CHAPTER IV

COVERED SERVICES AND LIMITATIONS

CHAPTER IV
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CHAPTER IV
COVERED SERVICES AND LIMITATIONS

GENERAL INFORMATION

The Department of Medical Assistance Services covers the following vision care services for Medicaid members:

Services	Member Age Limit
Diagnostic examinations and optometric treatment procedures and services	All Ages
Eye exercises (Orthoptics)	Only under 21
Lenses	Only under 21
Frames	Only under 21
Repair of lenses or frames	Only under 21
Professional ophthalmic dispensing fees	Only under 21
Medically necessary contact lenses (must be preauthorized)	Only under 21
Eye Prostheses	All Ages

MEMBER COPAY POLICY

All members are liable for copayments for vision services except for those under age 21 and individuals receiving long-term care services or hospice care. A $1.00 copayment should be collected for eye examinations and for non-emergency vision analysis (refractions) given to all members identified by Special Indicator (SI) Code C (through verification). Medicaid payment to vision care providers will be reduced by the member copayment amount.

FREEDOM OF CHOICE OF PROVIDER

Virginia Medicaid members are free to choose any participating vision provider licensed

by the State Regulatory Agency to provide a particular vision service. Members may choose either the same provider for purchasing glasses or a different provider from the one who performed the vision analysis.

Service Authorization 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 pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the Srv Auth entity notifies the individual and the provider in writing of the status of the request.

Changes in Medicaid Assignment

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

Communication

DMAS has contracted the services of a medical review organization (KePRO) to provide service authorization of all vision requests requiring authorization prior to rendering services. Effective May 19, 2012, regardless of the dates of service, service authorization through KePRO will be required.

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 and clicking on the *Forms* tab for fax forms to request services. A service specific checklist may be found by clicking on "Service Authorization Checklists" on KePRO's website. For educational material, click on the *Training* tab and scroll down to click on the *General* 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.

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.

SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

Effective April 1, 2012 certain services previously reviewed by DMAS' Medical Support Unit (MSU) will be reviewed by Keystone Peer Review Organization (KePRO), DMAS' service authorization contractor. KePRO will begin accepting requests, regardless of the dates of service, on April 1, 2012.

KePRO will allow retroactive reviews for service requests submitted through June 30, 2012. Refer to the DMAS Medicaid Memo dated March 9, 2012 titled "Services Currently Reviewed by DMAS' Medical Support Unit Moving to KePRO for Review, *effective April 1, 2012* and New Procedures Codes Requiring Service Authorization, *effective April 1, 2012"*. **Effective July 1, 2012 KePRO will not authorize requests retroactively for these procedure codes, regardless of the dates of service.** The only instance KePRO will approve services retroactively on and after July 1, 2012 is when the provider demonstrates retroactive Medicaid eligibility determination for members.

KePRO will accept requests through direct data entry (DDE), fax, telephone or US Mail. The preferred method is by DDE through KePRO's provider portal, Atrezzo Connect. To access Atrezzo Connect on KePRO's website, go to http://dmas.kepro.com. For direct data entry requests, providers must use Atrezzo Connect Provider Portal.

Provider Registration is Required to use Atrezzo Connect
The registration process for providers happens immediately on-line. From http://dmas.kepro.com, providers not already registered with Atrezo Connect may click on "*First Time Registration*" to be prompted through the registration process. Newly

registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount.

The Atrezzo Connect User Guide is available at http://dmas.kepro.com : Click on the *Training* tab, then the *General* tab.

Providers with questions about KePRO's Atrezzo Connect Provider Portal may contact KePRO by email at atrezzoissues@kepro.com.

For service authorization questions, providers may contact KePRO at providerissues@kepro.com. KePRO can also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

Faxing Requests to KePRO
Providers must use the specific fax form required by KePRO when requesting services. If the fax form is not accompanied by the request, KePRO will reject the request back to the provider and the provider must resubmit the entire request with the fax form. KePRO's website has information related to the service authorization processes for all Medicaid programs they review. Fax forms, service authorization checklists, trainings, and much more are on KePRO's website. Providers may access this information by going to http://dmas.kepro.com.

