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A KEPRO QUARTERLY NEWSLETTER • VIRGINIA MEDICAID SERVICE AUTHORIZATION • SPRING 2013

LTC Services: Conversion of Specialized Care and Long Stay Hospital Service Types in the KePRO Web Portal from Inpatient to Outpatient and the Service Authorization Information Checklist

Specialized Care/Long Stay Hospital Outpatient Request

Effective June 1, 2013, Specialized Care and Long Stay Hospital (SC/LSH) providers must submit service authorization requests to KePRO as an outpatient request, as opposed to an inpatient request. Treating the service as inpatient in KePRO's Web Portal has the unfortunate effect of requiring the provider to create a new case following every overnight leave from the facility. This change will allow providers to submit extension requests for authorization dates that are not contiguous with a previous span without having to build a new case.

This change only impacts what is received in the KePRO system, and has no impact on billing or claims processing.

in this edition

Service Authorization Information Checklist for Easier Submission

The Service Authorization Information checklist for Specialized Care/Long Stay Hospital requests is now available. The checklist assists providers with the type of clinical information needed by KePRO to review each request and will reduce the amount of clinical information that is currently faxed to KePRO.

Utilization of this checklist will provide a more concise service authorization request with appropriate clinical information. This will decrease the number of cases pended for additional clinical information and speed up the processing time. The checklist may be used as a tip sheet for all of the important items to include in your request, or as a template for your actual request where you would edit, copy, and paste into Atrezzo. Be sure to check your document before transmission, as some characters may change during the copy/paste process. The checklist is available on the KePRO web site at https://dmas.kepro.com.

DID YOU KNOW?

Providers can begin to submit respite requests to KePRO for continuation of services for any EDCD or DD waiver respite authorizations that end 6/30/2013 as early as June 1, 2013.

Traditional Service Tidbits

1. **All Service Authorization Requests or Inquiries:** Providers, please include a contact name and phone number in your submissions to KePRO for ALL Service Authorization requests and inquiries. This will enable KePRO to quickly contact you to resolve potential issues.

2. **Surgical Procedures Services:** Outpatient surgical procedures must be submitted under the **NAME and NPI #** of the **Servicing Physician** not the Facility. ***Please remember to enter a name and phone number for a contact person for every case.***

3. **DME Actual Cost versus Total Dollar Request:** When Actual Cost is required for submitted HCPCS, Actual Cost/each reflects Provider Discount Cost/each. Total Dollar Requested may represent mark-up or retail. Actual Cost and Total Dollar Requested amounts are only the same if the DME facility is the manufacturer. If using DMAS-363 Outpatient request form, see page 2 Column # 21 Actual Cost and Column #23 for Total Dollar Request.

DME Orthotics and CMN

- A CMN (DMAS-352 form) is required for all DME Service Authorization requests, and at every DME audit, the CMN will be reviewed. KePRO does not require you to submit the actual CMN when you request DME Service Authorization, but you do have to provide the clinical information from sections II, III, and /or IV of the CMN when you submit your request for Service Authorization.

- If KePRO pends a request and asks the provider to submit a CMN, providers need to respond to the pend within the stated timeframe.

- Many times providers inadvertently omit this information requiring the case to be pended for the required information. Providers are given five business days to respond to a DME pend request. If a provider does not reply to the pend or replies on Day 5, the Clinical Reviewer must wait the entire five days before proceeding with case processing, and this can create a huge delay in completing your request for equipment and/or supplies. However, if a provider replies within one business day, KePRO will process the request the next business day and there is no additional delay in processing.

- Please consider attaching the CMN (DMAS-352) to the new case you are creating in Atrezzo, or fax in a clear copy of the CMN (DMAS-352) to be attached to the case. If the Clinical reviewer is able to actually see the information on the CMN (DMAS-352) the processing will be shortened because the required information will be readily available. Orthotic Submissions: Service Type Orthotics, DME Manual, Appendix B HCPCS codes.

