Services Requiring Service Authorization, Transitioned from DMAS to KePRO, effective 4-1-2012.
Questions and Answers

#	Question	DMAS Response
1.	Where can the Memo be located which explains how and where to obtain authorization for services which used to be reviewed by the Medical Support Unit at DMAS?	The Memo named, "Services Currently Reviewed by DMAS' Medical Support Unit Moving to KePRO for Review and New Procedure Codes Requiring Service Authorization — Effective, April 1, 2012," is located at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/MedicaidMemostoProviders The above link to the Memo is accessible on the KePRO website: http://dmas.kepro.com
2.	I noticed this statement in the Memo: KePRO will allow retroactive reviews for service requests submitted through June 30, 2012 for all other procedure codes on the attached list that are not bolded or marked with asterisk. We are used to submitting the claim and being denied due to no authorization on file. As a result of the denial we request the authorization and then submit the bill to DMAS. Will I be able to use the same process?	No, Effective July 1, 2012, KePRO will not authorize requests retroactively for these procedure codes, regardless of the dates of service. The only instance KePRO will approve services retroactively on and after July 1, 2012 for the codes not bolded or marked with asterisk on the spreadsheet is when the provider demonstrates retroactive Medicaid eligibility determination for members.
3.	Do I submit the service authorization request using the benign procedure code?	Yes, within 2 business days of the procedure if the code is listed on the attached list of procedure codes at the end of the Memo and the applicable criteria is *McKesson SIMplus*®
4.	If a lesion removed comes back as a malignant lesion, does the request for service authorization have to be requested again?	No, only one authorization is required for the procedure or procedures when billed on the same claim. If the lesion is malignant, the appropriate criteria will be selected by the reviewer based on the tissue evaluation.
5.	I am trying to precert a 0302 Procedure code and KePRO tells me that they cannot approve the procedure prior to the removal of the lesion. I do not understand why I cannot get approval for this code before I actually perform the procedure. What if DMAS doesn't pay after the tissue sampling comes back negative?	Criteria used for lesion removal is based on tissue sampling that is why your cases are pended until you receive the results of the sampling. The review process for this type of procedure is done after the tissue is removed. These reviews must be requested within two days of lesion removal, and should not be requested prior to removal. The review criteria address benign lesions.
6.	What NPI # should be entered for 0300 and 0302 service type	The correct NPI # will belong to the Physician who is

	requests?	requesting the workup or the surgical procedure.
7.	Should the service authorization use the Facility NPI where the transplant will eventually take place or should it be the Provider who is requesting the work up for transplant procedure?	If a facility NPI is used for the procedure service authorization, the system will create an error. In order to obtain a service authorization number the physician's NPI must be the applicable NPI on the service authorization number. A separate request for the inpatient hospitalization must be submitted to KePRO within one business day of the actual inpatient hospitalization.
8.	What is the process when a code on the DMAS Procedure Code Fee File shown as 01, always needs a PA, and is listed on the Memo indicating that KePRO performs service authorization and the code is ended and replaced with a new code? For example, Code S3820 ended on 3-31-12 and was replaced with 81211.	When a code ends and is replaced with a new code and the new code is on the DMAS Procedure Code Fee File as 01, always needs a PA, KePRO will review the replacement code.
9.	How does KePRO proceed with the service authorization requests when the member has Medicare B?	For the codes listed on the attached list of procedure codes at the end of the Memo and the Medicaid member has Medicare Part B, service authorization requests are not required unless the Medicare claim is a non covered service or the claim has been denied or the benefits have become exhausted. KePRO will review these service authorization requests retrospectively. The provider must indicate the reason that Medicare has denied payment.