

March 27, 2014
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MEDICAID BULLETIN

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TO: PROVIDERS INDICATED

SUBJECT: QUALITY IMPROVEMENT ORGANIZATION (QIO) UPDATES

KEPRO's, the QIO, primary role is to prior authorize (PA) select Medicaid services including, but not limited to inpatient admissions, therapy services for adults and children and Durable Medical Equipment (DME). Effective April 1, 2014, the number of days required for providers to submit requests to the QIO as well as response times for the QIO to render determinations have been changed or revised as indicated below.

- All non-emergent requests for PA must be received by the QIO before the service is performed. In an emergency or any unplanned situation, requests must be received by the QIO within five (5) business days of the date of service.
- Except as indicated below, the response time for a decision by the QIO is five (5) business days from the receipt of the request. If a review requires a physician consultation, the QIO will have one (1) additional business day to render the decision.
 - For DME services the response time for a decision is 15 days from the date of receipt.
 - For beneficiaries under age twenty-one (21) receiving services in an Inpatient Psychiatric setting or Residential Treatment Facility, the response time for a decision is two (2) business days from the date of receipt.
- Requests for additional information by the QIO must be received within two (2) business days of the requested date.
- Members with Medicare Part A and B coverage will require a PA if Medicare has denied the service and Medicaid is expected to act as primary payor for the claim. Members with only Medicare Part B coverage will require a PA for any inpatient admission.

- Beneficiaries that have other primary insurance will **only require** a PA if the primary insurer denies the service and Medicaid is expected to pay as primary.
- Providers are required to file a PA request for beneficiaries that receive Medicaid eligibility after the service was performed; noting the retroactive eligibility on the request. KEPRO will not validate these retro requests; however, SCDHHS will audit these PAs on a monthly basis.

This policy directly affects Medicaid members enrolled in the fee-for-service program. If a Medicaid beneficiary is enrolled with one of the state's contracted Managed Care Organizations (MCOs), questions regarding prior authorization requirements should be directed to their MCO.

If you have any questions regarding this bulletin, please contact KEPRO at (855) 326-5219 or the Provider Service Center at (888) 289-0709. Thank you for your continued support of the Medicaid program.

/s/
Anthony E. Keck
Director