# VA insider

A KEPRO Quarterly Newsletter | Virginia Medicaid Service Authorization | Summer/Fall 2014

*KEPRO would like to thank all the providers who participated in our Annual Provider Satisfaction Survey. Your feedback is valuable to us as we strive to provide quality service to you every day.*

## TRADITIONAL SERVICES

**Provider reminder:**
Please include a contact name and phone number when submitting ALL Service Authorization requests and inquiries. This will allow us to quickly contact you to resolve potential issues.

**Are you interested in attending training sessions for your services?**
KEPRO conducts monthly training sessions online. If you are interested in attending a session, you can find the training calendar on the KEPRO/DMAS website at http:/dmas.kepro.com. Click on "Training Schedule" on the right side of your screen for a schedule of upcoming webinars and all of the previous PowerPoint presentations for each service.

The Atrezzo Connect Provider Portal Guide is also located on the Reference Material page at http:/dmas.kepro.com. You will find detailed instructions on how to submit requests online as opposed to fax or by phone. The Provider Portal is 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. Utilizing the Provider Portal can save you valuable time and resources.

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 KEPRO/DMAS website also has a link to Service Authorization Checklists. There are specific checklists for Inpatient and Outpatient services. At a glance, you can determine all the information required for each service type. Utilizing these checklists can avoid delays caused by missing information.

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## APPEALS

Do you know how to request an appeal? When KEPRO issues a denial, a fax letter is sent out to the provider. A denial information letter is then generated in the VAMMIS system and mailed from DMAS to the provider. This letter contains specific instructions on how to appeal the denied dates of service. In case you have misplaced your letter from DMAS, you can still appeal denied services within 30 days of the denial date. Detailed instructions for filing an appeal can be found in Chapter II in your Provider Manual. Provider Manuals for all services can be found on the Virginia Medicaid website at www.virginiamedicaid.dmas.virginia.gov

## WAIVERS

**Resubmitting for Continuation of Services**:
Per Medicaid memo dated 11/26/2012; providers must submit requests for continuation of services prior to the end date of the current authorized period. If the request is not received prior to the end date of the authorized period, the dates of service prior to the date the request was received by KEPRO may be administratively denied.

## FAXBACK LETTERS FOR INSUFFICIENT INFORMATION EXPLAINED

Faxback letters are utilized when required demographic information (e.g., member ID, provider ID, procedure codes, units, date of service, diagnosis code, and service type) is missing on fax submissions to KEPRO. Providers may also receive faxback letters due to inactive Medicaid eligibility, submission of an incorrect KEPRO form for the requested service type, name and member ID mismatch, etc.

Upon receipt of faxback notification, the provider needs to submit the missing information within one business day of receipt for all service types, excluding waivers. For waiver services, the information is due within three business days. If KEPRO does not receive the requested information within the required timeframes, the insufficient case will be voided. Providers can resubmit the entire request for service

authorization review in this case. However, the provider will still be held accountable and must resubmit all of the information in the required timeframe.

## EDCD WAIVER QUESTIONNAIRES

Respite Care and Personal Care/ Attendant Care questionnaires are now available via Atrezzo Provider Portal (Atrezzo Connect) case submissions. Completion of the questionnaires is required for successful submission of your online case. Utilization of the Atrezzo Provider Portal may reduce the need for providers to fax supporting documentation to KEPRO. Providers have the ability to attach all supporting documents via the Atrezzo Provider Portal located at http://dmas.kepro.com/

Some examples of the questions are listed below:

- Have you verified that the patient is eligible for the entire date span requested?
- Have Health, Safety and Welfare issues been identified with this patient?
- Is respite the sole service for this patient for your agency/ service facilitation?
- Is this request a transfer from another provider?

If you have questions or concerns about the questionnaire process, please call KEPRO at 1-888-827-2884.

# COMMONWEALTH COORDINATED CARE

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

Commonwealth Coordinated Care (CCC) is a new initiative to coordinate care for individuals currently served by both Medicare and Medicaid and who meet certain eligibility requirements.

For individuals enrolled in the CCC Program, the Medicare-Medicaid Plan (MMP) will honor the Srv Auth contractor's authorization for a period of at least 180 days or until the Srv Auth ends whichever is sooner, for providers in- and out-of network. For the individuals transferring from CCC back to Fee-For-Service (FFS), the Srv Auth entity will honor the CCC service authorization for Medicaid covered services for up to 30 days or the end of the authorization, whichever is sooner.

When a member enrolls in CCC, the provider should contact the CCC MMP to receive an authorization and information regarding billing for services if they have not been contacted by the MMP. When a member disenrolls from CCC and returns back to traditional FFS Medicaid, the provider must submit a request to the Srv Auth contractor within 30 days. The provider needs to advise the Srv Auth contractor that the request is for a CCC transfer. An authorization will be approved for the service/units and the same provider for 30 days from the date FFS became effective or the end of the authorized date, whichever is sooner. The following exceptions apply:

- The request will be rejected if:
  - The service is not a Medicaid covered service.
  - The provider is not an enrolled Medicaid provider for the service (in this situation, a Medicaid enrolled provider may submit a request to have the service authorized during the 30-day period).
- If the service has been authorized under CCC 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 transfers from CCC to FFS, and the provider requests an authorization for a service not previously authorized under CCC, this will be considered a new request. The continuity of care will not be applied.

For continued services, prior to the transition period service authorization expiring, providers must submit a request 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).

To learn more about CCC, please go to:
http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx.

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