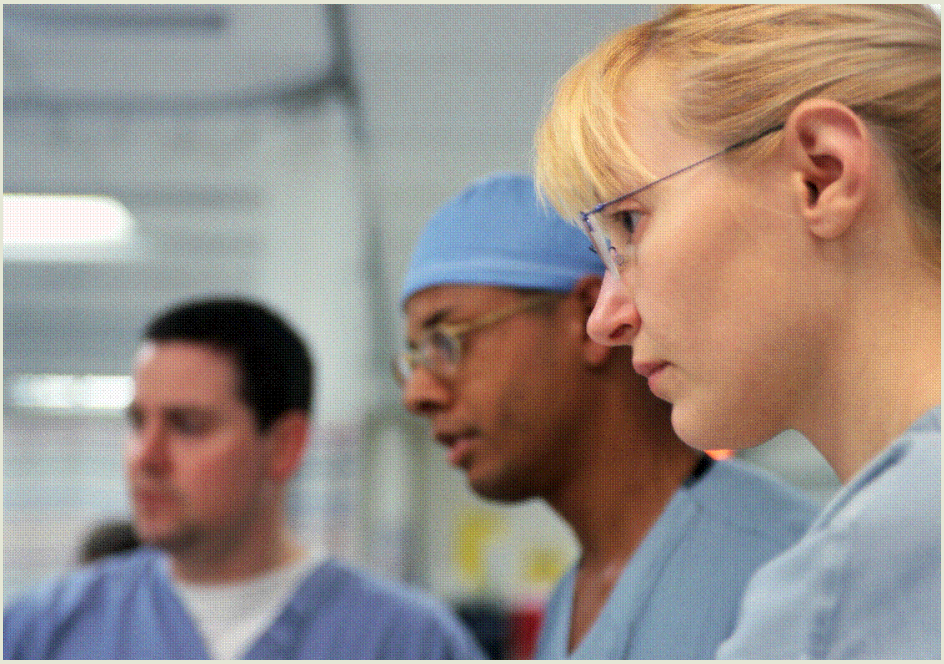
insider

A KEPRO QUARTERLY NEWSLETTER • VIRGINIA MEDICAID PRIOR AUTHORIZATION • SPRING 2008

Information Necessary to Process Reviews

In order to serve you better, we have compiled a list of information that providers sometimes omit when requesting a prior authorization. Including all necessary information enables us to process your request more efficiently, which benefits everyone.



INPATIENT MEDICAL/SURGICAL ACUTE SERVICES

1. *Day of Admission*

Be sure to include a complete set of vital signs on the day of admission. Please put a description of the CPT code in the *Intensity of Service* section, if a surgery is being requested. If surgery is not occurring on the day of admission, please document the reason(s) why it will not be performed that day.

2. *Submitting from a Physician Office*

For providers who are submitting from a physician's office, please include the name of the facility and the facility provider number. The servicing provider field in iEXCHANGE® is not referencing the doctor that will perform the procedure or order the admission; it is asking for the facility where the procedure will be performed or the admission will occur.

3. *Partial Authorizations in the Med/Surgical Setting*

When precertifying a case in which the patient is not eligible on the date of admission, but will become eligible during the admission, the **admit date** should always be entered into iEXCHANGE,® not the eligible date. Please include a note that you are requesting a partial authorization; note the eligible date and the reason for the partial authorization (eligibility begins or HMO disenrollment).

In generating partial authorizations, the reviewer will add the second line, which denotes the eligible date, but both dates are used in the generation of a partial authorization. When the partial authorization is transmitted to VAMMIS, there will be two lines on the prior authorization screen. The first line is the admission date, and will show a rejection; the second line is the KePRO decision, for the eligible date of service.

In Med/Surg Inpatient cases where the client is not eligible on the admission date, the SI/IS is taken from the first 24 hours of admission, **not** when the patient becomes eligible.

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In Med/Surg Inpatient cases where a case has been voided because the client was ineligible during the entire admission, but then became eligible after the case has been voided, **do not open a new case**.

You can access and open the old case using the clinicals already entered. Simply request that the case be re-opened.

And remember, always include your contact name, phone number, and fax number on all iEXCHANGE® and fax submissions.

Home Health Services

Make sure to furnish a home health provider NPI number, when submitting home health requests. If a provider submits a waiver API number, the system will generate an error.

