APPENDIX D
SERVICE AUTHORIZATION INFORMATIO

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INTRODUCTION – SERVICE AUTHORIZATION IN FEE-FOR-SERVICE (FFS) AND MANAGED CARE ORGANIZATIONS (MCO)

Service authorization is the process to review specific service requests 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.

Psychiatric Residential Treatment Facility Services (PRTF) and Therapeutic Group Home Services (TGH) are covered for Medicaid members under age twenty-one (21) and are administered through the DMAS Service Authorization Contractor. Any member admitted to a PRTF or a TGH is not excluded from managed care coverage; however, the PRTF and TGH services are carved out of managed care and service authorization decisions are administered through the DMAS Service Authorization Contractor.

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 contained within the claim's 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

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.

DMAS criteria for medical necessity will be considered if a service is covered under the State Plan or applicable waiver and is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve functional disability. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the standard of practice. [42 CFR 441.302 (c) (1)]

DMAS, its FFS service authorization contractor, or the MCO will approve, pend, reject, or deny all service requests. Requests that are denied for not meeting the medical necessity criteria are automatically sent to medical staff for a higher-level review. When a final disposition is reached the individual and the provider are notified in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice sent by DMAS or its FFS service authorization contractor or MCO will identify the individual's right to appeal the decision, in accordance with 42 CFR §431, Subpart E, and the Virginia

Administrative Code at 12VAC30-110-10 through 370. The provider and individual have the right to appeal adverse decisions to the Department.

If services cannot be approved for members under the age of 21 using the current criteria, DMAS, the FFS service authorization contractor, or the MCO will then review the request by applying EPSDT criteria. Individuals under 21 years of age qualifying under EPSDT may receive the requested services if services are determined to be medically necessary and, if applicable, are prior authorized by the Department, the FFS service authorization contractor, or a Cardinal Care managed care organization. A request cannot be denied as not meeting medical necessity unless it has been submitted for secondary physician review. DMAS, the FFS service authorization contractor and the MCO must follow the DMAS process for a secondary physician review of all denied service authorization requests.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply to an EPSDT request if the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Any treatment service that is not covered under the State's Plan for Medical Assistance can be covered for individuals under the age of 21 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. Treatment services that are approved under EPSDT but are not available through the State Plan for Medical Assistance are referred to as EPSDT Specialized Services. Refer to the EPSDT Supplement for additional information. Providers should contact the MCO for information on requesting EPSDT specialized services for youth enrolled in managed care. Providers should refer to Appendix A of the EPSDT Supplement for information on requesting EPSDT specialized services for youth in FFS.

CMS Interoperability Rule Mandate, Effective January 1, 2026

DMAS and its Prior Authorization Contractors and Managed Care Organizations (MCOs) have implemented changes mandated by the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule (CMS-0057-F). The initial notification is in the DMAS Medicaid Bulletin dated 12/5/2025.

The rule primarily shortens standard service authorization decision timeframes down from 14 days to 7 calendar days. These rules apply to Managed Care and Medicaid and CHIP Fee-for-Service (FFS). The following timeframes apply:

- Standard (non-urgent) requests: Response required from contractor to provider within 7 calendar days. This standard request timeframe can be extended by up to 14 calendar days if:
    - Member or provider requests an extension (for example, to gather additional information), or
    - The extension is justified due to the need for the service authorization

contractor or MCO to request additional medical evidence, or due to extraordinary or other non-routine circumstances, and is in the member's best interest.

- Expedited (urgent) requests: A response is required from the contractor to the provider upon determination that the standard timeframe could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
    - The service authorization contractor or MCO must make an expedited authorization decision within 72 hours after receipt of the request.
    - This expedited request timeframe can be extended by up to 14 calendar days, only if the extension is in the Member's best interest due to the need for additional information.
- Decision details: Contractors must provide a specific reason for denying a service authorization request.
    - Denial decision letters from the MCOs and service authorization contractors adhere to 42 CFR §438.242(b)(8) and 42 CFR §431.80(a) by clearly stating the reason for denial and informing Members of their right to appeal the decision.

- Public reporting: to promote transparency, DMAS and its MCOs must publicly report on an annual basis, certain FFS and Managed Care service authorization metrics about their processes, beginning March 31, 2026. This initial report is required to include metrics data from calendar year 2025. Each health plan will report their metrics data annually on their websites and DMAS will report FFS metrics data annually on its website. The public, including providers, will be able to review the DMAS and MCO websites to gain more insight into the service authorization processes.

For additional information, see the DMAS Bulletin posted 12/5/2025, titled **"**Interoperability and Prior Authorization Final Rule Implementation Update."

TRANSITION OF CARE BETWEEN MANAGED CARE PROGRAMS AND FEE-FOR- SERVICE (FFS)

Individuals Transitioning into MCOs

Providers should reference the Cardinal Care managed care contract to learn more about the requirements for individuals transitioning from FFS to managed care or from one MCO to another.

