Service Authorization Process for CCC Plus Waiver (Revised 7-7-2023)

Acentra HEALTH

Meet Our Company

CNSI + Kepro

With over six decades of combined experience, CNSI and Kepro have **come together to become:**

Acentra HEALTH

Our purpose is to accelerate better health outcomes through quality healthcare

Our vision is to be the vital partner for healthcare solutions in the public sector

Our mission is to continually innovate solutions that deliver maximum value and impact to those we serve

Acentra Health Overview

2023

Founded

Acentra Health was formed following the merger of CNSI and Kepro

3K

Employees

Skilled clinicians, technology experts, and industry leaders

45+

States

Serve 45 state agencies and 5 federal agencies

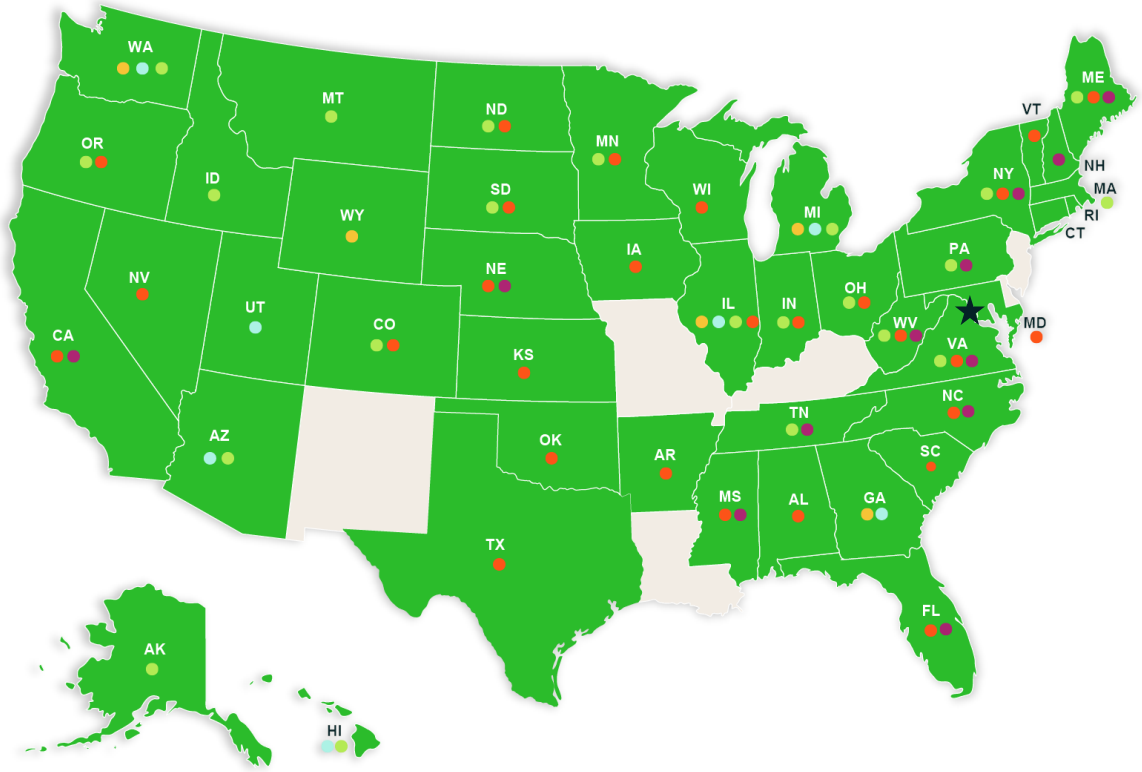
33

Locations

Headquartered in McLean, VA with 32 total company locations nationwide and a location in India

★ U.S. federal agencies we are partnered with:

- Centers for Medicare & Medicaid Services
- Department of Health & Human Services
- Department of Health Resources & Services Administration
- Department of Labor
- Department of Veterans Affairs



STATE CLIENTS

PROVIDER

CARE MANAGEMENT

CORE CLAIMS

QUALITY OVERSIGHT

ASSESSMENTS & CLINICAL ELIGIBILITY

Addressing Industry Challenges

Rising Health Costs

attributed to the aging population, chronic disease, antiquated systems, and rising administrative and service costs

Fragmented Care

is a barrier to true, whole-person integrated care

Lack of Data Sharing

and transparency within the industry that affects individuals, care plans, and health outcomes

Health Inequity

impact on individuals when socioeconomic factors are not considered in patient care plans

Provider Manual/Medicaid Memorandums

- DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS Web Portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/.

