

ATTENTION ALL HOME HEALTH AND DME PROVIDERS

***Effective July 1, 2017, All Home Health requests and specific DME items require a Face-to-Face Encounter performed by an approved practitioner.*

Please see the DMAS memo below, *Fee-for-Service Home Health and DME Face-to-Face Encounter Requirements*, dated June 9, 2017, for questions and a list of DME codes that require a face-to-face encounter:

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

The DMAS 363 and 352 forms have been updated with the new face-to-face encounter information. There is also a mandatory questionnaire on all Home Health cases that is required to be completed and requires face-to-face encounter information.



COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) PROGRAM BEGINS AUGUST 1, 2017

Members Transitioning into CCC Plus

For members that transition into the CCC Plus Program, the CCC Plus Health Plan will honor the Srv Auth contractor's authorization for a period of no less than 90 days or until the Srv Auth ends (whichever is sooner) for providers that are in-and out-of network.

When a member enrolls in CCC Plus, the provider should contact the CCC Plus Health Plan to obtain authorization and information regarding billing for services if they have not been contacted by the CCC Plus Health Plan.

Members Transitioning from CCC Plus and back to Medicaid Fee-For Service (FFS)

Should a member transition from CCC Plus to Medicaid FFS, the provider must submit a request to the Srv Auth contractor and needs to advise the Srv Auth Contractor that the request is for a CCC Plus transfer within 60 calendar days. This will ensure honoring the approval for the continuity of care period and waiving timeliness requirements. The Srv Auth Contractor will honor the CCC Plus approval up to the last approved date, but no more than 60 calendar days from the date of CCC Plus disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the Srv Auth contractor will apply medical necessity/service criteria.

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If the request is submitted to the Srv Auth Contractor after the continuity of care period,

- A. The dates of service within the continuity of care period will be honored for the 60 day timeframe;
- B. The dates of service beyond the continuity of care period and timeliness will be waived and reviewed for medical necessity. All applicable criteria will be applied on the first day after the end of the continuity of care period.
- C. For CCC Plus Waiver Services, Cap hours will be approved the day after the end of the continuity of care period up to the date of request. The continuation of service units will be dependent upon service criteria being met and will either be authorized or reduced accordingly as of the date of the request.

The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the beginning of the month. This will provide information for members who may be in transition from CCC Plus at the very end of the previous month.

Action Reason Code (ARC) 1892 means the date was auto closed by DMAS. Should there be a scenario where DMAS has auto closed (ARC 1892) the Srv Auth Contractor's service authorization but the member's CCC Plus eligibility has been retro-voided, continuity of care days will not be approved by the CCC Plus Health Plan since the member never went into CCC Plus. The Srv Auth contractor will re-open the original service authorization for the same provider upon provider notification.

CCC Plus Exceptions:

The following exceptions apply:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the Srv Auth Contractor will honor the CCC Plus approved days/units under the continuity of care period for up to 60 calendar days. The remaining dates of services will be reviewed and must meet service criteria, but timeliness will be waived as outlined above.)
- If the service has been authorized under CCC Plus for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once member is FFS, only Medicaid approved services will be honored for the continuity of care.
- If a member transitions from CCC Plus to FFS, and the provider requests an authorization for a service not previously authorized under CCC Plus, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Srv Auth Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, visit: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

ATTENTION WAIVERS PROVIDERS

Effective July 1, 2017, the Elderly or Disabled with Consumer Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined into one singular waiver, the Commonwealth Coordinated Care (CCC) Plus Waiver.

The CCC Plus Waiver:

- Delivers services through agency and consumer directed models.
- Is for adults 65 and older with a medical or nursing need and individuals less than 65 years old with a disability and a medical or nursing need.
- There is no waiting list for this waiver.

EDCD and Tech Waiver individuals may be eligible for the following services under the CCC Plus Waiver:

- Adult Day Health Care
- Personal Assistance Services
- Private Duty Nursing
- Respite Care
- Services Facilitation
- Assistive Technology
- Environmental Modifications
- Personal Emergency Response System (PERS)
- Transition Services



Respite Care Services

Effective July 1, 2017, the respite care service limit for all CCC Plus Waiver participants will be 480 hours **per state fiscal year**. Respite care authorizations for current Tech Waiver participants were updated automatically. For subsequent requests for FFS members, the provider must submit a request to continue services to the service authorization contractor prior to the end date of the current authorization.

Assistive Technology (AT) and Environmental Modifications (EM)

AT and EM will be available to all CCC Plus Waiver participants. AT and EM are limited to \$5,000 per participant **per state fiscal year**. AT and EM are not stand-alone waiver services and participants must receive either Adult Day Health Care (ADHC), personal care, private duty nursing, or respite care in order to be eligible for AT and EM. Providers should send service authorization requests to KEPRO for AT and EM approval beginning August 1, 2017 for participants in FFS. Providers serving CCC Plus members must submit service authorization requests to the member's managed care organization.

Private Duty Nursing (PDN)

PDN will continue to be available to those who meet the existing Tech Waiver level of care. Please refer to 12VAC30-120-1710 for the criteria for the Tech Waiver.

Early Periodic Screening and Diagnostic Treatment (EPSDT) Services and DD Waiver

Effective for services beginning on or after **August 1, 2017**, service authorization requests for the following services provided to individuals enrolled in one of the DD waivers are to be submitted to the Virginia Department of Behavioral Health and Developmental Services (DBHDS). DBHDS will utilize EPSDT rules and necessary documentation in authorizing these services for individuals under the age of 21.

Providers should stop sending EPSDT service authorization requests for these DD Waiver services to KEPRO effective July 31, 2017.

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Personal Care:

T1019 (agency directed)
S5126 (consumer directed)

Private Duty Nursing:

T1002 (RN)
T1003 (LPN)
G0493 (Congregate RN)
G0494 (Congregate LPN)

Assistive Technology:

T5999

For more information, contact the DMAS Helpline at 1-800-552-8627 or 804-786-6273 and see memos Revised Launch of CCC Plus Waiver, Effective July 1, 2017 dated July 19, 2017 and EPSDT Services and DD Waiver July 26, 2017 at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/MedicaidMemostoProviders>.

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