Appendix D (CCC Plus Waiver)

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INTRODUCTION

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.

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 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, 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 or its service authorization contractor will approve, pend, reject, or deny all service requests. Requests that are denied for not meeting the level of care 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 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.

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) PROGRAM

Individual's Transitioning into CCC Plus Program

Individuals who meet the benefit plan criteria are enrolled in the CCC Plus program. The CCC Plus MCO Health Plan honors the existing service authorization contractor's authorization and will automatically authorize services for a period of 30 days or until the service authorization end date whichever comes first. The continuity of care period applies to providers that are in and out of network with the MCO.

Individuals Transitioning from CCC Plus Program back to Medicaid Fee-for-Service (FFS)

Should an individual transition from CCC Plus back to Medicaid FFS, the provider must submit a request to the service authorization contractor and must indicate that the request is for a CCC Plus member who was disenrolled from an MCO into FFS. This will ensure honoring the (CCC Plus MCOs) approval of services for up to 60 days for the continuity of care period and waiving timeliness requirements. The service authorization contractor will honor the CCC Plus authorization up to the last approved date but no more than 60 calendar days from the date the CCC Plus disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the service authorization contractor will apply medical necessity/service criteria.

Review Process for Requests Submitted to the Service Authorization 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. For dates of service beyond the continuity of care period, timeliness will 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

C. For CCC Plus Waiver services, level of care cap hours will be approved the day after the end of the continuity of care period up to the date of the 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 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 CCC Plus at the very end of the previous month.

Should there be a scenario where DMAS has auto closed (ARC 1892) the service authorization contractor's service authorization but the individual's CCC Plus eligibility has been retro-voided, continuity of care days will not be approved by the CCC Plus health plan. The service authorization contractor will re-open the original service authorization for the same provider upon notification by the provider.

CCC Plus Exceptions

The following exceptions apply to continuity of care upon return to FFS Medicaid:

- 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 service authorization 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 an individual is FFS, only Medicaid approved services will be honored for the continuity of care.
- If an individual 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 service authorization 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).

Note: DMAS has published multiple Medicaid Bulletins and Provider Manuals that may be referred to for detailed CCC Plus information as posted on the Medicaid Web Portal located at this link: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/.

For additional information regarding the CCC Plus program, click on the DMAS website located at this link: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

MEDICAID EXPANSION

On January 1, 2019, Medicaid expansion became effective. The new eligibility rules provide quality, low-cost health care coverage to eligible adults.

The Expansion Aid Categories:

100, 101, 102, 103, 106 and 108 (Incarcerated Adults Medical/Surgery inpatient services only)

The Medicaid Expansion Benefit Plan includes the following services:

- Doctor, hospital and emergency room services
- Prescription drugs
- Laboratory and x-ray
- Maternity and newborn care
- Behavioral health services including addiction and recovery treatment
- Rehabilitative and habilitative services including physical, occupational, and speech therapies and equipment
- Family planning

• Transportation to appointments
• Home Health
• DME and supplies
• Long Term Support Services (LTSS) to include Nursing Facility, PACE and Home and Community Based Service
• Preventive and wellness
• Chronic disease management
• Premium assistance for the purchase of employer-sponsored health insurance coverage, if cost effective
• Referrals for job training, education and job placement

Communication

Provider manuals are located on the DMAS Medicaid Web Portal and the service authorization contractor's websites. The 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 http://dmas.kepro.com. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Waiver* tab.

The 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 Medicaid Web Portal. Changes identified in Medicaid Bulletin are incorporated within the manual.

The MMIS generates letters to providers, case managers, 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 Quality Management Review (QMR).

SERVICE AUTHORIZATION FOR WAIVER SERVICES:

CCC Plus Waiver Services

A Screening for Long-Term Services and Supports (LTSS) is a requirement for all individuals requesting enrollment into the CCC Plus Waiver. For information regarding Screening for LTSS see the *Screening for Medicaid Funded Long-Term Services and Support* provider manual.

The individual will need to be determined eligible for CCC Plus Waiver services by the LTSS Screening Team and be Medicaid eligible to receive CCC Plus Waiver services.

The available services in the CCC Plus Waiver are: adult day health care, assistive technology, environmental modifications, personal care services, private duty nursing, personal emergency response system (PERS), respite care services, skilled respite care services, service facilitation and transition services.

Depending on the service authorization entity, processes may vary slightly for requesting services. Please reference the chart at the end of this appendix for detailed instructions (Exhibits Section).

Private Duty Nursing Services

CCC Plus waiver referrals for private duty nursing (PDN) are received at DMAS for individuals enrolled in FFS. The screening process for enrollment and clinical criteria for PDN service is described in Chapter IV of this manual.

