South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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May 15, 2012

All

MEDICAID BULLETIN

TO: **All Providers**

SUBJECT: **Services Performed by KePRO, the Quality Improvement Organization (QIO) for S.C. Medicaid**

Effective June 1, 2012, KePRO will begin operations as the QIO for the South Carolina Department of Health and Human Services (SCDHHS), Medicaid. KePRO will be responsible for prior authorization (PA) of services as well as pre-payment and/or medical record review of select services. Patients with Medicare as primary payor are only required to obtain a PA if Medicare does not make a payment or the service is not covered by Medicare and Medicaid then becomes primary. Please note that Managed Care Organizations will continue to authorize services according to their specific plans for enrolled beneficiaries (members). Case Managers and Service Coordinators for CLTC and DDSN home and community-based waiver programs will continue to authorize services for their waiver participants.

On June 1, 2012, providers should begin contacting KePRO for authorization of services described below. In order to facilitate a smooth transition, during the month of June 2012, providers will receive the following warning message on the weekly remittance advice and on the web-tool.

NOTE: Effective July 1, 2012, claims or services that require prior authorization from the QIO (KePRO) will automatically reject if the authorization number is not present on the claim or is invalid. Please refer to the Medicaid Bulletin dated April 11, 2012 for a complete list of services that require prior authorization from KePRO.

For claims with dates of service prior to June 15, 2012, current edits relating to prior authorization will continue to be assigned. On July 1, 2012, the following newly automated edits will be in effect and claims will not be paid if one of these conditions exists.

Edit 837	Service Requires Prior Authorization from the QIO. No authorization number is on the claim or the authorization number is not on file for the member.
Edit 838	Service Requires Prior Authorization from the QIO and Prior Authorization on the claim is not valid. For example, the date of the service on the claim is not within the date range authorized by the QIO.
Edit 839	Inpatient Admission Requires Prior Authorization from the QIO for claims with date of admission on or after June 15, 2012. No authorization number is on the claim or the authorization number is not on file for the member.

KePRO will use nationally recognized standards of care, including McKesson's InterQual criteria for medical necessity determinations. Providers will receive notification of the review request by facsimile within 24 hours of receipt of the request unless otherwise noted in program policy. All requests for additional documentation from KePRO must be returned to them within 48 hours of the date of the request. If additional documentation is not received within the 48 hours, the claim will receive an administrative denial. For all denials, KePRO will notify the requesting provider via fax and the recipient by letter, the reason for the denial along with instructions for requesting a reconsideration of the adverse decision when applicable.

SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Hospital Admissions. All acute care hospital admissions, except deliveries and births, must be prior authorized. Requests for emergency admissions must be made within 48 hours of the date of the admission. KePRO will use McKesson's InterQual criteria for medical necessity and will provide a determination within 24 hours of the request for non-emergency situations. If a second level consultant's review is required, a determination will be made by the QIO within 48 hours of the initial request. The PA request could be initiated by either the physician or the hospital. The PA number, however, must be shared with all providers involved with the admission.

Organ Transplants. Heart, Lung, Liver, Pancreas, Small Bowel and Multi-organ transplants require prior authorization from KePRO. Authorization requests include the evaluation for the transplant and when applicable, the request to have the service performed in a certified transplant center that is either in SC or beyond the SC medical service area. A copy of the Transplant Prior Authorization Request Form should accompany a letter from the attending physician that includes, at a minimum, the type of transplant, the patient's current medical status, the patient's planned course of treatment and the name of the facility to which the patient is being referred. The QIO will review the request and issue an approval letter with an authorization number that will be used by the hospital and physicians. Approval of a transplant by the QIO will also serve as approval for the patient to be treated out of state, if applicable.

For members enrolled in a Medicaid MCO, KePRO will authorize the transplant event which includes services performed 72 hours prior to the admission, the transplant surgery and 90 days after surgery. The QIO will also authorize transplants for members enrolled in Medicare and/or private HMOs.

Surgical Justification. Attachment A is a list of surgical procedures that will require a prior authorization. Surgeries that are performed in an inpatient hospital setting will require only one authorization number. The responsibility for obtaining authorization for the surgical procedure rests with the attending physician. The reviewer will screen the medical information provided using the appropriate clinical criteria. The requesting provider will receive notification of approvals, denials or requests for additional information via facsimile.

In the case of a hysterectomy, prior authorization must be obtained even if the surgery follows a delivery. Providers should continue to use the Request for Surgical Justification Form. Urgent and emergent hysterectomy cases will be reviewed retrospectively.

