insider

Electronic Prior Authorization Requests are Strongly Encouraged for the Following Services

In an effort to move toward a "paperless" system and to streamline the prior authorization (PA) process, all providers who submit PA requests to KePRO are strongly encouraged to do so using Direct Data Entry (DDE) using KePRO's web based iEXCHANGE® system. All information submitted to KePRO for review of a prior authorization request, changes to existing cases, and additional information may be submitted using iEXCHANGE®

- Inpatient Acute Medical/ Surgical
- Inpatient Acute Psychiatric
- Inpatient Rehabilitation
- Inpatient Psychiatric - Private and State Mental Hospitals
- Intensive In-Home Services
- Outpatient Psychiatric Services
- Treatment Foster Care – Case Management Services
- Residential Psychiatric Treatment Care – Level C (RTC) Services
- Outpatient Substance Abuse Services

- Children's Group Home Services (Level A)
- Therapeutic Group Home Services (Level B)
- Community Mental Health Rehabilitative Services:
  - Intensive Community Treatment
  - Psychosocial Rehabilitation
  - Mental Health Support
  - Mental Health Case Management
  - Therapeutic Day Treatment/Therapeutic Partial Hospitalization.

iEXCHANGE® is easy to learn. You can access learning modules online anytime, 24/7. Just go to our web site: http://dmas.kepro.org, click on the training tab, then click on the iEXCHANGE®. Select the appropriate training module. Also, please view our training calendar on the web site for upcoming live training webinars.

The following is a listing of some of the online training KePRO provides, along with a brief description and guide that will help you with training:

in this edition

Electronic Prior Authorization Requests

Register for iEXCHANGE®: This is a brief module for first time users only. The module instructs providers how to register for an iEXCHANGE® log in ID and password. This is required for all users who have not yet registered.

Account Administrator Module 1: This module is for all account administrators. It provides an overview of iEXCHANGE®, as well as step by step directions for establishing your account profile.

Account Administrator Module 2: This module is for all account administrators. It provides step by step instructions for setting up submitting providers, frequent users, frequent procedure codes, and frequent diagnoses.

How to Submit an Initial Inpatient Case: This module is for all users. It provides step by step instructions for submitting an inpatient case using iEXCHANGE®. This module is especially useful for inpatient medical surgical, inpatient psychiatric, and inpatient rehab service types.

How to Submit an Initial Outpatient Case: This module is for all users. It provides step by step instructions for submitting an outpatient case using iEXCHANGE®. It is especially useful for outpatient rehab, imaging, DME, and home health service types.

How to Submit an Initial Behavioral Health Case: This module is for all users. It provides step by step instructions for submitting a behavioral health case using iEXCHANGE®. It is especially useful for outpatient psychiatric, RTC, Group Home Levels A & B, Intensive In Home, TFC-CM, Community Mental Health Rehabilitative service types, and Outpatient Substance Abuse.

How to Submit Additional Information, Continued Stay Requests, and Discharges: This module, for all users, provides an overview of how to manage a case, including submitting additional information, continued stay requests, submitting discharges, and what to do if you receive an error on your case. It is useful for all service types.

To learn more about iEXCHANGE®, attend one of our live provider training webinars at: http://dmas.kepro.org. KePRO will provide several iEXCHANGE® online trainings each month. You can access a calendar of dates and times for the various training modules on our web site, or you may call one of our customer service representatives for training information.

Try the Required PA Information Checklists for Easier Submission
Required Prior Authorization Information Checklists for requests are available online for most services to assist with gathering the required information for successful prior authorization request submissions. The Checklists are available on the our web site at http://dmas.kepro.org.

The checklists are available to assist providers with the type of clinical information needed by KePRO to review each request, and to provide concise, focused prior authorization requests with appropriate clinical information. Using these sheets, and referring to them during the submission process, will decrease the number of cases pended for additional clinical information and speed up our processing time. Each Checklist may be used as a tip sheet for all of the important items to include in your request, or can be used as a template for your actual request – simply edit, copy, and paste into iEXCHANGE®.

