CHAPTER V

SERVICE AUTHORIZATION

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INTRODUCTION

Service authorization (Srv Auth) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require Srv Auth and some may begin prior to requesting authorization.

Service authorization by the Medicaid Central Office is required for payment to be made for covered prostheses (artificial arms, legs, their necessary supportive devices, and breast prostheses).

PURPOSE OF SERVICE AUTHORIZATION

The purpose service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, and established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity.

GENERAL INFORMATION REGARDING SERVICE AUTHORIZATION

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for Srv Auth requests.

The Srv Auth entity will approve, pend, reject, or deny all completed Srv Auth requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request.

Retrospective review will be performed when a provider is notified of a patient's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service authorization for covered days prior to billing DMAS for these services. Providers must request a service authorization for retrospective review as soon as they are aware of the member's Medicaid eligibility determination.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care programs, the Srv Auth entity will honor the Medicaid MCO service authorization if the member has been disenrolled from the MCO. Similarly, the MCO will honor the Srv Auth contractor's authorization based upon proof of authorization from the provider, DMAS, or the Srv Auth Contractor that services were authorized while the member was eligible under fee-for-service (not MCO enrolled) for dates where the member has subsequently become enrolled with a DMAS contracted MCO.

Srv Auth decisions by the DMAS Srv Auth contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested. The Srv Auth contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify member eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled members, the provider must follow the MCO's Srv Auth policy and billing guidelines.

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) PROGRAM

Members Transitioning into CCC Plus:

For members that transition into the CCC Plus Program, the CCC Plus Health Plan will honor the Srv Auth contractor’s authorization for a period of not less than 90 days or until the Srv Auth ends whichever is sooner, for providers that are in-and out-of network.

When a member enrolls in CCC Plus, the provider should contact the CCC Plus Health Plan to obtain an authorization and information regarding billing for services if they have not been contacted the CCC Plus Health Plan.

Members Transitioning from CCC Plus and back to Medicaid Fee-For Service (FFS)

Should a member transition from CCC Plus to Medicaid FFS, the provider must submit a request to the Srv Auth contractor and advise the Srv Auth Contractor that the request is for a CCC Plus transfer within 60 calendar days. This will ensure honoring of the approval for the continuity of care period and waiving of timeliness requirements. The Srv Auth Contractor will honor the CCC Plus approval up to the last approved date but no more than 60 calendar days from the date of CCC Plus disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the Srv Auth contractor will apply medical necessity/service criteria.

Should the request be submitted to the Srv Auth Contractor after the continuity of care period:

A. The dates of service within the continuity of care period will be honored for the 60- day timeframe;
B. The dates of service beyond the continuity of care period, timeliness will be waived and reviewed for medical necessity, all applicable criteria will be applied on the first day after the end of the continuity of care period
C. For CCC Plus Waiver Services, Cap hours will be approved the day after the end of the continuity of care period up to the date of request. The continuation of service units will be dependent upon service criteria being met and will either be authorized or reduced accordingly as of the date of the request.

The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the *beginning* of the month. This will provide information for members who may be in transition from CCC Plus at the very end of the previous month.

Should there be a scenario where DMAS has auto closed (ARC 1892) the Srv Auth Contractor's service authorization but the member's CCC Plus eligibility has been retro-voided, continuity of care days will not be approved by the CCC Plus health plan and will not be on the transition reports since the member never went into CCC Plus. The Srv Auth contractor will re-open the original service authorization for the same provider upon provider notification.

CCC Plus Exceptions:

The following exceptions apply:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the Srv Auth Contractor will honor the CCC Plus approved days/units under the continuity of care period for up to 60 calendar days. The remaining dates of services will be reviewed and must meet service criteria but timeliness will be waived as outlined above.)
- If the service has been authorized under CCC Plus for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once member is FFS, only Medicaid approved services will be honored for the continuity of care.
- If a member transitions from CCC Plus to FFS, and the provider requests an authorization for a service not previously authorized under CCC Plus, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Srv Auth Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, click on the link: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

COMMONWEALTH COORDINATED CARE

For individuals enrolled in the Commonwealth Coordinated Care (CCC) Program, the Medicare-Medicaid Plan (MMP) will honor the Srv Auth contractor's authorization for a period of not less than 180 days or until the Srv Auth ends whichever is sooner, for providers in-and out-of network. When a member enrolls in CCC, the provider should contact the MMP to receive an authorization and information regarding billing for services if they have not been contacted by the MMP.

