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CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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CHAPTER II PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating provider is an agency or program that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and that has a current signed Participation Agreement with DMAS.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. Providers must sign the appropriate Participation Agreement and return it along with a copy of the required license, certification or approval necessary to First Health Services – Provider Enrollment Unit. An original signature of the provider is required. An agreement for an agency or institution must be signed by the authorized agent of the provider. DMAS must receive prior written notification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists. Provider enrollment forms may be found on the DMAS website at www.dmas.virginia.gov.

First Health Services (First Health) is the contractor responsible for provider enrollment. First Health will review the documentation from the provider and verify the provider qualifications. If the provider meets the qualifications as outlined in this chapter, First Health will send the provider notification that the application has been approved. The provider must maintain documentation (including relevant license, vendor agreement, letter of approval, personnel records, etc.) that verifies the provider's qualifications for review by DMAS staff.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. Providers of medical and health services for Medicaid recipients must obtain a National Provider Identifier (NPI) or an Atypical Provider Identifier (API) and submit the NPI/API to DMAS. The NPI/API replaces all previously assigned Medicaid provider numbers and must be included on all claims and correspondence submitted to Medicaid.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program. Forms referenced in this chapter may be found on the DMAS website at www.dmas.virginia.gov.

NPIs or APIs may be disclosed to other healthcare entities pursuant to CMS guidance. The NPI final rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs use in HIPAA standard transactions. DMAS may share your NPI/API with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to, referring provider NPIs/APIs and prescribing provider NPIs.

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REQUESTS FOR PARTICIPATION

Many of the services offered by the Children's Mental Health Program (CMH Program) can be provided by currently enrolled DMAS providers using an existing Participation Agreement. Providers with an active DMAS Participation Agreement that are enrolled as a provider of companion care, respite care, in-home residential, therapeutic consultation, service facilitation, environmental modification and/or family caregiver training services, may use the existing NPI or API to bill for services rendered to the CMH Waiver population. Qualified providers of transition coordination services may bill for services under existing Participation Agreements and/or interagency agreements. All terms and conditions of the Medicaid Participation Agreement remain in effect.

To become a Medicaid provider of services, the provider must request a Participation Agreement by writing, calling, or faxing the request to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

A signed copy of the Participation Agreement along with a copy of the required license, certification, or approval must be returned to First Health at the above address.

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements. Providers approved for participation in the Medicaid Program must perform the following activities, as well as any others specified by DMAS:

- For services that require licensure and/or certification, the provider must meet all licensure and/or certification requirements pursuant to 42CFR440.50 and 440.60 and any other applicable state or federal requirements;
- Document and maintain client case records in accordance with state and federal requirements;
- Immediately notify First Health Services-Provider Enrollment Unit, in writing, of any change in the information which the provider previously submitted to the First Health Services-Provider Enrollment Unit. For a change of address, notify First Health Services prior to the change and include the effective date of the change;
- Assure freedom of choice to the client or family/caregiver, as appropriate, in seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the services required and participating in the Medicaid Program at the time the service or services are performed;

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- Assure the freedom of the client or family/caregiver, as appropriate, to refuse medical care, treatment and services;
- Accept referrals for services only when staff is available to initiate services and perform such services on an ongoing basis;
- Provide services and supplies to clients in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C.§§ 2000d et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29U.S.C. § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42U.S.C. § 12101 et seq.), which provides comprehensive civil rights protections to clients with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications;
- Provide services and supplies to clients of the same quality and in the same mode of delivery as provided to the general public;
- Submit charges to DMAS for the provision of services and supplies to clients in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by DMAS' payment methodology beginning with the onset of the client's authorization date for the waiver services;
- Use program-designated billing forms for submission of charges;
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the care provided;
 - In general, such records must be retained for at least six years from the last date of service or as provided by applicable state or federal 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. Records of minors shall be kept for at least six years after such minor has reached the age of 18 years;
 - Policies regarding retention of records apply even if the provider discontinues operation. DMAS must be notified in writing of storage location and procedures for obtaining records for review should the need arise. The location and agent, or trustee must be within the Commonwealth of Virginia;
 - Documentation must be maintained which indicates the date, type of services rendered, and the number of hours/units provided, including the specific time frames.
- Agree to furnish information on request and in the form requested by DMAS, the Attorney General of Virginia or his authorized representatives, federal personnel, and

