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APPENDIX D

SERVICE AUTHORIZATION INFORMATION

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ALZHEIMER'S ASSISTED LIVING WAIVER SERVICE AUTHORIZATION

INTRODUCTION:

Service authorization (Srv Auth) is the process to approve specific services for enrolled Medicaid, FAMIS Plus or FAMIS individuals 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 (SRV AUTH):

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement, but does not guarantee payment for the service. Payment is contingent upon passing edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, provider enrollment, 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 (SRV AUTH):

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.

The service authorization entity will approve, pend, reject, or deny all completed service authorization requests. Requests that are denied for not meeting medical necessity criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider are notified in writing of the status of the request.

Retrospective review will be performed when a provider is notified of an individual's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service authorization for covered days prior to billing DMAS for these services. Providers must request a service authorization for retrospective review as soon as they are aware of the individual's Medicaid eligibility determination.

CHANGES IN MEDICAID ASSIGNMENT:

Because the individual may transition between fee-for-service and the Medicaid Managed Care Organization (MCO) program or the Program of All-Inclusive Care for the Elderly, the Srv Auth entity will honor the Medicaid Managed Care Organization service authorization if the individual has been retroactively dis-enrolled from the MCO. Similarly, the DMAS contracted MCO will

honor the service authorization entity authorization based upon proof of authorization from the provider, DMAS, or the service authorization entity that services were authorized while the individual was eligible under fee-for-service (not MCO enrolled) for dates where the individual has subsequently become enrolled with an MCO.

Service authorization decisions by the DMAS service authorization contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested and does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify individual eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled individuals, the provider must follow the MCO's service authorization policy and billing guidelines.

COMMONWEALTH COORDINATED CARE PLUS – EXCLUDED SERVICES:

Commonwealth Coordinated Care Plus (CCC Plus), is a managed long term services and supports program. This program focuses on improving access, quality, and efficiency through a coordinated delivery system that emphasizes integrated care and value-based payment models

The Alzheimer's Assisted Living (AAL) Waiver is excluded from the CCC Plus program. If a member becomes eligible for and chooses the AAL waiver, the member will be enrolled in the AAL waiver and may begin receiving services. The member will be transitioned out of CCC Plus and back into Medicaid FFS as soon as the waiver is added to the level of care.

The DMAS contractor will process the service authorization request for renewal of Medicaid members enrolled in an AAL Waiver. DMAS will perform SA requests for any new admissions into the AAL Waiver.

DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, click on the link: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

COMMONWEALTH COORDINATED CARE:

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

The Alzheimer's Assisted Living (AAL) Waiver is excluded from the CCC Program. If a member becomes eligible for and chooses the AAL waiver the member will be enrolled in the AAL waiver and may begin receiving services.

The DMAS service authorization contractor will process the service authorization request for the specific waivers/services listed for members dually enrolled in CCC. The request must include all the required documentation for a complete service authorization review. Providers will need to adhere to the timeliness requirements for new admission requests.

CCC will continue to cover the regular medical services until the end of the month. The member will be automatically dis-enrolled from CCC the last day of that month. The member will receive all services through fee-for-service Medicaid or Medicare effective the first day of the next month.

For CCC information, click on the following link: http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx.

CHANGES TO COMMONWEALTH COORDINATED CARE, EFFECTIVE DECEMBER 31, 2017:

December 31, 2017 will be the last covered day for the CCC Program. Members that are currently in this program will be transitioned into the Commonwealth Coordinated Care Plus (CCC Plus) Program, the Managed Long Term Services and Supports program administered by the Department of Medical Assistance Services (DMAS). The same rule will apply for the AAL Waiver as was applied in the CCC Program; this waiver will be excluded from the CCC Plus Program. DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, click on the link: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

COMMUNICATION:

Provider manuals are located on the DMAS portal and KEPRO website. The contractor's website has information related to the service authorization processes for programs identified in this guide. You may access this information by going to http://dmas.kepro.com and clicking on the *Forms* tab for fax forms to request waiver services. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Waiver* tab.

The service authorization 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 hearing impaired.

Updates or changes to the service authorization process for the specific services outlined in this guide will be posted in the form of a Medicaid Memo to the DMAS web portal. Changes identified in Medicaid Memorandum will be incorporated within the manual.

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination.