When a member disenrolls from CCC and returns back to traditional fee-for-service (FFS) Medicaid, the provider must submit a request to the Srv Auth contractor and needs to advise the Srv Auth Contractor that the request is for a CCC transfer. This will ensure honoring of the approval for the continuity of care period and waiving of timeliness requirements. The Srv Auth Contractor will honor the CCC approval up to the last approved date but no more than 60 calendar days from the date of CCC disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the Srv Auth Contractor 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 for the continuity of care period and timeliness will be waived.

The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the beginning of the month. This will provide information for members who choose to disenroll from CCC at the very end of the previous month.

The following exceptions apply:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the Srv Auth Contractor will honor the CCC approved days/units under the continuity of care period for up to 60 calendar days. The remaining dates of services will be reviewed and must meet service criteria but timeliness will be waived as outlined above.)
- If the service has been authorized under CCC for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.

- Once member is FFS, only Medicaid approved services will be honored for the continuity of care.
- If a member transfers from CCC to FFS, and the provider requests an authorization for a service not previously authorized under CCC, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Srv Auth Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

For information regarding CCC, click on the link: http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx.

CHANGES TO COMMONWEALTH COORDINATED CARE, EFFECTIVE DECEMBER 31, 2017:

December 31, 2017 will be the last covered day for the CCC Program. Members that are currently in this program will be transitioned into the Commonwealth Coordinated Care Plus (CCC Plus) Program, the Managed Long Term Services and Supports program administered by the Department of Medical Assistance Services (DMAS). DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, click on the link: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

COMMUNICATION

Provider manuals are located on the DMAS and KePRO websites. The contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to http://dmas.kepro.com and clicking on the *Forms* tab for fax forms to request services. A service specific checklist may be found by clicking on "Service Authorization Checklists" on KePRO's website. For educational material, click on the *Training* tab and scroll down to click on the *General* tab.

The Srv Auth entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf andhard-of-hearing.

Updates or changes to the Srv Auth process for the specific services outlined in this manual willbe posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION, EFFECTIVE APRIL 1, 2012

Certain services including Prosthetic Devices previously reviewed by DMAS' Medical Support Unit (MSU) will be reviewed by Keystone Peer Review Organization (KePRO), DMAS' service authorization contractor. KePRO will begin accepting requests, regardless of the dates of service, on April 1, 2012. KePRO will provide web based training sessions for providers. Providers may access these training sessions by going to http://dmas.kepro.com and clicking on the *Training* tab. KePRO will allow retroactive reviews for service requests submitted through June 30, 2012. Refer to the March 9, 2012 DMAS Medicaid Memo titled, "Services Currently Reviewed by DMAS' Medical Support Unit Moving to KePRO for Review, effective April 1, 2012 and New Procedures Codes Requiring Service Authorization, effective April 1, 2012". **Effective July 1, 2012, KePRO will not authorize requests retroactively, regardless of the dates of service.** The only instance KePRO will approve services retroactively on and after July 1, 2012 is when the provider demonstrates retroactive Medicaid eligibility determination for members.

KePRO will accept requests through direct data entry (DDE), fax, telephone or US Mail. The preferred method is by DDE through KePRO's provider portal, Atrezzo Connect. To access Atrezzo Connect on KePRO's website, go to http://dmas.kepro.com.

For direct data entry requests, providers must use Atrezzo Connect Provider Portal.

Provider Registration is Required to use Atrezzo Connect
The registration process for providers happens immediately on-line. From http://dmas.kepro.com, providers not already registered with Atrezzo Connect may click on "*First Time Registration*" to be prompted through the registration process. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount.

The Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the *Training* tab, then the *General* tab.

