



**KEPRO Provider Operations Manual for
WV Medicaid Behavioral Health Services
Version 3.1**

For the following Provider Groups:

- *Licensed Behavioral Health Centers*
- *Private Practitioners*
- *Partial Hospitalization Programs, Psychiatric Residential Treatment Facilities (PRTF) and Inpatient Psychiatric Hospitalization Programs*
- *Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)*
- *Licensed Independent Clinical Social Workers*

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*On behalf of the
State of West Virginia
Department of Health and Human Resources*

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INTRODUCTION

Our Company

KEPRO is a QIO-like entity designated by the Centers for Medicare and Medicaid Services. The combination of KEPRO and APS Healthcare in 2015 created an organization with unequalled experience with utilization management and prior authorization across the spectrum of health and human services. KEPRO brings 31 years of federal and state medical review and quality improvement experience which uniquely complements APS-WV's 15 year background in Medicaid behavioral health, intellectual/developmental disabilities, waiver program management and state-funded programs.

KEPRO is an integrated care management and quality improvement organization serving public and commercial health care markets.

KEPRO's Mission Statement

To advance the quality and efficiency of health care through integrated care management solutions tailored to the needs of our customers and stakeholders.

KEPRO's Vision Statement

To be an industry leader, known for our exceptional suite of products and services, our highly skilled professionals, and delivery of credible, measurable results to our customers and stakeholders.

Our Role

KEPRO is the contracted administrative service organization for WV DHHR's Bureau for Medical Services. All policies and procedures are approved by the State prior to implementation. KEPRO is committed to creating and maintaining supportive relationships with WV Medicaid providers. Highlights of this commitment include:

- Provider training sessions on utilization management, documentation, and best practices in a variety of formats (i.e., webinars, face-to-face). KEPRO conducts training and technical assistance to assist in improving the internal utilization management structure of provider practices.
- Coordination with other regulatory bodies within DHHR (OHFLAC, BCF, OQPI, BBHFF) to streamline and clarify clinical documentation expectations.
- Focused efforts on quality improvement and training by all KEPRO staff.
- Ongoing education of providers and members on a variety of topics/issues.

- Updates of ASO operational procedures to Medicaid healthcare providers and postings to the KEPRO website: <http://wvaso.kepro.com>
- Involvement with the State, members and providers to help improve the quality of care through utilization management, provider practice and program surveys, quality reviews, data analysis, and technical assistance.

Administrative Functions

The general scope of work is twofold: to provide comprehensive utilization management and to consult with DHHR on its long-range plans for behavioral healthcare. With this mandate, the overall responsibility is one of planning and managing the internal operations for behavioral healthcare utilization management with an emphasis on continual analysis that culminates in providing recommendations on the future system for providing state of the art behavioral healthcare programs in West Virginia. Through the ASO functions, KEPRO addresses the DHHR goals of effectively managing change, integrating systems of care, improving accountability, addressing regulatory concerns, exploring service options, improving the innovative use of technology, facilitating collaborative opportunities, and designing a coordinated system with effective outcomes for all stakeholders.

Specific duties required to achieve these goals include, but are not limited to, the following:

- Oversee the design, development, and implementation of all activities related to the statewide Utilization Management Program options.
- Responsible for the state, regional and community relations specific to this contract.
- Responsible for all program management activities.
- Responsible for executive-level provider relations and problem solving issues related to the specific UM activities.
- Providing necessary data to make appropriate, quality care decisions.
- Providing consultation and education that will assist the state with future systems planning.

KEPRO also assures that provider interactions are managed in a professional manner and, through the administrative function, provides a mechanism for providers to file complaints. This function includes issues relating to the general operation of the ASO and not complaints involving specific authorizations for services. Each complaint is documented on a complaint log and tracked through resolution. All provider complaints will be responded to in a timely fashion and all written complaints will receive a written response.

Medicaid Eligibility

The West Virginia Bureau for Medical Services coordinates eligibility and benefit determination for members through the Medicaid eligibility system. For each eligible member receiving or entering active treatment, it is the provider's responsibility to request prior authorization with KEPRO through the prescribed format at the initiation of the treatment. KEPRO will verify a member's Medicaid eligibility at the time of the requested service. Once Medicaid eligibility is determined for the date of service requested, a clinical review for medical necessity begins.

