KEPRO
INTELLIGENT VALUE

VA Insider

Virginia Medicaid Service Authorization

Summer 2016

Outpatient Rehabilitation Services Request Change

Procedural Change for Service Authorization Requests– Now in Effect

Providers are to submit a service authorization request to KEPRO for dates of service that cover the entire duration of the member's current plan of care, even if the dates of service span over the state's fiscal year (beginning July 1).

Providers are no longer required to submit an outpatient rehabilitative service authorization request to KEPRO in which the dates of service end June 30 (end of state fiscal year) and then resubmit another service authorization request to KEPRO after the initial five units have been utilized in the next state fiscal year (July 1 and after). Refer to DMAS memo dated June 3, 2015, for detailed information via the DMAS Web Portal at: www.virginiamedicaid.dmas.virginia.gov/wps/portal/medicaidmemotoproviders.

- Providers who obtain a service authorization approval for outpatient rehabilitative services from KEPRO with dates of service spanning the state's fiscal year (July 1), may utilize this service authorization number for claims submission for all dates of service included in the authorization.
- The provider must utilize the member's initial five units in the state fiscal year (beginning July 1 annually) that do not require service authorization.
- After the five units have been utilized, the provider continues to use the service authorization number given by KEPRO for all dates of service provided after the initial five units have been utilized through the last date of service approved on the service authorization.
- Providers are responsible to bill DMAS correctly for the first five units that do not require service authorization. Service authorization is required before payment will be made for any units over five annually. Providers may contact the Provider Helpline to determine if the first five units are available.

Benefits to Providers:

- Decreased volume of submission with an end date of June 30 and another submission with a begin date of July each fiscal year.
- Plans of care can span July 1 each fiscal year.

In this Edition

Provider Portal Available for All Outpatient Services

KEPRO's Provider Portal is available to use for ALL outpatient services!

Benefits of Direct Data Entry Submission:

- ***Submitting through direct data entry (DDE) puts the request in the worker queue immediately. For direct data entry (DDE) requests, providers must use Atrezzo Connect Provider Portal.*** For DDE submissions, service authorization checklists for some services may be accessed on KEPRO's website to assist the provider in assuring specific information is included with each request. Providers will not be charged for submission, via any media type, for service authorization requests submitted to KEPRO.

- Rules Driven Authorization (RDA) – these are a set of clinical criterion questions that will automatically populate in a questionnaire when requesting certain services or with specific diagnostic codes. If you see a questionnaire pop up, you must respond to the questions. The responses given by the provider must reflect what is in the member's documented record. If the responses match the criterion for the specific service or diagnosis, the case will bypass a reviewer and be approved, and automatically batch for transmission to MMIS. If the responses do not match the specific criterion, the case will go to a reviewer's queue which will follow the normal review process. If criteria are not met, then the request will go to the physician's queue and a physician will review the case and make a final determination.

Attestations – All providers will attest electronically that information submitted to KEPRO is within the member's documented record. If upon audit, the required documentation is not in the record, and the provider attested that it was present, retractions may be warranted as well as a referral to the Medicaid Fraud Control Unit within the Office of the Attorney General.

Inpatient Untimeliness Due to Observation Stay in Excess of 23 hours

Members admitted to the hospital in an Observation status must have an inpatient order written prior to an inpatient admission. If the member is in an observation status for greater than 23 hours and then changed to an inpatient status, the subsequent inpatient request that is submitted to KEPRO is considered untimely.

According to the DMAS Hospital Manual, Chapter 4: "Observation services are those services furnished on a hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests."

Services are billed as outpatient status. A hospital may bill for observation bed services for up to 23 hours. A patient stay of 24 hours or more will require inpatient precertification where applicable.

Please follow this rule when evaluating and converting members to inpatient status for continued services.

Hospital/Specialized Bed Requests Using E1399 Miscellaneous Code

When requesting a Hospital or Specialized Bed using the E1399 miscellaneous code please remember to include the following documentation in your request:

1. How the bed will be used to treat the medical condition
2. An Invoice (must be legible with items and cost clearly identified by provider)
3. How the member's needs have been and are currently being met
4. The member's functional abilities/disabilities
5. Manufacturer's description and picture of the E1399 item requested (i.e. manufacturer's brochure, pamphlet or specifications sheet)
6. Will the home support the electricity requirements of the bed?
7. Will the home support the weight of the bed
8. Other alternatives tried
9. Why a non-hospital bed would not meet the member's needs
10. Does the bed already include a mattress? (If yes, the provider should not submit a mattress code with E1399 request)
11. If requesting a SPECIALIZED HOSPITAL BED please include the following:

    a) Any less specialized options attempted
    b) Why did the lesser option not meet the member's needs
    c) Why is a standard hospital semi/total electric bed with support surface not sufficient

Note: In the Durable Medical Equipment (DME) Manual Appendix B, if there is no HCPCS code listed for the hospital/specialized bed being requested, use of the E1399 code is appropriate. However, when there is a Medicaid approved HCPCS code for the requested bed, providers must use that code.