- The correct Service Type for Orthotics submissions is 0092 for EPSDT services. Orthotics are for Medicaid members < age 21 UNLESS the member is ≥21 and is actively participating in an Intensive Rehabilitation Program. If the member is ≥21 and meets the criteria for Orthotics, the request will be processed under the Service Type 0100 (Durable Medical Equipment).

Behavioral Health

Medicaid Eligibility and Submissions

- Some providers have been finding the new eligibility edits challenging. The new edits that are in place will prevent providers from submitting requests for members who do not have active Medicaid coverage. Providers need to check eligibility prior to submitting the case. **Providers may verify eligibility by utilizing the DMAS web based Automated Response System (ARS) MediCall** by calling **1-800-884-9730** or **1-800-772-9996**. Also, access to the eligibility website is located at http://www.virginiamedicaid.dmas.virginia.gov.

- If the member is not Medicaid eligible for the dates requested, providers may wish to assist the member with contacting their local Department of Social Services (DSS) to reinstate Medicaid eligibility. Once this is done and eligibility is active in the DMAS MMIS, the provider may then submit a request.

- If the member is Medicaid eligible for only part of the date span requested and the provider has difficulty submitting the request, KePRO customer service can assist with this process. Please call **1-888-827-2884**.

Tips for Writing Clinical Information in Behavioral Health Service Authorization Requests

- Always use the correct checklist for the service being requested.
- Address each criteria. Provide specific behavioral examples of the member's mental illness symptoms and how those symptoms/behaviors interfere with functioning to the extent that they meet criteria. How are health and safety at risk? It is important to provide sufficient information since reviewers cannot make assumptions.
- If interventions are included in the criteria for the requested service, be very clear about the time frames regarding when the interventions occurred. Also, be clear about whether or not the interventions are related to mental health. For instance, state "psychiatric medication management" rather than "medication management." The term "medication management" could refer to medical treatment only.
- Make sure that the demographic information (age, name, gender) in the clinical information matches the Medicaid demographic information. Reviewers must ensure that the clinical information submitted is for the correct member.

2810 North Parham Road, Suite 305
Henrico, VA 23294
Toll-free: 888-827-2884
Tel: 804-622-8900
Fax: 877-652-9329
http://dmas.kepro.com

Behavioral Health Services Reminders for VICAP

- The CPT codes for individual and group therapy changed for 2013. Please submit your requests using the new codes, which can be found in the 12/21/12 Medicaid Special Memo. The interactive add-on codes do not require review by KePRO.
- Portal eligibility edits will prevent case submission if the member is not eligible for the requested dates of services. An error message will notify you that the member is not eligible for the ranges of dates you are requesting. If you receive this error message, check the members eligibility, and adjust the requested dates of service to match the eligibility information you have received. For assistance, please contact KePRO customer service at **1-888-827-2884**.
- If the member is not Medicaid eligible for the entire 30 days of the VICAP, KePRO staff will create a second line of service to capture any part of the ineligible 30 days. CSB'S can only bill for dates of service within the members eligibility. VICAP will still be considered valid for 30 days allowing the servicing provider of the recommended service to submit for authorization. Servicing provider will only be able to submit for Medicaid eligible dates of service.

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NPI Number Changes

- Providers who have been issued a new NPI number should immediately begin utilizing the new number for all case submissions to KePRO
- For existing cases with the old NPI# which require extensions or continuation of services, Providers who use Atrezzo portal must create a new case and reference the original case id number in the Clinical information section. The Provider must document that there has been an NPI number change and for KePRO to refer to the existing case ID.
- For faxed or phone requests the provider must document the existing case entered under old NPI number as well as documentation that there has been an NPI number change.
- Failure to follow these instructions will create a delay in processing your extensions. Also, if you utilize a case with an old NPI# requesting services after your new NPI number is in effect, you will not be able to receive payment unless you actually **use the new NPI number.**