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Service Authorization Process for Outpatient Rehabilitation Service (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

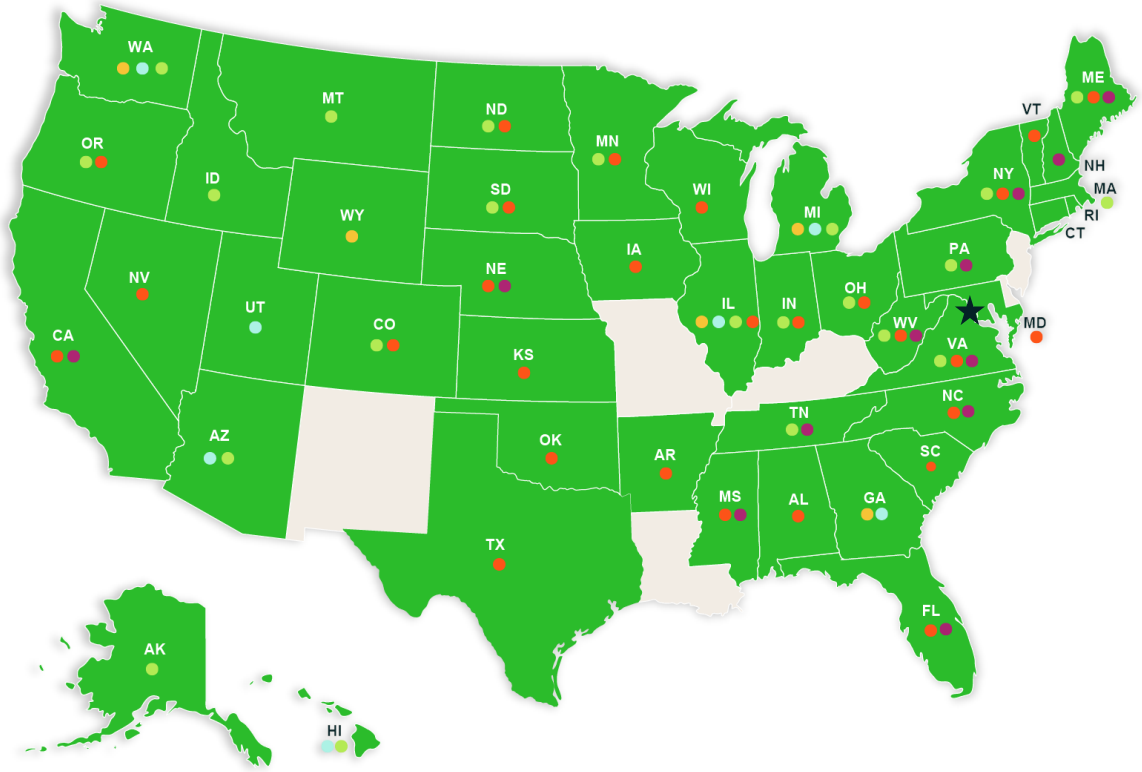
33

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.

Process for Outpatient Rehab Service Authorization Request

- Provider gathers information for the Service Authorization submission process.
- Member must be enrolled in Medicaid FFS and the Provider must be an approved DMAS provider.
- Service Authorization request is submitted via Atrezzo Next Generation (ANG) Next Generation (ANG) Connect, Fax, Phone or Mail.

Service Authorization Requests For Outpatient Rehab Timeliness

- Service authorization is required for all outpatient rehabilitation services.
- Visits include those services provided in-state by outpatient settings of acute and rehabilitation hospitals, nursing facilities and rehabilitation agencies. Out-of-state general and rehabilitation hospitals must request service authorization from Acentra Health.
- All requests for outpatient rehabilitation services must be submitted prior to services being rendered. An exception to this would be for retrospective review when the recipient becomes eligible for Medicaid.
- Requests for extended service beyond the initial authorization period must be submitted prior to the last authorized day in the certification period.
- If the request is not received within these noted timeframes, authorization begins when the request was submitted for service authorization.

Service Authorization Requests-Five Units

- Per DMAS Rehabilitation Manual, Appendix D, members have 5 units annually beginning July 1st that do not require service authorization for each service (OT, PT and SLP).

- "Annually" is defined as July 1 through June 30. If a provider knows that the member will need treatment beyond 5 units, the provider must request service authorization through Acentra Health.

- These 5 units per rehabilitative discipline without service authorization are renewable each July 1. The 5 units are specific to the member only, not per provider.

- Providers are to submit a service authorization request to Acentra Health for dates of service that cover the entire duration of the member's current plan of care, even if the dates of service span over the state's fiscal year (beginning July 1).

- Providers are no longer required to submit an outpatient rehab service authorization request to Acentra Health in which the dates of service end June 30 (end of state fiscal year) and then resubmit another service authorization request to Acentra Health after the initial five units have been utilized in the next state fiscal year (July 1 and after).

