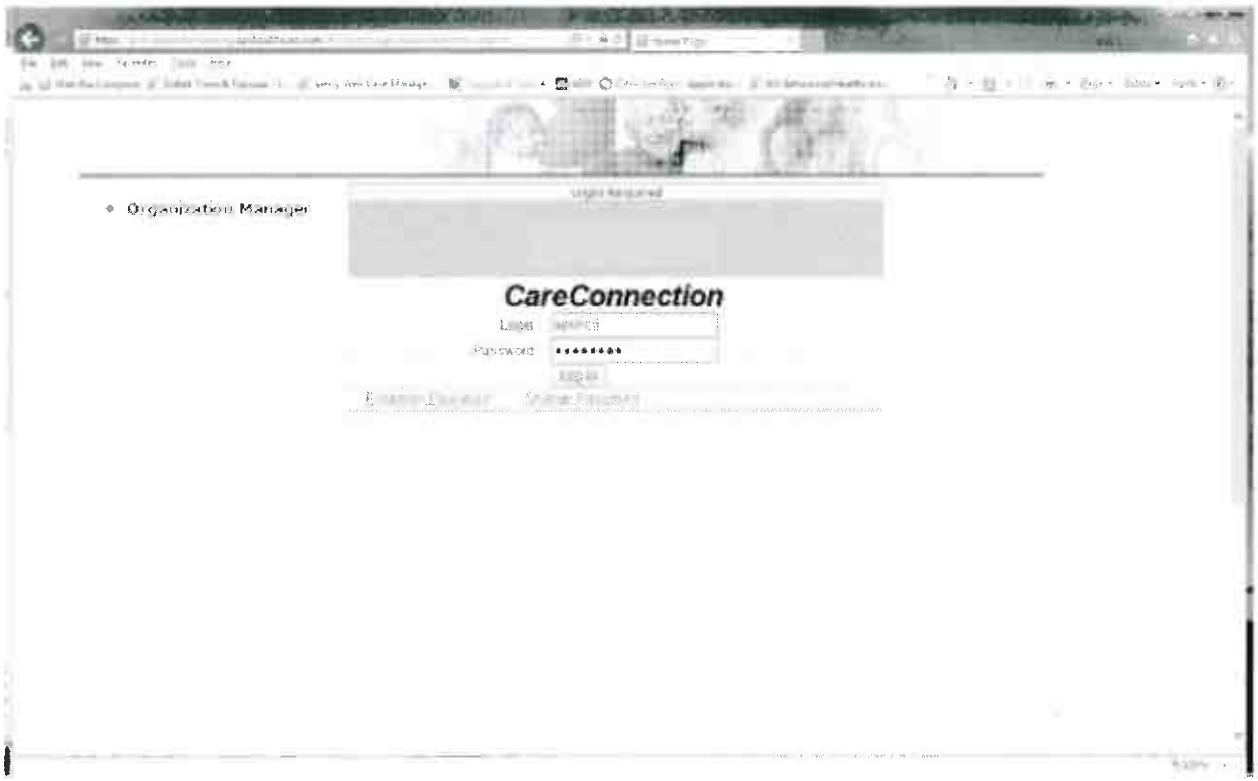
Imaging/Radiology/Laboratory Requests

There are certain Imaging, Radiology and Lab services that require prior authorization prior to billing and should be submitted within 10 business days. If the service is performed prior to obtaining an authorization, a request can be submitted up to 10 business days after the service. Please note: The request must meet medical necessity and there is no guarantee the procedure will be authorized.

To request an authorization, Providers will submit via the DDE portal. If you're an employee without a User ID to logon, you can fax the Imaging/Radiology/Lab Prior authorization request form to the fax number included on the form. Please Note: the system will need to be accessed to obtain the status of your request.