Clinical Services

KEPRO Clinical Services includes all clinical functions from prior authorization through retrospective reviews. The goal is to promote staff teamwork and partner with behavioral health providers to improve the quality of care and outcomes for members of behavioral health services in West Virginia. KEPRO Clinical Services:

- Develops appropriate utilization management guidelines, protocols, prior authorization rules, and clinical policies in accordance with the services provided under West Virginia Medicaid.
- Reviews prior authorization requests within established time frames per authorization guidelines.
- Integrates clinical information related to requests for prior authorization for appropriate and medically necessary services and determining appropriate services when discussing pended cases with providers.
- Provides input on training and communication to providers and internal staff related to clinical policies and procedures based on the analysis of information obtained through provider consultations and utilization data analysis.
- Establishes individualized recommendations for provider technical assistance and training related to clinical practices.

Utilization Guidelines

KEPRO works proactively with providers to build consensus around the appropriate level of care, treatment plan, and goals for WV Medicaid behavioral health providers. KEPRO believes that the relationship between treatment standards and clinical judgment is one of assistance and collaboration rather than one of control. The intent of treatment standards is to inform and guide, not to overrule clinicians' professional judgment.

To effectively authorize and review care, objective and measurable utilization management criteria and national criteria when available, based on sound clinical principles and processes, have been developed and included in the manual of UM Guidelines for each provider group. These criteria support fair, impartial, and consistent UM decision making that serves the best interests of enrollees, with consistency throughout West Virginia. KEPRO continues to work with the Department to refine these criteria throughout the programs.

UM Guidelines provide criteria for the service listings including the definition, level of service, target population, Medicaid option, initial authorization limits, and increments of re-authorization, admission criteria, continuing stay criteria, discharge criteria, service exclusions, clinical exclusions, documentation standards, and additional service criteria. The elements of these service listings are the basis for utilization management in conjunction with KEPRO clinical management staff. All UM Guidelines are approved by the Department.

Utilization Management

The Department seeks to ensure that each consumer can access needed services with the appropriate provider, intensity of service, and duration of care, with special attention to, involvement of, and collaboration with, natural and community supports. KEPRO is in place to support provider utilization management through troubleshooting and analysis to address the wide spectrum of organizational dynamics that form a provider's utilization management structure.

Providers should review and maintain this Provider's Operations Manual, the UM Guidelines, and all related updates.

Providers should frequently review the KEPRO website for current information regarding ASO policies and procedures at <http://wvaso.kepro.com>

In addition, providers must thoroughly review State Medicaid Guidelines posted at <http://www.dhhr.wv.gov/bms/Pages/default.aspx>

Authorization Process

KEPRO utilizes a multi-tiered, electronic data system found at this web address (<https://careconnectionwv.kepro.com>) for the purpose of authorizing services delivered to Medicaid members. As the WV Medicaid service complexity increases, the data demand increases to obtain relevant clinical information.

Requests may automatically authorize depending upon the service requested active Medicaid eligibility and if clinical UM criteria are met. An authorization number will be available to providers on our secure KEPRO website at: <https://careconnectionwv.kepro.com>.

Some services are designed not to automatically authorize due to their complexity. Those, along with other service requests that do not initially meet UM clinical criteria, will “*pend*” for clinical review.

Requests will be reviewed by a WV licensed clinician who may resolve the issue and proceed to authorization or will request clarification from the provider. The request for authorization may be placed in a “*review*” status while the provider submits additional clinical documentation for consideration.

If the received documentation indicates medical necessity, the request will be authorized. In the event medical necessity is not demonstrated, the clinical staff will discuss with the provider. The outcome may be to “*close*” the request if the provider agrees the request does not meet medical necessity criteria, or the outcome may be to proceed to physician review for potential denial of service.

In the event a denial decision is made by the physician reviewer, a status of “*deny*” will be issued. Further information regarding the physician review process is included later in this section.

Reauthorization/continued stay reviews help ensure that appropriate services are delivered and that either anticipated progress is being made toward the established clinical goals or the treatment plan is adjusted accordingly. This step allows KEPRO to obtain necessary additional information to document the medical necessity of ongoing care. The same submission and clinical review process detailed above is followed for these requests.