  - This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda.

  - The Internet is the most efficient means to receive and review current provider information.

  - If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting: Direct Mail Works at 1-804-303-1442. A fee will be charged for the printing and mailing of the manual updates that are requested.

Resources for Submitting Service Authorization Request to Acentra Health

KEPRO Website: https://dmas.kepro.com

DMAS Web Portal: https://vamedicaid.dmas.virginia.gov/

For any questions regarding the submission of Service Authorization requests, please contact KEPRO at 1-888-827-2884 or 1-804-622-8900.

For claims or general provider questions, please contact the DMAS Provider Helpline at 1-800-552-8627 or 1-804-786-6273.

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Methods Of Submission Service Authorization Requests To Acentra Health

All requests for CCC Plus Waiver Service Authorization must be submitted to Acentra Health via the Atrezzo Next Generation (ANG), effective September 1, 2015.

Reference DMAS Medicaid Memo dated June 15, 2015.

“Notification that Kepro is converting to an electronic process for submitting service authorization requests – Effective September 1, 2015”.

Service Authorization Process

CCC Plus Waiver – Service Type: 0900

Covered Services

Covered Services

The following are the services available under the EDCD Waiver by procedure code:

- T1019 – Agency Directed Personal Care
- S5126 – Consumer Directed Personal Care
- T1005 – Agency Directed Respite
- S5150 – Consumer Directed Respite
- S9125 – Skilled Respite Services
- S5160 – Personal Emergency Response System (PERS) Install

Covered Services (Cont'd)

- S5160 U1 – Personal Emergency Response System (PERS) Medication Monitoring Installation
- S5161 – Personal Emergency Response System (PERS)
- S5185 – Personal Emergency Response System (PERS) Medication Monitoring
- H2021 TD – Personal Emergency Response System (PERS) Nursing – RN
- H2021 TE – Personal Emergency Response System (PERS) LPN
- S5102 – Adult Day Healthcare

Service Authorization Process

Service Authorization Process for CCC Plus Waiver Services.

All requests for services must be submitted via Atrezzo Next Generation (ANG). Questionnaires must be completed for each service requested.

Agency Directed Personal Care – T1019

Request must be submitted by a Case Manager or Personal Care Provider. When completing the questionnaire, the information from the following forms will be required:

- DMAS-99, DMAS-97 A/B (Plan of Care), and DMAS-100 (if supervision is being requested) DMAS-100 A (PERS).
- DMAS-96, DMAS-97, and UAI (only for new enrollments).

Agency Directed Personal Care – T1019(CONT'D)

- Requested units are submitted weekly and will be authorized monthly. Example: If you are requesting thirty (30) hours a week of personal care services (Agency Directed) your treatment line units should reflect 138 units. 30 x 4.6 = 138 units.

- Requests for services must be submitted within ten (10) business days of the Start of Care (SOC) or within ten (10) business days of the provider's receipt of the DMAS 225. Provider must document DMAS 225 was received.

- Hours over the member's level of care cap and/or supervision hours are not retroactive. The request must be submitted on or prior to the SOC, to avoid an adverse action decision due to untimely submission

Agency Directed Personal Care – T1019(cont'd)

- Continuation of services must be submitted on or prior to the end date of the current authorized period.
- Services cannot be authorized prior to the date the DMAS 99 and DMAS 97A/B were completed.
- For new enrollments ONLY, services cannot be authorized prior to the signature date of the physician on the DMAS 96.

