APPENDIX C

PROCEDURES FOR SERVICE AUTHORIZATION OF MENTAL HEALTH SERVICES

Introduction

Service authorization is the process to approve specific services for an individual enrolled in Medicaid, or FAMIS by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization and some require service registration.

The purpose of service authorization is to validate that:

- the service requested is medically necessary, appropriate for the individual and provided by a provider licensed for the service by DBHDS and credentialed by DMAS or its contractor; and
- the planned activities and interventions conform with the scope of services identified in the service definition, all applicable regulations and the individual's needs and treatment interventions identified in the current ISP.

Service authorization does not guarantee payment for the service. Payment is contingent upon passing all edits within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid enrollment with DMAS or its contractor and ongoing medical necessity and treatment planning for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service.

To obtain service authorization, the provider shall demonstrate that the requested service is medically necessary and appropriate for the individual and that the planned activities and interventions conform with the scope of services identified in the service definition and the individual's needs and treatment goals identified throughout the individual's records, including the current treatment plan or ISP.

Initial service authorization requests shall:

- 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;
- clearly document how the individual's behaviors, within the last 30 calendar days, support the need for the amount of service units and the span of dates requested; and,
- demonstrate individualized preliminary treatment planning and initial conceptualization of goals.

Continued authorization requests must clearly document the above three bullets required for initial requests, demonstrate individualized and comprehensive treatment planning, documentation of the individual's current status and the individual's progress, or lack of progress toward goals and objectives in the ISP and documentation of discharge planning.

SERVICE AUTHORIZATION IN MEDICAID MANAGED CARE

Community Mental Health Rehabilitative Services (CMHRS), Enhanced

Behavioral Health (EBH), and Mental Health Case Management Services are included in the Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 managed care contracts. CCC Plus and Medallion 4.0 Medicaid Managed Care Organizations (MCOs) use DMAS' current program coverage criteria and program requirements to conduct service authorizations for members enrolled in managed care.

Treatment Foster Care Case Management, Psychiatric Residential Treatment Facility (PRTF) services and Therapeutic Group Home Services (formerly known as Level A and Level B) remain carved-out of CCC Plus and Medallion 4.0 at this time and continue to be service authorized by the behavioral health FFS contractor, currently Magellan of Virginia.

In order to be reimbursed for CMHRS, EBH and MHCM services provided to a CCC Plus or Medallion 4.0 MCO enrolled individual, providers must contract with and follow their respective MCO contract(s). The MCO may utilize different service authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For detailed information, please contact the MCO directly. Service authorization forms and processes are available on the DMAS website at https://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/. .Additional information is also available in the "Mental Health Services Doing Business with CCC Plus and Medallion 4.0 MCO's" document available on the DMAS website at https://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.

SERVICE AUTHORIZATION PROCESS FOR FFS

Service Registration

Registration is a key element to the success of a care coordination model. Registering a service with the FFS contractor as the service is being provided ensures that the care manager has a complete picture of all the services an individual is receiving. Registration also may assist with identifying gaps in services that may help an individual progress in their recovery.

Registration is a means of notifying the FFS contractor that an individual will be receiving behavioral health services, avoiding duplication of services and ensuring informed care coordination. Providers should refer to the Magellan of Virginia website for additional information and forms https://www.magellanofvirginia.com/for-providers/.

Registration may occur electronically, by phone or fax. Required elements to provide Magellan of Virginia include: (1) the individual's name and Medicaid/FAMIS identification number; (ii) the specific service to be provided, the relevant procedure code, begin date of the service, and the amount of the service that will be provided; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address. The provider should also have at least a provisional behavioral health related diagnosis for the individual being served.

Claims payments will be delayed if the registration is not completed.

Service Authorizations

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests.

When a service authorization is required, follow the FFS contractor service authorization process by completing the applicable authorization request methodology. Specifics regarding service authorization requests and submission timeframes can be located at www.MagellanofVirginia.com. Required forms are located on the Magellan of Virginia website at https://www.magellanofvirginia.com/for-providers/provider-tools/forms/.

The FFS contractor will approve, pend, reject, or deny all completed service authorization requests. Requests that are denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the service authorization entity notifies the individual and the provider in writing of the status of the request.

The FFS contractor will make an authorization determination based upon the information provided and if approved will address the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services in the authorization determination;

Retrospective review will be performed when a provider is notified of an individual's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service authorization for covered days prior to billing DMAS for these services. Providers must request a service authorization for retrospective review as soon as they are aware of the individual's Medicaid eligibility determination.

Once authorization is obtained, if the individual is discharged from the service and there are dates of service and units that have not been used, the provider must contact the FFS contractor to notify them of discharge from service so that the remaining dates or units may be available at a later date, or by another provider.

