



KePRO's Prior Authorization Process for Outpatient Rehabilitation Services

June 11, 2009



Keystone Peer Review Organization (KePRO)

- Innovative healthcare management solution company
- Contractor handles the prior authorization (PA) process for Medicaid, Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus clients in the fee-for-service programs.

Changes to Outpatient Rehab effective 7/1/2009

- Prior authorization for services requested prior to and on June 30, 2009 at 11:59 p.m. will use revenue codes for outpatient rehabilitation services. (This includes any Medicaid retroactive eligibility cases for relevant dates of service.)
- Revenue codes will not be used for new submissions beginning 7/1/2009



Changes to Outpatient Rehab effective 7/1/2009

Visits, after July 1, 2009, are defined by the CPT code used during a treatment session with a rehabilitation therapist when covered services are prescribed by a physician

Changes to Outpatient Rehab effective 7/1/2009

In the new statewide fee schedule, there will be 8 CPT procedure codes (and 1 **HCPCS code – S9129**) herein after referenced collectively as “CPT” codes. As of July 1, 2009 at midnight outpatient rehab providers must use the CPT codes listed below

Changes to Outpatient Rehab effective 7/1/2009

- 97110 Therapeutic procedure (PT), each 15 min. **Note:** unit = 15 minutes
- 97150 Therapeutic procedure(s) (PT), group. **Note:** unit = a group session = 1 visit
- 97001 Physical therapy evaluation. **Note:** unit = an evaluation = 1 visit
- 97530 Therapeutic activities (OT), each 15 min. **Note:** unit = 15 minutes
- **S9129** Therapeutic procedure(s) (OT), group. **Note:** unit = a group session = 1 visit
- 97003 Occupational therapy evaluation. **Note:** unit = an evaluation = 1 visit
- 92507 Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual. **Note:** unit = one treatment session = 1 visit
- 92508 Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals. **Note:** unit = a group session = 1 visit
- 92506 Evaluation of speech, language, voice, communication, and/or auditory processing.
- **Note:** unit = an evaluation = 1 visit

Changes to Outpatient Rehab effective 7/1/2009

- For CPT Codes 97110 and 97530, when requesting a Prior Authorization (PA) for these 2 codes, the units of time being requested should be based on the 15 minute interval and not based on a visit.

Changes to Outpatient Rehab effective 7/1/2009

- Refer to the DMAS Medicaid Memo dated May 27, 2009, "*Update on Outpatient Reimbursement Rates and Billing for Rehabilitation Agencies and CORFs*", for further information regarding the July 1, 2009 changes.



Information needed for OP Rehab submission- PT and OT cases

- Please submit the patient's primary diagnosis and date of onset of illness or injury.
- Please indicate the date of the patient's first visit with you. Has the patient previously received therapy for this diagnosis?

Information needed for OP Rehab submission PT and OT (continued)

- Please describe the patient's specific limitation with respect to ambulation- is the patient ambulatory?
- Does the patient require stand by assistance with ambulation?
- Does the recipient use an assistive device –indicate what device- i.e. walker, cane, etc.

Information needed for OP Rehab submission PT and OT (continued)

- Please describe the patient's specific limitation with respect to performing ADL's and indicate if patient requires assistance performing ADL's
- Please include short and long term goals with achievement dates



Information needed for OP Rehab submission PT and OT (continued)

- If the request is for continued therapy , please describe whether or not the patient has met previously described short and long term goals

Information needed for OP Rehab submission –ST cases

- Please submit patient's primary diagnosis and date of onset of illness/injury.
- Please provide the diagnosis that led to patient's speech disorder and indicate date or age the patient received the diagnosis.
- Please indicate the patient's first visit with you.

Information needed for OP Rehab submission –ST cases(continued)

- Has the patient previously received therapy for this diagnosis?
- Describe the patient's cognitive abilities-Is the patient able to comprehend instructions and accurately follow them?
- What is patient's current mode of communication?

Information needed for OP Rehab submission –ST cases(continued)

- Does the patient currently use an assistive device for speech/communication?
- If so, how long has patient been using this device?
- Describe any limitations to current communication methods.
- Describe long and short term goals with achievement dates.



Information needed for OP Rehab submission –ST cases(continued)

- If the request is for continued therapy, please describe whether or not the patient has met previously described short and long term goals



Helpful Hints for submitting PA Request- OP Rehabilitation

- Providers should bill their claims in date of service sequence. The initial allowable five units that do not require a PA should be billed and paid prior to billing for services that require a PA.

Helpful Hints for submitting PA Request- OP Rehabilitation

- KePRO will continue to process requests for rehabilitation services with Revenue Codes with dates of service on or prior to June 30, 2009. Each July 1, recipients have 5 visits that do not require PA for each service (OT, PT and SLP). If a provider knows that the recipient will need treatment beyond 5 visits, the provider must request PA through KePRO.



