Appendix D
Service Authorization

APPENDIX D
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INTRODUCTION – SERVICE AUTHORIZATION IN FEE-FOR-SERVICE (FFS) AND MANAGED CARE ORGANIZATIONS (MCO)

Service authorization is the process to review specific service requests 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 service authorization, and some may begin prior to requesting authorization.

Psychiatric Residential Treatment Facility Services (PRTF) and Therapeutic Group Home Services (TGH) are covered for Medicaid members under age twenty-one (21) and are administered through the DMAS Service Authorization Contractor. Any member admitted to a PRTF will be temporarily excluded from Managed Care until they are discharged. Any member admitted to a TGH is not excluded from the Program; however, the TGH service is carved out of managed care and is administered through the DMAS Service Authorization Contractor.

Purpose of Service Authorization

The purpose of 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 claim's 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, an 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

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 service authorization requests.

DMAS criteria for medical necessity will be considered if a service is covered under the State Plan or applicable waiver 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. [42 CFR 441.302 (c) (1)]

DMAS, its FFS service authorization contractor, or the MCO will approve, pend, reject, or deny all service requests. Requests that are denied for not meeting the medical necessity criteria are automatically sent to medical staff for a higher-level review. When a final disposition is reached the individual and the provider are notified in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice sent by DMAS or its FFS service authorization contractor or MCO will identify the individual's right to appeal the decision, in accordance with 42 CFR §431, Subpart E, and the Virginia

Administrative Code at 12VAC30-110-10 through 370. The provider and individual have the right to appeal adverse decisions to the Department.

If services cannot be approved for members under the age of 21 using the current criteria, DMAS, the FFS service authorization contractor, or the MCO will then review the request by applying EPSDT criteria. Individuals under 21 years of age qualifying under EPSDT may receive the requested services if services are determined to be medically necessary and, if applicable, are prior authorized by the Department, the FFS service authorization contractor, or a Cardinal Care managed care organization. A request cannot be denied as not meeting medical necessity unless it has been submitted for secondary physician review. DMAS, the FFS service authorization contractor and the MCO must follow the DMAS process for a secondary physician review of all denied service authorization requests.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply to an EPSDT request if the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Any treatment service that is not covered under the State's Plan for Medical Assistance can be covered for individuals under the age of 21 as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or its contractor as medically necessary. Treatment services that are approved under EPSDT but are not available through the State Plan for Medical Assistance are referred to as EPSDT Specialized Services. Refer to the EPSDT Supplement for additional information. Providers should contact the MCO for information on requesting EPSDT specialized services for youth enrolled in managed care. Providers should refer to Appendix A of the EPSDT Supplement for information on requesting EPSDT specialized services for youth in FFS.

TRANSITION OF CARE BETWEEN MANAGED CARE PROGRAMS AND FEE-FOR- SERVICE (FFS)

Individuals Transitioning into MCOs

Providers should reference the Cardinal Care managed care contract to learn more about the requirements for individuals transitioning from FFS to managed care or from one MCO to another.

Individuals Transitioning from Managed Care back to Medicaid FFS

Should an individual transition from an MCO back to Medicaid FFS, the provider must submit a request to the FFS service authorization contractor and must indicate that the request is for an MCO member who was disenrolled from an MCO into FFS. This will ensure honoring the MCOs approval of services for up to 60 days for the continuity of care period and waiving timeliness requirements. The FFS service

authorization contractor will honor the MCO authorization up to the last approved date but no more than 60 calendar days from the date the MCO's disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the FFS service authorization contractor will apply medical necessity/service criteria.

- If the provider is not an enrolled Medicaid provider, the request will be rejected.
- If the service has been authorized by an MCO for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once an individual is in FFS, the MCO approvals for Medicaid-covered services will be honored for the continuity of care period.
- If an individual transitions from an MCO to FFS, and the provider requests an authorization for a service not previously authorized under an MCO, this will be considered as a new request. The continuity of care will not be applied, and timeliness requirements for the service authorization will not be waived.