How to submit a Lab/Imaging/Radiology Request

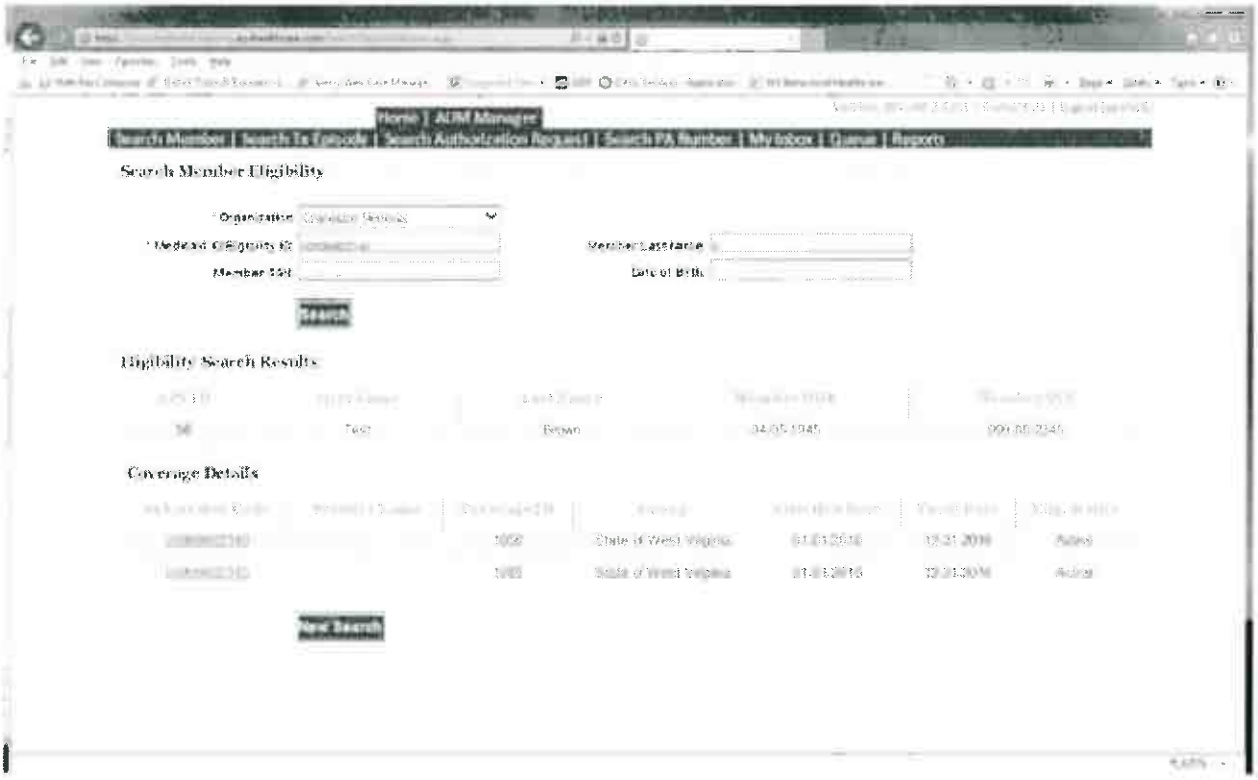
Go to https://providerportal.kepro.com and enter you login ID and password



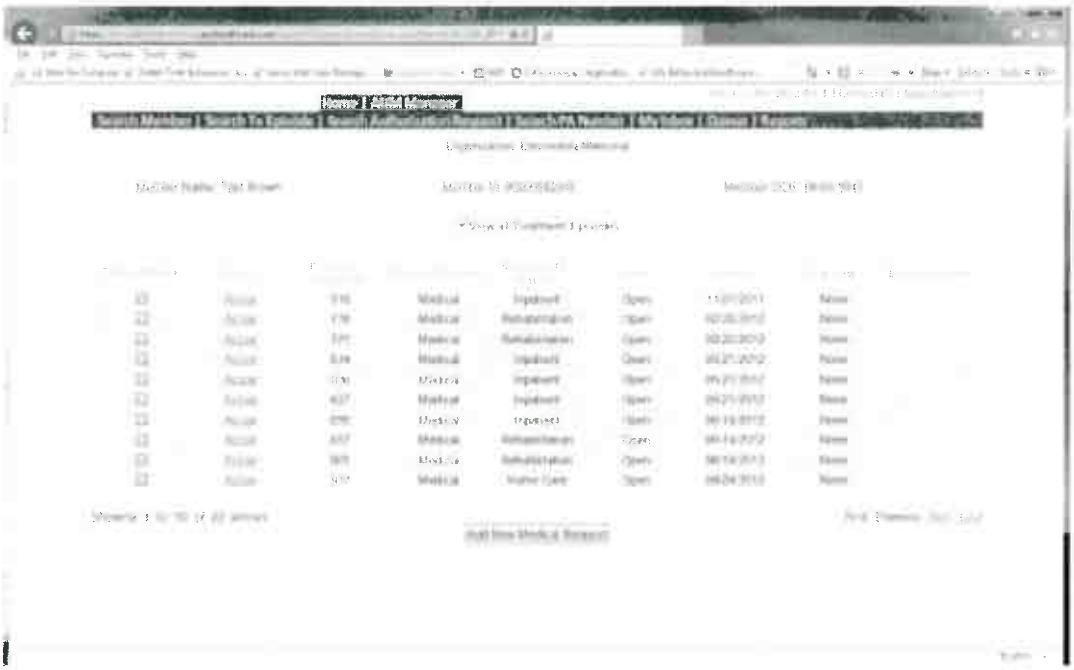
Click on AUM Manager Tab

Click on Search member and enter the WV Medicaid ID number and the member's last name then click Search. (Hint: you can enter the first initial of the last name and click search)

Under "Coverage Details," click on the subscriber code that matches the one you entered on the Search Member screen that has not termed.



