Acentra’s Service Authorization Process
Home Health Services Revised 8-8-2023

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

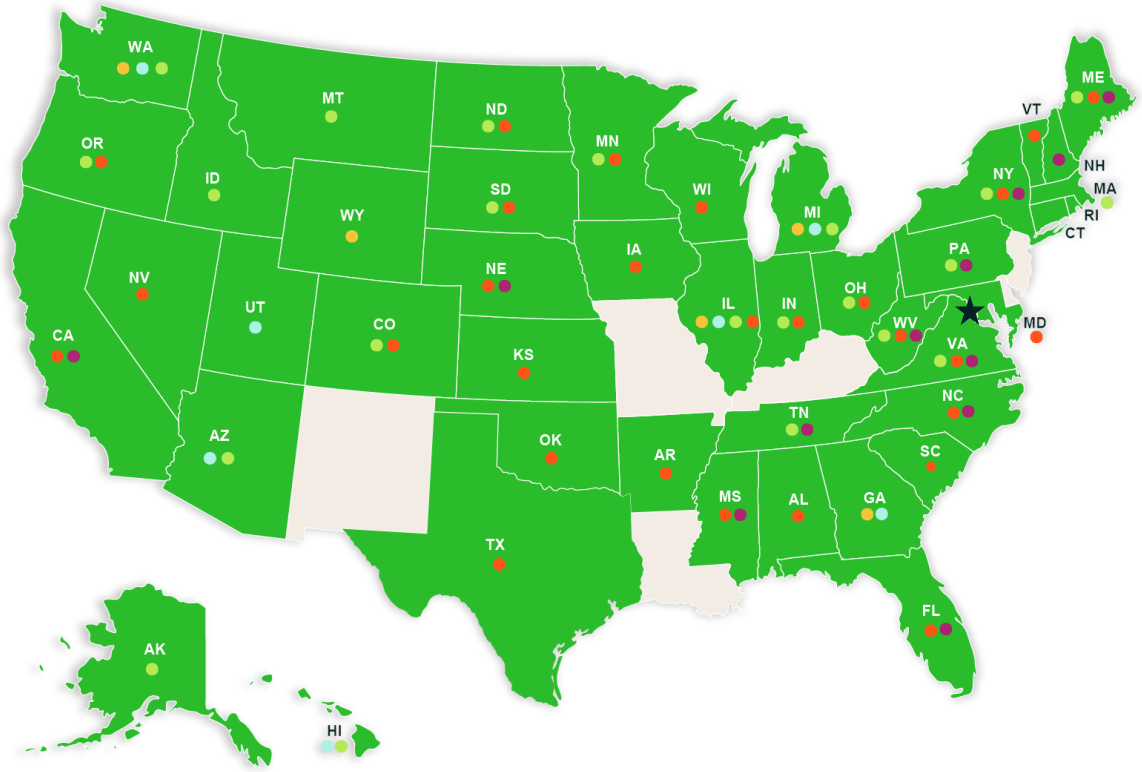
33

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

SERVICE AUTHORIZATION PROCESS FOR HOME HEALTH SERVICES

- Provider gathers information for the Service Authorization submission process.
- Provider verifies eligibility by using the DMAS web portal at: https://www.virginiamedicaid.dmas.Virginia.gov or MediCall at 1-800-884-9730 or 1-800-772-9996.
- Service authorization requests can be submitted via the Atrezzo New Generation Provider Portal, fax, phone or mail.

SERVICE AUTHORIZATION PROCESS FOR HOME HEALTH SERVICES

•The preferred submission method is Atrezzo New Generation Provider Portal. Provides 24 hour availability to submit and allows provider to check on status of case.

•Once request is entered into the system by a provider or Customer Service Representative a case ID number is assigned

INSUFFICIENT MEMBER INFORMATION

•If the member's requested demographic information is not complete, this will delay your case from being evaluated by the Clinical Reviewer.

•The Customer Service Representative will have to pend the case and request the insufficient information by fax notification from the provider.

•The provider will have until 11:59 PM the next business day to submit the insufficient information or the case will be voided in our system.

•A voided case is when there is not enough information to create a case (i.e. missing key demographic information). It is not a denial.

HOME HEALTH SERVICE TYPE (0500)

- It is extremely important that the request has the service type (0500) clearly marked.

- Omission delays the case from being placed in the correct work queue for the Clinical Reviewer to evaluate.

SERVICE AUTHORIZATION PROCESS FOR HOME HEALTH SERVICES

- A case is sent to the Home Health Work Queue for review by the Clinical Reviewer once all demographic information and the service type is entered.

- The review will evaluate the case for medical necessity by applying criteria.

CRITERIA USED TO REVIEW CASES FOR MEDICAL NECESSITY

- Criteria that is used for review consist of the Change Healthcare InterQual® Home Health and/or supplemental criteria/DMAS rules.

- The DMAS Provider Manuals provide additional information that will give important details regarding coverage of home health and the service authorization process.

DMAS HOME HEALTH PROVIDER MANUAL

- Access to the DMAS Provider Manuals may be found at the DMAS web portal at: https://vamedicaid.dmas.virginia.gov/provider.

- Under Provider Services section, select Provider Manuals. Select Home Health, Chapter IV (reviews covered services and limitations) and Appendix D (reviews the service authorization services).