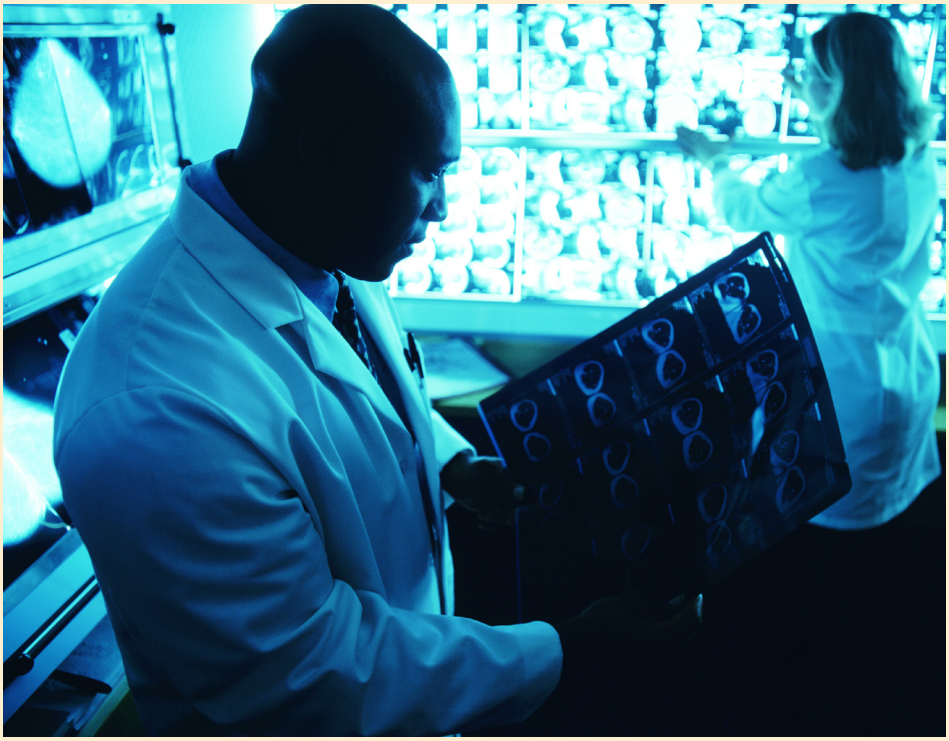
For fax and iEXCHANGE® submissions, please include a contact name and a phone and fax number (including area code) in the *Additional Comments* section, so we know who to contact if we need additional information.

Durable Medical Equipment (DME) Services

All prior authorization requests for DME must include information from section II, III, and IV of the certificate of medical necessity (DMAS-352 CMN). If there is no begin service date, list the physician's signature date on the front and/or back of the CMN.

Waiver Discharges

Please include prior authorization number and *To and From Dates* with your request.



Service Changes

Effective February 21, 2008, DMAS and KePRO made changes for prior authorization requests for four services: services for Elderly or Disabled with Consumer Direction (EDCD), Elderly Case Mgmt (ECM), and HIV/AIDS, and Technology Assisted Waivers. Changes include:

1. Submitting multiple servicing providers on the same prior authorization request is no longer permitted. You must submit a separate prior authorization request for each serving provider when a case is submitted.

2. KePRO's reviewers will no longer instantly provide a prior authorization number upon approval. When a case is approved by a KePRO reviewer, we post the prior authorization number into our CarePlanner® system within 24 hours (usually less) of approval.

In iEXCHANGE,® the prior authorization number will be displayed in the *Case Information* section. It will no longer be visible in the *Additional Comments* box. Notices to providers will be automatically generated and faxed once the case has been processed through to First Health/ VAMMIS.

The submission process for Developmental Disabilities has not changed.

Imaging Services

DMAS is no longer requiring prior authorization of the following CPT codes:

- 77012- Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection)
- 77013- Computed tomography guidance for, and monitoring of, parechymal tissue ablation
- 77014- Computed tomography guidance for placement of radiation therapy fields
- 77021- Magnetic resonance guidance for needle placement (e.g., biopsy, aspiration, injection, or placement of localization device) radiological supervision and interpretation
- 77022- Magnetic resonance guidance for, and monitoring of, parechymal tissue ablation.

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Providers that bill utilizing the UB claim form will need to continue to use revenue codes 0400, 0409 whenver the imaging service CPT codes on page 2 are performed, rather than revenue codes 0350-0359 or 0610-0619.

4. Level of Detail in Coding

Diagnosis and procedure codes are to be used at their highest number of digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes; some codes have fourth or fifth digits, which further clarify the diagnosis.

A three digit code is to be used if there is no further subdivision. When fourth and/or fifth digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that particular code.

For example, acute myocardial infarction, code 410, has fourth digits that describe the location of the infarction (e.g., 410.2 f, inferolateral wall), and fifth digits that identify the episode of care. It would be incorrect to report a code in category 410 without a fourth and fifth digit.

5. Resources Available on the Web

You may also refer to the DMAS web site at www.dmas.virginia.gov for further information regarding Medicaid Policy, Guidelines, and Provider Manuals.

These manuals are official publications of the Virginia Department of Medical Assistance Services (DMAS), and their contents are - to the extent appropriate - incorporated by reference into participation agreements signed by providers enrolled in the Virginia Medicaid program. DMAS is not responsible for the content or accuracy of reproductions, in whole or in part, of these manuals from any other source.

These manuals are not exhaustive of Medicaid law and should not be relied upon as a legal authority. The provider should always rely on its own counsel to ensure compliance with Medicaid laws.

Manuals issued by DMAS are periodically revised and updated.

Effective 5.23.08: NPI/API Numbers are Required

Effective May 23, 2008, providers will be required to use NPI/API numbers when submitting **new** requests to KePRO.

If providers submit new requests using legacy numbers, the request will be rejected, and the provider will need to resubmit the request using its NPI/API number.

Use your legacy provider number only to request extensions/changes for prior authorizations previously processed using your legacy provider number.

"HELPLINE"

The "HELPLINE" is available to answer your questions Monday through Friday, from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1.804.786.6273 - Richmond area and out-of-state long distance

1.800.552.8627 - All other areas (in-state, toll-free long distance)

Remember that the "HELPLINE" is for provider use only. Please have your Medicaid provider identification number available when you call.

All claims questions or concerns will be referred to the DMAS "HELPLINE. "

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