Physical and Occupational Therapy

Per Medicaid Policy, Members with traditional Medicaid can receive up to 20 visits for PT and OT therapy WITHOUT an authorization. Prior authorization is required for therapeutic services after the 20th visits. Request must be submitted within 10 business days BEFORE the 21st visit. Please note: The request must meet medical necessity and there is no guarantee additional therapeutic services will be approved. It is STRONGLY advised that no therapeutic treatment be given prior to authorization.

To request a Physical and/or Occupational Therapy authorization, Providers will submit via the DDE portal. If you're an employee without a User ID to logon, you can fax the Physical and/or Occupational Therapy 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.

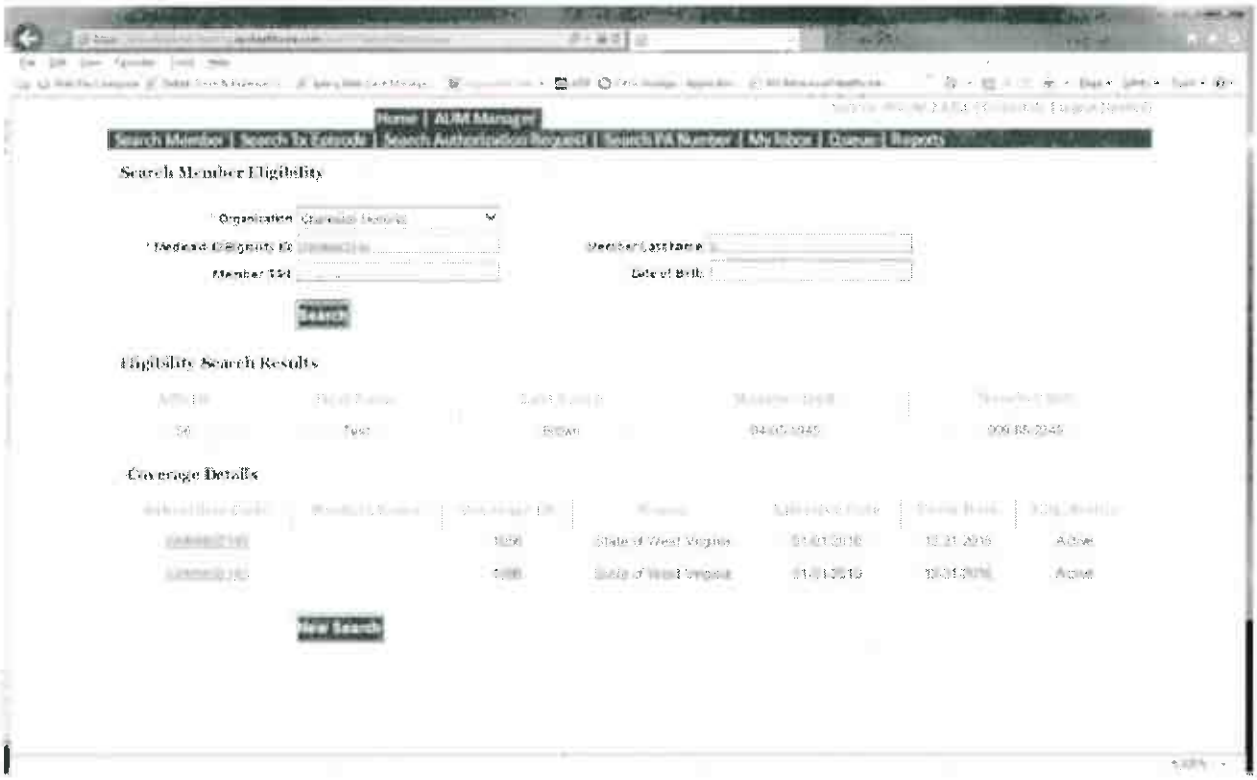
How to submit a Physical Therapy Request

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.

