



Appendix D: Service Authorization Information (Rehab)

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Appendix D: Service Authorization Information (Rehab)

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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.

Service Authorization for Intensive and Outpatient Rehabilitation Services

Submitting Requests for Service Authorization

The contracted entity that provides service authorization services to DMAS is Keystone Peer Review Organization (KEPRO). Contact information for KEPRO is as follows:

KEPRO

2810 N. Parham Road, Suite 305

Henrico, VA 23294

Phone:

(804) 622-8900 (Richmond)

1-888-827-2884 (Toll Free)

1-888-VAPAUTH

Fax: 1-877-652-9329

1-877-OKBYFAX

Service Authorization reviews will be performed by DMAS' service authorization contractor, Keystone Peer Review Organization, (KEPRO). All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests submitted to KEPRO.

All requests for services must be submitted prior to services being rendered. There will be no retroactive authorization. This means that if the provider is untimely submitting the request, KEPRO will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied, and appeal rights provided.

Change in the Submission of Service Authorization Requests to KEPRO

KEPRO will accept requests through direct data entry (DDE), by fax, telephone or US mail. The preferred method is by DDE through KEPRO's provider portal, Atrezzo Connect. To access Atrezzo Connect on KEPRO's website, go to <http://dmas.kepro.com>. For direct data entry requests, providers must use Atrezzo Connect Provider Portal.

How to Register for Atrezzo Connect

The registration process for providers occurs immediately on-line. From <http://dmas.kepro.com>, providers not already registered with Atrezzo Connect may click on "First Time Registration" to be prompted through the registration process. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount.

The Atrezzo Connect User Guide is available at <http://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.

Faxing Requests to KEPRO

Providers must use the specific fax form required by KEPRO when requesting services. If the fax form is not accompanied by the request, KEPRO will reject the request back to the provider and the provider must resubmit the entire request with the fax form. The DMAS 363 (*Outpatient Services Authorization Request Form*) is the appropriate fax form to use. Providers may fax requests to 1-877-652-9329. Forms are available on KEPRO's website at: <http://dmas.kepro.com>. Providers may click on the "Forms" tab to view a listing of all KEPRO fax forms, labeled by form number and service type.

Processing Requests at KEPRO:

KEPRO will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached KEPRO notifies the member and the provider in writing of the status of the request through the Medicaid Management Information System (MMIS) letter generation process.

If there is insufficient medical necessity information to make a final determination, KEPRO will pend the request back to the provider requesting additional information. If the information is not received within the time frame requested by KEPRO, the request will automatically be sent to a KEPRO physician for a final determination with all information that has been submitted. In the absence of clinical information, the request will be submitted to the KEPRO supervisor for review and final determination. Providers and members are issued appeal rights through the MMIS letter generation process for any adverse determination. Instructions on how to file an appeal is included in the MMIS generated letter.

If services cannot be approved for members under the age of 21 using the current criteria, KEPRO will then review the request by applying EPSDT criteria.

Review Criteria to be Used:

DMAS criteria for medical necessity will be considered if a service is covered under the State Plan and is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve functional disability. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the medical standard of practice. DMAS criteria may include CMS' Nationally Recognized Criteria (NRC). Therefore, all approvals must meet these agency criteria. All other criteria, including McKesson InterQual® or other McKesson review products, EPSDT, and physician review criteria are used for guidelines and reference purposes only.

McKesson InterQual®: KEPRO will apply McKesson InterQual® or other McKesson product criteria to certain services and DMAS criteria where McKesson InterQual® products do not exist.

The VaMMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination.

DMAS will not reimburse providers for dates of service prior to the date identified

on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individual's file, and are subject to review during Quality Management Review (QMR).

Direct all telephone inquiries regarding Service Authorization to the DMAS Provider Helpline at: 1-888-829-5373.

KEPRO does not review requests when members have Medicare Part B. If Medicare denies the requested stay, the provider may submit a request in writing for Srv Auth as a retrospective review. This must be submitted to KEPRO within 30 days of the notice of denial by Medicare. The justification for requesting retrospective review must be stated on the request.

Detailed documentation to address medical necessity, including discharge planning, must be submitted with each plan of care. KEPRO will review this information and determine if the request meets DMAS criteria for the initiation and continuation of care. Please refer to Chapter VI of this manual for documentation requirements.

How to Determine if Services Require Service Authorization

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/pr-fee_files.htm. You will now see a page entitled DMAS Procedure Fee Files. The information provided there will help to determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

To determine if a service needs Service Authorization, next 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.

