APPENDIX D
SERVICE AUTHORIZATION INFORMATION

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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://www.dmas.virginia.gov/for-providers/service-authorization/. 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 New Enrollment (hppcloud.com)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 they were required to travel to their 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 at Service Authorizations Home (Acentra Health/DMAS) | MES)

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: 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.

SERVICE AUTHORIZATION RECONSIDERATION

A provider must exhaust Acentra Health's internal reconsideration process for all services prior to submitting to DMAS Appeals. If a provider wants to have Acentra Health reconsider the initial determination, they must submit a reconsideration through the Atrezzo Next Generation (ANG) portal: https://atrezzo.acentra.com/ within 30 calendar days from the date of the initial determination letter. Providers must submit in ANG via the dropdown option to choose a 'reconsideration' task and attach or document within the note section with the additional information that is needed to show that the member meets criteria for the care that was denied or reduced. Please ensure you include any additional information or documentation that evidences that the member meets the criteria for the requested level of care. Reconsideration requests submitted outside the 30-day period will be denied as untimely and no further action will be taken on the service authorization request.

FACE-TO-FACE ENCOUNTER FOR FEE-FOR-SERVICE DME

This only applies to FFS members and not those enrolled in one of DMAS' managed care organizations (MCO), unless otherwise required in the provider's contract with the managed care plan.

No payment shall be made for DME (as defined in 12VAC30-50-165) unless a face-to-face encounter has been performed when required by an approved practitioner (outlined below) no more than six (6) months prior to the begin service date. The face-to-face encounter shall be related to the primary reason the individual enrolled in Medicaid requires DME.

The face-to-face encounter for DME must be conducted by one of the following four (4) practitioners:

- A physician licensed to practice medicine;
- A licensed nurse practitioner or licensed clinical nurse specialist within the scope of their practice under state law, working in collaboration and with a practice agreement with the physician who orders the Medicaid individual's services;

- A licensed physician assistant within the scope of their practice under state law and working under the supervision of the physician who orders the individual's services; or
- For individuals requiring DME immediately after an acute or post-acute stay, the attending acute or post-acute physician.

The practitioner performing the face-to-face encounter must document the clinical findings in the individual's medical record and communicate the clinical findings of the encounter to the ordering physician.

Providers must use the revised CMN form to document the new requirements. Completion of all elements related to the face-to-face requirements on the CMN will satisfy the face-to-face encounter documentation requirements.

Please refer to Chapters IV and VI of the DME Provider Manual for DME items that require service authorization. When a face-to-face encounter is required, providers must, during the service authorization process, "attest" that the face-to-face encounter requirement has been met. For those items that do not require a service authorization, the CMN with the face-to-face encounter documentation should be maintained in the individual's medical record.

NOTE: A face-to-face encounter is only required for Medicaid DME items that also require a face-to-face encounter under the Medicare program. If a face-to-face encounter is not required for a specific DME item under the Medicare program, then it is not required for the Medicaid program. For a list of fee-for-service DME codes that require a face-to-face, please refer to Chapters IV and VI of the DME Provider Manual.

Breast Pumps

DMAS will cover a manual or standard electric breast pump as medically necessary for the initiation or continuation of breastfeeding (up to the child's first birthday). These breast pump codes are available as of January 1, 2016:

- E0602 Manual breast pump, purchase – does **not** require service authorization;
- E0603 Single user electric breast pump, purchase – requires service authorization;
- E0604 Multi-user (Hospital grade) electric pump, rental – requires service authorization;
- E1399 Additional collection kit for use with the single and multi-user electric breast pumps - requires service authorization.

E0603 - Single user electric breast pumps - purchase

A personal use electric breast pump is designed for mothers who are breastfeeding without problems. A personal use electric breast pump is defined as a double electric (AC and/or DC) pump, intended for a single user and is capable of being used multiple times per day. Payment includes supplies necessary for operation of the pump (pump, adapter/charger, breast shields, bottles, lids, tubing, locking ring, connectors, valves, filters and membranes). DMAS medical necessity criteria as follows:

- Mother must express the desire to breastfeed;
- The pump must be FDA registered;
- The pump has a minimum one-year manufacturer's warranty; and
- The pump must have a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma.

