Outpatient Service Authorization Request Form
DMAS/ACENTRA HEALTH

Submit fax request for Service Authorization to: 1-877–OKBYFAX (877-652-9329)
Requests may be submitted up to 30 days prior to schedule procedures/services, provided Member is eligible.

1. ☐ **Initial** ☐ **Recertification** ☐ **Change** ☐ **Cancel** **Transfers:** ☐ **Provider** ☐ **Commonwealth Coordinated Care** ☐ **Commonwealth Coordinated Care Plus**

Recert: Enter previous SRV AUTH#. Change or Cancel: enter SRV AUTH# to be changed or canceled. SRV AUTH #

2. **Date of Request (mm/dd/yyyy)** / /

3. **Review Type (check one if applicable)**
☐ Retrospective Prepayment Review (Date notified of eligibility / /)
☐ Retroactive MCO disenrollment

4.
a. Member Medicaid ID Number (12 digit Number):

b. Eligibility (Mandatory)
☐ Medicaid FFS
☐ Medicaid Expansion

5. **Member Last Name**:

6. **Member First Name:**

7. **Date of Birth** (mm/dd/yyyy): / /

8. **Gender:**
☐ Male
☐ Female

9.
a. NPI/API/Requesting Service Provider Name & ID Number:

b. 9 digit Zip Code (Mandatory)

10. **Treatment Setting**
☐ Outpatient
☐ Provider's Office
☐ Home
☐ Intensive Outpatient

11. **Primary Diagnosis Code/ Description: (enter up to 5)**
1. 2.
3. 4.
5.

12.
a. NPI/API/Referring Provider Name and ID Number:

b. 9 digit Zip Code
(Mandatory)

13. **SRV AUTH Service Type:**
☐ 0092 EPSDT: Orthotics/Chiropractic/ Hearing Aids/Assistive Technology
☐ 0100 DME
☐ 0204 Outpatient Rehab
☐ 0303 Prosthetics
☐ 0450 MRI
☐ 0451 CAT
☐ 0452 PET
☐ 0500 Home Health

14. **Severity of Illness (See instructions pertaining to each SRV AUTH service type); Please see out of state provider requirements (Page 6) if applicable:**

15. **Intensity of Services (See instructions pertaining to each SRV AUTH service type); Please see out of state provider requirements (Page 8) if applicable:**

16. **Additional Comments (See instructions pertaining to each SRV AUTH service type :**
PLEASE SEE QUESTIONS UNDER ADDITIONAL INFORMATION

Number	17. HCPCS/ CPT/ Revenue Code	18. Code Description	19. Modifiers (if applicable)	20. Units Requested	21. Actual	22. Frequency	23. Total Dollar Requested	24. Dates of Service

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					Cost per Unit			From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
1.								/ /	/ /
2.								/ /	/ /
3.								/ /	/ /
4.								/ /	/ /
5.								/ /	/ /
6.								/ /	/ /
7.								/ /	/ /
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13.								/ /	/ /
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15.								/ /	/ /
16.								/ /	/ /
17.								/ /	/ /
18.								/ /	/ /
25. **Contact Name:**									
26. **Contact Telephone Number:**									
27. **Contact Fax Number:**									

DMAS 363
Revised: 12/2018

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14. Severity of Illness:

15. Intensity of Services:

16. Additional Comments:

16a. Non-Emergency outpatient MRI, CAT, PET

Required question:

In what state will this scan be performed?

16b. For all Home Health requests:

Required questions:

Has a face-to-face encounter been performed by an approved practitioner no more than 90 days prior to the start of service? Yes or No

IF NO

Will a face-to-face encounter be performed by an approved practitioner no more than 30 days after the start of services? Yes or No

16c. For specific DME item requests:

Required question: Has a face-to-face encounter been performed by an approved practitioner no more than 6 months prior to the start of service? Yes, No or N/A

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INSTRUCTIONS FOR OUTPATIENT ELECTRONIC FAX FORM

https://vamedicaid.dmas.virginia.gov/sa
www.dmas.virginia.gov

This FAX submission form is required for faxed outpatient Initial Certification, Recertification, and Retrospective Reviews. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information. Only information provided on Acentra Health forms can be entered. Do **not** send attachments or non-Acentra Health forms.

If Acentra Health determines that your request meets appropriate coverage criteria guidelines the request will be "tentatively approved" and transmitted to the DMAS Fiscal Agent for the final approval. Final approval is contingent upon passing remaining Member and provider eligibility/enrollment edits. The Service Authorization (SRV AUTH) number provided by the DMAS Fiscal Agent will be sent to you via U.S. mail process and will be available to providers registered on the web-based program Atrezzo Connect (**https://vamedicaid.dmas.virginia.gov/sa**) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS' Fiscal Agent prior to 5:30 PM of that day.

