APPENDIX C

PROCEDURES FOR PRIOR AUTHORIZATION OF PSYCHIATRIC SERVICES

Introduction

Prior authorization (PA) 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 PA and some may begin prior to requesting authorization.

Purpose of Prior Authorization

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

General Information Regarding Prior 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 PA requests.

The PA entity will approve, pend, reject, or deny all completed PA requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the PA entity notifies the individual and the provider in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the recipient's right to appeal the denial, in accordance with 42 CFR §200 *et seq* and 12 VAC 30-110 *et seq*. The provider also has the right to appeal adverse decisions to the Department.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care program, the PA entity is able to receive monthly information from and provide monthly information to the Medicaid managed care organizations (MCO) or their subcontractors on services previously authorized. The PA entity will honor the Medicaid MCO prior authorization for services and have system capabilities to accept PAs from the Medicaid MCOs.

Communication

Provider manuals are posted on the DMAS and contractor's websites. The contractor's website outlines the services that require PA, workflow processes, criterion utilized to make decisions, contact names and phone numbers within their organization, information on grievance and appeal processes and questions and answers to frequently asked questions.

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

Updates or changes to the PA 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.

APPEALS

The denial of pre-authorization for services not yet rendered may be appealed in writing by the Medicaid client within 30 days of the receipt of the notice of denial. The client or the client's authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488.

A provider may appeal an adverse decision for a service already provided by filing a written notice of appeal with the DMAS Appeals Division within 30 days of the provider's receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond, VA 23219

The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS.

Prior Authorization Process for Psychiatric Services

Inpatient Acute Psychiatric Services (Acute Hospitals and Acute Freestanding Hospitals)

Inpatient Acute Psychiatric Services in both acute hospitals and freestanding hospitals require prior authorization. Prior to the expiration of the initial assigned length of stay, if the recipient requires continued inpatient hospital care, the health care provider must contact KePRO, the PA Contractor, to initiate the concurrent review process. The provider must be able to provide KePRO review staff with the recipient's Medicaid identification number/preauthorization number and must be prepared to discuss the medical indications and plan of care for continued hospitalization The review analyst will apply InterQual ISD-AC criteria and supplemental criteria to the medical information provided and will assign an additional length of stay if criteria are met for continued inpatient hospitalization. Concurrent review will continue in the same manner until the recipient is discharged.

Planned/scheduled admissions must be preauthorized within 24 hours of admission, or on the next business day after admission. Obtaining prior authorization prior to admission is encouraged. Unplanned/urgent or emergency admissions must be preauthorized within 24 hours of admission, or on the next business day after admission. To request prior authorization, contact KePRO. KePRO will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. Specific information regarding the prior authorization requirements and methods of submission can be found at the contractor's website, DMAS.KePRO.org. 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. The program will take you through the steps needed to receive authorization for service requests.

Outpatient Psychiatric Services

Outpatient psychiatric services require prior authorization after 26 sessions in the first year of treatment. During the first year of treatment, there may be an additional 26 sessions when preauthorized. The initial 26 sessions must be used within one year of the first date of service (anniversary date) and cannot be carried over into subsequent years. There is a limit of 26 sessions in subsequent years, but these sessions must be preauthorized. The 26-visit restriction does not apply to the psychiatric diagnostic interview examination. However, each provider may only bill one psychiatric diagnostic interview examination within a 12-month period. The examination must meet medical necessity criteria. If the service limit is met for children under the age of 21, additional sessions may be available when medically necessary, through the EPSDT program.

To check whether authorization is required for additional psychiatric services (the individual has used all 26 initial sessions or all of the sessions subsequently authorized), call the Medicaid HELPLINE at 1-800-552-8627; provide the individual's Medicaid number; and ask for the record of utilization of psychiatric services. The claims history file contains information on paid claims. If a claim has not been paid, the number of available sessions will be overstated. Ask the patient whether he or she has seen another provider; check the records for any services provided but not paid; and ask the HELPLINE whether any other provider is indicated on the file and the last date of service for which a claim was paid.