After the continuity of care/transition period end date, providers must submit a request to the FFS service authorization contractor that meets the timeliness requirements for the service. The new request will be subject to a full clinical review (as applicable). The waiver services have exceptions, please refer to the waiver manuals for specific information.

Review Process for Requests Submitted to the FFS Service Authorization Contractor

After the Continuity of Care Period:

A. For dates of service beyond the continuity of care period, timeliness will not be waived and the request will be reviewed for level of care necessity; all applicable criteria will be applied on the first day after the end of the continuity of care period; and

B. For Managed Care Waiver services, if the provider does not submit a new service authorization during the continuity of care period, the individual's hours will be capped based on the Level of Care score in the Plan of Care at the conclusion of the continuity of care period. Changes to the authorized hours will not be made until the provider submits a new service authorization request. The FFS service authorization contractor will review whether service criteria continue to be met and make a determination on the hours going forward upon submission of the new service authorization request.

The best way to obtain the most current and accurate eligibility information is for providers to complete their monthly Medicaid eligibility checks at the beginning of the month. This will provide information for individuals who may be in transition to and from an MCO at the very end of the previous month.

Communication

Provider manuals are located on the DMAS Medicaid Web Portal and the FFS service authorization contractor's websites. The FFS service authorization 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 https://vamedicaid.dmas.virginia.gov/sa. For educational material, click on the Training tab and scroll down to click on the General tab. The FSS service authorization contractor 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 and hard-of-hearing.

Updates or changes to the service authorization process for the specific services outlined in this manual will be posted in the form of a Medicaid Bulletin to the DMAS MES Home Page. Changes identified in Medicaid Bulletins are incorporated within the manual.

The FAS and/or the FFS service authorization contractor generate letters to providers and enrolled individuals depending on the final determination. DMAS will not reimburse providers for dates of service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individual's medical record and are subject to review during post payment and Utilization Review.

MCOS: SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

In accordance with 42 CFR §438.210(b)(1), the Contractor's authorization process for initial and continuing authorizations of services must follow written policies and procedures and must include effective mechanisms to ensure consistent application of medical necessity review criteria for authorization decisions.

For more information, please refer to the Cardinal Care Managed Care contract. Please contact the individual's Medicaid MCO for information on submitting service authorization requests for individuals enrolled in managed care.

FEE-FOR-SERVICE: SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

Service authorization requests must be submitted electronically utilizing the FFS service authorization contractor's provider portal Atrezzo Next Generation (ANG).

Providers must submit requests for new admissions within the required timeframes for the requested service. If a provider is late submitting the request, the FFS service authorization contractor will review the request and make a determination based on the date it was received. The days/units that are not submitted timely are denied, and appeal rights provided.

Retrospective review will be performed when a provider is notified of an individual's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain a service authorization prior to billing DMAS. Providers must

request a service authorization for retrospective review as soon as they are aware of the individual's Medicaid eligibility determination.

**Note: Information submitted for service authorization must be documented in the medical record at the time of request. The request for service authorization must be appropriate to adequately meet the individual's needs. Any person who knowingly submits information containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Specific Information for Out-of-State providers

Out-of-state providers are held to the same service authorization processing rules as instate providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-state services to the FFS service authorization contractor. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to the FFS service authorization contractor, as timeliness of the request will be considered in the review process.

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.

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 which item 1 through 4 is satisfied at the time of the request to the FFS service authorization contractor. If the provider is unable to establish one of the four, the contractor will pend or reject the request until the required information is provided.

Out-of-State Provider Questionnaire (Found on the Provider Portal or at https://dmas.kepro.com/content/forms)

A. Question #2-Are the medical services 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: "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.