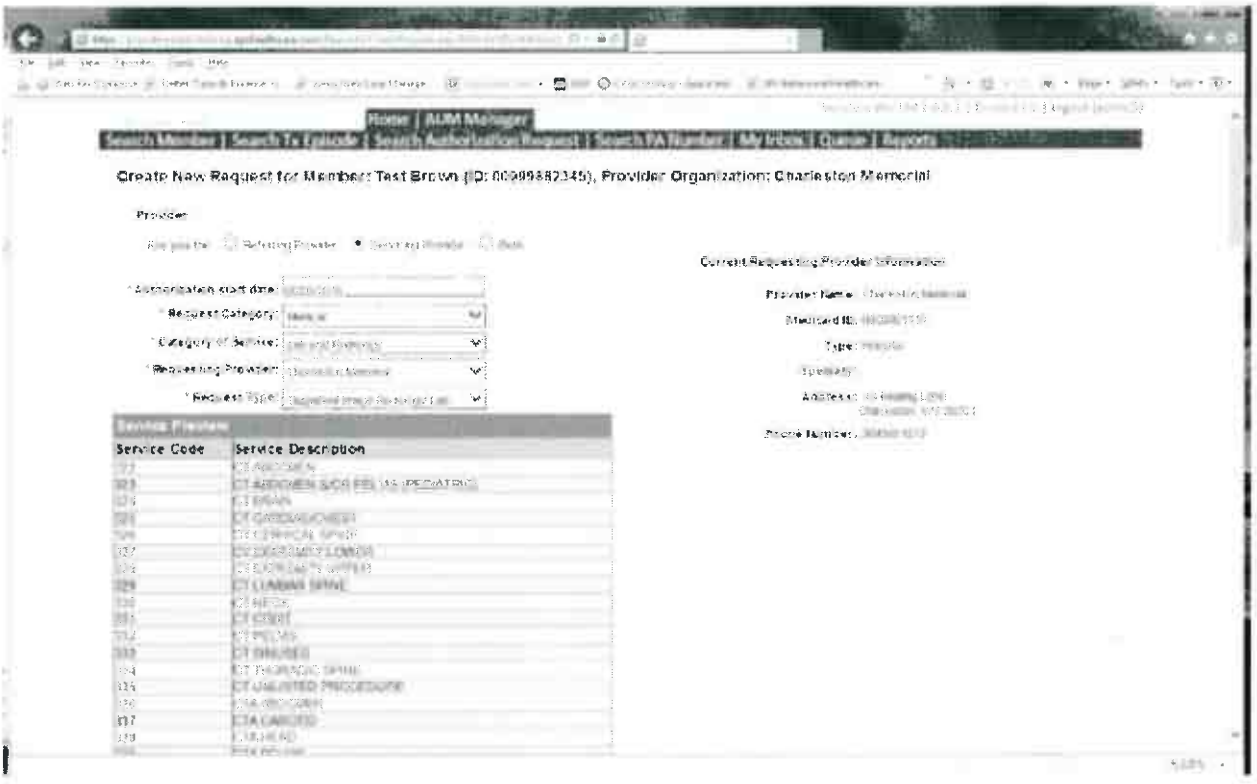
This will bring you to the Treatment Episode Screen which shows all the previous requests for the member. Click on the **ADD NEW MEDICAL REQUEST** button.



This brings you the Create New Request Screen. Under 'Provider,' you will need to choose rather you are the referring provider, servicing provider or both.

- Referring- Choose if requestor will **NOT** be billing WV Medicaid for requested service.
- Servicing- Choose if requestor **WILL** bill WV Medicaid for requested service
- Both- If you are an office that will be performing and billing for the service, this is the best option to use.