Consumer-Directed Personal Care – S5126

- Requested units are submitted weekly and will be authorized bi-weekly. Example: If you are requesting thirty (30) hours/week (Consumer Directed) Personal Care your treatment line units should reflect sixty (60) units. 30 hours/week x 2 = 60 units.

- The paid attendant may not be the parents of minor children who are receiving Waiver Services or the spouse of the individuals who are receiving Waiver Services.

- The person directing care cannot be the paid attendant.

- Requests for services must be submitted within ten (10) business days of the Start of Care (SOC) or within ten (10) business days of the provider's receipt of the DMAS 225. The provider must document DMAS 225 was received.

- Hours over the member's level of care cap and/or supervision hours are not retroactive. The request must be submitted on or prior to the SOC, to avoid an adverse action decision due to untimely submission

AGENCY DIRECTED RESPITE – T1005 AND CONSUMER-DIRECTED RESPITE (UNSKILLED) – S5150

- A maximum of 480 hours may be authorized per fiscal year with a duration of 730 days for all types of Respite combined (Skilled and Unskilled). The member must have an unpaid primary caretaker to receive Respite Services.
- A questionnaire must be completed using the information from the DMAS 99 and DMAS 97 A/B is required for Unskilled Respite.

Agency Directed LPN Skilled Respite – S9125 (TE)

- Waiver types include, but are not limited, to EDCD.
- Member must demonstrate a skilled nursing need (tube feeding, vent dependent, tracheotomy, oxygen, wound care, etc.)
- Physical Therapy or Occupational Therapy are NOT classified as a skilled need.
- Maximum of 480 hours may be authorized per fiscal year with a duration of 365 days. This includes both Skilled Respite and Unskilled Respite combined.
- Services may not be authorized prior to the physician’s signature and date on the DMAS 300 or CMS 485.

All Respite Services

- The maximum amount of combined Respite Care Services that a Member may receive is 480 hours in a fiscal year. Hours do not regenerate when the Member transfers from one provider to another.

- If transferring Respite Services from one provider to another, the new provider must verify with the previous provider the total number of Respite hours utilized prior to the new provider's Start of Care. If member is receiving both CD and Agency Directed Respite, the total number of requested hours between the two may not exceed 480 hours per fiscal year.

PERS Installation– S5160 and PERS Monitoring – S5161

- Waiver types include, but are not limited, to EDCD.
- Providers must complete a questionnaire when requesting services in Atrezzo Next Generation (ANG).
- PERS installation is requested/authorized for a one (1) month timeframe.
- Requests for PERS must be submitted to Acentra Health within ten (10) business days of the start of care date for new requests.
- Continuation of services must be submitted on or prior to the end date of the current authorized period.
- PERS cannot be the sole service authorized through the Waiver. Members must be receiving another qualifying waiver service (e.g., personal care, adult day care, or respite).
- PERS monitoring is authorized for one (1) unit of service monthly.
- PERS cannot be authorized if the Member has Supervision authorized on Personal Care POC.

PERS Installation– S5160 and PERS Monitoring – S5161 (CONT'D)

- Member must be fourteen (14) years old or older.
- Member must live alone or be alone for significant parts of the day and have no regular caregiver for extended periods of time.
- The Member may not receive PERS if she or he has a cognitive impairment as defined in the CCC Plus Waiver Manual.

PERS and Medication Monitoring Installation– S5160 U1 & PERS and Medication Monitoring – S5185

- Waiver types include, but are not limited, to EDCD.

- For S5185: If S5160 U1 – PERS Medication Monitoring Installation is not also requested, the provider must state that the PERS Medication Monitoring System is already installed (e.g., through private pay).

- A request for S5160 U1 must be accompanied by a request for S5185-PERS and Medication Monitoring.

- Must be physician ordered. Services cannot be authorized prior to the date of the physician order.

PERS and Medication Monitoring Installation– S5160 U1 & PERS and Medication Monitoring – S5185

- Authorization for medication monitoring is for one (1) unit of service monthly.
- Cannot be the sole service authorized through the Waiver. Members cannot be enrolled into the Waiver with this service.
- May not be authorized if the Member has supervision authorized on the Personal Care POC.