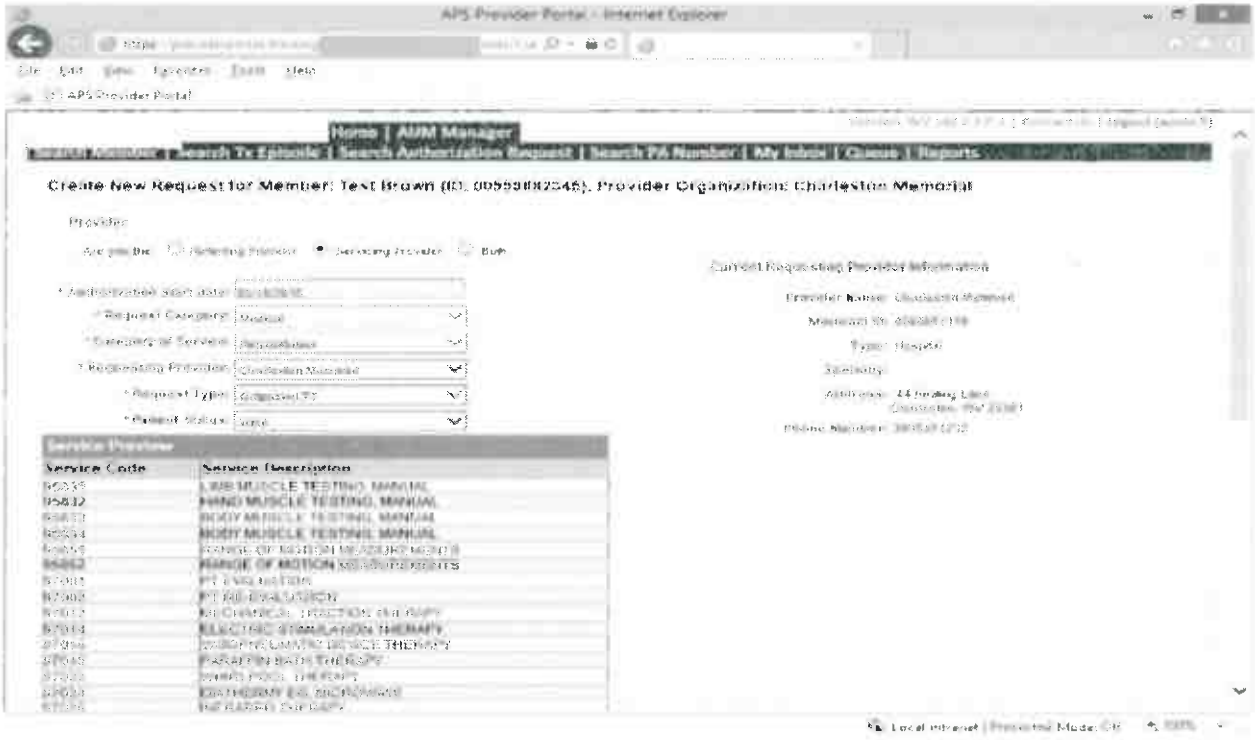


This will bring you to the Treatment Episode Screen which shows all the previous requests for the member. Click on the ADD NEW MEDICAL REQUEST button.

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- Please DO NOT choose this option