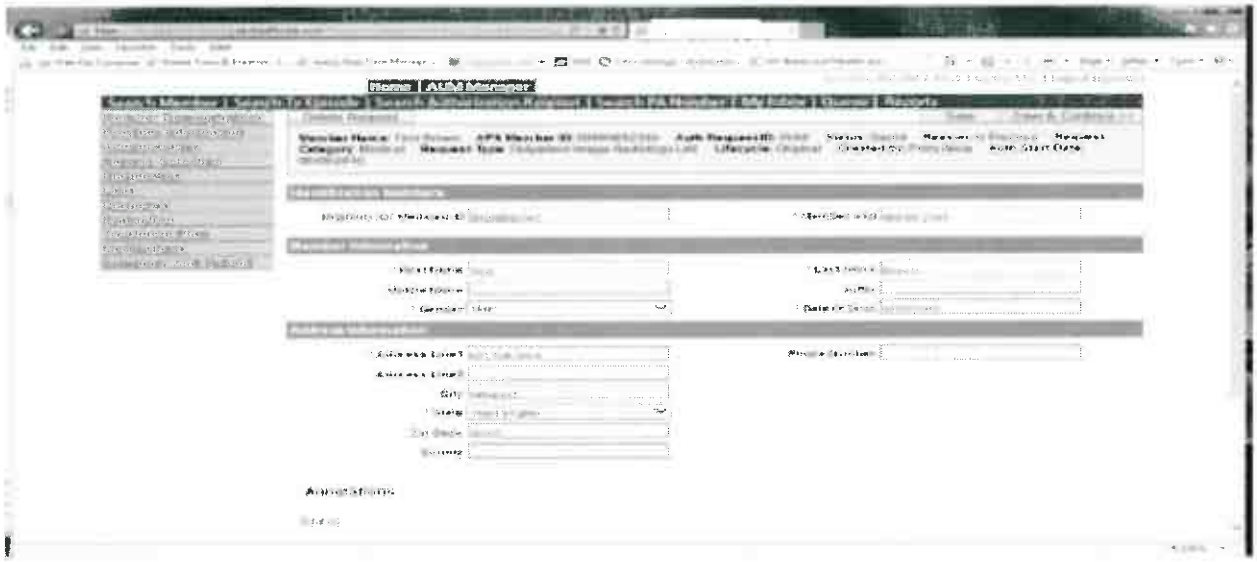
Next, enter the start date (the date of service) .If there is no scheduled date, use the date of service being submitted, the request category (Medical), the category of service (Lab and Radiology), choose the requesting provider(there will only be a list available if your registration is complete and your provider NPI numbers have been attached), and enter the request type(Outpatient Image Radiology Lab) scroll to the end of screen and click "Create Request"



If the member has previous treatment episodes, it will ask you if you want to Attach or Do Not Attach, just choose Do Not Attach. If the member does not have any previous treatments, click Continue

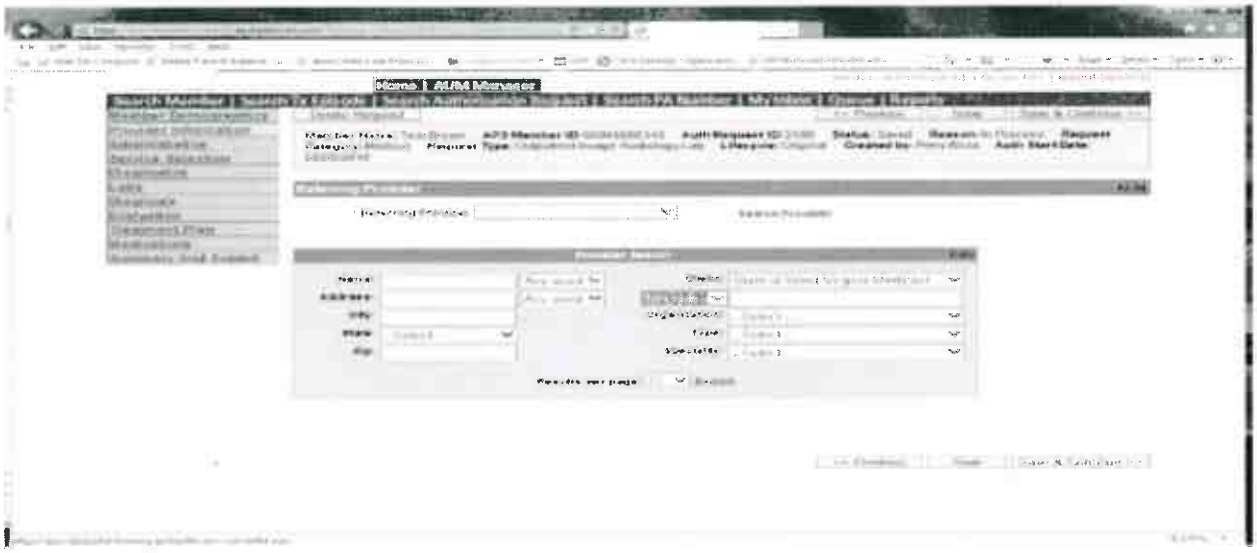
You are now ready to begin the application.

Member Demographics



If the address is not correct, change it and click Save and Continue. If everything is correct, simply click Save and Continue.

Provider



This brings you to the Provider Information screen. If you chose the referring provider option, this will auto-populate. This information cannot be changed.