Helpful Hints for submitting PA Request- OP Rehabilitation

- These 5 visits without PA are renewable each July 1st. KePRO will process all requests with an end date not to extend beyond June 30 of each year, in order to allow for the utilization of the 5 visits that do not require PA.

Prior Authorization Process for Outpatient Rehabilitation Services

- Provider gathers information for the PA submission process
- Provider verifies eligibility by using the DMAS web based ARS at <http://virginia.fhsc.com> or Medical 1-800-884-9730 or 1-800-772-9996
- PA request is submitted via iEXCHANGE®, fax, phone or mail.



Prior Authorization Process for Outpatient Rehabilitation Services

- The preferred submission method is iEXCHANGE®. Advantages: 24 hour availability to submit and allows provider to check on status of case.
- Once a request is entered into the system by a provider or customer service representative a case ID number is assigned.
- The case is then transferred the Outpatient Rehabilitation queue for a clinical reviewer to review



Insufficient Recipient Information

- If the recipient's requested demographic information is not complete, this will delay your case from being evaluated by the clinical reviewer. Example= OP Rehab provider submits revenue codes on a request for DOS 7/1/2009 and beyond.



Insufficient Recipient Information

- The customer service representative will have to pend the case and request the insufficient information by fax notification from the provider.
- The provider will have until 11:59 PM the next business day to submit the insufficient information or the case will be voided in our system.



Insufficient Recipient Information

- A voided case is when there is not enough information to create a case (i.e. missing key demographic information). It is not a denial.



Prior Authorization Process for Outpatient Rehabilitation Services

- It is extremely important that the request has the **service type** (0204) clearly marked.
- Omission delays the case from being placed in the correct work queue for the nurse reviewer to evaluate.



Prior Authorization Process for Outpatient Rehabilitation Services

- A case is sent to the OP Rehabilitation queue for review by the clinical reviewer once all demographic information and the service type is entered.
- The reviewer will evaluate the case for medical necessity by applying criteria.



Criteria used for Reviewing Cases for Medical Necessity

- Criteria that is used for review consists of the InterQual Rehabilitation and/or supplemental criteria/DMAS rules.
- The DMAS Provider Manuals provide additional information that will give important details regarding coverage of outpatient rehabilitation services and the prior authorization process.



Prior Authorization Process for Outpatient Rehabilitation Services

- Access to the DMAS Provider Manuals may be found at the DMAS website at <http://www.dmas.virginia.gov>.



What occurs when key clinical information is missing from the case?

- If additional clinical information is missing from the request after the initial evaluation of the case, the nurse reviewer will pend the case for 3 business days.
- Additional information is requested from the provider via phone or fax notification.



What occurs when key clinical information is missing from the case?

- The provider will have until 11:59 PM of the 3rd business day to supply this information.



Prior Authorization Process for Outpatient rehabilitation Services

- If the case can be approved, the clinical reviewer will post an approval note in iEXCHANGE® and a notification will be automatically sent to provider via fax.
- If the case cannot be fully approved by the clinical reviewer, it will be forwarded to a peer reviewer (MD) for medical necessity determination or a Supervisor for administrative denial reasons.



Prior Authorization Process for Outpatient Rehabilitation Services

- The determination is then transmitted to First Health and a prior authorization number is issued.
- In addition to the fax notification that KePRO sends out, First Health also sends a notification letter to the provider and recipient.

Submitting a Request via iEXCHANGE®

- Registration is required. User login and password is usually sent by email within 10 business days.
- Information may be found by going to the KePRO website <https://dmas.kepro.org>. For questions call 1-888-827-2884 or email at ProviderIssues@kepro.org.



Additional Methods of Submission

Requests may also be submitted via

- Fax at 877-652-9329
- Telephone at 888-827-2884 or 804-622-8900 (local)
- Mail to KePRO
2810 North Parham Rd, Suite 305
Richmond, VA 23284

Fax Forms Used for Submission

PA request fax forms are posted on the DMAS and KePRO websites.

- Use the DMAS 363 "Outpatient Prior Authorization Request Form" for outpatient rehabilitation requests.
- See number 13, "PA Service Type" and select the box for "0204" outpatient rehabilitation.

2 Versions

- A PDF version that providers can download and complete manually.
- An editable Word version



Should You Want to Appeal A KePRO Decision

Appeals are to be submitted in writing to:

**Director Appeals Division
Department of Medical Assistance
Services**

**600 East Broad Street, Suite 1300
Richmond, VA 23219**

(Additional information can be found in the
DMAS Provider Manuals.)

Resources

- KePRO Website
<https://dmas.kepro.org>
- DMAS Website
www.dmas.virginia.gov
- For any questions regarding the submission of PA requests, please contact KePRO at 888-827-2884 or 804-622-8900