Upon meeting clinical criteria and Medicaid financial eligibility, DMAS' Health Care Coordinator (HCC) enrolls the FFS/Medallion individual in the waiver. The DMAS HCC collaborates with the Discharge Planner/Screening entities to secure a PDN agency. Once PDN is secured, the HCC coordinates the start of care and informs the provider of the number of hours needed per week for PDN. The HCC authorizes PDN for individuals 21 years of age or over based on the findings of the assessment of the PDN Adult Referral Form (DMAS 108). Skilled respite services for waiver individuals are for the unpaid primary caregiver and may be authorized when requested. The need for additional services for FFS individuals are determined during home visits and phone contacts between the HCC and

provider agency.

Once DMAS enrolls the individual in the level of care (LOC) A and authorizes PDN as appropriate, the service authorization contractor may begin receiving requests for other CCC Plus waiver services. Since most individuals enrolled in PDN have many needs related to DME, providers may contact the service authorization contractor for DME and medical supply needs which are covered under Medicaid's State Plan Option.

NOTE: Refer to the chart at the end of this Appendix for services that require service authorization through KEPRO.

Submitting Requests for Service Authorization

Fee–for-service authorization reviews will be performed by DMAS' service authorization contractor, Keystone Peer Review Organization (KEPRO). All 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 submitted. Service authorization requests must be submitted electronically utilizing KEPRO's provider portal Atrezzo Connect (also known as Atrezzo).

Providers must submit requests for new admissions within ten business days of the start of care date in order for request to be timely and to avoid any gaps in service. If a provider is late submitting the request, the 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.

For continuation of services, if the individual continues to need waiver services, the provider must submit a request justifying the need for the continuance of service. If the request is not received prior to the end date of the current authorized period, providers may have a denial for dates of service up to the date the request was received.

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.

How to Register for Atrezzo

Provider registration is required to use Atrezzo Connect. The registration process for providers happens immediately on-line. To register, go to http://dmas.kepro.com, and click on "*Register*" to be prompted through the registration process. Newly registering providers will need their 10-digit Atypical Provider Identification (API) or National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. If you are a new provider who has not received a remittance advice from DMAS, please contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com to receive a registration code which will allow you to register for KEPRO's Atrezzo Connect Portal. Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the *Training* tab, then the *General* tab.

Submitting through Atrezzo puts the request in the reviewer queue immediately. Service authorization checklists and/or questionnaires may be accessed on KEPRO's website to assist the provider in assuring specific information is included with each request. Providers may access this information by going to http://dmas.kepro.com.

Already Registered with Atrezzo but Need Help Submitting Requests

It is imperative that providers currently registered use the portal for submitting all requests. For waiver providers, this includes admissions, discharges, continuation of care, change in hours, transfers, responding to pend requests, and all other transactions.

Registered Atrezzo providers do not need to register again. If a provider is successfully

registered, but need assistance submitting requests through the portal, contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com.

If a provider has registered for Atrezzo, and forgot their password, please contact the provider's administrator to reset the password or utilize the 'forgot password' link and respond to the security question to regain access. If additional assistance is needed by the administrator contact KEPRO at 1-888-827-2884 or www.atrezzoissues@kepro.com.

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

When contacting KEPRO please leave caller's full name, area code and phone number and the best time to be contacted.

Additional Information for Ease of Electronic Submission

In order to make electronic submission easier for the providers, KEPRO 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 Atrezzo 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 MMIS. 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

KEPRO is within the individuals 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 – for waiver providers, KEPRO and DMAS have reconfigured the questionnaires so they are shorter, require less information, take less time to complete and are more user friendly

Processing Requests at KEPRO:

KEPRO will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached, KEPRO notifies the provider. The individual and provider will receive a letter from DMAS regarding the status of the authorization request through the MMIS letter generation process.

When there is insufficient information to make a final determination of medical necessity, KEPRO will pend the request back to the provider and request additional information. The response includes specific timeframes for the additional information to be sent to KEPRO. When the information is not received within the timeframe requested by KEPRO, the information that was provided during the initial request will be automatically sent to a physician for review and a final determination will be made. In the absence of clinical information, the request will be submitted to the KEPRO supervisor for review and final determination. Providers and individuals 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.

Providers are given one opportunity to respond to a pended case. Providers must respond electronically utilizing KEPRO’s provider portal Atrezzo Connect (also known as Atrezzo). If the provider chooses to submit information prior to the pended due date, the case will be reviewed after the pended information is received. Once a case is reviewed and a decision has been rendered any additional information submitted after that timeframe will not be considered as part of the initial request.

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. [42CFR441.302 (c) (1)] [12VAC30-60-300]

HOW TO DETERMINE IF SERVICES REQUIRE SERVICE AUTHORIZATION

In order to determine if services need to be authorized, providers may 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/Content_pgs/pr-ffs_new.aspx. You will 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.

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 valueas 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.