

Community Mental Health Services Prior Authorization

Frequently Asked Questions

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***Updated 08/05/09

CATEGORY		
Assessments	<p>Upon initial entry to a service, regulations and manual require an assessment be performed. Reassessing the individual’s needs are part of the required periodic treatment review process. Currently, providers have no way to bill for the assessment separately from service treatment. Beginning August 1, 2009 providers may bill for the Mental Health Assessments for Therapeutic Day Treatment for Children and Adolescents, Intensive Community Treatment, Psychosocial Rehabilitation, Mental Health Support, and Day Treatment/Partial Hospitalization for Adults. Assessments do not require prior authorization. Assessments must be billed separately from the service treatment. DMAS will reimburse each provider up to 2 assessments in a fiscal year for a single recipient for each service type. Ongoing assessment is expected to be occurring throughout treatment. Billing for assessments does not apply to Mental Health Case Management Services.</p>	
	QUESTION	ANSWER
A1	<p>It is noted that billing for 2 assessments is allowable by DMAS. However, what occurs when a person goes into one of these services, stays for 2 months, then drops out for 2 months and comes back in the 5th month for services? Does there need to be another assessment done at that point? If so, then DMAS will pay for that 2nd assessment at that time (as per policy). Or does the individual still continue to qualify based on the initial assessment up to the end of the 6 months covered under the PA?</p> <p>What happens when the 2nd 6 month authorization expires and another assessment is needed? This would make 3 assessments within 1 fiscal year and the 3rd assessment’s cost is eaten by the provider. Is that correct?</p> <p>What happens when an individual changes providers? If an individual receives services for 3 months from Provider A, moves to another area and then changes providers in the 5th month, does the initial assessment still hold for that person or is there a new one required?</p>	<p>DMAS will reimburse for up to 2 assessments per service, per recipient and per provider, for each year (July 1 – June 30). If the provider has been reimbursed for two assessments per year, and an additional assessment is performed, the provider may not bill the units used for the third assessment under the service treatment code. Assessments billed under the service treatment code will be retracted, as the service treatment codes are for treatment, not for assessments. , if an individual has an authorized period but has lapsed treatment for up to and including 30 days a brief update may be performed in the form of a progress note. If the individual has lapsed treatment for greater than 30 days during an authorized period, an update may be performed in the form of a progress note if all assessments for the fiscal year have been utilized. If the assessor feels a more comprehensive assessment is needed and there are additional assessments available for the fiscal year, they may choose to bill the appropriate assessment code that corresponds to the service/treatment. Follow your agencies policies regarding discharge procedures.</p> <p>Correct. Per <i>new</i> rules, DMAS will reimburse each provider up to 2 assessments in a fiscal year for a single recipient for each service type. Ongoing assessment is expected to be occurring throughout treatment.</p> <p>The provider should use their clinical judgment when evaluating the need for an assessment. Each individual provider is required to complete their own assessment. DMAS is merely giving an alternative for reimbursement of assessments. There was no reimbursement specifically for assessments under past policy.</p>
A2	Will there be edits in place that will check for the billing and	Per regulations and manual, an assessment is to be performed prior to

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	<p>payment of an assessment/re-assessment prior to authorization requests being reviewed/approved and payment for ongoing services being made?</p> <p>During the 6 months of authorized services following the initial assessment, a provider does the re-assessment in the final month of the service period. Does that mean the provider is paid for the sixth month of service as well as for the re-assessment? It seems logical that would occur but the billing for the re-assessment would be during the same billing cycle for the 6th month of service. Will the computer billing system allow that?</p>	<p>initiation of services. Billing for the assessment code is optional. For EXISTING recipients with claims activity after 01/01/09, providers may continue billing without a PA up to 12/31/09 and claims will pay. We encourage providers to coordinate their PA request for continued services with the required periodic treatment review. However if the provider chooses to bill an assessment code, using the new codes, for an existing recipient prior to 01/01/10, then PA will be needed for continued payment for every date after the assessment is billed. Please note that it does not matter the status of the billed assessment code, once the assessment code hits the MMIS, PA is required (THIS IS FOR EXISTING RECIPIENTS FOR CONTINUED REIMBURSEMENT THROUGH 12/31/09) PA is required for all existing recipients January 1, 2010 for claims to pay.</p> <p>For NEW recipients, where there is no claims activity from January 1, 2009 for the service proposing to provide: PA is required for dates of service 8/1/09 forward. You may choose whether or not to bill the appropriate assessment, using the new codes.</p> <p>Yes, the provider is paid for the assessment if the 2 assessment limit has not been paid in the fiscal year. Yes, the provider will be paid for the services provided within the authorized period (from and through dates).</p>
A3	<p>Does the limit of two assessments per fiscal year apply to more than one provider?</p>	<p>Yes. Per new rules, two assessments are reimbursed per provider per fiscal year per recipient. In other words, two assessments per provider, per recipient, per fiscal year are allowed. This allows the provider to bill for an assessment if the recipient wants to change providers. The PA for treatment will only be authorized to one provider at a time and not allow overlapping dates between providers.</p>
A4	<p>Must providers bill for reassessments?</p>	<p>Assessment codes are always optional to bill. However see rule for billing existing recipients and assessment codes up to 12/31/09 in response #A2. Providers should always attempt to bill sequential dates of service. For existing recipients that have claims on file as of 01/01/09, you may bill for the re-assessment, but you will need a PA in place immediately prior to billing the treatment codes or claims will deny. Please complete your reassessment, then request a PA, and then</p>