Individuals Transitioning from Managed Care back to Medicaid FFS

Should an individual transition from an MCO back to Medicaid FFS, the provider must submit a request to the FFS service authorization contractor and must indicate that the request is for an MCO member who was disenrolled from an MCO into FFS. This will ensure honoring the MCOs approval of services for up to 60 days for

the continuity of care period and waiving timeliness requirements. The FFS service authorization contractor will honor the MCO authorization up to the last approved date but no more than 60 calendar days from the date the MCO's disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the FFS service authorization contractor will apply medical necessity/service criteria.

- If the provider is not an enrolled Medicaid provider, the request will be rejected.
- If the service has been authorized by an MCO for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once an individual is in FFS, the MCO approvals for Medicaid-covered services will be honored for the continuity of care period.
- If an individual transitions from an MCO to FFS, and the provider requests an authorization for a service not previously authorized under an MCO, this will be considered as a new request. The continuity of care will not be applied, and timeliness requirements for the service authorization will not be waived.

After the continuity of care/transition period end date, providers must submit a request to the FFS service authorization contractor that meets the timeliness requirements for the service. The new request will be subject to a full clinical review (as applicable). The waiver services have exceptions, please refer to the waiver manuals for specific information.

Review Process for Requests Submitted to the FFS Service Authorization Contractor

After the Continuity of Care Period:

A. For dates of service beyond the continuity of care period, timeliness will not be waived and the request will be reviewed for level of care necessity; all applicable criteria will be applied on the first day after the end of the continuity of care period; and

B. For Managed Care Waiver services, if the provider does not submit a new service authorization during the continuity of care period, the individual's hours will be capped based on the Level of Care score in the Plan of Care at the conclusion of the continuity of care period. Changes to the authorized hours will not be made until the provider submits a new service authorization request. The FFS service authorization contractor will review whether service criteria continue to be met and make a determination on the hours going forward upon submission of the new service authorization request.

The best way to obtain the most current and accurate eligibility information is for providers to complete their monthly Medicaid eligibility checks at the beginning of the month. This will provide information for individuals who may be in transition to and from an MCO at the very end of the previous month.

Communication

Provider manuals are located on the DMAS Medicaid Web Portal and the FFS service authorization contractor's websites. The FFS service authorization 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 https://vamedicaid.dmas.virginia.gov/sa. For educational material, click on the Training tab. The FSS 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 Bulletin to the DMAS MES Home Page. Changes identified in Medicaid Bulletins are incorporated within the manual.

The FAS and/or the FFS service authorization contractor generate letters to providers and enrolled individuals depending on the final determination. DMAS will not reimburse providers for dates of service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individual's medical record and are subject to review during post payment and Utilization Review.

MCOS: SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

In accordance with 42 CFR §438.210(b)(1), the Contractor's authorization process for initial and continuing authorizations of services must follow written policies and procedures and must include effective mechanisms to ensure consistent application of medical necessity review criteria for authorization decisions.

For more information, please refer to the Cardinal Care Managed Care contract. Please contact the individual's Medicaid MCO for information on submitting service authorization requests for individuals enrolled in managed care.

FEE-FOR-SERVICE: SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

Service authorization requests must be submitted electronically utilizing the DMAS MES Portal to access the contractor's application, Atrezzo Next Generation (ANG). All providers must log in through the DMAS MES portal, effective August 3, 2026.

Providers must submit requests for new admissions within the required timeframes for the requested service. If a provider is late submitting the request, the FFS service authorization contractor will review the request and make a determination based on the date it was received. The days/units that are not submitted timely are denied, and appeal rights provided.

Retrospective review will be performed when a provider is notified of an individual's

retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain a service authorization prior to billing DMAS. Providers must request a service authorization for retrospective review as soon as they are aware of the individual's Medicaid eligibility determination.

**Note: Information submitted for service authorization must be documented in the medical record at the time of request. The request for service authorization must be appropriate to adequately meet the individual's needs. Any person who knowingly submits information containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Specific Information for Out-of-State providers

Out-of-state providers are held to the same service authorization processing rules as instate providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-state services to the FFS service authorization contractor. Out-of-state providers may enroll with Virginia Medicaid by going to https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment. At the toolbar at the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box.

Out-of-State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers. Procedures and/or services may be performed out-of-state only when it is determined that they cannot be performed in Virginia because it is not available or due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period.

Services provided out-of-state for circumstances other than these specified reasons shall not be covered:

1) The medical services must be needed because of a medical emergency;
2) Medical services must be needed, and the recipient's health would be endangered if he were required to travel to his state of residence;
3) The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4) It is the general practice for recipients in a particular locality to use medical resources in another state.

The provider needs to determine which item 1 through 4 is satisfied at the time of the request to the FFS service authorization contractor. If the provider is unable to establish one of the four, the contractor will pend or reject the request until the required information is provided.