1. **Request type:** Place a √ or **X** in the appropriate box.
   - **Initial:** Use for all new requests. Resubmitting a request after receiving a reject would be an initial request also.
   - **Recertification:** A request for continued services (items) beyond the expiration of the previous Service Authorization would be a recertification request.
   - **Change**: a change to a previously approved request; the provider may change the quantity of units, dollar amount approved (DME) or dates of service due to changes in delivery or rescheduling and appointment. If additional units are requested for the same dates of service, enter the total number of units needed and not only the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders. The provider may not submit a "change" request for any item that has been denied or is pended.
   - **Cancel**: Use to cancel all or some of the items under one Service Authorization number. An example of canceling all lines is when an authorization is requested under the wrong Member number.
   - **Transfers:** **a) Provider:** Use when requesting a transfer of care between providers or a transfer of a providers NPI number.
     b) CCC: Use when a member disenrolls from CCC and returns back to traditional fee-for-service (FFS) Medicaid, the provider must submit a request to the Srv Auth contractor, within 30 days, indicating that the request is for a CCC transfer.
     c) CCC Plus: Use when a member transitions from CCC Plus to Medicaid FFS, the provider must submit a request to the Srv Auth contractor, within 60 days, indicating that the request is for CCC Plus transfer.
2. **Date of Request:** The date you are submitting the Service Authorization request.
3. **Review Type:** Place a √ or **X** in the appropriate box. Please refer to the Provider Manuals regarding Retrospective review policy and procedure for detailed information regarding the services being requested. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.

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4. **a. Member Medicaid ID Number:** It is the provider's responsibility to ensure the Member's Medicaid number is valid. This should contain 12 numbers.

   b. Eligibility: Identify the Members Eligibility Medicaid FFS or Medicaid Expansion**.** It is the provider's responsibility to check Member's Medicaid eligibility prior to Service Authorization submittal.

5. **Member Last Name:** Enter the Member's last name exactly as it appears on the Medicaid card.

6. **Member First Name:** Enter the Member's first name exactly as it appears on the Medicaid card.

7. **Date of Birth**: Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).

8. **Gender:** Please place a √ or **X** to indicate the sex of the member.

9. **a. NPI/API Requesting/Service Provider Name and ID Number:** Enter the requesting/service provider name and ID number, national provider identifier or atypical provider identifier.

   b. 9 digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted.

10. **Treatment Setting:** Place a √ or **X** to indicate the place of service.

11. **Primary Diagnosis Code/Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s). For dates od service 10/1/15 and beyond please use the appropriate ICD-10 code

12. **a. NPI/API Referring Provider Name and ID Number:** Enter the referring provider name and ID number, national provider identifier or atypical provider identifier for the provider requesting the service.

    b. 9 digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted,

13. **SRV AUTH Service Type:** Place a √ or **X** to indicate the category of service you are requesting. For Chiropractic or Orthotics: If Member is under 21 check "0092 EPSDT: Orthotics/Chiropractic/ Hearing Aids/Assistive Technology".

14. **Severity of Illness (Clinical indicators of illness including abnormal findings)*:**

    - One of the most important blocks on the form is the Severity of Illness. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information.
    - Provide the clinical information of chief complaint, history of present illness, pertinent past medical history (supportive diagnostic outpatient procedures), abnormal findings on physical examination, previous treatment, pertinent abnormalities in laboratory values, X- rays, and other diagnostic modalities to substantiate the need for service and level of service requested. (Always include dates, types & results [with dimensions/% as appropriate]).
    - Service Type specific instructions:

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DME	Provide all of the information listed in Section II of the CMN. Provide answers to all required Face to Face Encounter questions.
Home Health –Rehab	Describe the functional impairments, illness, injury and/or communication disorders that warrant treatment. Provide answers to all required Face to Face Encounter questions.
Home Health –Skilled Nursing *	Describe specific orders for nursing. Provide answers to all required Face to Face Encounter questions.
Rehab	Describe the functional impairments, illness, injury and/or communication disorders that warrant treatment.
Prosthetics	Describe the member's functional limitations, device acceptance, psychological/therapeutic value, employment possibility and prosthetic device history. Provide all of the information listed in numbers 15 through 17 on the DMAS-4001 (Physician Certification of Need.)
EPSDT Hearing Aids	Provide all of the relevant diagnostic information listed in Section II of the CMN (DMAS 352 form). Describe the severity of hearing loss as noted in the Audiological Evaluation Report.
EPSDT Assistive Technology	Provide the diagnosis related to the Assistive Technology request; the individual's functional limitation and its relationship to the requested Assistive Technology item. Describe any conjunctive treatment related to the use of the item; How the needs were previously met, identifying changes that have occurred which necessitate the Assistive Technology request; other alternatives tried or explored and a description of the success or failure of these alternatives.

