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MEMORANDUM

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

FROM: **JENNIFER L. GOBBLE**
Assistant Attorney General

DATE: **November 26, 2019**

SUBJECT: **Emergency Regulations**
Applicability of Utilization Review Requirements: Service Authorization

I have reviewed the attached emergency regulations that would clarify the documentation requirements for service authorization requests generally and requirements that are specific to community mental health and rehabilitative services to ensure proper utilization and cost efficiency. The regulations also reference other utilization control measures.

The changes in the attached emergency regulations are in accordance with directives in the 2018 *Acts of Assembly*, Chapter 2, Item 303.X.1, and 2019 *Acts of Assembly*, Chapter 854, Item 303.X.1, requiring DMAS to "make programmatic changes in the provision of . . . Community Mental Health services in order to ensure appropriate utilization and cost efficiency. The department shall consider all available options, including but not limited to, prior authorization, utilization review, and provider qualifications."

Based on my review, it is this Office's view that the Director of the Department of Medical Assistance Services, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code § 32.1-324, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Virginia Administrative Process Act (VAPA), and has not exceeded that authority.

The authority for this emergency action is found in Virginia Code § 2.2-4011(B), which provides 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 subdivision A.4 of Virginia Code § 2.2-4006.

Pursuant to Virginia Code § 2.2-4012, the attached emergency regulations shall become effective upon approval by the Governor and filing with the Registrar of Regulations. In addition, the emergency regulations shall be effective for no more than 18 months. If the Department intends to continue regulating the subject matter governed by these emergency regulations beyond 18 months, it will be necessary to replace these emergency regulations with regulations promulgated in accordance with Article 2 of the VAPA. A Notice of Intended Regulatory Action relating to the proposed replacement regulations must be filed with the Registrar within 60 days of the effective date of the emergency regulations. The proposed replacement regulations must be filed with the Registrar within 180 days after the effective date of the emergency regulations. Va. Code § 2.2-4011(C).

If you have any questions or need any additional information, please feel free to contact me at 786-4905.

cc: Kim F. Piner
Chief/Senior Assistant Attorney General

Emergency Text

Action:
Service Authorization
Stage: Emergency/NOIRA
11/26/19 1:52 PM [latest]

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

A. In accordance with the requirements in 42 C.F.R. Part 456 concerning utilization control of Medicaid services, the Department or its contractor shall implement utilization control measures, including but not limited to service authorization requirements, post-payment reviews, quality management reviews, and other reviews to monitor quality and appropriate utilization of Medicaid services. These ~~utilization~~ requirements shall apply to all Medicaid covered services unless otherwise specified.

B. Service authorization. Some Medicaid covered services require an approved service authorization prior to service delivery in order to be considered for reimbursement ~~to occur~~. Service authorization means the process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS individual by a DMAS service authorization contractor prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Service authorization does not guarantee payment for the service.

1. To obtain service authorization, ~~all providers' information supplied to~~ providers shall supply the Department of Medical Assistance Services (DMAS) or its contractor ~~shall be~~ with information supporting the medical necessity for the requested service that is fully ~~substantiated throughout~~ documented in individuals' medical records.

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

3. Continued authorization requests shall include the documentation requirements in subsections 1 and 2, as well as documentation of the individual's current status and the individual's progress, or lack of progress, towards goals and objectives in the ISP.

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

~~D.~~ C. DMAS or its contractor shall recover expenditures made for covered services when providers' documentation does not comport with standards specified in all applicable laws, regulations, and provider agreement requirements.

~~E.~~ D. Providers who are determined not to be in compliance with ~~DMAS~~ applicable laws, regulations, or provider agreement requirements shall be subject to 12VAC30-80-130 for the repayment of ~~those~~ overpayments ~~to DMAS~~.

~~F. Utilization review requirements specific to community mental health services and residential treatment services, including therapeutic group homes and psychiatric residential treatment facilities (PRTFs), 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 its contractor to be reimbursed. Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS or its contractor requires, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.~~

~~2. Health care entities with provisional licenses 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 provider contract with DMAS or its contractor for a service prior to rendering that service.~~

~~4. DMAS or its contractor shall apply a national standardized set of medical necessity criteria in use in the industry or an equivalent standard authorized in advance by DMAS. Services that fail to meet medical necessity criteria shall be denied service authorization.~~

~~5. For purposes of Medicaid reimbursement for services provided by staff in residency, the following terms shall be used after their signatures to indicate such status:~~

~~a. An LMHP-R shall use the term "Resident" after his signature.~~

~~b. An LMHP-RP shall use the term "Resident in Psychology" after his signature.~~

~~c. An LMHP-S shall use the term "Supervisee in Social Work" after his signature.~~

12VAC30-60-140. Community mental health services.

A. All community mental health services require utilization control measures, including but not limited to service authorization, post-payment reviews, quality management reviews, and other reviews to monitor quality and appropriate utilization of Medicaid services. Utilization control measures for these services shall be performed in accordance with the general requirements of 12VAC30-60-5 and this section, as well as the more specific requirements contained in 12VAC30-60-61 and 12VAC30-60-143.

B. Service Authorization.

1. Initial service authorization requests shall: (i) clearly document how the individual's behaviors within the last 30 calendar days demonstrate that each of the medical necessity criteria for the service have been met; (ii) clearly document how the individual's behaviors within the last 30 calendar days support the need for the number of service units and the span of dates requested; and (iii) demonstrate individualized and comprehensive treatment planning.

2. Continued authorization requests shall clearly document the items listed in subdivision 1 and 2, as well as the individual's current status and the individual's progress, or lack of progress, towards goals and objectives in the ISP.

~~A.~~ C. Utilization review general requirements. Utilization reviews shall be conducted, at a minimum annually for each enrolled provider, by the Department of Medical Assistance Services (DMAS) or its contractor. During each review, an appropriate sample of the provider's total Medicaid population will be selected for review. An expanded review shall be conducted if an appropriate number of exceptions or problems are identified.

~~B.~~ D. The review by DMAS or its contractor shall include the following items:

1. Medical or clinical necessity of the delivered service~~;~~.

2. The admission to service and level of care was appropriate~~;~~.

3. The services were provided by appropriately qualified individuals as defined in the Amount, Duration, and Scope of Services found in 12VAC30-50~~; and~~.

4. Delivered services as documented are consistent with recipients' Individual Service Plans, invoices submitted, and specified service limitations.

5. Licensure. To qualify as a Medicaid provider of community mental health services, the provider must have either a full, annual, triennial, or conditional license from the Department of Behavioral Health and Developmental Services (DBHDS). Health care entities with provisional licenses shall not be reimbursed as Medicaid providers of community mental health services.

6. Enrollment. All providers must be enrolled with DMAS. If services are provided to a member enrolled in a Medicaid managed care organization (MCO), the provider shall also follow the MCO enrollment requirements. Once a provider has been enrolled, it shall maintain, and update periodically as DMAS and the MCO requires, current provider enrollment documentation for each Medicaid service that the provider offers.