Service Authorization Processing For Prosthetics
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

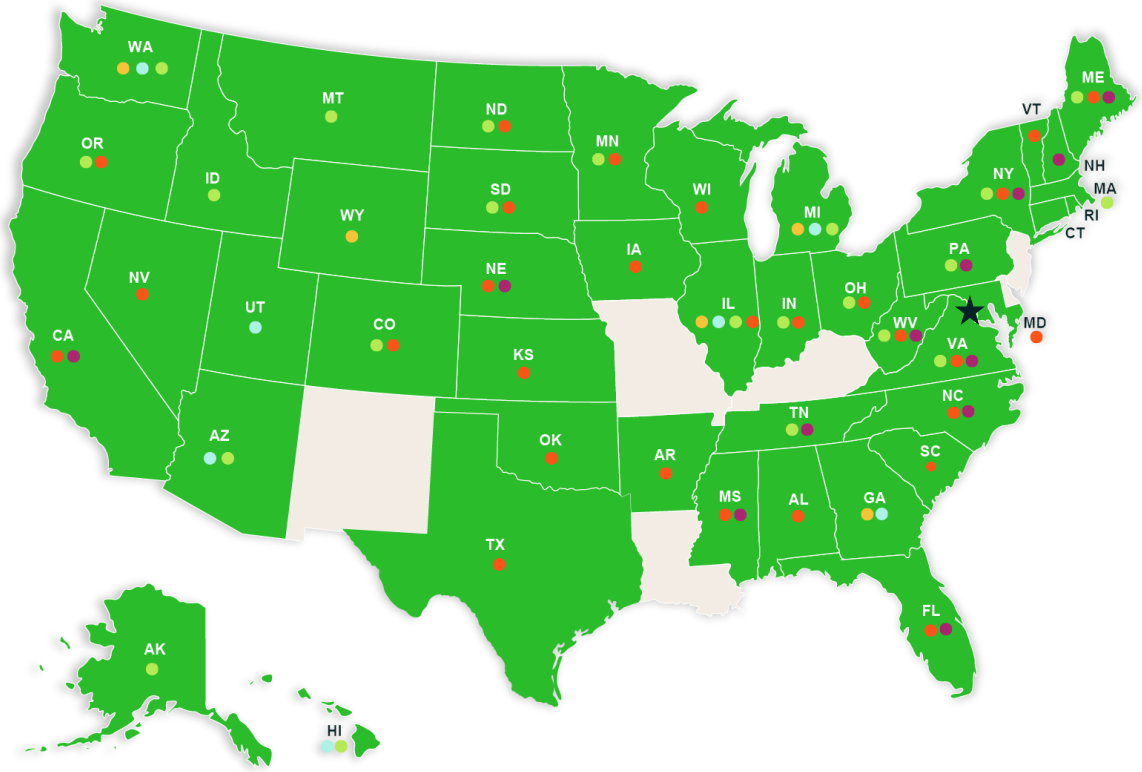
33

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

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.

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.

SERVICE AUTHORIZATION INFORMATION SPECIFIC TO PROSTHETICS

Prosthetic Device (Service Type 0303)

- Prosthetic Devices Manual, Chapters IV and V contains specific information for providers concerning Prosthetics and related devices.
- Prosthetic services shall mean the replacement of missing arms, legs, eyes, and breasts and the provision of an internal (implant) body part. Nothing in this regulation shall be construed to refer to orthotic services or devices or organ transplantation services. (12VAC30-50-210)
- Artificial arms and legs, and their necessary supportive attachments, implants, and breasts are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional license as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and service authorized for the minimum applicable component necessary for the activities of daily living (ADLs).

SERVICE AUTHORIZATION INFORMATION SPECIFIC TO PROSTHETICS (CONTINUED)

- Eye prostheses are provided when eyeballs are missing regardless of the age of the member or the cause of the loss of the eyeball. Eye prostheses are provided regardless of the function of the eye. Service Authorization is not required through DMAS's Service Authorization contractor.
- Prosthetics, not including orthotics (braces, splints, and supports), are covered for the general adult Medicaid population under the Prosthetics program.
- All medically necessary Prosthetics items under the State Plan may be covered only if they are necessary to carry out a treatment prescribed by a practitioner (physician, nurse practitioner, and physician assistant).
- Prosthetic device requests must be submitted by the provider prior to the prosthetic device being delivered.
- Service authorization approvals that are completed prior to the prosthetic device delivery are approved for medical necessity with the date span of one year.