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		bill for the PA and services covered with your PA dates. For new recipients, the treatment code will pay up to the 1, 5, or 10 unit service limit without PA. Once these limits are used, PA is always required.
A5	Is a single assessment for PSR required or can you combine services in one assessment?	Yes, a single PSR assessment is required. Since you are billing for assessments, each assessment must refer to the eligibility and medical necessity for that particular service. Also, for billing purposes, each service has a distinct assessment code modifier.
A6	If a recipients' reassessment is due 12/1/09, may we complete one on 11/1/09?	Yes, reassessment may be completed early, but if billed prior to 12/31/09 there must be a PA for all subsequent dates of service. PA is required as of January 1, 2010.
A7	Do providers need to do another reassessment to get another PA & when must this be completed?	Part of the required periodic treatment review process is to re-assess the need for continued services, review overall progress or lack of progress, assess for additional services, assured required documentation is in the record, etc. Assessments/Reassessments: upon initial entry to a service, regulations and manual require an assessment be performed. Reassessing the individual's needs are part of the required periodic treatment review process. You may choose to bill for the initial assessment, and/or "reassessment" performed during the required periodic treatment review process. Again, assessment codes are always optional to bill, and whether the provider chooses to bill assessments does not affect subsequent PA of services, with the exception of existing individuals through 12/31/09 – see response #A2.
A8	If a recipient is assessed for admission on April 30 2009, does he need a PA for May, 2009?	An assessment code cannot be billed for dates of service prior to August 1, 2009. The assessment codes are not valid until 8/1/09. Once the assessment code is billed on/after 8/1/09, and the 1, 5, or 10 unit service limit is used, all additional services must have PA. Prior authorization is not granted retroactively unless Medicaid Eligibility has been determined retroactively by DSS.
A9	MH Support Clients are hospitalized creating a break in service. These clients are reassessed (typically by the same case manager) before coming back in for services. This can happen up to 5 times a year. We are allowed reimbursement for two assessments per year; can we request additional payment using KePRO? Extension? Appeal?	Assessment codes do not require PA. DMAS will pay for 2 assessments per provider, per fiscal year, per recipient. KePRO cannot extend these 2 assessments. There is no appeal as this is the service limit. The provider may perform as many assessments as they feel are needed, however the reimbursement limit is 2 per provider per fiscal year per recipient per service. If providers bill for an assessment under the treatment code, DMAS will retract money. The assessment code is for

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		assessments; the treatment code is for treatment.
A10	The two assessments per year per provider rule: If a client is seen by different providers within our agency can we request reimbursement? Clients often times are in multiple programs or can be transferred to someone else's case load.	The 2 assessments per provider (number) per fiscal year per recipient are specific to the provider number submitted on the claim. The MMIS system will look to see the number of assessments paid per provider number and will stop payment when the provider is paid for 2 per recipient per fiscal year. If the case is transferred, it is expected that a certain amount of information is reported to the new provider. Each of the MH services has a separate assessment code; therefore, there are 2 assessments per provider number per fiscal year per recipient for each service. Your agency would need to determine procedures for billing based on agency and individual provider ID number. Payment will be made to the provider number that the PA is submitted under.
A11	Will DMAS require a specific assessment form? Or can we (CSB's) continue to use our forms.	There is no DMAS designated form to document or bill for assessments. Components of the assessments must meet guidelines outlined in DMAS provider manuals and must be included in the documentation. The findings must support ongoing clinical treatment for the service for which you are assessing.
A12	Is there a way to bill for an additional assessment when a third one is needed and the two allowed per year have already been billed, especially with services like MHS?	No, only two assessments per fiscal year, using the appropriate assessment code and modifier, can be billed per provider per recipient, per service. If an additional assessment is needed, the provider may document the assessment outcome in a progress note or update the most recent assessment information, date and sign.
*** A14	Sometimes the same clinician may do the intake as well as the assessment for the specific service. If they are done at the same time, do we bill for both or only one (and then which one), document separately or in the same larger assessment? This is obviously not an issue when we are doing the assessments at different times.	Yes. After doing the initial evaluation to determine what services an individual needs, bill the 90801, when completed by an LMHP. If you determine that Psychosocial Rehab is needed, you must perform an independent assessment for Psychosocial Rehab and bill the assessment code H0032, U6.
*** A15	If we have a client that is due for an assessment 8-1-09, therefore we would need to do an assessment the week prior. But A8 states we cannot bill for the assessment code prior to 8-1-09? Do we just eat the cost of the assessments that need to be done the last week in July?	You may assess the recipient and bill as usual until August 1, 2009. The assessment code will be in place and available to be used effective August 1, 2009.
*** A16	Our case management clients all come from other services in the agency such as Day Treatment or individual counseling within the	You may bill for case management for the initial evaluation. If the client is opened to this service then request PA. There should be an evaluation

