



INTEGRATED CARE MANAGEMENT AND QUALITY IMPROVEMENT



KePRO

Service Authorization Process Waiver Services

- **Service Authorization (Srv Auth) Submission Requirements for the following Waiver Service Types:**
 - **EDCD – 0900**
 - **AIDS – 0920**
 - **TECH - 0960**

Service Authorization Process

- The Srv Auth request fax form is the DMAS 98, “Community Based Care Request Form”.
- The Provider verifies eligibility by using the DMAS web based ARS system at:

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>

or by calling:

Medical at 1-800-884-9730 or 1-800-772-9996.

Requests should be submitted via:

- **iEXCHANGE** <http://dmas.kepro.com>
(registration required)
- **Fax: 877-652-9329**
- **Telephone: 888-827-2884 or 804-622-8900**
- **Mail: KePRO**
2810 N. Parham Rd, Suite 305
Henrico, Virginia 23294

Covered Services under:

- **EDCD (0900)**
- **AIDS (0920)**
- **Tech Waivers (0960)**

- **All AIDS Waiver members are eligible to receive Case Management services.**
- **Case Management is authorized as 10 units/month.**
- **For new AIDS Waiver enrollments, Case Management may not be the sole service authorized.**
- **Case Management may continue to be authorized when other services have been discontinued.**

Agency Directed Personal Care – T1019

- **Waiver types include, but not limited to EDCD and AIDS.**
- **Requests may be submitted by the Case Manager or Personal Care provider.**
- **If submitted by the Case Manager (for AIDS), all the required documentation completed by the servicing provider must be included with the request.**
- **Forms Required:**
 - **DMAS-98, DMAS-99, DMAS-97A/B (Plan of Care), and DMAS-100 (if supervision is being requested)**
 - **DMAS-96, DMAS-97, and UAI (only for new enrollments).**

Agency Directed Personal Care – T1019 (cont'd)

- Requested units are submitted as weekly and will be authorized as monthly.
- Dates of service are requested from the Start of Care (SOC) date and ongoing.
- Requests for services must be submitted within 10 business days of the SOC or within 10 business days of the provider's receipt of the DMAS 225. Provider must document date DMAS 225 received.
- Hours over the Member's level of care cap and/or supervision hours are not retroactive. The request must be submitted on the same day or prior to the SOC, to avoid and adverse decision due to untimely submission.

Agency Directed Personal Care – T1019 (cont'd)

- **The weekly hours requested on the DMAS 98 should reflect the total number of weekly hours on the Plan of Care.**
- **Services cannot be authorized prior to the date the DMAS 99 and DMAS 97A/B were completed.**
- **For new enrollments ONLY, services cannot be authorized prior to the signature date of the physician on the DMAS 96.**

Consumer-Directed Personal Care – S5126

- **Waiver types include, but not limited to EDCD and AIDS.**
- **Requested units are submitted as weekly and will be authorized as bi-weekly.**
- **The paid attendant may not be the parents of minor children who are receiving Waiver Services or the spouse of the individuals who are receiving Waiver Services.**

Consumer-Directed Personal Care – S5126 (cont'd)

- **The person directing care cannot be the paid attendant.**
- **Requirements for T1019 also apply to S5126.**

Agency-Directed Respite – T1005 and Consumer-Directed Respite (Unskilled) – S5150

- Waiver types include, but not limited to EDCD and AIDS.
- There must be an unpaid primary caregiver for AIDS waiver who lives in the home.
 - EDCD does not have this requirement
 - The Unpaid Primary Caregiver must live in the home with the member for AIDS waiver
- A maximum of 720 hours may be authorized per calendar year for all types of Respite combined (Skilled and Unskilled).
- The DMAS 99 and DMAS 97 A/B is required for Unskilled Respite.

Agency-Directed LPN Skilled Respite - S9125 (TE)

- **Waiver types include EDCD and AIDS.**
- **Member must demonstrate a skilled nursing need (tube feedings, vent dependant, tracheostomy, oxygen, wound care, etc.).**
- **Physical Therapy and Occupational Therapy are NOT classified as a skilled need.**
- **A maximum of 720 hours may be authorized per calendar year. This includes both Skilled Respite and Unskilled Respite combined.**
- **Services may not be authorized prior to the physician's signature and date on the DMAS 300 or CMS 485.**

All Respite Services

- **The maximum amount of combined Respite care services that a Member may receive is 720 hours in a calendar year. Hours do not regenerate when the Member transfers from one provider to another.**
- **If transferring Respite services from one provider to another, the new provider must verify with the previous provider the total number of Respite hours utilized prior to the new provider's Start of Care. Only the balance of Respite care hours available should be submitted with the service authorization request.**
- **If Member is receiving both CD and Agency Directed Respite, the total number of requested hours between the two may not exceed 720 hours per year.**