SERVICE AUTHORIZATION INFORMATION SPECIFIC TO PROSTHETICS (CONTINUED)

- Administrative denials would occur if the provider does not respond to a pended request for initial clinical information or submitted a request after the prosthetic device has been delivered and the member is not retro-eligible.
- Acentra is only contracted to perform service authorization requests on the master code list which can be found in the DMAS Prosthetics Manual CH IV,V.
- If a request is submitted for a CPT/HCPCS code not on the master list, the request will be rejected and the provider will be referred to the DMAS Provider Helpline.
- Change Healthcare InterQual®, CMS or DMAS Specific Criteria is utilized. When the request does not meet the applicable criteria, the case is automatically referred for physician review
- Application of EPSDT Criteria for members under the age of 21, are performed at a Physician Review level or as directed by Acentra’s Medical Director.

SERVICE AUTHORIZATION INFORMATION SPECIFIC TO PROSTHETICS CONTINUED

- If Prosthetic Device request is approvable and the HCPCS code does not have an assigned remit dollar amount and is designated “individual consideration” or “IC”, the provider should submit their cost and if the item is approved the provider will receive a thirty percent (30%) mark up.
- Some “L” prosthetic codes are temporary items needed immediately following surgery (post-op) - (i.e. L6380, L6382, L6384, L6386, L6388). A provider may need to request a temporary prosthetic and later submit a request for a permanent prosthetic. Provider documentation should include that the requested prosthetic is temporary.
- Prosthetics may be made from different materials: standard or ultralight. Ultralight materials cost more than standard materials (i.e. L5785). Ultralight materials require additional medical justification explaining why ultralight materials are needed instead of standard materials. If ultralight materials cannot be justified, the provider should request standard materials instead.
- If member is in a Nursing Facility or Hospice, prosthetic device may not be covered. See Chapter IV of the Prosthetic Device Manual.

SERVICE AUTHORIZATION INFORMATION SPECIFIC TO PROSTHETICS CONTINUED

- All service authorizations for prosthetic devices will be approved for one year (To and From dates for each request).
- Retrospective review will be performed when a provider is notified of a member’s retroactive eligibility for Virginia Medicaid coverage.
- Retrospective review will also apply when Medicaid dually eligible members exhaust their Medicare coverage.

SERVICE AUTHORIZATION INFORMATION SPECIFIC TO PROSTHETICS AND THE DMAS 363 FAX FORM

- The DMAS fax form utilized will be the DMAS 363.
- Per the DMAS 363 fax form, providers will need to also include responses from the DMAS-4001 Physician Certification of Need Form. Specifically, in regards to Severity of Illness, items #15 through 17, and for Intensity of Service, items #5 through 14 and 19 (physician signature & date).
- If patient-owned items need to be replaced, the provider must address item #13 on the DMAS-4001 fax form for Service Authorization. Documentation should include the following which the reviewer could pend for as needed:
  - What items the recipient is currently using and why that item is no longer appropriate for the recipient? This description shall include the reason why repairs could not be done or why the option to repair the items was not cost-effective.
  - The provider shall include a breakdown of what items need to be repaired and include the cost to repair the items to justify why the purchase of new items would be more cost-effective.
  - If the item is no longer appropriate due to a change in medical condition, limitations, and symptoms or if the items were provided inappropriately, the provider shall give justification to describe the circumstances.

SERVICE AUTHORIZATION REQUESTS FROM OUT-OF-STATE PROVIDERS

- Out-of-state providers must be enrolled with Virginia Medicaid in order to submit a request for out of state services to Acentra.
- If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is still encouraged to submit the request to Acentra, as timeliness of the request will be considered in the review process.
- These providers will not have a NPI number but may submit a request to Acentra.
- Acentra will advise out-of-state providers they 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", then "Provider Enrollment" in the drop down box. It may take up to 10 business days to become a Virginia participating provider.)

SERVICE AUTHORIZATION REQUESTS FROM OUT-OF-STATE PROVIDERS NOT ENROLLED IN VIRGINIA MEDICAID

- Acentra will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.
- If the provider responds with the necessary information within the 12 business days, the request will continue through the review process and a final determination will be made on the service request.
- If Acentra does not receive the information to complete the processing of the request within the 12 business days, the request will be rejected, 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.

PROTHETICS REVIEW PROCESS FOR OUT-OF-STATE REQUESTS

Prosthetic devices may be provided out-of-state only when the service cannot be performed in Virginia and/or meet any of the circumstances below. Services provided out-of-state for circumstances other than these specified reasons shall not be covered.

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.

Should the provider not respond or not be able to establish items 3 or 4 the request can be administratively denied. This decision is supported by 12VAC30-10-120 and 42 CFR 431.52.

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