APPENDIX C

PROCEDURES FOR SERVICE AUTHORIZATION OF RESIDENTIAL TREATMENT SERVICES

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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)]

~~Please see chapter 4 of each provider manual for specific coverage requirements that will need to be met during the service authorization process.~~

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 ~~and may receive services in excess of any service limit,~~ 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 physician review. DMAS, the FFS service authorization contractor and the MCO must ~~implement a~~ follow the DMAS process for physician review of all denied ~~cases~~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)

~~Continuity of Care Period~~

~~The continuity of care period is the first 30 calendar days of an individual's enrollment in a Managed Care Organization (MCO). For individuals receiving High Intensity Care Management services, the continuity of care period must be for the first 60 calendar days of an individual's enrollment. For pregnant individuals, the continuity of care period must be for the first 60 calendar days postpartum.~~

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 who meet the benefit plan criteria are enrolled into a managed care plan. The MCO honors the existing FFS service authorization contractor's authorization and will automatically authorize services for the Continuity of Care Period, or until the service authorization end date, whichever comes first. The continuity of care period applies to providers that are in and out of network with the MCO.~~

Individuals Transitioning ~~into~~ from ~~MCOs~~ Managed Care back to Medicaid ~~Fee-for-Service (~~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 the service is not covered by Medicaid, the request will be rejected.)~~
- 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~~to~~ 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.

~~Note: DMAS has published multiple Medicaid Bulletins and Provider Manuals that may be referred to for detailed MCO information as posted at this link: https://vamedicaid.dmas.virginia.gov/.~~

~~For additional information regarding MCO programs, click on the DMAS website located at this link: https://www.dmas.virginia.gov/for-providers/maternal-and-child-health/baby-care/.~~

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 ~~or~~ ~~XX~~ 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 ~~Quality Management~~ Utilization Review ~~(QMR)~~.

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 ~~30 days of completion of the case management open date to be timely~~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~~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. ~~The contractor will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.~~

~~If the FFS service authorization contractor 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 the FFS service authorization contractor does not receive the information to complete the processing of the request within the 12 business days, the FFS contractor will reject the request back to the provider, as the service authorization cannot be entered into Fiscal Agent System (FAS) without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request.~~

~~The MCO or FFS service authorization contractor will pend or reject the request until the enrollment process is complete. If the request is rejected, the provider must resubmit the entire request after they successfully complete the provider enrollment 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. ~~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.

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.

- ~~Pend the request utilizing established provider pend timeframes; and~~
- ~~Have the provider research and support one of the items above and submit back~~

~~to the Contractor their findings.~~

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 ~~(kepro.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 ~~Kepro~~ 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 ~~Kepro~~Acentra Health at 1-888-827-2884 or ANGissues@kepro.com.

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

When contacting ~~Kepro~~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, ~~Kepro~~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 ~~Kepro~~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 – ~~Kepro~~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

~~**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 require service registration.~~

~~**Service Registration**~~

~~Registration is a key element to the success of a care coordination model. Registering a service with Magellan of Virginia as the service is being provided ensures that the care coordinator 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.~~

~~When registration is required, the preferred method is to log into www.MagellanofVirginia.com https://portal.kepro.com/ and follow the protocol for registering the requested service. Please note that registration is necessary for claims to be paid.~~

~~Registration is a means of notifying Magellan of Virginia that an individual will be receiving behavioral health services, avoiding duplication of services and ensuring informed care coordination. Providers should register the start of any new service within two (2) business days of the service start date. Registration is required for Mental Health Case Management services effective December 1, 2013. Registration is required for Crisis Intervention and Crisis Stabilization Services effective April 1, 2014.~~

~~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 AUTHORIZATION~~S~~ – RESIDENTIAL TREATMENT SERVICES

~~The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS and Magellan of Virginia criteria for reimbursement. 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 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 authorizations for Psychiatric Residential Treatment Facilities (PR~~F~~TF) and Therapeutic Group Home (TGH) services are performed by ~~Magellan of Virginia~~the FFS service authorization contractor.