PERS Installation – S5160 and PERS Monitoring – S5161

- **Waiver types include, but not limited to EDCD and AIDS.**
- **PERS installation is requested/authorized for a one month timeframe.**
- **Services cannot be authorized prior to the date it is submitted to KePRO.**
- **Cannot be the sole service authorized through the Waiver. Members cannot be enrolled into the Waiver with this service.**
- **PERS monitoring is authorized for one unit of service monthly.**
- **PERS cannot be authorized if the Member has Supervision authorized on Personal Care POC.**

PERS Installation – S5160 and PERS Monitoring – S5161 (cont'd)

- **Member must be 14 years or older.**
- **Member must live alone or be alone for significant parts of the day and have no regular caregiver for extended periods of time.**
- **The Member may not receive PERS if she or he has a cognitive impairment as defined in the AIDS Waiver and ED CD provider Manuals.**

PERS and Medication Monitoring Installation- S5160 U1 & PERS and Medication Monitoring –S5185

- **Waiver types include, but not limited to EDCD and AIDS.**
- **For S5185: If S5160 U1- PERS Medication Monitoring Installation is not also requested, the provider must state that the PERS Medication Monitoring system is already installed (e.g. through private pay).**
- **A request for S5160 U1 must be accompanied by a request for S5185-PERS and Medication Monitoring.**
- **Must be physician ordered. Services cannot be authorized prior to the date of the physician order.**

PERS and Medication Monitoring Installation- S5160 U1 & PERS and Medication Monitoring –S5185

- **Authorization for medication monitoring is for 1 unit of service monthly.**
- **Cannot be the sole service authorized through the Waiver. Members cannot be enrolled into the Waiver with this service.**
- **May not be authorized if the Member has Supervision authorized on Personal Care POC.**

- **Waiver types include, but not limited to EDCD and AIDS.**
- **Must be authorized for S5185 PERS and Medication Monitoring.**
- **Authorization for PERS Nursing is for 1 unit of service bi-weekly.**
- **Please indicate whether or not you are requesting LPN or RN PERS monitoring by using the correct modifier.**

Private Duty Nursing (RN) - T1002 and Private Duty Nursing (LPN) - T1003

- **These codes are specific, but not limited to AIDS Waiver.**
- **Requires skilled nursing services ordered by a physician.**
- **Requested in daily or weekly hours, authorized monthly.**
- **Service Authorization cannot be granted before the physician signature date on the CMS 485.**

- **This code is specific to EDCD Waiver.**
- **Justification of need must include documentation of the number of days per week and hours of ADHC Services.**
- **Include the date the DMAS 301 is signed. Services cannot be authorized prior to the signature on the DMAS 301, (Must be signed within 5 visits of Start of Care date).**

T2038 – Transition Services (MFP)

Criteria:

Waiver Types Include , but not limited to 0900 (EDCD) or 0920 (AIDS)

- The Transition Coordinator must submit the request for transition services under EDCD Waiver.
- The authorization is always entered with the “through date” nine months after the authorized “from” date, even if the provider requests a shorter duration.
- Transition services may not be authorized for discharges from Acute Care, Psychiatric or Rehabilitation facilities.
- Case Manager must submit the request for Transition Services under AIDS Waiver.

Service Limits:

Entered as 1 unit per year.

T2038 – Transition Services (MFP)

Continued

Rules:

- **Level of Care must be present for either EDCD waiver or AIDS waiver.**
- **Use existing prior authorization service type 0900 for EDCD waiver or 0920 for AIDS waiver.**
- **The request for transition services must be submitted within 30 days of the NF/Long-Stay Hospital discharge date.**
- **One transition per lifetime per individual, MFP and all Waivers combined.**

H2015 Transition Coordination - MFP

Criteria:

- **Waiver Types Include , but not limited to 0900 (EDCD).**
- **In order to qualify for this service, the individual must have been a resident of a NF or Long-Stay Hospital immediately prior to EDCD Waiver enrollment.**

Service Limits:

- **Entered as 1 unit per Month.**
- **Services may not be authorized for more than 12 months after discharge from a facility. If requested for less than 12 months, the shorter period may be authorized.**

H2015 Transition Coordination – MFP Continued

Rules:

- The requested start of care date must be within 30 days of NF/Long-Stay Hospital discharge date.
- The authorized begin date of H2015 must not be prior to the begin date of EDCD enrollment on the LOC.
- H2015 may have already been authorized under MFP while in the facility; this does not affect the authorization through EDCD, except the existing MFP authorization must be ended if still active at EDCD enrollment.
- The MFP LOC (MP) may co-exist with the EDCD LOC when the MFP Srv Auth is ended.