When obtaining a reauthorization or continued stay review for an initially authorized service, it is recommended that providers submit a request to KEPRO at least one week or five business

days before the authorized service has expired. This allows KEPRO and providers to track recipients' schedules for concurrent or continued stay reviews, monitor utilization trends, and coordinate accurate and timely authorization information.

Consultations, Training & Technical Assistance

As a significant component of clinical services, KEPRO strives to stimulate, recognize and support efforts to improve the provision of behavioral health services in the state of West Virginia by recognizing evidence-based clinical and utilization management practices that are delivered at provider sites and practices throughout the state. In addition, trainers/consultants help assure quality outcomes are achieved through deliberate, focused training and evaluation of the system of behavioral healthcare.

Our coordinated team of experienced trainer/consultants provides ongoing and specific feedback to providers in order to assist them in improving both their clinical documentation practices and their utilization management structures. This team of trainer/consultants also maintains a strong link of communication with the clinical care management staff. Providers receive on-site technical assistance/trainings, feedback from clinical chart reviews, and precise consultative reports that may be utilized as tools to enhance provider performance. In the utilization management arena, providers receive a comprehensive systems analysis based on their need that allows for ongoing/continual growth in developing needed structures to assure improved outcomes. As program performance data are analyzed over time, providers are educated on the results and attend training that assists in improving their own internal utilization management structure.

The consultation process is guided by a thorough set of treatment record review procedures, and supported by a number of treatment record review tools and provider treatment record review scoring protocol as well as questions that evaluate the organizational competence of a provider group. All consultation tools are available on our website and approved by DHHR.

At the completion of the consultation review, an Exit Interview will be conducted with designated provider staff personnel. Specific case examples are included to aid in discussing areas of strength and those requiring additional focus. Providers will receive a copy of the Consultation report which will contain all findings during the site visit. KEPRO trainer/consultants are accessible by phone for providers to contact regarding questions or issues about the program and will contact the provider within ten (10) business days to ensure the consultation report was received.

In addition, in an effort to assist providers in addressing specific concerns and improving performance, KEPRO offers extensive technical assistance. Technical assistance is available regarding issues such as clinical practices, utilization management, information/data processing and tracking, and the prior authorization process.

Consultation Procedures

Clinical Records Sample

With participating providers a sample of clinical records of members receiving Medicaid behavioral health services will be requested for review. These samples are intended to reflect a

representation of the individuals receiving services by a provider and are based on the volume and complexity of the provider's service array. All service denials are included for review.

Schedule/Notification to Providers

Consultations will be scheduled in advance by the trainer/consultant designated for a specific provider. Providers will be contacted by phone in advance of a site visit or desk review. A list of charts for potential review will be provided by fax or electronically in advance of the scheduled visit, generally allowing three days notice to allow time to pull the requested charts. All site visits or office reviews will occur as scheduled. In the event that a scheduling conflict arises, the consultation will be rescheduled for the earliest possible date agreeable to all parties.

On-site or Desk Reviews

Consultants will conduct on-site or desk reviews with participating providers. As agents of the Bureau for Medical Services, consultants will explain the purpose of the consultation activities that may include interviews with key staff and a review of policies and procedures as well as the review of specific charts. The consultants will maintain confidentiality and providers are asked to provide an area for record review at their facility that is conducive to preserving confidentiality.

Exit Review

Upon completion of the consultation review, the consultant will conduct an exit review with provider staff. A summary of the initial findings will be discussed and areas for improvement will be identified. Consultants will also offer training on identified areas of need.

Provider Trainings

KEPRO offers training in venues and formats designed to meet the needs of providers. Training topics are identified by our contractors, consultation score results, and provider input. Training modules are developed through research and consultation to address the targeted areas. Training events may include lecture, panel discussion, question and answer sessions, and/or small group discussions or may be individualized for a specific provider.

