteria listed herein.

2. Only recipient-related activities provided in association with a face-to-face contact shall be reimbursable.

3. An ISP shall not be required for newly admitted recipients to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.

4. Other than the annual service limits, there shall be no restrictions (regarding numbers of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts. An ISP must be developed within 30 days of service initiation.

5. For recipients receiving scheduled, short-term counseling as part of the crisis intervention service, the ISP must reflect the short-term counseling goals.

6. Crisis intervention services may be provided outside of the clinic and billed, provided the provision of out-of-clinic services is clinically or programmatically appropriate for the recipient's needs, and it is included on the ISP. Travel by staff to provide out-of-clinic services shall not be reimbursable. Crisis intervention may involve contacts with the family or significant others.

7. Documentation must include the efforts at resolving the crisis to prevent institutional admissions.

12VAC30-60-255. Utilization review of case management

A. Utilization Review: Community substance abuse treatment services.

1. The Medicaid recipient shall meet the current Diagnostic Statistical Manual criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence shall not be covered.

2. Reimbursement shall be provided only for "active" case management. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires

regular direct or client-related contacts or activity or communication with the client or families, significant others, service providers, and others including a minimum of one face-to-face client contact within a 90-day period.

3. Except for a 30-day period following the initiation of this case management service by the recipient, in order to continue receiving case management services, the Medicaid recipient must be receiving another substance abuse treatment service;

4. Billing can be submitted for an active recipient only for months in which direct or client-related contacts, activity or communications occur.

5. There is a maximum annual service limit of 52 hours for case management services.

6. An initial Individual Service Plan (ISP) must be completed and must document the need for active case management before case management services can be billed. A comprehensive ISP shall be fully developed within 30 days of initiation of this service, which requires regular direct or recipient-related contacts or activity or communication with the recipient or families, significant others, service providers, and others including a minimum of one face-to-face client contact every 90 days. The case manager shall review the ISP every 90 days for the purpose of updating it or otherwise modifying it as appropriate for the recipient’s changing condition.

7. The ISP shall be updated at least every 90 days or within 7 days of a change in the recipient's treatment.

B. Utilization Review: Substance Abuse Treatment Case management services.

1. Utilization review general requirements. On-site utilization reviews shall be conducted. Reimbursement shall be provided only for "active" case management clients. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or activity or communication with the client or families, significant others, service providers, and others including a minimum of one face-to-face client contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

2. The Medicaid eligible individual shall meet the current Diagnostic and Statistical Manual of Mental Disorders criteria for an Axis I Substance Abuse Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence alone shall not be sufficient for reimbursement of these services.

3. The maximum annual limit for substance abuse treatment case management shall be 52 hours per year. Case management shall not be billed for persons in institutions for mental disease. Substance abuse treatment case management shall not be billed concurrently with any other type of Medicaid reimbursed case management.

4. The ISP must document the need for case management and be fully completed within 30 days of initiation of the service, and the case manager shall review the ISP every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the

next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review.

5. The ISP shall be updated at least annually.

6. The provider of case management services shall be licensed by DMHMRSAS as a provider of case management services.

12VAC30-80-32. Reimbursement for substance abuse services.

1. Outpatient psychotherapy services for assessment and evaluation or treatment of substance abuse furnished by physicians shall be reimbursed using the methodology in 12 VAC 30-80-190. For non-physicians, they shall be reimbursed at the same levels specified in 12 VAC 30-50-140 and 12 VAC 30-50-150.

2. Rates for other substance abuse services shall be based on the Agency fee schedule for 15 minute units of service. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency and quality of care. For each level of professional necessary to provide services described in 12VAC30-50-228 and 12VAC30-50-461, separate rates shall be established for licensed professionals, qualified substance abuse professionals (QSAP) and paraprofessionals. The same rates shall be paid to public and private providers.

12VAC30-120-310. Services exempted from MEDALLION referral requirements.

A. The following services shall be exempt from the referral requirements of MEDALLION:

1. Obstetrical and gynecological services (pregnancy and pregnancy related);

2. Psychiatric and psychological services, to include but not be limited to mental health, mental retardation services;

3. Family planning services;

4. Routine newborn services;

5. Annual or routine vision examinations (under age 21);

6. Emergency services;

7. EPSDT well-child exams;

8. Immunizations (health departments only);

9. All school health services provided pursuant to the Individuals with Disabilities Education Act (IDEA);

10. Services for the treatment of sexually transmitted diseases;

11. Targeted case management services;

12. Transportation services;

13. Pharmacy services;

14. Substance abuse treatment services ~~for pregnant women~~; and

15. MR waiver services and MH community rehabilitation services.

B. While reimbursement for these services may not require a referral, an authorization, or a referral and an authorization by the PCP, the PCP must continue to track and document them to ensure continuity of care.

12VAC30-120-380. Medallion II MCO responsibilities.

A. The MCO shall provide, at a minimum, all medically necessary covered services provided under the State Plan for Medical Assistance and further defined by written DMAS regulations, policies and instructions, except as otherwise modified or excluded in this part.

1. Nonemergency services provided by hospital emergency departments shall be covered by MCOs in accordance with rates negotiated between the MCOs and the emergency departments.

2. Services that shall be provided outside the MCO network shall include those services identified and defined by the contract between DMAS and the MCO. Services reimbursed by DMAS include dental and orthodontic services for children up to age 21; for all others, dental services (as described in 12VAC30-50-190), school health services (as defined in 12VAC30-120-360) and community mental health services (rehabilitative, targeted case management and the following substance abuse treatment services: emergency services (crisis); intensive outpatient services; day treatment services; substance abuse case management services; and opioid treatment services).

3. The MCOs shall pay for emergency services and family planning services and supplies whether they are provided inside or outside the MCO network.

B. Except for those services specifically carved out in section A above, EPSDT services shall be covered by the MCO. The MCO shall have the authority to determine the provider of service for EPSDT screenings.

C. The MCOs shall report data to DMAS under the contract requirements, which may include data reports, report cards for clients, and ad hoc quality studies performed by the MCO or third parties.

D. Documentation requirements.

1. The MCO shall maintain records as required by federal and state law and regulation and by DMAS policy. The MCO shall furnish such required information to DMAS, the Attorney General of Virginia or his authorized representatives, or the State Medicaid Fraud Control Unit on request and in the form requested.

2. Each MCO shall have written policies regarding enrollee rights and shall comply with any applicable federal and state laws that pertain to enrollee rights and shall ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees in accordance with 42 CFR 438.100.

E. The MCO shall ensure that the health care provided to its clients meets all applicable federal and state mandates, community standards for quality, and standards developed pursuant to the DMAS managed care quality program.

F. The MCOs shall promptly provide or arrange for the provision of all required services as specified in the contract between the state and the contractor. Medical evaluations shall be available within 48 hours for urgent care and within 30 calendar days for routine care. On-call clinicians shall be available 24 hours per day, seven days per week.

G. The MCOs must meet standards specified by DMAS for sufficiency of provider networks as specified in the contract between the state and the contractor.

H. Each MCO and its subcontractors shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of service. Each MCO and its subcontractors shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Each MCO and its subcontractors shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

I. In accordance with 42CFR 447.50 through 42CFR 447.60, MCOs shall not impose any cost sharing obligations on enrollees except as set forth in 12VAC30-20-150 and 12VAC30-20-160.

J. An MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his patient in accordance with 42 CFR 438.102.

K. An MCO that would otherwise be required to reimburse for or provide coverage of a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds and furnishes information about the service it does not cover in accordance with 42 CFR 438.102.