Covered Services Under Technology Assisted (TECH) Waiver - 0960

- **Environmental Modifications (S5165) and Environmental Modifications Maintenance (99199 U4)**
- **Assistive Technology (T1999) and Assistive Technology Maintenance (T1999 U5)**
- **All other services authorized by DMAS.**
- **The Srv Auth is end dated 30 days from the approved “date from” (Start of Care date) in the VAMMIS system.**

Covered Services Under Technology Assisted (TECH) Waiver - 0960 (cont'd)

- **Maximum Medicaid funded expenditure is \$5,000.00 per calendar year for all Environmental Modifications (EM) and Assistive Technology (AT) codes combined (i.e. \$5,000.00 for EM codes and \$5,000.00 for AT codes).**
- **May have multiple items requested within the calendar year by the same or different provider but can not exceed \$5,000.00.**
- **Cost can not be carried over from one calendar year to another.**

Covered Services Under Technology Assisted (TECH) Waiver - 0960 (cont'd)

- **Dates of Service authorized cannot cross over calendar years.**
- **This service does not include items covered in the State Plan for Medical Assistance as a Durable Medical Equipment and Supplies or through another program.**
- **Request may be submitted by DME providers, or Nursing Agencies (If by Nursing Agencies, a DME provider number is required).**

Environmental Modifications – S5165 and 99199 U4

- Service is available to individuals who are enrolled in and receiving Tech Waiver services.
- EDCD and AIDS must be enrolled in “Money Follows the Person” program (MFP) in order to receive EM effective 7/1/2009.
- Submitted documentation must include the description of the item, cost of materials, labor and must provide direct medical or remedial benefit to the individual.

Environmental Modifications (EM) – S5165 and 99199 U4 (cont'd)

- **Modification can not be duplicated.**
- **EM not authorized to bring substandard dwelling up to minimum habitation standards.**
- **EM must not increase square footage of residence.**

Assistive Technology (AT) - T1999 and T1999 U5

- **Service is available to individuals who are enrolled in and receiving Tech Waiver services.**
- **EDCD and AIDS must be enrolled in “Money Follows the Person” program (MFP) in order to receive AT effective 7/1/2009.**
- **Assistive Technology must be portable.**

Assistive Technology (AT) - T1999 and T1999 U5 (cont'd)

- **May have multiple items requested within the calendar year by the same or different provider but can not exceed \$5,000.00.**
- **Documentation must include the name and title of the qualified professional who recommended the AT via a therapeutic evaluation, to include a statement to the need and medical necessity for the purchase.**

Assistive Technology (AT) - T1999 and T1999 U5 (cont'd)

- **Dates of Service authorized cannot cross over calendar years.**
- **Items can not be duplicated or rented.**
- **Must be medically necessary, cost effective, and not for educational purposes only.**

Transfers From One Provider to Another Provider

- **The new provider must send KePRO the DMAS-98 for fax and mail requests, DMAS-97 A/B and DMAS 99 for Personal Care and Unskilled Respite, DMAS 100 (if Supervision present), DMAS 300 or CMS 485(for skilled respite), CMS 485 (for Private Duty Nursing), and the DMAS-225, or a transferring letter from the previous provider indicating the last billable date of service (If the previous provider has not submitted discharge request to KePRO).**
- **If unable to obtain documentation from previous provider despite multiple attempts, please include this information with the Srv Auth request.**
- **Requests for services must be submitted within 10-business days of the SOC, or within 10-business days of verification of Medicaid eligibility. Provider must document date DMAS-225 was received.**

Transfers From One Provider to Another Provider (cont'd)

- **Please refer to Chapter IV of the Medicaid Provider Manual for timely submission requirements for service authorization as some services cannot be retro authorized and must be submitted by Start of Care date.**
- **Hours over the Member's level of care cap and/or Supervision hours previously authorized may be approved from the SOC if the documentation supports the eligibility, medical necessity, and timely submission requirements have been met.**

Transfer From One Waiver to Another

- **It must be clearly indicated on the request that the Member is transferring from one waiver program to another.**
- **The end date of the current waiver the Member is transferring from should be the last date of service.**
- **Member must be discharged from previous waiver before they can be enrolled into a new waiver.**

Tips For Successful Requests

- **Submit correct API/NPI # for the procedure code being requested.**
- **Service Provider = The provider API/NPI# who will provide the service (If faxing, # 9 on DMAS 98).**
- **Submitting Provider = The provider submitting the Srv Auth request as the referring provider (If faxing, # 11 on DMAS 98).**

Tips For Successful Requests (Cont'd)

- **Only one service provider API/NPI # can be submitted per request.**
- **Be sure to include the required information from all required forms.**

Tips For Successful Requests (cont'd)

- **Refer to DMAS 98 instructions (Faxing) and questionnaires (iEXCHANGE entry), and/or the specific Medicaid provider manual for specific information regarding service criteria, documentation requirements, and service authorization process.**
- **Do not send duplicate requests via multiple faxes, iEXCHANGE, etc. unless specifically instructed by KePRO to re-send. This only congests the system and slows the review process.**

