APPENDIX C

PROCEDURES FOR SERVICE AUTHORIZATION OF MENTAL HEALTH SERVICES

Table of Contents

INTRODUCTION – SERVICE AUTHORIZATION IN FEE-FOR-SERVICE (FFS) AND MANAGED CARE ORGANIZATIONS (MCO) 4
Purpose of Service Authorization 4
General Information Regarding Service Authorization 4
TRANSITION OF CARE BETWEEN MANAGED CARE PROGRAMS AND FEE-FOR- SERVICE (FFS) 5
Individuals Transitioning into MCOs 5
Individuals Transitioning from Managed Care back to Medicaid FFS 6
Review Process for Requests Submitted to the FFS Service Authorization Contractor 6
Communication 7
MCOS: SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION 7
FEE-FOR-SERVICE: SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION 7
Specific Information for Out-of-State providers 8
Out-of-State Provider Requests 8
Out-of-State Provider Questionnaire (Found on the Provider Portal or at https://dmas.kepro.com/content/forms) 9
Submitting Secure Electronic Requests for Services 9
Current Portal Users 9
New Portal Users 10
Remember Me Functionality 10
Already Registered with ANG but Need Help Submitting Requests 11
Additional Information for Ease of Electronic Submission 11
HOW TO DETERMINE IF SERVICES REQUIRE SERVICE AUTHORIZATION 12
SERVICE AUTHORIZATION FOR MENTAL HEALTH SERVICES 15

Introduction

Service authorization is the process to approve specific services for an individual enrolled in Medicaid, or FAMIS by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization and some require service registration.

The purpose of service authorization is to validate that:

- the service requested is medically necessary, appropriate for the individual and provided by a provider licensed for the service by DBHDS and credentialed by DMAS or its contractor; and
- the planned activities and interventions conform with the scope of services identified in the service definition, all applicable regulations and the individual's needs and treatment interventions identified in the current ISP.

Service authorization does not guarantee payment for the service. Payment is contingent upon passing all edits within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid enrollment with DMAS or its contractor and ongoing medical necessity and treatment planning 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.

To obtain service authorization, the provider shall demonstrate that the requested service is medically necessary and appropriate for the individual and that the planned activities and interventions conform with the scope of services identified in the service definition and the individual's needs and treatment goals identified throughout the individual's records, including the current treatment plan or ISP.

Initial service authorization requests shall:

- clearly document how the individual's behaviors, within the last 30 calendar days, demonstrate that each of the medical necessity criteria for the service have been met;
- clearly document how the individual's behaviors, within the last 30 calendar days, support the need for the amount of service units and the span of dates requested; and,
- demonstrate individualized preliminary treatment planning and initial conceptualization of goals.

Continued authorization requests must clearly document the above three bullets required for initial requests, demonstrate individualized and comprehensive treatment planning, documentation of the individual's current status and the individual's progress, or lack of progress toward goals and objectives in the ISP and documentation of discharge planning.

SERVICE AUTHORIZATION IN MEDICAID MANAGED CARE

Community Mental Health Rehabilitative Services (CMHRS), Enhanced Behavioral Health (EBH), and Mental Health Case Management Services are

included in the Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 managed care contracts. CCC Plus and Medallion 4.0 Medicaid Managed Care Organizations (MCOs) use DMAS' current program coverage criteria and program requirements to conduct service authorizations for members enrolled in managed care.

Treatment Foster Care Case Management, Psychiatric Residential Treatment Facility (PRTF) services and Therapeutic Group Home Services (formerly known as Level A and Level B) remain carved-out of CCC Plus and Medallion 4.0 at this time and continue to be service authorized by the behavioral health FFS contractor, currently Magellan of Virginia.

In order to be reimbursed for CMHRS, EBH and MHCM services provided to a CCC Plus or Medallion 4.0 MCO enrolled individual, providers must contract with and follow their respective MCO contract(s). The MCO may utilize different service authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For detailed information, please contact the MCO directly. Service authorization forms and processes are available on the DMAS website at https://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/. .Additional information is also available in the "Mental Health Services Doing Business with CCC Plus and Medallion 4.0 MCO's" document available on the DMAS website at https://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.