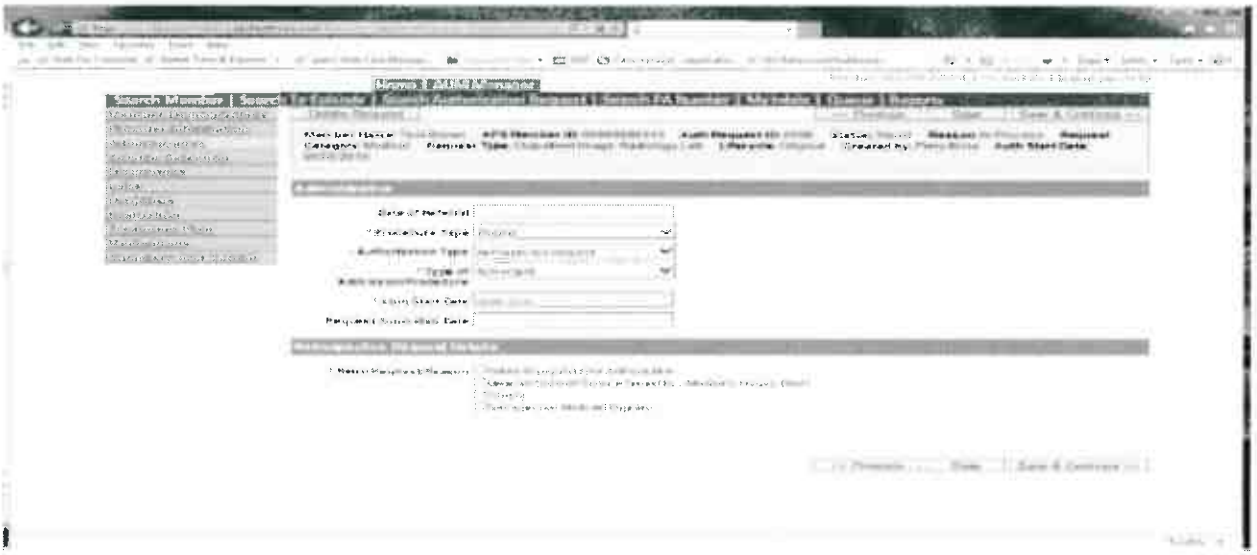
If you chose the servicing provider option, you will need to attach the referring physician information to the request. To find physician:

- Click on the Search provider
- Enter the physician's name in the Name field and change Any Words to ALL WORDS and click Search or
- You can select NPI, from the dropdown on the right side and enter the NPI number and click search
- DO NOT ENTER ANY OTHER INFORMATION IN ANY OTHER FIELDS. JUST NAME OR NPI NUMBER.
- Once you have found the physician you are looking for, click the paper clip to attach.
- Enter your direct phone number where you can be reached in the Contact Phone field
- Click Save and Continue.

Administrative

Answer all questions with the red *. Choose your Procedure Type. Choose Type of Admission/Procedure. ***Please note: Emergency/Medically urgent should only be chosen if it meets BMS definition of medically urgent.*** If the testing has already taken place and the start date is within 10 business days of admission date, the authorization type will be Prior.

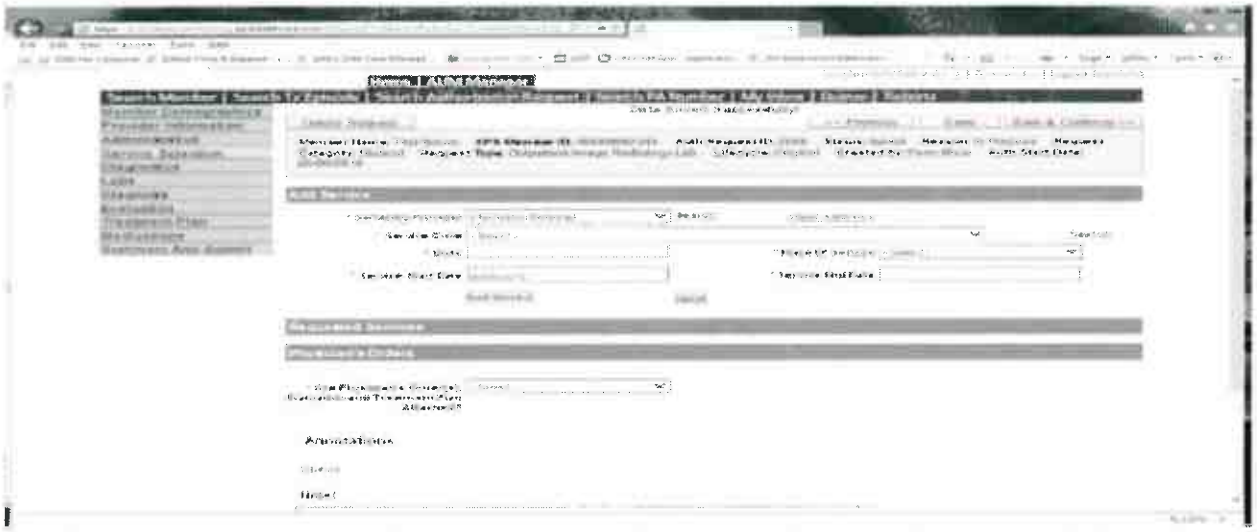
Administrative



If any other time span, the authorization type will be 'Retrospective Request.' Per BMS policy, there are timelines to request an authorization. If a request is submitted outside of the designated 10 day timeline, a retrospective policy denial letter will be issued. A retrospective reason will need to be selected and there are four options

- Failure to request prior authorization
- Medicaid covered service denied by-Member's primary payer-If this reason is chosen, documentation will need to be provided
- Other: If this reason is chosen, please make sure to provide as much information as possible.
- Retrospective Medicaid Eligibility-Only choose if Medicaid coverage has been backdated to cover date of service.