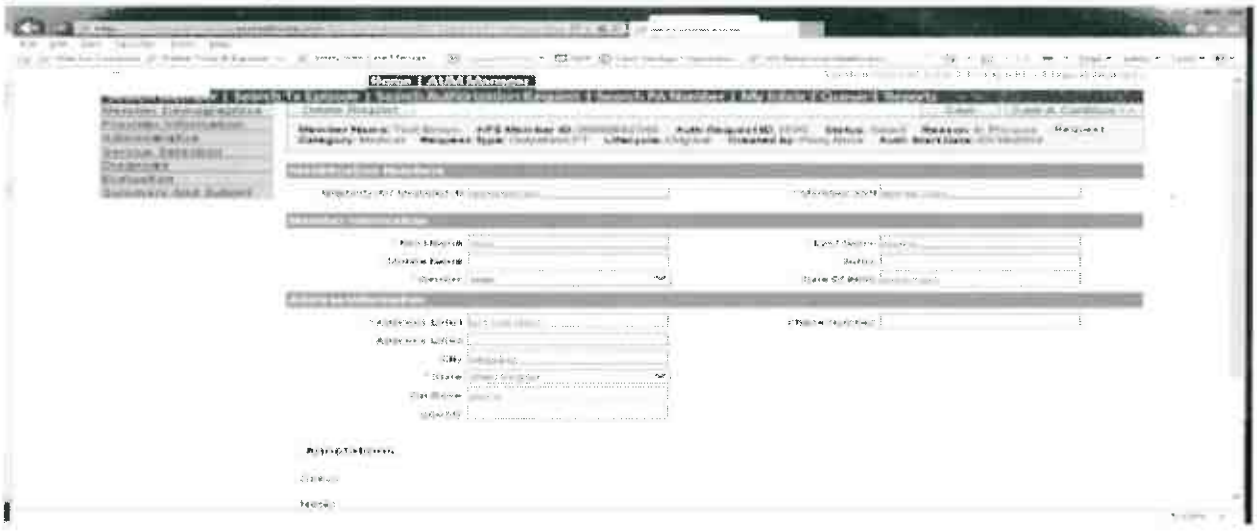
Next, enter the start date (the date of service) .If there is no scheduled date, use the date of service being submitted, the request category (Medical), the category of service (Rehabiltation), choose the requesting provider(there will only be a list available if your registration is complete and your provider NPI numbers have been attached), and enter the request type(Outpatient PT) 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.

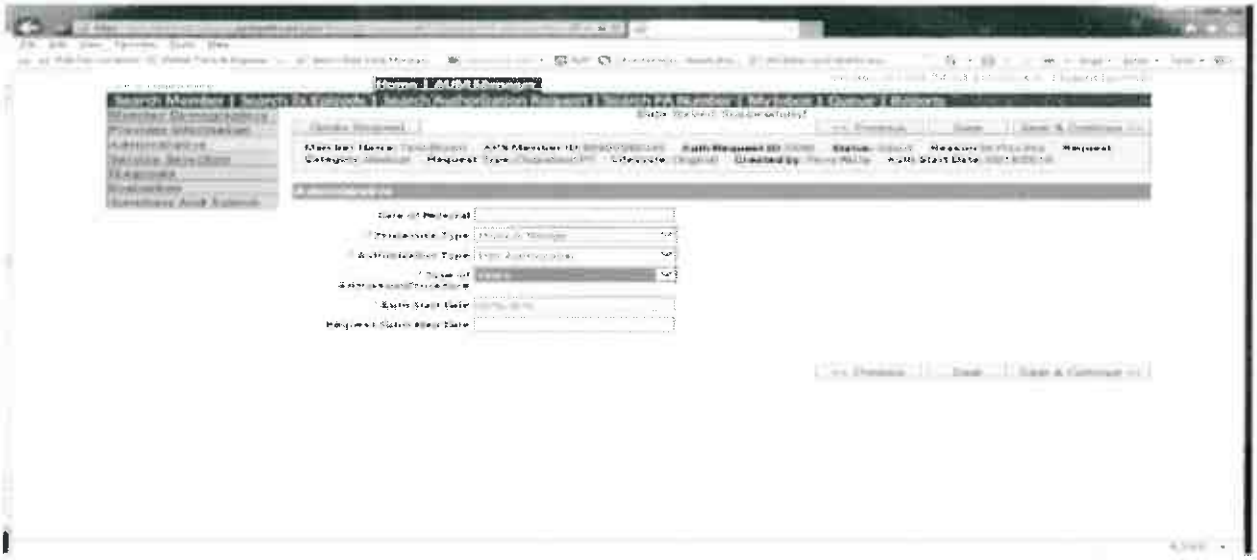
Provider

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:

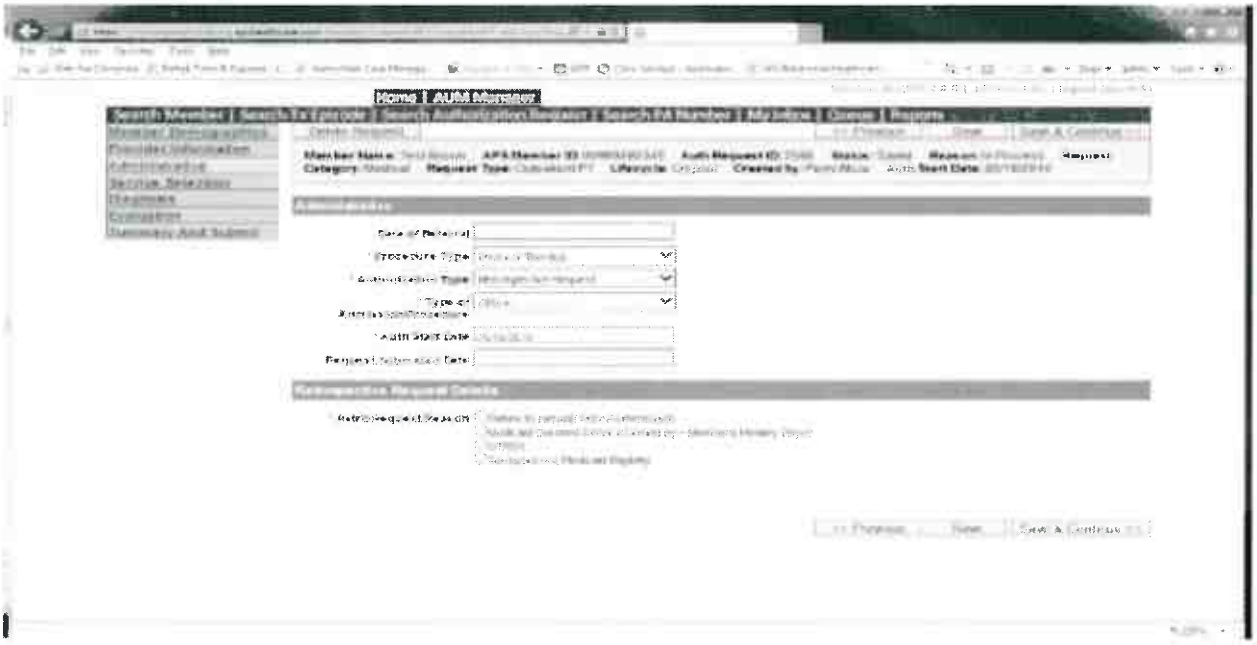
- Click on the Search provider
- Enter the physician's name in the Name field and change Any Words to ALL WORDS and click Search or
- You can select NPI, from the dropdown on the right side and enter the NPI number and click search
- DO NOT ENTER ANY OTHER INFORMATION IN ANY OTHER FIELDS. JUST NAME OR 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 *. Procedure Type=Physical Therapy. Choose Type of Admission/Procedure. ***Please note: Emergency/Medically urgent should only be chosen if it meets BMS definition of medically urgent.*** If the initial evaluation has already taken place and the start date is within 10 business days of admission date, the authorization type will still be Prior.