Providers with questions about KePRO's Atrezzo Connect Provider Portal may contact KePRO by email at atrezzoissues@kepro.com.

For servicee authorization questions, providers may contact KePRO at providerissues@kepro.com. KePRO can also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

Faxing Requests to KePRO
Providers must use the specific fax form required by KePRO when requesting services. If the fax form is not accompanied by the request, KePRO will reject the request back to the provider and the provider must resubmit the entire request with the fax form. KePRO's website has information related to the service authorization processes for all Medicaid programs they review. Fax forms, service authorization checklists, trainings, and much more are on KePRO's website. Providers may access this information by going to http://dmas.kepro.com.

Timeliness of Submission by Providers, Effective July 1, 2012 and Forward

All requests for services must be submitted prior to services being rendered. KePRO will allow a grace period through June 30, 2012 for providers to submit requests for services already rendered. This grace period only applies to the procedure codes attached to the DMAS Memo dated March 9, 2012 and titled **"**Services Currently Reviewed by DMAS' Medical Support Unit Moving to KePRO for Review, *effective April 1, 2012* and New Procedures Codes Requiring Service Authorization, *effective April 1, 2012"*. **Effective July 1, 2012 there will be no retroactive authorization**. This means that if the provider is untimely submitting the request, KePRO will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied, and appeal rights provided.

If a provider had a claims denial due to the absence of service authorization, KePRO will not perform retroactive authorization effective July 1, 2012. Providers may appeal the claims denial through DMAS.

Processing Requests at KePRO

KePRO will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached KePRO notifies the member and the provider in writing of the status of the request through the MMIS letter generation process.

If there is insufficient information to make a final determination, KePRO will pend the request back to the provider and request additional information. If the information is not received within the time frame requested by KePRO, the request will automatically be sent to a physician for a final determination with all information that has been submitted. Providers and members are issued appeal rights through the MMIS letter generation process for any adverse determination. Instructions on how to file an appeal is included in the MMIS generated letter.

If services cannot be approved for members under the age of 21 using the current criteria, KePRO will then review the request by applying EPSDT criteria.

Providers must submit requests to KePRO within 14 business days of the need for the prosthetic device and prior to rendering services. As of July 1, 2012 there will be no retroactive authorization. This means that if the provider is late submitting the request, KePRO will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied and appeal rights provided. KePRO will review completed requests within 3 business days of receipt and make a final determination.

Service authorization checklists may be accessed on KePRO's website to assist the provider in assuring specific information is included in the electronic request in order to make a final determination for prosthetics. Information from the DMAS 4001 *(Physician's Certification of Need)* may be used to complete the checklist. The service authorization checklists are not mandatory in order to complete the request.

If providers do not wish to use the service authorization checklist for web based requests, the provider may submit the completed DMAS 4001 *(Physician's Certification of Need)* as an attachment to the request when it is submitted.

Since the information from the DMAS 4000 *(Prosthetic Devices Preauthorization Request Form)* has been incorporated into the review process, there is no longer a need for the provider to complete it for the clinical record. The DMAS 4001 *(Physician's Certification of Need)* is still required to be fully completed and present in the clinical record and may be reviewed on post payment or quality management review.

The Srv Auth Contractor, KePRO, will apply InterQual criteria to the medical information provided and a service authorization number will be assigned to the request.

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 starting July 1, 2012. KePRO will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.

If KePRO 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 then continue through the review process and a final determination will be made on the service request.

If the request was pended for no provider enrollment and KePRO does not receive the information to complete the processing of the request within the 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 10 business days to become a Virginia participating provider.

OUT-OF-STATE PROVIDER INFORMATION

Effective March 1, 2013, there is a change in the policy and procedure for out-of-state requests submitted by out-of-state providers. This change impacts out-of-state providers who submit Virginia Medicaid service authorization requests to Keystone Peer Review Organization (KePRO), DMAS' service authorization contractor, and any other entity to include, but not limited to, DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) when providing service authorizations for the services listed in the DMAS memo dated February 6, 2013 and titled *"Notification of a Procedural Change for Out-of-state Providers Submitting Requests for Service Authorization Through KePRO"*.

