Appendix D: Service Authorization Information

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Appendix D: Service Authorization Information

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

PURPOSE OF SERVICE AUTHORIZATION (Hospital)

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.

Currently, the Traditional Inpatient and Outpatient services requiring authorization are reviewed by DMAS' service authorization contractor, Keystone Peer Review Organization, (KEPRO).

Effective December 1, 2013, Magellan of Virginia will be the Behavioral Health Services Administrator and perform service authorization for the following services:

Inpatient Psychiatric Services, service type 0401;

Freestanding Psychiatric Hospital Services, service type 0093;

Outpatient Psychiatric Services, service type 0050; and

Outpatient Substance Abuse Services 0051.

Magellan will begin accepting requests on December 1, 2013. Please refer to DMAS web site at www.dmas.virginia.gov for Magellan of Virginia contact information or contact the DMAS Helpline at 1-800-552-8627 or 804-786-6273.

General Information Regarding Service Authorization

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

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

Changes in Medicaid Assignment

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

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

Commonwealth Coordinated Care Plus (CCC Plus) Program

Members Transitioning into CCC Plus

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

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

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

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

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

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

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

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

CCC Plus Exceptions:

The following exceptions apply:

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

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

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

THE GOVERNOR'S ACCESS PLAN (GAP) (FEE-FOR-SERVICE MEMBERS) POST MEDICAID EXPANSION

Effective January 1, 2019, Virginia Medicaid will offer new health coverage for adults. Most GAP members will be enrolled automatically in this new program. Some GAP members will remain in fee-for-service and will receive their medical service authorization through DMAS' Service Authorization Contractor, Keystone Peer Review Organization (KEPRO). The

services received through fee-for-service will not change from the current GAP services. These members will **not** receive the new Medicaid Expansion benefits and will continue to use their GAP identification card through March 31, 2019, when the GAP program ends. KEPRO will accept requests for GAP (medical) services through March 31, 2019 at 11:59 pm, for dates of service through March 31, 2019. Requests received on and after April 1, 2019 will be rejected.

The Governor's Access Plan (GAP) for medical and behavioral health services is restricted to Virginia adults (ages 21 through 64) who have a serious mental illness. The GAP benefit plan includes limited medical coverage where some of these services require service authorization through KEPRO. Service authorization is required for the following Traditional medical services:

- Non-emergent, outpatient Magnetic Resonance Imaging (MRI scan)*
- Non-emergent, outpatient Computerized Axial Tomography (CAT scan)*
- Durable Medical Equipment: limited to overage Diabetic Supplies only
- Surgical Procedures (specific procedure codes only)
- Medical Device Services/Maintenance (specific procedure/HCPCS codes only)

*Only services performed in outpatient facility settings. All other services are limited to physician offices only. Physician office includes Health Department Clinics, Rural Health Clinics (RHC), and Federally Qualified Health Clinics (FQHC).

Should a service require service authorization under the GAP benefit plan, providers must submit a request according to the specific service type standards to meet the timeliness requirements (when appropriate) as well as medical documentation to meet the service specific criteria.

The specific DME diabetic supply codes covered by GAP are included in the Virginia Governor's Access Plan for the Seriously Mentally Ill (GAP) Manual, Attachment 2, Durable Medical Equipment Coverage, "Diabetic Products" section. Providers should review the GAP Manual and the exhibits to determine medical necessity criteria, the allowable amount

for each code (no service authorization required) and any overage amount that requires service authorization.

Refer to KEPRO's website http://dmas.kepro.com/ for procedure codes and HCPCS codes that are included in the GAP benefit and require service authorization by KEPRO. All codes are subject to change so providers must refer to KEPRO's website for any updates. Information may be found on the DMAS website, Service Authorization section, at the following link: http://www.dmas.virginia.gov/Content_pgs/pa-home.aspx.

For general GAP information, refer to the GAP Supplement C found on the DMAS web portal, Provider Services, Provider Manuals section. The GAP link also provides useful information: http://www.dmas.virginia.gov/Content_pgs/GAP.aspx.