Be sure to check your document before transmission, as some characters may change during the copy/paste process. Always provide a contact name and number so we may contact you if we have any questions.
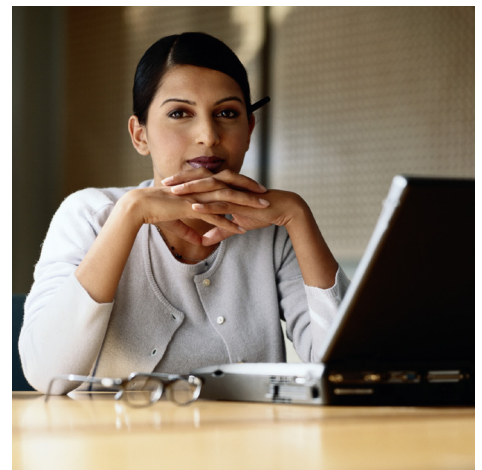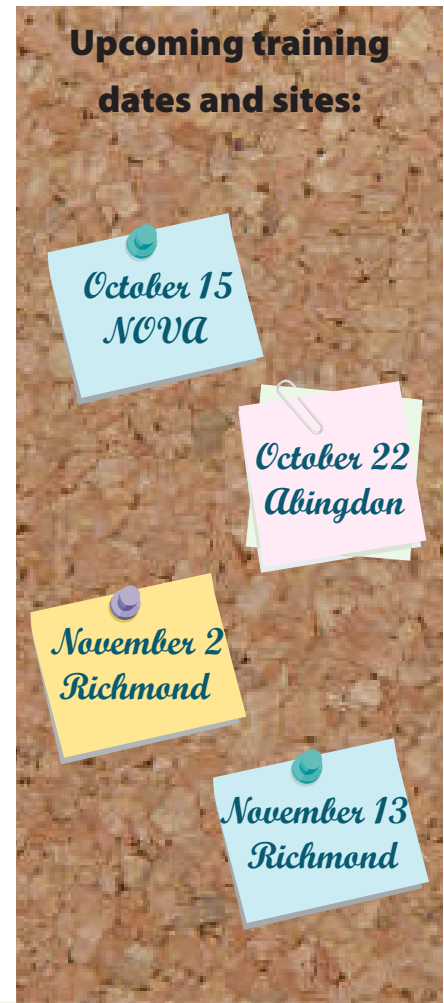
Change is Coming

DMAS will issue a Medicaid Memo in early October outlining changes for Intensive-In-Home (IIH) service requests. Changes include:

- The IIH program will require prior authorization after the first week of service initiation for new admissions. This is a change from the current process, which allows for the first twelve (12) weeks of service for new admissions without requiring prior authorization.

- Existing recipients are defined as a recipient who has had activity with any provider with a date of service of January 1, 2009 forward. If an existing recipient has a current prior authorization that extends beyond December 1, 2009, no action is needed. The prior authorization will be honored. When the prior authorization period ends, and if the recipient continues to be in need of treatment, a request may be submitted to KePRO to extend the treatment period.

- For existing recipients who are currently in their 12 week period without prior authorization, provider must submit a request to KePRO to obtain prior authorization for dates of services December 1, 2009 and beyond, if services are to continue beyond November 30, 2009. Prior authorization is needed for claims to pay with dates of service December 1, 2009 forward. Providers may begin requesting prior authorization through KePRO starting November 1, 2009, for dates of service December 1, 2009 forward.

- A week is defined as Sunday through Saturday. For new admissions, once the first week of service is provided, all subsequent services will require prior authorization. The one week that does not require prior authorization is not renewable annually and is for new admissions only. New admissions are defined as those individuals with no claims activity since January 1, 2009.