Service Authorization Requests-Five Units (CONT)

- Providers who obtain a service authorization approval for outpatient rehabilitative services from Acentra Health with dates of service spanning the state's fiscal year (July 1), may utilize this service authorization number for claims submission for all dates of service included in the authorization.
- The provider must utilize the member's initial five units in the state fiscal year (beginning July 1 annually) that do not require service authorization.
- After the five units have been utilized, the provider continues to use the service authorization number given by Acentra Health for all dates of service provided after the initial five units have been utilized through the last date of service approved on the service authorization.
- Providers are responsible to bill DMAS correctly for the first 5 units that do not require service authorization. Service authorization is required before payment will be made for any units over 5 annually. Providers may contact the Provider Helpline to determine if the first 5 units are available.

Service Authorization Requests-Five Units (CONT)

- Provider to check on member's service limits. Providers may obtain information regarding service limit utilization by contacting any of the following:
  - ✓ DMAS Provider Help Line 1-800-552-8627 (in-state long distance)
  - ✓ 1-804-786-6273 (local and out-of-state customers)
  - ✓ MediCall System 1-800-772-9996
  - ✓ 1-800-884-9730
  - ✓ 1-804-965-9732 (Richmond area)
  -
- Automated Response System (ARS): www.vamedicaid.dmas.virginia.gov

Service Authorization Requests-Five Units (CONT)

- Provider to ask member if therapy received by the member in the fiscal year (to meet 5 svc limits).
- Provider to include in service authorization request to Acentra Health documentation to indicate that the member has previously received therapy (member should advise provider that prior therapy was received from another provider previously).
- Acentra Health will review requests on a case-by-case basis and have the right to request additional information from provider.

Service Authorization Outpatient Rehab Guidelines

- In-state general and rehabilitation hospital providers use DMAS-approved revenue codes.
- Out-of-State general hospital providers and out-of-state rehabilitation hospital providers may submit requests using revenue codes 0420, 0430, and 0440. These codes may ONLY be submitted by out-of-state general hospital providers and out-of-state rehabilitation hospital providers. These services may be provided out of state only when the service cannot be performed in Virginia

DMAS Approved CPT Codes

- These codes may only be submitted by in-state private rehab providers, CORFs, physicians, etc.
  - 97110 Therapeutic procedure (PT), each 15 min. Note: unit = 15 minutes
  - 97150 Therapeutic procedure(s) (PT), group. Note: unit = a group session = 1 visit
  - 97530 Therapeutic activities (OT), each 15 min. Note: unit = 15 minutes
  - S9129 Therapeutic procedure(s) (OT), group. Note: unit = a group session = 1 visit
  - 92507 Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual. Note: unit = one treatment session = 1 visit
  - 92508 Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals. Note: unit = a group session = 1 visit

DMAS Approved CPT Codes for Outpatient Rehab (CONT)

- CPT speech therapy evaluation codes
  - 92521 Evaluation of speech fluency (e.g., stuttering, cluttering)
  - *Note: unit = an evaluation = 1 visit
  - 92522 Evaluation of speech sound production (e.g., Articulation, phonological process, apraxia, dysarthria)
  - *Note: unit = an evaluation = 1 visit
  - 92523 Evaluation of speech sound production (e.g. Articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g. receptive and expressive language)
  - * Note: unit = an evaluation = 1 visit
  - 92524 Behavioral and qualitative analysis of voice and resonance
  - * Note: unit = an evaluation = 1 visit

DMAS Approved Revenue Codes

- These codes may only be submitted by in-state general and rehabilitation hospital providers.

  - Physical Therapy: 0421 0423 0424
  - Occupational Therapy: 0431 0433 0434
  - Speech Therapy: 0441 0443 0444

DMAS Approved Revenue Codes for Out-Of-State Providers

- Out-of-state general hospital providers and out-of-state rehabilitation hospital providers (Provider Types 091, 085) may submit requests using revenue codes:
  - Physical Therapy: 0420
  - Occupational Therapy: 0430
  - Speech Therapy: 0440
- *1 unit = 1 visit
- These codes may be used for evaluations, individual visits and/or group visits.

Out-of-State Providers Revenue Codes and Requests

- Requests for revenue codes 0420, 0430, 0440 may be submitted only by out-of-state general hospital providers and out-of-state rehabilitation hospital providers. These services may be provided out-of-state only when the service cannot be performed in Virginia and/or meet any of the circumstances below.

- 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:

1. The medical services must be needed because of a medical emergency.
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. 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;
4. It is the general practice for recipients in a particular locality to use medical resources in another state.

Out-of-State Providers Revenue Codes and Requests

- 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 8 & 9 for guidelines when processing out of state requests, including 12VAC30-10-120.