Communication

Provider manuals are located on the DMAS web portal and KEPRO website. The contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to http://dmas.kepro.com. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Inpatient* tab.

The service authorization 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.

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 Memo to the DMAS website. Changes will be incorporated within the manual.

Overview

Inpatient Service Authorization

DMAS has contracted the services of a medical review organization to provide service authorization of all inpatient hospital admissions.

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 (paper, electronic, fax, etc.), for service authorization requests.

Currently, the Traditional Inpatient services requiring authorization are reviewed by DMAS' service authorization contractor, Keystone Peer Review Organization, (KEPRO).

Submitting Requests for Service Authorization to KEPRO

Service authorization requests will be accepted by DMAS' service authorization contractor, Keystone Peer Review Organization, (KEPRO) through November 30, 2013 for Behavioral Health Services. Effective December 1, 2013, KEPRO will not receive Inpatient Psychiatric Services, service type 0401; Freestanding Psychiatric Hospital Services, service type 0093; Outpatient Psychiatric Services, service type 0050; and Outpatient Substance Abuse Services, service type 0051.

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 to KEPRO.

**Note to providers: The information submitted to KEPRO 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 member's needs. Any person who knowingly submits information to KEPRO 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.

Submitting Srv Auth Requests for Inpatient Acute Hospital Admissions Effective September 1, 2015

Effective September 1, 2015, requests for Inpatient Acute Hospital admissions will only be accepted electronically utilizing KEPRO's provider portal Atrezzo Connect (also known as Atrezzo). The only inpatient service type requiring Atrezzo portal submission is Inpatient Acute Hospital (service type 0400). For detailed information refer to the June 15, 2015 DMAS memo.

How to Register for Atrezzo Connect

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, the *General* tab and then *Atrezzo Connect - Registration*.

Submitting Requests via Atrezzo Connect

Once registered, inpatient acute hospital providers will use the Atrezzo portal for submitting all requests. This includes admissions, change requests, transfers, responding to pend requests, and other applicable transactions.

Registered Atrezzo providers do not need to register again. If a provider is successfully registered, but need assistance submitting requests through the portal, an Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the *Training* tab, the *General* tab and then *Atrezzo Connect – Portal User Guide*.

Providers can also contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com for additional assistance with registering and any questions regarding submitting srv auth requests.

For inpatient acute hospital requests completion of the inpatient questionnaire is now required. All providers will attest electronically that information submitted to KEPRO is within the member's documented 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.

All admissions must be authorized within 1 business day of the admission. A business day is defined as 12:00 am – 11:59 pm Monday – Friday with the exception of State recognized holidays. To initiate service authorization of the admission the provider must provide the member's name; the identification number; the admitting physician's name; the primary care physician's name (if applicable); the admission diagnosis and ICD diagnosis code(s); the medical indication for hospitalization; and the plan of care. The Srv Auth Contractor will apply InterQual® ISD-AC criteria or supplemental criteria when InterQual® criteria does not specifically meet DMAS' coverage criteria. A service authorization number will be assigned for admission for medical/surgical services or for the initial admission and length of stay for psychiatric inpatient services. Medical/surgical services must have their own service authorization number and cannot be combined with a psychiatric service authorization. Due to the different payment methodology, DMAS will not reimburse claims that have conflicting diagnosis codes on the claim versus the type of service authorization provided. It is the responsibility of the provider to request the appropriate service authorization (psychiatric versus med/surg) at the time of the Srv Auth request.

Service Authorization Process for Psychiatric Services

Inpatient Acute Psychiatric Services in both acute hospitals and freestanding hospitals require service authorization by Magellan of Virginia effective December 1, 2013.

- Planned/scheduled admissions must be submitted within 24 hours of admission, or on

the next business day after admission. Obtaining service authorization for the admission is encouraged.

- Unplanned/urgent or emergency admissions must be submitted within 24 hours of admission, or on the next business day after admission.