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***Out of State Provider Requirement**	Services provided out of state for circumstances other than these specified reasons shall not be covered. 1. In what state is the provider rendering the service and/or delivering the item physically located? 2. The medical services must be needed because of a medical emergency; 3. Medical services must be needed and the member's health would be endangered if they were required to travel to his/her state of residence; a. Please explain why the member cannot travel. 4. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; 5. It is the general practice for members in a particular locality to use medical resources in another state. 6. In what state will this service be performed? 7. Can this service be provided by a provider in the state of Virginia? a. If no, please provide justification to explain why the item/service cannot be provided in Virginia? See the applicable service type specific instructions above when requesting one of these services. See the applicable service type specific instructions above when requesting one of these services.

**** Effective 11/01/2016, Imaging Out of State Providers must submit requests for non-emergency, outpatient MRI, CAT, PET scans to DMAS Medical Support Unit (MSU). Acentra Health will accept requests for non-emergency, outpatient, out of state MRI, PET and CAT scans prior to midnight October 31, 2016. See DMAS Memo dated 10/19/2016 for detailed information. Requests submitted to Acentra Health on and after November 1st, 2016, will be rejected.**

15. **Intensity of Services (Proposed/Actual monitoring and therapeutic services)*:**

- This is another critical area of the form. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information.
- This field must include the treatment plan for the member. List the services, procedures, or treatments that will be provided to the member.
- Service Type specific instructions:

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DME	Provide all of the information listed for each line item in Section III and IV of the CMN. Include all items and not only those that require Service Authorization. (If there is no begin service date, list the physician's signature date that is below Section III on pg. 1 and on pg.2 of CMN if applicable.
Home Health	Describe long term and short term goals with achievement dates.
Home Health –Skilled Nursing	Specific description of goals and achievement dates; Specific description of procedures, especially if requesting comprehensive visits; If requesting ongoing comprehensive visits, specify why goals have not been accomplished.
Rehab	Identify if the plan of care is a 60-day plan of care (acute) or an annual plan of care (non-acute); Describe the long term and short term goals with achievement dates; Documentation of meeting program goals. **Out of State Rehab Providers** **Only Providers with these Provider Types: 085(Out-of-State Rehab Hosp); 057 (Rehab Agencies) and 091(Out-of-State Hospital) can submit request(s) for Outpatient Rehab services utilizing any of the following Revenue Codes: • 0420: Physical Therapy (P.T.)-General – 1 Unit = 1 Visit • 0430: Occupational Therapy (O.T.)-General – 1 Unit = 1 Visit • 0440: Speech Language Pathology-General – 1 Unit = 1 Visit
Prosthetics	Provide all of the information listed in numbers 5through 14 on the DMAS-4001 (Physician Certification of Need.) List the physician's signature date, number 19 on the DMAS-4001.
EPSDT Hearing Aids	Provide all of the information listed for each line item in Section III and IV of the CMN. List the items that require Service Authorization. Discuss reasons for exceptional coverage requests. Document the medical and functional reasons that demonstrate why a specific device is medically justified over a standard, less expensive device. Include the medical justification from the Audiological Evaluation Report for the specific devices being requested.
EPSDT Assistive Technology	Describe how the Assistive Technology item will treat the individual's medical condition. Describe the quantity needed and the medical reason the requested amount is needed; the frequency of use; the estimated length of use of the item. Describe how the Assistive Technology item is required in the individual's home or community environment and the individual's or caregiver's ability, willingness, and motivation to use the Assistive Technology item.

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***Out of State Provider Requirement**	Services provided out of state for circumstances other than these specified reasons shall not be covered. 1. In what state is the provider rendering the service and/or delivering the item physically located? 2. The medical services must be needed because of a medical emergency; 3. Medical services must be needed and the member's health would be endangered if they were required to travel to his/her state of residence; a. Please explain why the member cannot travel. 4. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; 5. It is the general practice for members in a particular locality to use medical resources in another state. 6. In what state will this service be performed? 7. Can this service be provided by a provider in the state of Virginia? a. If no, please provide justification to explain why the item/service cannot be provided in Virginia? See the applicable service type specific instructions above when requesting one of these services.