Submitting Secure Electronic Requests for Services

The FFS service authorization contractor utilizes Atrezzo Next Generation (ANG) as the secure web portal for providers to submit service authorization requests. ANG is highly intuitive and user-friendly and includes enhanced security features requiring providers to log in with multi-factor authentication (MFA). The goal of MFA is to provide a multi- layered security defense system. Multi-factor authentication is a method that requires users to verify identity using multiple independent methods. MFA implements additional credentials such as a PIN sent via email or text, or a verification call made to a pre- registered phone number.

Current Portal Users

As a Provider who uses Atrezzo currently, providers will only need to complete MFA registration for the ANG portal. The provider will utilize their existing username and password. The instructional prompts will guide you through completing Multi-Factor Authentication (MFA) Registration. From the login screen, click the link to complete the multi-factor authentication registration at your first login. This will be a one-time registration process. After entering the Atrezzo Provider Portal URL (https://portal.kepro.com/), the login page will display. To begin the registration process, enter your Atrezzo username and password and click Login, and follow the prompts.

New Portal Users

Providers who have not used Atrezzo or ANG are considered new portal users and

need to register their service authorization provider account. The instructions will guide you through completing the Multi-Factor Authentication (MFA) Registration, which is a one-time process. The provider will have an Atrezzo Portal Administrator who will create your secure ANG account. Once logged in, the ANG system will send an email back to the provider with a link for Atrezzo Registration. Click the link to begin the MFA registration process. The registration link will expire within 2 days of receipt. If you have not completed the registration process within the 2 days, the provider's Atrezzo Portal Administrator will have to obtain a new link via email.

Providers can select the best multi-factor authentication method, either phone or email, and follow the instructions as ANG guides you through the MFA process.

1) When choosing an authentication method, you will be required to enter an email address for both options. Only choose the Email option if you do not have access to a direct phone line (landline or mobile).

2) A phone registration will require a direct line with 10-digits; extensions are not supported.

Remember Me Functionality

These instructions are to enable your computer to remember your login credentials for four (4) hours. You should NOT use this option if you use a shared device. When the Remember Me button is checked on the login screen, external users will be able to login without entering Atrezzo credentials or MFA for four (4) hours. To use this feature, check Remember Me box then click Login with Phone or Login with Email and follow the prompts.

For the next four (4) hours, when accessing Atrezzo, you will click Login with Phone or Login with Email and bypass the login credentials and MFA steps. After four (4) hours, you will need to login with your credentials and MFA when prompted. You must use the same login option (Login with Phone or Login with Email) for the Remember Me functionality to remember the credentials. If you select a different login option, you will be required to enter MFA credentials. To turn off this feature, uncheck the Remember Me box, before clicking Login with Phone or Login with Email, and you will be prompted to enter login credentials and MFA at the next sign-on.

NOTE: This feature will only work if the browser is configured to "continue where you left off" by reopening tabs on startup. The Remember Me functionality will work as long as the browser remains open, but if the browser is closed, the Remember Me functionality will not work without following the below instructions to configure the system to continue where you left off when last logged in Chrome Configuration Google Chrome is the preferred browser for Atrezzo Next Generation Edge Configuration is included in the instructional materials on the FFS service authorization contractor's website (Atrezzo Help) (https://www.kepro.com/atrezzo-

help).

Already Registered with ANG but Need Help Submitting Requests

It is imperative that providers currently registered use the portal for submitting all requests. For Health Department providers, this includes admissions, discharges, changes in units requested, responding to pend requests, and all other transactions.

Registered ANG providers do not need to register again. If a provider is successfully registered, but need assistance submitting requests through the portal, contact Acentra Health at 1-888-827-2884 or ANGissues@kepro.com.

Providers registered for ANG, who have forgotten their password, may contact the provider's administrator to reset the password or utilize the 'forgot password' link then respond to their security question to regain access. If additional assistance is needed by the provider's administrator contact Acentra Health at 1-888-827-2884 or ANGissues@kepro.com.

If the person with administrative rights is no longer with the organization, contact Acentra Health at 1-888-827-2884 or ANGissues@kepro.com to have a new administrator set up.