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	<p>Child and Family Program. We have always just admitted the client from these programs without a separate assessment assuming that the information from the other program would suffice. Should we be doing our own assessment of case management referrals and if so, can we bill separately for this assessment, even though the child had an intake earlier for the other program. I don't want to double bill or double the workload, but if a case management assessment is warranted, I would like to bill for the CM Assessment.</p>	<p>performed through the assessment for each service in which the recipient is enrolled. The assessment must clearly state how the recipient meets the eligibility criteria for that specific service, i.e. TDT, CM. Billing for other assessments does not apply to Mental Health Case Management Services and there is no separate billable assessment code for MHCM services.</p>
<p>*** A17</p>	<p>Can I use the units that do not require PA anytime during the individual's treatment, much like a "coupon" or "wild card"?</p>	<p>No, the units that do not require PA are only allowed once an assessment visit is billed for new admissions. These units are counted consecutively immediately after the admission and treatment codes are billed.</p>
<p>Case Management</p>	<p>MH Case Management will be authorized by KePRO at 1 unit per month, for up to 12 months. The 'grace period' for CM is considered 8/1/09 – 12/31/09 and is defined as the period where claims will pay without PA. After the allowed grace period (ends 12/31/09), all individuals (new and existing) are allowed 1 unit of CM without PA. The 1 unit without PA is effective 01/01/10. Once this 1 unit has been used, all subsequent requests require PA. 1 visit that does not require PA is not renewable annually.</p>	
	<p align="center">QUESTION</p>	<p align="center">ANSWER</p>
<p>CM1</p>	<p>From the wording, here it appears that existing individuals as well as new individuals will get the first month of case management without a PA. Thus July will be paid for by DMAS for existing individuals. During July (30 days) all CSBs will have to submit a PA request for these existing individuals as well as any new case management individuals.</p> <p>This is different from the first discussion we had in March where case management had been mentioned as being transitioned in over a period of 3-6 months. That was due to the large numbers of persons who receive case management and the need for CSBs to plan adequately for use of iEXCHANGE for this large group of individuals. Since many case management cases have quarterly reviews, it was discussed that when these were done would be the best time for getting PA's. Obviously there has been a change on this component.</p> <p>This potentially creates an administrative nightmare for CSBs as well as KePRO and the DMAS MMIS system as there will always be an extremely high number of PA case management submissions during July each year. It is also noted that effective July 1, 2010,</p>	<p>The reimbursement rate is a flat, one time rate for a single month, or any portion of the month (in which all required CM activities/services are provided). Mandatory PA for new and existing cases begins January 1, 2010.</p> <p>Assessment codes are not used for Case Management. Currently, providers have one month (1 unit) to bill, then PA is required. The PA does not need to be ended unless the provider is no longer providing service to the individual.</p>

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	<p>First Health will no longer be the contractor for MMIS/Billing. That in itself causes concern for July 2010.</p> <p>Whenever there is a lapse in case management service (could be 1 month or many months) does a new assessment have to be completed? It appears that it does per the regulations. This means that the re-assessment has to be done within 30 days of the individuals' return to case management service. Also, does the existing prior authorization have to be ended and then a new authorization requested?</p> <p>It is problematic anyway that all of the required medical, psychological and psychiatric services can be done in that time frame of 30 days. Since one month of service is paid for by DMAS without a PA in first year of service only (thus one month is paid in a lifetime), the provider will have to provide case management services for a period of time until a PA is approved. Unless of course there will be a retroactive payment allowed from the first date of an individual coming in for case management services. That, however, is not mentioned anywhere and thus it is assumed not allowable.</p>	<p>A task of mental health case management is to complete an evaluation or assessment for services. DMAS does not pay for an assessment for case management as a separate billing code. Providers are to use their clinical judgment when evaluating the need for a new complete evaluation/assessment. If the lapse in treatment has been for a brief period of time a progress note update may suffice.</p> <p>Currently the MMIS does not allow for overlaps for the same procedure code and same dates of service for the same individual. We will allow the provider's current authorized period to expire if there is a lapse in service and no services are provided. If services resume after a lapse and the resuming of services occur within the authorized period, there is no need to obtain another PA, if the recipient continues to meet criteria. However, if the resuming of services takes place after the authorized period has expired, a new PA is required for claims to pay. This may be effective for the other services as well.</p> <p>PAs will be allowed to expire. In the case where another provider makes a request for dates that overlap the first PA, KePRO will contact the first provider once to attempt to obtain the last date of service. If the provider does not respond, the first PA will be end dated by KePRO the day immediately prior to the second provider's requested start date.</p> <p>The provider may request PA 30 days prior to the end date of the current authorization period. As long as KePRO receives the request for PA timely (prior to expiration of current PA), the provider will not be penalized in regard to the PA dates, and claims payment. Information regarding timely filing of claims is in Ch 5 of the CMHRS Manual. DMAS has always allowed a one year period for timely filing of claims.</p>
<p align="center">CM2</p>	<p>Only one month is allowed in a lifetime. No re-assessments after lapses in services. This is clinically inappropriate. How can a pre-authorization be appropriately obtained when any length of time has lapsed between episodes of care. This is asking us to do</p>	<p>CM should be providing ongoing assessment of progress and service needs. It is intrinsic to the CM service. Criteria for meeting eligibility for the service are not extensive. Please see the CMHRS manual for criteria. The assessment/reassessment is incorporated in to the current</p>