KePRO's service authorization process for certain services will include determining if the submitting provider is considered an out-of-state provider. Out-of-state providers are defined as those providers that are either physically outside the borders of the Commonwealth of Virginia or do not provide year end cost settlement reports to DMAS. Please refer to the above referenced DMAS memo dated February 6, 2013. Additional information is provided below.

Out-of-State Provider Requests
Authorization requests for certain services can be submitted by out-of-state providers. Procedures and/or services may be performed out-of-state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period.

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.

The provider needs to determine item 1 through 4 at the time of the request to the Contractor. If the provider is unable to establish one of the four, the Contractor 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

"Effective September 12, 2016, KEPRO added additional questions to the Out-of-state Provider questionnaire (found on the Provider Portal):

a. Question #2 - If the medical services are needed, will the recipient's health be endangered if required to travel to state of residence? If a provider answers "Yes", then additional question #2.1.1 asks: "Please explain the medical reason why the member cannot travel".
b. Question #5 - "In what state is the provider rendering the service and/or delivering the item physically located?"
c. Question #6 - "In what state will this service be performed?"
d. Question 7 - "Can this service be provided by a provider in the state of Virginia? If a provider answers "No", then additional question #7.2.1 asks: "Please provide justification to explain why the item/service cannot be provided in Virginia." Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10-120 and 42 CFR 431.52.

Review Criteria to be Used

DMAS criteria for medical necessity will be considered if a service is covered under the State Plan and is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve functional disability. 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. Therefore, all approvals must meet these agency criteria. All other criteria, including McKesson InterQual®, EPSDT and physician review criteria are used for guidelines and reference purposes only.

McKesson InterQual®: KePRO will apply McKesson InterQual® criteria to certain services and DMAS criteria where McKesson InterQual® does not exist.

SERVICE AUTHORIZATION INQUIRIES

Since implementation of the Virginia Medicaid Management Information System (VAMMIS), service authorization letters are system generated. All decisions are updated in VAMMIS and assigned a service authorization number. The decision information is available to providers through the Automated Response System (ARS).

Authorization status is available 24 hours per day, 7 days per week through the ARS. Providers can complete registration for the ARS online at www.virginiamedicaid.dmas.virginia.gov, or can contact the Provider Helpline at:

1-800-552-8627 (in-state long distance toll-free); or
(804) 786-6273 (out-of-state, Richmond area and long distance).

SERVICE AUTHORIZED SERVICES FOR RETROACTIVE ELIGIBILITY

For services requiring service authorization, all service authorization criteria must be met in order for the claim to be paid. For those services occurring in a retroactive eligibility period, authorizations will be performed by DMAS or their contractor retrospectively.

HOW TO DETERMINE IF SERVICES NEED SERVICE AUTHORIZATION

In order to determine if services need to be service authorized, providers should go to the DMAS website: http://dmasva.dmas.virginia.gov and look to the right of the page and click on the section that says Procedure Fee Files which will then bring you to this: http://www.dmas.virginia.gov/pr-fee_files.htm You will now see a page entitled DMAS Procedure Fee Files. The information provided there will help you determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

To determine if a service needs Service Authorization, you would then determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the TXT version. The TXT version is recommended for users who wish to download this

document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be prior authorized as it will contain a numeric value for the PA Type, such as one of the following:

00 – No PA is required
01 – Always needs a PA
02 -Only needs PA if service limits are exceeded
03- Always need PA, with per frequency.

To determine whether a service is covered by DMAS you need to access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides you special coverage and/or payment information. A Procedure Flag of "999" indicates that a service is non-covered by DMAS.

EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT SERVICE AUTHORIZATION

EPSDT is a Federal law (42 CFR § 441.50 et seq) which requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, and is composed of two parts:

1. EPSDT promotes the early and universal assessment of children's healthcare needs through periodic screenings, and diagnostic and treatment services for vision, dental and hearing. These services must be provided by Medicaid at no cost to the member.

