

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	
Chapter Subject	Page-Revision Date	
Service Authorization Information	—12/2/2015	

DRAFT

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	
Chapter Subject	Page-Revision Date	
Service Authorization Information	—12/2/2015	

**APPENDIX D
TABLE OF CONTENTS**

	<u>Page</u>
INTRODUCTION	1
Purpose of Service Authorization	1
General Information Regarding Service Authorization	1
Changes in Medication	1
Commonwealth Coordinated Care (CCC) – Excluded Waiver Services	2
Communication	2
SERVICE AUTHORIZATION OF TECH WAIVER SERVICES	4
SUBMITTING REQUEST FOR SERVICE AUTHORIZATION	4
Processing Requests at KEPRO	5
Out of State Provider Requests	7
Review Criteria to be Used	8
DISCHARGE/AGENCY TO AGENCY TRANSFER	8
HOW TO DETERMINE IF SERVICES NEED SERVICE AUTHORIZATION	8
Early Periodic Screening Diagnosis & Treatment Service Authorization	9
EXHIBITS	13

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	1
Chapter Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

Introduction

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 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

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 denied for not meeting medical necessity 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.

Retrospective review will be performed when a provider is notified of a patient'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 member's Medicaid eligibility determination.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care programs, the Srv Auth entity will honor the Medicaid MCO service authorization if the member has been disenrolled from the MCO. Similarly, the MCO will honor the Srv Auth contractor's authorization based upon proof of authorization from the provider,

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	2
Chapter Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

~~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 (CCC) – Excluded Waiver Services:

~~Commonwealth Coordinated Care is a program where members who have full Medicare and Medicaid benefits and meet all eligibility criteria are able to receive coordinated care through a managed care environment. The program objective is to coordinate delivery of primary, preventive, acute, behavioral, and long-term care services and supports.~~

~~CCC services do not cover the following waivers: Tech Waiver, DD Waiver, ID Waiver, Day Support, and Alzheimer Assisted Living Waivers. If a member becomes eligible for or receives a slot in one of these CCC excluded waivers, the member will be enrolled in the Waiver and may begin receiving Waiver services. CCC will continue to cover the regular medical services until the end of the month. The member will be automatically disenrolled from CCC the last day of that month. The member will receive all services through fee-for-service Medicaid or Medicare effective the first day of the next month. The DMAS service authorization contractor will process the service authorization request for the specific waivers/services listed for members dually enrolled in CCC. The request must include all the required documentation for a complete service authorization review. Providers will need to adhere to the timeliness requirements for new admission requests.~~

Communication

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

~~The Srv Auth entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.~~

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	3
Chapter Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

Updates or changes to the Srv Auth process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

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

SERVICE AUTHORIZATION OF TECH WAIVER SERVICES

Depending on the Srv Auth entity, processes may vary slightly for requesting Srv Auth. Please reference the chart at the end of this Appendix for detailed instructions (Exhibits Section).

Referrals to be screened for the TW are received at DMAS through the Aging Services Unit. Screening processes for enrollment and clinical criteria for the TW are described in detail in Chapter IV.

Upon meeting clinical criteria and Medicaid financial eligibility, DMAS' Health Care Coordinator (HCC) enrolls the individual in the waiver. Each individual on the waiver is assigned a DMAS HCC who works with the Discharge Planner/Screening Entities to secure a private duty nursing (PDN) agency. Once PDN is secured, the HCC coordinates the start of care and informs the provider of the number of hours needed per week for PDN. The HCC authorizes PDN based on the findings of the assessment and the age-appropriate scoring tool. Respite services for each individual may also be authorized when requested. Needs for additional services are determined upon home visits and phone contacts between the HCC and provider agency.

Once DMAS enrolls the individual in the TW and authorizes PDN, the Srv Auth contractor may begin receiving requests for respite services, environmental modifications, and assistive technology. Since most individuals enrolled in the TW have many needs related to DME, providers may contact the contractor for DME and medical supply needs which are covered under Medicaid's State Plan Option. PDN is the only stand-alone service in this waiver.

See chart at the end of this Appendix for services that require service authorization through KEPRO.