Identification Numbers

- **Medicaid ID number consists of 12 digits (example-123456789012)**
- **KePRO Case Number consists of 9 digits with one dash (example-07000-0000).**
- **Srv Auth number generated by Affiliated Computer Systems (ACS) is 11 digits (example-12345678901).**
- **Without the correct number of digits, it will take longer to process the request.**

Case Number

- **A case number is generated after a service authorization has been submitted.**
- **The case number is different from the Srv Auth number.**
- **The case number is used for tracking the case through the KePRO system.**
- **The service authorization number is posted in iEXCHANGE and sent via fax for all submissions.**

Receiving a Srv Auth Number from ACS

- **Obtain the Srv Auth number from determination letters sent by ACS.**
- **Srv Auth notification letters are sent to the provider “mail to” address on file with the Provider Enrollment Unit.**
- **If there is no "Mail to" address, the letter goes to the service address.**

Receiving a Srv Auth Number from ACS (cont'd)

- **Providers who wish to change their “mail to” address may do so by contacting:**

**Virginia Medicaid Provider Enrollment Services
P. O. Box 26803
Richmond, VA 23261-6803**

Phone: 888-829-5373 (in state toll-free) or 1-804-270-5105

Fax: 888-335-8476 (in state toll-free) or 1-804-270-7027

Receiving a Srv Auth Number from ACS (cont'd)

- **Medicall at 1-800-884-9730 or 1-800-772-9996**
- **You may obtain the Srv Auth number from the web-based ARS at: <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>**
- **The ARS system is easy to use. It is accessible to anyone with an internet-connected PC and a web browser.**
- **New users must register for ARS online at: <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>. Users will receive a phone call from ACS (within 72 hours of registration) with instructions.**

Submitting Additional Information

- If upon review of the documentation submitted for a Srv Auth request is determined to be insufficient to process the request, the Customer Service Staff and/or Clinical Reviewer will “pend” the request for the additional information.
- To submit additional information on a pended case:

Via iEXCHANGE-

Providers may submit additional information through iEXCHANGE by choosing “add to comments” (NOTE: The “extend case” feature is used when requesting additional days of coverage only). Whenever a provider adds to comments, this puts the case back in the nurse review queue.

FAX / PHONE-

Providers will receive a KePRO fax notice requesting additional information. Please submit this information by following the instructions provided on the “additional information request”. Please label the document as additional information.

Retroactive Reviews

- **Providers must submit all required information to KePRO within 10 business days of initiating care or within 10 business days of receiving verification of Medicaid Eligibility from the local DSS (DMAS 225), or as otherwise specified in the provider manuals. Be sure to submit the date the DMAS 225 was received to support timely submission.**
- **Please refer to Chapter IV of the Medicaid Provider Manual for timely submission requirements for service authorization as some services cannot be retro authorized and must be submitted by Start of Care date.**
- **These “retro reviews” can also be submitted via iEXCHANGE, fax, mail, or phone and should include all of the required clinical documentation.**

Submitting Changes to an Existing Case (for all formats)

- If you are requesting a discharge – please request under the existing case number to be discharged. Do not request a new case.
- If you are requesting a change (increase or decrease) in **dates, units, or hours**, please request under the existing case number, do not open a new case for these types of requests.
- Requesting or creating new cases in place of updating existing cases only delays processing time and causes duplicate and overlapping date errors.

Overlapping Dates with the Same Provider

- For on-going service authorizations, check your files and verify the dates that have been previously authorized, denied or pended before submitting your request.
- Submit your request using the correct begin and end dates of service.
- If your new Srv Auth request overlaps with an approved or denied existing Srv Auth, your new request will be rejected and returned to you via fax to correct the beginning and/or ending dates of service. (Overlap errors are due to the same member, same provider type, same service, with same or overlapping dates)
- If requested dates do not overlap, contact KePRO for a review of the case error.

Submitting an Appeal

All appeal requests are to be submitted in writing to:

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

Program Changes and Updates

**Check the Medicaid Memos and Manuals
online at:**

www.dmas.virginia.gov

Click on the link to Providers Services

or

<http://dmas.kepro.com>

Reference Materials

- **[Elderly or Disabled with Consumer Directed Services Manual Chapter IV and Appendix E](#)**
- **[Aids Waiver Case Management Manual, Chapter IV and Appendix E](#)**
- **[Technology Assisted Waiver and Private Duty Nursing Services Manual Chapter IV](#)**
- **Training Information, Srv Auth educational resources, Srv Auth Fax Forms, & DMAS Manuals at:**

<http://dmas.kepro.com>

Important Resources

- **KePRO (1-888-827-2884)**
- **PAUR06@dmas.virginia.gov**
- **ProviderIssues@kepro.com**



Questions???