Service Authorization Process for Durable Medical Equipment (DME) (Revised 7-7-2023)

Acentra HEALTH

Meet Our Company

CNSI + Kepro

With over six decades of combined experience, CNSI and Acentra Health 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 Acentra Health

3K

Employees

Skilled clinicians, technology experts, and industry leaders

45+

States

Serve 45 state agencies and 5 federal agencies

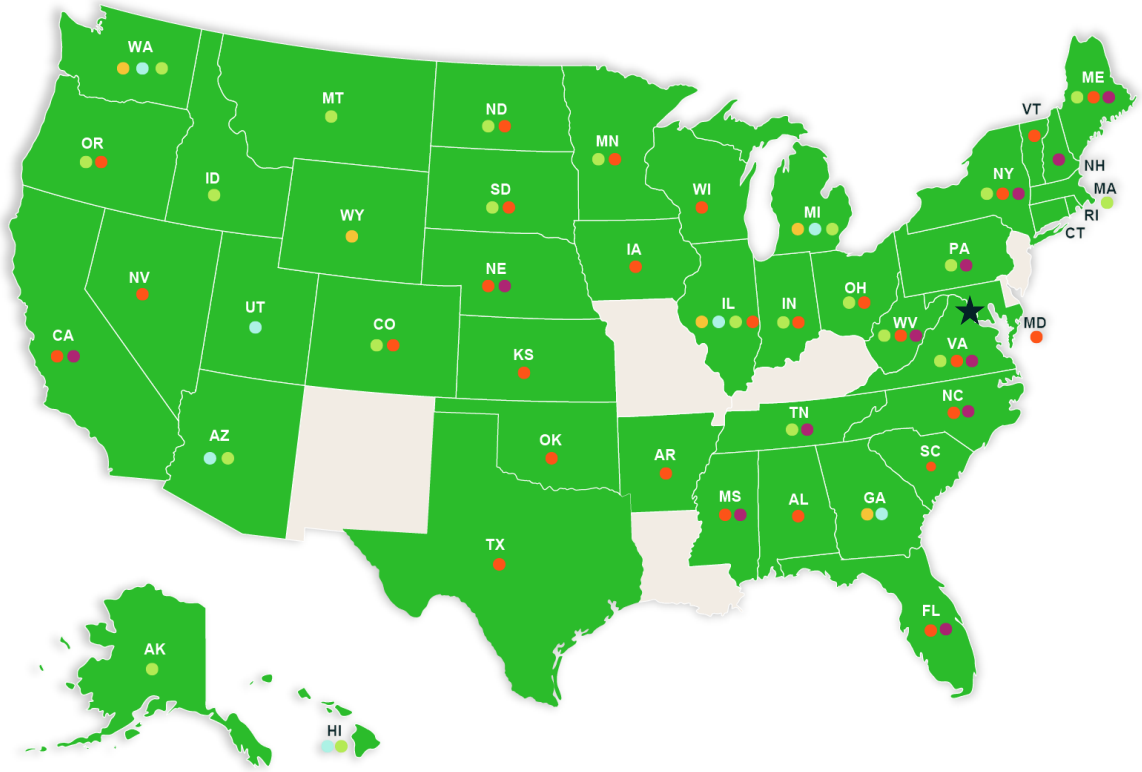
33

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

- Acentra Health Website: https://dmas.kepro.com

- DMAS Web portal: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

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

Submitting Service Authorization Requests

- The Service Type for Durable Medical Equipment Services can be:
  - 0100 DME
  - 0092 Pediatric Orthotics (EPSDT)
- Requests may be submitted via:
  - Atrezzo Provider Portal Connect
  - Fax: 1-877-652-9329
  - Telephone: 1-888-827-2884 or (local) 1-804-622-8900
  - Mail: KEPRO, 6802 Paragon Place, Suite 440 Richmond, VA 23230