Service Authorization is required for the following services:

- Therapeutic Group Home Services: H2020 HW (CSA); H2020 HK (non-CSA)

- Psychiatric Residential Treatment Facility: Revenue Code 1001 (CSA); Revenue Code 1001 (non-CSA)
- EPSDT Therapeutic Group Home Services: H0019
- EPSDT Psychiatric Residential Treatment Facility: T2048 Revenue Code 0961
- EPSDT One-to-One Services: H2027

All initial requests for services must be submitted within one business day of admission. Continued stay requests and EPSDT one-to-one services must be submitted by the requested start date. Continued stay requests for residential treatment services may be submitted no sooner than twenty-one days before the requested start date.

If a provider is untimely submitting the request, the FFS service authorization 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.

~~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 Magellan of Virginia's service authorization process by completing the applicable authorization request methodology [i.e., Request Higher Level of Care, Service Request Application (SRA) Service Authorization request, or Treatment Request Form]. Specifics regarding service authorization requests can be located at www.MagellanofVirginia.com.~~

~~Magellan of Virginia 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 youth and the provider in writing of the status of the request.~~

~~Magellan of Virginia 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 a youth'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 youth's Medicaid eligibility determination.~~

~~Once authorization is obtained, if the youth is discharged from the service and there are dates of service and units that have not been used, the provider must contact Magellan of Virginia 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.~~

~~Magellan's of Virginia 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, Magellan of Virginia 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 the initial period you requested is denied and the youth 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 they now meet criteria.

Providers are responsible to keep track of utilization of services, regardless of the number of providers. Magellan of Virginia 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.

Retro Medicaid Eligibility

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

Changes in Medicaid Assignment

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

Youth Who Are Enrolled With DMAS Contracted **Medicaid** **Managed Care** Organizations (MCOs)

Many Medicaid youth are enrolled with one of DMAS' contracted MCOs. In order to be reimbursed for services provided to an MCO enrolled youth that are included in the MCO

~~contract, 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 youth. For detailed information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx. Additional information about the CCC Plus program can be found at: http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.~~

Youth ~~who are authorized by Magellan of Virginia~~admitted ~~in~~to a PRTF~~s and EPSDT PRTFs will be~~ are disenrolled from Medicaid managed care ~~the MCO~~while youth admitted to a TGH remain in Medicaid managed care. Residential Treatment Services are carved out of the managed care contract and service authorized by the FFS service authorization contractor. ~~as PRTF services are reimbursed for all Medicaid youth through the Medicaid fee-for-service program. TGH services and EPSDT TGH services are carved-out of the MCO contracts and are reimbursed directly through Medicaid fee-for-service. See the table below for additional information. TGH providers should contact the youth's MCO to arrange for services that are allowed to be reimbursed outside the TGH per diem and that are included in the managed care contract.~~Behavioral health and medical services other than TGH services that require service authorization are service authorized by the MCO for youth in TGH enrolled in managed care.

~~**Service**~~	~~**In MCO Contract?**~~	~~**Comments**~~
~~Therapeutic Group Home~~	~~No~~	~~For MCO enrolled youth, the provider must follow the DMAS coverage rules and guidelines.~~
~~EPSDT Therapeutic Group Home~~	~~No~~	~~For MCO enrolled youth, the provider must follow the DMAS coverage rules and guidelines~~
~~Psychiatric Residential Treatment Facility~~	~~No~~	~~MCO Exclusion-Disenrollment~~
~~EPSDT Psychiatric Residential Treatment Facility~~	~~No~~	~~MCO Exclusion-Disenrollment~~

~~**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 Residential Treatment Services manual, and the Magellan of Virginia Handbooks.~~

