APPENDIX C

PROCEDURES FOR SERVICE AUTHORIZATION OF PSYCHIATRIC SERVICES

Introduction

Service authorization is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require 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 claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity. Magellan of Virginia handles service authorization requests for fee for service behavioral health service providers. The Medicaid Managed Care Organizations (MCOs) handle the service authorizations for their enrolled members.

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 service authorization requests.

DMAS contractors will approve, pend, reject, or deny all completed service authorization requests. When a final disposition is reached the service authorization entity notifies the individual and the provider in writing of the status of the request.

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.

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 to the service authorization contractor no later than 30 days from the date notified of Medicaid eligibility; if the request is submitted later than 30 days from the date of notification, 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 MCOs, Magellan of Virginia will honor the Medicaid MCO service authorization if the individual has been disenrolled from the MCO. Similarly, the MCO will honor Magellan of Virginia's authorization based upon proof of authorization from the provider, DMAS or Magellan of Virginia 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.

Service authorization decisions by the MCOs and Magellan of Virginia are based upon medical necessity review and decisions apply to the individuals benefit for dates of service requested. DMAS contractors' decisions do not guarantee Medicaid eligibility or enrollment. It is the provider's responsibility to verify the individual's eligibility and to check for MCO enrollment versus fee-for-service 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 and Magellan of Virginia's websites. The DMAS website has information related to the service authorization processes for fee-for-service and MCO enrolled members.

DMAS contractors provide communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the service authorization process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual. Providers should consult with the member's MCO or Magellan of Virginia with any questions or issues about service authorizations.

Individuals Who Are Enrolled with DMAS Contracted Managed Care Organizations

Many Medicaid individuals are enrolled with one of DMAS' contracted Managed Care Organizations (MCO) including Medallion 3.0, Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 (effective 8/1/2018). In order to be reimbursed for inpatient acute psychiatric, outpatient psychiatric, and outpatient substance use treatment services provided to an MCO enrolled individual, providers must contract with and follow their respective contract with the MCO. 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. Additional information about the Medicaid MCO program can be found at:

- http://www.dmas.virginia.gov/#/med3 (Medallion 3.0)
- http://www.dmas.virginia.gov/#/cccplus (CCC Plus) and
- http://www.dmas.virginia.gov/#/med4 (Medallion 4.0)

Information regarding MCO coverage of Residential Services is available in the Residential Treatment Services Manual. Information regarding MCO coverage for Community Mental Health Rehabilitative Services (CMHRS) and Treatment Foster Care Case Management (TFC-CM) is located in the CMHRS Manual.

Service	In MCO Contract?	Comments
Inpatient psychiatric services including free-standing psychiatric services.	Yes	For MCO enrolled individuals, the provider must follow their respective contract with the MCO. Contact the MCO directly.
Outpatient psychiatric services including Mental Health Clinic Services	Yes	Same as above

Service Authorization Process for Psychiatric Services

Inpatient Acute Psychiatric Services (Acute Hospitals and Acute Freestanding Hospitals)

Inpatient Acute Psychiatric Services in both acute hospitals and freestanding hospitals require service authorization. To request service authorization for psychiatric services, contact Magellan of Virginia or the MCO. Planned/scheduled admissions must be service authorized within 24 hours of admission, or on the next business day after admission. Obtaining service authorization prior to admission is encouraged. Unplanned/urgent or emergency admissions must be service authorized within 24 hours of admission, or on the next business day after admission.

Prior to the expiration of the initial assigned length of stay, if the individual requires continued inpatient hospital care, the health care provider must contact Magellan of Virginia or the MCO, to initiate the concurrent review process. The provider must be able to provide the medical indications and plan of care for continued hospitalization. The review analyst will apply medical necessity criteria to the medical information provided and will assign an additional length of stay if criteria are met for continued inpatient hospitalization. Concurrent review will continue in the same manner until the

individual is discharged. Providers need to contact the MCOs or Magellan of Virginia for questions regarding medical necessity criteria.

Outpatient Psychiatric Services

Effective July 26, 2017, outpatient psychiatric services, including Mental Health Clinic Services, no longer require service authorization and sessions are no longer limited to 26 annually per member. This change applies to dates of service beginning July 26, 2017.

Providers are strongly encouraged to use the APA CPT code book for clarification of the codes and their usages. DMAS and its contractors do not advise providers about how to code or bill for the services they provide.

Program criteria for this service are described in detail in Chapter IV of this manual. Provider criteria are described in detail in Chapter II of this manual.

For individuals with co-occurring psychiatric and substance use disorder conditions, providers are expected to integrate the treatment. Psychiatric and substance use disorder services may be provided concurrently if medical necessity criteria are met for each service. Collaboration and coordination of care among all treating practitioners shall be documented.

For more information on substance use disorder services, refer to the *ARTS* Provider Manual.

Effective 8/1/2018, TFC-CM has been moved to the CMHRS Manual.

Timeliness of Submission by Providers, Effective November 1, 2012 and Forward

All requests for services must be submitted prior to services being rendered. This means that if a provider is untimely submitting the request, DMAS or its contractor 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.

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 DMAS or its contractor. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to DMAS or its contractor, as timeliness of the request will be considered in the review process.

Out-of-State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers of RTC-Level C services and freestanding psychiatric hospitals (Provider Type PCT003) for service type 0093. These specific 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 item 1 through 4 at the time of the request to the DMAS contractor. If the provider is unable to establish item number 3 or 4, the provider will need to follow up with the DMAS contractor to determine what will need to be provided for coverage of the member in this out of state setting.

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied based on 12VAC30-10-120 and 42 CFR 431.52.

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.