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 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 within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity.

General Information Regarding Service Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests.

The service authorization contractor 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.

Once authorization is obtained, if the member is discharged from the service and there are dates of service and units that have not been used, the provider must contact the service authorization contractor 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.

The MMIS 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, the service authorization contractor 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 providers 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 at that time as long as that request is not a retro-request for service. The new request must explain how and why they now meet criteria.

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 and IIH) 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. The service authorization contractor can approve a service authorization request up to six months.

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 (see Chapter I).

When To Submit Requests To KePRO For Service Authorization For New Individuals

A. For New Individuals Starting Services

Psychosocial Rehab (H2017)
Mental Health Support Services (H0046)
Therapeutic Day Treatment for Children and Adolescents/Day Treatment and Partial Hospitalization for Adults (H0035)
Intensive Community Treatment (H0039)
Intensive In Home Services (H2012)
Mental Health Case Management (H0023)

Note that for Intensive In Home, Therapeutic Day Treatment for Children and Adolescents and Mental Health Support Service (for youth up to age 21) an Independent Clinical Assessment must be performed by a CSB or BHA.

Individuals who have not received services between January 1, 2009 and the present are considered new cases. Once the initial service specific provider required assessment is completed and it is determined that the individual meets criteria for treatment, new cases are allowed a limited number of units without service authorization. The units allotted that do not require service authorization are not renewable annually and are only allowed for new cases. After these limits without service authorization are used, member may receive additional units with service authorization. If the individual transfers to another provider, or there is a lapse in services, the allotted units that do not require service authorization are not reset. The

provider must contact KePRO with the discharge date if treatment ends before the service authorization expires.

The following table represents the service, the number of units available without service authorization for new members , the period when service authorization is required, and the total annual units allowable for each service. Providers must use the appropriate procedure codes, as described, in this table when requesting service authorization from KePRO.

For all subsequent years the fiscal year is from July 1 through June 30. Procedure Code and Service Description	Number of Units that do not require Service Authorization – New Cases Only	When Is SERVICE AUTHORIZATION Required?	Annual Service Limits - Includes Number Of Units That Do Not Require Service Authorization (Fiscal Year Is July 1 – June 30)*
H2017 – Psychosocial Rehab	10 units of service	For services continuing beyond 10 units	936 units/fiscal yr.
H0035 – Therapeutic Day Treatment for Children and Adolescents/Day Treatment and Partial Hospitalization for Adults	5 units of service	For services continuing beyond 5 units	780 units/fiscal yr.
H0039 – Intensive Community Treatment	5 units of service	For services continuing beyond 5 units	130 units/fiscal yr.
H0046 – Mental Health Support Services	5 units of service	For services continuing beyond 5 units	372 units/fiscal yr.
H0023 – Mental Health Case Management	1 unit of service	For services continuing beyond 1 unit	12 units/ fiscal yr. (1 unit per calendar month)

The provider must submit service authorization requests for services to KePRO. KePRO will make a determination within 3 business days from the date of receipt, provided all required information is submitted with the initial request.

Retro Medicaid Eligibility

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

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care programs, the service authorization Contractor will honor the Medicaid MCO service authorization if the member has been disenrolled from the MCO. Similarly, the

MCO will honor the service authorization contractor's authorization based upon proof of authorization from the provider, DMAS, or the service authorization Contractor that services were authorized while the member was eligible under fee-for-service (not MCO enrolled) for dates where the member has subsequently become enrolled with a DMAS contracted MCO.

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. The service authorization contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify member eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled members, the provider must follow the MCO's service authorization policy and billing guidelines.

Individuals Who Are Enrolled With DMAS Contracted Managed Care Organizations

Many Medicaid members are enrolled with one of the Department's contracted Managed Care Organizations (MCO). In order to be reimbursed for inpatient acute psychiatric, outpatient psychiatric, and outpatient substance abuse 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/mc-medallionII.htm.

Individuals who are authorized by DMAS service authorization Contractor into Treatment Foster Care Case Management (TFC-CM) or Residential Treatment Center (RTC) will be disenrolled from the MCO as TFC-CM and RTC services are reimbursed for all Medicaid individuals through the Medicaid fee-for-service program. Also, Community Mental Health Rehabilitation 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
Inpatient psychiatric services including free-standing psychiatric services.	Yes	For MCO enrolled individuals, the provider must follow their respective contract with the MCO. Contact the MCO directly.
Outpatient psychiatric services	Yes	Same as above

Community Mental Health Rehabilitation Services	No	Same as FFS. For MCO enrolled individuals, the provider must follow the DMAS coverage rules and guidelines.
TFC-CM	No	Same as FFS. Providers contact KePRO for service authorization. If the service meets DMAS criteria, DMAS Service Authorization Contractor notifies DMAS to disenroll the individual from the MCO.
RTC	No	Same as above
Outpatient substance abuse (SA) treatment services	Yes	For MCO enrolled individuals, the provider must follow their respective contract with the MCO. Contact the MCO directly.
SA Crisis Intervention	No	For MCO enrolled individuals, the provider must follow the DMAS coverage rules and guidelines.
SA Intensive Outpatient	No	Same as above
SA Day Treatment	No	Same as above
Opioid Treatment – including methadone	No	Same as above
SA Case Management	No	Same as above

Communication

Provider manuals are located on the DMAS and KePRO websites. The contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to http://dmas.kepro.com and clicking on the *Forms* tab for questionnaires and fax forms to request services. A service specific checklist may be found by clicking on "Service Authorization Checklists" on KePRO's website. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Behavioral Health* 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 Memo to the DMAS website. Changes will be incorporated within the manual.

SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

DMAS' Service Authorization Contractor, KePRO, is moving to their own Provider Portal "Atrezzo Connect" effective October 31, 2011 at 6:00 a.m. The previous system (iEXCHANGE™) will not be available to providers, effective 5:00 p.m., October 28, 2011. For direct data entry requests, providers must begin using the new Atrezzo Connect Provider Portal. The new Atrezzo Connect Provider Portal advantages include easier system changes when DMAS program changes occur and specific prompts and edits related to certain programs in the new system. DMAS-related information from the previous system will be transferred into KePRO's new Atrezzo Connect Provider Portal prior to October 31, 2011.

The registration process for providers is much simpler and quicker than with iEXCHANGE™ and happens immediately on-line. Existing iEXCHANGE™ users can log onto Atrezzo Connect without re-registering, using a special username consisting of their iExchange group ID, a hyphen, and their iExchange username. The initial password is also the iExchange group ID. They will then be given a one-time opportunity to change their username and password. Users from providers not currently registered with iExchange will select a username and password and then establish their legitimate connection to the selected NPI# by providing information taken from the most recent remittance advice. After logging in, Group administrators and Administrators within Atrezzo can specify other users within their organization and establish preferences for servicing providers, diagnoses and procedure codes. The Atrezzo Connect User Guide is available at dmas.kepro.com: Click on the Training tab, then the General tab.

If providers are unable to access the KePRO's website for the Atrezzo Connect Provider Portal or have authorization questions, they may contact KePRO at providerissues@kepro.com. They may also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

KePRO will also accept requests by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. Specific information regarding the service authorization requirements and methods of submission may be found on the contractor's website at https://dmas.kepro.com.

Independent Clinical Assessment for Children's Rehabilitative Services

Effective July 18, 2011, the Department of Medical Assistance Services (DMAS) will require an independent clinical assessment as a part of the service authorization process for Medicaid and FAMIS children's IIH, TDT, and MHSS (up to the age of 21) requires that an Independent Clinical Assessment be conducted by a Community Services Board (CSB) or Behavioral Health Authority (BHA) in order to access children's community-based mental health rehabilitative services.

The current process for requesting service authorizations from KePRO remains the same with one exception. The authorization checklists have been revised to include new

questions. If the provider submits a service authorization request without record of having a current (within 30 days) Independent Clinical Assessment, KePRO will administratively reject the request. An independent assessment must be obtained prior to re-submitting the request.

If the independent assessment does not recommend the requested service and the service provider agrees with the independent clinical assessment recommendation, no service authorization request will be submitted to KePRO. If the service provider documented a significant change in the child's life since the independent clinical assessment that may change the independent assessor's recommendation, the service provider must contact the independent assessor to discuss the recommendation. The CSB/BHA may modify the independent clinical assessment as deemed necessary. All modifications must be submitted to KePRO electronically via Atrezzo Connect prior to the submission of a service authorization request for that service.

If the independent assessor does not recommend the service and the parent/legal guardian disagrees with the recommendation, the parent/legal guardian may approach a service provider requesting the service. If, after conducting the service specific assessment, the service provider identifies additional documentation beyond the independent clinical assessment that demonstrates the service is clinically indicated, the service provider may submit a service authorization request to KePRO. KePRO will review the service authorization submission and the independent assessment, and make a determination

For children and youth currently receiving Intensive In-Home, Therapeutic Day Treatment, or Mental Health Support Services (under 21), an Independent Clinical Assessment will be required within thirty (30) days of the current service authorization expiration date. The Independent Clinical Assessment will be required as part of the first service re-authorization request for dates of service on and after September 1, 2011. The provider of the services shall inform the parent/legal guardian that an Independent Clinical Assessment is needed prior to the submission of the request if services are to continue. The provider of services may assist the parent/legal guardian to access the Independent Clinical Assessment by informing them of the requirement and providing contact information. The Independent Clinical Assessment must be completed prior to submitting the service re-authorization request to KePRO, or the request will be administratively rejected.

Service Authorization Process For Intensive In-Home Services (H2012)

Effective July 18, 2011, an Independent Clinical Assessment (ICA) must be conducted by the CSB/BHA prior to the authorization of new service requests for IIH services for dates of service beginning on or after July 18, 2011. New services are defined as services for which the individual has been discharged from or never received prior to July, 17, 2011.

Effective September 1, 2011, a completed Independent Clinical Assessment will be required for those individuals up to the age of 21 who are currently receiving services and their service re-authorization is due for dates of service on or after September 1, 2011 for IIH. Appointments for the Independent Clinical Assessment may be scheduled up to thirty days in advance of the expiring current service authorization (see Independent

Clinical Assessment for Children's Rehabilitative Services section Chapter IV of this manual)

Intensive In-Home Services (H2012) requires service authorization before any treatment (beyond the assessment) are reimbursed. The service specific provider assessment (H0031) will continue to be allowed without service authorization. The service specific provider assessment additionally corroborates the need for treatment and is used to develop the individual service plan.

Service authorization decisions will be made utilizing DMAS criteria identified throughout this manual.