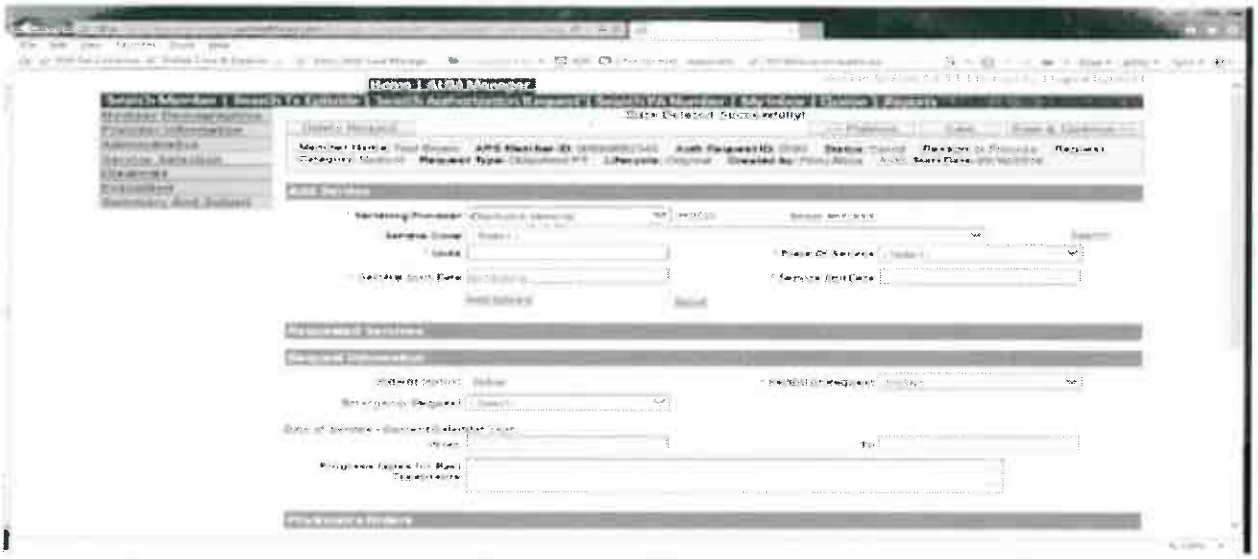
Administrative



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.

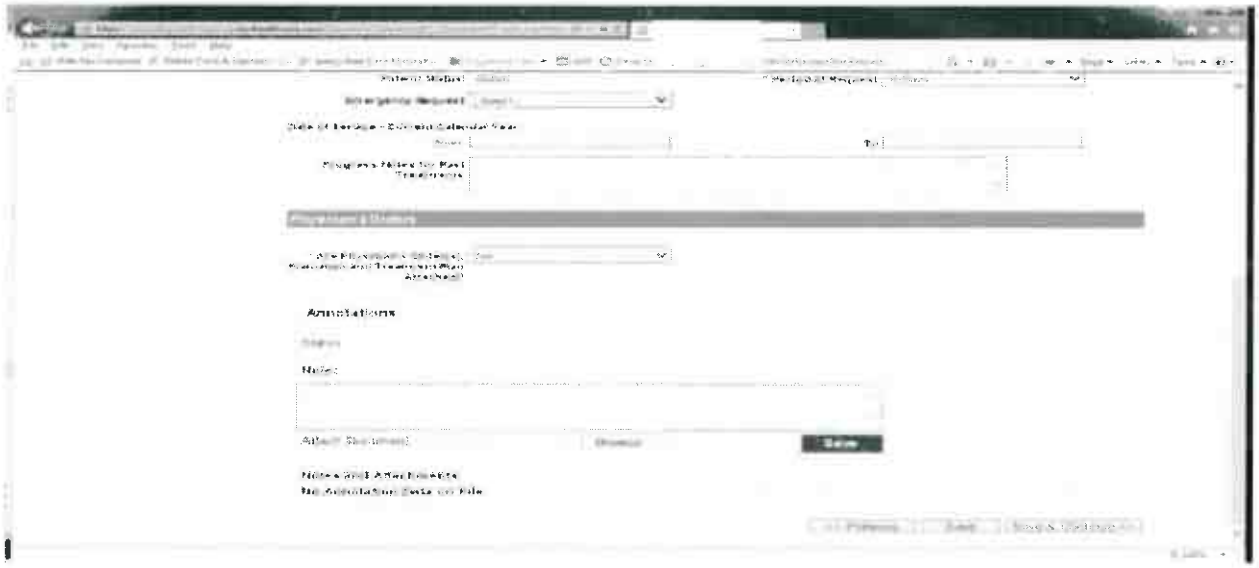
To find Servicing Provider:

- 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

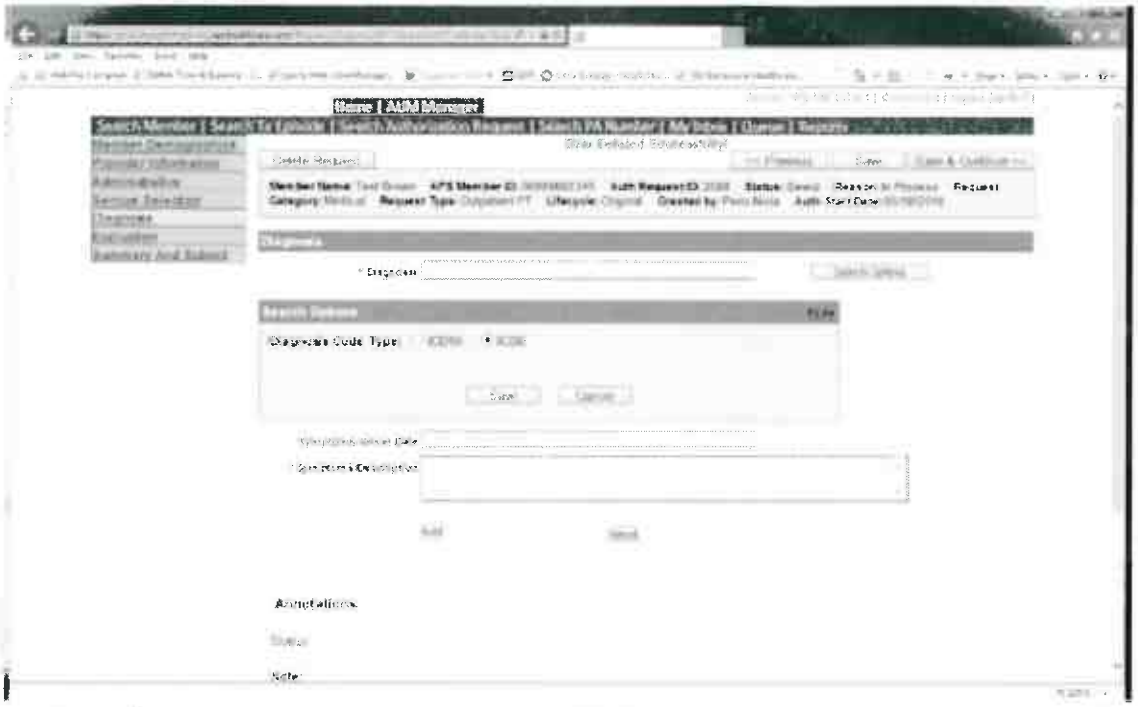
Choose your service code from the dropdown box. Choose place of service (office). For initial requests, each modality entered units will have to total to 40 units. For established requests, change units to number you are requesting for each service, and then click the "Add Service" button.

