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APPENDIX C

PROCEDURES FOR SERVICE AUTHORIZATION OF

COMMUNITY MENTAL HEALTH REHABILITATIVE SERVICES

Introduction

Service authorization is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization and some require service registration.

Service Registration

Registration is a key element to the success of a care coordination model. Registering a service with Magellan as the service is being provided ensures that the care coordinator has a complete picture of all the services an individual is receiving. Registration also may assist with identifying gaps in services that may help an individual progress in their recovery.

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

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

Registration may occur electronically, by phone or fax. Required elements to provide Magellan include: (1) the individual's name and Medicaid/FAMIS identification number; (ii) the specific service to be provided, the relevant procedure code, begin date of the service, and the amount of the service that will be provided; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address. The provider should also have at least a provisional behavioral health related diagnosis for the individual being served.

Claims payments will be delayed if the registration is not completed.

Service Authorizations

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS and Magellan criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by Magellan of Virginia.

Various submission methods and procedures are fully compliant with the Health

Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests.

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

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

Magellan will make an authorization determination based upon the information provided and if approved will address the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services in the authorization determination;

Retrospective review will be performed when a provider is notified of 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.

Once authorization is obtained, if the individual is discharged from the service and there are dates of service and units that have not been used, the provider must contact Magellan to notify them of discharge from service so that the remaining dates or units may be available at a later date, or by another provider.

Magellan's MIS system has edits that do not allow the same service to be authorized for different providers for the same dates. In the case where a second provider makes a request for dates that overlap, with the first provider on file, the second provider should contact the previous provider to advise that the service authorization needs to be ended. Should the second provider not be successful in obtaining release of the initial service authorization, Magellan will then make one attempt to contact the previous provider to obtain an end date. If there is no response by the prior provider, the service authorization and the second provider's request is processed.

Providers should request a cancellation of a service authorization when there has been no service utilization within the authorized date span. Canceling a service authorization means that it never should have existed and no claims will be or have been billed against the service authorization.

If the initial period you requested is denied and the individual later meets criteria a new request may be submitted for the current dates of service as long as that request is not a retro-request for service. The new request must explain how and why they now meet

criteria.

Providers are responsible to keep track of utilization of services, regardless of the number of providers. Magellan has provided various methods for the providers to research utilization.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

Retro Medicaid Eligibility

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

Changes in Medicaid Assignment

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

<u>Individuals Who Are Enrolled With DMAS Contracted Managed Care Organizations</u>

Many Medicaid individuals are enrolled with one of DMAS' contracted MCO. In order to be reimbursed for inpatient acute psychiatric and outpatient psychiatric treatment services provided to an MCO enrolled individual, providers must contract with and follow their respective contract with the MCO. The MCO may utilize different service authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For detailed information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx. Additional information about the CCC Plus program can be found at: http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.

Individuals who are authorized by Magellan into Psychiatric Residential Treatment Facilities (PRTF), EPSDT PRTF and EPSDT Therapeutic Group Home (TGH) will be

disenrolled from the MCO as PRTF services are reimbursed for all Medicaid individuals through the Medicaid fee-for-service program. Therapeutic Group Home (TGH) services are carved-out of the MCO contracts and are reimbursed directly through Medicaid fee-for-service. See the table below for additional information.

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

Communication

Provider manuals are located on the DMAS website and Provider Handbooks are located on the Magellan websites. Magellan's website has information related to the service authorization processes for programs identified in this manual. Providers under contract with Magellan of Virginia should consult the Magellan National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider for additional information.

Magellan provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the service authorization process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the Community Mental Health and Rehabilitative Services (CMHRS) manual and the Magellan Handbooks.

SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION/REGISTRATION

Medical Necessity Review Process Changes

Beginning on July 1, 2017 Psychiatric Residential Treatment Services and Therapeutic

Group Home services will begin using different Medical Necessity Criteria. Changes in the service authorization process will be implemented on July 1, 2017 when Magellan will stop using the current medical necessity criteria for Level A and Level B Group home Services and will instead make authorization decisions in the new Therapeutic Group Home services using new medical necessity criteria and IACCT review process.

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

The IACCT team will gather relevant information from which Magellan will use to render a medical necessity determination.

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

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

Timeliness of Submission by Providers,

All requests for services must be submitted prior to services being rendered. This means that if a provider is untimely submitting the request, Magellan will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied, and appeal rights provided.

Specific Information for Out of State Providers

Out of state providers are held to the same service authorization processing rules as in state providers and must be enrolled with Virginia Medicaid prior to submitting a request for out of state services to Magellan. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to Magellan, as timeliness of the request will be considered in the review process. Magellan will pend the request back to the provider to allow the provider to become successfully enrolled .

Out of State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers of PRTF, TGH and EPSDT services in those levels of care. These specific procedures and/or services may be performed out of state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where

the procedure and/or service cannot be performed in the necessary time period. Additional information may be found in Chapter II of this manual.

Early Periodic Screening Diagnosis and Treatment Service Authorization Process (EPSDT)

The EPSDT service 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 individual receiving services.

Any treatment service which is not otherwise covered under the State’s Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or its contractor as medically necessary. Therefore, services may be approved for persons under the age of 21 enrolled in Medicaid, FAMIS Plus and FAMIS Fee For Service (FFS) if the service/item is physician ordered will correct a medical condition, make it better, or prevent the child’s health status from worsening.

All Medicaid, FAMIS (FFS) and FAMIS Plus services that are currently authorized by the service authorization contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor’s website, MagellanofVirginia.com

EPSDT is not a specific Medicaid program. EPSDT is distinguished only by the scope of treatment services available to children who are under the age of 21. Because EPSDT criteria (service/item is physician ordered and is medically necessary to correct, ameliorate “make better” or maintain the individual’s condition) must be applied to each service that is available to EPSDT eligible children, EPSDT criteria must be applied to all pre 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, waiver individuals may access EPSDT treatment services when the treatment service is not available as part of the waiver for which they are currently enrolled.

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 wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this may be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.

- Another example using mental health services would be as follows: A child has been routinely hitting her siblings; the child has received a total of 26 weeks for Intensive In Home services to address this behavior. Because the behavior has decreased, but new problematic behaviors have developed such as nighttime elopement and other dangerous physical activity, more weeks of treatment therapy was requested for the child. The service limit was met for this service. But because there is clinical evidence from the treatment providers to continue treatment, Magellan may approve the request because there is clinically appropriate evidence which documents the need to continue treatment in a variation or continuation of the current treatment modalities.

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 do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Developmental Disabilities and Behavioral Health Division for consideration under the EPSDT program. Examples of non covered services are inclusive of but are not limited to the following services: hearing aids, non waiver personal care, assistive technology, specialized inpatient treatment and nursing. All service requests must be for a service that is listed in (Title XIX Sec. 1905.[42 U.S.C. 1396d] (r)(5)).

Developmental Disabilities and Behavioral Health Division
EPSDT Services
Contact Information:

Fax - 804-612-0043
Phone - 804-786-6134

Managed Care Organizations (MCOs) cover EPSDT for medical services and supplies, however, State Plan Option Services are carved out and only reimbursed by DMAS.

For Medicaid/FAMIS Plus children enrolled in a Medicaid–contracted Managed Care Organization (MCO), the provider must receive a service authorization from the MCO.