The first 26 weeks of each fiscal year are considered State Plan Option Services, and any additional weeks must be requested through EPSDT. Regardless of when services start for the first treatment year, the number of allowable weeks is re-set on July 1of each year.

Required Information For Service Authorization For Intensive In-Home Services

Initial Review:
For the initial review request, the provider must submit the following information:

1) Provider Contact Name:
2) Provider Contact Number:
3) Was an Independent Clinical Assessment completed through the CSB/BHA? ☐ Yes ☐No
4) a. If Yes, what was the date of the assessment?
   b. If, No, please explain why.
   (Your request for service authorization will be rejected if no assessment has been completed at this time).
5) Name of the CSB/BHA completing the Independent Clinical Assessment
6) What service(s) was recommended from that assessment?
7) Has the member been discharged from a Level A, B or C facility within the past 30 days?☐ Yes ☐No
   a. If Yes, date of discharge:
      (If Yes, the Independent Clinical Assessment is not required).
   b. If No, the Independent Clinical Assessment is required to be completed within 30 days of this request. Please answer questions #4 – #6.
8) Is This a Retro Review: ☐ Yes ☐No
   a. If retro request, date provider was notified of Medicaid eligibility:
9) Have Health, Safety and Welfare issues been identified with this Member?☐ Yes ☐ No

a. Has a CPS referral been made? ☐Yes ☐No

b. If no, what intervention(s) have been taken to address this concern?

10) Requested Start Date:

11) Admission Date:

12) Projected Discharge Date:

13) Have treatments / services been tried or explored in the past 30 days : ☐Yes ☐ No

a. List treatments /services and indicate if successful or unsuccessful:

14) Has the local CSB been contacted to determine if Mental Health Case Management services are being provided?

☐Yes ☐ No

15) Identify how services set in child's residence are more likely to be successful than a clinic.

16) Does the Member demonstrate a clinical necessity arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities? ☐Yes ☐ No

17) Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

a. Does the Member have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community? ☐ Yes ☐ No

b. Does the Member exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary? ☐Yes ☐ No

c. Does the Member exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior? ☐Yes ☐ No

18) Current Symptoms/Behaviors:

Provide a narrative of the behaviors exhibited over the past 30 days that place the child at risk of removal from the home due to a clinical need and warrant the requested level of care. **(Explain the frequency, intensity and duration of each behavior, and progress/lack of progress towards treatment goals, as they relate to questions 15-17). Include medications/changes.:**

Concurrent Review

The provider must submit the following information no earlier than 30 days prior to the end of the current authorization:

1. Provider Contact Name:
2. Provider Contact Number:

3. Is this the first Continued Stay review since the July 18, 2011, implementation of the Independent Clinical Assessment? ☐ Yes ☐ No
4. Is this the first Continued Stay review after discharge for a Level A, B, or C facility since the July 18, 2011, implementation of the Independent Clinical Assessment? ☐ Yes ☐ No
   (If Yes to # 3 and # 4, an Independent Clinical Assessment is required to be completed within 30 days of this request).
5. Date of the Independent Clinical Assessment.
6. Name of the CSB/BHA completing the Independent Clinical Assessment.
7. What service(s) was recommended from that assessment?
8. Requested Start Date:
9. Admission Date:
10. Projected Discharge Date:
11. Is This a Retro Review: ☐ Yes ☐ No
    a. If retro request, date provider was notified of Medicaid eligibility:
12. Have Health, Safety and Welfare issues been identified with this Member? ☐ Yes ☐ No
    a. Has a CPS referral been made? ☐ Yes ☐ No
    b. If no, what intervention(s) have been taken to address this concern?
13. Have the 26 weeks of service under State Plan Option (SPO) been used? ☐ Yes ☐ No
    a. If Yes, is this a request for additional weeks of service under EPSDT, if medical necessity continues to be met? ☐ Yes ☐ No

14. Has the local CSB been contacted to determine if Mental Health Case Management services are being provided?
    ☐ Yes ☐ No
15. Identify how continued services set in child's residence are more likely to be successful than a clinic:

16. Does the Member demonstrate a clinical necessity arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities? ☐ Yes ☐ No
17. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:
    a. a. Does the Member have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or

community? ☐Yes ☐ No
b. Does the Member exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary? ☐Yes ☐ No
c. Does the Member exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior? ☐Yes ☐ No

18. Has the Member's level of functioning improved with respect to the goals outlined in the ISP and the Member can reasonably be expected to maintain these gains at a lower level of treatment? ☐Yes ☐ No
19. Provide a narrative of the behaviors exhibited over the past 30 days that place the child at risk of removal from the home due to a clinical need and warrant the requested level of care. **(Explain the frequency, intensity and duration of each behavior, and progress/lack of progress towards treatment goals, as they relate to questions 15-18). Include medications/changes.:**

"Out-Of-Home" and "At-Risk" Defined:

An out-of-home placement (at risk of) is defined as one or more of the following:

- Level A or Level B group home
- Regular foster home (if currently residing with biological family and due to behavior problems is at risk of move to DSS custody)
- Treatment foster care placement (if currently residing with biological family or a regular foster family and due to behavior problems is at risk of removal to a higher level of care) (IIH services would be provided to the child and the biological family or the foster family)
- Level C residential facility
- Emergency shelter (for child only, due to MH/behavioral problems),
- Psychiatric hospitalization
- Juvenile justice/incarceration placement (detention, corrections)

At-Risk is defined as one or more of the following:

- Within the past two weeks of the date of the IIH assessment, screened by an LMHP or MH agency for escalating behaviors that have put the child or others at immediate risk of physical injury.
- The parent or legal guardian is unable to manage the mental, behavioral or emotional problem in the home and is actively seeking alternate out of home placement (within the past 2-4 weeks [it needs to be a current problem, not a threat of removal from the home that the parent has made in the past and not acted on]).
- History of failed services within the past 30 days from one of the following:

  - Crisis Intervention
  - Crisis Stabilization
  - Outpatient Psychotherapy
  - Outpatient Substance Abuse Services
  - Mental Health Support (older adolescent)
- Recommendation for IIH by treatment team/FAPT team for a member currently in one of the following:
  - RTC Level C (transition)
  - Group Home Level A or B (transition)
  - Acute Psychiatric Hospitalization (transition)
  - Foster Home (transition, or foster parent is unwilling to continue)
  - MH case management
  - Crisis Intervention
  - Crisis Stabilization
  - Outpatient Psychotherapy
  - Outpatient Substance Abuse Services

If a service authorization request is not approved, a member may meet level of intensity for one of the following services listed below as described in the Community Mental Health or Psychiatric Services Manual:

Crisis Intervention,
Crisis Stabilization,
Mental Health Support (older adolescent).
Outpatient Psychotherapy,
Outpatient Substance Abuse Services,

If the child has exceeded the regulatory limits within the fiscal year, and continues to require additional services, these services may be requested through DMAS Service authorization Contractor under EPSDT. It is the providers responsibility to track service limits and request EPSTD coverage when needed. The EPSDT authorized period will always end on or before 6/30; on 7/1 of each year, the state plan service limits are utilized before EPSDT can be authorized. Providers are responsible for monitoring service limits and utilization.

The service authorization contractor will accept requests via direct data entry (DDE). Specific information regarding the service authorization requirements and methods of submission may be found at the contractor's website, DMAS.KePRO.com. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

Service Authorization for Therapeutic Day Treatment (TDT) for Children & Adolescents (TDT) (H0035)

Effective July 18, 2011, an Independent Clinical Assessment must be conducted by the

CSB/BHA prior to the authorization of new service requests for TDT services for dates of service beginning on or after July 18, 2011. New services are defined as services, for which the individual has been discharged from or never received prior to July, 17, 2011.

Effective September 1, 2011, a completed Independent Clinical Assessment will be required for those individuals up to the age of 21 who are currently receiving services and their service re-authorization is due for dates of service on or after September 1, 2011 for IIH. Appointments for the Independent Clinical Assessment may be scheduled up to thirty days in advance of the expiring current service authorization (see Independent Clinical Assessment for Children's Rehabilitative Services section Chapter IV of this manual)

TDT is a combination of psychotherapeutic interventions combined with education and mental health treatment offered in programs of two or more hours per day with groups of children and adolescents with significant functional impairments in major life activities due to mental, behavioral, or emotional illness in a non-residential setting.

An initial review is required to be submitted to the service authorization contractor at admission and every 6 months. Continued stay reviews are required to be submitted to the service authorization contractor prior to the end of the current approval.

Required Information For Initial Service Authorization For TDT Service:

Initial Review:
For the initial review request, the provider must submit the following information:

1. Provider Contact Name:
2. Provider Contact Number:
3. Was an Independent Clinical Assessment completed through the CSB/BHA? ☐ Yes ☐No
4. a. If Yes, what was the dated of the assessment?
   b. If, No, please explain why.
   (Your request for service authorization will be rejected if no assessment has been completed at this time).
5. Name of the CSB/BHA completing the Independent Clinical Assessment
6. What service(s) was recommended from that assessment.
7. Has the member been discharged from a Level A, B or C facility within the past 30 days?☐ Yes ☐No
   a. If yes, date of discharge:
      i. (If yes, the Independent Clinical Assessment is not required).

ii. b. If no, the Independent Clinical Assessment is required to be completed within 30 days of this request. Please answer questions #4 – #6.

8. Is This a Retro Review: ☐Yes ☐ No
   a. If Retro Request, date provider was notified of Medicaid eligibility:
9. Requested Start Date:
10. Admission Date:
11. Service Authorization End Date:
12. Units Requested:
13. Does the member exhibit significant functional impairments in major life activities due to a mental, behavioral, or emotional illness, which have become more disabling over time: ☐Yes ☐No

14) Must meet **two** of the following:

- Does the member have difficulty establishing or maintaining normal interpersonal relationships to such a degree they are at risk of hospitalization or out of home placement due to conflicts with family or community: ☐Yes ☐No
- Does the member exhibit such inappropriate behaviors that repeated interventions by the mental health, social services, educational or judicial system are necessary?: ☐Yes ☐No
- 16) Does the member exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior: ☐Yes ☐ No

15) Must meet **one** of the following:

- Does the member require year-round treatment to sustain behavioral or emotional gains: ☐Yes ☐ No
- Does the member have problems so severe that they cannot be addressed in self-contained or resource classrooms (ED) without this programming during the school day or as a supplement to the school day: ☐Yes ☐ No
- Would the member otherwise be placed on homebound instruction due to severe emotional or behavioral problems that interfere with learning: ☐Yes ☐ No
- Does the member have emotional or behavioral problems, or both, so severe that the child cannot function in preschool enrichment or early intervention programs without therapeutic day treatment services: ☐Yes ☐No
- Does the member:

- Have deficits in social skills or peer relations or in dealing with authority: ☐Yes ☐No
- Display hyperactivity: ☐Yes ☐No
- Demonstrate poor impulse control: ☐Yes ☐No
- Exhibit signs of extreme depression ☐Yes ☐No or
- Demonstrate signs of being marginally connected with reality: ☐Yes ☐ No

16) Describe current symptoms and behaviors or other pertinent information as they relate to questions # 13-16 above. **Explain the frequency, intensity and duration of each behavior.**

Concurrent Review
The provider must submit the following information no earlier than 30 days prior to the end of the current authorization:

1. Provider Contact Name:
2. Provider Contact Number:
3. Is this the first Continued Stay review since the July 18, 2011, implementation of the Independent Clinical Assessment? ☐ Yes ☐No
4. Is this the first Continued Stay review after discharge for a Level A, B, or C facility since the July 18, 2011, implementation of the Independent Clinical Assessment? ☐ Yes ☐No
5. (If Yes to # 3 and # 4, an Independent Clinical Assessment is required to be completed within 30 days of this request).
6. Date of the Independent Clinical Assessment.
7. Name of the CSB/BHA completing the Independent Clinical Assessment.
8. What service(s) was recommended from that assessment?
9. Requested Start Date:
10. Admission Date:
11. Service Authorization End Date:
12. Units Requested:
13. Must meet **two** of the following:
    - Does the member have difficulty establishing or maintaining normal interpersonal relationships to such a degree they are at risk of hospitalization or out of home placement due to conflicts with family or community: ☐Yes ☐No

- 13) Does the member exhibit such inappropriate behaviors that recent multiple interventions by the mental health, social, educational or judicial system are necessary: ☐ Yes ☐ No
- 14) Does the member exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior: ☐Yes ☐ No

14) Must meet **one** of the following:

- Does the member require year-round treatment to sustain behavioral or emotional gains: ☐Yes ☐ No
- Does the member have problems so severe that they cannot be addressed in self-contained or resource classrooms (ED) without this programming during the school day or as a supplement to the school day: ☐Yes ☐ No
- Would the member otherwise be placed on homebound instruction due to severe emotional or behavioral problems that interfere with learning: ☐Yes ☐ No
- Does the member have emotional or behavioral problems, or both, so severe that the child cannot function in preschool enrichment or early intervention programs without therapeutic day treatment services: ☐Yes ☐No
- Does the member:
  - Have deficits in social skills or peer relations or in dealing with authority: ☐Yes ☐No
  - Display hyperactivity: ☐Yes ☐No
  - Demonstrate poor impulse control: ☐Yes ☐No
  - Exhibit signs of extreme depression ☐Yes ☐No or
  - Demonstrate signs of being marginally connected with reality: ☐Yes ☐ No

14) Describe current symptoms and behaviors or other pertinent information as they relate to questions # 12-14 above. **Explain the frequency, intensity and duration of each behavior.**

If the child has exceeded the regulatory limits within the fiscal year, and continues to require additional services, these 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 must be utilized before EPSDT can be authorized.

Service Authorization for Mental Health Support Service (MHSS) (H0046)

Effective July 18, 2011, an Independent Clinical Assessment must be conducted by the CSB/BHA prior to the authorization of new service requests for MHSS for youth under 21 years of age for dates of service beginning on or after July 18, 2011. New services are defined as services for which the individual has been discharged from or never received prior to July, 18, 2011.

Effective September 1, 2011, a completed Independent Clinical Assessment will be required for those individuals up to the age of 21 who are currently receiving services and their service re-authorization is due for dates of service on or after September 1, 2011 for IIH. Appointments for the Independent Clinical Assessment may be scheduled up to thirty days in advance of the expiring current service authorization (see Independent Assessment for Children's Rehabilitative Services section Chapter IV of this manual)

An Independent Clinical Assessment is not required for adults over 21.

An initial review is required to be submitted to the service authorization contractor at admission and every 6 months. Continued stay reviews are required to be submitted to the service authorization contractor prior to the end of the current approval, but no earlier than 30 days.

<u>Required Information For Initial Service Authorization For MHSS Service:</u>

Initial Review:
For the initial review request, the provider must submit the following information:

1. Provider Contact Name:
2. Provider Contact Number:
3. Was an Independent Clinical Assessment completed through the CSB/BHA? ☐ Yes ☐No
4. a. If Yes, what was the date of the assessment?
   b. If, No, please explain why.
   (Your request for service authorization will be rejected if no assessment has been completed at this time).
5. Name of the CSB/BHA completing the Independent Clinical Assessment
6. What service(s) was recommended from that assessment?
7. Has the member been discharged from a Level A, B or C facility within the past 30 days?☐ Yes ☐No
   a. If Yes, date of discharge:
   (If yes, the Independent Clinical Assessment is not required).

b. If No, the Independent Clinical Assessment is required to be completed within 30 days of this request. Please answer questions #4 – #6.