- Acentra's website at: https://dmas.kepro.com, click on "DMAS Manuals".

REVENUE CODES

Home Health Revenue Codes (PA Submission-Prefix revenue code with a capital “R” but do not submit claims with the “R” prefix)	
Revenue Code	Code Description
0550	Skilled Nursing Assessment
0551	Skilled Nursing Care, Follow-Up Care
0559	Skilled Nursing Care. Comprehensive Visit
0571	Home Health Aide Visit (no PA required) ***limited to 32 visits per Fiscal year with no provision for extension.**
0424	Physical Therapy, Home Health Assessment
0421	Physical Therapy, Home Health Follow-up Visit
0434	Occupational Therapy, Home Health Assessment
0431	Occupational Therapy, Home Health Follow-Up Visit
0444	Speech-Language Services, Home Health Assessment
0441	Speech-Language Services, Home Health Follow-Up Visit

DOCUMENTATION REQUIRED IN ORDER TO DETERMINE IF MEMBER MEETS CRITERIA

- For maintenance services include the following:
  - Can the member perform the procedure?
  - If the member cannot perform the procedure, is there a caregiver who is willing and able to perform the procedure?
  - If the provider states that there is no one willing or able to perform the service, further explanation may be needed.
  - B-12 injections and insulin injections should include the following documentation: The physician certifies that there is a need for a home health visit for this procedure, no one else is willing or able to perform the procedure, and information to support that the procedure is medically necessary.

DOCUMENTATION REQUIRED IN ORDER TO DETERMINE IF MEMBER MEETS CRITERIA

For central venous access devices (dressing changes, etc.) – provide the following information:

•Is the member currently getting medication through the line, if so how frequently is it being accessed, what type of central line is it (PICC, Groshog, Hickman, Porta Cath, etc.)?

•The physician certifies that there is a need for a Home Health Visit for this procedure, no one else is willing or able to perform the procedure, information to support that the procedure is medically necessary.

HELPFUL TIPS FOR HOME HEALTH

Provide the following information:

- Was the member recently discharged from hospital or nursing facility? Is member home-bound or confined to a bed? Describe the reason for the referral and the members condition. Example: Member just discharged from hospital with new onset of diabetes, needs diabetic teaching, is wheelchair bound, with minimal support system. Please do not just send in the hospital history and physical.
- What services will be rendered under each skill set needed. Example: Skilled nursing, wound care, frequency, treatment, physical therapy, gait training, balance, therapeutic exercise, occupation therapy, ADL's, adaptive equipment training.
- If submitting via fax, using the editable version is very helpful, making it easier to read.

HELPFUL TIPS FOR HOME HEALTH (CONT'D)

- All requests must be submitted prior to services being rendered except if the request is a retrospective review, i.e. member receives Medicaid Eligibility after services rendered or order is received on a Friday evening and the services are provided Saturday or Sunday. In this instance, the request should be submitted on the next business day. Retrospective cases are still reviewed for medical necessity by using the same criteria. Please provide all clinical information. If denied by Medicare and then submitted to Medicaid this would be a retrospective review.
- Contact information including name and direct phone extension number is especially important if the reviewer has any questions concerning the case.
- Each July 1st, members have five (5) visits that do not require Service Authorization for each service (skilled nursing, OT, PT, Speech Therapy).
- If a provider knows that the member will need treatment beyond five (5) visits, the provider must request Service Authorization through Acentra.

WHAT HAPPENS WHEN KEY CLINICAL INFORMATION IS MISSING FROM THE CASE

- If additional clinical information is missing from the request after the initial evaluation of the case, the Clinical Reviewer will pend the case for three (3) business days.
- Additional information is requested from the provider fax notification.
- The provider will have until 11:59 PM of the third business day to supply this information.

SERVICE AUTHORIZATION PROCESS FOR HOME HEALTH SERVICE

- If the case can be approved, the clinical reviewer will post an approval note in the Atrezzo New Generation Provider Portal and a notification will be automatically sent to the provider via fax.

- If the case cannot be fully approved, it will be forwarded to a peer reviewer (MD) for medical necessity determination or a Supervisor for administrative denial reasons.

CASE CONTINUATION

- If subsequent physician’s order and/or plan of care are submitted for the same member and by the same provider, a new case identification number is not required for up to 365 days.
- The provider should submit the request under the existing case identification number.
- The existing case identification number will be used until the maximum number of service authorization lines has been utilized.
- A new case identification number will be needed if one fifteen (15) service authorization lines or 365 days are exceeded.

COMMONWEALTH COORDINATED CARE

- Members have the choice to opt out of CCC eligibility. If the member has Medicaid Fee-for-Service (FFS) benefits reinstated, Acentra will honor the CCC approval for the same provider up to the last approved date but no more than sixty (60) calendar days from the date of CCC disenrollment. For continuation of services beyond sixty (60) days, Acentra will apply medical necessity/service criteria. Should the request be submitted after the continuity of care period, it will be reviewed as a retrospective review for the dates of service outside of the dates honored and timeliness will be waived.
- Acentra will verify retro-eligibility in MES under member eligibility.

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.

EPSDT – EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT

This program is for members under the age of 21 and is in place to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly.

Some Home Health requests will be approved under the already established Home Health Criteria, but for those cases where the Home Health Criteria are not met and the member is under age 21, EPSDT criteria will be applied to the case as well.

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

THANK YOU