Intensive Rehabilitation Services

Service Authorization for Intensive Rehabilitation Services

All requests for Service Authorization, as well as any information submitted in response to pend letters, must be directed to the DMAS Srv Auth contractor. The rehabilitation providers have the option of submitting Service Authorization requests either telephonically, on paper, by fax, or other means described by the Srv Auth contractor on their website, www.dmas.kepro.com. There may be circumstances where the provider will be required to submit written documentation in order to obtain Service Authorization. All requests for Service Authorization must be received through KEPRO within 72 hours of admission. Requests received after 72 hours will be denied up to the date the request is received. If the member continues to meet medical necessity criteria and is still in the facility, the request may be approved starting the day the request is received at KEPRO.

DMAS will conduct post payment review audits for intensive rehabilitation providers and will strongly enforce the 72-hour notification policy. Failure to comply may result in the retraction of payment. Srv Auth must be obtained whether Medicaid is the primary payer, except for Medicare-crossover claims. KEPRO will not accept reviews for members who have Medicare Part A. If Medicare denies the requested stay and/or if the Medicare benefits are exhausted, the provider may submit a Srv Auth request for retrospective review within 30 days of the notice of denial or exhaustion by Medicare. Retrospective reviews 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.

Within 72 hours of the Intensive Rehab admission, the provider must submit a request for Srv Auth to KEPRO. The review analyst will assign an initial length of

stay. The provider must contact KEPRO prior to the Srv Auth end date if services are to extend beyond the initial authorization period.

CORF providers must submit service authorization requests under Srv Auth service type 0204 (Outpatient Rehab) using the appropriate NPI number.

If the provider fails to submit information for the continued stay and the authorization period expires, retroactive authorization will not be granted. Authorization will begin with the date the continued stay request is received at KEPRO.

KEPRO will apply *McKesson InterQual® Criteria, Rehabilitation, Adult & Pediatric* for determining medical necessity.

In addition, DMAS requires the following for Intensive Rehab Services:

- The member meets *McKesson InterQual® Criteria, Rehabilitation, Adult & Pediatric* criteria upon admission and continued stay. These criteria may be obtained through:

McKesson Health Solutions LLC
275 Grove Street

Suite 1-110

Newton, MA 02466-2273

Telephone: 800-274-8374

Fax: 617-273-3777

Website: www.mckesson.com or www.InterQual.com

Outpatient Rehabilitation Services

Service Authorization for Outpatient Rehabilitation Services

Providers enrolled as “general hospital, in state” shall use the DMAS designated revenue codes when requesting service authorization.

All providers including outpatient rehabilitation agencies, comprehensive outpatient rehabilitation facilities (CORF), physicians and professionals shall use the DMAS designated CPT codes listed below.

Reference the chart below to determine the appropriate code to be used when requesting Srv Auth through KEPRO. The chart indicates the specific unit/visit equivalency.

In-state general hospital and in-state rehabilitation hospital providers (Provider Types 001,014) use DMAS approved revenue codes:	
0424	Physical Therapy, Evaluation
0421	Physical Therapy, Individual
0423	Physical Therapy, Group
0434	Occupational Therapy, Evaluation
0431	Occupational Therapy, Individual
0433	Occupational Therapy, Group
0444	Speech Language Services, Evaluation
0441	Speech Language Services, Individual
0443	Speech Language Services, Group
	1 unit = 1 visit for these revenue codes

In-state private rehabilitation agencies, CORFs, and physician providers (Provider Types 057,019,020, respectively) use DMAS approved CPT codes:	
97110	Therapeutic procedure, Physical Therapy, each 15 minutes. 1 unit = 15 minutes.
97150	Therapeutic procedure, Physical Therapy, Group. 1 unit = a group session
97161*	Physical Therapy evaluation: low complexity 1 unit = an evaluation
97162*	Physical Therapy evaluation: moderate complexity 1 unit = an evaluation
97163	Physical Therapy evaluation: high complexity 1 unit = an evaluation.
97530	Therapeutic procedure, Occupational Therapy, each 15 Minutes. 1 unit = 15 minutes.
S9129	Therapeutic procedure, Occupational Therapy, Group. 1 unit = a group session.
97165*	Occupational Therapy evaluation: low complexity 1 unit = an evaluation

97166*	Occupational Therapy evaluation: moderate complexity 1 unit = an evaluation
97167	Occupational Therapy evaluation: high complexity 1 unit = an evaluation.
92507	Treatment of speech, language, voice, communication, and / or auditory processing disorder; Individual. 1 unit = one treatment session
92508	Treatment of speech, language, voice, communication, and / or auditory processing disorder; Group, 2 or more individuals. 1 unit = one treatment session.