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- the state Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records survives any termination of the provider agreement;
- 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 recipients of Medicaid;
 - Pursuant to 42C.F.R. Part 431, Subpart F, 12VAC30-20-90, and any other applicable state or federal law, hold confidential and use for authorized DMAS' purposes only all medical assistance information regarding clients served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS in conjunction with the cited laws. DMAS shall not disclose medical information to the public;
 - Notify DMAS of change of ownership. When ownership of the provider changes, DMAS must be notified at least 15 calendar days before the date of change;
 - For all facilities covered by § 1616(e) of the Social Security Act in which home and community-based waiver services will be provided, be in compliance with applicable standards that meet the requirements for board and care facilities;
 - Suspected Abuse or Neglect. Pursuant to §§ 63.2-1509 and 63.2-1606 of the Code of Virginia, if a participating provider knows or suspects that a home and community-based care recipient is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge to the local DSS protective services worker, to DMAS, and to DMHMRSAS Offices of Licensing and Human Rights as applicable;
 - Adherence to provider Participation Agreement and the DMAS provider service manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider agreements and in the DMAS Provider Manual.

PROVIDER QUALIFICATIONS

The Children's Mental Health (CMH) Program offers the following services: community transition services, companion services (agency and consumer-directed), respite services (agency and consumer-directed), environmental modifications, family and caregiver training, in-home residential support services and therapeutic consultation. Definitions of provider terms and provider qualifications to provide these services are listed below.

Definitions

The following definitions apply to providers of CMH Program services:

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Licensed mental health professional (LMHP): A LMHP is a clinician in the human services field defined in 12VAC30-50-226 as an individual licensed in Virginia as a physician, a clinical psychologist, a professional counselor, a clinical social worker, psychiatric nurse practitioner or a psychiatric clinical nurse specialist.

Qualified mental health professional (QMHP): A QMHP is a clinician in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a psychiatric diagnosis. As outlined in 12 VAC30-50-226, clinicians that meet QMHP qualifications include a:

1. Physician who is a doctor of medicine or osteopathy and is licensed in Virginia;
2. Psychiatrist who is a doctor of medicine or osteopathy, specializing in psychiatry and is licensed in Virginia;
3. Psychologist who has a master's degree in psychology from an accredited college or university with at least one year of clinical experience;
4. Social worker who has a master's or bachelor's degree from a school of social work accredited or approved by the Council on Social Work Education and has at least one year of clinical experience;
5. Registered nurse who is licensed as a registered nurse in the Commonwealth and has at least one year of clinical experience; or
6. Mental health worker who has at least:
 - a. A bachelor's degree in human services or a related field from an accredited college and who has at least one year of clinical experience;
 - b. Registered Psychiatric Rehabilitation Provider (RPRP) registered with the International Association of Psychosocial Rehabilitation Services (IAPSRS) as of January 1, 2001;
 - c. A bachelor's degree from an accredited college in an unrelated field with an associate's degree in a human services field. The individual must also have three years clinical experience;
 - d. A bachelor's degree from an accredited college and certification by the International Association of Psychosocial Rehabilitation Services (IAPSRS) as a Certified Psychiatric Rehabilitation Practitioner (CPRP);
 - e. A bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field. The individual must also have three years clinical experience; or
 - f. Four years clinical experience.

Paraprofessional: A paraprofessional is an individual as defined in 12 VAC30-50-226 who, at a minimum, meets at least one of the following criteria:

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1. Registered with the International Association of Psychosocial Rehabilitation Services (IAPRS) as an Associate Psychiatric Rehabilitation Provider (APRP);
2. 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;
3. 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, gerontology clients, or special education clients. The experience may include supervised internships, practicums and field experience.
4. A minimum of 90 hours classroom training in behavioral health and 12 weeks of experience under the direct personal supervision of a QMHP providing services to persons with mental illness and at least one year of clinical experience (including the 12 weeks of supervised experience).
5. 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.
6. Licensure by the Commonwealth as a practical nurse with at least one year of clinical experience.