When contacting Acentra Health please leave the requestor's full name, area code, telephone number and the best time to be contacted.

Additional Information for Ease of Electronic Submission

To make electronic submission easier for the providers, Acentra Health and DMAS have completed the following:

1) Rules Driven Authorization (RDA) – These are a set of clinical criterion questions that will automatically populate in a questionnaire when requesting certain services

or with specific diagnostic codes. The provider must respond to the questions found on the questionnaire on the ANG Portal. The responses given by the provider must reflect what is documented in the individuals medical record. If the responses match the criterion for the specific service or diagnosis, the case will bypass a reviewer and be approved, and automatically batch for transmission to FAS. If the responses do not match the specific criterion, the case will go to a reviewer's queue which will follow the normal review process. If criteria are not met, then the request will go to the physician's queue and a physician will review the case and make a final determination.

2) Attestations – All providers will attest electronically that information submitted to Acentra Health is within the individual's documented record. If upon audit, the required documents are not in the record, and the

provider attested that they were present; retractions may be warranted as well as a referral to the Medicaid Fraud Control Unit within the Office of the Attorney General.

3) Questionnaires – Acentra Health and DMAS have configured questionnaires, so they are short, require less information, take less time to complete and are user- friendly.

HOW TO DETERMINE IF SERVICES REQUIRE SERVICE AUTHORIZATION

To determine if services need to be authorized, providers may go to the DMAS website: https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/procedure-fee-files- cpt-codes/. This page is titled Procedure Fee Files & CPT Codes. 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.

The provider must determine whether to use the CSV or the TXT format. The CSV is a comma separated value and the TXT is a text format. Either version provides the same information.

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. The Procedure Fee File will indicate when a code requires a service authorization as it will contain a numeric value 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 access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides special coverage and/or payment information. A Procedure Flag of “999”

indicates that a service is non-covered by DMAS.

Providers may also refer to the Provider Service Type Grid and Crosswalk available on the FFS service authorization contractor website at: https://vamedicaid.dmas.virginia.gov/sa.

INTENSIVE REHABILITATION SERVICES

Service Authorization for Intensive Rehabilitation Services

All requests for Service Authorization, as well as any information submitted in

response to pend letters, must be directed to the DMAS Srv Auth contractor (Acentra Health). Rehabilitation providers shall submit Service Authorization requests through Acentra's secure portal Atrezzo Next Generation (ANG). There may be circumstances where the provider will be required to submit written documentation in order to obtain Service Authorization. All requests for Service Authorization must be received through Acentra Health within 72 hours of admission. Requests received after 72 hours will be denied up to the date the request is received. If the member continues to meet medical necessity criteria and is still in the facility, the request may be approved starting the day the request is received at Acentra Health.

DMAS will conduct post payment review audits for intensive rehabilitation providers and will strongly enforce the 72-hour notification policy. Failure to comply may result in the retraction of payment. Srv Auth must be obtained whether Medicaid is the primary payer, except for Medicare-crossover claims. Acentra Health will not accept reviews for members who have Medicare Part A. If Medicare denies the requested stay and/or if the Medicare benefits are exhausted**,** the provider may submit a Srv Auth request for retrospective review within 30 calendar days of the notice of denial or exhaustion by Medicare. Retrospective reviews will be performed when a provider is notified of a patient's retroactive eligibility for Virginia Medicaid coverage. Prior to billing Medicaid the provider must have a Srv Auth. The health care provider should request a Srv Auth for retrospective review within 30 calendar days of the notice of Medicaid eligibility.

Within 72 hours of the Intensive Rehab admission, the provider must submit a request for Srv Auth to Acentra Health. The review analyst will assign an initial length of stay. The provider must contact Acentra Health prior to the Srv Auth end date if services are to extend beyond the initial authorization period.