Service Selection



If you chose the servicing provider option, this will auto-populate. This information cannot be changed. If you chose the referring provider option, you will need to attach the Servicing Provider information to the request.

To find Servicing Provider:

- Click on the Search provider
- Enter the name in the Name field and change Any Words to ALL WORDS and click Search or
- You can select NPI from the dropdown on the right side and enter the NPI number and click search
- DO NOT ENTER ANY OTHER INFORMATION IN ANY OTHER FIELDS. JUST NAME OR NPI NUMBER.
- Once you have found the provider you are looking for, click the paper clip to attach.
- Click Save and Continue.

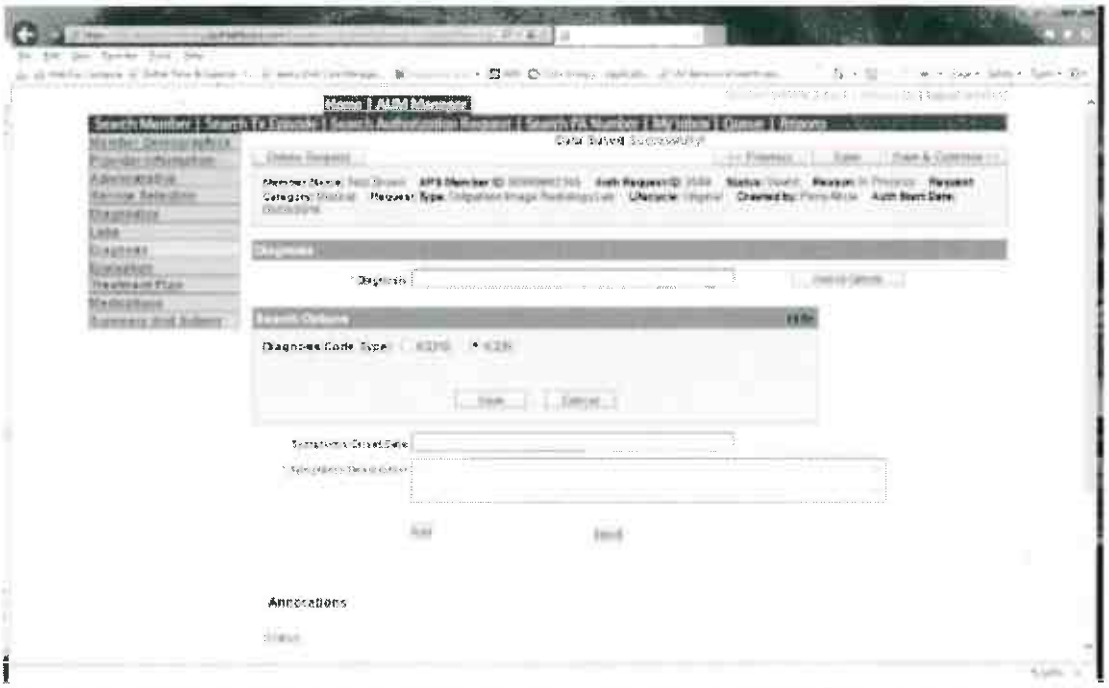
Service Selection

You are now ready to choose your service code. CPT (procedure)codes are grouped under several service codes. Choosing by the description attached to group service codes can cause errors in your request. The most efficient way is to click SEARCH located to the right of service code line. In the dropdown box, key the CPT (procedure)code in the Service Code/Group Name space and click Search. Click the paper click to attach code to request. The example shows a search for CPT(procedure) code 70542. Choose Place of Service. Units will auto generate. Please DO NOT change units. If you need more units, please indicate in the annotation box and then click save to save note. The service date span will be 90 days. Please DO NOT CHANGE service end date. Click ADD SERVICE