**** Effective 11/01/2016 Imaging Out of State Providers. Acentra Health will accept requests for non-emergency, outpatient, out of state MRI, PET and CAT scans prior to midnight October 31, 2016. These requests will receive a final determination by Acentra Health within the standard processing time frames. Providers who submit cases to Acentra Health are to wait for the final determination from Acentra Health. Do not submit a request to DMAS MSU if it has already been submitted to Acentra Health. Requests submitted to Acentra Health on and after November 1st, 2016, will be rejected.**

2. **Additional Comments:** This area must be used for further information and other considerations and circumstances to justify your request for medical necessity or the number of services. Describe expected prognosis or functional outcome. List additional information for each item to meet the criteria in the Regulations, DMAS Manual, and InterQual criteria (see SRV AUTH chapter in the DMAS Manuals).

- **Non-Emergency outpatient MRI, CAT, PET**
  - **Required question:**
    - In what state will this scan be performed? (**Identify physical location of where services will be rendered)**

****Effective 7/1/2017, All Home Health requests and specific DME items require a Face to Face Encounter performed by an approved practitioner.**

Please see DMAS memo for questions and a list of DME codes that require a face to face encounter.

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https://vamedicaid.dmas.virginia.gov/provider/library

- **All Home Health requests:**
  - **Required questions:**
    - Has a face-to-face encounter been performed by an approved practitioner no more than 90 days prior to the start of service? Yes or No

IF NO

    - Will a face-to-face encounter be performed by an approved practitioner no more than 30 days after the start of services? Yes or No

- **For specific DME item requests:**
  - **Required question:**
    - Has a face-to-face encounter been performed by an approved practitioner no more than 6 months prior to the start of service? Yes, No or N/A

3. **HCPCS/CPT/Revenue Code:** Provide the HCPCS/CPT/Revenue procedure code.
   a. **NOTE:** Hearing Aid providers only list codes requiring service authorization. Refer to Medicaid Memo dated 9/26/2012 and related Memo dated 10/3/2012.

   - See Attachment "A" for list of Revenue/CPT Codes utilized by All DMAS Approved Providers for Outpatient Rehab Services.

   b. Please reference the Medicaid Memos for OP Rehab providers: 5/27/09, 6/29/10, 3/19/12 and the new **6/03/15** memo regarding the new service authorization process for Outpatient Rehab at the link below:

   c. Refer to Medicaid Memo dated 9/26/2012 and related Memo dated 10/3/2012 for EPSDT Hearing Aid and EPSDT Assistive Technology providers at the link below:

   d. Refer to Medicaid Memo dated 02/06/2013 for Out of State Providers Submitting Requests for Service Authorization through Acentra Health at the link below:

   e. Refer to Medicaid Memo dated 12/01/2015 for the, " Implementation of Breast Pumps requiring Service Authorization through Acentra Health" at the link below:

https://vamedicaid.dmas.virginia.gov/provider/library

   - When submitting srv auth requests, providers must select the **most appropriate** speech therapy evaluation code based on the physician's order and diagnosis. Providers may only use one code per member per date of service (DOS) for each srv auth request. When medically necessary, providers may submit the same or another speech therapy evaluation code using different dates of service (no duplicate dates or overlapping dates with previous srv auth request).

4. **Code Description:** Provide the HCPCS/CPT/Revenue procedure code description. For NEOP, provide the type of scan and location.