The FFS contractor's MIS system has edits that do not allow the same service to be authorized for different providers for the same dates. In the case where a second provider makes a request for dates that overlap, with the first provider on file, the second provider should contact the previous provider to advise that the service authorization needs to be ended. Should the second provider not be successful in obtaining release of the initial service authorization, the FFS contractor will then make one attempt to contact the previous provider to obtain an end date. If there is no response by the prior provider, the service authorization and the second provider's request is processed.

Providers should request a cancellation of a service authorization when there has been no service utilization within the authorized date span. Canceling a service authorization means that it never should have existed and no claims will be or have been billed against the service authorization.

If an initial request is denied and the individual later meets criteria, a new request may be submitted for the current dates of service as long as that request is not a retro-request for service. The new request must explain how and why the individual now meets criteria.

Providers are responsible to keep track of utilization of services, regardless of the number of providers. The FFS contractor has provided various methods for the providers to research utilization.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

When To Submit Requests To the FFS Contractor For Service Authorization (including registrations)

For New Individuals Starting Services

Mental Health Skill-building Services (H0046)
Therapeutic Day Treatment for Children and Adolescents (H2016)
Intensive In-Home Services (H2012)
Mental Health Intensive Outpatient (S9480)
Mental Health Partial Hospitalization Program (H0035)
Assertive Community Treatment (H0040)
Applied Behavior Analysis (various codes, see Appendix D)
Multisystemic Therapy (H2033)
Functional Family Therapy (H0036)
Treatment Foster Care Case Management (T1016)
Mobile Crisis Response (H2011)
Community Stabilization (S9482)
23-Hour Crisis Stabilization (S9485)
Residential Crisis Stabilization Unit (H2018)

Individuals who have not received services between January 1, 2009 and the present are considered new cases.

The provider must submit service authorization requests for services to the FFS contractor. The FFS contractor will make a determination within five (5) business days for Therapeutic Day Treatment (TDT) and within three (3) business days for other mental health services from the date of receipt, provided all required information is submitted with the initial request. The provider must contact the FFS contractor with the discharge date if treatment ends before the service authorization expires.

Retro Medicaid Eligibility

Retroactive requests for authorizations will not be approved with the exception of retroactive Medicaid eligibility for the individual. When retroactive eligibility is obtained, the request for authorization must be submitted no later than 30 days

from the date that the individual's Medicaid was activated. If the request is submitted later than 30 days from the date of activation, the request will be authorized beginning on the date it was received.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care programs, the FFS contractor will honor the Medicaid MCO service authorization based upon proof of authorization from the provider, DMAS, or the MCO if the individual has been disenrolled from the MCO. Similarly, the MCO will honor the FFS contractor's authorization based upon proof of authorization from the provider, DMAS, or the FFS contractor that services were authorized while the individual was eligible under fee-for-service (not MCO enrolled) for dates where the individual has subsequently become enrolled with a DMAS contracted MCO. Providers shall contact the FFS contractor and the MCOs for the specific continuity of care requirements.

Service authorization decisions by the FFS contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested. The FFS contractor's decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify individual eligibility and to check for MCO enrollment. For MCO enrolled individuals, the provider must follow the MCO's service authorization policy and billing guidelines.

Communication

Provider manuals are located on the DMAS website and Provider Handbooks are located on the Magellan of Virginia websites. Magellan of Virginia's website has information related to the service authorization processes for programs identified in this manual. Providers under contract with Magellan of Virginia should consult the Magellan National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider for additional information.

Magellan of Virginia provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the service authorization process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the Mental Health Services manual and the Magellan of Virginia Handbooks.

Early and Periodic Screening, Diagnostic and Treatment Service Authorization Process (EPSDT)

The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq.) requires a broad range of outreach, coordination, and health services under

EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of youth's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the individual receiving services.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or its contractor as medically necessary. Therefore, services may be approved for persons under the age of 21 enrolled in Medicaid, FAMIS Plus and FAMIS Fee For Service (FFS) if the service/item is physician ordered will correct a medical condition, make it better, or prevent the child's health status from worsening.

All Medicaid, FAMIS (FFS) and FAMIS Plus services that are currently authorized by the service authorization contractor are services that can potentially be accessed by youth under the age of 21. However, in addition to the traditional review, youth who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, MagellanofVirginia.com

EPSDT is not a specific Medicaid program. EPSDT is distinguished only by the scope of treatment services available to youth who are under the age of 21. Because EPSDT criteria (service/item is physician ordered and is medically necessary to correct, ameliorate "make better" or maintain the individual's condition) must be applied to each service that is available to EPSDT eligible youth, EPSDT criteria must be applied to all service authorization reviews of Medicaid services.

EPSDT Review Process:

Individuals under 21 years of age qualifying under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary and are prior authorized by the Department. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.