# APPENDIX C

## PROCEDURES FOR SERVICE AUTHORIZATION OF PSYCHIATRIC SERVICES

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## 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)~~

## 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 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://vamedicaid.dmas.virginia.gov/sa. ~~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.~~ https://vamedicaid.dmas.virginia.gov/provider 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://vamedicaid.dmas.virginia.gov/sa/forms~~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 https://acentra.com/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 VAProviderIssues@acentra.com~~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 VAProviderIssues@acentra.com~~ANGissues@kepro.com~~.

If the person with administrative rights is no longer with the organization, contact Acentra at 1-888-827-2884 or VAProviderIssues@acentra.com~~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://vamedicaid.dmas.virginia.gov/sa/reference ~~https://dmas.kepro.com/reference-material~~.

~~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~~psychiatric services in both psychiatric units of general acute care hospitals and freestanding psychiatric hospitals require service authorization. To request service authorization for inpatient psychiatric services, contact ~~Magellan of Virginia~~the FFS service authorization contractor 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~~the FFS service authorization contractor 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~~should contact the ~~MCOs or~~ FFS service authorization contractor ~~Magellan of Virginia~~ or the MCO for questions regarding medical necessity criteria.

*Outpatient Psychiatric Services*

Providers should follow the guidance in the "How to Determine if Services Require Service Authorization" section of this Appendix to determine if an outpatient CPT code requires service authorization for FFS. For individuals enrolled in managed care, providers should contact the individual's MCO for information on service authorization requirements for 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;
1. 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.~~