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	<p>assessments for free. If we agree to re-assess and they don't meet criteria we have to eat this cost.</p>	<p>monthly rate. There is no separate assessment code/rate for MH CM as part of the service itself is an assessment of needs.</p> <p>The 'grace period' for CM is considered 8/1/09 – 12/31/09 and is defined as the period where claims will pay without PA. After the allowed grace period (ends 12/31/09), all individuals (new and existing) are allowed 1 unit of CM without PA. The 1 unit without PA is effective 01/01/10. Once this 1 unit has been used, all subsequent requests require PA. We suggest that providers begin staggering requests for PA in order not to disrupt services to your recipients and to ensure claims will continue to pay.</p> <p>After the allowed grace period (ends 12/31/09), A new client is only allowed a unit of CM without PA only once. If this has been used, there would be no units without PA available.</p> <p>Effective 01/01/10, CM has 1 unit (PA) service limit before PA is required. If the provider has a PA for 12 months, and the service lapses sometime in that period, the provider will not request a concurrent PA for the subsequent 12 months. However 2 years later, the provider gets the same individual back to assess for CM. There is no longer a 1 unit service limit since it was used already. If the individual does not meet criteria for CM, the provider is unable to bill for case management visit.</p>
<p align="center">CM3</p>	<p>Allowing only 1 unit of service without a pre-authorization. This presents a problem when there is a lapse in service and a new assessment needs to be completed per the regulations. We would not be able to bill without the assessment but a new assessment is required if there is a lapse in services. This may not be a big deal if it is just a couple of months but what if it is 6 or 8 months of a lapse in service. Do we just have to eat the cost of the assessment if they end up not qualifying when we re-assess. There are also some requirements for medical, psychiatric and psychological reports that we may have difficulty obtaining within 30 days that allow us to do a thorough intake. Turn around time for attesting to having all necessary documentation too short.</p>	<p>Refer to answer #CM2 above</p>
<p align="center">CM4</p>	<p>General questions on case management. If an individual during the course of an already approved PA moves from being SED to SMI, will there need to be a new request for authorization? Also, will there be any distinction on the Prior Authorizations for SMI, SED,</p>	<p>No there would not be a need for a new PA. This would be part of the ongoing assessment. The authorized period remains in effect until the end date of the PA, or the provider requests it end, whichever comes first.</p>

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	<p>ATR?</p>	<p>Mental Health Case Management is designed for three different populations, but with the same eligibility criteria and required activities for each population. The Community Mental Health Rehabilitative Services Manual (Chapter IV, page 46) describes the requirements for each population. In general, the SMI category is for persons 18 years and older. At risk of SED is for children through age 7 and SED is for children through age 17. If a recipient "changes" populations, a new assessment or PA is not required.</p> <p>If the client qualifies for case management through a different population definition ('at risk', SED, or SMI) a new PA is not required as long as the client continues to meet the CM service criteria. Medicaid eligibility is not affected by change in age, or change in population definition category.</p>
<p>*** CM5</p>	<p>There are currently multiple forms for requesting PA for MHCM. Which form are we supposed to use when requesting PA from KePRO?</p>	<p>CSBs are more used to addressing the MHCM population by the titles of Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and At Risk of Serious Emotional Disturbance (AT Risk), rather than by age. The PA request forms are titled by age grouping. KePRO will add the title of the populations that the CSBs are accustomed to on the existing forms so that it is clear which form to use for the corresponding population.</p>
<p>*** CM6</p>	<p>Can we request 8 units of case management as opposed to the 11 initially, to get the continued authorization to match the required reauthorization? Staff would like the KePRO authorization timeframe to match the reauthorization timeframe currently in place with our clients.</p>	<p>Yes, providers may request up to 12 months. It is recommended to request PA at the next quarterly review visit.</p>
<p>*** CM7</p>	<p>If a child has an authorization for case management in place and then begins with in-home services, do we have to release the case management authorization prior to submitting the authorization for in-home since the child cannot receive both services at the same time?</p>	<p>No, you do not need to release the case management PA prior to submitting the IIH request for PA. Prior to submitting the request for PA the MHCM and IIH provider should communicate and coordinate to avoid any overlapping billing. DMAS looks at these billing trends and targets providers that bill and get paid for the overlapping billing between these 2 services. Only one provider may receive payment.</p>
<p>*** CM8</p>	<p>Can you please provide clarification regarding the MH-CM PA grace period. Please indicate which statement below is accurate: A) All clients, new and existing, will not require a PA for MH-CM</p>	<p>A) This is true B) This is true</p>

