Appendix C: Service Authorization Information (Lab)

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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

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/FAMIS 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. Medallion 3 MCO-enrolled members are subject to service authorization requirements of the individual's MCO.

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 individual and the provider is notified 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 (MCO) 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)

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 changes 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. 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 DMAS' Service Authorization Contractor, Keystone Peer Review Organization (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 others limited to physician's office 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 Durable Medical Equipment and Supplies Manual, Appendix B, "Diabetic Products" section. Providers should review Chapter IV and Appendix B 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 (Lab)

Provider manuals are located on the DMAS web portal and KePRO websites. 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 and clicking on the Forms tab for questionnaires and fax forms to request services. A service specific checklist may be found by clicking on "Service Authorization Checklists" on KEPRO's website. For educational material, click on the Training tab and scroll down to click on the General or Outpatient 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 Srv Auth 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.

Service Authorization Process (Lab)

Effective August 1, 2003, the Department of Medical Assistance Services (DMAS) implemented a mandatory service authorization process for all non-emergency, planned and scheduled, outpatient Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiograph (MRA), Computerized Axial Tomography (CAT), and Positron Emission Tomography (PET) scans. These service authorization requirements apply to 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 service authorization and reimbursement for these non-emergency, outpatient scans at in state facilities only. For out-of-state facilities, refer to the section titled, "**Specific Information for Out-of-State Providers**."

DMAS has contracted with (Keystone Peer Review Organization (KePRO) to conduct medical appropriateness reviews utilizing InterQual® ISX criteria, a McKesson Health Solutions, LLC

product. To request service authorization, contact KePRO. For information regarding the service authorization submission process, refer to the “Submitting Requests for Service Authorizations” section in Appendix C.

**Effective November 1, 2016, out-of-state non emergent MRI, CT, Scan and PET Scans must be submitted to DMAS Medical Support Unit. KEPRO WILL CONTINUE to review Virginia in state Imaging.

It is the responsibility of the ordering physician or his/her representative, the hospital or outpatient facility or radiologist to contact KePRO for Virginia In state Imaging Provider request ONLY and provide the necessary information and medical appropriate indications for the specific type of 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. Likewise, if the Medicare benefits are exhausted, the health care provider must submit a Srv Auth request for retrospective review within 30 days of the notice of denial or exhaustion by Medicare. 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, the hospital or outpatient facility or radiologist must contact KePRO for retrospective authorization from Virginia in state Providers ONLY. 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.

For recipients with other third party coverage (other than Medicare), the ordering physician or his/her representative, the hospital or outpatient facility or radiologist must contact KePRO prior to the scan for a service authorization from Virginia in state Providers ONLY. There will be no retrospective reviews done for recipients with other third party coverage since the service authorization from Medicaid is to occur before the scan is done. 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 outpatient facility to have the scan performed. The ordering physician or his/her representative, the hospital or outpatient facility or radiologist must contact KePRO for retrospective authorization within one business day of the scan being performed, when requested by Virginia in state Providers. 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.

Submitting Requests for Service Authorization (Lab)

DMAS' Service Authorization Contractor, KePRO, is moving to their own Provider Portal "Atrezzo Connect" effective October 31, 2011 at 6:00 a.m. The previous system (iEXCHANGE™) will not be available to providers, effective 5:00 p.m., October 28, 2011. For direct data entry requests, providers must begin using the new Atrezzo Connect Provider Portal. The new Atrezzo Connect Provider Portal advantages include easier system changes when DMAS program changes occur and specific prompts and edits related to certain programs in the new system. DMAS-related information from the previous system will be transferred into KEPRO's new Atrezzo Connect Provider Portal prior to October 31, 2011.

The registration process for providers is much simpler and quicker than with iEXCHANGE™ and happens immediately on-line. Existing iEXCHANGE™ users can log onto Atrezzo Connect without re-registering, using a special username consisting of their iEXCHANGE™ group ID, a hyphen, and their iEXCHANGE™ username. The initial password is also the iEXCHANGE™ group ID. They will then be given a one-time opportunity to change their username and password. Users from providers not currently registered with iEXCHANGE™ will select a username and password and then establish their legitimate connection to the selected NPI# by providing information taken from the most recent remittance advice. After logging in, Group administrators and Administrators within Atrezzo can specify other users within their organization and establish preferences for servicing providers, diagnoses and procedure codes. The Atrezzo Connect User Guide is available at dmas.kepro.com: Click on the Training tab, then the General tab.

Providers with questions about KEPRO's Atrezzo Connect Provider Portal may contact KePRO by email at atrezzoissues@kepro.com. For service authorization questions, providers may contact KePRO at providerissues@kepro.com. KePRO can also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

KePRO will also accept requests 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 may be found on the contractor's website at https://dmas.kepro.com.

OUT-OF-STATE PROVIDER INFORMATION

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".

KEPRO's service authorization process for certain services 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

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. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to KEPRO, as timeliness of the request will be considered in the review process. KEPRO will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.

If KEPRO 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 does not receive the information to complete the processing of the request within the 12 business days, KEPRO 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 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

"Effective September 12, 2016, KEPRO added additional questions to the out-of-state provider questionnaire (found on the Provider Portal):

a. Question #2 - If the medical services are needed, will the recipient's health be endangered if required to travel to state of residence? If a provider answers "Yes", then additional question #2.1.1 asks: "Please explain the medical reason why the member cannot travel."
b. Question #5 - "In what state is the provider rendering the service and/or delivering the item physically located?"
c. Question #6 - "In what state will this service be performed?"
d. Question #7 - "Can this service be provided by a provider in the state of

   Virginia? If a provider answers "No", then additional question #7.2.1 asks: "Please provide justification to explain why the item/service cannot be provided in Virginia."

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10120 and 42 CFR 431.52.

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 services:

Covered Service
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

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