8. Is This a Retro Review: ☐Yes ☐ No
   a. If Retro Request, date provider was notified of Medicaid eligibility
9. Requested Start Date:
10. Admission Date:
11. Service Authorization End Date:
12. Units Requested:
13. Does the member demonstrate a clinical need for this service arising from a mental, behavioral or emotional illness, which results in significant functional impairments in major life activities and affects their ability to remain stabilized in the community: ☐Yes ☐No
14. Must meet at **two** of the following:

- Does the member have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization , homelessness, or isolation from social support: ☐Yes ☐No
- Does the member require help with basic living skills such as maintaining personal hygiene, food preparation and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized: ☐Yes ☐No
- Does the member exhibit such inappropriate behaviors that repeated interventions by mental health, social service, or the judicial system are necessary: ☐ Yes ☐ No
- Does the member exhibit difficulty in cognitive behavior such that they are unable to recognize personal danger or significantly inappropriate social behavior: ☐ Yes ☐No

15. Describe current symptoms and behaviors or other pertinent information as they relate to questions # 13-15 above. **Explain the frequency, intensity and duration of each behavior.**

Concurrent Review
The provider must submit the following information no earlier than 30 days prior to the end of the current authorization:

1) Provider Contact Name:
2) Provider Contact Number:

3) Is this the first Continued Stay review since the July 18, 2011, implementation of the Independent Clinical Assessment? ☐ Yes ☐ No
4) Is this the first Continued Stay review after discharge for a Level A, B, or C facility since the July 18, 2011, implementation of the Independent Clinical Assessment? ☐ Yes ☐ No
   (If Yes to # 3 and # 4, an Independent Clinical Assessment is required to be completed within 30 days of this request).
5) Date of the Independent Clinical Assessment.
6) Name of the CSB/BHA completing the Independent Clinical Assessment.
7) What service(s) was recommended from that assessment?
8) Requested Start Date:
9) Service Authorization End Date:
10) Units Requested:
11) Does the member demonstrate a clinical need for this service arising from a mental, behavioral or emotional illness, which results in significant functional impairments in major life activities and affects their ability to remain stabilized in the community: ☐ Yes ☐ No
12) Must meet two of the following;

- Does the member have difficulty in establishing or maintaining normal interpersonal relationships, to such a degree, that they are at risk of hospitalization , homelessness or isolation from social support: ☐ Yes ☐ No
- Does the member require help with basic living skills such as maintaining personal hygiene, food preparation and maintaining adequate nutrition or managing finances? to such a degree that health or safety is jeopardized; ☐ Yes ☐ No
- Does the member exhibit such inappropriate behaviors that repeated interventions by mental health, social services or the judicial system are necessary; ☐ Yes ☐ No
- Does the member exhibit difficulty in cognitive behavior such that they are unable to recognize personal danger or significantly inappropriate social behavior: ☐ Yes ☐ No

13) Describe current symptoms and behaviors or other pertinent information as they relate to questions # 11-13 above. **Explain the frequency, intensity and duration of each behavior**.

Service Authorization For Community-Based Residential Services For Children And Adolescents Under 21 (Level A) - H2022 HW (CSA), H2022 HK (Non CSA) & Therapeutic Behavioral Services (Level B) – H2020 HW (CSA) H2020 HK (Non-CSA)

Level A & Level B residential treatment must be service authorized by the DMAS service authorization contractor.

The service authorization contractor will apply current InterQual® Level of Care, Behavioral Health Criteria, Residential & Community-Based Treatment, and DMAS criteria.

Required Information for Service Authorization

Initial Review:
Within 3 business days of admission, the provider must submit demographic information and the following:

- For CSA requests only, the 3 digit locality code is required. (The locality code will reflect the locality that has fiscal responsibility for the Medicaid member and should be submitted to the provider by the referral source).
- A primary diagnosis of mental illness that meets the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I disorder. All 5 axes are required to be in the medical record. If this is a dual diagnosis of Mental Health (MH) and Substance Abuse, the focus of treatment must be the MH problem. Medicaid does not cover inpatient treatment for substance abuse disorders.
- Description of symptoms and behaviors within the last week.
- If the individual is unable to be managed safely at a less intensive level of service a statement is required identifying what service(s) were tried and how they failed.
- Description of the child's current support system.
- Provide date of Certification of Need (CON)/Independent Team Certification. Confirm all required information and appropriately dated signatures are included on the CON.
- Provide date of Initial Plan of Care (IPC), confirm all required information and appropriately dated signatures included.
- Provide date of UAI (CSA) or assessment (non-CSA) supporting placement at this level of care.

If all criteria are met, the service authorization contractor will approved for 6 months. All DMAS criteria must continue to be met during the authorized period for reimbursement to take place.

Continued Stay Review (same provider):
No earlier than 30 days prior to the end of the current authorization period, the provider must submit demographic information and the following:

- For CSA cases confirmation of the 3-digit locality code.
- A primary diagnosis of mental illness that meets the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I disorder. All 5 axes are required to be in the medical record. If this is a dual diagnosis of Mental Health (MH) and Substance Abuse Services (SAS), the focus of treatment must be the MH problem. Medicaid does not cover inpatient treatment for substance abuse disorders.
- Description of symptoms and behaviors within the last month.
- Description of functioning within the last month.
- Provide date of Comprehensive Individual Plan of Care (CIPOC) and confirm all required information and appropriately dated signatures are included on the CIPOC.
- Provide date of most recent CIPOC update (current to within past 30 days), and confirm all required information and appropriately dated signatures are included on the CIPOC update.
- Provide anticipated discharge date.

If all criteria are met, the PA Contractor will approved for 6 months. All DMAS criteria must continue to be met during the authorized period for reimbursement to take place.