Service Selection

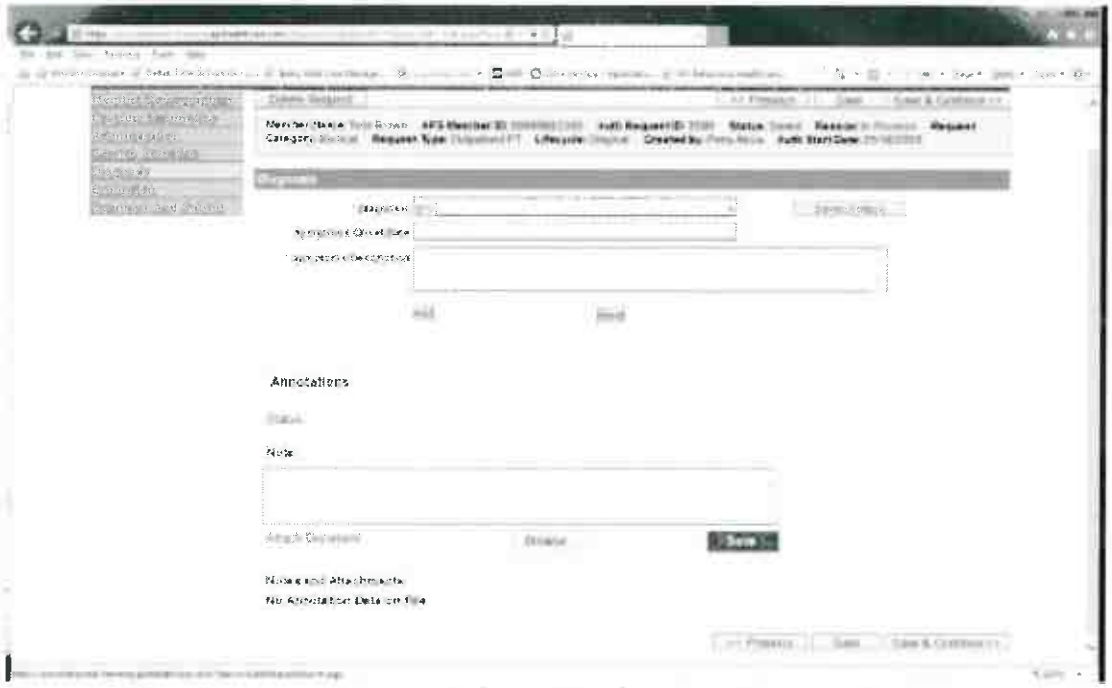


Choose your period of request. Answer the question if the physician's order(s) evaluation and treatment plan are attached. If yes, please attach documentation in the annotations box below. If no, please indicate reason why. This documentation is required so if planning to fax, indicate "Will Fax" and Click SAVE and Continue