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	4
Chapter Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

~~SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION~~

~~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.~~

~~PROCEDURAL CHANGE SUBMITTING SERVICE AUTHORIZATION REQUESTS TO KEPRO~~

~~Effective September 1, 2015, service authorization requests must be submitted electronically utilizing KEPRO's provider portal Atrezzo Connect (also known as Atrezzo).~~

~~How to Register for Atrezzo~~

~~Provider registration is required to use Atrezzo Connect. The registration process for providers happens immediately on-line. To register, go to <http://dmas.kepro.com>, and click on "Register" to be prompted through the registration process. Newly registering providers will need their 10-digit Atypical Provider Identification (API) or National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. If you are a new provider who has not received a remittance advice from DMAS, please contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com to receive a registration code which will allow you to register for KEPRO's Atrezzo Connect Portal. Atrezzo Connect User Guide is available at <http://dmas.kepro.com>. Click on the *Training* tab, then the *General* tab.~~

~~Submitting through Atrezzo puts the request in the reviewer queue immediately. Service authorization checklists and/or questionnaires may be accessed on KEPRO's website to assist the provider in assuring specific information is included with each request. Providers may access this information by going to <http://dmas.kepro.com>.~~

~~Already Registered with Atrezzo but Need Help Submitting Requests~~

~~It is imperative that providers currently registered use the portal for submitting all requests. For waiver providers, this includes admissions, discharges, continuation of care, changes in hours, transfers, responding to pend requests, and all other transactions.~~

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	5
Chapter Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

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

~~If a provider has registered for Atrezzo, and forgot their password, please contact the provider's administrator to reset the password or utilize the 'forgot password' link and respond to the security question to regain access. If additional assistance is needed by the administrator, contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com.~~

~~If the person with administrative rights is no longer with the organization, contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com to have a new administrator set up.~~

~~When contacting KEPRO the caller should leave a full name, area code and phone number and the best time to be contacted.~~

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

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 MMIS letter generation process.~~

~~If there is insufficient information to make a final determination of medical necessity, KEPRO will pend the request back to the provider and request additional information. The response includes specific timeframes for the additional information to be sent to KEPRO. If the information is not received within the time frame requested by KEPRO, the information that was provided during the initial request will be automatically sent to a physician for review and a final determination will be made. 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.~~

~~Providers are given one opportunity to respond to a pended case. Providers must respond electronically utilizing KEPRO's provider portal Atrezzo Connect (also known as~~

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	6
Chapter Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

Atrezzo). If the provider chooses to submit information prior to the pended due date, the case will be reviewed after the pended information is received. After a case is reviewed and a decision has been rendered any additional information submitted after that timeframe will not be considered as part of the initial request.

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.

The providers may submit a request at any time once the service authorization has been completed by DMAS' Tech Waiver staff. However, providers must submit requests for new admissions to KEPRO within 10 business days of the start of care date in order for request to be timely and to avoid any gaps in service. If a provider is late 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.

For continuation of services, if the individual continues to need waiver services, the provider must submit a request justifying the need for the service to the service authorization contractor. If the request is not received prior to the end of the current authorized period, providers may have a denial for dates of service up to the date the request was received. There is no automatic renewal of service authorizations.

Service authorization questionnaires (each specific to certain services) may be accessed through KEPRO's electronic submission process to assist the provider in assuring specific information is included in the electronic request in order to make a final determination for a service. Information from the DMAS required form(s) and/or required documentation may be used to complete a checklist or questionnaire.

Required Forms

Providers must upload a completed CMS 485 and/or a verbal order which must be signed and dated by the physician for all initial/recertification requests.

The Srv Auth Contractor, KEPRO, will apply service specific criteria to the medical information provided and a service authorization number will be assigned to the request.

Specific Information for Out of State Providers

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

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	7
Chapter Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

~~will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.~~

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

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

~~Out of state providers may enroll with Virginia Medicaid by going to <https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment>. At the toolbar at the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box. It may take up to 10 business days to become a Virginia participating provider.~~

Out of State Provider Requests

~~Authorization requests for certain services can be submitted by out of state providers. Procedures and/or services may be performed out of state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period.~~

~~Services provided out of state for circumstances other than these specified reasons shall not be covered.~~

- ~~1. The medical services must be needed because of a medical emergency;~~
- ~~2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;~~
- ~~3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;~~
- ~~4. It is the general practice for recipients in a particular locality to use medical resources in another state.~~

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	8
Chapter Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

The provider needs to determine item 1 through 4 at the time of the request to the Contractor. If the provider is unable to establish item number 3 or 4 the Contractor will:

- Pend the request for 20 days
- Have the provider research and confirm items 3 or 4 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 action reason code 3110 (ARC). This decision is also supported by 12VAC30-10-120 and 42 CFR 431.52.