Transition Coordination Services

Providers must have a DMAS Participation Agreement to provide either Mental Health Case Management Services or Treatment Foster Care services in order to perform Transition Coordination Services. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Transition Coordination services providers must have training or special skills needed to work with individuals with serious emotional disturbances (SED). The following professionals may provide transition coordination services:

1. DMAS enrolled providers of treatment foster care case management;
2. DMAS enrolled providers of mental health case management services; and
3. Local Comprehensive Services Act (CSA) coordinators or Family Assessment and Planning Team (FAPT) members who meet the knowledge, skills, and abilities established for mental health case managers. The qualifications for mental health case managers, as outlined in 12 VAC 30-50-420, includes, at a minimum the following:

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a. Knowledge of:

- 1) Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, mental retardation, and substance abuse treatment programs;
- 2) The nature of serious mental illness, mental retardation, and substance abuse depending on the population served, including clinical and developmental issues;
- 3) Different types of assessments, including functional assessments, and their uses in service planning;
- 4) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;
- 5) The service planning process and major components of a service plan;
- 6) The use of medications in the care or treatment of the population served; and
- 7) All applicable federal and state laws, state regulations, and local ordinances.

b. Skills in:

- 1) Identifying and documenting an individual's needs for resources, services, and other supports;
- 2) Using information from assessments, evaluations, observation, and interviews to develop individual service plans;
- 3) Identifying services and resources within the community and established service system to meet the individual's needs; and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal habilitative/rehabilitative and life goals; and
- 4) Coordinating the provision of services by public and private providers.

c. Abilities to:

- 1) Work as team members, maintaining effective inter- and intra-agency working relationships;
- 2) Work independently, performing position duties under general supervision; and
- 3) Engage and sustain ongoing relationships with individuals receiving services.

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Agency-Directed Companion Services

Providers must have a current DMAS Participation Agreement to provide companion services. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Companion services providers must meet one of the following qualifications:

1. Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) licensed provider of residential services, supportive in-home residential services, day support services or respite services; or
2. DMAS enrolled personal care/respite services provider.

Agencies that provide companion services must employ individuals to provide companion care. Companions must have training or special skills needed to work with individuals with SED.

DMAS enrolled providers must employ individuals who meet the following qualifications:

- Be at least 18 years of age;
- Be capable of providing companion services as specified in the client's ISP;
- Possess basic reading, writing and math skills;
- Be capable of following a plan of care with minimal supervision;
- Submit to criminal history record check and, if the recipient is a minor, the Child Protective Services Central Registry. The companion will not be compensated for services provided to the client if the records check verifies the companion has been convicted of crimes described in § 37.2-416 or § 32.1-162.9:1 of the Code of Virginia or if the companion has a complaint confirmed in the DSS Child Protective Services Central Registry;
- Possess a valid Social Security number;
- Be willing to attend a training at the family/caregiver request;
- Receive an annual TB screening; and
- Understand and agree to comply with the DMAS CMH Program requirements as described in DMAS guidance documents.

Agencies are required to have a qualified companion care supervisor to monitor companion services. At a minimum, the supervisor must meet the qualifications to be a QMHP.

Companions may be members of the client's family, but may not be the parent of a minor child receiving services, the client's spouse, a legally responsible relative or legal guardian for the

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client. Payment will not be made for services furnished by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide the care. Relatives who provide companion services must meet the same standards as providers who are unrelated to the individual.

Medicaid-reimbursed companion services may not be provided by adult foster care providers or any other paid (regardless of the payment source) caregivers for a client residing in that home.

Agency-Directed Respite Services

Providers must have a current DMAS Participation Agreement to provide respite services. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Respite services providers must meet one of the following qualifications:

1. DMAS enrolled respite services provider;
2. DMHMRSAS licensed provider of residential services or respite services; or
3. Department of Social Services (DSS) approved foster care home-for-children provider.

The agency must employ assistants who have completed a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to a client, the provider must obtain documentation that the assistant has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways:

1. Registration as a certified nurse aide;
2. Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant or home health aide; or
3. Meeting DMAS paraprofessional qualifications.

Additional qualifications for individuals who provide respite care services through an agency include:

1. Physical ability to do the work;
2. Ability to read and write English to the degree necessary to perform the required tasks;
3. Willingness to submit to a criminal history record check and submit to a record check under the State's Child Protective Services Registry, which verifies that the assistant has not been convicted of crimes described in the Code of Virginia 32.1-162.9:1; and
4. Must have training or special skills needed to work with individuals with SED.

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DMAS-enrolled respite services providers must employ or subcontract with a QMHP or LMHP to supervise all assistants.

Respite care assistants may be members of the client's family, but may not be the parent of a minor child receiving services, the client's spouse, a legally responsible relative or legal guardian for the client. Payment will not be made for services furnished by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide the care. Relatives who provide respite care must meet the same standards as providers who are unrelated to the individual.