SERVICE AUTHORIZATION PROCESS FOR FFS

Service Registration

Registration is a key element to the success of a care coordination model. Registering a service with the FFS contractor as the service is being provided ensures that the care manager has a complete picture of all the services an individual is receiving. Registration also may assist with identifying gaps in services that may help an individual progress in their recovery.

Registration is a means of notifying the FFS contractor that an individual will be receiving behavioral health services, avoiding duplication of services and ensuring informed care coordination. Providers should refer to the Magellan of Virginia website for additional information and forms https://www.magellanofvirginia.com/for-providers/.

Registration may occur electronically, by phone or fax. Required elements to provide Magellan of Virginia include: (1) the individual's name and Medicaid/FAMIS identification number; (ii) the specific service to be provided, the relevant procedure code, begin date of the service, and the amount of the service that will be provided; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address. The provider should also have at least a provisional behavioral health related diagnosis for the individual being served.

Claims payments will be delayed if the registration is not completed.

Service Authorizations

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 service authorization requests.

When a service authorization is required, follow the FFS contractor service authorization process by completing the applicable authorization request methodology. Specifics regarding service authorization requests and submission timeframes can be located at www.MagellanofVirginia.com. Required forms are located on the Magellan of Virginia website at https://www.magellanofvirginia.com/for-providers/provider-tools/forms/.

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

The FFS contractor will make an authorization determination based upon the information provided and if approved will address the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services in the authorization determination;

Retrospective review will be performed when a provider is notified of an individual's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service authorization for covered days prior to billing DMAS for these services. Providers must request a service authorization for retrospective review as soon as they are aware of the individual's Medicaid eligibility determination.

Once authorization is obtained, if the individual is discharged from the service and there are dates of service and units that have not been used, the provider must contact the FFS contractor to notify them of discharge from service so that the remaining dates or units may be available at a later date, or by another provider.

The FFS contractor's MIS system has edits that do not allow the same service to be authorized for different providers for the same dates. In the case where a second provider makes a request for dates that overlap, with the first provider on file, the second provider should contact the previous provider to advise that the service authorization needs to be ended. Should the second provider not be successful in obtaining release of the initial service authorization, the FFS contractor will then make one attempt to contact the previous provider to obtain an end date. If there is no response by the prior provider, the service authorization and the second provider's request is processed.

Providers should request a cancellation of a service authorization when there has been no service utilization within the authorized date span. Canceling a service authorization means that it never should have existed and no claims will be or have been billed against the service authorization.

~~If an initial request is denied and the individual later meets criteria, a new request may be submitted for the current dates of service as long as that request is not a retro-request for service. The new request must explain how and why the individual now meets criteria.~~

~~Providers are responsible to keep track of utilization of services, regardless of the number of providers. The FFS contractor has provided various methods for the providers to research utilization.~~

~~Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.~~

INTRODUCTION – SERVICE AUTHORIZATION IN FEE-FOR-SERVICE (FFS) AND MANAGED CARE ORGANIZATIONS (MCO)

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

Purpose of Service Authorization

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claim's payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity.

General Information Regarding Service Authorization

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

DMAS criteria for medical necessity will be considered if a service is covered under the State Plan or applicable waiver and is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve functional disability. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the standard of practice. [42 CFR 441.302 (c) (1)]

DMAS, its FFS service authorization contractor, or the MCO will approve, pend, reject, or deny all service requests. Requests that are denied for not meeting the

medical necessity criteria are automatically sent to medical staff for a higher-level review. When a final disposition is reached the individual and the provider are notified in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice sent by DMAS or its FFS service authorization contractor or MCO will identify the individual's right to appeal the decision, in accordance with 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 370. The provider and individual have the right to appeal adverse decisions to the Department.