Prior to the expiration of the initial assigned length of stay, if the member requires continued inpatient hospital care, the health care provider must contact the Contractor's review staff to initiate the concurrent review process. The health care provider must be able to provide the Contractor's review staff with the member's Medicaid identification number/service authorization number and must be prepared to discuss the medical indications and plan of care for continued hospitalization The review analyst will apply InterQual ISD-AC criteria or supplemental criteria to the medical information provided and will assign an additional length of stay if criteria are met for continued inpatient hospitalization. Concurrent review will continue in the same manner until the member is discharged. Refer to the Psychiatric Services Provider Manual, Appendix C for specific information regarding service authorization.

Medical /Surgical Inpatient Services

Inpatient Acute Services in acute hospitals require service authorization. On admission, the patient must meet criteria for inpatient hospitalization and have a treatment plan in place that requires an inpatient level of care.

- Planned/scheduled admissions must be service authorized within 24 hours of admission, or on the next business day after admission. Obtaining service authorization prior to the admission is encouraged.
- Unplanned/urgent or emergency admissions: these admissions will be permitted before any service authorization procedures and must be service authorized within 24 hours of admission or on the next business day after the admission.

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 provider must have a Srv Auth. The health care provider should request a Srv Auth for retrospective review within 30 days of the notice of Medicaid eligibility.

Effective April 1, 2012, the provider shall obtain service authorization for the following services from the DMAS Service Authorization Contractor, KEPRO. The inpatient

hospitalization services must be authorized separately from the physician's service authorization by KEPRO:

- Out-of-state Services
- Gastric Bypass
- All Cosmetic Procedures-including Breast Reduction
- Prostheses (excluding Orthotics)

Admissions require service authorization by the Srv Auth Contractor. Effective September 1, 2015, service authorization requests for Inpatient Acute Hospital, (service type 0400), must be submitted electronically utilizing KEPRO's provider portal Atrezzo Connect (also known as Atrezzo). Refer to page 6 of this appendix for instructions on registering for Atrezzo and submitting through the provider portal.

The Srv Auth Contractor will provide a service authorization number for the admission date. Under the DRG reimbursement methodology, no continued stay reviews will be conducted for members receiving general acute medical/surgical services. For those members who do not meet InterQual criteria on admission but do meet the criteria later in the hospitalization, the service authorization must be obtained within one business day of the patient's meeting the criteria.

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 provider must have a Srv Auth. The health care provider should request a Srv Auth for retrospective review within 30 days of the notice of Medicaid eligibility. The review analyst will apply McKesson InterQual® ISD-AC criteria to the admission information provided for general acute medical/surgical admissions. Psychiatric admissions and lengths of stay will be retrospectively authorized in the same manner using the McKesson InterQual® ISD-AC criteria or supplemental criteria. If the hospitalization is found to meet medical necessity criteria, a service authorization number will be assigned and the approved admission date or dates of service will be identified.

The hospital must bill the complete dates of service for inpatient services. It is important to understand that service authorization approval certifies the medical necessity of the hospitalization, but service authorization does not guarantee claim payment. Non-

authorized (denied) inpatient services will not be covered or reimbursed by DMAS. When submitting a bill, the following information must match the service authorization: the member's name, member identification number, authorized dates of service, and the assigned service authorization number in Locator 63 of the UB-04CMS-1450 Universal Claim form. Regardless of service authorization, if the invoice reflects a transplant, sterilization, hysterectomy, or abortion ICD procedure or diagnosis code, the claim will pend for DMAS manual review. If the required DMAS form is not attached, the claim will be reduced or denied according to DMAS policy. Likewise, if the patient is over the age of 21 years and the service authorized stay is for psychiatric hospitalization and exceeds the 21-day in a 60-day period service limit, the claim will pend for DMAS manual review. Any admissions which exceed 21 days in a 60-day period for the same or similar diagnosis will have days reduced or denied