Consumer-Directed (CD) Services: Services Facilitation

Companion and respite services may also be delivered in a consumer-directed model where the client or family/caregiver is responsible for hiring, training, supervising, and firing of staff. Clients or family/caregivers who choose the CD option must receive support from a CD services facilitator. This is not a separate waiver service, but is required in conjunction with CD respite and companion services.

Services facilitators must have a current DMAS Participation Agreement to provide CD services facilitation services. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator must operate from a physical business office and employ sufficient qualified CD services facilitators to perform the needed ISP development and monitoring, reassessments, service coordination, and support activities as required. In addition, the CD services facilitator must have the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

It is preferred that employees of the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a QMHP. In addition, it is preferable that the CD services facilitator have two years of satisfactory experience in the human services field working with persons with SED. The CD services facilitator must possess a combination of work experience and relevant education which indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities must be documented on the application form, found in supporting documentation, or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include, but are not necessarily limited to:

Knowledge of:

- Types of functional limitations and health problems that may occur in clients with SED, or clients with other disabilities, as well as strategies to reduce limitations and health problems;
- Equipment and environmental modifications that may be required by clients with SED that reduce the need for human help and improve safety;

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- Community-based and other services, including psychiatric residential treatment facility (PRTF) placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide respite and companion services;
- CMH Program requirements, as well as the administrative duties for which the services facilitator will be responsible;
- CMH Program requirements, as well as the administrative duties for which the client and family/caregiver will be responsible;
- Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;
- Interviewing techniques;
- The client's and family/caregiver's right to make decisions about, direct the provisions of, and control CD respite and companion services, including hiring, training, managing, approving time sheets, and firing an assistant/companion;
- The principles of human behavior and interpersonal relationships; and
- General principles of record documentation.

Skills in:

- Negotiating with clients, family/caregivers and service providers;
- Assessing, supporting, observing, recording, and reporting behaviors;
- Identifying, developing, or providing services to clients with SED; and
- Identifying services within the established services system to meet the client's needs.

Ability to:

- Report findings of the assessment or onsite visit, either in writing or an alternative format for clients who have visual impairments;
- Demonstrate a positive regard for clients and their families;
- Be persistent and remain objective;
- Work independently, performing position duties under general supervision;
- Communicate effectively, orally and in writing; and
- Develop a rapport and communicate with persons from diverse cultural backgrounds.

If the CD services facilitator is not a QMHP, the CD services facilitator must have QMHP consulting services available, either by a staffing arrangement or through a contracted consulting arrangement. The QMHP consultant is to be available as needed to consult with clients and CD services facilitators on issues related to the needs of the client.

The CD services facilitator cannot be the client, the client's case manager, direct service provider, spouse, parent or legally responsible party of the client who is a minor child, or a family/caregiver employing the assistant/companion.

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Consumer-Directed Companion Services

For CD companion services, clients will hire their own companions and manage and supervise the companions' performance. If a client is unable to direct his or her own services, a family/caregiver may act on his or her behalf.

Companions must meet the following requirements:

1. Be at least 18 years of age;
2. Have the required skills to perform CD services as specified in the client's ISP;
3. Possess basic reading, writing, and math skills;
4. Be capable of following a care plan with minimal supervision;
5. Submit to a criminal history record check within 15 days from the date of employment and, if the client is a minor, the Child Protective Services Central Registry. The companion will not be compensated for services provided to the client if the records check verifies the companion has been convicted of crimes described in § 37.2-416 or § 32.1-162.9:1 of the Code of Virginia; or if the companion has a complaint confirmed by the DSS Child Protective Services Central Registry.
6. Possess a valid Social Security number;
7. Be willing to attend training at the client's and family/caregiver's request;
8. Must have training or special skills needed to work with individuals with SED;
9. Receive an annual TB screening; and
10. Understand and agree to comply with the DMAS CMH Program requirements as described in DMAS guidance documents.

Companions may be members of the client's family, but may not be the parent of a minor child receiving services, the client's spouse, a legally responsible relative or legal guardian for the client. Payment will not be made for services furnished by other family members unless there is objective written documentation as to why there are no other providers available to provide the care. Relatives who provide companion services must meet the same standards as providers who are unrelated to the individual.

Medicaid-reimbursed companion services may not be provided by adult foster care providers or any other paid (regardless of the payment source) caregivers for a client residing in that home.

Consumer-Directed Respite Services

For CD respite services, clients will hire their own assistants and manage and supervise the assistants' performance. If a client is unable to direct his or her own services, a family/caregiver may act on his or her behalf.

