**Virginia Department of Medical Assistance Services**

**Addiction and Recovery Treatment Services (ARTS)**

**Preferred Office-Based Addiction Treatment (OBAT) Provider Attestation and Application**

*Must accompany the DMAS Preferred OBAT Credentialing Checklist and Preferred OBAT Staff Roster*

**Last Updated December 5, 2023**

Preferred OBAT providers shall provide services consistent with the Department of Medical Assistance Services (DMAS) policies as found in the Addiction and Recovery Treatment Services (ARTS) Provider Manual [[1]](#footnote-2) including the Preferred OBAT and Opioid Treatment Program Supplement[[2]](#footnote-3) and the Substance Abuse and Mental Health Services Administration Tip 63[[3]](#footnote-4).

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| **Primary Office-Based Addiction Treatment Service Location** | | | | | | | | |
| Legal Name of Provider: | | |  | | | | | |
| Program Name (if applicable): | | | | | |  | | |
| Street Address: | | | |  | | | | |
| City/State/Zip Code: | | | |  | | | | |
| NPI(s)# |  | | | | | | DEA# |  |
| Accreditation (if applicable): | | | | AAAHC HFAP CARF  COA  TJC | | | | |
| Site Treatment Setting  (Check one) | | | | Physician/Nurse Practitioner Office Outpatient clinic FQHC/Health Department/Rural Health Clinic CSB Behavioral Health Clinic and Services | | | | |
| Preferred OBAT Point of Contact Name: | | | | |  | | | |
| Direct Phone Number: | |  | | | | Email Address: | |  |

**Network Organizational Credentialing Standards Attestation**

By completing and submitting this form, you attest that your agency and practitioners meet the DMAS requirements for the Preferred OBAT providers’ support systems, staff, and therapies requirements defined in the aforementioned DMAS Provider Manual.

**Mobile Clinic Addendum**

If you are planning to deliver Preferred OBAT services through a Mobile Clinic, you will need to submit the “Mobile Clinic Addendum” to this application packet.

**Applying for ARTS Preferred OBAT Recognition**

If your organization and practitioners meet the ARTS requirements for Preferred OBAT recognition, you must complete and include all the following and submit to DMAS for review to [SUD@dmas.virginia.gov](mailto:SUD@dmas.virginia.gov):

* **ARTS Preferred OBAT Provider Attestation Form;**
* **Preferred OBAT Provider Credentialing Checklist;**
* **Preferred OBAT Staff Roster indicating the licensed practitioners enrolled with the Virginia Department of Medical Assistance Services’ Provider Services Solution (PRSS) vendor;**
* **A screen print showing license or certification with current dates (including proof of autonomous practice); and**
* **Staff and scheduling plan including a description of how you will handle emergencies and/or on-call services, as well addressing individuals needing to start on buprenorphine outside the prescriber's office hours.**
* **For Mobile Clinic consideration, the Mobile Clinic Addendum**

**Note:** The application should reflect day-to-day operations and staff roles that are specific to the site of the Preferred OBAT application. **Providers submitting multiple applications for various sites without staff and community specific details will not be accepted; DMAS will accept one OBAT provider application at a time unless stipulated otherwise.** All applications are reviewed within **30 calendar days of receipt** on a first received, first reviewed basis.

**Model of Care Description: Day-to-Day Operations Specific to this Site**

1. Describe the working arrangement between the provider and the treatment professional (employee, contractor) per 12VAC30-130-5020 herein referred to as prescriber.

1a. If the Credentialed Addiction Treatment Professionals are proposed to provide clinical services to more than one site, please specify how many Full-time/part-time equivalent employment hours they will dedicate to this location, and how their hours will impact availability at any other approved OBAT sites.

1. Describe how your prescriber(s) will meet a patient’s needs during medical or mental health emergencies, Opioid Use Disorder and/or Alcohol Use Disorder emergencies, or their need to start on substance use medications within 24-48 hours when they occur outside of their scheduled hours (i.e., weekends, after-hours, days when prescriber is not on-site)?

**Please provide a detailed description of your organization’s protocols and associated staffing as these situations occur including hospitalization as a last resort.**

2a. Please describe your plan for continued operations should a prescriber or licensed behavioral health practitioner suddenly leave your practice or is on extended leave.

1. Please provide the name of the individual and their function within the interdisciplinary team.
2. Prescriber:
3. Licensed Behavioral Health Practitioner:
4. Care coordinator:
5. Peer Recovery Support Specialist **(if applicable)**:
6. Other key staff **(if applicable)**:
7. Describe how your organization meets the following requirement per 12VAC30-130-5060: “*The interdisciplinary team must include Credentialed Addiction Treatment Professionals acting within the scope of their practice and trained in the treatment of substance use disorder including opioid use disorder in collaboration with an addiction credentialed physician or physician extenders*.” Providers shall describe how you provide interdisciplinary care coordination to patients, including descriptions of interdisciplinary team meetings (who attends, frequency, documentation, etc.).