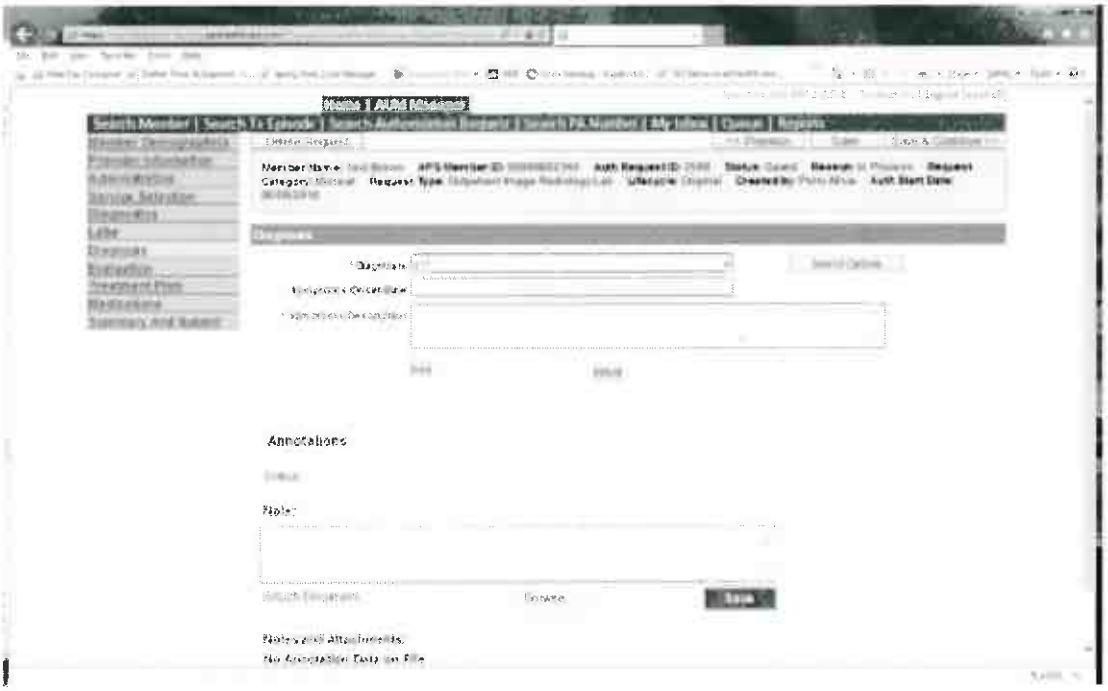
Answer question if physician's order(s), evaluation and treatment plan attached. If Yes, be sure to attach physician's order in the below annotations box. If no, the information will need to be faxed and should be indicated in the dropdown box. This is REQUIRED information. Click Save and Continue.

Diagnostics and Labs tab do not require information to be entered (no red *) but you can complete information if you choose. Please be sure to click Save and Continue after each screen.

Diagnosis

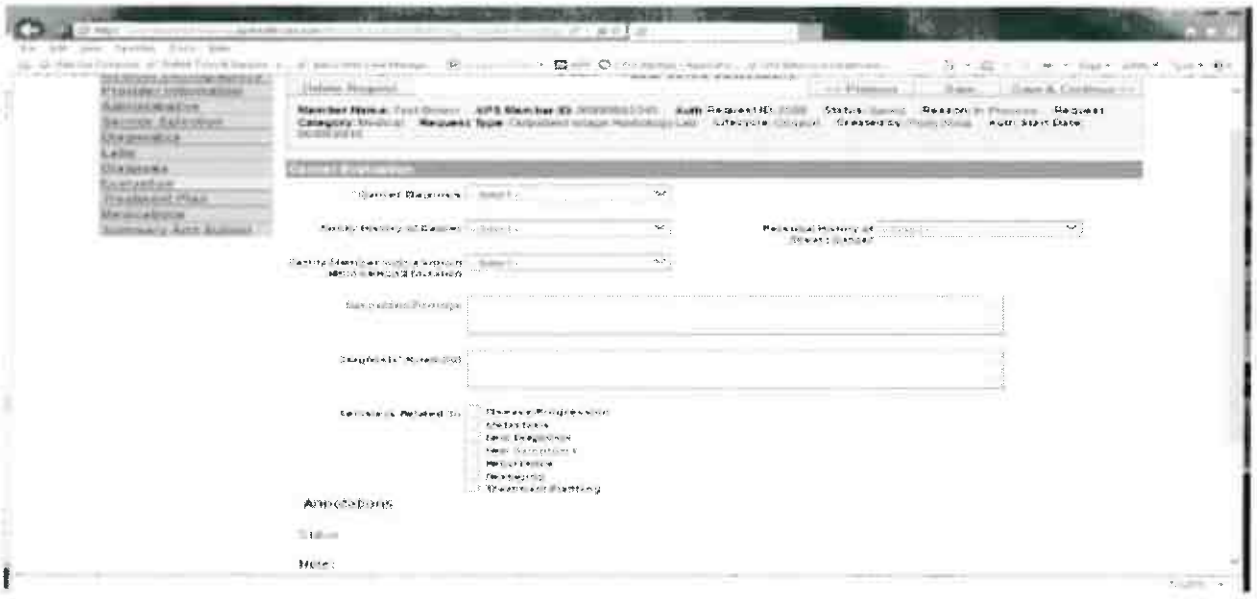


The Diagnosis screen is the next mandatory screen. ICD-10 diagnosis is required. The diagnosis code should be in the correct format for the date of service submitted. If your date of service requires an ICD-9 diagnosis code, prior to entering the numbers before the decimal, click the search options button, select ICD-9 and click save.