- The provider needs to determine items 1 through 4 at the time of the request to the Contractor. If the provider is unable to establish one of the four, Acentra Health will:

  - Pend the request utilizing established provider pend timeframes

  - Have the provider research and support one of the items above 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 Acentra Health. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to Acentra Health, as timeliness of the request will be considered in the review process. Acentra Health will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.
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- If Acentra Health receives the information in response to the pend for the provider's enrollment from the newly enrolled provider within the 12 business days, the request will 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 Acentra Health does not receive the information to complete the processing of the request within 12 business days, Acentra Health will reject the request back to the provider, as the service authorization can not 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 10 business days to become a Virginia participating provider.

Helpful Hints for Submitting Service Authorization Request - OP Rehabilitation

- Member must meet the following:

  - Physician must prescribe prior to the provision of services and be medically necessary services.
  - Impairment due to illness or injury.
  - Member must require the skills of a licensed therapist.
  - There must be an active plan of care by a licensed therapist.
  - Services include physical and occupational therapies, and speech-language pathology.

Outpatient Rehab Submissions-Physical Therapy (PT) and Occupational Therapy (OT)

- Please submit the Member’s primary diagnosis and date of onset of illness or injury.
- Please indicate the date of the Member’s first visit with you. Has the Member previously received therapy for this diagnosis?
- Please describe the Member’s specific limitation with respect to ambulation. Is the Member ambulatory?
- Does the Member require stand by assistance with ambulation?
- Does the Member use an assistive device? Indicate what device - i.e. walker, cane, etc.

Outpatient Rehab Submissions-Physical Therapy (PT) and Occupational Therapy (OT)

- Please describe the Member’s specific limitation with respect to performing ADLs and indicate if Member requires assistance performing ADLs.
- Please include short and long-term goals with achievement dates.
- Please include frequency and duration as stated on the Plan of Care.
- If the request is for continued therapy, describe whether the Member has met previously described short and long-term goals.
- If goals not met, Please describe progress made towards achieving short and long-term goals.

Outpatient Rehab Submissions-Speech Therapy (ST)

- Please submit Member’s primary diagnosis and date of onset of illness /injury.
- Please provide the diagnosis that led to Member’s speech disorder and indicate date or age the Member received the diagnosis.
- Please indicate the Member’s first visit with you.
- Has the Member previously received therapy for this diagnosis?
- Describe the Member’s cognitive abilities. Is the Member able to comprehend instructions and accurately follow them?
- What is Member’s current mode of communication?

Outpatient Rehab Submissions-Speech Therapy (ST)

- Does the Member currently use an assistive device for speech /communication?
- If so, how long has Member been using this device?
- Describe any limitations to current communication methods.
- Describe long and short-term goals with achievement dates.
- Describe frequency and duration as stated on Plan of Care.
- If the request is for continued therapy, please describe whether or not the Member has met previously described short and long-term goals.

Acentra Health's Service Authorization Process

- The preferred submission method is Atrezzo Next Generation (ANG) Next Generation (ANG) Connect.
- Advantages:
  - 24-hour availability to submit and allows provider to check on status of case.
  - Once a request is entered into the system by a provider or provider service representative a case ID number is assigned.
  - The case is then transferred the Outpatient Rehabilitation queue for a clinical reviewer to review.

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. Example = OP Rehab professional submits revenue codes on a request instead of using CPT codes.
- 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.

Acentra Health's Service Authorization Process

- It is extremely important that the request has the service type (0204) clearly marked.
- Omissions delay the case from being placed in the correct work group for the clinical reviewer to evaluate.
- A case is sent to the OP Rehabilitation work group for review by the clinical reviewer once all demographic information and the service type is entered.
- The reviewer will evaluate the case for medical necessity by applying criteria

Criteria Used to Review for Medical Necessity

- Criteria used for review consist of Change Healthcare InterQual® Rehabilitation and /or DMAS contract guidelines.

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

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 3 business days.
- Additional information is requested from the provider via phone or fax notification.
- The provider will have until 11:59 PM of the 3rd 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.

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.

Additional Methods of Submission

- Requests may also be submitted via:
- Fax at: 877-652-9329
- Telephone at: 888-827-2884 or 804-622-8900 (local)
- Mail to: Acentra Health
  - 6802 Paragon Place
    Suite 440
  - Richmond, VA 23230

Fax Forms Used for Submission

- Service Authorization request fax forms are posted on the DMAS and Acentra Health websites.
  - Use the DMAS 363 “Outpatient Service Authorization Request Form” for Outpatient Rehabilitation requests.
  - See number 13, “Service Authorization Service Type” and select the box for “0204 Outpatient rehabilitation.”
  - DMAS 363 fax form is formatted in an editable Word version that allows providers to save the form and input responses directly onto the form. These forms can be changed and it’s the provider’s responsibility to use the current document.
  - Use of the Service Authorization fax request form will expedite processing and is preferred if providers are not using Atrezzo Next Generation (ANG) Next Generation (ANG) Connect.

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

THANK YOU

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