insider

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

Waiver Services

Effective January 1, 2013, fee for service Medicaid services are authorized with specific end dates, regardless of the authorizing entity (KePRO, DMAS, DBHDS). Members/Individuals who had authorizations without a specific end date did not have their services/ units reduced, but were given a specific end date for their existing service authorization. If the member/ individual continues to need services past the authorization end date, Providers must now submit a new service authorization request.

DMAS placed definitive end dates on all service authorizations. For dormant authorizations in which there had been no claims activity against the current service authorization since November 1, 2011 and the authorization extended past December 31, 2012, DMAS end dated the service authorization with the new end date 12/31/2012.

DMAS end dated all other authorizations that were open-ended or extended past December 31, 2014, with an end date in the year 2014. Providers received a letter generated from the MMIS with the new service authorization end date. KePRO and the Department of Behavioral Health and Developmental Services (DBHDS) received these authorizations with the new end date. The Service Authorization number for billing purposes has not changed.

For the DD Waiver all service authorization begin and end dates will fall within the Plan dates and will not extend beyond the Plan year. Continuation of service requests must be submitted to KePRO, DMAS' Service Authorization Contractor, prior to the current Plan end date. All authorizations with end dates extending beyond the Plan year will be cut back to the Plan end date.

in this edition

Traditional Services: Virginia Medicaid Web Portal

DID YOU KNOW?

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advice. Providers must register through the Virginia Medicaid Web Portal in order to access this information.

The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Help Desk, toll free, at 1-866-352-0496, from 8:00 a.m. to 5:00 p.m., Monday through Friday, except holidays.

The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KePRO's Provider Portal, at http://dmas.kepro.com.

Members Who Are Dually Eligible with Medicare A and Medicare B as Primary and Medicaid as Secondary

Service authorization from KePRO is required prior to billing Medicaid when Medicare is exhausted or has denied the claim. Please refer to the Medicaid Provider Manuals for complete instructions. The Medicaid Provider Manuals are located at www.virginiamedicaid.dmas.virginia.gov under Provider Services, Provider Manuals.

Medicare A Primary and Inpatient Admissions

KePRO's Clinical Reviewer will review the service authorization request for medical necessity only when the provider indicates that Medicare A has denied the claim, or that the benefits have exhausted. When this occurs, the service authorization request will be treated as retrospective eligibility and will be reviewed by KePRO without applying the timeliness requirement in regard to requesting the service authorization.

When a provider requests a service authorization where the member is dually eligible and the provider does not indicate that Medicare A has exhausted or denied the claim, KePRO's Clinical Reviewer will close the case and send a notification to the provider indicating that the case was closed, but if the provider determines that the benefits were denied or exhausted, then the same case can be reopened and reviewed as a retrospective review.

Helpful Hints for Inpatient Surgical Admissions

When requesting Service Authorization for Inpatient Surgical Admissions, please include the name of the surgery. If the member is to be admitted prior to the day of surgery, the clinical documentation supporting medical necessity for the pre op day is required.

- If the surgery is on the McKesson InterQual© Inpatient Surgery List, then no further clinical information is needed.
- If the requested surgery is not on the approved McKessson InterQual© Inpatient Surgery List, then supportive documentation regarding the medical necessity for Inpatient admission is required.

Surgical Procedures Requiring Dual Authorization

- Some surgical procedure codes require dual authorization from KePRO.
- Examples of dual authorization for surgical procedures are: Transplant, bariatric surgery, and some cosmetic surgery.
- The Surgical procedure may require Service Authorization under service type 0302 (Surgical Procedures) and 0300 (Organ Transplant Services).
- The Inpatient admission would require Service Authorization under service type 0400.

HOW TO FIND OUT IF PROCEDURE CODE REQUIRES SERVICE AUTHORIZATION

In order to determine if services need to be prior authorized, providers should go to the DMAS website: http://dmasva.dmas.virginia.gov, and look to the right of the page. Click on the section that says Procedure Fee Files, which will bring you to http://www.dmas.virginia.gov/pr-fee_files.htm. You will see a page titled DMAS Procedure Fee Files. The information provided on the Fee File will help you determine if a procedure code needs prior authorization or if a procedure code is not covered by DMAS.

You can access the file through CSV or TXT format. The CSV is a comma separated value; the TXT is text format. Depending on the software available on your PC, you may easily use the CSV or TXT version. The TXT version is recommended for users who wish to download this document into a database application.

The CSV version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will indicate if a code needs to be prior authorized by the following numeric values:

00 – No PA is required

01 – Always needs a PA

02 – Needs PA only if service limits are exceeded

03 – Always need PA, with per frequency.

To determine if a service is covered by DMAS, you need to access the Procedure Rate File Layout page from the DMAS Procedure Fee Files. Flag codes indicate special coverage and/or payment information. A Procedure Flag of "999" indicates that the service is not covered by DMAS.

Tips for "Srv Auth" of Non Emergent Imaging Scans (CAT, MRI AND PET)

1. Check eligibility before submitting a case to ensure that the member is enrolled in Medicaid FFS for the requested service dates. If the member is enrolled in an MCO (HMO) plan, KePRO does not issue Service Authorization.

2. Imaging studies are authorized for a 90 day date span, contingent upon member eligibility.

3. If the member is enrolled in a Medicare B plan, Service Authorization by KePRO is not required unless the claim has been billed and denied by Medicare B. In this case, when submitting a request for retro Service Authorization to KePRO, please state that Medicare B was billed and denied.

4. If imaging studies are approved under a facility name and NPI as Service Provider and the scan needs to be changed to a different facility, a request must be submitted (under the original case) to KePRO to cancel the original Service Authorization number. KePRO will then cancel the original Service authorization number in the original case. After the original Service Authorization number is cancelled, KePRO will change the NPI number in the original case to reflect the new Service Provider. To decrease the incidence of this situation, providers should consider using an individual physician NPI number for the Service Provider instead of using a facility NPI number.

5. Out of State providers may request Service Authorization for scans. Effective 3/1/2013, the Out of State provider must provide a reason for the Out of State request. A DMAS Medicaid Provider Memo was sent on February 6, 2013, advising providers of this requirement.

Behavioral Health

TIDBITS FOR OUTPATIENT PSYCHIATRIC SERVICE

Providers can access the KePRO website for the CPT code change information. New CPT codes were effective 1-1-13. To locate a new CPT code in Atrezzo/Portal: the "procedures" box under CPT has a drop down with "ICD9." Most of the new codes are located here.

1. Please be specific regarding the member's current symptoms, behaviors, and functioning ability or capacity.
2. Do not request a start date that is earlier than the date the request is submitted unless the request is a retroactive eligibility request.

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

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