VA insider

A KEPRO Quarterly Newsletter Virginia Medicaid Service Authorization Fall 2013

Q&A FOR OUT-OF-STATE PROVIDERS SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

1. **Where can I find the DMAS Memo for the Out-of-State Provider requirement?**

The Memo, dated February 6, 2013, is titled, *Notification of a Procedural Change for Out of State Providers Submitting Requests for Service Authorization through KEPRO — Effective March 1, 2013.* It is available on the Virginia Medicaid Service Authorization website. The link to all DMAS Memos is provided below.

https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/MedicaidMemostoProviders

2. **What date did the change take effective?**

The change became effective on March 1, 2013

3. **Are MSU (Medical Support Unit) Services included with this Memo?**

Please refer to the DMAS Memo dated February 6, 2013. Page 2 contains a chart of services impacted.

4. **Do providers have to document evidence and submit to KEPRO all four criteria indications on the Out-of State Provider Policy?**

No, out-of-state providers should include **one** of the four criteria indications when submitting requests for service authorization to KEPRO.

5. **Are "border providers" included in the out of state provider requirement?**

"Border providers" are included in the out-of- state (OOS) provider requirement. DMAS identifies "border providers" as providers within 50 miles of the Virginia border. Out of state providers are determined by their FIPS code, not by their provider class type. Refer to the DMAS Memo dated February 6, 2013 for details and services included in the requirement.

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SERVICE AUTHORIZATION SUBMISSION REMINDERS FOR ALL PROVIDERS

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 on passing all edits contained within the claims 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.

It is the provider's responsibility to check eligibility prior to **all** service authorization submissions.

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advice. Providers must register through the Virginia Medicaid Web Portal in order to access this information.

The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Help Desk, toll free, at 1-866-352-0496, from 8:00 a.m. to 5:00 p.m., Monday through Friday, except holidays.

The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status on KEPRO's Provider Portal at http://dmas.kepro.com.

The member's Medicaid eligibility is subject to change; therefore, it is crucial that providers check the system. The member may have enrolled in a Medicaid MCO, now have fee-for-service Medicaid, or all Medicaid coverage may have expired. It is important to verify **all** other insurance coverage with the member and caregiver, as well as referring providers.

Providers must submit requests in a timely manner to avoid reduction or denial of treatment services for timeliness. When cases are pended for additional information, the provider needs to respond to the specific information requested within the stated guidelines to prevent further delay or denial of the request. Be sure to respond on or before the due date noted on the request. KEPRO requests for additional information may be sent through Atrezzo or by faxed letters.

Valid phone/fax numbers are essential. Missing numbers or incorrect demographic information will delay receipt of important notifications from KEPRO regarding your request.

Please paint a clear, concise clinical picture when submitting information from medical records. DMAS manuals for providers are located on the KEPRO/DMAS website at http://dmas.kepro.com. These manuals

Reading this newsletter electronically? Click the links to access information.

provide important information and guidance regarding submission of Service Authorizations, DMAS administrative requirements, and medical necessity criteria.

If your request for Service Authorization has been denied, please follow the instructions for appeal noted on the denial letter from DMAS. All appeal documentation (including appeal letter and related medical records) must first be submitted to DMAS, not KEPRO, for validation in order to begin the appeals process.

Be sure to address the reasons for the denial noted on your denial letter from KEPRO, and supply the requested information with your appeal. Don't forget to include the service authorization number that is on the letter.

DMAS will then submit the appeal notification to KEPRO. DMAS will also include information with this notification concerning any hearings that have been requested. KEPRO will review all appeal related documentation and a decision will be rendered. DMAS will review all of the appeal documents and issue a final decision letter. This letter will contain information regarding additional appeal rights if KEPRO's denial decision has been upheld.

Please note- appeals must be received by DMAS within 30 days from the date of your VaMMIS denial letter, or it will be considered an untimely filed appeal by DMAS.

KEPRO customer service can assist you if you experience any difficulties with this process. Please call our toll free number 1-888-827-2884, Monday through Friday between the hours of 8am-7pm EST, if you have any questions or concerns about your request for service authorization.

REMINDER - DURATION OF WAIVER SERVICE AUTHORIZATIONS

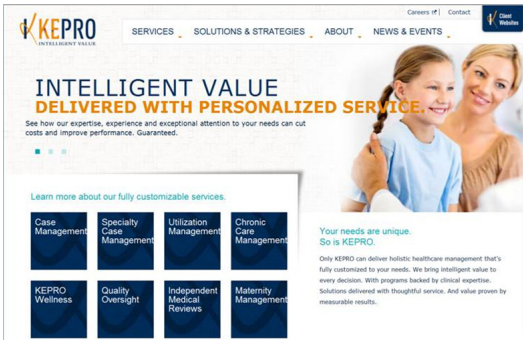
If the member/individual continues to be in need of service past the authorized end date, the provider must submit a request for continued services. Providers must submit written justification for each service as identified in DMAS' service criteria, and include it with the request to extend the service authorization.

Documentation submitted for each request must support the need for the service(s) being requested. Providers must check the MMIS generated letter to determine the new authorization expiration date. There are no automatic renewals of service authorizations. Please refer to the November 26, 2012 Medicaid Memo for additional information.

BEHAVIORAL HEALTH CONTRACT REMINDER

KEPRO's Behavioral Health contract will end on December 1, 2013. KEPRO will complete all reviews submitted to us prior to that date. Please do not submit any Behavioral Health reviews to KEPRO after November 30, 2013.

Magellan Health Services is the new vendor. The Virginia Medicaid Web Portal will offer guidance and assistance during this transition. Visit www.virginiamedicaid.dmas.virginia.gov.



KEPRO REBRANDING!

KEPRO has a new look, a new logo, and an updated website to reflect our new brand promise of I***ntelligent Value***.

What does KEPRO mean by *Intelligent Value*? In a nutshell, our work is founded in intelligence –our clinical expertise and data driven insights. These factors achieve value for you and your members. Since 1985, KEPRO has helped more than 20 million members lead healthier lives through clinical expertise, integrity and compassion. Our values are promises we keep every day, which is why we keep growing with our clients. Visit our new website to learn more!

http://www.kepro.org

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