Timeliness of Submission by Providers, Effective July 1, 2012 and Forward
All requests for services must be submitted prior to services being rendered. KePRO will allow a grace period through June 30, 2012 for providers to submit requests for services already rendered. This grace period only applies to the procedure codes attached to the DMAS Memo dated March 9, 2012 and titled "Services Currently Reviewed by DMAS' Medical Support Unit Moving to KePRO for Review, *effective April 1, 2012* and New Procedures Codes Requiring Service Authorization, *effective April 1, 2012"*. **Effective July 1, 2012 there will be no retroactive authorization.** This means that if the provider is untimely 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.

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 Medicaid Management Information System (MMIS) letter generation process. For organ transplants, an additional letter will be faxed to the provider.

Providers who have received an approved service authorization prior to April 1, 2012 from DMAS' Medical Support Unit will receive an additional letter generated by the MMIS. This letter is to ensure that all approved service authorizations are accessible to KePRO. These letters will be mailed between March 9, 2012 and April 1, 2012.

If there is insufficient medical necessity information to make a final determination, KePRO will pend the request back to the provider requesting additional information. If the information is not received within the time frame requested by KePRO, the request will automatically be sent to a physician for a final determination with all information that has been submitted. In the absence of clinical information, the request will be submitted to the

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.

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.

Specific Information for Service Type 0304 Medical Device, services/maintenance
Provider must submit requests to KePRO within 14 business days of the need and prior to rendering services. As of July 1, 2012 there will be no retroactive authorization. The only exception will be member retroactive eligibility determination. This means that if the 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. KePRO will review completed requests within 3 business days of receipt and make a final determination.

Specific Information for Out of State Providers
Out of state providers (non-participating, enrolled) are held to the same service authorization processing rules as in state (participating, enrolled) 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 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 starting July 1, 2012. KePRO will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled. Providers will not be penalized if DMAS does not process the enrollment request within 12 business days.

If KePRO receives confirmation of the provider's enrollment with Virginia Medicaid within 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 confirmation of the provider's enrollment within the 12 business days, KePRO will reject the request back to the provider, as the service authorization cannot be entered into MMIS without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request. Timeliness from the prior submission will not be considered with the re-submission.

Any provider not enrolled with Virginia Medicaid may do so 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.

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. DMAS criteria may include CMS' Nationally Recognized Criteria (NRC).

Therefore, all approvals must meet these agency criteria. All other criteria, including McKesson InterQual®, SIMplus®, or other McKesson review products, EPSDT, and physician review criteria are used for guidelines and reference purposes only.

McKesson InterQual®: KePRO will apply McKesson InterQual®, SIMplus® criteria or other McKesson product criteria to certain services and DMAS criteria where McKesson InterQual® products do not exist.

COVERED SERVICES AND LIMITATIONS

The following reflects Virginia Medicaid covered services and coverage limitations related to vision service.

Diagnostic Examinations and Other Optometric Treatment Procedures

- A **routine** comprehensive eye examination as defined under Comprehensive Ophthalmological services in the American Medical Association CPT Code Book, is allowed only once every 24 months. The National Standard Code for this service is found in Appendix B. For extenuating medically indicated circumstances where less than 24 months have elapsed since the last examination, explain the situation on an attachment to the CMS-1500 (12-90).
- For **non-routine** eye examinations and other optometric treatment procedures, which the provider is qualified by his or her license to perform, use CPT five-digit codes found in the AMA CPT code book. These books may be purchased from:

  Order Department: OP 054192
  American Medical Association
  Post Office Box 10950
  Chicago, IL 60610-0946

- **Eye Exercises** (orthoptics) are covered **only** for persons under 21 years of age under Virginia Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Reimbursement will be provided for medically indicated orthoptics based on an EPSDT referral to a Medicaid participating EPSDT provider: an ophthalmologist or an optometrist.
- All orthoptic sessions must be medically necessary. If more than six sessions are required, the seventh and subsequent sessions billed to Medicaid requires written documentation supporting the continuing need. This documentation must be attached to the CMS-1500 (12-90). The CMS-1500 (12-90) will be reviewed by DMAS medical consultants and be approved for payment as appropriate. The appropriate CPT/HCPCS code for orthoptics is 92065-orthoptic and/or pleoptics training, with continuing medical direction and evaluation.

