



## INTEGRATED CARE MANAGEMENT AND QUALITY IMPROVEMENT

# KePRO's Service Authorization Process for Outpatient Rehabilitation Services



# Keystone Peer Review Organization (KePRO)

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

# **Changes to Outpatient Rehab effective 8/1/2010 for Physicians and Professionals**

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- **Revenue codes will not be used for new submissions beginning 7/1/2009.**
- **Visits, after July 1, 2009, are defined by the DMAS approved CPT code used during a treatment session with a rehabilitation therapist when covered services are prescribed by a physician.**

## **Changes to Outpatient Rehab Effective 8/1/2010 for Physicians and Professionals**

- **Refer to the DMAS Medicaid Memo dated June 29, 2010, "*Notice of Prior authorization Requirements for Outpatient Rehabilitation Services Provided by Physicians and Professionals*" for further information, regarding the August 1, 2010 changes.**
- **Refer to the DMAS Rehabilitation Manual and Appendix D.**

# DMAS Approved CPT Codes for Outpatient Rehab

- **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 Outpatient Rehab Agencies and CORFs**

# Changes to Outpatient Rehab effective 7/1/2009 for Outpatient Rehab Agencies and CORFs

- **Service authorization for services requested service 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 for Outpatient Rehab Agencies and CORFs

**Visits, after July 1, 2009, are defined by the DMAS approved 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 for Outpatient Rehab Agencies and CORFs

**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, excluding hospitals must use the CPT codes listed below.**

# Changes to Outpatient Rehab effective 7/1/2009 for Outpatient Rehab Agencies and CORFs

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# Changes to Outpatient Rehab effective 7/1/2009 for Outpatient Rehab Agencies and CORFs

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

# 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 Cases (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 Cases (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 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.**

# 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 SA Request- OP Rehabilitation

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

## Helpful Hints for Submitting SA Request- OP Rehabilitation (Continued)

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

## Helpful Hints for Submitting SA Request- OP Rehabilitation (Continued)

- ***These 5 visits without SA are renewable each July 1<sup>st</sup>. 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 SA. (This is applicable to all OP Rehab providers including hospitals.)***

## Helpful Hints for Submitting SA Request- OP Rehabilitation (Continued)

- **Hospital providers use Revenue codes.**
- **OP Rehab Agencies and CORFs use the designated CPT codes- 7/1/09.**
- **Physicians and Professionals use the designated CPT codes- 8/1/10.**

## KePRO's Service Authorization Process for Outpatient Rehabilitation Services

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

## KePRO's Service Authorization Process for Outpatient Rehabilitation Services

- **The preferred submission method is iEXCHANGE<sup>®</sup>. 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.**
- The customer service representative will have to pend the case and request the insufficient information by fax notification from the provider.**

## Insufficient Recipient Information

- **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.**
- **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.**

## **KePRO's Service 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.**

# KePRO's Service Authorization Process for Outpatient Rehabilitation Services (Continued)

- **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 service authorization process.**

## KePRO's Service Authorization Process for Outpatient Rehabilitation Services

- Access to the DMAS Provider Manuals may be found at the DMAS website at: <http://www.dmas.va.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 clinical 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 3<sup>rd</sup> business day to supply this information.**

## **KePRO's Service Authorization Process for Outpatient Rehabilitation Services**

- If the case can be approved, the clinical reviewer will post an approval note in iEXCHANGE<sup>®</sup> 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.**

# KePRO's Service Authorization Process for Outpatient Rehabilitation Services (Continued)

- **The determination is then transmitted to DMAS Fiscal Agent and a service authorization number is issued.**
- **In addition to the fax notification that KePRO sends out, DMAS Fiscal Agent 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](mailto: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**  
**Henrico, VA 23294**

# Fax Forms Used for Submission

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

- **Use the DMAS 363 “Outpatient Service Authorization Request Form” for outpatient rehabilitation requests.**
- **See number 13, “SA Service Type” and select the box for “0204 outpatient rehabilitation.”**
- **DMAS 363 fax form is formatted in an editable Word version that allows providers to save the form and input responses directly onto the form. These forms can be changed and it’s provider responsibility to use current document.**
- **Use of the SA fax request form will expedite processing and is preferred if providers are not using iEXCHANGE.**

# 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, 11<sup>th</sup> Floor  
Richmond, VA 23219**

**Additional information can be found in the DMAS  
Provider Manuals.**

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

# Questions After iEXCHANGE and Website Demonstration