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	<p>until 1/1/10. B) Existing clients will not require a PA for MH-CM until 1/1/10 C) New clients after 8/1/09 will require a MH-CM within 30 days.</p>	<p>C) Assessment must still be completed within 30 days; however, PA is not required until 1/1/10. Please note that although PA is not required until 01/01/10, we want providers to request PA well in advance of 01/01/10 to keep the flow of PA processing at adequate turnaround times.</p>	
*** CM9	Will all the PAs for such cases end as of 7/31/10?	No, the PAs do not end. PAs extend across fiscal years.	
*** CM 10	Do the maximum units allowed for pre-existing Case Mgmt cases, 12 units/months, start counting down as of 8/1/09 for all cases?	No. The 12 units are authorized starting from when you get the PA. The PA may extend across the fiscal year. However, they MMIS is counting the units on the claims from 8/1/09 to 6/30/10 for this fiscal year only. Subsequent years are the fiscal year 7/1/yy to 6/30/yy. The units on the claims cannot exceed 12 per fiscal year.	
Prior Authorization	Beginning August 1, 2009 Prior Authorization (PA) will be required for Therapeutic Day Treatment for Children and Adolescents, Intensive Community Treatment, Psychosocial Rehabilitation, Mental Health Support, Mental Health Case Management, and Day Treatment/Partial Hospitalization for Adults with Virginia Medicaid's PA contractor, Keystone Peer Review Organization (KePRO). Once the assessment is completed and it is determined that the individual meets criteria for additional services, new cases are allowed a limited number of units without prior authorization. The units that do not require PA are not renewable annually and are only allowed for new individuals. Once the units that do not require prior authorization are used, all subsequent units require PA. After these limits are met, individuals may receive additional units, for up to 6 months, with prior authorization.		
		QUESTION	ANSWER
	PA1	When can we start requesting PAs and using the new assessment code?	Providers may begin requesting PA the last week in July for dates of service in August.
	PA2	Do authorizations for Provider A have to be cancelled before Provider B can request authorizations for services?	<p>If there is no overlap in the dates, then there is no need for provider A to submit an end date. The system has edits that do not allow the same service to be authorized under different providers for the same dates.</p> <p>Providers should request a cancellation of a PA when there has been no service utilization within the authorized date span. Canceling a PA means that it never should have existed and no claims will be or have been billed against the PA.</p> <p>Discharging means that services have been provided, the provider will or has billed for services rendered, and the recipient will no longer be served by this provider for this service. The Discharge Date is the last date service had been provided to the recipient.</p>

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		To respond to the question: if Provider A did not utilize any services during the authorized period, then the PA would need to be canceled. If the provider A has an authorized period that overlaps dates with Provider B, then Provider A must send KePRO a discharge request to include the last date service was actually provided.
PA3	If an initial review and PA is denied, what is the length of the denial period?	The initial denial period is the period you requested. If the individual later meets criteria at some point during that same time period, you may request PA at that time and explain why they now meet criteria.
PA4	Should the units allowed prior to a PA for new clients be deducted from the maximum allowed annual limit of units?	Yes.
PA5	For ICT, what if you request and use less than 62 units in 6 months? Do you still have any unused units available?	Providers have a maximum of 130 units per fiscal year and may request more during the second half of the year, if they have more than 62 units left. However, you may not exceed the total annual amount of units allowed by regulation and as outlined in DMAS provider manuals. Please note that for any of these services (except MHCM) it is a suggestion to request up to half the units in a 6-month period in an effort to spread the services throughout the year. We realize that not every instance is the same and providers may request less than half the units or more than half the units. This may be determined by the provider when they plan treatment.
PA6	If you need more units than you requested, can you request a PA change from KePRO?	Yes, each provider may request a change in a PA from KePRO for more or less units than the original request.
PA7	What if a recipient goes to another provider or if a recipient has received services from another provider and wants to enroll in your program?	Providers should check with ARS a web based tool at https://uac.fhsc.com/iac/pages/unsecured/common/home.jsf , Medicaid 800-772-9996, 800-884-9730, or 804-965-9732 or the DMAS Provider Helpline 800-552-8627, or 804-786-6273 to determine how many units are still available to determine the amount to request for a PA. All of these will be up and running on August 1, 2009.
PA8	Will first five units of ICT be paid even if PA is denied?	Yes. However, if PA is denied for not meeting criteria, post payment review will be conducted to determine if the initial 5 units met criteria.
PA9	If you forget to request a PA can you get a retroactive prior authorization approval?	There is no retroactive PA. PA starts from the day it is received by KePRO. This is true for all services. The only time a retroactive PA may be granted is if an individual has been determined for retroactive Medicaid Eligibility by the DSS worker.