Diagnosis

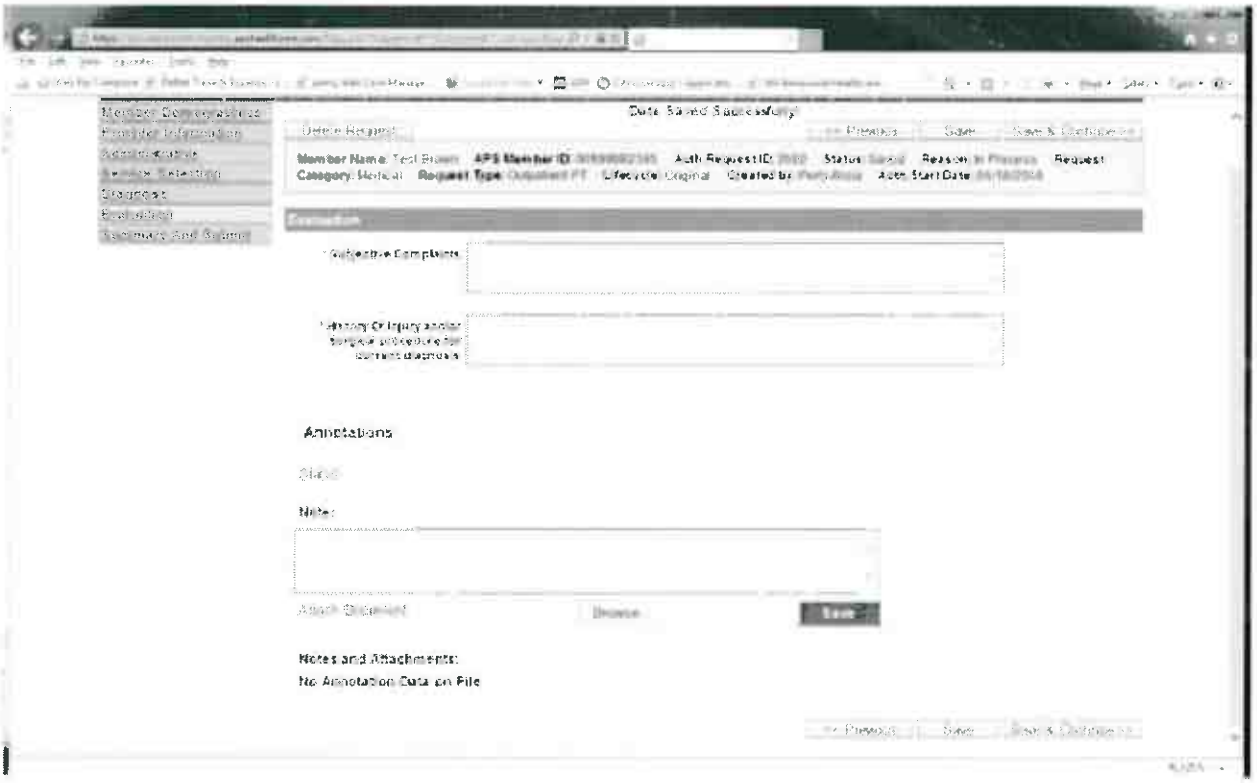


The Diagnosis screen is the next mandatory screen. ICD-10 diagnosis is required. The diagnosis code should be in the correct format for the date of service submitted. If your date of service requires an ICD-9 diagnosis code, prior to entering the numbers before the decimal, click the search options button,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



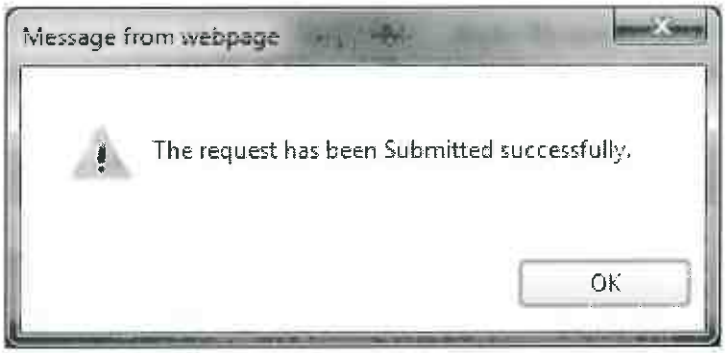
Please answer all questions with red *. Click Save and Continue

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 may be received. Click continue

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



Helpful PT/OT Tips

- Initial requests for PT/OT have a 40 unit cap for service codes. For PT/OT requests, please include the following with each request: a physician order that is signed and dated, the initial evaluation, recent progress notes indicating progress toward treatment goals and a treatment plan including long and short term goals and the number of visits anticipated to meet established goals.
- For school-aged children, submit a signed document from parent/guardian that they have notified the school district that they cannot seek Medicaid reimbursement for the service Or an IEP or notification from the school district that the required services are not available or are insufficient to meet the member's needs (this is required for speech therapy services as well).
- If a member is/has received BOTH ot/pt in the calendar year, please note that in the documentation. Remember both ot/pt combined count for the 20 initial visits a member may receive without full clinical review.
- If multiple codes are being requested, the total of these codes cannot exceed 40.
- Under the Requested Services, change the unit amount to 1. This allows multiple codes to be selected without exceeding the service limitations. When service limitations are exceeded, the C3 system will produce an error code, and will not allow the case to be submitted.
- After all the codes are selected and units changed from 40 to 1, documentation can be made in the annotations box regarding what code and how many units are being requested for each.
- This information can also be attached via uploading to the case, or by fax.
- 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.
- When faxing the request please make sure that all information requested about the provider is on the prior authorization form, including name, NPI number and address of the provider. This helps ensure that the proper provider is on your authorization request.
- There is a master code list available at: http://wvaso.kepro.com
- The master code list can tell you if a code requires and how many visits per year are allowed.
- If the member has alternative benefit plan coverage their initial visits require an authorization and must be submitted within timeliness guidelines
- With PT/OT each unit requested equals 15 minutes.
- To ensure a request can be entered into the KEPRO portal the 2nd page of the authorization must be fully filled out, for example fields such as Period of Request, Frequency of Visits and Subjective Complaints.