Durable Medical Equipment - Miscellaneous HCPCS Codes

Miscellaneous codes will not be recognized for the sole purpose of cost variances. If a HCPCS code is not listed in the Appendix B, the provider can use an appropriate miscellaneous code for coverage consideration. In order for the service authorization contractor and the post payment auditing contractor(s) to determine the appropriate reimbursement for miscellaneous items, all of the following must be provided and kept on file in the member's record:

- A complete description of the item(s) being supplied;
- A copy of the supplier's invoice or the dealer cost information to document the cost of the item(s); and
- Any discount received must be indicated.

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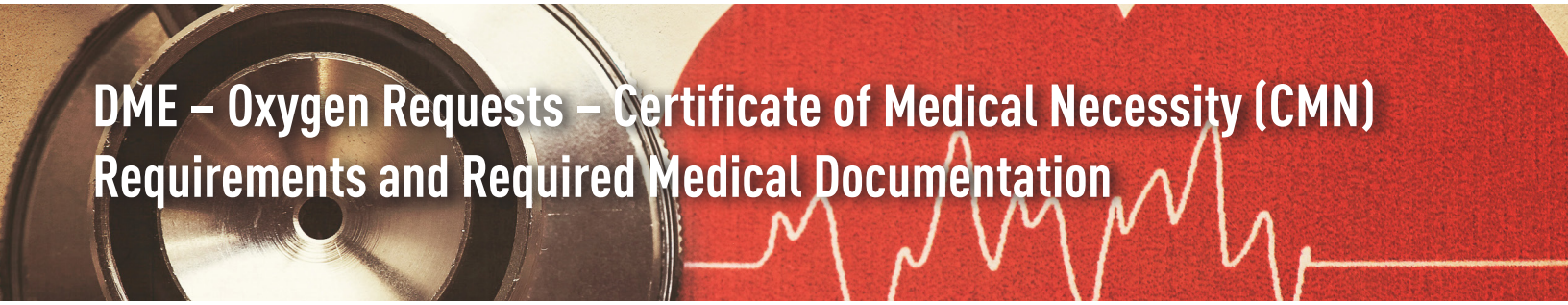
Durable Medical Equipment - Miscellaneous HCPCS Codes continued...

The manufacturer's invoice, the dealer's price list showing the dealer's cost of the item, or a statement from the manufacturer detailing estimates of cost for specially designed items, are all acceptable documentation. The documentation must include the manufacturer's cost, any discounts provided to the provider, and the provider's ancillary cost of providing the DME and or supplies to the member. The reimbursement amount is determined by adding 30 percent to the providers cost for the item.

If an estimate is used for specially constructed items, upon receipt of the manufacturer's invoice, if the cost is less than reported on service authorization, the provider must only bill 30 percent over the cost of that item. Likewise, if the cost is more than the original estimates, the provider may submit a change request to the service authorization contractor for consideration (See Appendix D for more service authorization information). Documentation of the actual cost of the item billed must be in the member's record. – DME Manual, Chapter IV, pages 9-10.

Virginia Medicaid approved DME miscellaneous codes are found in the DME Manual, Ch. IV, pages 10-11 and the DME Manual, Appendix B.



DME – Oxygen Requests – Certificate of Medical Necessity (CMN) Requirements and Required Medical Documentation

Any respiratory/oxygen equipment and supplies must be practitioner ordered via the CMN. The flow rate, frequency, and duration of use and duration of need must be documented. Coverage of home oxygen and oxygen equipment will be considered reasonable and necessary for members with hypoxemia as evidenced by clinical findings. (12 VAC 30-50-165) Medical Documentation

The practitioner must have examined the member within 30 days of the start of therapy.

The CMN must include all of the following:

- A diagnosis of the disease requiring home use of oxygen;
- The oxygen flow rate; and
- An estimate of the frequency, duration of use (e.g., 2 liters per minute, 12 hours a day) and duration of need (e.g., six months or lifetime). Oxygen that is ordered PRN must include justification to determine the amount of oxygen that is reasonable and necessary for the member.

The CMN is valid for 12 months for adults and 6 months for children.

- The CMN must also include the results of a blood gas study ordered and evaluated by the attending practitioner.
- Pulse Oximetry
- DME Manual, Ch. IV, pages 42-43

For more detailed information on respiratory/ oxygen equipment and supplies, please refer to the DME Manual, Ch. IV, pages 42-46 and the DME Manual, Appendix B.

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KM-CN-6.3.2016