If services cannot be approved for members under the age of 21 using the current criteria, DMAS, the FFS service authorization contractor, or the MCO will then review the request by applying Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) criteria. Individuals under 21 years of age qualifying under EPSDT may receive the requested services if services are determined to be medically necessary and, if applicable, are prior authorized by the Department, the FFS service authorization contractor, or a Cardinal Care managed care organization. A request cannot be denied as not meeting medical necessity unless it has been submitted for secondary physician review. DMAS, the FFS service authorization contractor and the MCO must follow the DMAS process for a secondary physician review of all denied service authorization requests.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply to an EPSDT request if the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Any treatment service that is not covered under the State's Plan for Medical Assistance can be covered for individuals under the age of 21 as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or its contractor as medically necessary. Treatment services that are approved under EPSDT but are not available through the State Plan for Medical Assistance are referred to as EPSDT Specialized Services. Refer to the EPSDT Supplement for additional information. Providers should contact the MCO for information on requesting EPSDT specialized services for youth enrolled in managed care. Providers should refer to Appendix A of the EPSDT Supplement for information on requesting EPSDT specialized services for youth in FFS.

TRANSITION OF CARE BETWEEN MANAGED CARE PROGRAMS AND FEE-FOR- SERVICE (FFS)

Individuals Transitioning into MCOs

Providers should reference the Cardinal Care managed care contract to learn more about the requirements for individuals transitioning from FFS to managed care or from one MCO to another.

Individuals Transitioning from Managed Care back to Medicaid FFS

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

- If the provider is not an enrolled Medicaid provider, the request will be rejected.
- If the service has been authorized by an MCO for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once an individual is in FFS, the MCO approvals for Medicaid-covered services will be honored for the continuity of care period.
- If an individual transitions from an MCO to FFS, and the provider requests an authorization for a service not previously authorized under an MCO, this will be considered as a new request. The continuity of care will not be applied, and timeliness requirements for the service authorization will not be waived.

After the continuity of care/transition period end date, providers must submit a request to the FFS service authorization contractor that meets the timeliness requirements for the service. The new request will be subject to a full clinical review (as applicable). The waiver services have exceptions, please refer to the waiver manuals for specific information.

Review Process for Requests Submitted to the FFS Service Authorization Contractor

After the Continuity of Care Period:

A. For dates of service beyond the continuity of care period, timeliness will not be waived and the request will be reviewed for level of care necessity; all applicable criteria will be applied on the first day after the end of the continuity of care period; and

B. For Managed Care Waiver services, if the provider does not submit a new service authorization during the continuity of care period, the individual's hours will be capped based on the Level of Care score in the Plan of Care at the conclusion of the continuity of care period. Changes to the authorized hours will not be made until the provider submits a new service authorization request. The

FFS service authorization contractor will review whether service criteria continue to be met and make a determination on the hours going forward upon submission of the new service authorization request.

The best way to obtain the most current and accurate eligibility information is for providers to complete their monthly Medicaid eligibility checks at the beginning of the month. This will provide information for individuals who may be in transition to and from an MCO at the very end of the previous month.

Communication

Provider manuals are located on the DMAS Medicaid Web Portal and the FFS service authorization contractor's websites. The FFS service authorization contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to https://dmas.kepro.com. For educational material, click on the Training tab and scroll down to click on the General tab. The FSS service authorization contractor provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the service authorization process for the specific services outlined in this manual will be posted in the form of a Medicaid Bulletin to the DMAS MES Home Page. Changes identified in Medicaid Bulletins are incorporated within the manual.

The FAS and/or the FFS service authorization contractor generate letters to providers and enrolled individuals depending on the final determination. DMAS will not reimburse providers for dates of service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individual's medical record and are subject to review during post payment and Utilization Review .

MCOS: SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

In accordance with 42 CFR §438.210(b)(1), the Contractor's authorization process for initial and continuing authorizations of services must follow written policies and procedures and must include effective mechanisms to ensure consistent application of medical necessity review criteria for authorization decisions.