Limits: One purchase every three (3) years. Request must be medically justified. Request duration is 30 days (for pick up/delivery). DMAS allows for one additional purchase every three years with medical justification.

E0604 – Multi-user (Hospital grade) electric pumps - rental

Multi-user/Hospital grade electric pumps are designed to initiate and maintain a milk supply when a baby is not feeding well. The pump must be FDA registered and have a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma.

DMAS coverage of hospital grade rental pumps must meet the medical necessity criteria below:

- When the infant is premature at 24-34 weeks of gestation, and the mother is pumping
  breast milk, awaiting the baby's ability to nurse directly from the breast;
- When the infant is premature at 35-37 weeks of gestation and continues to experience difficulty coordinating suck and swallow, and the mother is pumping breast milk, awaiting the baby's ability to nurse directly from the breast;
- For infants with cleft lip and/or palate or ankyloglossia who are not able to nurse directly
  from the breast;
- For infants with cardiac anomalies or any medical condition that makes them unable to
  sustain breast feeding due to poor coordination of suck and swallow or fatigue;
- For multiples (including twins), until breast-feeding at the breast is established consistently;
- When the mother has an anatomical breast problem, which may resolve with the use of
  breast pump, such as insufficient glandular tissue;
- For any infants for medical reasons who are temporarily unable to nurse directly from the
  breast, such as NICU babies, or during any hospitalization of the mother or baby which will
  interrupt nursing; or
- When the infant has poor weight gain related to milk production and pumping breast milk
  is an intervention in the provider's plan of care and infant has a documented weight loss of 7% or greater despite use of conventional breast pump.

A hospital grade breast pump is not medically necessary when one of the above criteria

are not met or when it is requested solely to allow for the mother's return to work or mother's or family convenience.

Limits: Up to 6 months initial rental period based on medical necessity. 12-month **maximum** rental period per member with medical justification. Requests for additional months after the initial 6 months must include why purchase of a single user electric pump (E0603) will not meet member's needs.

E1399 – Collection kits for use with the single and multi-user electric breast pumps
One collection kit for electric breast pumps includes necessary supplies and collection containers. The service limit is one additional kit per single or multi-user electric breast pump authorization. Providers must include medical justification when requesting an additional kit. Each breast pump includes an initial collection kit. Providers must bill their Usual and Customary Charge (UCC). Additional collection kits have a maximum reimbursement rate; 1 unit equals 1 kit. **There is no mark up for additional collection kits.**

Limits: One (1) per service limit period for single-user and multi-user electric pumps. Request must be medically justified; provider must indicate pump is owned or rental and that the additional collection kit is appropriate for member owned (or rental) pump. Request duration: 30 days (for pick up/delivery).

DME providers must submit medical justification to KEPRO when requesting these codes. Providers must have a completed CMN (DMAS 352) on file.

DME SERVICE AUTHORIZATION PROCESS

The "Medicaid DME Supplies Listing"/Appendix B which is based on the Health Care Financing Administration Common Procedure Coding System (HCPCS), describes equipment and supplies and identifies those which require service authorization. Service authorization is required for items identified with a "Y" in the authorization column of the DME Listing/Appendix B, and for any item exceeding the established limits identified in the "limit" column of the DME Listing/Appendix B. **The DME Listing/Appendix B identifies the information above. It does not determine coverage of an item. Coverage criteria are in Chapter IV of the Durable Medical Equipment and Supplies Manual and the Virginia Administrative Code.**

Service authorization is requested by the enrolled DME provider and not by healthcare professionals involved with the enrollee's care. The provider completes and/or gathers the necessary documentation to meet the Medicaid criteria as described in Chapter IV of this manual.