KEPRO trainings may be statewide, regional, or provider specific. To accommodate the needs of our wide range of providers, trainings on some topics may be open to all interested parties (subject to facility limitations), while others may be offered by invitation only. While every effort will be made to provide adequate advance notice to providers, some trainings may require a short planning time frame to address pressing concerns and meet the needs of providers. Training announcements include the training topic, learning objectives, target population, dates, time, location, and continuing education information. Training information may be provided through phone calls, mailings, email, fax and/or website posting. A training module or topic objective will be established for all trainings, along with a roster of participants and completed evaluations.

New Provider Orientation

The provider orientation program is KEPRO'S first step in the development of long-lasting partnerships with providers. Orientation is offered to ensure that providers develop effective utilization management. During the initial implementation of the ASO process, KEPRO held extensive provider orientation trainings. As the ASO process continues, orientation with new providers is scheduled as they begin participation and with existing providers as new services

are established. Orientation activities are provided in the form of focused training or technical assistance, depending upon the needs of the provider.

Denials and Appeals

Denials of requests for service authorization will be communicated directly to both the member/guardian and the service provider. Denials may be further appealed by following established state procedures for Administrative or Fair Hearing Appeal. Below is the multi-step internal KEPRO denial process:

1) LEVEL ONE APPEAL

This process involves a physician review before a final determination of denial is made. The Level I Physician reviews the case based on available clinical data. The Level I physician may approve the request and an authorization will be issued or the physician may determine medical necessity is not demonstrated. The provider is notified of the decision to authorize or deny.

If the potential denial of service is for a WV Medicaid member under the age of 21, a Peer to Peer option is given to the provider before a denial is issued. A Peer to Peer discussion is a provider physician to Level One physician conversation related to the case. The provider must request a peer review within seven (7) business days of the initial physician decision to deny. The outcome of the peer review will lead to an authorization for the service or a Level One denial issued.

A denial notice will be sent to both the provider and member. The member will also receive a Fair Hearing form.

2) RECONSIDERATION (LEVEL II) APPEAL

The provider may request a Level II physician review within sixty (60) days of the first denial notice. The provider may submit additional documentation for consideration by the Level II physician reviewer. This reviewer is independent of the Level I reviewer. The outcome of this review will be authorization of the service or denial. There is no peer to peer option at this level. A denial notice will be sent to both the provider and member. The member will also receive a Fair Hearing form.

3) THIRD LEVEL APPEAL - The State External Appeal Process

Document/Desk Review for Provider

If a provider disagrees with the Level II appeal/reconsideration decision and has not been reimbursed for services provided, a Document/Desk Review may be requested with the Bureau for Medical Services regarding this case. A written request for a Document/Desk Review within thirty (30) days from receipt of the reconsideration decision should be sent to the address included in the denial notice.

State Fair Hearing for a WV Medicaid Member:

If the member has not received the service in question and disagrees with the denial decision, the member may appeal to the Bureau for Medical Services within 90 days of the

date of the denial notification. The Fair Hearing Form included with the denial notice should be completed and returned to the address on the form.

Treatment and Pay Considerations (per State guidelines)

During the appeal process, members already receiving the service(s) requested in the prior authorization request should continue to receive treatment. Regardless of the outcome of the Appeal, the service will be authorized through the duration of the appeal for those individuals who have received the denied service within the past ninety (90) days and for whom continuation of service was requested and denied. Medicaid coverage will continue during the course of the Appeal process. Providers will hold their claims for payment until the end of the process, at which time the Provider and Member will be notified of the duration and scope of reimbursable services.

If the recipient is new to the behavioral health system (i.e. individuals who have not received behavioral health services within the past ninety (90) days or who have not received the service specified in the prior authorization request) there is no assurance of coverage during the Appeal process. If Providers choose to render service, they do so at risk. Services rendered will only be covered if the reconsideration or appeal decision reverses the initial denial of service.

Claims Submission and Reimbursement

KEPRO is not responsible for accepting provider claims, claims/payment research, or other claims related inquiries.

The contracted State Medicaid intermediary has responsibility for claims payment for this program and receives an upload of approved service authorizations. Providers should continue to submit billing information and any questions regarding payment directly to the State's Medicaid claims payment intermediary.

Information Services

The Information Services Department is primarily responsible for provider technical assistance and training, as well as the compilation of data and its analysis for both internal and external standards and ad hoc reporting. Numerous monthly, quarterly and annual routine reports and a large variety of ad hoc reports are generated for the Bureaus of DHHR, other state agencies, providers and other stakeholders.