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 standard of practice.

DISCHARGE/AGENCY TO AGENCY TRANSFER

- If a member is discharged from TW private duty nursing, the DMAS HCC will enter the discharge for private duty nursing and respite care in VaMMIS and in LOC.
- If a member transfers Respite services from one agency to another, the provider will need to notify the Srv Auth contractor by submitting a copy of the DMAS 225 with the discharge date. The new provider will need to submit a transfer request for Respite services to the Srv Auth contractor along with the required forms.

HOW TO DETERMINE IF SERVICES NEED 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 you determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	9
Chapter Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

To determine if a service needs Service Authorization, you would then determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the TXT version.

The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be service 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.

For Durable Medical Equipment (DME) and Supplies, see the DME Provider Manual.

Early Periodic Screening Diagnosis and Treatment Service Authorization

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 children'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 member.

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 a DMAS contracted managed care organization 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 and is

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	10
Chapter Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

medically necessary to correct, ameliorate (make better) or maintain the individual's condition. (Title XIX Sec. 1905.[42 U.S.C. 1396d] (r)(5)).

All Medicaid and FAMIS Plus services that are currently service authorized by the Srv Auth contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, <http://dmas.kepro.com> and clicking 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.

EPSDT is not a specific Medicaid program. EPSDT is distinguished only by the scope of treatment services available to children 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 children, EPSDT criteria must be applied to all service authorization reviews of service authorized Medicaid services. Service requests that are part of a community based waiver are the sole exception to this policy. Waivers are exempt from EPSDT criteria because the federal approval for waivers is strictly defined by the state. The waiver program is defined outside the parameters of EPSDT according to regulations for each specific waiver. However, waiver members may access EPSDT treatment services when the treatment service is not available as part of the waiver for which they are currently enrolled.

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

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	11
Chapter Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

~~wheelchair does ameliorate his medical condition and allows him to be transported safely.~~

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

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

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

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

- ~~Hearing Aids and Related Devices~~
- ~~Assistive Technology specific services identified in chart below~~
- ~~Private Duty Nursing~~
- ~~Personal Care and Attendant Care Services~~

~~Requests for services **not service authorized by KEPRO** may be sent to:
 EPSDT Service Authorization Coordinator
 Fax: 804-452-5462 Phone: 804-786-6134~~

Manual-Title	Chapter	Page
Technology Assisted Waiver	App-D	12
Chapter-Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

SERVICES REVIEWED BY DMAS SERVICE AUTHORIZATION CONTRACTOR

HCPCS Code	Procedure Description	Authoring Agency	Notes
S5165	Environmental Modifications Structural Modification	Srv Auth Contractor	All EM codes combined cannot exceed \$5000 per calendar year
S5165	Environmental Modification Supply Cost Only	Srv Auth Contractor	All EM codes combined cannot exceed \$5000 per calendar year
S5165	Environmental Modification Transportation Modification	Srv Auth Contractor	All EM codes combined cannot exceed \$5000 per calendar year
99199 U4	Environmental Modifications Maintenance	Srv Auth Contractor	All EM codes combined cannot exceed \$5000 per calendar year
S5165	Environmental Modifications Rehab	Srv Auth Contractor	All EM codes combined cannot exceed \$5000 per calendar year
T1999	Assistive Technology Rehabilitation	Srv Auth Contractor	All AT codes combined cannot exceed \$5000 per calendar year
T1999	Assistive Technology Off the Shelf item	Srv Auth Contractor	All AT codes combined cannot exceed \$5000 per calendar year
T1999 U5	Assistive Technology Maintenance Cost	Srv Auth Contractor	All AT codes combined cannot exceed \$5000 per calendar year
S9125 TD	Respite Care: Agency Directed, RN Skilled Nursing	Srv Auth Contractor	Maximum 360 hours per calendar year
S9125 TE	Respite Care: Agency Directed, LPN Skilled Nursing	Srv Auth Contractor	Maximum 360 hours per calendar year

SERVICES REVIEWED BY DMAS HEALTH CARE COORDINATORS

HCPCS Code	Procedure Description	Authoring Agency	Notes
T1002	Skilled Nursing Services, RN	DMAS	As determined by DMAS HCC
T1003	Skilled Nursing Services, LPN	DMAS	As determined by DMAS HCC
T1019	Personal Care	DMAS	As determined by DMAS HCC
T1001 U1	Congregate Nursing—LPN (Congregate Nursing—LPN)	DMAS	As determined by DMAS HCC
T1000 U1	Congregate Nursing—RN	DMAS	As determined by DMAS HCC
T1031 TE	Congregate Respite—LPN	DMAS	As determined by DMAS HCC
T1030 TD	Congregate Respite—RN	DMAS	As determined by DMAS HCC