Service authorization is not required for normal maternity/newborn inpatient care. This includes normal vaginal deliveries, ICD procedure code(s) with a length of stay less than or equal to three days from the date of admission; caesarian section deliveries, ICD procedure code, with a length of stay less than or equal to five days from the date of admission; and newborns who are in the normal nursery, revenue code 0170 or 0171, with a length of stay less than or equal to five days from the infant's date of birth. Service authorization will be required for the entire newborn stay if the infant is in any other nursery setting (i.e., revenue codes 0172, 0173, 0174, 0175, or 0179) for any part of the stay. The Srv Auth Contractor (KEPRO) must service authorize maternity and newborn stays which do not fall within these parameters, and the service authorization must be on file with DMAS prior to billing for the stay.

Service Authorization Requests

To minimize time when submitting a service authorization request, consider the following suggestions. The suggestions are:

Certain procedures done as outpatient do require service authorization. If the patient is subsequently admitted to the hospital due to postoperative complications, the provider must submit a request within one (1) business day.

Medicaid defines "observation beds" as outpatient services and does not require service authorization.

For psychiatric inpatient services, no telephone call is necessary if the patient is discharged prior to the date the length of stay assignment ends. However, the provider must contact the Srv Auth Contractor to extend the length of stay if the patient stays beyond the assigned length of stay. The exception to this is for the adult patient who stays beyond 21 days. The hospital is only responsible for obtaining service authorization for the first 21 days of inpatient psychiatric care.

Effective April 1, 2012, certain procedures require authorization through KEPRO. Requests must be sent to KEPRO, the DMAS Service Auth Contractor. Once the procedure has been authorized, the hospital must contact KEPRO, the Srv Auth Contractor to obtain authorization if inpatient admission is required. Cosmetic surgery performed solely to enhance appearance is not a covered service. Prior to April 1, 2012 claims submitted must have the letter of authorization from Medical Support attached to the claim, as well as the Srv Auth number in block 63, at the time of submission, or the claim will be denied. Effective April 1, 2012, claims submitted must have the Srv Auth number on the claim that was assigned to that procedure code.

Cosmetic Surgery

Cosmetic surgery is not covered when provided solely for the purpose of improving appearance. The exclusion of cosmetic surgery does not apply to congenital deformities or to deformities due to recent injury. When surgery also restores or improves a physiological function, it is not considered cosmetic surgery.

Effective April 1, 2012, authorization must be obtained from the DMAS Srv Auth Contractor (KEPRO) prior to services being provided. All requests for service authorization must be made by direct data entry (DDE) or by fax to KEPRO.

The claim must contain the authorization number assigned to that procedure code.

Note: A Fee File listing the Procedure Codes Requiring Service Authorization can be found on DMAS website at

http://www.dmas.virginia.gov/pr-fee_files.htm.

Note: If the procedure is performed as an inpatient, separate service authorization for the inpatient hospitalization by the DMAS Srv Auth Contractor (KEPRO) is required for the inpatient admission.

Gender Dysphoria

Surgical services and facial feminization or masculinization services for the treatment of Gender Dysphoria require prior authorization from the DMAS Medical Support Unit as outlined in the Gender Dysphoria Supplement of the *Physician/Practitioner Provider Manual*. Submit service authorization requests by fax to 804-452-5450. If surgical and procedural services for the treatment of Gender Dysphoria are performed as an inpatient, a separate service authorization for the inpatient hospitalization by the DMAS Service Authorization Contractor (KEPRO) is required for the inpatient admission. Gender dysphoria surgical and procedural services must be authorized by the DMAS Medical Support Unit before the inpatient hospitalization can be authorized by the DMAS Service Authorization Contractor (KEPRO).

Elective Surgery

The Virginia Medicaid Program defines elective surgery as surgery not medically necessary to restore or materially improve a body function. This includes surgery for conditions such as morbid obesity, virginal breast hypertrophy, and procedures that might be considered cosmetic.