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PA10	What is the turn around time for PA?	The turn around timeframe is three business days.
PA11	What about overlapping PA dates?	There are currently system edits in place that do not allow the same service (procedure code) to be authorized with any overlapping dates, with different providers (same recipient).
PA12	What if you request more units than the maximum units allowed per fiscal year?	KePRO may approve more than are allowed however, the MMIS edits will prevent payment that goes beyond the maximum service limit. This applies to all CMHRS services. Providers are responsible to keep track of utilization of services, regardless of the number of providers. DMAS has provided various methods for the providers to research utilization. These methods are SURS, MediCall, ARS, and the DMAS HelpLine. Children can still request for extensions of service beyond the usual limits through the EPSDT program. All service limits shall be enforced in the MMIS. If the child has exceeded the regulatory limits within the fiscal year, and continues to require additional services, services may be requested through KePRO under EPSDT. The EPSDT authorized period will always end on or before 6/30; on 7/1 of each year, the state plan service limits will need to be utilized before EPSDT can be authorized.
PA13	When a recipient has both MHSS and PSR services, will they have one PA#?	Separate providers will have their own PA#. The same provider may have one PA# if requested by the provider to be under one PA number. When the provider requests additional services, they must give KePRO the PA number they want the service to be authorized under. KePRO will not search the PA file to determine if there is an existing PA.
PA14	Is there a PA grace period for a recipient who starts services 8/1/09?	For new clients you should request PA immediately. The 'grace period' for new recipients admitted on or after 8/1/09 is the services limit period that does not require PA.
PA15	What happens when a recipient switches from another provider?	The existing provider must contact KePRO to notify them of the changes to the PA and make a discharge/cancellation of their PA via iEXCHANGE. Refer to Question #PA2.
PA16	How do we request a PA if a recipient is enrolled in a service, but does not yet have Medicaid?	Once you have been notified of Medicaid eligibility, the provider has 30 days to submit a PA request to KePRO. Once the recipient becomes Medicaid eligible, then request PA from the date the recipient became eligible. KePRO cannot accept requests if there is no Medicaid ID number.

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PA17	Can a client get 2 or 3 different MH services at the same time through KePRO by 2 or 3 different clinicians at same agency?	<p>Yes, each PA will have a specific recipient/ID, specific MH service (procedure code), specific from and through dates this service is authorized, a specific number of units for that service spanning the from and through dates, and the provider's NPI.</p> <p>Depending on how the providers iEXCHANGE Administrator sets up the staff's accounts, each person having access to view cases will be able to see if the case is already requested and the status of that case.</p>
PA18	Will a new PA number be given for each type of MH service the client requests?	New requests that have never been submitted before will have a new PA number. If the provider adds another service, you may request that it be authorized under the same PA number, however <u>the provider must know what the existing PA number is, and enter it on the request for the service being added.</u> If there is no PA number requested to put additional services under, a new PA number will be issued.
PA19	How long does it take to process KePRO PA request for any of the MH services?	Currently, KePRO has 3 business days to process IIH and OP Psych requests. The average turnaround time to process a request has been 2 – 2.5 days.
PA20	Will clinicians try and request all the units or sessions they need for the care of the client for a 6 month period?	Yes. We are recommending that providers request up to half the annual service limit for a 6-month period. However, if the provider medically justifies the need for more than half the service limit, it may be authorized. However, you may not exceed the total annual amount of units allowed by regulation and as outlined in DMAS provider manuals. Each case is different. We are asking that clinicians use their professional judgment when planning the use of service limits.
PA21	If a client starts out self pay in one of the MH programs; then later gets Medicaid funding how will pre-approval for MH services be sought by KePRO?	Make the request to KePRO when you receive notice that the recipient is Medicaid eligible. You may request dates of service retro-actively to the date of Medicaid eligibility. This is the only instance KePRO will PA retro-actively (with Medicaid eligibility retro-actively determined).
PA22	How will discharging a client be regulated on KePRO?	KePRO does not regulate client discharges; they act upon a provider's request to discharge a recipient from their provider number. Providers can go into the case in iEXCHANGE and simply enter in the Update Section "discharging client as of (date)" and KePRO will end date the authorization with the provider. This allows another provider's request to be processed without lapse in services to the recipient. The discharge date is defined as the last date service was actually provided to the recipient. PAs will be allowed to expire. In the case where another