For more information, please refer to the Cardinal Care Managed Care contract. Please contact the individual's Medicaid MCO for information on submitting service authorization requests for individuals enrolled in managed care.

FEE-FOR-SERVICE: SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

Service authorization requests must be submitted electronically utilizing the FFS

service authorization contractor's provider portal Atrezzo Next Generation (ANG).

Providers must submit requests for new admissions within the required timeframes for the requested service. If a provider is late submitting the request, the FFS service authorization contractor will review the request and make a determination based on the date it was received. The days/units that are not submitted timely are denied, and appeal rights provided.

Retrospective review will be performed when a provider is notified of an individual's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain a service authorization prior to billing DMAS. Providers must request a service authorization for retrospective review as soon as they are aware of the individual's Medicaid eligibility determination.

**Note: Information submitted for service authorization must be documented in the medical record at the time of request. The request for service authorization must be appropriate to adequately meet the individual's needs. Any person who knowingly submits information containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Specific Information for Out-of-State providers

Out-of-state providers are held to the same service authorization processing rules as instate providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-state services to the FFS service authorization contractor. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to the FFS service authorization contractor, as timeliness of the request will be considered in the review process.

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.

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 they were required to travel to their 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 FFS service authorization contractor. If the provider is unable to establish one of the four, the contractor will pend or reject the request until the required information is provided.

Out-of-State Provider Questionnaire (Found on the Provider Portal or at https://dmas.kepro.com/content/forms)

A. Question #2-Are the medical services 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: "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 12VAC30-10-120 and 42 CFR 431.52.

Submitting Secure Electronic Requests for Services

The FFS service authorization contractor utilizes Atrezzo Next Generation (ANG) as the secure web portal for providers to submit service authorization requests. ANG is highly intuitive and user-friendly and includes enhanced security features requiring providers to log in with multi-factor authentication (MFA). The goal of MFA is to provide a multi- layered security defense system. Multi-factor authentication is a method that requires users to verify identity using multiple independent methods. MFA implements additional credentials such as a PIN sent via email or text, or a verification call made to a pre- registered phone number.

Current Portal Users

As a Provider who uses Atrezzo currently, providers will only need to complete MFA

registration for the ANG portal. The provider will utilize their existing username and password. The instructional prompts will guide you through completing Multi-Factor Authentication (MFA) Registration. From the login screen, click the link to complete the multi-factor authentication registration at your first login. This will be a one-time registration process. After entering the Atrezzo Provider Portal URL (https://portal.kepro.com/), the login page will display. To begin the registration process, enter your Atrezzo username and password and click Login, and follow the prompts.

New Portal Users

Providers who have not used Atrezzo or ANG are considered new portal users and need to register their service authorization provider account. The instructions will guide you through completing the Multi-Factor Authentication (MFA) Registration, which is a one-time process. The provider will have an Atrezzo Portal Administrator who will create your secure ANG account. Once logged in, the ANG system will send an email back to the provider with a link for Atrezzo Registration. Click the link to begin the MFA registration process. The registration link will expire within 2 days of receipt. If you have not completed the registration process within the 2 days, the provider's Atrezzo Portal Administrator will have to obtain a new link via email.

Providers can select the best multi-factor authentication method, either phone or email, and follow the instructions as ANG guides you through the MFA process.

1) When choosing an authentication method, you will be required to enter an email address for both options. Only choose the Email option if you do not have access to a direct phone line (landline or mobile).

2) A phone registration will require a direct line with 10-digits; extensions are not supported.

Remember Me Functionality

These instructions are to enable your computer to remember your login credentials for four (4) hours. You should NOT use this option if you use a shared device. When the Remember Me button is checked on the login screen, external users will be able to login without entering Atrezzo credentials or MFA for four (4) hours. To use this feature, check Remember Me box then click Login with Phone or Login with Email and follow the prompts.