Lenses (Under 21 Years of Age)

- Lens charges must reflect only the provider's laboratory costs; they may not exceed the average and reasonable wholesale costs.

- HCPCS procedure codes for lenses are found in Appendix B.
- Attach the supplier's invoice where possible.
  - For more expensive lenses, place a "22" modifier in Locator 24D of the CMS-1500 (12-90) and explain the medical justification on an attachment.
  - Each lens is considered a separate procedure and should be billed as "1" or "2" in Locator 24G of CMS-1500 (12-90).
- Ophthalmic lenses may be made of either: (1) plastic with scratch-resistant coating or (2) glass.
- Tinted lenses are covered only when they can be medically justified (e.g., photophobia, albinism).
- Photogray lenses and lenses for cosmetic purposes are not covered by the Program.
- Contact lenses are not covered by Virginia Medicaid except through service authorization by DMAS' Service Authorization contractor. Authorization will be based on medical necessity and that eyeglasses cannot accomplish the optometric treatment.

Eyeglass Frames

- Frame charges must reflect only the provider's actual laboratory cost; they may not exceed the average and reasonable wholesale cost.
  - The appropriate HCPCS procedure code for frames is found in Appendix B.
  - For special medically justified frames, place a "22" modifier in Locator 24D of the CMS-1500 (12-90) and explain the medical justification on attachment.
  - The entire eyeglass frame is billed as one procedure.
- Eyeglass frames should be durable ZYL frames (plastic), such as Opti-Colors. Wire frames are covered, however, Medicaid will not reimburse the provider any more for wire frames than the provider would receive for plastic frames. The provider cannot balance bill the member for any difference in cost.

Repair of Eyeglass Frames And/Or Replacement Of Broken Lenses

- The appropriate HCPCS procedure codes are are found in Appendix B.
- The repair of frames and lenses is normally limited to once every 12 months. If a repair is made in less than 12 months, place "22" modifier in Locator 24D of CMS-1500 (12-90) and explain the medical justification on an attachment.

Attach a medical justification statement and a detailed repair statement including the costs.

- The repair or replacement of non-covered services is not covered by the Program.

Professional Ophthalmic Dispensing Service

- Professional services, such as measuring, fitting, verifying, and adjusting the eyeglasses and providing an eyeglass case, are covered services. There are no corresponding national codes to bill for the lens or frames dispensing fees. The frames dispensing fee will be included in the frames purchasing fee. The lens dispensing fee will be added to the HCPCs code billed for the lens.

Note: Provider charges should include the lens dispensing fee. If a lens HCPCs code is priced for individual consideration (HCPCs codes V2100 to V2118, V2200 to V2220, V2300 to V2309 and V231), the provider should submit their actual invoice cost.

Ocular Prostheses

Eye prostheses are provided when eyeballs are missing regardless of the age of the member or the cause of the loss of the eyeball. Eye prostheses are provided regardless of the function of the eye. Service authorization is not required, but post-payment review is conducted.

VISION CARE PROVIDER'S ROLE IN THE PRESCRIPTION DRUG PROGRAM

Ophthalmologists and optometrists licensed by a state regulatory agency to prescribe drugs may prescribe legend drugs for Medicaid members.

The provider's normal procedure for prescribing drugs should be followed. However, the prescriber's Medicaid provider number must be included on all prescriptions for Medicaid members.