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5. **Modifiers (if applicable):** Enter up to 4 modifiers as applicable. DME providers enter modifier as appropriate based upon the Durable Medical Equipment and Supplies Listing/Appendix B found in the DMAS DME provider manual information.
6. **Units Requested**: Based on physician's orders, plan of care, or CMN provide the number of services/visits requested. Knowledge of InterQual/DMAS criteria will be extremely helpful. DME providers: Only identify the number of units' necessary in excess of the established allowable for the time span requested. Place numbers only in the Units Requested block. Units requested as 2/2 months or 100/box/month or 7 days cannot be keyed and will be rejected.
7. **Actual Cost per Unit or Usual and Customary (DME providers only)**: Enter information in this column for codes identified in Appendix B as individual consideration (IC) or usual and customary. For IC, enter actual cost per unit less any incentives/discounts or reductions received from the manufacturer. For items identified in Appendix B as usual and customary, enter the provider's usual and customary charge to the generic public. The provider must retain documentation supporting this dollar amount. **Prosthetic, EPSDT Hearing Aid and EPSDT Assistive Technology providers only:** for codes identified as individual consideration (IC), enter actual cost per unit less any incentives/discounts or reduction received from the manufacturer. The provider must submit and retain documentation supporting this dollar amount.
8. **Frequency:** Enter Frequency usage of Service requested
9. **Total Dollars Requested (DME providers only)**: Enter the dollar amount requested for items listed as usual and customary or IC in the appendix B of the DMAS DME provider manual. In the Appendix B, each code is listed with a set fee, as usual and customary or IC. The Total Dollars Requested is the total for all units requested in that line. For items listed as usual and customary enter your usual and customary charge to the general public. For items listed as IC enter the dollar amount requested. The provider must retain documentation supporting verification of cost (a manufacturer's invoice, brochure with cost information from the manufacturer, cost estimate on letterhead from the manufacturer, etc.) This cost is per unit of the item being requested, e.g. 1ea, 1 pair, or 1 box of 100. **Prosthetic, EPSDT Hearing Aid and EPSDT Assistive Technology providers only:** Enter the total dollar amount requested.
10. **Dates of Service**: Indicate the planned service dates using the mm/dd/yyyy format. The From and Thru date must be completed even if they are the same date.
11. **Contact Name**: Enter the name of the person to contact if there are any questions regarding this fax form.
12. **Contact Telephone Number:** Enter the phone number with area code of the contact name.
13. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/reject.

***Note: Incomplete data may result in the request being denied; it is very important that this field be completed as thoroughly as possible with the pertinent medical/clinical information.**
The purpose of Service Authorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Service Authorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the Member's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

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Attachment "A"

Revenue Code Used by Provider types (001-Hosp, In state-General/ 014 Rehab Hospital-In-State)	Revenue Code Used by Provider Types (085-Out-of-State Rehab Hosp/091-Out-of-State Hosp)	Procedure Code Used by all other DMAS Approved Providers
0421	0420	97110
0423	0430	97150
0424	0440	97001
0431	Left Blank on Purpose	97530
0433	Left Blank on Purpose	S9129
0434	Left Blank on Purpose	97003
0441	Left Blank on Purpose	92507
0443	Left Blank on Purpose	92508
0444	Left Blank on Purpose	92506 **(Code ended 12/31/13; 4 new codes used effective 1/1/2014, see below)**

NOTE: Providers please reference the Medicaid Memos for OP Rehab providers: 5/27/09, 6/29/10 3/2012, and NEW 6/03/15 Memo at the link provided below :

https://vamedicaid.dmas.virginia.gov/provider/library

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New CPT speech therapy evaluation codes effective 1/1/2014

92521 (effective 1/1/2014)	Evaluation of speech fluency (eg, stuttering, cluttering)
92522 (effective 1/1/2014)	Evaluation of speech sound production (eg. Articulation, phonological process, apraxia, dysarthria)
92523 (effective 1/1/2014)	Evaluation of speech sound production (eg. Articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg. Receptive and expressive language)
92524 (effective 1/1/2014)	Behavioral and qualitative analysis of voice and resonance

New CPT physical and occupation therapy evaluation codes effective 1/1/2017

97163 (effective 1/1/2017) Replaces 97001 (PT evaluation) which ended 12/31/2016	Physical Therapy Evaluation: high complexity (45 minutes)
97167 (effective 1/1/2017) Replaces 97003 (OT evaluation) which ended 12/31/2016	Occupational Therapy Evaluation: high complexity (60 minutes)

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New Breast Pump codes effective 1/1/2016

E0603 -Single user electric breast pumps - purchase	Breast pump, electric (AC and/or DC), single user, any type, includes all necessary supplies and initial collection kit. Purchase only (no rental)..
E0604 - Multi-user (Hospital grade) electric pumps - rental	Breast pump, multi-user (Hospital grade, electric (AC and/or DC), any type includes initial collection kit. Rental only (no purchase).
E1399 Additional Collection Kit	1 kit includes necessary supplies and collection containers. Purchase only (no rental).

Note: E0602 - Manual breast pumps are available.
Srv Auth is not required for this procedure code. Please refer to the DME Manual, Appendix B for all breast pump codes, service limits, and rate information and the DME Manual Ch. IV for coverage criteria. Also, Medicaid Memo, ""Fee-For-Service Medicaid/FAMIS/FAMIS MOMS: Coverage of Lactation Services — *Effective January 1, 2016*"" dated 12/1/2015 is available at:

https://vamedicaid.dmas.virginia.gov/provider/library