CPT codes 90805, 90807, 90809, 90811, 90813, and 90815 include medical evaluation and management and only psychiatrists, psychiatric nurse practitioners and psychiatric clinical nurse specialists may bill these codes when appropriate.

Claims for services that exceed the sessions available to the individual without authorization will be denied. DMAS is not responsible for claims denied because the service limit has been reached.

Prior Authorization Request Process

To request prior authorization for psychiatric services, contact KePRO, the DMAS prior authorization contractor. KePRO will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. Specific information regarding the prior authorization requirements and methods of submission may be found at the contractor's website, DMAS.KePRO.org. 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. The program will take you through the steps needed to receive authorization for service requests.

Once authorization is obtained, if the recipient is discharged from the service and there are dates of service and units that have not been used, contact KePRO 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 psychiatric services sessions are separate from the substance abuse treatment. When medically necessary, there may be concurrent authorizations for psychiatric services and substance abuse treatment. For persons with co-occurring psychiatric and substance abuse conditions, providers are encouraged to integrate the treatment. The most appropriate service, either psychiatric or substance abuse treatment would be prior authorized. If the service limit of three sessions in a seven-day period will be exceeded, another level of service may be more appropriate, such as Intensive Outpatient Services or Substance Abuse Day Treatment. Criteria for both services are described in the Medicaid Community Mental Health Rehabilitative Services manual available on the DMAS website.

Outpatient Substance Abuse Services

Outpatient substance abuse services require prior authorization after 26 sessions in the first year of treatment. During the first year of treatment, there may be an additional 26 sessions when preauthorized. The initial 26 sessions must be used within one year of the first date of service (anniversary date) and cannot be carried over into subsequent years. There is a limit of 26 sessions in subsequent years, but these sessions must be preauthorized. The 26-visit restriction does not apply to the psychiatric diagnostic interview examination. However, each provider may only bill one substance abuse treatment diagnostic interview examination within a 12-month period. The examination must meet medical necessity criteria. If the service limit is met for children under the age of 21, additional sessions may be available when medically necessary, through the EPSDT program.

To check whether authorization is required for additional substance abuse services (the individual has used all 26 initial sessions or all of the sessions subsequently authorized), call the Medicaid HELPLINE at 1-800-552-8627; provide the individual's Medicaid number; and ask for the record of utilization of substance abuse treatment services. The claims history file contains information on paid claims. If a claim has not been paid, the number of available sessions will be overstated. Ask the patient whether he or she has seen another provider; check the records for any services provided but not paid; and ask the HELPLINE whether any other provider is indicated on the file and the last date of service for which a claim was paid.

CPT codes 90804 through 90815, 90846, 90847, 90853 and 90857 are designated for Substance Abuse services, with the HF modifier.

CPT codes 90805, 90807, 90809, 90811, 90813, and 90815 include medical evaluation and management and only psychiatrists, psychiatric nurse practitioners and psychiatric clinical nurse specialists may bill these codes when appropriate.

Substance Abuse Treatment Practitioners are only eligible to provide CPT codes with HF modifiers, excluding the evaluation and management codes.

Claims for services that exceed the sessions available to the individual without authorization will be denied. DMAS is not responsible for claims denied because the service limit has been reached. Claims paid that exceed the service limits may be subject to retraction at the time of an audit.

Prior Authorization Request Process

To request prior authorization for substance abuse services, submit a fax request to DMAS at

1-866-364-3526. The fax form (363-A) is available in an electronically-fillable format on the DMAS website at www.dmas.virginia.gov. A printable version is available on the website and in the "Exhibits" section at the end of this chapter. Instructions for completing the form are included. Be sure to complete all sections of the form, and include all required information. PA requests may be submitted no earlier than 30 days prior to the start of service.

