Appendix B: EPSDT (DD)

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INTRODUCTION

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

Purpose of Service Authorization (DD)

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. All requests for SA shall be submitted to Department of Behavioral Health and Developmental Services (DBHDS) by the individual's support coordinator through the DBHDS Waiver Management System (WaMS). 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/FAMIS eligibility, the provider's continued enrollment as a DMAS provider, 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

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

The SA entity will approve, pend, reject, or deny all completed SA requests. DBHDS will be authorizing the following services under EPSDT:

- **S9123, S9124 – EPSDT Private Duty Nursing (Individual RN and LPN)**
- **G0493 and G0494 - EPSDT Private Duty Nursing (Congregate RN and LPN)**
- **T5999 – EPSDT Assistive Technology**

Changes in Benefit Plans (DD)

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

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

Communication (DD)

Provider manuals are located on the DMAS portal www.dmas.virginia.gov and DBHDS website. The DBHDS website has information related to the SA processes for programs identified in this manual. You may access this information by going to www.dbhds.virginia.gov or contacting the DD Waivers helpline at 807-663-7290.

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

Service Authorization for the Developmental Disabilities Waivers

General Information

Prior to requesting authorization of services under the DD waivers, an individual must be deemed Medicaid eligible by the Department of Social Services and meet waiver eligibility criteria. It is important to note that an individual can only be enrolled in one waiver at a time; if transferring from one waiver to another, there cannot be overlaps in dates. Please see Chapter IV for enrollment processes. All Individual Support Plans (ISP) will be submitted each plan year with a maximum duration of 12 months regardless of the time of

year the plan was initiated.

Developmental Disabilities Waiver Services (BI/FIS/CL) Requiring Authorization

Prior to submitting claims to the DMAS Virginia Medicaid Management Information System (VAMMIS) all requests must be submitted to DBHDS via the Waiver Management System (WaMS) by the individual's support coordinator and include the Individual Support Plan approved by DBHDS.

REVIEW CRITERIA TO BE USED (DD)

EPSDT specialized services are available only for Medicaid members **under age 21.** *EPSDT specialized services are not a covered service by DMAS for individuals age 21 and older.*

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

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

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

Individuals enrolled in Home and Community-Based waivers that provide a service available

through EPSDT must obtain the service through EPSDT. These services include Assistive Technology and Private Duty Nursing. Requests which do not meet the medical necessity criteria through the EPSDT program may not be provided through the waiver program.

EPSDT Assistive Technology (DD)

Assistive Technology is defined as specialized medical equipment, supplies, devices, controls, and appliances not available under the Virginia *State Plan for Medical Assistance*. Assistive Technology items directly enable individuals to increase their abilities to perform ADLs or to perceive, control, or communicate with the environment in which they live. Assistive Technology items are expected to be portable.

To meet the definition of Assistive Technology, requested items must meet all of the following requirements. Assistive Technology must:

- be able to withstand repeated use;
- be primarily and customarily used to serve a medical purpose and be medically necessary and reasonable for the treatment of the individual's disability or to improve a physical or mental condition;
- generally not be useful to a person in the absence of a disability, physical or mental condition; and
- be appropriate for use in both the home and community.

Service Authorization Review Process:

Criteria: Only Assistive Technology items that are determined to be medically necessary may be covered for reimbursement by DMAS. The following criteria must be satisfied

through the submission of adequate and verifiable documentation satisfactory to DMAS or the contractor. Assistive Technology must be:

- A reasonable and medically necessary part of an Individual Support plan;
- Consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual;
- Not furnished solely for the convenience of the family, attending physician, or other practitioner or supplier;
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and
- Provided at a safe, effective, and cost-effective level that is suitable for use by the individual.

Assistive Technology must directly support the individual and be for the express purpose of diagnosing, treating or preventing (or minimizing the adverse effects of) illness, injury or other impairments to an individual's physical or mental health. Therefore, services that do not directly support the individual or environmental services dealing exclusively with an individual's surroundings rather than the individual are not covered. Further, even if the requested service does involve some direct support for the individual, it cannot be covered unless the device is related to the diagnosis reason for the service request. Example, if a child can effectively communicate, they don't need an iPad for communication. The child needs to be diagnosed with a communication disorder or autism with communication difficulties and documented that the iPad can benefit their communication.

Individuals and caregivers are responsible for determining if the individual is receiving the appropriate Assistive Technology in the school system and suggesting that the child's Individualized Education Plan (IEP) include Assistive Technology. In cases where Assistive Technology is requested for use during school hours and not included in the IEP, the provider must obtain documentation from the school indicating why the Assistive

Technology is not included in the child's IEP. Items covered under the Individuals with Disabilities Education Act (IDEA) cannot be covered under EPSDT. Items intended to be used in a school setting that are needed for educational purposes are not covered. For information regarding Medicaid covered school services, please see the School Health Services Manual located on the DMAS web portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

Timeliness:

Timeliness for provider submission does apply.

