Service Authorization Process for EPSDT (Assistive Tech, Chiropractic, Orthotics, Hearing Aids) 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

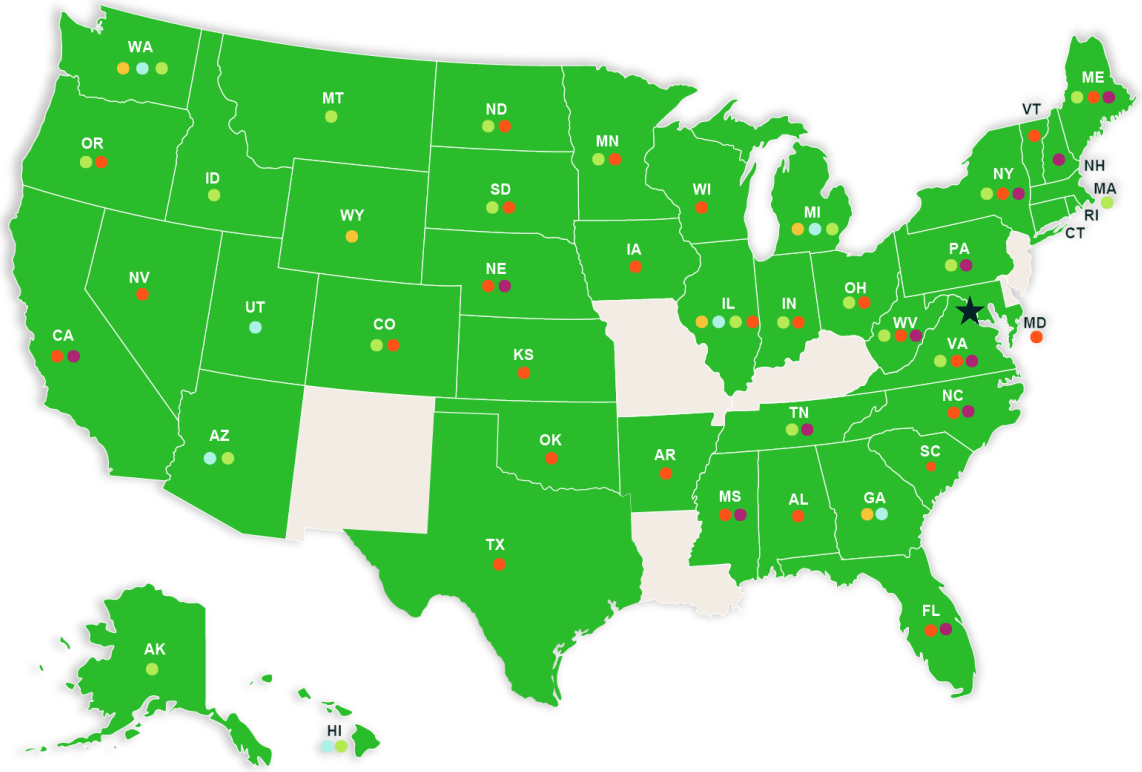
33

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.

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.

EPSDT Specialized Services

- EPSDT specialized services are available only for Medicaid members under age 21.
- EPSDT specialized services are not a covered service by DMAS for individuals age 21 and older.
- Specialized services through the EPSDT program are used to correct or ameliorate physical or developmental disability identified during EPSDT screening services and the individual may be referred by the EPSDT screener or Primary Care Provider (PCP) for specific services. These services must be medically necessary with appropriate documentation to support each service authorization request. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the standard of practice. All approvals must meet these agency criteria.

EPSDT Specialized Services

- EPSDT specialized services are not available under the Virginia State Plan for Medical Assistance. Specialized services or items consist of a range of unique individualized services that are medically necessary to correct or ameliorate persons under the age of 21. Specialized services are available through Managed Care Organizations (MCO) and in Fee for Service (FFS) with the same scope of benefit. Select EPSDT services are authorized as part of the DD Waiver service coordination directly by DBHDS.

- Services, equipment or supplies already covered by the Virginia State Plan for Medical Assistance may not be requested for reimbursement under EPSDT.

- Individuals enrolled in Home and Community-Based waivers that provide a service available through EPSDT must obtain the service through EPSDT. These services include Assistive Technology and Private Duty Nursing. Requests which do not meet the medical necessity criteria through the EPSDT program may not be provided through the waiver program.

