Provider Notice

Thank you for your continued support in helping Magellan Complete Care of Virginia (MCC of VA) members live healthier lives.

Please review the below updates and reminders from our Utilization Management (UM) Department.

1. MCC of VA does not require medical necessity determination for medical and behavioral health services for which MCC of VA is secondary payer. If MCC of VA becomes primary payer because the member has exhausted primary payer's benefits, the service is not a covered benefit for the primary payer, or the provider or facility does not accept the primary insurance, then a prior authorization and medical necessity review will be required for each service that MCC of VA will be paying as the primary payer.
2. Effective immediately, outpatient EGD, Esophagogastroduodenoscopy (CPT codes: 43233, 43235—43251, 43255, 43257, 43259) no longer requires a prior authorization for in-network providers.
3. Behavioral Health inpatient concurrent reviews will be conducted every 2 business days. If clinical documentation for a concurrent review is sent in on a Friday after 5 p.m., it will not be reviewed until the following Monday. If the information sent in does not meet medical necessity criteria the continued stay could be denied back to the last authorized day.
4. An updated prior authorization request form was posted on www.MCCofVA.com in July. This form is intended for all service authorization requests, except:
    - Addiction and Recovery Treatment Services (ARTS), and
    - Community Mental Health Rehabilitative Services (CMHRS)

    For these, continue to utilize the Department of Medical Assistance Services (DMAS) approved service authorization request forms.
5. When submitting prior authorization requests (medical and behavioral) please include the address you would like all communications (approvals, adverse determinations, etc.) to be sent to.
6. When submitting a service authorization request for an initial review, **or** a concurrent review for a hospital inpatient level of care, please include the National Provider Number (NPI) and the Taxpayer Identification Number (TIN) on the service authorization request form. This is to ensure the correct provider locations are being loaded in the case, and that the letters are being sent out to the correct providers/locations.

7. After the initial Temporary Detention Order (TDO) period (24-96 hours for individuals under age 18 and 24-72 hours for adults age 18 and over) is over a hearing will take place. During the hearing one of the following three options will take place: 1) member signs in voluntarily, 2) the judge/special justice may commit the member involuntarily to the hospital for varying time periods (e.g. up to 18 days), or 3) the member may be discharged. MCC of VA may begin to apply medical necessity criteria after either option 1 or 2 is decided (as option 3 wouldn't apply).

8. The following existed in previous contract language and should be a reminder: effective July 1, 2019 DMAS implemented changes to the way Temporary Detention Orders (TDO) are reimbursed by DMAS-contracted Managed Care Organizations (MCOs) for adults 21-64 years of age. Effective July 1, 2019 TDO admissions to freestanding psychiatric hospitals for adults 21-64 years of age will not be covered by the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) programs. TDO admissions prior to June 30, 2019 will remain covered by the MCO.

   The TDO reimbursement changes apply exclusively to freestanding psychiatric hospitals that serve adults 21-64 years of age enrolled in a DMAS contracted Managed Care Organization.

   This change will simplify TDO claims processes for the freestanding psychiatric hospitals and result in all eligible members in the Medicaid program regardless of their managed care enrollment status being reimbursed for TDO's directly by DMAS.

   For individuals 21-64 years of age enrolled in an MCO and Temporary Detention Ordered to a private freestanding Institute of Mental Disease (IMD) or a state freestanding IMD, providers should submit the TDO claim to the state TDO program. Providers should follow the claims processing instructions as defined in the DMAS Hospital Manual Appendix B: Temporary Detention Order.

9. Below are turnaround time reminders for each plan for initial requests (first request for service):

Timeframes for CCC Plus members:

Service Authorization decision timeframes	**Turnaround times**
Physical Health	
Inpatient (standard or expedited)	**Standard** - 1 business day if all clinical information is available or up to 3 business days if additional clinical information is required; or, as expeditiously as the member's condition requires

