Department of Medical Assistance Services
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http://www.dmas.virginia.gov

MEDICAID BULLETIN

TO: All Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) MCOs and Providers

FROM: Karen Kimsey, Director
Department of Medical Assistance Services (DMAS)

DATE: 12/13/2019

SUBJECT: Provider Reimbursement for Licensed Mental Health Professionals

The purpose of this bulletin is to emphasize requirements of Va. Code § 38.2-3407.10:1 as amended March 21, 2019 (see below) for the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) Managed Care Organizations (MCOs). This section of the Code of Virginia requires carriers that credential physicians or mental health professionals in its network to establish reasonable protocols and procedures for reimbursing new provider applicants for services provided to covered persons during the period in which the applicant's completed credentialing application is pending. This law was also amended to apply this requirement to MCOs that issue coverage pursuant to Title XIX of the Social Security Act, 42 USC § 1396 et seq. (Medicaid).

Please note that while this law made additions to the payment process for mental health professionals, provider screening responsibilities under the 21st Century Cures Act remain in force as do all other applicable Federal laws and regulations.

§ 38.2-3407.10:1. Reimbursement for services rendered during pendency of physician's or mental health professional's credentialing application.

DEFINITIONS:

"Carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services or mental health services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services, or mental health services.

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual covered by a health benefit plan.

"Mental health professional" means a person who by education and experience is professionally qualified and licensed in Virginia to provide counseling interventions designed to facilitate an

individual's achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses which interfere with mental health and development.

"Mental health services" means benefits with respect to items or services provided by mental health professionals for mental health conditions as defined under the terms of a health benefit plan.

"Network" means a group of participating physicians or mental health professionals who provide health care services under the carrier's health benefit plan that requires or creates incentives for a covered person to use the participating physicians or mental health professionals.

"New provider applicant" means a physician or mental health professional who has submitted a completed credentialing application to a carrier.

"Participating mental health professional" means a mental health professional who is managed, under contract with, or employed by a carrier and who has agreed to provide health care services to covered persons with an expectation of receiving payments, other than coinsurance, copayments, or deductibles, directly or indirectly from the carrier.

B. A carrier that credentials the physicians or mental health professionals in its network shall establish reasonable protocols and procedures for reimbursing new provider applicants, after being credentialed by the carrier, for health care services or mental health services provided to covered persons during the period in which the applicant's completed credentialing application is pending. At a minimum, the protocols and procedures shall:

1. Apply only if the new provider applicant's credentialing application is approved by the carrier;
2. Permit reimbursement to a new provider applicant for services rendered from the date the new provider applicant's completed credentialing application is received for consideration by the carrier;
3. Apply only if a contractual relationship exists between the carrier and the new provider applicant or entity for whom the new provider applicant is employed or engaged; and
4. Require that any reimbursement be paid at the in-network rate that the new provider applicant would have received had he been, at the time the covered health care services were provided, a credentialed participating physician or mental health professional in the network for the applicable health benefit plan.

C. Nothing in this section shall require reimbursement of the new provider applicant-rendered services that are not benefits or services covered by the carrier's health benefit plan.

D. Nothing in this section requires a carrier to pay reimbursement at the contracted in-network rate for any covered medical services provided by the new provider applicant if the new provider applicant's credentialing application is not approved or the carrier is otherwise not willing to contract with the new provider applicant.

E. Payments made or retroactive denials of payments made under this section shall be governed by § 38.2-3407.15.

F. If a payment is made by the carrier to a new provider applicant or any entity that employs or engages such new provider applicant under this section for a covered service, the patient shall only be responsible for any coinsurance, copayments, or deductibles permitted under the insurance contract with the carrier or participating provider agreement with the physician or mental health professional. If the new provider applicant is not credentialed by the carrier, the new provider applicant or any entity that employs or engages such physician or mental health professional shall not collect any amount from the patient for health care services or mental health services provided from the date the completed credentialing application was submitted to the carrier until the applicant received notification from the carrier that credentialing was denied.

G. New provider applicants, in order to submit claims to the carrier pursuant to this section, shall provide written or electronic notice to covered persons in advance of treatment that they have submitted a credentialing application to the carrier of the covered person, stating that the carrier is in the process of obtaining and verifying the following pursuant to credentialing regulations:

“Notice of Provider credentialing and re-credentialing.

Your health insurance carrier is required to establish and maintain a comprehensive credentialing verification program to ensure that its physicians and mental health professionals meet the minimum standards of professional licensure or certification. Written supporting documentation for (i) physicians or (ii) mental health professionals who have completed their residency or fellowship requirements for their specialty area more than 12 months prior to the credentialing decision shall include:

1. Current valid license and history of licensure or certification;
2. Status of hospital privileges, if applicable;
3. Valid U.S. Drug Enforcement Administration certificate, if applicable;
4. Information from the National Practitioner Data Bank, as available;
5. Education and training, including postgraduate training, if applicable;
6. Specialty board certification status, if applicable;
7. Practice or work history covering at least the past five years; and
8. Current, adequate malpractice insurance and malpractice history covering at least the past five years.

Your health insurance carrier is in the process of obtaining and verifying the above information in order to determine if your physician or mental health professional will be credentialed or not."

H. The provisions of this section shall not apply to coverages issued by a Medicare Advantage plan, but shall apply to health maintenance organizations that issue coverage pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid).

I. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

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Medicaid Expansion

New adult coverage began January 1, 2019. Providers will continue to use the same web portal and enrollment verification processes in place today to verify Medicaid expansion coverage. In ARS, individuals eligible in the Medicaid expansion covered group will be shown as "MEDICAID EXP." If the individual is enrolled in managed care, the "MEDICAID EXP" segment will be shown as well as the managed care segment, "MED4" (Medallion 4.0), or "CCCP" (CCC Plus). Additional Medicaid expansion resources for providers can be found on the DMAS Medicaid Expansion webpage at: http://www.dmas.virginia.gov/#/medex.

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627