Comprehensive outpatient rehabilitation facilities (CORF) providers must submit service authorization requests under Srv Auth service type 0204 (Outpatient Rehab) using the appropriate NPI number.

If the provider fails to submit information for the continued stay and the authorization period expires, retroactive authorization will not be granted. Authorization will begin with the date the continued stay request is received at Acentra Health.

Acentra Health will apply *Change Healthcare InterQual® Criteria, Rehabilitation, Adult & Pediatric* for determining medical necessity.

In addition, DMAS requires the following for Intensive Rehab Services:

- The member meets *Change Healthcare InterQual® Criteria, Rehabilitation, Adult & Pediatric* criteria upon admission and continued stay. These criteria may be obtained through:

Change Healthcare Technologies, LLC
5995 Windward Parkway, Suite 500
Alpharetta, GA. 30005
Telephone: 615-932-3000
Fax: 404-420-2300

Website: https://www.changehealthcare.com

OUTPATIENT REHABILITATION SERVICES

Service Authorization for Outpatient Rehabilitation Services

Providers enrolled as "general hospital, in state" shall use the DMAS designated revenue codes when requesting service authorization.

All providers including outpatient rehabilitation agencies, comprehensive outpatient rehabilitation facilities (CORF), physicians and professionals shall use the DMAS designated CPT codes listed below.

Reference the chart below to determine the appropriate code to be used when requesting Srv Auth through Acentra Health. The chart indicates the specific unit/visit equivalency.

In-state general hospital and in-state rehabilitation hospital providers (Provider Types 001,014) use DMAS approved revenue codes:	
0424	Physical Therapy, Evaluation
0421	Physical Therapy, Individual
0423	Physical Therapy, Group
0434	Occupational Therapy, Evaluation
0431	Occupational Therapy, Individual
0433	Occupational Therapy, Group
0444	Speech Language Services, Evaluation
0441	Speech Language Services, Individual
0443	Speech Language Services, Group
	1 unit = 1 visit for these revenue codes

In-state private rehabilitation agencies, CORFs, and physician providers (Provider Types 057,019,020, respectively) use DMAS approved CPT codes:	
97110	Therapeutic procedure, Physical Therapy, each 15 minutes. 1 unit = 15 minutes.
97112*	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities 1 unit = 15 minutes.
97140*	Manual therapy techniques (e.g. mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions. 1 unit = 15 minutes.
97150	Therapeutic procedure, Physical Therapy, Group. 1 unit = a group session
97161*	Physical Therapy evaluation: low complexity 1 unit = an evaluation
97162*	Physical Therapy evaluation: moderate complexity 1 unit = an evaluation
97163	Physical Therapy evaluation: high complexity

	1 unit = an evaluation.
97530	Therapeutic procedure, Occupational Therapy, each 15 Minutes. 1 unit = 15 minutes.
S9129	Therapeutic procedure, Occupational Therapy, Group. 1 unit = a group session.
97165*	Occupational Therapy evaluation: low complexity 1 unit = an evaluation
97166*	Occupational Therapy evaluation: moderate complexity 1 unit = an evaluation
97167	Occupational Therapy evaluation: high complexity 1 unit = an evaluation.
92507	Treatment of speech, language, voice, communication, and / or auditory processing disorder; Individual. 1 unit = one treatment session
92508	Treatment of speech, language, voice, communication, and / or auditory processing disorder; Group, 2 or more individuals. 1 unit = one treatment session.

*For CPT Codes 97110 (PT) and 97530 (OT), when requesting a Service Authorization (Srv Auth) for these 2 codes, the units of time being requested should be based on the 15-minute interval and not based on a visit.

*Coverage for CPT Codes 97112 and 97140 is effective for dates of service on or after December 1, 2019.

Example: PT therapist has determined that a recipient needs to have an hour a day, three times a week for a total of four weeks of physical therapy. The Srv Auth request for PT would be for a total of 48 units (4 units per day times, 3 times a week, times 4 weeks = 48 units).

