VA insider

A KEPRO Quarterly Newsletter | Virginia Medicaid Service Authorization | Winter 2016

OUTPATIENT REHABILITATION REQUESTS CHANGE

Procedural Change for Service Authorization Requests for Outpatient Rehabilitation Services - *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 when the dates of service end June 30 (end of the 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.

- 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), which do not require service authorization.
- After the five units have been utilized, the provider will continue 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 end date of 6/30 each fiscal year
  - Plans of care can span past 7/1 each fiscal year

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OUTPATIENT PORTAL USE

The portal is available for use for ALL outpatient services!

Benefits of DDE Submission:

- Submitting through Direct Data Entry (DDE) puts the request in the worker queue immediately. For DDE requests, providers must use the 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 that 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 - 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, be approved, and automatically batch for transmission to the Medicaid

Reminder!
2016 is a leap year. Please be aware when making authorization requests that February has 29 days.

Benefits of DDE Submission
continued

Management Information System (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.

PROVIDER PORTAL CASE LOOK-UP

Requesting and Servicing Provider: If you are listed as the requesting AND the servicing provider, you are able to look up an existing case by utilizing the Case Identification Number and Member Search.

Servicing Provider Only: If you are listed as the servicing provider, you are not able to access the case utilizing the Case Identification Number. All requesting providers must do the following to look up an existing case:

1. Complete a Member Search
2. Select the member
3. Select the Servicing Provider tab
4. Select the correct case from the cases that are listed for the member

ATTENTION EDCD, PERSONAL CARE, AND ADULT DAY HEALTHCARE PROVIDERS

Please make sure you are entering the requested units correctly when submitting Elderly or Disabled with Consumer Directed (EDCD) waiver service authorization requests.

Requested units should be entered as follows:

- Personal Care - **Requested units are submitted as weekly and will be authorized as monthly**. **Example**: If you are requesting 30 hrs/week of Agency Directed Personal Care Services (T1019), your treatment line units should reflect 138 units.
  Formula: 30 hrs/wk x 4.6 = 138 units

- Attendant Care - **Requested units are submitted as weekly and will be authorized as bi-weekly**. **Example**: If you are requesting 30 hrs/week of Consumer Directed Attendant Care Services (S5126), your treatment line units should reflect 60 units.
  Formula: 30 hrs/wk x 2 = 60 units

- Adult Day Healthcare - **Requested units are submitted as days/week and will be authorized as monthly**. **Example**: If you are requesting 5 days/week of ADHC Services (S5102), your treatment line units should reflect 23 units.
  Formula: 5 days/wk x 4.6 = 23 units

REMINDER: Please complete the questionnaire **CORRECTLY**. Please pay close attention to all notes that appear when you select yes or no to a particular question. For additional information regarding the process, please click here and select the "Waivers" tab to access the EDCD Waiver Service Authorization PowerPoint presentation.

BREAST PUMP AUTHORIZATION

A manual or standard breast pump will be covered as medically necessary for the initiation or continuation of breastfeeding up to the child's first birthday by utilizing the following information:

E0602 - Manual Breast Pump - Purchase
Manual breast pumps typically consist of a single breast pump shield, a collection device, and a hand-controlled lever to create suction and express milk. This item is single user and purchase only. No service authorization is required.

E0603 - Single User Electric Breast Pump - Purchase
A personal use electric breast pump is defined as a double electric (AC and/or DC) pump, intended for a single user, and is capable of being used multiple times per day. Payment includes supplies necessary for operation of the pump (pump, adapter/charger, breast shields, bottles, lids, tubing, locking ring, connectors, valves, filters, and membranes). This item is single user and purchase only. Service authorization is required.

Breast Pump Authorization *continued*

E0604 - Multi-user (Hospital Grade) Electric Pump - Rental
Multi-user/hospital-grade electric pump is designed to initiate and maintain a milk supply when a baby is not feeding well. This is a multi-user item and is for rental only.

E1399 - Additional Collection Kits - Purchase
Additional collection kits for member-owned or pump rentals. This item is single user and purchase only. Service authorization is required.

For additional information on guidelines and criteria that must be met for breast pump authorizations, please review the Medicaid Memo, MOMS: Coverage of Lactation Services – effective January 1, 2016, and dated December 1, 2015; available at: https://www.ecm.virginiamedicaid.dmas.virginia.gov

APPEALS: OBSERVATION STAY IN EXCESS OF 23 HOURS RESULTING IN UNTIMELY DENIALS FOR INPATIENT HOSPITAL STAY

According to DMAS Hospital Manual, Chapter 4, pg. 14: DMAS will pay for observation bed services when billed on an outpatient invoice under the following conditions:

- Observation bed services are covered if they are reasonable and necessary to evaluate a medical condition to determine the appropriate level of treatment.
- Non-routine observation for underlying medical complications after surgery or diagnostic services is covered. Medical documentation of the complication is required.
- 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**.
- When inpatient admission is required following observation services, observation charges will be combined with the appropriate inpatient admission and shown on the inpatient bill. Observation bed charges and inpatient hospital charges will not be reimbursed for the same day.

Please note that if the member is in an observation status for **greater** than 23 hours and then changed to an inpatient status, the subsequent inpatient request submitted to KEPRO is considered untimely if the request is not submitted within one business day of the required inpatient admission date.

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