Service Authorization Information Specific to Hearing Aids and Related Devices

- Hearing Aid services are only available for Medicaid members under the age of 21 through EPSDT.
- Only hearing aid providers (provider type 038) and audiologists (provider type 044) may submit hearing aid requests.
- Providers must submit requests when they are aware of the need for hearing aid/service and prior to delivery.
- Providers should expect a response from KEPRO within three (3) business days of receipt. These services are also available as MCO carved-out services.
- KEPRO will utilize Change Healthcare InterQual Criteria in making medical necessity determinations for hearing aids and related devices.
- Where Change Healthcare InterQual Criteria do not exist, KEPRO will utilize DMAS criteria as specified in the EPSDT Hearing and Audiology Manual found under Provider Resources/Manuals on the DMAS web portal.

Service Authorization Information Specific to Hearing Aids and Related Devices

- Requests for new hearing devices (new hearing aids) must contain the following:

- Completed CMN (Certificate of Medical Necessity), DMAS-352, signed by a physician including HCPCS codes for all related services;

- Most recent audiological evaluation report

- 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 mark up cost 30%.

- Discuss reasons for exceptional coverage requests

Service Authorization Information Specific to Hearing Aids and Related Devices

- Requests for special cost consideration or repairs must contain the following:

  - Quote from supplier to document provider’s wholesale cost or cost description for requests to exceed allowed reimbursement rates.

  - Discuss reasons for exceptional coverage requests.

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

  - Contractor would receive quote from provider, verify cost and if request approved, mark up cost 30%.

Service Authorization Information Specific to Hearing Aids and Related Devices

- DMAS 363 form is the Outpatient Services Authorization Request Form which must be used to submit this request via FAX.
- DMAS 352 – Certificate of Medical Necessity (CMN) or information relating to the Hearing Aids and Related Devices must be completed.
- Most Recent Audiology Evaluation should be submitted with the FAX
- Provider’s Invoice Cost should also be submitted if there are price considerations over and above the UCC

- Please follow the instructions on the DMAS 363 and the DMAS 352

EPSDT (0092) Hearing Aids and Related Devices Procedure Codes

Procedure Codes	Procedure Code Definition
V5014	Repair/Modification Of Hearing Aid
V5030	Hearing Aid, Monaural, Body Worn, Air Conduction
V5040	Hearing Aid, Monaural, Body Worn, Bone Conduction
V5050	Hearing Aid, Monaural, In The Ear (Ite)
V5060	Hearing Aid, Monaural, Behind The Ear (Bte)
V5070	Glasses, Air Conduction
V5080	Glasses, Bone Conduction
V5095	Semi-Implantable Middle Ear Hearing
V5100	Hearing Aid, Bilateral, Body Worn
V5120	Binaural, Body
V5130	Hearing Aid, Binaural, Ite
V5140	Hearing Aid, Binaural, Bte
V5150	Binaural, Glasses
V5170	Hearing Aid, Cros, In The Ear
V5180	Hearing Aid, Cros, Behind The Ear
V5210	Hearing Aid, Bicros, In The Ear
V5220	Hearing Aid, Bicros, Behind The Ear
V5242	Hearing Aid, Analog, Monaural, Cic (Completely In The Ear Canal)
V5243	Hearing Aid, Analog, Monaural, Itc (In The Canal)
V5244	Hearing Aid / Digitally Programmable Analog / Monaural / CIC
V5245	Hearing Aid / Digitally Programmable Analog / Monaural / ITC (Canal)
V5246	Hearing Aid / Digitally Programmable Analog / Monaural / ITE (In-the-Ear)
V5247	Hearing Aid / Digitally Programmable Analog / Monaural / BTE (Behind-the-Ear)
V5248	Hearing Aid, Analog, Binaural, Cic
V5249	Hearing Aid, Analog, Binaural, Itc
V5250	Hearing Aid / Digitally Programmable / Analog /Binaural /CIC (Completely in Canal)
V5251	Hearing Aid / Digitally Programmable / Analog /Binaural /ITC (Canal)