Out-of-State Provider Questionnaire (Found on the Provider Portal at Service Authorizations Home (Acentra Health/DMAS) | MES)

A. Question #2-Are the medical services needed; will the recipient's health be endangered if required to travel to state of residence? If a provider answers "Yes", then additional question #2.1.1 asks: "Please explain the medical reason why the member cannot travel".

B. Question #5- "In what state is the provider rendering the service and/or delivering the item physically located?"

C. Question #6- "In what state will this service be performed?"

D. Question #7- "Can this service be provided by a provider in the state of Virginia? If a provider answers "No", then additional question #7.2.1: "Please provide justification to explain why the item/service cannot be provided in Virginia."

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10-120 and 42 CFR 431.52.

Submitting Secure Electronic Requests for Services

The FFS service authorization contractor utilizes Atrezzo Next Generation (ANG) as the application for providers to submit service authorization requests. ANG is highly intuitive and user-friendly and includes enhanced security features. Providers must first be enrolled with DMAS. Once successfully enrolled with DMAS as an enrolled provider, the provider will register to use ANG by contacting Acentra Health Customer Service at 1-888-827-2884.

Current Portal Users

Effective August 3, 2026, all providers must log into the contractor's service authorization application through the DMAS MES Portal.

New Portal Users
Providers who have not used Atrezzo (ANG) are considered new portal users and need to register their service authorization provider account.

Already Registered with ANG but Need Help Submitting Requests

It is imperative that providers currently registered use the DMAS MES portal for submitting all requests. This includes admissions, discharges, changes in units requested, responding to pend requests, and all other transactions.

Registered ANG providers do not need to register again. If a provider is

successfully registered, but need assistance submitting requests through the portal, contact Acentra Health Customer Service at 1-888-827-2884 or VAProviderissues@Acentra.com.

Providers registered for ANG, who have forgotten their password, may contact the provider's administrator to reset the password or utilize the 'forgot password' link then respond to their security question to regain access. If additional assistance is needed by the provider's administrator contact Acentra Health Customer Service at 1-888-827-2884 or VAProviderissues@Acentra.com.

If the person with administrative rights is no longer with the organization, contact Acentra Health Customer Service at 1-888-827-2884 or VAProviderissues@Acentra.com to have a new administrator set up.

When contacting Acentra Health, please leave the requestor's full name, area code, telephone number and the best time to be contacted.

Additional Information for Ease of Electronic Submission

To make electronic submission easier for the providers, Acentra Health and DMAS have completed the following:

1. Rules Driven Authorization (RDA) – This is an automated decision-making process that determines eligibility for services, procedures, or medications by applying DMAS-defined clinical, administrative, and policy rules stored in ANG. Clinical criteria questions automatically populate in the ANG portal based on requested services or diagnostic codes. Providers must complete the questionnaire using information from the individual's medical record. If responses meet criteria, the case is auto-approved and sent to FAS. If not, it is routed to a reviewer for standard review and, if necessary, escalated to a physician for final determination.

2. Attestations – All providers will attest electronically that information submitted toAcentra Health is within the individual's documented record. If upon audit, the required documents are not in the record, and the provider attested that they were present; retractions may be warranted as well as a referral to the Medicaid Fraud Control Unit within the Office of the Attorney General.

3. Questionnaires – Acentra Health and DMAS have configured questionnaires so they are short, require less information, take less time to complete, and are user-friendly.

HOW TO DETERMINE IF SERVICES REQUIRE SERVICE AUTHORIZATION

To determine if services need to be authorized, providers may go to the DMAS website: Procedure Fee Files & CPT Codes This page is titled Procedure Fee

Files & CPT Codes. The information provided there will help you determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

The provider must determine whether to use the CSV or the TXT format. The CSV is a comma separated value and the TXT is a text format. Either version provides the same information.

The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. The Procedure Fee File will indicate when a code requires a service authorization as it will contain a numeric value as one of the following:

00- No PA is required

01- Always needs a PA

02- Only needs PA if service limits are exceeded

03- Always need PA, with per frequency.

To determine whether a service is covered by DMAS access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides special coverage and/or payment information. A Procedure Flag of "999"

indicates that a service is non-covered by DMAS.

Providers may also refer to the Provider Service Type Grid and Crosswalk available on the FFS service authorization contractor website at: https://vamedicaid.dmas.virginia.gov/sa.

SERVICE AUTHORIZATION RECONSIDERATION

A provider must exhaust Acentra Health's internal reconsideration process for all services prior to submitting to DMAS Appeals. If a provider wants to have Acentra Health reconsider the initial determination, they must submit a reconsideration through the Atrezzo Next Generation (ANG) portal: https://atrezzo.acentra.com/ within 30 calendar days from the date of the initial determination letter. Providers must submit in ANG via the dropdown option to choose a 'reconsideration' task and attach or document within the note section with the additional information that is needed to show that the member meets criteria for the care that was denied or reduced. Please ensure you include any additional information or documentation that evidences that the member meets the criteria for the requested level of care. Reconsideration requests submitted outside the 30-day period will be denied as untimely and no further action will be taken on the service authorization request.