~~SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION/REGISTRATION~~

~~Medical Necessity Review Process Changes~~

~~Effective July 1, 2017, PRTF and TGH services began using different Medical Necessity Criteria and the IACCT review process.~~

~~Authorizations will be issued using a maximum duration of 30 calendar days per admission based on medical necessity requirements and to allow for complex care coordination in order to transition to an appropriate level of care.~~

~~The IACCT team will gather relevant information from which Magellan of Virginia will use to render a medical necessity determination. See the IACCT appendix to this manual for additional information.~~

~~The service review process used by Magellan of Virginia will assess the plan of care and treatment plan to determine if the services are adequate to treat the youth's needs in the PRTF or TGH setting. The Magellan of Virginia review will focus more intensively on the quality of care for the youth while in the residential service setting.~~

~~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.~~

Service Authorization requirements applicable to both TGHs and PRTFs:

1. Authorization shall be required and shall be conducted by ~~Magellan of Virginia~~the FFS service authorization contractor using medical necessity criteria specified in this manual.

2. Youth shall have a valid psychiatric diagnosis and meet the medical necessity criteria as defined in this manual to satisfy the criteria for admission. The diagnosis shall be current, as documented within the past 12 months. If a current diagnosis is not available, the youth will require a mental health evaluation by an LMHP, LMHP-R, LMHP-RP or LMHP-S employed or contracted with the independent certification team to establish a diagnosis, recommend and coordinate referral to the available treatment options.

3. At authorization, an initial length of stay shall be agreed upon by the youth and parent or legally authorized representative with the treating provider ~~and the treating provider~~ who shall be responsible for evaluating and documenting evidence of treatment progress, assessing the need for ongoing out-of-home placement and obtaining authorization for continued stay.

4. Information that is required to obtain authorization for these services shall include:
    a. A completed state-designated uniform assessment instrument approved by DMAS completed no more than 30 calendar days prior to the date of submission;
    b. A certificate of need completed by an independent certification team specifying all of the following:
        i. the ambulatory care and Medicaid or FAPT-funded services available in the community do not meet the specific treatment needs of the youth;
        ii. alternative community-based care was not successful;
        iii. proper treatment of the youth's psychiatric condition requires services in a 24-hour supervised setting under the direction of a physician; and
        iv. the services can reasonably be expected to improve the youth's condition or prevent further regression so that a more intensive level of care will not be needed;
    c. Diagnosis, as defined in the most current Diagnostic Statistical Manual (DSM), and based on an evaluation by an LMHP, LMHP-R, LMHP-RP or LMHP-S completed within 30 days of admission or if the diagnosis is confirmed, in writing, by an LMHP, LMHP-R, LMHP-RP or LMHP-S after reviewing a previous evaluation completed within one year of admission;
    d. A description of the youth's behavior during the seven days immediately prior to admission;
    e. A description of alternate placements and ~~CMHRS and traditional~~ behavioral health services pursued and attempted and the outcomes of each service;
    f. The youth's level of functioning and clinical stability;
    g. The level of family involvement and supports available; and
    h. The initial plan of care (IPOC).
5. For a continued stay authorization or a reauthorization to occur, the youth shall meet the medical necessity criteria as defined in this manual to satisfy the criteria for continuing care. The length of the authorized stay shall be determined by ~~DMAS or its~~ the FFS service authorization contractor. A current Comprehensive Individual Plan of Care (CIPOC) and a current (within 30 calendar days) summary of progress related to the goals and objectives of the CIPOC shall be submitted to DMAS or its contractor. The service provider shall also submit:

a. A state uniform assessment instrument if updated since the last service authorization request;

b. Documentation that the required services have been provided as defined in the CIPOC;

c. Current (within the last 14 calendar days) information on progress related to the achievement of all treatment and discharge-related goals; and

d. A description of the youth's continued impairment and treatment needs, problem behaviors, family engagement activities, community-based discharge planning and care coordination, and need for a residential level of care.

6. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services requirements applicable to TGH and PRTFs: ~~Service limits may be exceeded based on medical necessity for youth eligible for EPSDT.~~ EPSDT services may involve service modalities not available to other youth, such as applied behavioral analysis and neuro-rehabilitative services. Individualized services to address specific clinical needs identified in an EPSDT screening shall require authorization by the FFS service authorization ~~DMAS or its~~ contractor. ~~In unique EPSDT cases,~~ The FFS service authorization ~~DMAS or its~~ contractor may authorize specialized services beyond the standard TGH or PRTF medical necessity criteria and program requirements, as medically and clinically indicated to ensure the most appropriate treatment is available to each youth. Treating service providers authorized to deliver medically necessary EPSDT services in TGHs and PRTFs on behalf of a Medicaid-enrolled youth shall adhere to the individualized interventions and evidence based progress measurement criteria described in the CIPOC and approved for reimbursement by the FFS service authorization ~~DMAS or its~~ contractor. All documentation, independent certification team, family engagement activity, therapeutic pass, and discharge planning requirements shall apply to ~~cases~~ service authorizations approved as EPSDT PRTF or TGH.

7. Both initial and ~~concurrent~~ continued stay authorizations will be issued using a maximum duration of 30 calendar days based on medical necessity requirements and to allow for complex care coordination in order to transition to an appropriate level of care. Initial EPSDT ~~cases~~ TGH and PRTF service authorization requests will be authorized for a maximum duration of 60 calendar days based on medical necessity requirements. ~~Concurrent~~ EPSDT TGH and PRTF continued stay service authorization requests~~cases~~ will be authorized for a maximum duration of 90 days based on medical necessity requirements.

8. If a youth requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 7 days in a PRTF or 10 days in a TGH, for Medicaid purposes, the authorization will be end-dated and addressed as a discharge. Any subsequent admission to a PRTF or TGH is considered a new

admission. If a youth requires acute psychiatric admission, the authorization will be end-dated and addressed as a discharge, Any subsequent admission to a PRTF or TGH would also be considered a new admission.
Note: None of the days away from the PRTF or TGH for acute medical, acute psychiatric, runaway, or detention are billable under a DMAS authorization for PRTF or TGH.

~~**Timeliness of Submission by Providers**~~
~~All initial requests for services must be submitted within one business day of admission and continued stay requests must be submitted by the requested start date. This means that if a provider is untimely submitting the request, Magellan of Virginia 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 Magellan of Virginia. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to Magellan of Virginia, as timeliness of the request will be considered in the review process. Magellan of Virginia will redirect the request back to the provider to allow the provider to become successfully enrolled.~~

~~**Out of State Provider Requests**~~
~~Authorization requests for certain services can be submitted by out-of-state providers of PRTF, TGH and EPSDT services in those levels of care. 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. Additional information may be found in Chapter II of this manual.~~

EPSDT Specialized Service~~s~~ Authorization Process – Residential

Services not included in the residential per diem and that are not otherwise covered under the state plan can be considered for coverage under EPSDT specialized services. EPSDT 1:1 services as described in Chapter IV of this manual is an example of an EPSDT Specialized Service that has program requirements and medical necessity criteria. Providers can submit a request for EPSDT 1:1 service~~s~~ using the EPSDT Residential 1:1 Care request form located on the FFS service authorization contractor's provider portal.

Providers can submit requests for other EPSDT specialized services in Residential settings by using the following process:

- Complete the PRTF and TGH questionnaire in the FFS service authorization contractor's provider portal indicating that the request is an EPSDT request.

- Attach documentation to the request describing the EPSDT specialized service being requested and documentation supporting the medical necessity for the service.

~~The EPSDT service is Medicaid's comprehensive and preventive child health program for youth 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 youth 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 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, MagellanofVirginia.com~~

~~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 youth'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 Medicaid services.~~

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

~~Individuals under 21 years of age qualify 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 DMAS or its contractor. 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.~~