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		provider makes a request for dates that overlap the first PA, KePRO will contact the first provider once to attempt to obtain the last date of service. If the provider does not respond, the first PA will be end dated by KePRO the day immediately prior to the second provider's requested start date.
PA23	Will we (CSB's) need to have a Business Agreement with KePRO?	No. KePRO is contracted to act on behalf of DMAS with our providers and KePRO has the BAA with the Department. By virtue of the Virginia Medicaid Provider Agreement, providers have a BAA with DMAS. Therefore it is not necessary for providers to have a direct BAA with KePRO.
PA24	Each July 1 the service limits are reset by DMAS, do we (the provider) reset our tracking systems and do we have to reapply for authorizations?	<p>The provider should reset their tracking systems to know how many services are provided to the individual. This information can be found on ARS, MediCall, SURS, or the DMAS HelpLine. It is important to remember that these tools (ARS, MediCall, SURS, and the HelpLine) only track units used for paid claims. If any provider holds off or lags in billing, these systems will not have accurate counts of service utilization. The authorization end date may span across July 1. So, when the service limits are re-set, you may already have an existing authorization. Providers must pay attention to the end date of the authorization for each specific service. It is suggested that if services need to continue beyond the end date authorized, providers submit a request to KePRO within 30 days of the authorized end date.</p> <p>On July 1st next year, if a provider has an authorized period that spans past July 1, 2010, they need to determine the number of units used in the authorized period and how many are remaining from July 1 to the end of the authorized period.</p>
PA25	Will KePRO be able to accept a file (with multiple requests) or will our only option be to enter each request individually?	KePRO is able to accommodate multiple services requested in the same submission.
PA26	ICT Services: Often times our clients exhaust their service limits in a year (130 units) can we request an authorization extension increasing their service limits and be reimbursed?	The service limit is in regulation. KePRO cannot authorize more than the regulatory limit allows. In the case of a transfer, the cumulative combination of units for all providers cannot exceed 130 units (or the service limit for any service), the MMIS claims system will not pay greater than the service limit. Providers may look in ARS, MediCall, SURS or contact the DMAS HelpLine for determining utilization of these services.

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PA27	<p>ICT: A slide during training indicates must have 3 consecutive months or more of failed supportive services (other than case management or outpatient psychiatric services), such as crisis intervention, crisis stabilization, mental health support or partial hospitalization and demonstrates a resistance to seek out and use appropriate treatment options (DMAS requirement)”</p> <p>It is a more restrictive “fail first” policy than currently exists and will cause significant issues when needing to engage the homeless, treatment resistant and those coming out of hospitals.</p>	<p>We are clarifying the criteria presented in the trainings. The criteria shall remain as stated currently in the Medicaid manual.</p>
PA28	<p>Now that the implementation date has been changed, the providers only have 5 months instead of 6 to obtain PA for existing clients. Will the date for PA required for existing clients be extended out an extra month as well?</p>	<p>No, the implementation of PA will occur August 1, 2009, and PA will be required in order to bill for services starting January 1, 2010. The ‘grace period’ for CM is considered 8/1/09 – 12/31/09 and is defined as the period where claims will pay without PA. After the allowed grace period (ends 12/31/09), all individuals (new and existing) are allowed 1 unit of CM without PA. The 1 unit without PA is effective 01/01/10. Once this 1 unit has been used, all subsequent requests require PA. We suggest that providers begin staggering requests for PA in order not to disrupt services to your recipients and to ensure claims will continue to pay. Once you obtain a PA number, it is required on the claim for payment.</p>
*** PA29	<p>Does the assessment/reassessment for psychosocial rehab services have to be completed before an initial authorization to KePRO is completed and submitted?</p>	<p>The assessment/reassessment (procedure code+ mod) for psychosocial rehab is recommended to be completed prior to requesting PA from KePRO. The information collected at the assessment/reassessment should be used to provide updated information to justify that criterion is met when the request is made.</p>
*** PA30	<p>If the client loses coverage for a month or two, and then gets it back, does the authorization we had in place pick back up or do we have to do another one?</p>	<p>The authorization does not end unless you request an end date. If the claim is billed during a period of non-eligibility the MMIS edits will recognize that eligibility ended for that month and will not pay, even though there may be a PA in place. When a claim is billed, the system always looks to assure recipient and provider is eligible on dates billed. You do not need to get a new PA.</p>
*** PA31	<p>If we have children who are young (birth through 17) and meet the population definition and the eligibility criteria for Targeted Case Management, but who do not have an ICD diagnosis, what would be acceptable as a required diagnosis for submitting a PA in order to bill for those services?</p>	<p>For the purpose of obtaining a PA thru KePRO a diagnosis code is required. The diagnosis should be in relation to the symptoms exhibited and relate as closely as possible to the individual’s condition and symptoms. The diagnosis submitted to obtain PA will not post in the MMIS system; the MMIS claims system does not look for a “match” to</p>