When extended utilization or unusual amounts of equipment and/or supplies are required, the provider must request service authorization. If the item does not require service authorization or does not exceed the established limits, the provider may provide and bill

for these items up to the established limit without service authorization. If service authorization is required, service authorization must be obtained regardless of whether or not Medicaid is the primary payer, except for Medicare-crossover claims.

The purpose of service authorization is to validate that the service or item being requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not automatically guarantee payment for the service. Payment is contingent upon passing all edits contained within the claims payment process; the member's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided. Service authorizations are specific to a member, a provider, a service code, an established quantity, and for specific dates of service. (12 VAC 30-50-165)

Appendix B

The Appendix B is based upon the Healthcare Common Procedure Coding System (HCPCS), which describes equipment and supplies, coverage limitations, and service authorization requirements. Service authorization by Medicaid is not required when Medicare is the primary payer.

When extended utilization or unusual amounts or types of equipment or supplies are required, the provider must request service authorization from the Department of Medical Assistance Services' (DMAS) service authorization contractor. Items not identified in the Appendix B listing require service authorization and may be submitted for service authorization under the appropriate miscellaneous HCPCS code. Lack of a specific HCPCS code for the item does not determine coverage. The appropriate miscellaneous code may be used and submitted for service authorization.

Providers must maintain documentation in accordance with the coverage criteria, documentation requirements, and Certificate of Medical Necessity (CMN) requirements as defined in Chapters IV and VI of this Provider Manual, regardless of whether or not service authorization is required.

Miscellaneous HCPCS Codes

Miscellaneous codes may only be used when the item requested differs significantly in narrative description from the established HCPCS code. Miscellaneous codes will not be recognized for the sole purpose of cost variances**.** In order for the service authorization contractor to determine the appropriate reimbursement for miscellaneous items not in the Appendix B with a fee, all of the following information must be provided:

- A complete description of the item(s) being supplied;
- A copy of the manufacturer's/supplier's invoice or the dealer cost information to document
  the cost of the item(s);

- For any specially designed items, a statement from the manufacturer detailing cost; and
- Any discount received must be indicated.

The service authorization file in VAMMIS combines all like miscellaneous DME codes into one 'summary' line, which carries the status of AC (approved combined). Providers see the AC line on their service authorization notification report and in order to bill for miscellaneous DME lines, providers will need to total the authorized amounts as well as the authorized units for each of the miscellaneous codes and submit this total or 'summary line' amount as one-line item on the claim.

The provider should bill the total number of units and the total authorized fee once all supplies are delivered. If the provider does not deliver all units at one time the provider can follow the instructions below:

1. Submit a change request to the DMAS Srv Auth Contractor. The provider will request a change to the line item that was not delivered by either decreasing the number of units or voiding the line item for the DME/supplies that was not delivered and if necessary create a new service authorization for item not delivered;
2. Wait until all DME/supplies are delivered to submit the claim for reimbursement; or
3. If the provider has already billed for the all DME/supplies but has not delivered all units, the provider will need to adjust the claim. If it is found on post payment audit that the provider has billed all units but not delivered all units the provider may have funds retracted.

For DME items that have a national code but do not have a DMERC or rate for July 1, 2010 mark-up of 30 percent of the actual cost (less any discounts available to the DME provider), as determined by the service authorization contractor. If the provider receives a manufacturer/supplier discount and cost plus 30% mark-up equates to greater than the manufacturer's suggested retail price (MSRP), then reimbursement will be the MSRP. The provider should mark box 23 on the Outpatient Service Authorization Request Form/ DMAS 363 (7/2010) with the cost plus 30% mark up. The reimbursement will be based on the provider description of the item(s) or supplies. Providers should review instructions for the DMAS 363 form prior to completing the form. Adequate and complete descriptions, quantities, and the unit price are essential for the evaluation of the charge.