Appendix D
Service Authorization

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INTRODUCTION

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 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

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 or its service authorization contractor will approve, pend, reject, or deny all service requests. Requests that are denied for not meeting the level of care 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 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.

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) PROGRAM

Individual's Transitioning into CCC Plus Program

Individuals who meet the benefit plan criteria are enrolled in the CCC Plus program. The CCC Plus MCO Health Plan honors the existing service authorization contractor's authorization and will automatically authorize services for a period of 30 days 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 from CCC Plus Program back to Medicaid Fee-for-Service (FFS)

Should an individual transition from CCC Plus back to Medicaid FFS, the provider must submit a request to the service authorization contractor and must indicate that the request is for a CCC Plus member who was disenrolled from an MCO into FFS. This will ensure honoring the (CCC Plus MCOs) approval of services for up to 60 days for the continuity of care period and waiving timeliness requirements. The service authorization contractor will honor the CCC Plus authorization up to the last approved date but no more than 60 calendar days from the date the CCC Plus disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the service authorization contractor will apply medical necessity/service criteria.

Review Process for Requests Submitted to the Service Authorization Contractor After the Continuity of Care Period:

A. The dates of service within the continuity of care period will be honored for the 60 day timeframe;
B. For dates of service beyond the continuity of care period, timeliness will 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
C. For CCC Plus Waiver services, level of care cap hours will be approved the day after the end of the continuity of care period up to the date of the request. The continuation of service units will be dependent upon service criteria being met and will either be authorized or reduced accordingly as of the date of the 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 CCC Plus at the very end of the previous month.

Should there be a scenario where DMAS has auto closed (ARC 1892) the service authorization contractor's service authorization but the individual's CCC Plus eligibility has been retro-voided, continuity of care days will not be approved by the CCC Plus health plan. The service authorization contractor will re-open the original service authorization for the same provider upon notification by the provider.

CCC Plus Exceptions

The following exceptions apply to continuity of care upon return to FFS Medicaid:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the service authorization contractor will honor the CCC Plus approved days/units under the continuity of care period for up to 60 calendar days. The remaining dates of services will be reviewed and must meet service criteria but timeliness will be waived as outlined above.)
- If the service has been authorized under CCC Plus for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once an individual is FFS, only Medicaid approved services will be honored for the continuity of care.
- If an individual transitions from CCC Plus to FFS, and the provider requests an authorization for a service not previously authorized under CCC Plus, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the service authorization contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

Note: DMAS has published multiple Medicaid Bulletins and Provider Manuals that may be referred to for detailed CCC Plus information as posted on the Medicaid Web Portal located at this link: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/.

For additional information regarding the CCC Plus program, click on the DMAS website located at this link: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

MEDICAID EXPANSION

On January 1, 2019, Medicaid expansion became effective. The new eligibility rules provide quality, low-cost health care coverage to eligible adults.

The Expansion Aid Categories:
100, 101, 102, 103, 106 and 108 (Incarcerated Adults Medical/Surgery inpatient services only)

The Medicaid Expansion Benefit Plan includes the following services:

- Doctor, hospital and emergency room services
- Prescription drugs
- Laboratory and x-ray
- Maternity and newborn care
- Behavioral health services including addiction and recovery treatment
- Rehabilitative and habilitative services including physical, occupational, and speech therapies and equipment
- Family planning
- Transportation to appointments
- Home Health
- DME and supplies
- Long Term Support Services (LTSS) to include Nursing Facility, PACE and Home and Community Based Service
- Preventive and wellness
- Chronic disease management
- Premium assistance for the purchase of employer-sponsored health insurance coverage, if cost effective
- Referrals for job training, education and job placement

Communication

Provider manuals are located on the DMAS Medicaid Web Portal and the service authorization contractor's websites. The 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 http://dmas.kepro.com. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Waiver* tab.

~~The 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 Medicaid Web Portal. Changes identified in Medicaid Bulletin are incorporated within the manual.~~

~~The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination. DMAS will not reimburse providers for dates of service prior to the date 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 Review (QMR).~~

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.