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

If the child has been in placement for more than 30 days, the information required to be submitted for authorization will include the continued stay review information noted above, as well as information on any failed services, the support system, the Certificate of Need (CON) the IPC and the UAI.

Service Authorization For Day Treatment/Partial Hospitalization (DT/PH) (H0035)

DT/PH is a combination of diagnostic, medical, psychiatric, psychosocial and psycho-educational treatment modalities for individuals over the age of 20 with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment who do not require inpatient treatment. Services are offered in programs of two or more hours per day provided to groups of individuals in a non-residential setting.

Required Information For Service Authorization

Initial review required to be submitted to the service authorization contractor at admission. Continued stay reviews are required to be submitted to the service authorization contractor prior to the end of the current approval.

Clinical information needed from provider for application of Day Treatment/Partial Hospitalization (DT/PH) criteria:

Initial Review (new provider to member)

- For DT/PH, individuals must meet the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I or Axis II Mental Health Disorder. V codes are not acceptable as stand alone diagnoses.
- If there is a dual diagnosis of Mental Health (MH) and SA, services must be integrated.
- Describe symptoms/severity of illness:
- Must demonstrate a clinical necessity for the services with significant functional impairments in major life activities.
- Must meet at least two of the following:
    - Have difficulty establishing or maintaining normal interpersonal relationships to the degree they are at risk of hospitalization or homelessness; or
    - Require help with basic living skills such as personal hygiene, preparing food, maintaining nutrition or managing finances to such a degree health or safety is jeopardized; or
    - Have behaviors that require repeated interventions by the mental health, social services or judicial system; or
    - Be unable to recognize personal danger or significantly inappropriate social behavior.

Continued Stay Review (same provider)

- For DT/PH, individuals must meet the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I or Axis II Mental Health Disorder. V codes are not acceptable as stand alone diagnoses.
- Describe the continued need for DT/PH:
    - Must continue to demonstrate a clinical necessity for the services with significant functional impairments in major life activities.
    - Must continue to meet at least two of the following:
    - Have difficulty establishing or maintaining normal interpersonal relationships to the degree they are at risk of hospitalization or homelessness; or
    - Require help with basic living skills such as personal hygiene, preparing food, maintaining nutrition or managing finances to such a degree health or safety is jeopardized; or
    - Have behaviors that require repeated interventions by the mental health, social services or judicial system; or
    - Be unable to recognize personal danger or significantly inappropriate social behavior.

Service Authorization for Psychosocial Rehabilitation (PSR) (H2017)

PSR Service is for adults. The program should be of two or more consecutive hours per day, provided to groups of adults in a non-residential setting. The program should include assessment, education on diagnosed mental illness and medications, independent living skills, social and interpersonal skills in a supportive, structured program.

Initial review required to be submitted to the service authorization contractor at admission and every 6 months. Continued stay reviews are required to be submitted to the service authorization contractor prior to the end of the current approval.

Clinical information needed from provider for application of PR criteria:

Initial Review (new provider to member)

- For PR, individuals must meet the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I or Axis II Mental Health Disorder. V codes are not acceptable as stand alone diagnoses.
- If there is a dual diagnosis of Mental Health (MH) and SA, services should be integrated.
- Describe symptoms/severity of illness:
  - Individual must exhibit significant functional impairments in major life activities due to a mental, behavioral, or emotional illness.
- Must meet **two** of the following:
  - Have difficulty establishing or maintaining normal interpersonal relationships to the degree they are at risk of hospitalization, homelessness, or isolation from social supports; or
  - Have behaviors that require repeated interventions by the mental health, social services or judicial system; or
  - Be unable to recognize personal danger or significantly inappropriate social behavior; or
  - Require help in basic living skills to such a degree that health or safety is jeopardized.
- Individual must meet one of the following:
  - Have experienced long-term or repeated psychiatric hospitalizations; or
  - Lack daily living skills and interpersonal skills; or
  - Have limited or on-existent support system; or
  - Be unable to function in the community without intensive intervention; or
  - Require long-term services to be maintained in the community.

Continued Stay Review (same provider)

- For PR, individuals must meet the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I or Axis II Mental Health Disorder. V codes are not acceptable as stand alone diagnoses
- Describe the continued need for PR:
- Must continue to meet two of the following:
  - Have difficulty establishing or maintaining normal interpersonal relationships to the degree they are at risk of hospitalization, homelessness, or isolation from social supports; or
  - Have behaviors that require repeated interventions by the mental health, social services or judicial system; or
  - Be unable to recognize personal danger or significantly inappropriate social behavior; or
  - Require help in basic living skills to such a degree that health or safety is

jeopardized.
- Individual must continue to meet one of the following:
- Have experienced long-term or repeated psychiatric hospitalizations; or
- Lack daily living skills and interpersonal skills; or
- Have limited or on-existent support system; or
- Be unable to function in the community without intensive intervention; or
- Require long-term services to be maintained in the community.

Service Authorization for Intensive Community Treatment (ICT) (H0039)

ICT is an array of mental health services for adults with serious emotional illness who need intensive levels of support and service in their natural environment to enhance functioning in the community.

Initial review required to be submitted to the service authorization contractor at admission. Continued stay reviews are required to be submitted to the service authorization contractor prior to the end of the current approval. The service authorization contractor will authorize request based on medical necessity for up to 6 month.