For non-hospital providers: Four (4) specific codes are utilized for speech therapy evaluation as follows:

92521	Evaluation of speech fluency (e.g. stuttering, cluttering)
92522	Evaluation of speech sound production (e.g. Articulation, phonological process, apraxia, dysarthria
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)
92524	Behavioral and qualitative analysis of voice and resonance

Note: 1 unit = 1 evaluation
When submitting srv auth requests, providers must select the most appropriate speech therapy evaluation code based on the physician's order and diagnosis. Providers may only use one code per member per date of service (DOS) for each srv auth request. When medically necessary, providers may submit the same or

another speech therapy evaluation code using different dates of service (no duplicate dates or overlapping dates with previous srv auth request).

Example #1: Provider receives physician's order for speech therapy evaluation. Initial srv auth request submitted for 92521, 1 unit, for DOS 7/12/17. Evaluation not completed due to member's medical condition. Second request submitted (to complete evaluation) for 92521, 1 unit, for DOS 7/14/17.

Example #2: Initial srv auth request submitted for 92523, 1 unit, for DOS 7/12/17. Evaluation completed. New physician's order written as result of initial evaluation findings. Second request submitted for augmentative communication eval using 92522, 1 unit, for DOS 7/23/17.

For non-hospital (outpatient rehab) providers: Effective for dates of service on or after December 1, 2018, DMAS will provide coverage for all levels of PT and OT evaluation. The CPT codes are:

97161	Physical Therapy evaluation: low complexity 1 unit = an evaluation
97162	Physical Therapy evaluation: moderate complexity 1 unit = an evaluation
97163	Physical therapy evaluation: high complexity
97165	Occupational Therapy evaluation: low complexity 1 unit = an evaluation
97166	Occupational Therapy evaluation: moderate complexity 1 unit = an evaluation
97167	Occupational therapy evaluation: high complexity

Providers may only use one code per member per date of service (DOS) for each srv auth request. These codes are used for initial evaluations and for re-evaluations when another evaluation is medically necessary and/or a member has had a significant change in their medical condition. The evaluation codes are specific to Medicaid members for billing purposes.

Note: If a member has received an evaluation prior to 12/1/2018, providers should utilize CPT code 97163 or 97167 for the dates of service being requested.

Service Limitations

Physical therapy, occupational therapy, and speech-language pathology services shall be limited to five (5) visits per rehabilitative discipline annually without service authorization. Initial therapy evaluations are included in the 5 visits. (For definition of visits please reference chart above). Visits include those services provided by outpatient settings of acute and rehabilitation hospitals, nursing facilities, rehabilitation agencies, and home health agencies. Limits are specific per discipline and member, regardless of the number of providers rendering services. "Annually" is defined as July 1 through June 30. The provider must maintain documentation to justify the need for services. Srv Auth is required before payment will be made for any visits over annually.

Evaluations must be related to the admission or readmission to service or to a significant change in the condition of the member. For continued authorization

beyond the initial period, providers must submit a request prior to the Srv Auth end date. Reimbursement shall not be made for additional services without Srv Auth. Care rendered beyond the 5th visit allowed annually which has not been authorized shall not be approved for reimbursement.

Srv Auth must be obtained whether or not Medicaid is the primary payer, except for Medicare-crossover claims. Srv Auth is required when more than 5 visits are medically necessary. When a member has Medicare Part B coverage, Srv Auth is not required. If Medicare denies the claim and/or if Medicare benefits are exhausted, the provider may request authorization as a retrospective review. Retrospective review will be performed when a provider is notified of a patient's retroactive eligibility for Virginia Medicaid coverage. Prior to billing Medicaid, the health care provider must request a retrospective service authorization.