Psychiatric Residential Treatment Facility Services (PRTF) and Therapeutic Group Home Services (TGH) are covered for Medicaid members under age twenty-one (21) and are administered through the DMAS Service Authorization Contractor. Any member admitted to a PRTF will be temporarily excluded from Managed Care until they are discharged. Any member admitted to a TGH is not excluded from the Program; however, the TGH service is carved out of managed care and is administered through the DMAS Service Authorization Contractor.

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. 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. 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 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.

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 (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 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 ANGissues@kepro.com.

If the person with administrative rights is no longer with the organization, contact Acentra Health at 1-888-827-2884 or 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.

SERVICE AUTHORIZATION FOR CCC+ WAIVER SERVICES:

~~**CCC Plus Waiver Services**~~

A Screening for Long-Term Services and Supports (LTSS) is a requirement for all individuals requesting enrollment into the CCC Plus Waiver. For information regarding Screening for LTSS see the ~~*Screening for Medicaid Funded*~~ *Long-Term Services and Support*s *Screening* ~~provider~~ manual.

The individual will need to be determined eligible for CCC Plus Waiver services by the LTSS Screening Team and be Medicaid eligible to receive CCC Plus Waiver services.

The available services in the CCC Plus Waiver are: adult day health care, assistive technology, environmental modifications, personal care services, private duty nursing, personal emergency response system (PERS), respite care services, skilled respite care services, service facilitation and transition services.

Depending on the service authorization entity, processes may vary slightly for requesting services. Please reference the chart at the end of this appendix for detailed instructions (Exhibits Section).

Private Duty Nursing Services

CCC Plus waiver referrals for private duty nursing (PDN) are received at DMAS for individuals enrolled in FFS. The screening process for enrollment and clinical criteria for PDN service is described in Chapter IV of this manual.

Upon meeting clinical criteria and Medicaid financial eligibility, DMAS' Health Care Coordinator (HCC) enrolls the ~~FFS/Medallion~~ individual in the waiver. The DMAS HCC collaborates with the Discharge Planner/Screening entities to secure a PDN

agency. Once PDN is secured, the HCC coordinates the start of care and informs the provider of the number of hours needed per week for PDN. The HCC authorizes PDN for individuals 21 years of age or over based on the findings of the assessment of the PDN Adult Referral Form (DMAS 108). Skilled respite services for waiver individuals are for the unpaid primary caregiver and may be authorized when requested. The need for additional services for ~~FFS~~ individuals are determined during home visits and phone contacts between the HCC and provider agency.

Once DMAS enrolls the individual in the level of care ~~(LOC) A~~ and authorizes PDN as appropriate, ~~the~~DMAS's service authorization contractor may begin receiving requests for other CCC Plus waiver services. Since most individuals enrolled in PDN have many needs related to DME, providers may contact ~~the~~DMAS's service authorization contractor for DME and medical supply needs which are covered under Medicaid's State Plan Option.

NOTE: Refer to the chart at the end of this Appendix for services that require service authorization ~~through KEPRO~~.

~~Submitting Requests for Service Authorization~~

~~Fee-for-service authorization reviews will be performed by DMAS' service authorization contractor, Keystone Peer Review Organization (KEPRO). All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests submitted. Service authorization requests must be submitted electronically utilizing KEPRO's provider portal Atrezzo Connect (also known as Atrezzo).~~

~~Providers must submit requests for new admissions within ten business days of the start of care date in order for request to be timely and to avoid any gaps in service. If a provider is late submitting the request, the 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.~~

~~For continuation of services, if the individual continues to need waiver services, the provider must submit a request justifying the need for the continuance of service. If the request is not received prior to the end date of the current authorized period, providers may have a denial for dates of service up to the date the request was received.~~

~~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.

How to Register for Atrezzo

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

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

Already Registered with Atrezzo but Need Help Submitting Requests

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

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

If a provider has registered for Atrezzo, and forgot their password, please contact the provider's administrator to reset the password or utilize the 'forgot password' link and respond to the security question to regain access. If additional assistance

is needed by the administrator contact KEPRO at 1-888-827-2884 or www.atrezzoissues@kepro.com.

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

When contacting KEPRO please leave caller's full name, area code and phone number and the best time to be contacted.