*For CPT Codes 97110 (PT) and 97530 (OT), when requesting a Service Authorization (Srv Auth) for these 2 codes, the units of time being requested should be based on the 15- minute interval and not based on a visit.

*Coverage for these codes is effective for dates of service on or after December 1, 2018.

Example: PT therapist has determined that a recipient needs to have an hour a day, three times a week for a total of four weeks of physical therapy. The Srv Auth request for PT would be for a total of 48 units (4 units per day times, 3 times a week, times 4 weeks = 48 units).

For non-hospital providers: Four (4) specific codes are utilized for speech therapy evaluation as follows:

92521	Evaluation of speech fluency (e.g. stuttering, cluttering)
92522	Evaluation of speech sound production (e.g. Articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (e.g. Articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g. Receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance

Note: 1 unit = 1 evaluation

When submitting srv auth requests, providers must select the most appropriate speech therapy evaluation code based on the physician’s order and diagnosis. Providers may only use one code per member per date of service (DOS) for each srv auth request. When medically necessary, providers may submit the same or another speech therapy evaluation code using different dates of service (no duplicate dates or overlapping dates with previous srv auth request).

Example #1: Provider receives physician’s order for speech therapy evaluation. Initial srv auth request submitted for 92521, 1 unit, for DOS 7/12/17. Evaluation not completed due to member’s medical condition. Second request submitted (to complete evaluation) for 92521, 1 unit, for DOS 7/14/17.

Example #2: Initial srv auth request submitted for 92523, 1 unit, for DOS 7/12/17. Evaluation completed. New physician’s order written as result of initial evaluation findings. Second request submitted for augmentative communication eval using 92522, 1 unit, for DOS 7/23/17.

For non-hospital (outpatient rehab) providers: Effective for dates of service on or after December 1, 2018, DMAS will provide coverage for all levels of PT and OT evaluation. The CPT codes are:

97161	Physical Therapy evaluation: low complexity 1 unit = an evaluation
97162	Physical Therapy evaluation: moderate complexity 1 unit = an evaluation
97163	Physical therapy evaluation: high complexity

97165	Occupational Therapy evaluation: low complexity 1 unit = an evaluation
97166	Occupational Therapy evaluation: moderate complexity 1 unit = an evaluation
97167	Occupational therapy evaluation: high complexity

Providers may only use one code per member per date of service (DOS) for each srv auth request. These codes are used for initial evaluations and for re-evaluations

when another evaluation is medically necessary and/or a member has had a significant change in their medical condition. The evaluation codes are specific to Medicaid members for billing purposes.

Note: If a member has received an evaluation prior to 12/1/2018, providers should utilize CPT code 97163 or 97167 for the dates of service being requested.

Service Limitations

Physical therapy, occupational therapy, and speech-language pathology services shall be limited to five (5) visits per rehabilitative discipline annually without service authorization. Initial therapy evaluations are included in the 5 visits. (For definition of visits please reference chart above). Visits include those services provided by outpatient settings of acute and rehabilitation hospitals, nursing facilities, rehabilitation agencies, and home health agencies. Limits are specific per discipline and member, regardless of the number of providers rendering services. "Annually" is defined as July 1 through June 30. The provider must maintain documentation to justify the need for services. Srv Auth is required before payment will be made for any visits over annually.

Evaluations must be related to the admission or readmission to service or to a significant change in the condition of the member. For continued authorization beyond the initial period, providers must submit a request prior to the Srv Auth end date. Reimbursement shall not be made for additional services without Srv Auth. Care rendered beyond the 5th visit allowed annually which has not been authorized shall not be approved for reimbursement.

Srv Auth must be obtained whether or not Medicaid is the primary payer, except for Medicare-crossover claims. Srv Auth is required when more than 5 visits are medically necessary. When a member has Medicare Part B coverage, Srv Auth is not required. If Medicare denies the claim and/or if Medicare benefits are exhausted, the provider may request authorization as a retrospective review. 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 health care provider must request a retrospective service authorization.