1. Describe how comprehensive treatment for other physical and mental health conditions will be provided as needed either on-site or through collaboration with other providers. Referring providers shall be within reasonable access geographically to the member and **must be a Medicaid provider currently accepting new patients.** Include a description of how your practice integrates medical and behavioral health services with addiction services including the following:

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| **Type of Treatment** | **Available Onsite or Through Referral** | **If Through Referral, List Specific Name of Practitioner(s) or Facility** |
| Infectious disease screening (i.e. HIV, Hepatitis A/B/C, syphilis, and tuberculosis) | Choose an item. |  |
| Infectious disease treatment | Choose an item. |  |
| Primary Care | Choose an item. |  |
| Reproductive Health services (i.e., contraception, prenatal services, gynecologic services, etc.) | Choose an item. |  |
| Higher levels of treatment as needed for an unstable patient (i.e. Inpatient Detoxification, Intensive Outpatient Programs, Partial Hospitalization Programs, Residential Treatment) | Choose an item. |  |

1. Describe relationships with pharmacies including who is willing to accept new patients from your practice to fill MOUD prescriptions, and the average distance from your practice to those pharmacies.

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| I hereby certify that all information contained in this document is true and accurate and meets the above requirements. I further understand that any information entered in this document that subsequently is found to be false may result in termination of any agreement that I have or may enter into with DMAS and/or its contractors. I agree to maintain professional liability insurance coverage for direct care staff as referenced in this document and to update roster annually. In compliance with the DMAS Provider Participation Agreement and ARTS Attestation and Application, provider attests that it will permit only staff members who are fully licensed and/or meet DMAS program requirements established for Addiction and Recovery Treatment Services to see and treat Medicaid and FAMIS eligible members. I hereby give permission and consent for DMAS and/or its contractors, to obtain and verify information provided in this form and consent to the release by any person, organization or other entity to DMAS and/or its contractors, of all information relevant to the evaluation of my ability to render addiction recovery and treatment services in a cost-effective manner and my moral and ethical qualifications, and agree to hold harmless any such person or organization from any cause of action based on the release of such information to DMAS and/or its contractors. By signing this attestation, I agree that all statements are true and agree to abide by any contracted requirements for the services delivered under the authority of this agreement. | | | | | | |
| **Printed Name:** | |  | **Title:** |  | | | |
| **Signature:** |  | | | | Date: |  |

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| **Practitioner Name and Credentials**  Please list and indicate the method of service delivery with staff name and credentials; also, list staff providing services on-site followed by those providing services via telemedicine or mobile clinic. | | **Prescribers Only:**  **Medication Induction**  ***(Indicate days of week****)* | **OBAT Dedicated Hours per Day of Week** | | | | | | | | | | | | | **Responsibilities** | | | | | | | | | | |
| Prescribing/ Medication Management | Behavioral Health Intake/ Evaluation | Psychotherapy Individual or Group | Psychotherapy Family | Substance Use Disorder Counseling Individual/Group | Medical Intake Evaluation | Care Coordination | Peer Recovery Support Services | Labs | Urine/Saliva drug testing | Infectious Disease Screening |
| **Name/Credentials** | **Mode of Delivery** | M | | T | | W | | Th | | F | | S | | Su |
| *John Smith, MD* | *Telemedicine* | *T, Thu* |  | | *4* | |  | | *4* | |  | |  | |  | *X* |  |  |  |  | *X* |  |  | *X* | *X* | *X* |
| *John Smith, MD* | *Mobile Clinic* | *S* |  | |  | |  | |  | |  | | *2* | |  | *X* |  |  |  |  | *X* |  |  | *X* | *X* | *X* |
| *Jane Doe, LCSW* | *On-site* | *N/A* | *8* | | *8* | | *8* | | *8* | | *8* | |  | |  |  | *X* | *X* |  | *X* |  |  |  |  |  |  |
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1. [Addiction and Recovery Treatment Services | MES (virginia.gov)](https://vamedicaid.dmas.virginia.gov/pdf_chapter/addiction-and-recovery-treatment-services#gsc.tab=0) [↑](#footnote-ref-2)
2. [Opioid Treatment Services Supplement (updated 8.2.23\_Final.pdf (virginia.gov)](https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-08/Opioid%20Treatment%20Services%20Supplement%20%28updated%208.2.23_Final.pdf) [↑](#footnote-ref-3)
3. <https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC> [↑](#footnote-ref-4)