- Assistive technology requests must be submitted by the provider prior to the assistive technology service being delivered.

- Service authorization approvals that are completed prior to the assistive technology service being rendered are approved for the dates of service requested by the provider; 1 unit for 30 days.

- Administrative denials would occur if the provider did not respond to a pended request for initial clinical information or submitted a request after the assistive technology service was rendered and the member is not retro-eligible.

- Established timeframes listed above are also applicable to out of state providers. The only exception is for those out of state providers who are not enrolled as a participating provider with Virginia Medicaid.

Requests for new Assistive Technology devices must contain the following:

1. Physician Letter of Medical Necessity
2. Therapist's evaluation report (If signed by the physician this can serve as the Letter of Medical Necessity)
3. Quote from supplier to document provider's wholesale cost or cost description for

requests to exceed allowed reimbursement rates. Provider to submit quote, showing cost and if request approved, then markup cost 30%.

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

Any medical necessity denials for EPSDT Assistive Technology for individuals under the age of 21, are performed at a Physician Review level at DMAS. This does not apply to administrative denials.

EPSDT Private Duty Nursing

Private duty nursing is continuous medically necessary nursing provided for an individual. Private duty nursing agencies provide professional nursing services to individuals in a home or community-based setting. Private duty nursing must be provided by a registered nurse (RN) or licensed practical nurse (LPN) employed by a DMAS-enrolled private duty nursing provider.

Congregate Private Duty Nursing (G0493, G0494): *Congregate private duty nursing is provided by one nurse when more than one individual who requires private duty nursing resides in the same home*. Congregate private duty nursing shall be limited to a maximum ratio of one private duty nurse to two individuals who receive nursing via the Waiver or EPSDT. When three or more waiver/EPSDT individuals share a home, service staff ratios are determined by assessing the combined needs of the individuals. Congregate cases may require individual nursing hours in addition to the congregate hours.

Individual Private Duty Nursing (S9123, S9124): Individual Private Duty Nursing (PDN) service means nursing services that are provided by a Registered Nurse (RN) or Licensed Practical Nurses (LPN) to one individual and are designed to provide the individual continuous nursing care. PDN services are available to individuals who require more hours per week of nursing care than may be provided under Skilled Nursing in the waivers.

Private duty nursing provides individualized medically necessary nursing treatment or preventive nursing supports that correct, ameliorate or maintain the health condition.

Private duty nursing services are limited to the hours of skilled medical care and skilled supervision as specified in the POC and limited to the number of hours approved by DMAS. Plans may be submitted for any time period between 60 days and 6 months.

Criteria: The EPSDT Medical Needs Assessment form will determine the medical necessity for EPSDT nursing for a total day's duration. There are five levels of nursing care. Nursing needs of the individual indicate the type and complexity of care. The amount of care authorized may differ from this level based on the plan of care and the hours in which the nursing services are scheduled. Private duty nursing services are limited to the hours of skilled medical care and skilled supervision as specified in the POC and limited to the number of hours approved by DMAS. Private duty nursing service authorizations may be valid for the duration of the POC.

The levels of private duty nursing care are defined as:

r **A** Score (1-6) points

Maximum nursing (Individual Consideration up to 8 hrs / day)

r **B** Score (7-22) points

Maximum nursing 8 hrs / day

r **C** Score (23-36) points

Maximum nursing 12 hrs / day

r **D** Score (37-49) points

Maximum nursing 16 hrs / day

r **E** Score (50 or more) points

Maximum nursing (Individual Consideration)

Timeliness: Timeliness for provider submission does apply. Initial request for services must be submitted 10 business days prior to the start of care (SOC). The CMS 485 must be signed and dated by the physician within 10 business days of the initial SOC. Continued stay

reviews are required to be submitted to the Contractor prior to the end of the current decision.

New Requests:

- Signed and dated DMAS-62 form by the physician, physician's assistant, or certified nurse practitioner.

- Home Health Certification and Plan of Care (use the CMS 485 or equivalent to meet documentation requirements) signed and dated by the physician.

Continuation Requests

- DMAS-62 - Medical Needs Assessment Form (a new DMAS-62 is required every 6 months) signed and dated by the physician, physician's assistant, or certified nurse practitioner.

  Home Health Certification and Plan of Care (may use the CMS 485 or equivalent to meet documentation requirements) signed and dated by the ordering physician who is most familiar with the care needs of the individual. The CMS 485 must be reviewed and updated by the ordering physician with each continuation request.

- The Home Health Certification and Plan of Care must contain the individual's Medicaid ID number, provider number, and documentation which reflects the nursing care as described in the Medical Needs Assessment (DMAS-62) form.

Any medical necessity denials for EPSDT Private Duty nursing for individuals under the age of 21, are performed at a Physician Review level at DMAS. This does not apply to administrative denials.