Effective April 1, 2012, authorization must be obtained from the DMAS Srv Auth Contractor (KEPRO) prior to services being provided. All requests for service authorization must be made by direct data entry (DDE) or by fax to KEPRO.

The claim must contain the authorization number assigned to that procedure code.

Note: A Fee File list including the Procedure Codes Requiring Service Authorization

can found on the DMAS website at http://www.dmas.virginia.gov/pr-fee_files.htm.

Note: If the procedure is performed as an inpatient, separate service authorization for the inpatient hospitalization by the DMAS Srv Auth Contractor (KEPRO) is still required for the inpatient admission.

Transplant Surgery

Effective November 1, 2016, all transplants, with the exception of corneas, require service authorization from DMAS Medical Support Unit. A separate service authorization for the inpatient hospitalization by the DMAS Srv Auth Contractor (KEPRO) is still required for the inpatient admission.

Transplant services which are covered when medically necessary and are not experimental or investigational are: kidney and corneal transplants without age limits (effective September 7, 1989); heart, lung, and liver transplants without age limits (effective July 1, 2000); coverage of bone marrow transplants for individuals over 21 years of age is allowed for a diagnosis of lymphoma, breast cancer leukemia, and myeloma. Effective November 2017, DMAS now provides coverage for stem cell transplants for members 21 and over with a diagnosis of either Aplastic Anemia, Heritable Bone Marrow Syndrome, Paroxysmal Nocturnal Hemoglobinuria, Beta Thalassemia major or Sickle Cell Disease when a member meets medically necessary criteria. Under EPSDT, any other medically necessary transplant procedures that are not experimental or investigational are limited to persons under the age of 21 (effective July 19, 1993).

In addition, specific criteria issued by Medicaid concerning patient and facility selection must be followed for all transplant services. The treating facility and transplant staff must be recognized by Virginia Medicaid as being capable of providing high-quality care in the performance of the requested transplant, and the patient must be considered as acceptable for coverage.

All transplants except cornea transplants require service authorization by DMAS Medical Support Unit. Submit the service authorization requests by fax to 804-452-5450. The

inpatient hospitalization services are authorized separately by the Srv Auth Contractor, KEPRO. The transplant must be authorized before the inpatient hospitalization can be authorized.

The following criteria must be followed for patient and facility selection for all transplants except kidney, bone marrow (for diagnosis of lymphoma, breast cancer, or leukemia), and cornea transplants.

I. Patient Selection Criteria (See 12 VACS 30-50-360.)

A. The following general conditions must be met:

1. Coverage will not be provided for investigational or experimental procedures;

2. There must be no available effective, alternative medical or surgical therapies with outcomes that are at least comparable;

3. The transplant procedure and use of the procedure in treatment of the specific condition for which it is proposed must be clearly demonstrated to be medically effective; and

4. Service authorization by DMAS is required. The service authorization request must contain the information and documentation as required by DMAS.

B. The following specific conditions regarding patient selection (if required for specific transplant) must be met:

The patient selection criteria of the transplant center where the surgery is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. The transplant team or program must review the member's medical condition and, based upon the transplant center's criteria, determine that the member is an appropriate candidate for the transplant procedure.

Transplant procedures will be service authorized only if the selection of the patient adheres to the transplant center's selection criteria, based upon review by DMAS of the information submitted by the transplant team or center.

Patient selection criteria used by the transplant center must include, at a minimum, the following:

a. Current medical therapy has failed, and the patient has failed to respond to appropriate therapeutic management;

b. The patient is not in an irreversible terminal state; and

c. The transplant is likely to prolong life and restore a range of physical and social function suited to activities of daily living.

II. Facility Selection Criteria Start

A. The following general conditions must be met:

1. Procedures must be performed out-of-state only when the authorized transplant cannot be performed in the Commonwealth of Virginia (the Commonwealth) because the services are not available or, due to capacity limitations, the transplant cannot be performed in the necessary time period; and

2. Criteria applicable to transplant services and facilities in the Commonwealth also apply to out-of-state transplant services and facilities.