Information needed for DME requests

- From CMN (DMAS-352) – Certificate of Medical Necessity
  - The CMN and any supporting verifiable documentation must be completed (signed and dated by the physician, nurse practitioner, or physician assistant) within sixty (60) days from the time the ordered DME & supplies are provided to the member. This information can be found in the DME & Supplies Manual, CH. IV.
- Please include the following clinical information (all information from the CMN – DMAS-352):
  - Mobility Impairments
  - Endurance Impairments
  - Restricted Activity
  - Skin Breakdown if Applicable (Site, Size, Depth and Drainage)

Information needed for a request (CONT)

- Impaired Respiration if Applicable with Most Recent PO2 Level
- Does the member require assistance with ADLs
- Speech Impairments
- Required Nutritional Supplements
- Is the item suitable for use in home
- Does the patient/caregiver demonstrate willingness/ability to use the equipment
- Date patient last examined by MD
- List ICD code, diagnosis description and date of onset.

Information needed for DME request (CONT)

- For Each Item Requested:
  - Begin Service Date
  - HCPCS Code
  - Item Description
  - Length of Time Needed
  - Quantity Ordered per Month
  - Quantity/Frequency of Use
  - Practitioner (Nurse Practitioner, Physician Assistance or Physician Signature and Date)

Information needed for a request (cont'd)

- Please indicate if items are Rentals or Purchases
- Please also include a brief description of the patient condition including:
    - Current Symptoms
    - Reason the Equipment is Needed

This information assist the reviewers in further assessing the patient's condition.

TIPS for Submitting requests

- DME Service Authorization Checklist are available at http://dmas.kepro.com.
- When requesting a wheelchair, please include the wheelchair evaluation results and the correct wheelchair code.
- E1399s – Cannot be used if a Valid HCPCS code exists
- A list of Non-Covered items is available in the DME & Supplies Manual, Chapter IV.
- For CPAP/BiPAP machines please include the most current Sleep Study results.

Reference materials

- Criteria used for review consists of Change Healthcare InterQual Durable Medical Equipment, DME & Supplies Manual, Virginia Administrative Code, EPSDT and DMAS Rules.
- The DMAS DME & Supplies Manual give important information regarding coverage of DME items and the Service Authorization process. For Specific Service Authorization information, please reference Appendix D.
- Coverage criteria is in Chapter IV of the DME & Supplies Manual and the Virginia Administrative Code.

Retroactive reviews

- Service Authorization request for retroactively eligible members or “retro-reviews” are only for cases that the member has Medicaid retroactive eligibility.
- Requested Start of Care date should be entered as the first day hands-on service was provided to the individual once Medicaid eligibility was effective.
- On the fax form, please mark “Retro Eligibility” and indicate if review is due to Medicare B denial, or MCO disenrollment.
- Please include MCO service authorization number (#).

Continuous Glucose Monitors (CGM)

Review the clinical documentation for the indications in the 2016 CGM memo (**Memo Link**).

- In brief, these are Type 1, self- monitoring ≥ 4 times a day, FBS > 150. Hypoglycemia < 50 or hypoglycemic unawareness, insulin pump or injections ≥ 3 times a day. Purchase equipment.
- Type 2, >16 years old, other criteria as above. Purchase equipment.
- Pregnant individuals, criteria same as Type 1 or 2, on insulin. Rental of equipment.

For each request you must have the clinical documentation, a completed CMN-352 from the provider, and a supplier's invoice with their cost for the equipment, including any discounts.

DME Incontinence supplies

- ~~Home Care Delivered, Inc~~All incontinence supply requests must adhere to DME requirements. is the sole DME contractor for the provision of Incontinence and Related Supplies for all Virginia Medicaid fee-for-service members.
- Refer to the updated DME and Supplies Manual, Chapter IV and Appendix D.

- Diapers
- Pull-ups
- Panty Liners
- Chux
- Washable Pads
  - Note: A4335 miscellaneous incontinence code may only be used by Home Care Delivered.