Procedure Codes	Procedure Code Definition
V5252	Hearing Aid / Digitally Programmable / Analog /Binaural /ITE (In-the-Ear)
V5253	Hearing Aid / Digitally Programmable / Analog /Binaural /BTE(Behind-the Ear)
V5254	Hearing Aid, Digital, Monaural, Cic
V5255	Hearing Aid, Digital, Monaural, Itc
V5256	Hearing Aid, Digital, Monaural, Ite
V5257	Hearing Aid, Digital Monaural Bte
V5258	Hearing Aid, Digital, Binaural, Cic
V5259	Hearing Aid, Digital, Binaural, Itc
V5260	Hearing Aid, Digital, Binaural, Ite
V5261	Hearing Aid, Digital, Binaural, Bte
V5264	Ear Mold/ Insert, Not Disposable, Any Type
V5266	Battery For Use In Hearing Device
V5267	Hearing Aid Supplies
V5273	Assistive Listening Device Cochlear Implant Type
V5274	Assistive Listening Device (Not Otherwise Classified)
V5281	Assistive Listening Device, FM system, Monaural
V5282	Assistive Listening Device, FM system, Binaural
V5283	Assistive Listening Device, FM /DM Neck, loop induction receiver
V5284	Assistive Listening Device, FM /DM, ear level receiver
V5285	Assistive Listening Device, FM /DM, direct audio input
V5286	Assistive Listening Device, personal FM /DM blue tooth receiver
V5287	Assistive Listening Device, personal FM /DM receiver, not otherwise classified
V5288	Assistive Listening Device, personal FM /DM transmitter, assistive listening device
V5289	Assistive Listening Device, Personal FM/DM Adapter/Boot coupling Device for receiver, any type
V5290	Assistive Listening Device, Transmitter or Microphone, any type
V5298	Hearing Aid, Not Otherwise Classifi
V5299	Hearing Service, Miscellaneous

Service Authorization Information Specific to Prosthetics (CONT)

- 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 Provider Manual.
- 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.
- McKesson 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 (CONT)

- 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 (CONT)

- 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 items 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 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.

Prosthetics 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.

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.

Orthotic Services
Service Authorization Review Process

Orthotic device services include devices that support or align extremities to prevent or correct deformities or to improve functioning, and services necessary to design the device, including measuring, fitting, and instructing the patient in its use.

Orthotics must be:

- Ordered by the physician on the DMAS-352 (CMN);
- Directly and specifically related to an active, written, and physician-approved treatment or discharge plan;
- Based upon a physician's assessment of the member's rehabilitation potential where the member's condition will improve significantly in a reasonable and predictable period of time, or must be necessary to establish an improved functional state of maintenance; and
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational).

Orthotic Services
Service Authorization Review Process

Children do not have to be enrolled in Children's Specialty Services to receive orthotics. All medically necessary orthotics are covered for children under the age of 21 years. The orthotist participating as a Medicaid DME provider coordinates the completion of the DMAS-352 (CMN) with the prescribing physician using the correct HCPCS "L" procedure
codes.

Service authorization through Atrezzo Next Generation (ANG) is required.

Documentation of provider cost will be required for "L" procedure codes that do not have an established reimbursement allowance. Reimbursement (under HCPCS "L" codes to the DME orthotic provider is all inclusive; no supplemental reimbursement will be made for the time involved in fitting, measuring, and designing the orthotic, or for providing the member with instructions for the proper use.

Chiropractic Services
Service Authorization Review Process

Chiropractic services are available for Medicaid members under the age of 21 and through the DMAS EPSDT program. This service cannot be authorized for Medicaid members age 21 and older.

Chiropractors (Provider Type 026) are the only providers to submit these requests.

Acentra will apply Change Healthcare InterQual® to certain services and DMAS criteria where Change Healthcare Interqual® products do not exist.

If unable to approve a request, then Acentra will apply EPSDT criteria. The Chiropractic CPT codes requiring service authorization are listed below.

Chiropractic CPT codes to submit for service authorization:

- 98940 Chiropractic Manipulative Treatment (Cmt); Spinal, One To Two Regions
- 98941 Chiropractic Manipulative Treatment (Cmt); Spinal, Three To Four Regions
- 98942 Chiropractic Manipulative Treatment (Cmt); Spinal, Five Regions
- 98943 Chiropractic Manipulative Treatment (Cmt); Extraspinal, One Or More Region

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, 6thth 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