DMAS began conducting on site provider trainings in September continuing throughout November 2009. For more information on the dates and sites, visit http://www.dmas.virginia.gov/ln-upcoming_events.htm.

Upcoming training dates and sites:

October 15 NOVA

October 22 Abingdon

November 2 Richmond

November 13 Richmond

H1N1 Novel Swine Flu

The CDC continues to take aggressive action to respond to an expanding outbreak caused by novel H1N1 swine flu. CDC's response goals are to:
1. Reduce transmission and illness severity
2. Provide information to help health care providers, public health officials, and the public address the challenges posed by this emergency.

The CDC has approved a vaccine, and it is issuing and updating interim guidance daily in response to the rapidly evolving situation. CDC's Division of the Strategic National Stockpile (SNS) continues to send antiviral drugs, personal protective equipment, and respiratory protection devices to all 50 states and U.S. territories to help them respond to the outbreak. The swine influenza A (H1N1) virus is susceptible to the prescription antiviral drugs oseltamivir and zanamivir. In addition, the government and manufacturers have begun the process of developing a vaccine against this new virus.

There are still things you can do to protect yourself and family. These common sense tips will help keep you and your loves ones safe and healthy:
- Wash your hands with soap and water or a hand sanitizer like Purell®.
- Don't cover your mouth with your hands when you cough or sneeze. Cough and sneeze into your arm or tissue
- When you greet people, don't shake hands or exchange kisses
- Avoid contact with people with flu symptoms
- If you develop flu-like symptoms, stay home
- Plan ahead: what will you do for childcare if your local school closes?

Reminders & Helpful Hints

Inpatient Psychiatric Providers

This is just a reminder that it is your responsibility as the provider to submit your reviews, initial and concurrent, in a timely manner. KePRO has traditionally sent out reminders as a courtesy and will continue to do so, but if you have not received a reminder and the review is due, you should go ahead and submit it.

Your request for concurrent review will be due the next business day after the last day requested. For example, if you request 4 days, Monday through Thursday; your concurrent review will be due on Friday. If you request 3 days, Wednesday thru Friday, your concurrent review will be due on Monday.

iEXCHANGE® Registration
During the iEXCHANGE® registration process, all providers are prompted to create a user name and password for the Provider Portal. Upon completing iEXCHANGE® registration, you will receive an email advising you to retrieve your iEXCHANGE® log in Information from the Provider Portal.

Suggestion:
Create a user name that relates to your company name or individual name. First initial, last name is always easy to remember and most likely meets provider network log in requirements! User names, such as family member names and birthdays, are easily forgotten and can cause issues with security.

Outpatient Rehab Providers

Nothing is more frustrating than submitting a request for prior authorization and waiting for a response. Just when you think you've gotten your answer, you're being asked to answer questions! Here are some tips that will make the process smoother and shorter!

1. Check the recipient's Medicaid eligibility. The recipient's Medicaid eligibility might change and you may not know until you check the system. The recipient can be switched to Medicaid MCOs or fee-for-service, or Medicaid coverage may have ended. Check for ALL other insurances. Ask the recipient or caregiver!

2. Did you know that if a patient has Medicare Part B, you do not need to get a Medicaid prior authorization? It's true! You only need to get prior authorization if benefits have been exhausted or denied. If a recipient has a commercial insurance as primary, you also need to get a Medicaid authorization because Medicaid will pay for any co-pays or balances. Remember to submit a prior authorization request to KePRO prior to rendering the service.

3. Use iEXCHANGE®. It's easy and it's fast! If you already use iEXCHANGE®, did you know you can extend existing requests? For example, if there is a physician's order increasing the frequency on a plan of care and you need 10 additional PT visits, you can add them to your original request instead of creating a new case. You can also request multiple services, i.e., PT, OT, and ST evaluations on one request, as opposed to opening three cases.

4. Submit requests in a timely fashion. Avoid delays in treatment; keep your supervisor, billing department, physicians, and recipients happy! This includes requests for additional information, for which you would get a letter notifying you of the due date.