Out-of-state providers submitting requests for service authorization

Out-of- State providers need to determine and document evidence that one of the following items is met at the time the service authorization request is submitted to the service authorization contractor:

- The medical services must be needed because of a medical emergency;
- Medical services must be needed and the recipient's health would be endangered if they were required to travel to their state of residence;
- 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;
- It is the general practice for recipients in a particular locality to use medical resources in another state.

Authorization requests for certain services can also be submitted by out-of-state facilities. Refer to the Out-of-State Request Policy and Procedure on pages eight (8) and nine (9), for guidelines when processing out-of-state requests, including 12VAC30-10-120.

Out-of-state providers submitting requests for service authorization

The provider needs to determine item one (1) through four (4) at the time of the request to the contractor. If the provider is unable to establish one of the four (4) KEPRO will:

- Pend the request utilizing established provider pend timeframes
- Have the provider research and support one of the items on the previous slide and submit back to the Contractor their findings.

Specific Information for Out-of-State Providers:

- Out-of-State providers are held to the same service authorization processing rules as in state providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-state services to KEPRO. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to KEPRO, as timeliness of the request will be considered in the review process. KEPRO will pend the request back to the provider for twelve (12) business days to allow the provider to become successfully enrolled.
- If KEPRO received the information in response to the pend of the provider's enrollment from the newly enrolled provider within the twelve (12) business days, the request will the continue through the review process and a final determination will be made on the service request.

Out-of-state providers submitting requests for service authorization

Specific Information for Out-of-State Providers:

- If the request was pended for no provider enrollment and KEPRO does not receive the information to complete the processing of the request within twelve (12) business days, KEPRO will reject the request back to the provider, as the service authorization cannot be entered into MMIS without the providers National Provider Identification (NPI).
- Once the provider is successfully enrolled, the provider must resubmit the entire request.
- Out-of-State providers may enroll with Virginia Medicaid by going to https://www.virginiamedicaid.dmas.Virginia.gov/wps/myportal/providerenrollment.
- At the toolbar at the top of the page, click on “Provider Services” and then “Provider Enrollment” in the drop-down box. It may take up to ten (10) business days to become a Virginia participating provider.

Resources

- Check the Medicaid Memos and Manuals online at: https://www.vamedicaid.dmas.Virginia.gov.
- DME & Supplies Manual, Appendix B and Appendix D, Click on the link to Providers Services or http://dmas.kepro.com.

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Resources (cont'd)

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

DMAS Web Portal: https://www.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

Submitting a Request via Atrezzo Next Generation (ANG)

- Registration is required. User login and password is given once successful registration occurs
- Information may be found by going to the Acentra Health website at: https://dmas.kepro.com.
- For questions call 1-888-827-2884 or email at: ProviderIssues@kepro.com or Atrezzo Next Generation (ANG) Next Generation (ANG) issues@kepro.com.

Key Information Missing

- If additional clinical information is missing from the request after the initial evaluation of the case, the clinical reviewer will pend the case for 5 (five) business days.
- Additional information is requested from the provider via phone or fax notification.
- The provider will have until 11:59 PM of the 5th business day to supply this information.
- If the case can be approved, the clinical reviewer will post an approval note in Atrezzo Next Generation (ANG) Next Generation (ANG) Connect and a notification will be automatically sent to provider via fax.
- If the case cannot be fully approved by the clinical reviewer, it will be forwarded to a physician reviewer for medical necessity determination or a Supervisor for administrative denial reasons.

To Appeal an Acentra Health Decision

- Appeals are to be submitted in writing to:

  - Director Appeals Division
  - Department of Medical Assistance Services
  - 600 East Broad Street, 6th Floor
  - Richmond, VA 23219

- Additional information can be found in the DMAS Provider Manuals.

DMAS Helpline Information and Resources

- The “HELPLINE” is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays.
- Acentra Health Website: https://dmas.kepro.com
- DMAS web portal: https://www.virginiamedicaid.dmas.virginia.gov
- For any questions regarding the submission of Service Authorization requests, please contact Acentra Health at 888-827-2884 or 804-622-8900.
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THANK YOU