Providers may obtain information regarding service limit utilization by contacting any of the following:

DMAS Provider HelpLine 1-800-552-8627 (in-state long distance)

1-804-786-6273 (local and out-of-state customers)



MediCall System 1-800-772-9996

 1-800-884-9730

 1-804-965-9732 (Richmond area)

Automated Response System (ARS):
www.viriniamedicaid.dmas.virginia.gov

Service Authorization Processing

Srv Auth for outpatient rehabilitation services must be obtained through KEPRO. All Srv Auth requests, as well as any information submitted in response to pend letters, must be directed to KEPRO. If the provider fails to submit information prior to the completion of the 5th visit, retroactive authorization will not be granted. Authorization will begin with the date the request is received at KEPRO. Any service provided without Srv Auth in excess of the 5th visit limitation will not be reimbursed.

Initial Review for Outpatient Rehab

When Srv Auth is requested before or at the initiation of services, the provider may use the physician’s order. DMAS (or KEPRO) will make a decision to approve, pend, deny, or reject the request. If the request is approved, an authorization will be given for a specific number of units and dates of service. Visits provided up to and including the 5th visit, may be billed without Srv Auth if the member’s service limits have not been used. Providers may contact ARS or MediCall for information on the service limits already provided to a member.

Recertification Review for Outpatient Rehab

Prior to the last Srv Auth end date, or the next visit, the provider must submit a request for continued Srv Auth. This request will be reviewed to determine if DMAS criteria and documentation requirements are met. Documentation requirements are located in Chapter VI of this manual. A decision will be made to approve, pend, deny, or reject the request. Approvals will include a specific number of units and dates of service.

For Outpatient Rehab Services, DMAS requires the member meets *McKesson InterQual®*, *Outpatient Rehabilitation & Chiropractic* criteria upon initial and/or recertification review. These criteria may be obtained through:

McKesson Health Solutions LLC 275
Grove Street

Suite 1-110

Newton, MA 02466-2273

Telephone: 800-274-8374

Fax: 617-273-3777

Website: www.mckesson.com or www.InterQual.com

NOTE TO ALL OUTPATIENT REHAB PROVIDERS: On July 1st of each year, the 5 service limits/units per discipline for rehab agencies, CORFs, physicians, professionals and out of state providers and the 5 service limits/visits per discipline for general, in-state hospitals and out of state providers is renewed. If a provider knows that the member will need treatment beyond 5 visits, they must request Srv Auth through KEPRO.

Procedural Change for Service Authorization Requests for Outpatient Rehabilitation Services

As stated in the DMAS Memo dated June 3, 2015, providers are to submit a service authorization request to KEPRO for dates of service that cover the entire duration of the member's current plan of care, even if the dates of service span over the state's fiscal year (beginning July 1).

KEPRO's New Process:

- Providers who obtain a service authorization approval for outpatient rehabilitative services from KEPRO with dates of service spanning the state's fiscal year (July 1), may utilize this service authorization number for claims submission for all dates of service included in the authorization.
- The provider must utilize the member's initial five units in the state fiscal

year (beginning July 1 annually) that do not require service authorization.

- After the five units have been utilized, the provider continues to use the service authorization number given by KEPRO for all dates of service provided after the initial five units have been utilized through the last date of service approved on the service authorization.
- Providers are responsible to bill DMAS correctly for the first five units that do not require service authorization. Service authorization is required before payment will be made for any units over five annually. Providers may contact the Provider Helpline to determine if the first five units are available.

Out-of-State Provider Information for Intensive and Outpatient Rehabilitation

The following information is the current 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 including Inpatient Intensive Rehabilitation 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 located on the Medicaid Web Portal for more information.

Out-of-State general hospital providers and out of state rehabilitation hospital providers may request these revenue codes:

0420	Physical Therapy (P.T.) - General; 1 unit = 1 visit
0430	Occupational Therapy (O.T.) - General; 1 unit = 1 visit
0440	Speech Language Pathology - General; 1 unit = 1 visit

Intensive Rehabilitation Information for Out-of-State Provider Requests

Out-of-state providers, located close to the proximity of the VA State line and who are enrolled with Virginia Medicaid as a **provider class type 085 (Out of State Rehab Hospital)** need to determine and document evidence that one of the following items are met at the time the service authorization request is submitted to the service authorization contractor:

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.

Outpatient Rehabilitation Information for Out-of-State Provider Requests

Authorization requests for certain services including 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.

Early Periodic Screening Diagnosis and Treatment Service (EPSDT) Authorization

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, 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)).

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.