B. To qualify for coverage, the facility must meet, at a minimum, the following criteria:

1. The transplant program staff has demonstrated expertise and experience in the medical and surgical treatment of the specific disorder necessitating the

transplant procedure;

2. The transplant surgeon(s) has been trained in the specific transplant technique at an institution with a well-established program for the specific procedure;

3. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

4. The facility has staff or access to staff with expertise in tissue typing, and immunological and immunosuppressive techniques;

5. Adequate blood bank support services are available;

6. Adequate arrangements exist for donor procurement services;

7. The faculty must have current full membership in the United Network for Organ Sharing for facilities where solid organ transplants are performed;

8. Membership exists in a recognized bone marrow registry program for bone marrow transplant programs;

9. The transplant facility or center can demonstrate satisfactory transplant outcomes for the procedure being considered;

10. Transplant volume at the facility is consistent with maintaining quality services; and

11. The transplant center will provide adequate psychosocial and social support services for the transplant member and family.

Reimbursement

Reimbursement for covered liver, heart, lung, and bone marrow transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of: (a) a prospectively determined, procedure-specific flat fee determined by the agency, or (b) a prospectively determined, procedure-specific percentage of usual and customary charges or actual charges. The reimbursement will cover: procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The reimbursement does not include pre- and post-hospitalization for the transplant procedure, pre-transplant evaluation, or organ search. Reimbursement for approved transplant procedures that are performed out-of-state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. All claims for the transplant hospitalization must be submitted to:

Manager, Payment Processing Unit

Division of Program Operations

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

OUTPATIENT HOSPITAL SERVICES

Outpatient Defined

Currently, the Traditional Outpatient services requiring authorization are reviewed by DMAS' service authorization contractor, Keystone Peer Review Organization, (KEPRO).

Effective December 1, 2013, Magellan of Virginia will be the Behavioral Health Services Administrator and perform service authorization for the following Outpatient services: Outpatient Psychiatric Services, service type 0050 and Outpatient Substance Abuse Services 0051.

Please refer to the DMAS web site at www.dmas.virginia.gov for Magellan of Virginia contact information or contact the DMAS Helpline at 1-800-552-8627 or 804-786-6273.

When a hospital uses the category "day patient" (i.e., an individual who received hospital services during the day and is not expected to be lodged in the hospital at midnight), the individual is classified as an outpatient. NOTE: If the procedure is performed as an inpatient, separate service authorization by the DMAS Srv Auth Contractor (KEPRO) is required for inpatient admission. If the service is authorized through Magellan of Virginia, refer to the DMAS web site at www.dmas.virginia.gov for Magellan of Virginia contact information or contact the DMAS Helpline at 1-800-552-8627 or 804-786-6273.

Certain outpatient surgical procedures will continue to require service authorization. Effective April 1, 2012, DMAS Medical Support will no longer be reviewing these requests. DMAS Service Authorization Contractor, KEPRO, will begin reviewing service authorization requests for these specific procedure codes. For a listing of the codes, refer to the Fee File found on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/pr-ffs_new.aspx. Instructions regarding the Fee File may be found later in this appendix. Additionally, timeliness will now apply. KEPRO will allow retroactive reviews for service requests submitted through June 30, 2012 only. Effective July 1, 2012, KEPRO will not authorize requests retroactively for these procedure codes, regardless of the dates of service. The only instance KEPRO will approve services retroactively on and after July 1, 2012 is when the provider demonstrates retroactive Medicaid eligibility for members. For specific details regarding timeliness service authorization instructions, service processes and forms; refer to the Physician/Practitioner Manual, Appendix D.