2. EPSDT also compels state Medicaid agencies to cover other services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" [make better] a defect, physical or mental illness, or condition [health problem] identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service for adults under the state plan. For more information, visit: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

All Medicaid and FAMIS Plus services that are currently service authorized by the Srv Auth contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission

may be found at the contractor's website, DMAS.KePRO.com. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX OR 1-877-652-9329.

Example of EPSDT Review Process:

- The following is an example of the type of request that is reviewed using EPSDT criteria: A durable medical equipment (DME) provider may request coverage for a wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.

The review process as described is to be applied across all non waiver Medicaid programs for children. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT program. Examples of non covered services are inclusive of but are not limited to the following services: residential substance abuse treatment, behavioral therapy, specialized residential treatment not covered by the psychiatric services program. All service requests must be a service that is listed in (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).

NOTE: Effective November 1, 2012, EPSDT specialized services that are service authorized by Keystone Peer Review Organization (KePRO), DMAS' service authorization contractor include:

Hearing Aids and Related Devices
Assistive Technology
Private Duty Nursing
Personal Care and Attendant Care Services

Requests for services **not service authorized by KePRO** may be sent to:
EPSDT Service Authorization Coordinator
Fax: 804-612-0043 Phone: 804-786-6134

INSTRUCTIONS FOR THE COMPLETION OF THE CERTIFICATION OF NEED FORM

Item 1. Enter the name of the patient.

Item 2. Enter the patient's 12-digit Medicaid number.

Item 3. Enter the date of the most recent amputation for the limb to be replaced by the prosthesis.

Item 4. Enter the patient's date of birth.

Item 5. Enter the patient's current weight.

Item 6. Enter the patient's current height.

Item 7. Enter the diagnosis for which the patient had the amputation (if applicable).

Item 8. Enter the reason for the patient's amputation (if not described in Item 7).

Items 9-13. To be completed by the prescribing physician.

Item 14. To be completed by the prescribing physician. Please note that all special components of the prosthesis must be medically justified components, not convenience items.

Items 15-17. To be completed by the prescribing physician.

Item 18. Enter the physician's name.

Item 19. Enter the physician's signature.

Item 20. Enter the physician's address.

Item 21. Enter the physician's telephone number.

If additional space is needed for explanations of certain items, include a letter addressing these items

EXHIBITS

Please use this link to search for DMAS Forms:
https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch

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CERTIFICATION OF NEED FORM (DMAS-4001)

PHYSICIAN CERTIFICATION OF NEED

Dear Doctor:

To expedite the processing of request for funding of prosthetic devices for your patient, the Department of Medical Assistance Services seeks your assistance in contributing medical information so that an appropriate decision can be made promptly. Please complete the following where applicable and forward to the prosthetist for their submission with the preauthorization request form or send to Medical Support Section, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

1. _____ Patient's Name
2. _____ Medicaid Recipient I.D. Number
3. _____ Date of Amputation
4. _____ Date of Birth
5. _____ Weight
6. _____ Height
7. _____ Diagnosis
8. _____ Reason for Amputation
9. Are other amputations anticipated within the next twelve months?
10. If this patient has undergone a lower extremity amputation, please include the date the patient last ambulated:
11. Please list any current significant medical conditions and their present treatments, e.g. arthritis, vascular disease, neuropathy, diabetes:
12. Is the patient cognitive and physical status sufficient to enable learning the use of a prosthesis?
13. If the patient has had a prosthetic limb, why does it need to be replaced or repaired?
14. Additional medical justification for special prosthetic components, e.g. lightweight equipment, special terminal devices, modified sockets, modified feet, etc.:

PHYSICAL EXAMINATION

15. Please indicate strength testing of all extremities, including range of motion across all joints. This should include the contralateral limb:
16. Are there any signs on examination consistent with vascular disease in the contralateral limb? Give it's present condition and viability.
17. Are there any conditions that would preclude or delay the use of prosthesis, i.e., edema, open wound, contractures or poor skin viability?

18. _____ Physician's Name
19. _____ Physician's Signature _____ Date
20. _____ Street Address
21. _____ Physician's Phone Number

_____ City, State, Zip Code

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