Respite provider qualifications include, but are not necessarily limited to, the following requirements. The assistant must:

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1. Be at least 18 years of age;
2. Have the required skills to perform CD services as specified in the client's ISP;
3. Possess basic reading, writing and math skills;
4. Be capable of following a care plan with minimal supervision;
5. Submit to a criminal history record check within 15 days from the date of employment, and if the client is a minor, the Child Protective Services Central Registry. The assistant will not be compensated for services provided to the client if the records check verifies the assistant has been convicted of crimes described in § 32.1-162.9:1 or § 37.2-416 of the Code of Virginia or if the assistant has a complaint confirmed by the DSS Child Protective Services Central Registry;
6. Possess a valid Social Security number;
7. Be willing to attend training at the client's and family/caregiver's request;
8. Must have training or special skills needed to work with individuals with SED;
9. Receive periodic TB screening; and
10. Understand and agree to comply with the DMAS CMH Program requirements.

Assistants may be members of the client's family, but may not be the parent of a minor child receiving services, the client's spouse, a legally responsible relative or legal guardian for the client. Payment will not be made for services furnished by other family members unless there is objective written documentation as to why there are no other providers available to provide the care. Relatives who provide CD respite services must meet the same standards as providers who are unrelated to the client.

Medicaid-reimbursed respite services may not be provided by adult foster care providers or any other paid (regardless of the payment source) caregivers for a client residing in that home.

Environmental Modifications

Providers must have a current DMAS Participation Agreement to provide environmental modifications as a durable medical equipment provider. DMAS will permit only a provider to bill for Medicaid reimbursement for environmental modifications provided by individuals or companies contracted by the provider to make the necessary modifications.

Providers must have a business license and comply with all applicable federal, state or local building codes and laws.

Family/Caregiver Training

A provider must have a current DMAS Participation Agreement to provide family and caregiver training. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

The following criteria apply to providers of family/caregiver training:

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- Individuals who provide family/caregiver training must work for an agency or organization that has a provider agreement with DMAS to provide family/caregiver training or be eligible to individually enroll with Medicaid as a provider of this service;
- All individuals who provide family/caregiver training must have the appropriate licensure or certification as required for the specific professional field associated with the training area; and
- Providers must have demonstrated experience or knowledge of the training topic and have training or special skills needed to work with individuals with SED.

The following practitioners may enroll as individual providers of family/caregiver training:

- A psychologist licensed by the Department of Health Professions, Board of Psychology;
- A licensed clinical social worker (LCSW) licensed by the Department of Health Professions, Board of Social Work;
- A licensed professional counselor (LPC) licensed by the Department of Health Professions, Board of Counseling;
- A marriage and family therapist licensed by the Department of Health Professions, Board of Counseling;
- A psychiatric nurse practitioner licensed by the Department of Health Professions, Board of Nursing; and
- A psychiatric clinical nurse specialist (CNS) licensed by the Department of Health Professions, Board of Nursing and certified by the American Nurses Credentialing Center.

Organizations eligible to participate include in-home and outpatient mental health providers licensed by DMHMRSAS.

In-Home Residential Support

Providers must have a current DMAS Participation Agreement to provide in-home residential support services. The agency or individual designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

In-home residential support service providers must be licensed by DMHMRSAS as a provider of supportive residential services. In addition to licensing requirements, individuals providing residential support services are required to participate in training specified by DMAS in the characteristics of SED. The training must include appropriate interventions, training strategies, and support methods for individuals with SED. Providers must have a designated supervisor to

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provide supervision and oversight of direct care staff. At a minimum, the supervisor must meet the qualifications to be a QMHP or LMHP.

Providers may employ or contract with individuals who meet the requirements to provide in-home residential support, but the agency or provider must have a provider agreement with DMAS to provide in-home residential support and bill for the services provided by those individuals.

In-home residential support providers may be members of the client's family, but may not be the parent of a minor child receiving services, the client's spouse, a legally responsible relative or legal guardian for the client. Payment may not be made for services rendered by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who provide in-home residential support services must meet the same standards as providers who are unrelated to the individual.