Non-Emergency, Outpatient MRI, CAT and PET Scans

DMAS implemented a mandatory service authorization process for all non-emergency, planned and scheduled outpatients, Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiograph (MRA), Computerized Axial Tomography (CAT), and Position Emission Tomography (PET) scans. These service authorization requirements apply for all Medicaid clients enrolled in fee-for-service, as well as FAMIS clients enrolled in fee-for-service, or Primary Care Case Management (PCCM) programs and must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or as an emergency through the hospital's emergency room. The following information outlines the procedures for obtaining procedures for obtaining service authorization and reimbursement for these non-emergency, outpatient scans.

DMAS has contracted with KEPRO to conduct medical appropriateness reviews utilizing InterQual® ISX criteria, a McKesson Health Solutions, LLC product. To request service authorization, contact KEPRO. KEPRO will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. Specific information regarding the service authorization requirements and methods of submission can be found at the contractor's website, http://dmas.kepro.com. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329. The program will take you through the steps needed to receive authorization for service request.

It is the responsibility of the ordering physician or his/her representative, hospital, facility or radiologist to contact KEPRO and provide the necessary information and medical appropriateness indications for the scan being ordered.

Upon receipt of the case, a reviewer will reassess the information against InterQual® ISX (Indications for Imaging Studies and X-rays) criteria. If the case information satisfies the criteria, an approval is given for the requested diagnostic test. If the documentation submitted does not satisfy the criteria, a referral will be made to a peer reviewer for the determination.

If the patient has Medicare Part B, service authorization is not required unless Medicare has been billed and denied. When this occurs, the ordering physician or his/her representative, hospital, facility or radiologist must contact KEPRO for retrospective authorization.

Likewise, if the patient has been determined to be eligible for Medicaid covered services retrospectively, and his/her coverage is made retroactive to include the scanning date of service, the ordering physician or his/her representative, hospital, facility or radiologist must contact KEPRO for retrospective authorization. Also, urgent scans that are performed prior to obtaining service authorization must be retrospectively authorized. The definition of an urgent scan is when the ordering physician identifies an urgent need to have a scan performed the same day as seen by the physician.

The physician sends the patient immediately to the hospital or scanning facility to have the scan performed. The ordering physician or his/her representative, hospital, facility or radiologist must contact KEPRO for retrospective authorization within one business of the scan being performed. When contacting KEPRO to perform retrospective review, notify KEPRO that Medicare Part B has been denied, or that the patient has retroactive eligibility, or that the scan was performed on an urgent basis and provide the necessary information and medical appropriateness indications for the scan that has already been performed.

OUT-OF-STATE PROVIDER INFORMATION (Hospital)

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

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

Specific Information for Out-of-State Providers

(Effective March 1, 2013, affected providers include Outpatient Rehabilitation agencies.) Effective November 1, 2016, all requests for non-emergent CAT, MRI, or PET scans will be service authorized by DMAS Medical Support Unit. Submit the request by fax to 804-452-5450. Upon receipt of the case, a reviewer will reassess the information against InterQual® ISX (Indications for Imaging Studies and X-rays) criteria. If the case information satisfies the criteria, an approval is given for the requested diagnostic test. If the documentation submitted does not satisfy the criteria, a referral will be made to a peer reviewer for the determination.

Out-of-state providers are held to the same service authorization processing rules as in state providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-state services to KEPRO or DMAS. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to KEPRO or DMAS, as timeliness of the request will be considered in the review process. KEPRO or DMAS will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.

If KEPRO or DMAS receives the information in response to the pend for the provider's enrollment from the newly enrolled provider within the 12 business days, the request will then continue through the review process and a final determination will be made on the service request.

If the request was pended for no provider enrollment and KEPRO or DMAS does not receive the information to complete the processing of the request within the 12 business days, KEPRO or DMAS will reject the request back to the provider, as the service authorization cannot be entered into MMIS without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request.

Out-of-state providers may enroll with Virginia Medicaid by going to https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment. At the toolbar at the top of the page, click on *Provider Services* and then *Provider Enrollment* in

the drop down box. It may take up to 10 business days to become a Virginia participating provider.

