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GAP Services that Require Service Authorizations through KEPRO

The Governor's Access Plan (GAP) for medical and behavioral health services is restricted to Virginia adults (ages 21 through 64) who have a serious mental illness. This benefit plan includes limited medical services that require service authorization (srv auth) through KEPRO. Srv auth is required for the following Traditional medical services:

- Non-emergent, outpatient Magnetic Resonance Imaging (MRI scan)*
- Non-emergent, outpatient Computerized Axial Tomography (CAT scan)*
- Durable Medical Equipment: limited to overage Diabetic Supplies only
- Surgical Procedures (specific procedure codes only)
- Medical Device Services/Maintenance (specific procedure/HCPCS codes only)

*Only services performed in outpatient facility settings. All others are limited to physician's office only. Physician office includes Rural Health Clinics (RHC) and Federally Qualified Health Clinics (FQHC).

****Listed below are procedure codes/HCPCS codes that currently require service authorization through KEPRO. Procedure codes and HCPCS are subject to change so providers must refer to attached list for any updates.**

Providers must submit a request according to the specific service type standards to meet the timeliness requirements (when appropriate) as well as medical documentation to meet the service specific criteria.

For general GAP information, refer to the GAP Supplement C found on the DMAS web portal, Provider Services, Provider Manuals section. This GAP link also provides useful information: http://www.dmas.virginia.gov/Content_pgs/GAP.aspx.

HCPS/Procedure Codes are subject to change and this list will up updated periodically

Service Type	Service Description	Coverage
0450	**Magnetic Resonance Imaging (MRI scan)**	Non-emergent, outpatient; Only services performed in outpatient facility settings. All others limited to physician's office only. Physician's office includes FQHC and RHC clinics.
0451	**Computerized Axial Tomography (CAT scan)**	Non-emergent, outpatient Only services performed in outpatient facility settings. All others limited to physician's office only. Physician's office includes FQHC and RHC clinics.

Service Type	Service Description	Coverage
0304	**Medical Device Services/Maintenance**	Current HCPCS/procedure codes under this service type that require service authorization are not covered under GAP; this list will be updated as new procedure codes are added to the service authorization file and are covered under GAP; procedures are limited to physician's office only. Physician's office includes FQHC and RHC clinics.

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Service Type	Service Description	Coverage
0302	**Surgical Procedures**	Specific procedure codes only listed below; this list will be updated as new procedure codes are added to the service authorization file and are covered under GAP; procedures performed are limited to physician's office only. Physician's office includes FQHC and RHC clinics.
CODE	**Procedure Description**	
17106	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQ	
17107	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQ	
17108	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQ	
30220	INSERTION, NASAL SEPTAL PROSTHESIS (BUTTON)	
36470	INJECTION OF SCLEROSING SOLUTION; SINGLE VEIN	
36471	INJECTION OF SCLEROSING SOLUTION; MULTIPLE VEINS, SAME LEG	
36511	THERAPEUTIC APHERESIS; FOR WHITE BLOOD CELLS	
41820	GINGIVECTOMY, EXCISION GINGIVA, EACH QUADRANT	
41828	EXCISION OF HYPERPLASTIC ALVEOLAR MUCOSA, EACH QUADRANT (SPECIFY)	
41830	ALVEOLECTOMY, INCLUDING CURETTAGE OF OSTEITIS OR SEQUESTRECTOMY	
41870	PERIODONTAL MUCOSAL GRAFTING	
41872	GINGIVOPLASTY, EACH QUADRANT (SPECIFY)	
41874	ALVEOLOPLASTY, EACH QUADRANT (SPECIFY)	
63650	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY, EPIDURAL	
63663	REVISION INCLUDING REPLACEMENT, WHEN PERFORMED, OF SPINAL NEUROSTIMULATOR ELECTRODE PERCUTANEOUS ARRAY(S), INCLUDING FLUOROSCOPY, WHEN PERFORMED	
63664	REVISION INCLUDING REPLACEMENT, WHEN PERFORMED, OF SPINAL NEUROSTIMULATOR ELECTRODE PLATE/PADDLE(S) PLACED VIA LAMINOTOMY OR LAMINECTOMY, INCLUDING FLUOROSCOPY, WHEN PERFORMED	
63685	INSERTION OR REPLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING	
63688	REVISION OR REMOVAL OF IMPLANTED SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER	
64553	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; CRANIAL NERVE	
64555	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; PERIPHERAL NERVE	
64560	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; AUTONOMIC NERVE	
64561	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; SACRAL NERVE (TRA	
64565	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; NEUROMUSCULAR	
64566	POSTERIOR TIBIAL NEUROSTIMULATION, PERCUTANEOUS NEEDLE ELECTRODE, SINGLE	
67914	REPAIR OF ECTROPION; SUTURE	
67915	REPAIR OF ECTROPION; THERMOCAUTERIZATION	
67917	REPAIR OF ECTROPION; BLEPHAROPLASTY, EXTENSIVE (EG, KUHNT-SZYMANOWSKI OR T	
67921	REPAIR OF ENTOPION; SUTURE	
67922	REPAIR OF ENTOPION; THERMOCAUTERIZATION	
95978	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM (EG,	
97605	NEGATIVE PRESSURE WOUND THERAPY (EG, VACUUM ASSISTED DRAINAGE COLLECTION),	
97606	NEGATIVE PRESSURE WOUND THERAPY (EG, VACUUM ASSISTED DRAINAGE COLLECTION),	
S2083	ADJUSTMENT OF GASTRIC BAND DIAMETER VIA SUBCUTANEOUS PORT BY INJECTION OR	

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Service Type	Service Description	Coverage
0100	Durable Medical Equipment	limited to overage Diabetic Supplies only listed below

PROVIDER CLASS TYPE 62 COVERED SERVICES FOR GAP

Diabetic Products

UCC = Usual and Customary Charge IC = Individual Consideration

HCPCS Code	Description	Billing Unit	SA Type	Fee	Limit
	Supplies				
A4250	Urine test or reagent strips or tablet	Tablets or Strips - 100	N	$38.88	3/2 Months
A4253	Blood glucose test or reagent strips for home blood glucose monitor,	Strips - 50	N	**$10.41**	3/Month
A4256	Normal, low, and high calibrator solution/chips	Pkg.(5 ml vials)	N	**$4.00**	1/Month
A4258	Spring-powered device for lancet	Each	N	**$2.52**	1/month
A4259	Lancets	Box (of 100)	N	**$10.22**	3/2 Months
S8490	Insulin Syringes	100/box	N	$29.67	1/Month
A4245	Alcohol wipes	Box of 100	N	$4.08	1/Month
	Glucose Monitors				
E0607	Home blood glucose monitor	Each	N	**$65.75**	1/36 Months
E2100	Blood glucose monitor with integrated voice synthesizer	Each	Y	**$597.01**	
E2101	Blood glucose monitor with integrated lancing/blood sample	Each	N	**$185.58**	
E0607 RR	Home blood glucose monitor	Day	N	$0.21	3 Months
E2100 RR	Blood glucose monitor with integrated voice synthesizer	Day	N	**$1.83**	
E2101 RR	Blood glucose monitor with integrated lancing/blood sample	Day	N	**$0.60**	
	Replacement Batteries				
A4233	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each	Each	N	**$0.58**	1/6 Months
A4234	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each	Each	N	**$2.50**	
A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each	Each	N	**$1.06**	
A4236	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each	Each	N	**$1.19**	