Additional Information for Ease of Electronic Submission

In order to make electronic submission easier for the providers, KEPRO 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 Atrezzo 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 MMIS. 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 is within the individuals 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 – for waiver providers, KEPRO and DMAS have reconfigured the questionnaires so they are shorter, require less information, take less time to complete and are more user friendly

Processing Requests at KEPRO:

KEPRO will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached, KEPRO notifies the provider. The individual and provider will receive a letter from DMAS regarding the status of the authorization request through the MMIS letter generation process.

When there is insufficient information to make a final determination of medical necessity, KEPRO will pend the request back to the provider and request additional information. The response includes specific timeframes for the additional information to be sent to KEPRO. When the information is not received within the timeframe requested by KEPRO, the information that was provided during the initial request will be automatically sent to a physician for review and a final determination will be made. In the absence of clinical information, the request will be submitted to the KEPRO supervisor for review and final determination. Providers and individuals are issued appeal rights through the MMIS letter generation process for any adverse determination. Instructions on how to file an appeal is included in the MMIS generated letter.

Providers are given one opportunity to respond to a pended case. Providers must respond electronically utilizing KEPRO's provider portal Atrezzo Connect (also known as Atrezzo). If the provider chooses to submit information prior to the pended due date, the case will be reviewed after the pended information is received. Once a case is reviewed and a decision has been rendered any additional information submitted after that timeframe will not be considered as part of the initial request.

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. [42CFR441.302 (c) (1)] [12VAC30-60-300]

HOW TO DETERMINE IF SERVICES REQUIRE SERVICE AUTHORIZATION

In order to determine if services need to be authorized, providers may 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/Content_pgs/pr-ffs_new.aspx. You will see a page entitled DMAS Procedure Fee Files. The information provided there will help you determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

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 valueas 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.~~

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CCC PLUS WAIVER SERVICES

Procedure Code	Service Description	Required Service Authorization Documentation (Some services may require providers to complete a questionnaire. Visit the Service Authorization Contractor's website for more information.)	Service Authorization By:
S5126	Consumer Directed (CD) Personal Care	Provider must complete a personal care questionnaire in the Atrezzo Portal. Cannot exceed level of care cap without prior approval. Hours cannot exceed 56 hours per week unless exception criteria has been met. The maximum service authorization duration is up to 12 months.	DMAS Service Authorization Contractor
	Supervision Component of CD Personal Care	Providers must complete the personal care questionnaire, which includes criteria questions regarding supervision. Supervision is not retro authorized. DMAS-100 is required. A letter from the employer is needed to document work hours ~~if the request is for supervision hours seven (7) days a week~~. The provider will need to upload the information in the Atrezzo Portal.	DMAS Service Authorization Contractor
T1019	Agency Directed (AD) Personal Care	Provider must complete a personal care questionnaire in the Atrezzo Portal Cannot exceed level of care cap without prior approval. Hours cannot exceed 56 hours per week unless exception criteria has been met.	DMAS Service Authorization Contractor

		The maximum service authorization duration is up to 12 months.	
	Supervision Component of AD Personal Care	Providers must complete the personal care questionnaire, which includes criteria questions regarding supervision. Supervision is not retro authorized. DMAS-100 is required. A letter from the employer is needed to document work hours ~~if the request is for supervision hours 7 days a week~~. The provider will need to upload the information in the Atrezzo Portal.	DMAS Service Authorization Contractor
S5150	Respite Care (CD)	Provider must complete a T1005/S5150 questionnaire in the Atrezzo Portal May have multiple authorizations for multiple providers or types of respite services BUT combined utilization of hours cannot exceed 480 hours/ fiscal year July 1-June 30. The maximum service authorization duration is up to 24 months	DMAS Service Authorization Contractor
T1005	Respite Care (AD)	Provider must complete a T1005/S5150 questionnaire in the Atrezzo Portal Entered as **RESPI** in VAMMIS. May have multiple authorizations for multiple providers or types of respite services BUT combined utilization of hours cannot exceed 480 hours/ fiscal year July 1-June 30. The maximum service authorization duration is up to 24 months.	DMAS Service Authorization Contractor