Service Authorization decision timeframes	Turnaround times
	Expedited - 1 business day or up to 72 hours from receipt of request; or, as expeditiously as the member's condition requires (whichever is less)
Concurrent inpatient (acute)	1 business day or up to 72 hours from receipt of request; or, as expeditiously as the member's condition requires (whichever is less)
Outpatient/Early and Periodic Screening Diagnostic, and Treatment (EPSDT) outpatient (standard)	3 business days; or, up to 5 business days if additional clinical information is required
Outpatient (expedited)	No later than 72 hours from receipt of request; or, as expeditiously as the member's condition requires
Long Term Services and Supports to include: CCC Plus waiver (including waiver services through EPSDT), nursing facility, long stay hospital, hospice, etc. (standard)	5 business days; if additional information is needed, the request may be extended for 5 additional business days (with a documented request for additional information from the provider); **or** as expeditiously as the member's condition requires
Long Term Services and Supports to include: CCC Plus waiver (including waiver services through EPSDT), nursing facility, long stay hospital, hospice, etc. (expedited)	No later than 72 hours from receipt of request; or, as expeditiously as the member's condition requires
Outpatient drug authorizations	Within 24 hours of the request; if additional information is needed a response will be provided within 2 business days
Behavioral Health	
Standard UM review (to include outpatient, CMHRS)	3 business day or up to 5 business days if additional clinical information is required; or, as expeditiously as the member's condition requires
Initial and concurrent inpatient	1 business day or up to 72 hours from receipt of request; or, as expeditiously as the member's condition requires (whichever is less)

Service Authorization decision timeframes	Turnaround times
Expedited urgent – pre-service inpatient	3 hours
Expedited urgent reviews for other urgent services	24 hours
AARTS ASAM Levels 2.1-3.1	72 hours or as expeditiously as the member's condition requires if all clinical information is available; or, if additional clinical information is required and is not received within 120 hours from the date the request was initially received, the case needs to be routed to MD for lack of clinical information review
AARTS ASAM Levels 3.3-4.0	24 hours or as expeditiously as the member's condition requires if all clinical information is available; or, if additional clinical information is required and is not received within 72 hours from the date the request was initially received, the case needs to be routed to MD for lack of clinical information review

Timeframes for Medallion 4.0 members:

Service Authorization decision timeframes	Turnaround times
Physical Health (and Behavioral Health)	
Standard (inpatient) authorizations	**Standard -** 14 calendar days or as expeditiously as the member's condition requires **Expedited -** 72 hours from receipt of request; or, as expeditiously as the member's condition requires
Outpatient authorizations	**Standard -** 14 calendar days or as expeditiously as the member's condition requires **Expedited -** 72 hours from receipt of request; or, as expeditiously as the member's condition requires

Service Authorization decision timeframes	Turnaround times
Concurrent inpatient (acute)	Within 72 hours (3 calendar days) from receipt of the request
ARTS ASAM Levels 2.1-3.1	72 hours or as expeditiously as the member's condition requires if all clinical information is available; or, if additional clinical information is required and is not received within 120 hours from the date the request was initially received, the case needs to be routed to MD for lack of clinical information review
ARTS ASAM Levels 3.3-4.0	24 hours or as expeditiously as the member's condition requires if all clinical information is available; or, if additional clinical information is required and is not received within 72 hours from the date the request was initially received, the case needs to be routed to MD for lack of clinical information review
Outpatient drug authorizations	Within 24 hours of the request; if additional information is needed a response will be provided within 2 business days

10. Below are the maximum allowable timeframes for service authorizations of the case types contained in the table below. Shortened authorization periods allow for closer monitoring of a service, and therefore improved utilization management. Any request for authorization longer than allowed, **or** exceptions to the timeframes below should be sent for secondary review with a medical director.

UM case type	Approvable timeframe (MAX)	Notes
Home Health	2 months	
Rehabilitation, outpatient	6 weeks	
Outpatient surgery/procedure	1 month	
Diagnostic test/ Hi-Tech imaging	1 month	
Dental services	2 months	
Out-of-Network (OON) office visits - all other	1 month	

UM case type	Approvable timeframe (MAX)	Notes
Out-of-Network (OON) office Visit - OB/GYN, oncology	6 months	
Durable Medical Equipment (DME)	6 months	Ventilator maintenance service approvable for 1 year for tech waiver members and members with chronic vent.
Orthotics/prosthetics	6 months	
Private Duty Nursing (PDN)	6 months	
Personal Care Services (PCS) - Medallion 4.0	6 months	
Home Infusion Therapy (HIT)	Varies	Per treatment plan