Enter the letter and numbers before the decimal of the diagnosis code, wait for the dropdown list, and choose the code from the list, enter symptoms in the Symptoms box, and click the Add button under the Symptoms box. Do this for as many diagnoses codes you have. Click Save and Continue

Evaluation

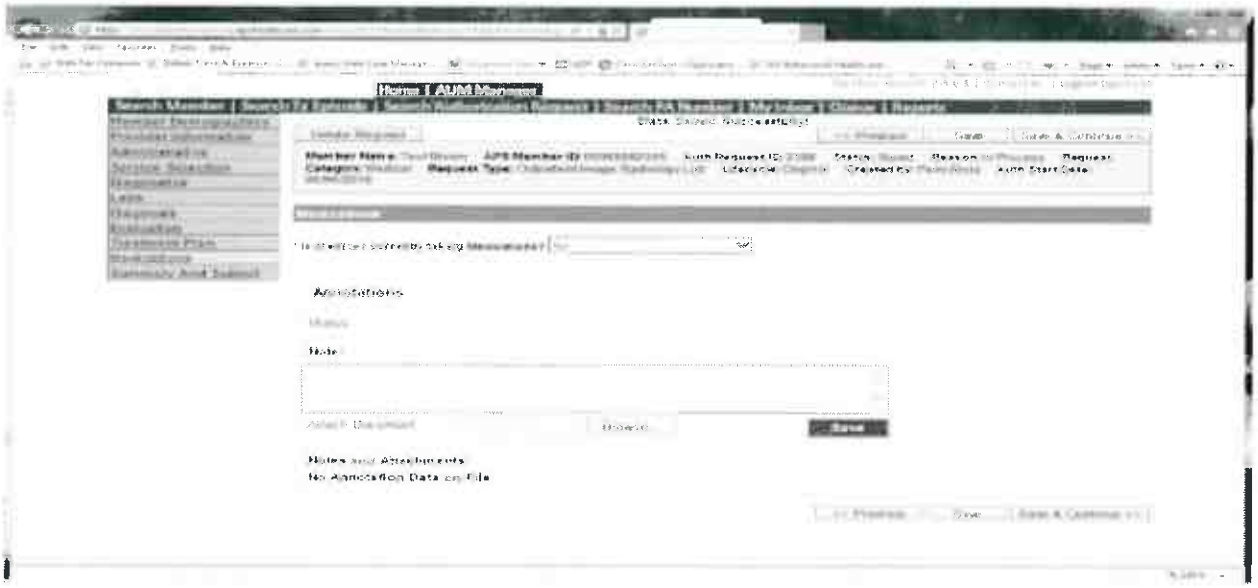


Please answer Cancer Diagnosis. If the answer is Yes, the Date of Cancer Diagnosis and what service related to questions will require an answer. If no, choose no. Click Save and Continue.

Treatment Plan

Please answer all questions with red *. Click Save and Continue

Medications



This brings you the Medications screen. This is not a mandatory screen but if you want to list medications, please leave the answer as NO, and either copy and paste, or download and attach list in the Annotations/Note sections. If you are going to fax, enter a note in the Annotations/Note Section, WILL FAX, click the blue SAVE button under the notes section. Click Save and continue to the Summary and Submit page.

Summary and Submit

The Summary and Submit page allows you to scroll the document from the beginning to the end. Look over it to make sure all things have been entered correctly, scroll back up to the top of the page and click SUBMIT in the top left hand corner and NOT the SUBMIT button at the bottom of the request. **Clicking the submit button at the bottom of the page does not allow the submitter to see any errors or warning boxes that require action.**

A warning box will be received. Click continue

And then Click OK, once the message that your request was successfully submitted has displayed.

Helpful Tips and Tricks for Imaging/Radiology/Lab Requests

- Please update the contact information for your office under the Referring provider section, including extensions in case of questions from the reviewers.
- A written or electronic order which includes the provider signature, the date of the testing, a diagnosis and the type of procedure requested is REQUIRED!
- Do not choose 323 CT abdomen and pelvis for adults. This is used for pediatrics.
- Do not guess by searching the description given. CPT codes can be searched.
- Document CPT code being performed.
- Double check the services selected by clicking details under the service selection.
- If multiple codes are being requested under the same service code, please indicate codes and units needed.
- The Master Code list is available to providers.
- Code changes need to be submitted within 10 business days of the procedure.
- Be sure diagnosis code is appropriate (example: ICD-9 prior to 10/01/2015 and ICD-10 after 10/01/2015).
- If clinical is being faxed, please document in an annotations box.
- When faxing additional documentation be sure to include the Authorization Request ID on the coversheet.
- Remember to report conservative treatment history (e.g. physical therapy/duration; home exercise/duration) and NSAIDS history (duration/dosages)- these are the two most commonly omitted items that are required for review. If these interventions are contraindicated specify reason in medical justification.
- Include previous imaging (MRI, CT, X-RAY) results and date(s) of procedures