PERS Nursing (RN)- H2021 TD and PERS Nursing (LPN)-H2021 TE

- Waiver types include, but are not limited, to EDCD.
- Must be authorized for S5185 PERS and Medication Monitoring.
- Authorization for PERS Nursing is for one (1) unit of service bi-weekly.
- Please indicate whether or not you are requesting LPN or RN PERS monitoring by using the correct modifier (TD or TE).

Adult Day Healthcare – S5102

This code is specific to EDCD Waiver.

- Requests for Adult Day Healthcare (ADHC) must be submitted to Acentra Health within ten (10) business days of the start of care for a new request.
- Continuation of services must be submitted on or prior to the end date of the current authorized period.
- The questionnaire must be completed .
- Requested units are submitted as days/weeks and will be authorized as monthly. Example: If you are requesting two (2) days/week of ADHC, your treatment line units should reflect ten (10) units; three (3) days/week = 14; four (4) days/week = 19; five (5) days/week = 23.
- The DMAS 301 must be signed. Services cannot be authorized prior to the signature on the DMAS 301 (must be signed within five (5) visits of Start of Care date).

Transfer From One Provider To Another Provider

The new provider must submit a request to Acentra Health via Atrezzo Next Generation (ANG) and complete the questionnaire utilizing information from:

- DMAS-97 A/B and DMAS 99 for Personal Care and Unskilled Respite,
- DMAS-100 (if supervision is present),
- DMAS-300 or CMS-485 (for skilled respite) and the
- DMAS-225, or a transferring letter from the previous provider indicating the last billable date of service (if the previous provider has not submitted discharge request to Acentra Health).
- If unable to obtain documentation from previous provider despite multiple attempts, please include this information in the clinical note section of the SRV AUTH Request.
- Requests for Services must be submitted within ten (10) business days of the SOC, or within ten (10) business days of verification of Medicaid eligibility. Provider must document the date in which DMAS-225 was received.

EPSDT Assistive Technology (AT)

*Items intended to be used in a school setting that are needed for educational purposes are not covered.

Assistive Technology (AT). T5999 – EPSDT Assistive Technology. This is not a stand-alone service and must be authorized in addition to one of the other services available in this waiver.

Assistive Technology is defined as specialized medical equipment, supplies, devices, controls, and appliances not available under the Virginia State Plan for Medical Assistance. Assistive Technology items directly enable individuals to increase their abilities to perform ADLs or to perceive, control, or communicate with the environment in which they live. Assistive Technology items are expected to be portable.

EPSDT Assistive Technology (AT) Service Authorization Review Process

Criteria: Only Assistive Technology items that are determined to be medically necessary may be covered for reimbursement by DMAS. The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to DMAS or the contractor. Assistive Technology must be:

- A reasonable and medically necessary part of an Individual Support plan;
- Consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual;
- Not furnished solely for the convenience of the family, attending physician, or other practitioner or supplier;
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and
- Provided at a safe, effective, and cost-effective level that is suitable for use by the individual

EPSDT Assistive Technology (AT) Service Authorization Review Process

Timeliness for provider submission does apply.

- Assistive technology requests must be submitted by the provider prior to the assistive technology service being delivered.
- Service authorization approvals that are completed prior to the assistive technology service being rendered are approved for the dates of service requested by the provider; 1 unit for 30 days.
- Administrative denials would occur if the provider did not respond to a pended request for initial clinical information or submitted a request after the assistive technology service was rendered and the member is not retro-eligible.
- Established timeframes listed above are also applicable to out of state providers. The only exception is for those out of state providers who are not enrolled as a participating provider with Virginia Medicaid.

EPSDT Assistive Technology (AT) Service Authorization Review Process

Requests for new Assistive Technology devices must contain the following:

1. Physician Letter of Medical Necessity

2. Therapist's evaluation report (If signed by the physician this can serve as the Letter of Medical Necessity)

3. Quote from supplier to document provider's wholesale cost or cost description for requests to exceed allowed reimbursement rates. Provider to submit quote, showing cost and if request approved, then markup cost 30%.