The substance abuse treatment sessions are separate from the psychiatric services. When medically necessary, there may be concurrent authorizations for substance abuse treatment and psychiatric services. For persons with co-occurring psychiatric and substance abuse conditions, providers are encouraged to integrate the treatment. The most appropriate service, either psychiatric or substance abuse treatment would be prior authorized. If the service limit of three sessions in a seven-day period will be exceeded, another level of service may be more appropriate, such as Intensive Outpatient Services or Substance Abuse Day Treatment. Criteria for both services are described in the Medicaid Community Mental Health Rehabilitative Services manual available on the DMAS website.

Covered services and discharge criteria are covered in Chapter IV of this manual.

Psychiatric Residential Treatment (Level C)

Residential Treatment (Level C) requires prior authorization within one business day of admission. To request prior authorization, contact KePRO, the DMAS prior authorization contractor. KePRO will accept requests via direct data entry (DDE) or by facsimile. There are attachments required to be submitted for both the initial review and subsequent reviews. The preferred method is through DDE for a quicker response. Specific information regarding the prior authorization requirements and methods of submission may be found at the contractor's website, DMAS.KePRO.org. 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. The program will take you through the steps needed to receive authorization for service requests.

For an initial review request, the provider will need to submit demographic information, as well as 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 recipient and should be submitted to the provider by the referral source.)
- For CSA requests only, the Reimbursement Rate Certification (See the "Exhibits" section at the end of Chapter IV for a sample form)
- For CSA requests only, CAFAS or PECFAS scores current within 90 days of admission (the individual item scores are required) (If the child is under age four or over age seventeen, provide as many item numbers as possible and specify where the tool is not appropriate for the child's age).

- Certificate of Need or, for non-CSA requests, the DMH224 (See the "Exhibits" section at the end of Chapter IV for sample forms)
- Initial Plan of Care (IPC) (See the "Exhibits" section at the end of chapter IV for a sample form. This sample form is not required to be used as shown, but the IPC must, at a minimum, include all elements of the sample.) The IPC must include:

    - DSM IV diagnosis, all five axes;
    - Description of behavior seven days prior to admission;
    - Description of alternative placement tried and outcomes;
    - Child's functional level and clinical stability;
    - Treatment goals and objectives;
    - Treatment interventions to be provided, including medications; and
    - Discharge planning, including an estimated length of stay.

- *For non-CSA residential placements only* – Pre-authorization may be submitted to KePRO seven days prior to the admission date. All of the above information is required (except where indicated for CSA requests only), and all criteria for authorization remain the same.

For residential treatment, the provider must submit their continued stay material to KePRO before the end of the current authorization but no earlier than ten calendar days before the end of the current authorization.

When submitting requests for a continued stay review, the provider must submit demographic information, as well as the following:

- For CSA requests only, the CAFAS or PECFAS scores, current within 90 days.
- Comprehensive Individual Plan of Care (CIPOC) (See "Exhibits" section at the end of chapter IV for a sample form.) The sample form is not required to be used as shown, but the CIPOC used must, at a minimum, include all elements of the sample, to include the following:

    - DSM-IV;
    - Symptoms and behaviors that support residential care;
    - Treatment goals, objectives, interventions, and target date for achievement;
    - Orders for medications, therapies, and 21 therapeutic interventions;
    - Summary of progress and justification for continued stay; and
    - Discharge Plan.

- Most recent CIPOC 30-day Progress Update (See the "Exhibits" section at the end of chapter IV for a sample form.) The sample form is not required to be used as shown, but the Progress Update used must, at a minimum, include all elements of the sample to include the following:

    - Any changes to the CIPOC;

- List individual and family therapy dates that occurred for the past 30 days; and
- Summary of progress and justification for continued stay.

Retroactive requests for authorizations will not be approved with the exception of retroactive Medicaid eligibility for the recipient. When retroactive eligibility is obtained, the request for authorization should be submitted no later than 30 days from the date notified of Medicaid eligibility,

If the child has been in placement for more than 14 days, the information required to be submitted for authorization will include both the initial review and continued stay review information noted above.