Out-of-State Provider Requests

Authorization requests for certain services including Non-emergent Scans and 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;
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 Contractor. If the provider is unable to establish one of the four, the Contractor will:

- Pend the request utilizing established provider pend timeframes
- Have the provider research and support one of the items above and submit back to the Contractor their findings

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.

How to Determine if Services Need to be Authorized

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

To determine if a service needs service authorization, you would then determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the TXT version. The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be prior authorized as it will contain a numeric value for the PA Type, such as one of the following:

00 – No PA is required

01 – Always needs a PA

02 -Only needs PA if service limits are exceeded

03- Always need PA, with per frequency.

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

EARLY PERIODIC SCREENING DIAGNOSIS AND

TREATMENT SERVICE (EPSDT) AUTHORIZATION (Hospital)

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

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

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

All Medicaid and FAMIS Plus services that are currently service authorized by the Srv Auth contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, http://dmas.kepro.com. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX OR 1-877-652-9329.

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 he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.

- Another example using mental health services would be as follows: A child has been routinely hitting her siblings; the child has received 20 individualized counseling sessions and 6 family therapy sessions to address this behavior. Because the behavior has decreased, but new problematic behaviors have developed such as nighttime elopement and other dangerous physical activity, more therapy was requested for the child. The service limit was met for this service. But because there is clinical evidence from the therapy providers to continue treatment, the contractor should approve the request because there is clinically appropriate evidence which documents the need to continue therapy in a variation or continuation of the current treatment modalities.

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

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

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

Hearing Aids and Related Devices

Assistive Technology

Private Duty Nursing

Personal Care and Attendant Care Services

Requests for EPSDT services **not contracted to be reviewed and authorized by KEPRO** may be sent to:

DMAS Medical Support Unit

Fax: 804-452-5450 Phone: 804-786-8056

MEDICAID EXPANSION

On January 1, 2019, Medicaid expansion became effective. Individuals eligible for Medicaid expansion are:

- Adults ages 19-64,
- Not Medicare eligible,
- Not already eligible for a mandatory coverage group,
- Income from 0% - 138% Federal Poverty Level (FPL), and
- Individuals who are 100% - 138% FPL with insurance from the Marketplace.

The new expansion Aid Categories:

Aid Category	Description
AC 100	Caretaker Adult, Less than or equal to 100% of the Federal Poverty Level (FPL) and greater than LIFC
AC 101	Caretaker Adult, Greater than 100% FPL
AC 102	Childless Adult, Less than 100% FPL
AC 103	Childless Adult, Greater than 100% FPL
AC 106	Presumptive Eligible Adults Less than or equal to 133% FPL
AC 108	Incarcerated Adults

The Medicaid Expansion Benefit Plan includes the following covered services:

Doctor, hospital and emergency room services including primary and specialty care
Prescription drugs
Laboratory and x-ray
Maternity and newborn care
Behavioral health services, including addiction and recovery treatment
Rehabilitative services, including physical, occupational, and speech language therapies
Family planning
Transportation to appointments for Medicaid approved services
Home Health
DME and supplies
Long Term Support Services (LTSS), including Nursing Facility, PACE and Home and Community Based Services, including waivers
Preventive and wellness services, including annual wellness exams, immunizations, smoking cessation and nutritional counseling
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

All of the inpatient and outpatient services currently submitted and reviewed by KEPRO remain the same. There are no new expansion benefits that require service authorization by KEPRO.

REFERENCE OF MANUALS FOR SERVICE AUTHORIZATION

Psychiatric Inpatient Services

Please refer to the "Psychiatric Manual" Service Authorization appendix.

Medical /Surgical Inpatient Services

Please refer to the "Hospital Manual" Service Authorization appendix.

Durable Medical Equipment and Supplies (DME)

Please refer to the “DME Manual” Service Authorization appendix.

Service Authorization Process for Physician Services

Please refer to the “Physician/Practitioner Manual” Service Authorization appendix.

Rehabilitation Services

Please refer to the “Rehabilitation Manual” Service Authorization appendix.