Clinical information needed from provider for application of Behavioral Health: Residential & Community-Based Treatment criteria:

Initial Review

- For ICT services, individuals must meet the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I or Axis II Mental Health Disorder. (**DMAS requirement**)
- If this is a dual diagnosis of Mental Health (MH) and SA, services must be integrated.
- The individual must meet one or more of the following criteria:
    - Is at high risk for psychiatric hospitalization or for becoming or remaining homeless, or require intervention by the mental health or criminal justice system due to inappropriate social behavior;
        - Describe risk
        - Describe problems in ability to form relationships
        - Describe role performance at work, school and in caring for dependents
        - Describe support system or lack thereof
        - Describe the current living situation; and/or
    - Has a history (three months or more) of a need for intensive mental health treatment or treatment for serious mental illness and substance abuse and demonstrates a resistance to seek out and utilize traditional treatment options.
        - Describe need

        - Describe resistance

- Describe specific symptoms that interfere with primary activities of daily living (ADLs) that prevent independent functioning and intensive treatment and support)

Continued Stay Review

- For ICT, individuals must meet the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I or Axis II Mental Health Disorder.

- Within past month:
    - Describe symptoms and behaviors
    - Describe specific functioning
        - Social/interpersonal behavior
        - Ability to manage IADLs
        - Medication compliance

Service Authorization For Mental Health Case Management (MHCM) (H0023)

MHCM is for children, adolescents and adults. The service is to assist with accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs.

Initial review required to be submitted to the service authorization contractor at admission and annually thereafter. Continued stay reviews are required to be submitted to the service authorization contractor prior to the end of the current approval period.

Clinical information needed from provider for application of MHCM criteria:

Initial Review (new provider to member)

Describe symptoms/severity of illness:

Birth through age 7 - Must exhibit being **<u>at risk of serious emotional disturbance</u>** and meet at least one of the following criteria: (a rule-out, or an adjustment disorder diagnosis, or V Code is acceptable)

- The child exhibits behavior or maturity that is significantly different from most children of the child's age and that is not primarily the result of developmental disabilities or mental retardation; or
- Parents or persons responsible for the child's care have predisposing factors themselves, such as inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, that could result in the child developing serious emotional or behavioral problems; or
- The child has experienced physical or psychological stressors, such as living in poverty, parental neglect, or physical or emotional abuse, that have put him or her at risk for serious emotional or behavioral problems; and

- **Birth through age 17** - Individuals must exhibit serious emotional disturbance

that meets the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I or Axis II Mental Health Disorder. OR…

- Child must exhibit all of the following:
  - Problems in personality development and social functioning that have been evident over the past year; and
  - Problems that are significantly disabling based on social functioning of peers; and
  - Problems that have become more disabling over time; and
  - Service needs that require significant intervention by more than one agency.

- **Adults, age 18+ -** Individuals must meet the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I or Axis II Mental Health Disorder. Adjustment Disorder or V codes are not acceptable as stand alone diagnoses.
- If there is a dual diagnosis of Mental Health (MH) and SA, services should be integrated.
- Must exhibit severe and recurrent disability from mental illness and meet 2 of the following:
  - Is unemployed; is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.
  - Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
  - Has difficulty establishing or maintaining a personal social support system.
  - Requires assistance in basic living skills.
  - Exhibits inappropriate behavior that often results in intervention by mental health or judicial system.

Continued Stay Review (same provider)

Describe the continued need for MHCM:

- Within past month, continued symptoms and behaviors, as follows:

- **Birth through age 7** - must continue to exhibit being at **risk of serious emotional disturbance** and meet at least one of the following criteria:

- The child exhibits behavior or maturity that is significantly different from most children of the child's age and that is not primarily the result of developmental disabilities or mental retardation; or
- Parents or persons responsible for the child's care have predisposing factors themselves, such as inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, that could result in the child developing serious emotional or behavioral problems; or
- The child has experienced physical or psychological stressors, such as living in poverty, parental neglect, or physical or emotional abuse, that have put him or her at risk for serious emotional or behavioral problems; and
- An Axis I diagnosis is required for claims payment. This may be a rule-out, or an

adjustment disorder diagnosis, or V Code.

- **Birth through age 17** - Individuals must exhibit serious emotional disturbance that meets the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I or Axis II Mental Health Disorder. OR…

  - Child must continue to exhibit all of the following:
  - Problems in personality development and social functioning that have been evident over the past year; and
  - Problems that are significantly disabling based on social functioning of peers; and
  - Problems that have become more disabling over time; and
  - Service needs that require significant intervention by more than one agency.

- **Adults, age 18+ -** Individuals must meet the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I or Axis II Mental Health Disorder. Adjustment Disorder or V codes are not acceptable as stand alone diagnoses.
- If there is a dual diagnosis of Mental Health (MH) and SA, services must be integrated.
- Must continue to exhibit severe and recurrent disability from mental illness and meet 2 of the following:

- Is unemployed due to diagnosis (and not the job market); is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.
- Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
- Has difficulty establishing or maintaining a personal social support system.
- Requires assistance in basic living skills.
- Exhibits inappropriate behavior that often results in intervention by mental health or judicial system.

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 member.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or 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, DMAS.KePRO.com. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX OR 1-877-652-9329.

EPSDT is not a 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 members 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, the contractor 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 Maternal and Child 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, substance abuse treatment on an inpatient basis, assistive technology, residential behavioral & substance abuse, in home supportive services 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)).

Maternal and Child Health Division 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.