S9125 TD (RN) S9125 TE (LPN)	Respite Care Agency Respite Services Skilled	Provider must complete a tech waiver respite care questionnaire in the Atrezzo Portal Entered as **RESPI** in VAMMIS. May have multiple authorizations for multiple providers or types of respite services BUT combined utilization of hours cannot exceed 480 hours/ fiscal year July 1-June 30. There must be a skilled nursing need (e.g. tube feedings, injections, etc.) The maximum service authorization duration is up to 24 months.	DMAS Service Authorization Contractor
H2021 TD	PERS Nursing - RN	Provider must complete a PERS questionnaire in the Atrezzo Portal Must be authorized for S5185 (PERS and Medication Monitoring). PERS cannot be a sole service. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. The maximum service authorization duration is up to 12 months.	DMAS Service Authorization Contractor
H2021 TE	PERS Nursing - LPN	Provider must complete a PERS questionnaire in the Atrezzo Portal Must be authorized for S5185 (PERS and Medication Monitoring).	DMAS Service Authorization Contractor

		PERS cannot be a sole service. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. The maximum service authorization duration is up to 12 months.	
S5160	PERS Installation	Provider must complete a PERS questionnaire in the Atrezzo Portal PERS cannot be a sole service. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. The maximum service authorization duration is up to 30 calendar days.	DMAS Service Authorization Contractor
S5160 U1	PERS and Medication Installation	Provider must complete a PERS questionnaire in the Atrezzo Portal PERS cannot be a sole service. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. The maximum service authorization duration is up to 30 calendar days.	DMAS Service Authorization Contractor
S5161	PERS Monitoring	Provider must complete a questionnaire in the Atrezzo Portal	DMAS Service Authorization

		PERS cannot be a sole service. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. The maximum service authorization duration is up to 12 months.	Contractor
S5185	PERS and Medication Monitoring	Provider must complete a PERS questionnaire in the Atrezzo Portal PERS cannot be a sole service. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. The maximum service authorization duration is up to 12 months.	DMAS Service Authorization Contractor
S5102	Adult Day Health Care	Provider must complete a PERS questionnaire in the Atrezzo Portal The maximum service authorization duration is up to 12 months.	DMAS Service Authorization Contractor
T2038	Transition Services	Transition services is available one-time per lifetime of an individual. Maximum lifetime available amount is $5000; Utilized within 9 months of request. The LOC must show that the individual was a resident of a Nursing Facility, a Long-Stay Hospital or IMD (1, 2, L, IMD or a combination thereof on the LOC) for 90 consecutive days prior to CCC Plus Waiver enrollment. Request for services must be	DMAS Service Authorization Contractor

		made within 30 calendar days of transition from the ~~higher~~ institutional level of care to ~~a lower~~waiver level of care.	
S5165 99199 U4	Environmental Modifications (EM) EM Maintenance	Environmental Modifications/Maintenance: Maximum limit is $5,000 per fiscal year per individual for all EM procedure codes combined.	DMAS Service Authorization Contractor
T1999 T1999 U5	Assistive Technology (AT) AT Maintenance	Assistive Technology/Maintenance: Maximum limit is $5,000 per fiscal year per individual for all AT procedure codes combined.	DMAS Service Authorization Contractor
T1002	Private Duty Nursing Service RN	Refer to the ~~Commonwealth Coordinated Care Plus~~CCC+ Waiver ~~Services Provider~~ Manual, Chapter IV for requirements.	DMAS HCC
T1003	Private Duty Nursing Service LPN	Refer to the ~~Commonwealth Coordinated Care Plus~~CCC+ Waiver ~~Services Provider~~ Manual, Chapter IV for requirements.	DMAS HCC

T1000 U1	Congregate Nursing RN	Refer to the ~~Commonwealth Coordinated Care Plus~~CCC+ Waiver ~~Services Provider~~ Manual, Chapter IV for requirements.	DMAS HCC
T1001 U1	Congregate Nursing LPN	Refer to the ~~Commonwealth Coordinated Care Plus~~CCC+ Waiver ~~Services Provider~~ Manual, Chapter IV for requirements.	DMAS HCC
T1030 TD	Congregate Nursing Respite RN	Refer to the ~~Commonwealth Coordinated Care Plus~~CCC+ Waiver ~~Services Provider~~ Manual, Chapter IV for requirements.	DMAS HCC
T1031 TE	Congregate Nursing Respite LPN	Refer to the Commonwealth Coordinated Care Plus Waiver Services Provider Manual, Chapter IV for requirements.	DMAS HCC