Outpatient Therapy. For recipients age 21 and over, physical, occupational and speech therapies (PT/OT/ST) performed in an outpatient hospital setting must be prior authorized. At a minimum, physical therapy services must improve or restore physical functioning as well as prevent injury, impairments, functional limitations and disability following disease, injury or loss of

a body part. Occupational therapy must prevent, improve or restore physical and/or cognitive impairment following disease or injury. Speech language pathology must improve or restore cognitive functioning, communication skills and/or swallowing skills following congenital or acquired disease or injury.

InterQual criteria for outpatient rehabilitation will be used to support medical necessity. **Attachment B** is the list of therapy codes that will require PA. KePRO will authorize the initial evaluation and the first 4 weeks of therapy upon request. At 4 weeks a concurrent review is performed to re-evaluate the patient's condition and response to treatment. At that time the provider may request up to an additional 8 weeks of therapy.

For claims with dates of service on or after June 1, 2012 hospital providers will be required to submit the Revenue Code and the applicable CPT procedure code as defined in the CPT reference guide for the specified therapy. For therapy procedures defined in 15 minute sessions, SCDHHS will define 15 minutes as 1 unit of service. Therapy sessions are limited to 4 units per date of service.

Durable Medical Equipment. The following DME services require prior authorization from KePRO - Evaluation and pre-certification for Cranial Molding Orthotic Devices, Manual and Power (motorized) Wheel Chairs and wheel chair accessories. KePRO will use nationally developed clinical rules and best practices for medical necessity determinations such as McKesson's InterQual for Durable Medical Equipment. Providers will continue to submit the Certificate of Medical Necessity along with the physician's order. **Attachment C** lists codes that require prior authorization from KePRO. Please refer to your DME provider manual for the list of codes that require PA from SCDHHS.

Physician Referred Rehabilitative Behavioral Health Services. Physicians referring the beneficiary for treatment must submit a fax cover sheet and completed SCDHHS Medical Necessity Statement (MNS) and/or applicable forms to the QIO. Physicians may only refer beneficiaries who are active on their caseloads.

If additional visits are needed to address the identified goals, re-authorization of services will be required for both adults and children. To request re-authorization the physician must submit a completed SCDHHS LIP Authorization form, and an updated standardized Diagnostic Assessment or behavioral health screening tool that validates the medical necessity. Re-authorization requests must be faxed into KePRO two weeks PRIOR to expiration of authorized visits. Failure to obtain re-authorization prior to the provision of services will result in denial or recoupment of payment.

Physicians, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) requesting additional visits over the 12 allowed should continue to submit those requests on the SCDHHS Mental Health form prior to the 13th visit as required.

Physician referrals for diagnostic and crisis services <u>not</u> required to be listed on the Individual Plan of Care require only the submission of the completed SCDHHS LIPs Referral to be faxed to the QIO and to the LIP rendering the service. The QIO will review the form and fax the authorization. Please refer to the appropriate policy manual for specific services not required to be listed on the Individual Plan of Care.

Other Medical Review Services

Prepayment Reviews. Current Medicaid services that include surgical pre-payment reviews such as Sterilizations, Abortions, ICF/MR Level of Care Reviews, Inpatient Psychiatric/Outpatient Community Rehabilitative Services will continue to require a review for medical necessity by the QIO. Please refer to your Medicaid provider manual for policies related to these services.

KePRO will also be responsible for conducting a review of Utilization Review Plans for acute care hospitals, mental hospitals and Intermediate Care Facilities (ICF). The written plans must meet the requirements outlined in the Code of Federal Regulations at the following location: for acute care hospitals 42 CFR§456.100-145; for mental hospitals 42 CFR§456.200-245; for ICFs 42 CFR§456.400-438. KePRO will contact each facility prior to June 30 of each year in preparation of their review.

During the month of May 2012, KePRO will conduct facility and provider trainings. Webinar trainings will be offered for providers that are unable to attend one of their 4 regional trainings. If you have not registered for one of the on-site trainings, please visit the SCDHHS website at www.scmedicaidprovider.org for registration information.

Requests for prior authorizations from KePRO may be submitted using one of the following methods.

KePRO Customer Service Phone:	855-326-5219
KePRO Fax #	855-300-0082
For Provider Issues email:	atrezzoissues@Kepro.com

Additionally, the KePRO website is currently available for viewing. Please visit them at http://scdhhs.kepro.com. There you will find additional information about KePRO's web based PA submission; upcoming trainings and any new policies or procedural changes affecting Medicaid's QIO process.

If you have any questions, comments or concerns regarding this bulletin, we encourage you to submit them to www.comments@scdhhs.gov.

Anthony E. Keck
Director

Attachments