Activities of the Department include the following:

- Consultations with internal and external IS Coordinators.
- Manages and analyzes data for recommendations on system changes, utilization projections, and quality improvements.
- Design reporting formats and compiles/collects necessary data.
- Provides for tracking of clinical, consultation, quality and utilization data.
- Liaison to entities interfacing with the Behavioral Health CareConnection®.

ASO Reporting

The KEPRO ASO produces a variety of reports related to utilization management activities, service request authorization and pend rates, denials, utilization trends, and ad hoc reports for the Bureau for Medical Services. Reporting activities for the Bureau for Children and Families include monthly utilization, individual consumer reports related to transitional authorizations, and analysis of utilization trends. For the Bureau for Behavioral Health and Health Facilities, KEPRO provides a summary of records validated and forwarded to the Bureau, rates of eligibility, and quarterly reports regarding provider compliance with Federal Block Grant Reporting Requirements. Annually the tables required to complete the Federal Mental Health and Substance Abuse Block Grants are also submitted.

Quality Improvement

KEPRO is wholly committed to quality service and quality programs. Rather than relegating “quality” to a department on the organizational chart, we are committed to incorporating the principles of quality service and continuous quality improvement into each activity and program we undertake. Recognizing the only effective means to service and system excellence is through a deliberate, on-going effort.

To materially improve system performance, quality improvement efforts must be pervasive in every aspect of operation. The KEPRO integrated quality management strategy involves the monitoring and evaluation of measures related to all participants and functions. This approach unites members, families, providers, DHHR, and KEPRO, resulting in system wide flow of information from service recipient to policymaker, yielding higher satisfaction among all stakeholders.

APPENDIX I

Glossary of Terms, Abbreviations, Acronyms

- ASO – Administrative Services Organization chosen by the Department to develop and implement a statewide system of utilization management for specific healthcare services.
- Appeal– Following the Review and Reconsideration process, a request for KEPRO to change a decision it has made in regard to a care management denial of authorization for service.
- BMS - Bureau for Medical Services; the administrator of the Medicaid program for the State of West Virginia.
- BCF – Bureau for Children and Families
- BBHF – Bureau for Behavioral Health and Health Facilities
- CMS – Centers for Medicaid & Medicare Services (formerly HCFA); federal provider that regulates and contributes financial resources to State Medicaid programs
- Care Manager: KEPRO staff member, with a clinical background, who holds a degree and licensure in their field and is responsible for clinical review of service authorizations.
- Complaint - Dissatisfaction formally communicated, verbally or in writing, to any KEPRO staff by a Member or Provider that does not involve an authorization denial.
- Denial: A final decision by KEPRO, following the Review process and the Reconsideration process, to deny authorization for service.
- Department of Health and Human Resources (“the Department” or “DHHR”) – The State administrator of various programs, including Medicaid, that benefit the citizens of West Virginia.
- IS- Information Services, a department within KEPRO
- Member – A Medicaid recipient seeking services from an approved provider.
- Outcomes - A set of quantitative measures, which track the progress of the service delivery system toward the goals and the expectations of the member, and in accord with accepted practice and regulation.

- “Pended” or “Pending” –The status of a request for authorization that is flagged or held for clinical review based on data patterns discovered through the preliminary computer review against utilization guidelines.
- QI - Quality Improvement, the continuous process of planning, identifying, monitoring, analyzing results, instituting corrections and evaluating the progress of a system or organization.
- Renegotiation: Agreement between Provider and KEPRO staff regarding a change in service recommendation. The provider will be instructed to submit an authorization request for the negotiated service that will take the place of the service that was closed.
- Review: Status of an authorization request that has been pended for clinical review and is actively under discussion with Provider staff.
- Utilization Management - The prospective, concurrent or retrospective assessment of the medical necessity and appropriateness of services. Utilization management activities typically consist of service authorization, concurrent and retrospective reviews of treatment, and an effective care coordination process.
- Claims Payer - The Medicaid intermediary currently responsible for paying provider claims for the West Virginia Medicaid programs.