The prescribing of drugs should be in accordance with community standards of medical and pharmacological practices and consistent with economy. Physicians are expected to write generic prescriptions, specifying a brand name only when it is medically necessary. In acute illnesses, prescribed drugs should be limited to the quantity needed for the course of treatment for the illness. Maintenance drugs for chronic illnesses should be prescribed in quantities reflecting at least a 30-day supply or 100 units/doses, except when contraindicated by the patient's physical or psychological condition.

Coverage and Limitations

Prescription services are provided to Medicaid members as described below.

Legend drugs are covered except for the following:

- Anorexiant drugs prescribed to suppress appetite; however, service authorization may be requested if the medical indication is to treat attention deficit disorders or narcolepsy. If approved, reimbursement is allowed for the prescription only from one pharmacy selected by the patient and when prescribed by one designated provider. Utilization is monitored.

- DESI (Drug Efficacy Study Implementation) drugs considered by the Food and Drug Administration (FDA) to be less than effective. Compound prescriptions, which include a DESI drug are not covered. A current list of the DESI drugs is provided in Appendix C of this manual and will be updated by periodic replacement pages to this manual.

  EXCEPTION: Dipyridamole, under the brand name Persantine only, is covered when prescribed for the FDA-approved indication: as an adjunct to Coumarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac valve replacements. Physicians must indicate the diagnosis on the prescription. The pharmacist may submit a claim for reimbursement only when the approved diagnosis is documented, and the documentation must remain on file in the pharmacy.

  Dipyridamole products other than the brand name Persantine are classified as DESI drugs and are not covered by Medicaid.

- Investigational/experimental drugs and drugs which have been recalled.

- Food services and dietary or nutritional supplements that do not constitute a legend/schedule drug under Virginia law EXCEPT when preauthorized and EXCEPT as provided for in a hospital or nursing facility and included in the overall cost of inpatient care. Supplements will be preauthorized through home health only when the supplements are required as the sole source and are administered via mechanical device. Supplements may be authorized through EPSDT or the technology-assisted or AIDS waiver when the supplements are required as the primary nutritional source.

  NOTE: Retrovir is covered to treat patients with symptomatic HIV (Human Immunodeficiency Virus) infections (AIDS and advanced ARC, Aids-Related Complex). No special procedures are required for prescribing this drug.

Non-legend drugs (over-the-counter) are only covered as described below:

- Coverage is allowed for the following:

  - Family planning drugs and supplies
  - Insulin
  - Syringes and needles, **except** for members residing in nursing facilities
  - Diabetic test strips for members under 21 years of age

- Specific therapeutic categories, which are covered for nursing facility members

are:

- Analgesics
- Antacids
- Antidiarrheal
- Antivertigo preparations
- Cough and cold preparations
- Dermatologicals
- Hemorrhoid preparations
- Laxatives
- Ophthalmic preparations
- Vitamins, minerals, and hematinics

Copayment on Drugs

Members are required to pay the dispensing pharmacy $1.00 for generic drugs and $3.00 for brand name drugs for each original and refill legend drug prescription, insulin, syringes, and needles. This copayment does not apply to members under age 21, institutionalized patients, hospice patients, and pregnancy-related or family planning drugs and supplies.

Multiple Source Drugs - Payment Basis

Under the authority of 1902 (a) (30) (A) and the regulations in 42 CFR 447.332, the Centers for Medicare and Medicaid Services (CMS) establishes a specific upper limit for certain multiple source drugs if the following requirements are met:

- All of the formulations of the drug approved by the Food and Drug Administration (FDA) have been evaluated as therapeutically equivalent in the current edition of the publication Approved Drug Products With Therapeutic Equivalence Evaluations (including supplements or in successor publications).

- At least three suppliers list the drug, which has been classified by the FDA as category "A" in its publication Approved Drug Products With Therapeutic Equivalence Evaluations (including supplements or in successor publications) and in the current editions (or updates) of published compendia of cost information for drugs available for sale nationally (e.g., Red Book, Blue Book, Medi-Span).