For CSA requests, if the Reimbursement Rate Certification is amended by the locality at any time during an authorization period, whether approved or denied, the most current rate certification must be submitted to KePRO. KePRO will adjust the rate on the authorization to reflect the most current rate certification. The rate entered on the CSA authorization is the rate that will be reimbursed on submitted claims.

KePRO will apply the residential treatment services criteria to the information provided and will assign an initial or additional length of stay, if criteria are met, not to exceed 90 days.

Treatment Foster Care Case Management

Treatment Foster Care Case Management requires prior authorization within 10 days of admission. To request prior authorization, contact KePRO, the DMAS prior authorization contractor. KePRO will accept requests via direct data entry (DDE) or by facsimile. The preferred method is through DDE for a quicker response. Specific information regarding the prior authorization requirements and methods of submission may be found at the contractor's website, DMAS.KePRO.org. 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. The program will take you through the steps needed to receive authorization for service requests.

For an initial review request, the provider will need to submit demographic information, as well as the following information:

- CAFAS or PECFAS scores current within 90 days of admission (the individual item scores are required) (If the child is under age four (4) or over age 17, provide as many item numbers as possible and specify where the tool is not appropriate for the child's age).
- DSM IV Diagnosis;
- A list of services to be provided in the first 45 days of placement;
- A description of the child's immediate behavior prior to admission that correlate to the CAFAS or PECFAS scores;

- Confirmation of the FAPT assessment
- Locality code

For a continued stay review request, the provider will need to submit demographic information, as well as the following:

- CAFAS or PECFAS scores current within 90 days (the individual item scores are required) (If the child is under age four (4) or over age 17, provide as many item numbers as possible and specify where the tool is not appropriate for the child's age).
- DSM IV Diagnosis;
- Confirmation on face-to-face visits;
- Confirmation that continued TFC-CM is needed to meet the child's needs; and
- Confirmation that the CTSP and 90-Day Progress Reports are completed as required.
- Locality code

If the child has been in placement for more than 45 days, the information required to be submitted will include both the initial review and continued stay review information noted above.

Retroactive requests for authorizations will not be approved with the exception of retroactive Medicaid eligibility for the recipient. When retroactive eligibility is obtained, the request for authorization should be submitted no later than 30 days from the date notified of Medicaid eligibility.

Effective March 1, 2007, authorization for TFC-CM will be for a single unit only for each month. Only one provider is eligible for authorization and payment for each month. If a recipient is discharged during an authorized period after 2-28-07, continue to notify KePRO of the discharge date. If an approval is for a full month, but the discharge date is mid-month, KePRO will not change the authorization for that month, only for subsequent months, since only one unit is authorized for each month, and only one provider can bill for that unit. If a new provider begins service mid-month, and the previous provider already has authorization for the month, the new provider's authorization will begin on the first of the next month. For example, provider A has an authorization for 3-1-07 through 12-31-07 for 10 units, and notifies KePRO of discharge on 4-18-07. KePRO will reject the dates of service beginning 5-1-07 through 12-31-07. Provider B submits a request for dates of service 4-19-07 forward. KePRO may approve dates of service 5-1-07 forward. Provider B will not receive authorization for 4-19-07 through 4-30-07, since provider A already has an authorization for the one unit available for the month of April.

Early Periodic Screening Diagnosis and Treatment

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 recipient.

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 a DMAS-contracted managed care organization 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 and is medically necessary to correct, ameliorate (make better) or maintain the individual's condition. (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).

All Medicaid and FAMIS Plus services that are currently preauthorized by the PA 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.org. 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 prior 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 recipients 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 should 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 20 individualized counseling sessions and 6 family therapy sessions 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 therapy was requested for the child. The service limit was met for this service. But because there is clinical evidence from the therapy providers to continue treatment, the contractor should approve the request because there is clinically appropriate evidence which documents the need to continue therapy 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, substance abuse treatment on an inpatient basis, non waiver personal care, assistive technology, and nursing. All service requests must be a service that is listed in (Title XIX Sec. 1905*.[42 U.S.C. 1396d]* (r)(5)).