Manual Title	Chapter	Page
Technology Assisted Waiver	App. D	13
Chapter Subject	Page-Revision-Date	
Service Authorization Information	-12/2/2015	

EXHIBITS

TABLE OF CONTENTS	PAGE
SERVICE AUTHORIZATION WAIVER SERVICES.....	1-4

SERVICE AUTHORIZATION WAIVER SERVICES

Exhibit 1: This chart details the service authorization requirements for waiver services.

National Code	Description	Srv Auth Units Requested	Srv Auth Units Approved	Service limits	Units	Extensions	Comments
T1999	Assistive Technology Off-shelf item	1	Month	All AT codes combined cannot exceed \$5,000.00 in a calendar year. Is not a standalone service- must have Srv Auth for Skilled Private Duty Nursing in order to be Srv Auth by contractor. Never retro authorized.	Units=1	Maybe multiple items up to combined plan year limit. Items requested for same/overlapping dates must be entered on 1 Srv Auth line, 1 unit with the total cost.	Srv Auth by Contractor; Specialized medical equipment, devices, controls not available under the State Plan for Medical Assistance. Must provide quote and description with the least expensive cost effective manner plus 30% mark up. Effective January 1, 2013, the maximum service authorization duration is up to 30 days.
T1999 U5	Assistive Technology Maintenance Cost	1	Month	All AT codes combined cannot exceed \$5,000.00 in a calendar year. Is not a standalone service- must have Srv Auth for Skilled Private Duty Nursing in order to be Srv Auth by contractor. Never retro authorized.	Units=1	Maybe multiple items up to combined plan year limit. Items requested for same/overlapping dates must be entered on 1 Srv Auth line, 1 unit with the total cost.	Srv Auth by Contractor; Specialized medical equipment, devices, controls not available under the State Plan for Medical Assistance. Must provide quote and description with the least expensive cost effective manner plus 30% mark up. Effective January 1, 2013, the maximum service authorization duration is up to 30 days.
T1001 U1	Congregate Nursing-LPN	Day	Month	Can never exceed 16 hours in a 24 hour day. Never retro authorized	Hour	Requires the 485 which includes the physician signature for care	Srv Auth by DMAS In a congregate living arrangement the approved hours applies per household. CMS 485 Nursing plan of care (Q60days). Effective January 1, 2013, the maximum service authorization duration is up to 24 months.

T1000 U1	Congregate Nursing—RN	Day	Month	Can never exceed 16 hours in a 24 hour day. Never retro authorized	—Hour	Requires the 485 which includes the physician signature for care	Srv Auth by DMAS In a congregate living arrangement the approved hours applies per household. CMS 485 Nursing plan of care (Q60days). Effective January 1, 2013, the maximum service authorization duration is up to 24 months.
T1031 TE	Congregate Respite—LPN	Year	Year	360 hours per calendar year per household. Never retro authorized	—Hour	Requires the 485 which includes the physician signature for care	Srv Auth by DMAS In a congregate living arrangement this same limit applies per household. CMS 485 Nursing plan of care (Q60days).
T1030 TD	Congregate Respite—RN	Year	Year	360 hours per calendar year per household. Never retro authorized	—Hour	Requires the 485 which includes the physician signature for care	Srv Auth by DMAS In a congregate living arrangement this same limit applies per household. CMS 485 Nursing plan of care (Q60days).
S5165	EM Environmental Modifications—Structural, Modification	+	Month	All EM codes combined cannot exceed \$5,000.00 in a calendar year. Is not a standalone service—must have Srv Auth for Skilled Private Duty Nursing in order to be Srv Auth by contractor. Never retro authorized	Units=1	Maybe multiple modifications up to combined annual \$ limit.	Srv Auth by Contractor; Must be a physical adaptation to an individual's home and or place of residence. Cannot be to bring a substandard dwelling up to standard. Must provide quote and description at providers cost. Effective January 1, 2013, the maximum service authorization duration is up to 30 days.
99199 U4	Environmental Modifications—Maintenance	+	Month	All EM codes combined cannot exceed \$5,000.00 in a calendar year. Is not a standalone service—must have Srv Auth for Skilled Private Duty Nursing in order to be Srv Auth by contractor. Never retro authorized	Units=1	Maybe multiple modifications up to combined annual \$ limit.	Srv Auth by Contractor; May be used to maintain or repair an EM previously provided. Must provide quote and description at providers cost. Effective January 1, 2013, the maximum service authorization duration is up to 30 days.