For the next four (4) hours, when accessing Atrezzo, you will click Login with Phone or Login with Email and bypass the login credentials and MFA steps. After four (4) hours, you will need to login with your credentials and MFA when prompted. You must use the same login option (Login with Phone or Login with Email) for the Remember Me functionality to remember the credentials. If you select a different

login option, you will be required to enter MFA credentials. To turn off this feature, uncheck the Remember Me box, before clicking Login with Phone or Login with Email, and you will be prompted to enter login credentials and MFA at the next sign-on.

NOTE: This feature will only work if the browser is configured to "continue where you left off" by reopening tabs on startup. The Remember Me functionality will work as long as the browser remains open, but if the browser is closed, the Remember Me functionality will not work without following the below instructions to configure the system to continue where you left off when last logged in Chrome Configuration Google Chrome is the preferred browser for Atrezzo Next Generation Edge Configuration is included in the instructional materials on the FFS service authorization contractor's website (Atrezzo Help) (https://www.kepro.com/atrezzo-help).

Already Registered with ANG but Need Help Submitting Requests

It is imperative that providers currently registered use the portal for submitting all requests. For Health Department providers, this includes admissions, discharges, changes in units requested, responding to pend requests, and all other transactions.

Registered ANG providers do not need to register again. If a provider is successfully registered, but need assistance submitting requests through the portal, contact Acentra Health at 1-888-827-2884 or ANGissues@kepro.com.

Providers registered for ANG, who have forgotten their password, may contact the provider's administrator to reset the password or utilize the 'forgot password' link then respond to their security question to regain access. If additional assistance is needed by the provider's administrator contact Acentra Health at 1-888-827-2884 or ANGissues@kepro.com.

If the person with administrative rights is no longer with the organization, contact Acentra Health pat 1-888-827-2884 or ANGissues@kepro.com to have a new administrator set up.

When contacting Acentra Health please leave the requestor's full name, area code, telephone number and the best time to be contacted.

Additional Information for Ease of Electronic Submission

To make electronic submission easier for the providers, Acentra Health and DMAS have completed the following:

1) Rules Driven Authorization (RDA) – These are a set of clinical criterion questions that will automatically populate in a questionnaire when requesting certain services

or with specific diagnostic codes. The provider must respond to the questions found on the questionnaire on the ANG Portal. The responses given by the provider must reflect what is documented in the individuals medical record. If the responses match the criterion for the specific service or diagnosis, the case will bypass a reviewer and be approved, and automatically batch for transmission to FAS. If the responses do not match the specific criterion, the case will go to a reviewer's queue which will follow the normal review process. If criteria are not met, then the request will go to the physician's queue and a physician will review the case and make a final determination.

2) Attestations – All providers will attest electronically that information submitted to Acentra Health is within the individual's documented record. If upon audit, the required documents are not in the record, and the provider attested that they were present; retractions may be warranted as well as a referral to the Medicaid Fraud Control Unit within the Office of the Attorney General.

3) Questionnaires – Acentra Health and DMAS have configured questionnaires, so they are short, require less information, take less time to complete and are user- friendly.

HOW TO DETERMINE IF SERVICES REQUIRE SERVICE AUTHORIZATION

To determine if services need to be authorized, providers may go to the DMAS website: https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/procedure-fee-files- cpt-codes/. This page is titled Procedure Fee Files & CPT Codes. The information provided there will help you determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

The provider must determine whether to use the CSV or the TXT format. The CSV is a comma separated value and the TXT is a text format. Either version provides the same information.

The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. The Procedure Fee File will indicate when a code requires a service authorization as it will contain a numeric value 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 access the Procedure Rate

File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides special coverage and/or payment information. A Procedure Flag of "999"

indicates that a service is non-covered by DMAS.

Providers may also refer to the Provider Service Type Grid and Crosswalk available on the FFS service authorization contractor website at: https://dmas.kepro.com/reference- material.