4. Provider to document why a specific device is medically justified over a standard, less expensive device.

Any medical necessity denials for EPSDT Assistive Technology for individuals under the age of 21, are performed at a Physician Review level at DMAS. This does not apply to administrative denials.

Transfers From One Provider To Another Provider (Cont'd)

- Please refer to the CCC Plus Waiver Manual Appendix D for timely submission requirements for service authorizations as some services cannot be retro authorized and must be submitted by Start of Care date.
- Hours over the Member's level of care cap and/or supervision hours previously authorized may be approved from the SOC if the documentation supports the eligibility, medical necessity, and timely submission requirements have been met.

Transfers From One Waiver To Another Waiver Program

- It must be clearly indicated on the request that the Member is transferring from one (1) waiver program to another.
- The following are a list of Waiver Programs: Personal Care, Adult Day Care, Respite Care or PACE.
- Member must be discharged from previous waiver before they can be enrolled into a new waiver.

Tips For Successful Requests

- Submit the correct Atypical Provider Identifier (API)/National Provider Identifier (NPI) number for the procedure code being requested.
- Servicing Provider = The provider API/NPI number who will provide the service.
- Submitting Provider = The provider submitting the SRV AUTH Request as the referring provider.
- Refer to specific Medicaid provider manual for specific information regarding service criteria, documentation requirements, and service authorization process.
- Do not send duplicate requests via Atrezzo Next Generation (ANG). This only congests the system and slows the review process down.

Retroactive Reviews

- Providers must submit all required information to Acentra Health within ten (10) business days of initiating care or within ten (10) business days of receiving verification of Medicaid Eligibility from the local DSS (DMAS 225), or as otherwise specified in the provider manuals. Be sure to submit the date the DMAS 225 was received to support timely submission.
- Refer to Chapter IV of the Medicaid Provider Manual for timely submission requirements for service authorization as some services cannot be retro authorized and must be submitted by Start of Care date.

SUBMITTING CHANGES TO AN EXISTING CASE (FOR ALL FORMATS)

- If you are requesting a discharge, request under existing case number to be discharged. **DO NOT SUBMIT A NEW CASE**.
- If you are requesting a change (increase or decrease) in dates, units, or hours, request under the existing case number, **DO NOT OPEN A NEW CASE FOR THESE TYPES OF REQUEST.**
- Requesting or creating new cases in place of updating existing cases only delays processing time, causes duplication and overlapping date errors.
- There is no automatic renewal of service authorizations.
- Providers must submit requests for continuation of care needs, with supporting documentation, prior to the expiration of the current authorization.

Overlapping Dates With The Same Provider

- For on-going service authorizations, check your files and verify the dates that have been previously authorized, denied or pended before submitting your request.
- Submit the request using the correct begin (start) and through (end) dates of service.
- If the new SRV AUTH Request overlaps with an approved or denied existing SRV AUTH, the new request will be rejected and returned via fax to correct the beginning and/or ending dates of service. Overlap errors are due to same member, same provider type, same service, with same or overlapping dates.
- If requested dates do not overlap, contact Acentra Health for a review of the case error.

Virginia Medicaid Web Portal

- DMAS offers a web-based internet option to access information regarding Medicaid or FAMIS member eligibility, claim status, check status, service limits, service authorizations, and electronic copies of remittance advices.
- Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: **https://vamedicaid.dmas.virginia.gov/**
- If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m., Monday through Friday, except on holidays.
- The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.
- Providers may also access service authorization information including status via Acentra Health's Atrezzo Next Generation at http://dmas.kepro.com (will be changed when new URL is ready for use).

DMAS Helpline Information

The DMAS “HELPLINE” (800-552-8627) is available to answer questions Monday through Friday, 8:00 a.m. to 5:00 p.m., except on holidays.

THANK YOU

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