Providers may obtain information regarding service limit utilization by contacting any of the following:

DMAS Provider HelpLine	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.virginiamedicaid.dmas.virginia.gov

Service Authorization Processing

Srv Auth for outpatient rehabilitation services must be obtained throughAcentra Health. All Srv Auth requests, as well as any information submitted in response to pend letters, must be directed to Acentra Health. If the provider fails to submit information prior to the completion of the 5th visit, retroactive authorization will not be granted. Authorization will begin with the date the request is received at Acentra Health. Any service provided without Srv Auth in excess of the 5th visit limitation will not be reimbursed.

Initial Review for Outpatient Rehab

When Srv Auth is requested before or at the initiation of services, the provider may use the physician's order. DMAS (or Acentra Health) will make a decision to approve, pend, deny, or reject the request. If the request is approved, an authorization will be given for a specific number of units and dates of service. Visits provided up to and including the 5th visit, may be billed without Srv Auth if the member's service limits have not been used. Providers may contact ARS or MediCall for information on the service limits already provided to a member.

Recertification Review for Outpatient Rehab

Prior to the last Srv Auth end date, or the next visit, the provider must submit a request for continued Srv Auth. This request will be reviewed to determine if DMAS criteria and documentation requirements are met. Documentation requirements are located in Chapter VI of this manual. A decision will be made to approve, pend,

deny, or reject the request. Approvals will include a specific number of units and dates of service.

For Outpatient Rehab Services, DMAS requires the member meets *Change Healthcare InterQual*®, *Outpatient Rehabilitation & Chiropractic* criteria upon initial and/or recertification review. These criteria may be obtained through:

Change Healthcare Technologies, LLC
5995 Windward Parkway, Suite 500
Alpharetta, GA. 30005
Telephone: 615-932-3000
Fax: 404-420-2300
https://www.changehealthcare.com

NOTE TO ALL OUTPATIENT REHAB PROVIDERS: On July 1st of each year, the 5 service limits/units per discipline for rehab agencies, CORFs, physicians, professionals and out of state providers and the 5 service limits/visits per discipline for general, in-state hospitals and out of state providers is renewed. If a provider knows that the member will need treatment beyond 5 visits, they must request Srv Auth through Acentra Health.

Procedural Change for Service Authorization Requests for Outpatient Rehabilitation Services

Acentra Health Process:

- 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 five units that do not require service authorization. Service authorization is required before payment will be made for any units over five annually. Providers may contact the Provider Helpline to determine if the first five units are available.

OUT-OF-STATE PROVIDER INFORMATION FOR INTENSIVE AND OUTPATIENT REHABILITATION

The following information is the current policy and procedure for out of state requests submitted by out of state providers.

Acentra Health's service authorization process for certain services including Inpatient Intensive Rehabilitation 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.

Out-of-State general hospital providers and out of state rehabilitation hospital providers may request these revenue codes:

0420	Physical Therapy (P.T.) - General; 1 unit = 1 visit
0430	Occupational Therapy (O.T.) - General; 1 unit = 1 visit
0440	Speech Language Pathology - General; 1 unit = 1 visit

INTENSIVE REHABILITATION INFORMATION FOR OUT-OF-STATE PROVIDER REQUESTS

Out-of-state providers, located close to the proximity of the VA State line and who are enrolled with Virginia Medicaid as a **provider class type 085** (**Out of State Rehab Hospital**) need to determine and document evidence that one of the following items are met at the time the service authorization request is submitted to the service authorization contractor:

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 which item 1 through 4 is satisfied at the time of the request to Acentra Health. 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 their findings back to Acentra Health.

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.

OUTPATIENT REHABILITATION INFORMATION FOR OUT-OF-STATE PROVIDER REQUESTS

Authorization requests for certain services including Outpatient Rehabilitation agencies 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;
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- Pend the request utilizing established provider pend timeframes
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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.

EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT SERVICE (EPSDT) 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 on Acentra Health's website https://vamedicaid.dmas.virginia.gov/sa They may also be reached by phone at 1-888-827-2884.

Examples 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 the child now requires several different adaptations that cannot be attached to the 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 the child's medical condition.

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.