~~When To Submit Requests To the FFS Contractor For Service Authorization (including registrations)~~

~~For New Individuals Starting Services~~

- ~~Mental Health Skill-building Services (H0046)~~
- ~~Therapeutic Day Treatment for Children and Adolescents (H2016)~~
- ~~Intensive In-Home Services (H2012)~~
- ~~Mental Health Intensive Outpatient (S9480)~~
- ~~Mental Health Partial Hospitalization Program (H0035)~~
- ~~Assertive Community Treatment (H0040)~~
- ~~Applied Behavior Analysis (various codes, see Appendix D)~~
- ~~Multisystemic Therapy (H2033)~~
- ~~Functional Family Therapy (H0036)~~
- ~~Treatment Foster Care Case Management (T1016)~~
- ~~Mobile Crisis Response (H2011)~~
- ~~Community Stabilization (S9482)~~
- ~~23-Hour Crisis Stabilization (S9485)~~
- ~~Residential Crisis Stabilization Unit (H2018)~~

~~Individuals who have not received services between January 1, 2009 and the present are considered new cases.~~

~~The provider must submit service authorization requests for services to the FFS contractor. The FFS contractor will make a determination within five (5) business days for Therapeutic Day Treatment (TDT) and within three (3) business days for other mental health services from the date of receipt, provided all required information is submitted with the initial request. The provider must contact the FFS contractor with the discharge date if treatment ends before the service authorization expires.~~

~~Retro Medicaid Eligibility~~

~~Retroactive requests for authorizations will not be approved with the exception of retroactive Medicaid eligibility for the individual. When retroactive eligibility is obtained, the request for authorization must be submitted no later than 30 days from the date that the individual's Medicaid was activated. If the request is submitted later than 30 days from the date of activation, the request will be authorized beginning on the date it was received.~~

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care programs, the FFS contractor will honor the Medicaid MCO service authorization based upon proof of authorization from the provider, DMAS, or the MCO if the individual has been disenrolled from the MCO. Similarly, the MCO will honor the FFS contractor's authorization based upon proof of authorization from the provider, DMAS, or the FFS contractor that services were authorized while the individual was eligible under fee-for-service (not MCO enrolled) for dates where the individual has subsequently become enrolled with a DMAS contracted MCO. Providers shall contact the FFS contractor and the MCOs for the specific continuity of care requirements.

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

Communication

Provider manuals are located on the DMAS website and Provider Handbooks are located on the Magellan of Virginia websites. Magellan of Virginia's website has information related to the service authorization processes for programs identified in this manual. Providers under contract with Magellan of Virginia should consult the Magellan National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider for additional information.

Magellan of Virginia 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 Mental Health Services manual and the Magellan of Virginia Handbooks.

Early and Periodic Screening, Diagnostic and Treatment Service Authorization Process (EPSDT)

The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq.) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of youth's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and

~~treatment more costly. Examination and treatment services are provided at no cost to the individual receiving services.~~

~~Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or its contractor as medically necessary. Therefore, services may be approved for persons under the age of 21 enrolled in Medicaid, FAMIS Plus and FAMIS Fee For Service (FFS) if the service/item is physician ordered will correct a medical condition, make it better, or prevent the child's health status from worsening.~~

~~All Medicaid, FAMIS (FFS) and FAMIS Plus services that are currently authorized by the service authorization contractor are services that can potentially be accessed by youth under the age of 21. However, in addition to the traditional review, youth 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, MagellanofVirginia.com~~

~~EPSDT is not a specific Medicaid program. EPSDT is distinguished only by the scope of treatment services available to youth who are under the age of 21. Because EPSDT criteria (service/item is physician ordered and is medically necessary to correct, ameliorate "make better" or maintain the individual's condition) must be applied to each service that is available to EPSDT eligible youth, EPSDT criteria must be applied to all service authorization reviews of Medicaid services.~~

~~**EPSDT Review Process:**~~

~~Individuals under 21 years of age qualifying under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary and are prior authorized by the Department. 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.~~

SERVICE AUTHORIZATION FOR MENTAL HEALTH SERVICES

Details on service authorization requirements for Mental Health Services is located within each service-specific Appendix of this manual.