T1019	Personal Care	Week	Month	ADULTS ONLY- MUST BE 21 YEARS OF AGE OR OLDER. Is not a stand-alone service. Cannot exceed level of care cap without Srv Auth. Maximum 8 hours per 24-hour period	Hour	Cannot exceed level of care cap without Srv Auth. Maximum 8 hours per 24-hour period Does not include supervision time.	Srv Auth by DMAS. May be authorized to assist PCG with ADL care and is not a skilled nursing service or replacement. Effective January 1, 2013, the maximum service authorization duration is up to 12 months.
S5160	PERS Installation	†	Month	Is not a standalone service must have Srv Auth for Skilled Private Duty Nursing	Units=1		Srv Auth by DMAS. Effective January 1, 2013, the maximum service authorization duration is up to 30 days.
S5161	PERS Monitoring	†	Month	Is not a standalone service must have Srv Auth for Skilled Private Duty Nursing	Units=1		Srv Auth by DMAS. Effective January 1, 2013, the maximum service authorization duration is up to 12 months.
H2021-TD	PERS-RN	†	Month	Is not a standalone service must have Srv Auth for Medication monitoring and Skilled Private Duty Nursing	Units=1		Srv Auth by DMAS. Effective January 1, 2013, the maximum service authorization duration is up to 12 months.
H2021-TE	PERS-LPN	†	Month	Is not a standalone service must have Srv Auth for Medication monitoring and Skilled Private Duty Nursing	Units=1		Srv Auth by DMAS. Effective January 1, 2013, the maximum service authorization duration is up to 12 months.
S5160-U1	Medication Monitoring Installation	†	Month	Is not a standalone service must have Srv Auth for Skilled Private Duty Nursing	Units=1		Srv Auth by DMAS. Effective January 1, 2013, the maximum service authorization duration is 30 days.
S5185	Medication Monitoring Monthly	†	Month	Is not a standalone service must have Srv Auth for Skilled Private Duty Nursing	Units=1		Srv Auth by DMAS. Effective January 1, 2013, the maximum service authorization duration is up to 12 months.
T1003	Private Duty Nursing-LPN (Skilled)	Day	Month	Can never exceed 16 hours in a 24-hour day. Never retro authorized	Hour	Requires the 485 which includes the physician signature for care	Srv Auth by DMAS CMS 485 Nursing plan of care (Q60days). May have multiple Srv Auth's for multiple providers BUT combined Srv Auth's cannot exceed

							total hours authorized per month. Effective January 1, 2013, the maximum service authorization duration is up to 24 months.
T1002	Private Duty Nursing—RN (Skilled)	Day	Month	Can never exceed 16 hours in a 24 hour day. Never retro authorized	Hour	Requires the 485 which includes the physician signature for care	Srv Auth by DMAS CMS 485 Nursing plan of care (Q60days). May have multiple Srv Auth's for multiple providers BUT combined Srv Auth's cannot exceed total hours authorized per month. Effective January 1, 2013, the maximum service authorization duration is up to 24 months.
S9125 TE	Respite Care Agency Respite Services Skilled LPN	-Year	Year	360 Hrs./Calendar Yr. Never retro authorized	Services allow for a total of 360 hours per calendar year all types of RCS combined	Requires the 485 which includes the physician signature for care	Srv Auth Contractor CMS 485 Nursing plan of care (Q60days). May have multiple Srv Auth for multiple providers BUT combined Srv Auth's cannot exceed 360 hours/calendar year service limits. Effective March 1, 2014, the maximum service authorization duration is up to 24 months
S9125 TD	Respite Care Agency Respite Services Skilled RN	-Year	Year	360 Hrs./Calendar Yr. Never retro authorized	Services allow for a total of 360 hours per calendar year all types of RCS combined	Requires the 485 which includes the physician signature for care	Srv Auth by Contractor CMS 485 Nursing plan of care (Q60days). May have multiple Srv Auth for multiple providers BUT combined Srv Auth's cannot exceed 360 hours/calendar year service limits. Effective March 1, 2014, the maximum service authorization duration is up to 24 months