Therapeutic Consultation

Providers must have a current DMAS Participation Agreement to provide therapeutic consultation services. An individual consultant with the necessary qualifications may obtain a DMAS Participation Agreement or be employed by or contracted with an agency with a Participation Agreement to provide the services. The individual or agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

Providers must be Virginia-licensed or certified practitioners in psychology, social work, occupational therapy, therapeutic recreation, rehabilitation, speech/language therapy, professional counseling, marriage and family therapy, medicine, or psychiatric nursing (psychiatric clinical nurse specialist or psychiatric nurse practitioner). Behavioral consultation performed by these individuals may also be a covered waiver service. Providers must have training or special skills needed to work with individuals with SED.

Providers of therapeutic consultation include the following Virginia licensed or certified practitioners:

- A psychiatrist licensed by the Department of Health Professions, Board of Medicine;
- A psychologist licensed by the Department of Health Professions, Board of Psychology;
- A LCSW licensed by the Department of Health Professions, Board of Social Work;
- A LPC licensed by the Department of Health Professions, Board of Counseling;
- A marriage and family therapist licensed by the Department of Health Professions, Board of Counseling;
- A psychiatric CNS licensed by the Department of Health Professions, Board of Nursing and certified by the American Nurses Credentialing Center;

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- A psychiatric nurse practitioner licensed by the Department of Health Professions, Board of Nursing;
- An occupational therapist registered by the National Board for Certification in Occupational Therapy and licensed by the Department of Health Professions, Board of Medicine;
- A Certified Therapeutic Recreation Specialist with certification from the National Council for Therapeutic Recreation Certification;
- A Rehabilitation Engineer or certified rehabilitation specialist;
- A Board Certified Behavior Analyst certified by the Behavior Analyst Certification Board;
- A Board Certified Associate Behavior Analyst certified by the Behavior Analyst Certification Board; or
- An individual with endorsement in Positive Behavioral Supports (PBS) by the Partnership for People with Disabilities.

Professionals rendering therapeutic consultation services, including behavioral consultation services, must meet all applicable state or national licensure, endorsement or certification requirements. Behavioral consultation may be performed by professionals based on the professionals' work experience, education, and demonstrated knowledge, skills, and abilities

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 individual with a disability 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. Each Medicaid participating provider is responsible for making provisions for such disabled individuals in the provider's programs and activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. The provider's signature on the claim indicates compliance with the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding non-compliance with these requirements.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal,

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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)** - Virginia Medicaid will pay the amount of any deductible or coinsurance 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 Medicaid Program payments shall be made for a patient covered by Workers' Compensation.
- **Other Health Insurance** - When an individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the 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 Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and DMAS is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in the § 8.01-66.9, Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 to:

Third Party Liability Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

REVIEW OF PROVIDER PARTICIPATION STANDARDS AND CONTRACTS

DMAS is responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies. Periodically, DMAS will recertify each provider for Participation Agreement renewal with DMAS to provide home and community-based waiver services. A provider's noncompliance with DMAS policies and procedures, as required in the provider's Participation Agreement, may result in a written request from DMAS for a corrective action

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plan. The corrective action plan details the steps the provider must take and the length of time permitted to achieve full compliance with the plan to correct the deficiencies which have been cited.

TERMINATION OF PROVIDER PARTICIPATION

The Participation Agreement will be 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 of voluntary termination must be made to the FIRST HEALTH/Provider Enrollment Unit thirty (30) calendar days prior to the effective date.

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to recipients subsequent to the date specified in the termination notice. Termination by DMAS shall be treated as an adverse action, and in certain instances the provider shall be entitled to a reconsideration and/or hearing as identified in the following section.

Subsection 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of State law.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action. Adverse action for purposes of this section includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review.

The provider is afforded a reconsideration process. The provider will have thirty (30) calendar days to submit information for written reconsideration. If, upon reconsideration, the denial is upheld in whole or part, the provider has the right to a first-level informal appeal of the reconsideration decision, pursuant to Va. Code §2.2-4019. A provider may appeal an adverse decision by filing a written notice of appeal with the DMAS Appeals Division within 30 calendar days of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed and must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond, VA 23219

If the denial is upheld, in whole or in part, as a result of the first-level informal appeal, the provider has the right to file for a second-level formal appeal, pursuant to Va. Code § 2.2-4020.

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The provider must file a request for a formal appeal within 30 calendar days of receipt of the first-level informal appeal decision. The notice of appeal and supporting documentation shall be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond, VA 23219

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 a lump sum cash payment is not made, interest will 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 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.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information. Providers enrolled at multiple locations or who are a member of a group using one central office may receive multiple copies of manuals, updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing the Mail Suppression Form and returning it to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Upon receipt of the completed form, FH-PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