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		what was submitted for obtaining a PA.
*** PA32	If providers submit a request that spans across the 8/1 effective date for PA, what will happen in the PA process? What decision will be made?	KePRO will look at the request and make a determination starting from 8/1/09 to the end of the date requested. The PA start date will be 8/1/09 and will end on the date the provider requested. The reason code you will see on the decision letter from First Health will say "1030 – SERVICE IS MEDICALLY NECESSARY; DATES OF SERVICE AND/OR UNITS CHANGED; HOWEVER SERVICES WERE NOT REDUCED." This means that the dates authorized have been reduced from what was requested, the units may have been changed from what was requested, but the services were not reduced.
*** PA33	Regarding the checklists for authorization, we are wondering which should be used for existing clients during this initial authorization period. Initial checklist or continuing checklist?	If the individual has been receiving services with your agency and you are requesting PA for the first time, use the continuing checklist. If the individual is new to your agency and has never been serviced before, use the initial checklist.
*** PA34	I was informed by a colleague that Medicaid will not accept prior authorizations or extensions for Mental Health Support & Therapeutic Day Treatment until August. Can you confirm that, and supply me with a date?	The start date for processing prior authorization for these services is August 1.
*** PA35	Do the dates of the prior authorization and the dates for the service plan have to coincide? I would assume that they do but would like to have a definitive answer so that we can determine if it would be better to have a regular schedule for our prior authorizations (i.e. do the prior authorization for all individuals receiving MH supports in July and January) or to keep them spread throughout the year and coincide with the dates of the service plan.	It would be helpful for you agency if the prior authorization dates and service plan dates coincide. The six month reauthorization process would be a good time to submit a PA request. The clinical documentation that you need is already being completed as part of the six month review.
*** PA36	If we were to have a system for completing prior authorizations twice a year could we do a prior authorization for fewer than 6 months when we initiate services with an individual so that the next assessment fit into said schedule?	Yes. The provider determines the begin and end date. This would be an agency decision.
*** PA37	Since there is no longer a monthly cap on the number of units provided for MH supports I assume that the plans need to justify the total number of units requested for entire 6 months rather than justifying monthly usage. Is that correct?	Providers should assure that the time requested and billed for any visit is justified. The ISP must be comprehensive.
*** PA38	Will all authorizations need to be completed prior to Aug 1 and	PA will be available for new and existing clients as of 8/1/09, new

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	<p>amended at plan date, or do we have until January 2010 to complete the authorizations as plan dates arise.</p>	<p>recipients should be assessed and you can request a PA via iEXCHANGE at admission. For existing clients, providers have until 1/1/2010 to request a PA; we suggest that you do not wait until the last minute. These existing clients (those who have received the service or have paid claims between 1/1/09-7/31/09) should have a PA requested at the date of their next Quarterly Review, six month reassessment, ISP rewrite or other date when an assessment would likely be performed. Keeping to the required documentation dates of each client will avoid additional assessments being completed in order to get the info need to support eligibility and clinical necessity for KePRO to make an appropriate determination.</p>
<p>iEXCHANGE</p>	<p>In an effort to move towards a “paperless” system and to streamline the prior authorization process, all Behavioral Health providers who submit PA requests to KePRO are strongly encouraged to do so via Direct Data Entry (DDE) using KePRO’s web based iEXCHANGE™ system effective August 1, 2009. All information submitted to KePRO for review of a prior authorization request, changes to existing cases, and additional information may be submitted via iEXCHANGE™. Virginia Medicaid providers have been successfully submitting requests to KePRO via iEXCHANGE™ since 2006. There is a high level of satisfaction with this submission method, and few problems have been reported.</p>	
	<p align="center">QUESTION</p>	<p align="center">ANSWER</p>
<p>IX1</p>	<p>I am concerned that the requirement for electronic submission of auths does not seem to contemplate any technological glitches or problems on either the provider’s end or on the KePRO end. While I fully understand and support the value of moving to all electronic submissions I think it is risky to providers and recipients to flip a switch on July 1 for this purpose. I suggest 2 things:</p> <ul style="list-style-type: none"> • Given a large number of providers that will be new to the system, using new processes and the increased volume for KePRO a longer transition to the requirement should be allowed.-perhaps 3 months. • The manual should also allow exceptions when technical problems exist on either end. This is different from a blanket exception for a provider to become capable to submit electronically. 	<p>Providers have been using iEXCHANGE since KePRO started in 2006. The system works the same way for all services the only difference is the program criteria for each service. KePRO has established procedures in place to handle any glitches to iEXCHANGE. These procedures include alternative methods of receiving requests in a timely manner to avoid denials.</p>
<p>IX2</p>	<p>Will a clinician person be able to see what the client has got requested <u>currently if employed</u> at same agency?</p>	<p>Yes, the iEXCHANGE Administrator can set up access rights.</p>
<p>IX3</p>	<p>Will iEXCHANGE be able to accept multiple PA submission for multiple recipients using one provider NPI number?</p>	<p>Yes. It is expected that the NPI number for which billing will occur, be used for all recipients for that provider. iEXCHANGE has the capacity to accept large numbers of requests using one provider NPI number.</p>

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			The payment will go to the address associated with the NPI number submitted and posted in MMIS.
General		QUESTION	ANSWER
	G1	Are appeals allowed for KePRO prior authorizations?	Yes. Appeals are to be sent to DMAS as instructed in the letter generated from First Health.
	*** G2	We have several clients that I need to check for prior Medicaid service and to see if they have any remaining weeks available to them. Due to problems reaching the helpline at various times I wondered if there an alternative to using the above number to get the information that I need to check Medicaid service and remaining weeks in order open charts on our clients?	The Helpline is the option for now. After August 1, 2009, providers should check with ARS a web based tool at https://uac.fhsc.com/iac/pages/unsecured/common/home.jsf , Medicaid 800-772-9996, 800-884-9730, or 804-965-9732 or the DMAS Provider Helpline 800-552-8627, or 804-786-6273 to determine how many units are still available to determine the amount to request for a PA.