DMAS will not reimburse providers for dates of service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individual's file, and are subject to review during post payment and Quality Management Review (QMR).

SERVICE AUTHORIZATION OF WAIVER SERVICES:

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

Service authorization is required by submission of all required documentation. This process will be completed by DMAS for new admissions and by the DMAS service authorization contractor for annual service authorization renewal.[12VAC30-130-90]

SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION:

Service Authorization reviews for renewal of services will be performed by DMAS' service authorization contractor, Keystone Peer Review Organization (KEPRO).

KEPRO accepts service authorization requests through direct data entry (DDE), fax, phone and 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 is immediate and on-line. From http://dmas.kepro.com, providers not already registered with Atrezzo Connect may click on the Atrezzo icon on the website to register. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount.

Providers who have never billed DMAS for services may contact KePRO by telephone to submit their request for services. Once the provider receives a YTD 1099 they will be able to register with Atrezzo Connect.

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 may also be reached by phone at 1-888-827-2884.

KEPRO's website has information related to the service authorization processes for all Medicaid programs they review. Fax forms, service authorization checklists, trainings, methods of submission and much more are on KEPRO's website. Providers may access this information by going to http://dmas.kepro.com.

PROCESSING REQUESTS:

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

If there is insufficient information to make a final determination, KEPRO will pend the request back to the provider and request 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. 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 must submit new or transfer requests to DMAS within ten business days of the start of care date or providers verification of Medicaid eligibility. For continuation of services, if the individual continues to need waiver services, the provider must submit a request justifying the need for the service to KEPRO. 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.

There are no automatic renewals of service authorizations. Providers must submit a service authorization request if an individual requires continued services or the current authorization will end without renewal. All authorizations should be submitted prior to the first date services are rendered or prior to the last day of the current authorization in order for submissions to be timely and to avoid gaps in service.

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 functioning related to a 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.

HOW TO DETERMINE IF SERVICES NEED SERVICE AUTHORIZATION:

In order to determine if services need to be service authorized, providers should go to the DMAS website: http://dmasva.dmas.virginia.gov and look to the right of the page and click on the section that says Procedure Fee Files which will then bring you to this: http://www.dmas.virginia.gov/pr-fee_files.htm From here 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.

To determine if a service needs Service Authorization, determine whether 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 needed. The Procedure Fee File will indicate 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 serv auth is required
- 01-Always needs a serv auth
- 02-Only needs serv auth if service limits are exceeded
- 03-Always need serv auth, 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 you special coverage and/or payment information. A Procedure Flag of "999" indicates that a service is non-covered by DMAS.

ALZHEIMER'S ASSISTED LIVING (AAL) WAIVER

AAL Waiver provides support in a community-based assisted living facility that specializes in the support and treatment of Alzheimer's or Alzheimer's-related dementia for individuals with a disability or older adults who meet the nursing facility level of care criteria, are determined to be at risk of nursing facility placement, and for whom services under the Waiver are the critical

element that enables the individual to remain in the assisted living facility rather than being placed in a nursing facility.

The Department will be responsible for assuring the health, safety, and welfare (HSW) for each waiver individual. All information received by the service authorization contractor must be evaluated to determine if there are concerns regarding the HSW of the individual. If issues are identified, procedures provided by the Department must be followed, including a documented report from the Service Authorization Contractor to Adult Protective Services.

Each service available in the AAL Waiver has its own specific criteria. The Service Authorization Contractor must receive specific clinical information, as outlined in the DMAS Alzheimer's Assisted Living Waiver Regulations in order to process each service request within the Waiver.

Requests for resumption of AAL services received after a discharge must include the enrollment process, even if the same provider is resuming care. If an individual is hospitalized or does not receive Waiver services for more than 30 days, the provider must submit a request to discharge with his or her actual last day of service. (12VAC 30-120-1610 G)

ALZHEIMER'S WAIVER SERVICES REQUIRING REVIEW BY DMAS AND SERVE AUTHORIZATION CONTRACTOR:

Procedure Code	Service Description	Required Service Authorization Documentation
T2031	Alzheimer's Waiver Assisted Living	PAS Screening: UAI, DMAS 96 (for new enrollments only). History and Physical Documentation of Alzheimer's diagnosis – DMAS 413 Verification of Auxiliary Grant Status