5. Use the correct procedure codes and units. It's fairly easy to remember:
   - Hospitals use revenue codes
   - Non-hospitals use CPT codes.

6. Outpatient Rehab agency providers may reference the DMAS memo dated 5/27/09 and the *Rehabilitation Manual*, Appendix D, for additional information. Use the correct diagnosis. The primary diagnosis should be what is being treated. The secondary diagnosis should be what's causing the need for treatment. It should also be updated on each POC.

Use additional diagnoses to help paint a picture. Many times you know what caused what you're treating. It's very helpful to us to know that. Don't just provide a therapy treatment diagnosis. For example, a female patient comes to PT with a bladder issue. She has, in the recent past, been hospitalized for transverse myelitis, which can affect the bowel and bladder. Having transverse myelitis listed as a secondary diagnosis could potentially help a reviewer to understand why PT would work on bladder issues, and therefore

not pend the case to a physician reviewer, thus delaying therapy.

7. Use the correct ICD-9 codes, down to the 4th or 5th digit. Be careful what you key in or write down. One incorrect digit can give you a diagnosis you didn't intend.

8. Paint a clinical picture! Consider what you're submitting with each request. Please use the Outpatient Rehabilitation Authorization Checklist at http://dmas.kepro.org. By answering these questions, and following the tips above, you should have submitted all the necessary information to obtain process your prior authorization request.

Outpatient Psychiatric Providers

• Providers must supply detailed clinical information regarding symptoms, behaviors, and the impact on the client's daily functioning.

• Providers should not submit requests with dates that overlap their previous authorization, as those requests cannot be processed. If additional sessions are needed, the provider needs to state how many sessions are needed by the original end date and the reason why more

sessions are needed. This is called a change request. Concurrent requests should start with the next day after the previous authorization ended.

• When a child is in a group home setting and outpatient therapy sessions are requested for that child, the individual licensed provider (not the group home the child is in) must request the services under his/her individual NPI number. Please submit the name of the individual licensed provider and the NPI number.

RTC-C

• The longer a patient has been in care, the more continued requests need to address recipient's involvement/ cooperation in treatment, progress within treatment, and how continued services can reasonably be expected to improve symptoms.

• To avoid pended requests for continued stays, please address the following:
   ◊ Continued complex presenting symptoms that are amenable to treatment
   ◊ Recipient's involvement and cooperation with treatment
   ◊ Continued impairment in level of functioning
   ◊ Continued need for a restrictive setting
   ◊ How ambulatory care resources in the community will not meet treatment needs
   ◊ Continued services can be expected to improve condition or prevent further regression.

Waivers
Change Request
We encourage providers to submit requests for Waiver Services through the iEXCHANGE® system. The following is information pertaining to how to submit change requests more efficiently and to decrease the likelihood that the request is pended for additional information, thus delaying receipt of your prior authorization number.

• If you are submitting a request for discharge and you already have an existing request in CarePlanner, you don't need to create a new one. Pull up your existing request, select "Add Comment," and type in "requesting a discharge," then a brief explanation and the patient's last date of service.

• If you are submitting a change request for a decrease or increase in hours and you already have an existing request in CarePlanner, you don't need to create a new one. Pull up the existing case and click on "Extend Request" to add another service line with the new requested hours and dates of service. If you are requesting:

1. Hours within the level of care cap, just provide the date of the most recent DMAS 99

2. An increase in hours above client's level of care, provide all information from the most recent DMAS 99, along with date completed

3. An increase in hours above client's level of care cap, provide a breakdown of the requested hours, along with justification for any excessive hours

4. An increase in hours above a client's level of care cap with a split shift, submit a breakdown of the hours for both shifts, justification for any excessive hours, and hours aide/attendant will be in the home for both plans of care

5. Supervision hours, submit all information from DMAS 100 for review.