The upper limit for multiple source drugs for which a specific limit has been established does not apply if a physician **certifies in his or her handwriting that a specific brand is "medically necessary"** for a particular member. The handwritten phrase "brand necessary" or "brand medically necessary" must appear on the face of the prescription. A dual line prescription form does not satisfy the certification requirement. A checkoff box on a form is not acceptable. The "brand necessary" documentation requirement applies to telephoned prescriptions. **This certification authorizes the pharmacist to fill the prescription with the requested brand name product and not to dispense the generic product listed in the Virginia Voluntary Formulary.**

In addition, the Department of Medical Assistance Services has established a Virginia Maximum Allowable Cost for some multiple source drugs listed in the Virginia Voluntary

Formulary, which are not designated as federal maximum allowable drugs. Again, unless the physician follows the procedures outlined above for specifying a brand necessary drug, the Virginia Maximum Allowable Cost per unit will be used to determine the allowable payment.

CLIENT MEDICAL MANAGEMENT

As described in Chapters III and VI of this manual, the State may designate certain members to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the Medicaid member's ID card. A Medicaid-enrolled physician who is not the designated primary provider may provide and be paid for services to these members only:

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the member.
- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians.
- For other services covered by DMAS which are excluded from Client Medical Management Program requirements.

Routine vision care services (routine diagnostic exams for members of all ages and eyeglasses for members under age 21) provided to restricted members are excluded from the requirement for a written referral. These are services billed using codes listed in Appendix B of the *Vision Care Manual*.

Medical treatment for diseases of the eye and its appendages requires a written referral or may be provided in a medical emergency. Ophthalmologists and other physicians skilled in the treatment of diseases of the eye and its appendages must coordinate medical treatment with the primary care physician. The primary care physician must complete a Practitioner Referral Form (DMAS-70) when making a referral to another physician or clinic. The referral physician must follow special billing instructions found in this manual to receive reimbursement for restricted members.

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

The Medicare Catastrophic Coverage Act of 1988 and other legislation require state Medicaid programs to expand the coverage of services to certain low-income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs).

QMB Coverage Only

Members in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit less the member's copayment on allowed charges for all Medicare-covered services. The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage

Members in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance on allowed charges for **all** Medicare-covered services **plus** coverage of **all** other Medicaid-covered services listed in Chapter I of this manual. This group's Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY – QMB EXTENDED." These members are responsible for copay for pharmacy services, health department clinic visits, and vision services.

All Others

Members without ANY of these messages at time of verification will be eligible for those covered services listed in Chapter I of this manual.

Early Periodic Screening Diagnosis and Treatment Service Authorization

EPSDT 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 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, DMAS.KePRO.com. Click 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 separate 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, if services are not covered under traditional Medicaid FFS or under a waiver program then EPSDT may be an alternative.

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 car seat for a child who is 7 who has a diagnosis of cerebral palsy. DME policy indicates that DMAS only purchases equipment for use in the member's home. This child's spasticity and contractures require the child to have a special car seat to be transported safely in the car. The contractor would not approve this request under DME medical necessity criteria because the equipment is for use outside the home. However, this may be reviewed under EPSDT because the car seat does ameliorate his medical condition and allows him to be transported safely.

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, including waivers, do not provide the relevant treatment service, then the service request will be sent by the service authorization contractor directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT program. All service requests must be a service that is listed in (Title XIX Sec. 1905*.[42 U.S.C. 1396d]* (r)(5)).

Requests may be sent to:
EPSDT Service Authorization Coordinator
Fax: 804-612-0043 Phone: 804-225-3231

How To Determine If Services Require 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 to determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

To determine if a service needs Service Authorization, next 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 prior 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.~~

~~EXHIBITS~~

~~Please use this link to search for DMAS Forms:~~
~~https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch~~

~~Page~~

~~PRACTITIONER REFERRAL FORM (DMAS-70)~~

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